Quality, Safety & Experience Committee

Tue 29 November 2022, 09:00 - 12:00

Agenda

09:00 - 09:10
10 min

1. Standing Items

1.1. Welcome & Introductions

Susan Elsmore

1.2. Apologies for Absence

Susan Elsmore

1.3. Declarations of Interest

Susan Elsmore

1.4. Minutes of the QSE Committee Meeting held on 30 August 2022 and the Special QSE Meeting on 11 October 2022.

Susan Elsmore

- 1.4a Draft PUBLIC QSE Minutes 30.08.22MD.NF.SE.pdf (13 pages)
- 1.4b SPECIAL QSE minutes 11.10.22MD.NF.pdf (16 pages)

1.5. Action Log – Following the meeting held on 11 October 2022

Susan Elsmore

- 1.5 Draft QSE Public Action Log v2 - November.pdf (3 pages)

1.6. Chair's Action taken since last meeting

Susan Elsmore

- Approval of the Research Governance Policy (UHB 099)

- 1.6 Signed Request for Chairs Action (Research Governance Policy)_(1).pdf (2 pages)
- 1.6a RGG Minutes 6th July 2022.(4).pdf (8 pages)
- 1.6b RESEARCH GOVERNANCE POLICY for publication(1).pdf (21 pages)

09:10 - 11:25
135 min

2. Items for Review & Assurance

2.1. Medicine Clinical Board Assurance Report (including a Patient Story)

Jason Roberts / Meriel Jenney

25 minutes

- 2.1 Medicine Clinical Board QSE Assurance Report October 2022.pdf (18 pages)

2.2. Quality Indicators Report

Jason Roberts

10 minutes

2.2 QI November 22 - final v2.pdf (21 pages)

2.3. Maternity Services Update - Verbal

Jason Roberts

10 minutes

2.4. HIW Activity Overview Including:

Jason Roberts / Meriel Jenney

50 minutes

a) HIW Report regarding the Emergency Unit (30 minutes)

b) HIW Report from visit to Stroke Centre (10 minutes)

c) HIW Report regarding Cardiothoracic services (10 minutes)

2.4 HIW Activity Reports.pdf (21 pages)

2.5. BREAK – 10 minutes

2.6. CHC Reports

Jason Roberts / Meriel Jenney

5 minutes

The Community Health Council Full Reports can be found under the Supporting Documents folder on AdminControl & the CAV website.

2.6 Community Health Council Activity - QSE MTG - 29.11.22.pdf (3 pages)
2.6a Appendix 1 - CHC Scrutiny Dates.pdf (1 pages)

2.7. Board Assurance Report – Patient Safety

Nicola Foreman

5 minutes

2.7 BAF Patient Safety Covering report - 2022.NF (003).pdf (3 pages)
2.7a Patient Safety Risks.pdf (21 pages)

2.8. Corporate Risk Register

Nicola Foreman

5 minutes

2.8 Corporate Risk Register - QSE Update November 2022.pdf (4 pages)
2.8a Detailed Corporate Risk Register November 2022.pdf (3 pages)

2.9. Safeguarding Annual Report

Jason Roberts

5 minutes

2.9 Safeguarding Annual Report 2021-2022 (003).pdf (2 pages)
2.9a Annual Report 2021 22.pdf (45 pages)

2.10. Mortality Indicators Update

Meriel Jenney

10 minutes

2.10 Mortality Indicators 2022.pdf (5 pages)

11:25 - 11:35
10 min

3. Items for Approval / Ratification

3.1. Policies for ratification including:

10 minutes

1. *Concerns, Complaints, Claims Policy (UHB 332)*
2. *Medical Equipment Policy and Procedure (UHB 082)*
3. *Ionising Radiation Policy (UHB 344)*
4. *Exposure of Patients to Ionising Radiation Procedure (UHB 345)*
5. *Radioactive Substances Risk Management Policy (UHB 463) and Procedure (UHB 464).*
6. *Exposure of Staff and Public to Ionising Radiation Procedure (UHB 465).*
7. *Venepuncture for non-clinically qualified research staff Policy (UHB 364) and Procedure (UHB 365)*

- 3.1 Policies Cover Report v2.pdf (3 pages)
- 3.1.1a Concerns, Complaints, Claims Policy.pdf (51 pages)
- 3.1.1b Concerns, Complaints, Claims Policy EHIA.pdf (24 pages)
- 3.1.2a Medical Equipment Management Policy.pdf (7 pages)
- 3.1.2b Medical Equipment Management Procedure.pdf (31 pages)
- 3.1.3 Ionising Radiation Policy.pdf (3 pages)
- 3.1.4 Exposure of Patients to IR Procedure.pdf (22 pages)
- 3.1.5a Radioactive Substances RM Policy.pdf (3 pages)
- 3.1.5b Radioactive Substances RM Procedure.pdf (21 pages)
- 3.1.6 Exposure of Staff and Public to IR Procedure.pdf (19 pages)
- 3.1.7a Venepuncture for Non NMC Registered Research Staff Policy.pdf (2 pages)
- 3.1.7b Venepuncture for Non NMC Registered Research Staff Procedure.pdf (11 pages)

11:35 - 11:55
20 min

4. Items for Noting & Information

4.1. WHSSC QPSC Chair's Report

Nicola Foreman

10 minutes

- 4.1 WHSSC QPSC Chair's Report - August 2022.pdf (15 pages)

4.2. Minutes from Clinical Board QSE Sub Committees:

Jason Roberts / Meriel Jenney

1. *CD&T Clinical Board and Patient Experience Sub-Committee – 16 August 2022 & 20 September 2022*
2. *Medicine Clinical Board – 18 August 2022*
3. *Specialist – 27 June and 8 August 2022*
4. *Surgical – 19 July 2022 and 20 September 2022*
5. *Children and Women's Clinical Board – 30 August 2022*
6. *Clinical Effectiveness Committee*

- 4.2.1a CDT CB Minutes 16.08.22.pdf (14 pages)
- 4.2.1b CDT Minutes 20.9.22.pdf (14 pages)
- 4.2.2 Medicine CB Minutes 18.08.22.pdf (10 pages)
- 4.2.3 Specialist CB Minutes 08.08.22.pdf (6 pages)
- 4.2.4a Surgical Minutes 19.07.22.pdf (13 pages)
- 4.2.4b Surgical Minutes 20.09.22.pdf (12 pages)
- 4.2.5a C&W Minutes 30.08.22.pdf (9 pages)
- 4.2.5b C&W CB Minutes 27.09.2022.pdf (10 pages)

11:55 - 11:55
0 min

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

Susan Elsmore

11:55 - 11:55
0 min

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

i) *Private Minutes - 30 August 2022*

ii) *Any Urgent / Emerging Themes – Verbal*

iii) *Maternity Services Update – Ockenden Framework Review*

iv) *DNAR Orders at St. Davids Hospital Update*

11:55 - 11:55
0 min

7. Any Other Business

Susan Elsmore

11:55 - 11:55
0 min

8. Review of the Meeting

Susan Elsmore

11:55 - 11:55
0 min

9. Date & Time of Next Meeting:

Tuesday 10 January 2023 at 9am via MS Teams

11:55 - 11:55
0 min

10. Declaration

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

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 30 August 2022 at 09.00am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authorities / Chair of the Committee
Present:		
Gary Baxter	GB	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
Ceri Phillips	CP	Vice Chair of Cardiff and Vale University Health Board
In Attendance		
Claire Beynon	CB	Deputy Director of Public Health
Mike Bond	MB	Managing Director for Acute
Nicola Foreman	NF	Director of Corporate Governance
Abigail Harris	AH	Executive Director of Strategic Planning
Angela Hughes	AH	Assistant Director of Patient Experience
Meriel Jenney	MJ	Executive Medical Director
Helen Kemp	HK	Deputy Clinical Board Director - PCIC
Fiona Kinghorn	FK	Executive Director of Public Health
Anna Mogie	AM	Interim Deputy Director of Nursing - PCIC
Urvisha Perez	UP	Audit Wales
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Stephen Allen	SA	Chief Officer – Community Health Council
Observing		
Christopher Ball	CB	Ageing Well Programme Manager
Timothy Davies	TD	Head of Corporate Business
Urvisha Perez	UP	Auditor Audit Wales
Aron White	AW	Nurse Informatics Lead
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Marcia Donovan	MD	Head of Corporate Governance
Lisa Dunsford	LD	Director of Operations - PCIC
Akmal Hanuk	AH	Independent Member – Community
Rajesh Krishnan	RK	Associate Medical Director (Clinical Governance and Patient Safety)
Anna Llewellin	AL	Director of Nursing - PCIC
Fiona Kinghorn	FK	Executive Director of Public Health
Catherine Phillips	CP	Executive Director of Finance

QSE 22/08/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 22/08/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 22/08/003	**Declarations of Interest** No declarations were noted.	
QSE 22/08/004	**Minutes of the Committee meeting held on 15 June 2022** The minutes of the meeting held on 15 June 2022 were received. The Executive Nurse Director (END) advised the Committee that he had not agreed to Chair the POCT group and asked for the minutes to reflect that discussions were ongoing with the Executive Medical Director (EMD) and the Executive Director of Therapies and Health Sciences (EDTHS) as to who would chair the POCT group moving forward and work with the CD&T Clinical Board.	

	The Committee resolved that: a) The minutes of the meeting held on 15 June were approved as a true and accurate record of that meeting pending the above amendment.	
QSE 22/08/005	**Action Log following the Meeting held on 15 June 2022** The Action Log was received, and all ongoing actions discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 15 June 2022 was noted	
QSE 22/08/006	**PCIC Clinical Board Assurance Report** The PCIC Clinical Board Assurance Report was received. The Interim Deputy Director of Nursing – PCIC (IDDNP) presented the Committee with a Patient Story video which showed care home residents talking about their experiences with Covid-19 lockdowns and how it had affected them. The CC thanked the IDDNP for the story and noted that it had been very insightful and showed the isolation that had been experienced by the patients. The Chief Officer – Community Health Council (COCHC) asked if the video could be made available as it would be helpful to put onto the Community Health Council's website. The Senior Corporate Governance Officer sent the video to the COCHC. The IDDNP thanked all of the PCIC staff who had continued to work exceptionally hard to ensure safe care had continued within the community. The Committee was advised of the key issues identified within the PCIC Clinical Board Assurance Report. • Significant pressures had been seen due to increased demand and staffing shortages. It was noted that the teams had worked flexibility and had been deployed to other areas to help mitigate risks. • There had been significant pressures on the Primary Care team due to the General Medical Services (GMS) sustainability issues and it was noted that there were now increased risks in Dental services and further action would need to be taken to secure additional staff and suitable premises. • Deaths in HMP Cardiff - it was noted that to improve integrated working across general and Mental Health teams working within the Prison, a new Head of Healthcare post had been established. It was noted that all deaths within the Prison were investigated under the NRI, HIW and the Public Services Ombudsman with any lessons learned being subject to action plans monitored via the Quality, Safety and Experience Committee. • Covid testing and immunisation -it was noted that teams continued to deliver against all national requirements and more than 1,300,000 vaccines had been delivered. The Committee was advised that the Autumn boosters would commence from 1 September 2022 and that there had been an internal audit of the immunisation delivery and reasonable assurance had been received. • The Health and Social Care (Quality and Engagement) (Wales) Act 2020 would need to be implemented from Spring 2023. It would impose several new duties on all Clinical Boards, including PCIC, particularly around the Duty of Quality and the Duty of Candour aspects of the Act. It was noted that the Act applied to both managed and commissioned services which added greater complexity to effective implementation within PCIC. • The Medical Examiner Service was due to be fully implemented for all non-coronial deaths (in hospital and in the community) from April 2023. It was noted that local implementation	

	arrangements for the Mortality Review process were being developed in line with the Mortality Review Model Framework issued by the Delivery Unit in July 2021. • A large amount of work was being undertaken around menopause, spirometry to improve patient pathways within GP practices. • Acute Response Team – it was noted that due to a change in the staffing position within the team, a review of the governance underpinning the anticoagulation arm of the ART service was undertaken. A decision had been taken to suspend all new anticoagulation referrals into the service from Secondary Care. Interim arrangements were currently in place for other Clinical Boards to retain the dosing and prescribing responsibility until the patient was stabilised and could safely be transferred over to and accepted by Primary Care. The IDDNP concluded that a lot of work had been undertaken by the PCIC Clinical Board since an assurance report was last presented to the Board and noted that in particular the Optometry team led by the PCIC Optometric Advisor had undertaken a huge volume of work around patient pathways for digital retinal screening. She added that that the Optometry team had been nominated for a number of national awards for their work. The Deputy Clinical Board Director – PCIC (DCBDP) reiterated what the IDDNP had stated and thanked all staff for the huge amount work put in during the face of Covid-19, staffing issues and noted their incredible resilience. The Managing Director for Acute (MDA) advised the Committee that due to the hard work seen within the PCIC Clinical Board, it had helped with the management of flow into the acute arena and thanked staff for their input. The UHB Vice Chair advised the Committee that the work within the PCIC Clinical Board had not received the recognition deserved and noted that due to his work with the Welsh Health Specialised Services Committee he had a good understanding of the issues within PCIC and the unprecedented pressures seen. He added that it was worth mentioning the great work undertaken by the Cardiff and Vale Health Inclusion Service (CAVHIS) which was led by a group of dedicated professionals working with patients not normally mentioned, such as sex workers and refugees. It was noted that the work done by CAVHIS was vital because the vulnerable groups put great pressure on A&E and secondary services, so the way in which CAVHIS manage the patients helped to reduce demand there. The CC advised the Committee that the spotlight was often on the PCIC Clinical Board and noted that the assurance report was only provided once a year. Hence discussions would be required offline to identify the balance of reporting and how to reveal and highlight all of the work that was being undertaken by the Clinical Board as it worked well alongside Secondary Care. The DCBDP noted that the PCIC was trying to work with the Welsh Health Specialised Services Committee (WHSSC) to see if they would consider all Wales funding and added that work was also being looked at to work with Health Education and Improvement Wales (HEIW) on the sub specialities in general practice from an MDT perspective. **The QSE Committee resolved that:** a) The current position and also the actions taken since the previous report to strengthen assurance and manage risks within PCIC Clinical Board, were noted.	
QSE 22/08/007	**Quality Indicators Report** The Quality Indicators Report was received. The Assistant Director of Patient Experience (ADPE) advised the Committee that she would take the report as read and would highlight some key areas which included:	

- Concerns – There were increasing numbers per month - up to 446 which was considerably high. However an overall 30 working day response time was achieved for all concerns, which had remained consistent at 82%.

- Ombudsman case - From 1st April 2022, the Health Board dealt with 37 Ombudsman's cases, with 15 currently under investigation.

- Nationally Reportable Incident (NRI) – It was noted that there was a backlog with NRI closure forms but that a development of an improvement trajectory had been undertaken to see a sustained improvement in the closure of cases whilst maintaining the quality investigations and the learning/improvement plans.

- Pressure Damage – The ADPE advised the Committee that a lot of work had been undertaken to reduce hospital acquired pressure damage and that as the quality indicators were built upon, the overall picture could be viewed.

- The Quality, Safety and Experience Framework – The Committee was advised that a lot of elements of the Framework were now being implemented across the Health Board.

- Compliance with Patient Safety Notices (PSN) – The Committee was advised that the Health Board was not fully compliant with 2 PSNs. However, both had been progressed and the Health Board will be compliant with all Health Board actions by December 2022.

- Hospital Infections – The Committee was advised that there was a reduction expectation position for 2022/23.

- Patient Feedback – It was noted that over 31,000 people used the feedback machines in the Mass vaccination Centres and that 98% rated their care as very good/good

- Preparation for the Duty of Candour and the Duty of Quality – It was noted that the team was currently working on staff awareness and the organisational preparation for implementation of the Duty of Candour (DOC).

  It was noted that a steering group had been established to commence in September 2022, with several task and finish groups to ensure the Organisation was ready for the implementation of the DOC.

  The ADPE advised the Committee that the vision was for live data reporting of quality metrics.

The CC asked when it would be likely to achieve live data and analysis.

The END responded that information around that would be raised later on in the meeting when discussing the Tenables Quality Dashboard Presentation.

The CC asked how compliance would be reported to the QSE Committee around the PSNs.

The Assistant Director of Quality and Patient Safety (ADQPS) responded that they would be brought to every QSE Committee.

The Director of Corporate Governance (DCG) advised the Committee that the Audit and Assurance Committee also tracked the PSNs.

The END advised the Committee that the amount of work being undertaken by the ADPE and their team was huge and noted that the Health Board had the lowest cases being investigated by the Ombudsman, which was reflective of the way complaints were handled by the teams.

He added that the NRI work was also reported monthly to Welsh Government (WG) and the Delivery Unity (DU).

The END concluded by raising his concerns regarding staffing levels and advised the Committee that it was being monitored closely.

The QSE Committee resolved that:

	a) The content of the report and the developing process to monitor Quality Indicators was noted.	
QSE 22/08/008	**HIW Activity Overview to include:** *1) HIW report relating to WAST and review of patient safety, privacy, dignity and experience whilst waiting in ambulance during delayed handovers.* The Health Inspectorate Wales (HIW) Activity Overview was received. The ADQPS advised the Committee that the report picked up any inspections or reviews that had taken place since the last report to the Committee, as well as providing an update with respect to the HIW, Welsh Ambulance Service (WAST), Emergency Unit (EU) handover inspection that was undertaken in 2021. She added that she would take the paper as read and would identify the salient points which included: • Inspection in Cardiothoracic Surgery ward at Llandough Hospital (UHL) where HIW found that the service provided safe and effective care and that patients were very complimentary of the staff. It was noted that there were a number of recommendations made in relation to general estates, the layout of the ward, the location of the resuscitation trolley and compliance with mandatory training, as well as displaying of patient information, in particular with respect to raising concerns. An action plan was developed and was put in place. • An update had been provided on the action plan developed to address the recommendations made through the thematic review of the WAST and EU handover. It was noted that it had been a national review and that whilst the pressures at the front door continued both in the Health Board and nationally, the improvements identified to address the recommendations from HIW had largely been completed and were being implemented. • Primary Care Contractor Reviews – The ADQPS advised the Committee that it was important to note that the responsibility for implementing any improvements and recommendations that had been identified as a result of reviews sat firmly with the independent contractor. However information could be provided to assure the Committee that the reviews were all very positive, both in Dental and in General Practice. • Unannounced three-day inspection of the EU in June 2022. It was noted that as a result of that inspection a number of immediate assurance recommendations were made and that whilst the report was yet to be published the team had responded in regards to factual accuracy. It was noted that once the report was published, it would be brought back to the Committee with a full action plan, time scales and the relevant leads associated with each action. The Executive Medical Director (EMD) advised the Committee that the HIW inspection of EU feedback had been slightly kind and noted that the Health Board was seeking to exceed the recommendations they had put in place and to focus on important issues such as drug storage, patient experience and the significant problems of flow through the EU. The MDA agreed with the EMD and noted that the gravity of the current situation did not come through in the feedback report and noted that the Health Board was going into the Winter with many different variables, such as union strikes and the increased cost of living etc. He added that the teams were starting to formulate plans around that and noted that it was important to be open and honest with the Committee. The UHB Vice Chair thanked the staff working on the implementation of actions and noted that it was reassuring to see that the teams were not relying on HIW reports to identify where the problems were and that the teams were being proactive in recognising what was required.	**JR/AO**

	The QSE Committee resolved that: a) The level of HIW activity across a broad range of services was noted. b) The assurance provided by the improvements implemented and by the processes to monitor and audit the improvements was noted. c) It was agreed that the appropriate processes were in place to address and monitor the recommendations.	
QSE 22/08/009	**Community Health Council Activity Review** The Community Health Council Activity Review was received. The END advised the Committee that the Health Board had asked for an oversight of CHC activities and that this was the first report received by the Committee. It was noted that the CHC engagement and feedback with the Health Board consisted of three areas which included: • Announced Scrutiny Visits • Unannounced Scrutiny Visits • Service Reviews The Committee was advised that the CHC had suspended announced scrutiny visits during the Covid-19 pandemic and had recommenced them in Quarter 2. It was noted that the CHC had provided the Health Board with the final reports and recommendations to three areas which included: • Ward B1 Cardiology, UHW - CHC Visit Final Report • Lakeside Wing, UHW - CHC Final Report • Stroke Rehabilitation Unit, UHL - CHC Final Report It was noted that a number of themes had been identified within the reports and that the main themes included: • Visiting restrictions • Lack of Day Room and TV facilities • Lack of Quiet Room • Improvement to showering facilities for patients with mobility issues • Improved storage facilities The END advised the Committee that the full reports were available to view if required. The COCHC thanked staff and patients who had engaged with the CHC during their visits and noted that the comments coming from patients around the quality of care from staff was very apparent. He added that sometimes the “small things” could be forgotten such as staff saying “good morning” to patients and noted that they were an important step to make patients feel valued.	

	The contents of the report and the CHC feedback and recommendations. **The QSE Committee resolved that:** a) The contents of the report and the CHC feedback and recommendations were noted.	
QSE 22/08/010	**Quality, Safety and Experience Implications arising from IMTP** The Quality, Safety and Experience Implications arising from IMTP were received. The ADPE advised the Committee that QSE was a golden thread running throughout the IMTP. It was noted that there was a lot of focus on Primary Care in order to reduce the need for patients to go into hospital. It was noted that the Health Board had developed a five-year QSE framework with frontline staff, patients, carers, relatives and external regulators with a focus on quality, safety and the patient experience, extended across all settings where healthcare was provided. The ADPE advised the Committee that the framework aligned very well with the IMTP. The progress of the IMTP was about ensuring it was a good and safe experience for people with a focus on Primary Care. **The QSE Committee resolved that:** a) The alignment of the QSE Framework and the IMTP as set out in the report was noted.	
QSE 22/08/011	**Update on Falls** The update on Falls was received. The ADQPS highlighted a number of key points. It was noted that inpatient falls had decreased to between 4.97 and 5.97 per thousand bed days. It was noted that falls were reported as a proportion of the number of patients that the Health Board had in hospital beds at the time which allowed benchmarking nationally. It was noted that in 2020 the falls data was ranging between 6.6 and 7.35 per thousand bed days and that the current improvement could be attributed to the impact of focused improvement initiatives taken forward through the Falls Delivery Group, such as the shared learning through the Falls review panel and better engagement in patient falls training. The ADPQS advised the Committee on injurious falls reportable to WG. It was noted that hip fractures sustained as an inpatient had reduced from 10.37% of all Health Board hip fractures recorded on the National Hip Fracture Database in April 2016 to 5.41% in April 2022. That was a significant achievement and there was a continued reduced trajectory. It was noted that, as recommended by the Royal College of Physicians, the Health Board continued to hold a regular Falls Review Panel in order to provide scrutiny of completed falls investigation reports. Feedback was provided directly to Clinical Boards and organisational learning from inpatient falls was shared throughout the Health Board via an infographic. It was noted that themes from falls incidents had been fairly consistent and included the following: • lack of knowledge, • deviation from guidance, • need for training, • lack of orthostatic hypotension assessment, • MFRA not completed at correct time, • lack of evidence of medication review • deviation from bed rails and enhanced supervision guidance. The ADQPS advised the Committee that falls were not currently part of the mandatory training for Health Board employees and that the Falls Delivery Group was proposing that falls training was	

	included in the mandatory training list and an e- learning module had already been prepared by the outgoing Patient Safety Organisational Learning Manager. It was noted that the Community falls and that attendances in the EU, as a result of falls, were increasing. It was noted that WAST had a project in place to support picking up patients and to try and put in place some early interventions to prevent future falls, but also to avoid hospital admission. The ADQPS advised the Committee that one of the very significant pieces of work that had been in place for a number of years was the Stay Steady Clinics. It was noted that the Stay Steady Clinics were established through partners on the Delivery Group in 2018 and they were run by Health Board physiotherapists, and offered a multi-factorial assessment of falls risks for individuals who had been screened as suitable for the Clinic. The Committee was advised that the participation in the national audits continued, with latest data from the National Audit of Inpatient Falls provided within the report. It was noted that the Health Board's performance had improved from 64% in 2021 to 81% of cases where patients had been checked for injury before being moved and exceeded the National Audit of Inpatient Falls (NAIF) overall performance. It was noted, however, that cases where a safe manual handling method was used had dropped from 100% to 25%. The CC commended the report and noted Cardiff Council had been running a falls project for a long time and had met with WAST because of the service they provided which was an avoidance of ambulatory support required. The ADQPS noted that the Cardiff Council falls project was a key member of the delivery group and that the Falls Delivery Group functioned as a multi-agency and multi-disciplinary group. **The QSE Committee resolved that:** a) The assurance provided by the Process and quality data was noted.	
QSE 22/08/012	**Tendables Quality Dashboard Presentation (Verbal)** The Tendables Quality Dashboard Presentation was received. The END advised the Committee that it had previously been discussed that it would be useful to bring a suite of indicators to the Committee and that the information received today was to provide assurance to the Committee that software would now be used to provide quality data which could be easily translated and interpreted into a dashboard format for the Committee. The Nurse Informatics Lead (NIL) provided the Committee with a demonstration as to how the application Tendable would work. He advised the Committee that Tendable was an audit and inspection app and provided a view of the EU audits. It was identified that staff visiting the EU department could log into the Tendables application and answer various questions about the EU such as: • What is happening now? • Patient Questions • Staff Experience • Environment and Facilities The NIL noted that the inspection was then logged and could be processed into data, such as charts, tables and reports.	

	The END advised the Committee that the application would help with the Independent Member Patient Safety Walkaround's (PSW) and noted that training would be provided so that they could use the application. The NIL advised the Committee that at present over 900 audits had been undertaken on the Tendables app in 20 Clinical areas. He added that in September 2022 a new model would be introduced whereby each Clinical area would have: • Core standards audit – A suite of questions that were applicable to all areas regardless of speciality • Infection, Prevention and Control – A suite of questions that were applicable to all areas regardless of speciality. • Care Specifics – Specific questions for specific areas which could be turned on or off depending on what monitoring was required. The NIL reiterated that all of the data could be collected and then correlated into charts, tables and reports to then provide assurance to the QSE Committee and to the Board where appropriate. The Independent Member – Third Sector (IMTS) advised the Committee that the application would prove very useful on Patient walkarounds. She noted that the data received showed the Nursing data and asked if there was data for facilities staff, such as porters and cleaners. The NIL responded that at the moment, data was not available for other staffing groups but it would be in the future. The IMTS asked how confident the NIL was that staff who had raised concerns within the application would receive a timely response and that they could be as honest as possible with answers. The NIL responded that it was mainly the Red-Cross team in EU asking the questions to staff and logging their responses on the application which generated more honest responses from staff. He added that the Senior Lead Nurses for the department has set up a notification on the app so that once an audit was completed, the results could be reviewed in real-time. The Director of Corporate Governance noted how it would be beneficial in terms of saving time writing up the reports following the PSW visit. The COCHC asked if the information from Tendable could be shared with the CHC to help inform their visits. The CC responded and asked the DCG if there would be any problems with sharing Health Board data to an external body. The DCG responded that there was no issue with data being shared as it was not Patient Identifiable. The END added that there were different levels of observation within the application and so data could be given to external areas such as the CHC and HIW. He concluded that the application would improve PSW data and also improve audits within the departments which would bring everything together into once place which would provide beneficial assurance to various Committees of the Board. Saunders.Nathan 28/11/2022 15:01:12 **The QSE Committee resolved that:** a) The Tendables Quality Dashboard Presentation was noted.	
QSE 22/08/013	**Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response**	

	The Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response was received. The Auditor for Audit Wales (AAW) advised the Committee that Quality Governance Report was presented to the Audit and Assurance Committee in July 2022 where it was noted that the QSE Committee should receive it as well. It was noted that Audit Wales looked at whether the Health Board's governance arrangements supported the delivery of high quality, safe and effective services. The AAW noted that Audit Wales had examined both the operational and corporate approach to Quality Governance. She advised the Committee of some key points within the report which included: • It was found that the Health Board had agreed quality and safety priorities but that there was scope to better align those to operational and corporate priorities. • It was found that risks were managed appropriately but that there were opportunities for improvement arrangements for the monitoring of mortality. • It was noted that morbidity reviews had been developed but significant improvement would be required for Clinical audit. • It was found that the Health Board had a well-established values and behaviours framework but that more work was needed to develop an open and supportive culture. • The departure of key Clinical Executives potentially posed a risk to rolling out and embedding the new Quality, Safety and Patient Framework but it was noted that the Health Board had allocated additional resource to help achieve its goals. • The oversight and monitoring arrangements for quality and safety was good and the use of data had matured well but there were opportunities for the QSE Committee agendas to be more dynamic to reflect new and emerging quality risks. The AAW advised the Committee that seven recommendations had been made by Audit Wales which could be reviewed by the Committee and she thanked staff for supporting the review. The DCG advised the Committee that the Audit Wales report was a fair reflection of where the Health Board was and noted that since the publication of the report, a number of areas had progressed. She added that the agenda could be updated and would be picked up at the next agenda setting meeting for the QSE Committee. **The QSE Committee resolved that:** a) The Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response was noted.	**NF**
QSE 22/08/014	**Board Assurance Framework – Patient Safety** The Board Assurance Framework – Patient Safety was received. The DCG advised the Committee that there were currently nine key risks on the BAF, agreed by the Board in May 2022, which were impacting upon the Strategic Objectives of the Health Board. It was noted that Patient Safety and Workforce were two of those key risks. The END advised the Committee that to move forward and reduce the risk in Workforce, recruitment of staff would have to be significant. He added that the CEO had offered a sobering but transparent story at the last Board meeting around the difficulties seen within workforce numbers and noted that it was very difficult to navigate improvement within that.	

	It was noted that international recruitment had continued as well as streamlining from Universities, but noted that the gap still remained. The END advised the Board that a piece of work on retention was ongoing with a focus on an all Wales basis and that conversations being held with Nursing colleagues across Wales as well as internally to the Health Board. The CC advised the Committee that the risks could be reviewed as per the recommendation with the aim to provide the Board with assurance that the QSE Committee would be looking at recruitment concerns at every meeting. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety and Workforce to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety, was reviewed.	
QSE 22/08/015	**Annual Letter from the Ombudsman** The Annual Letter from the Ombudsman was received. The ADPE advised the Committee that the letter was received every year and that this year's letter provided a positive picture for the Health Board. She added that there would be over 4,000 concerns received by the end of the year and that so far only 9 cases had been reviewed by the Ombudsman which was testament to the team and the Health Board. It was noted that the Board had received the Annual Letter from the Ombudsman. **The QSE Committee resolved that:** a) The Annual Letter from the Ombudsman was noted	
QSE 22/08/016	**Interventions not normally undertaken (INNU) policy and intervention list** The Interventions not normally undertaken (INNU) policy and intervention list was received. The Deputy Director of Public Health (DDPH) advised the Committee of the changes made to the INNU policy and she provided Members with the refreshed INNU policy and list together with an accompanying Equality Impact Assessment. It was noted that a full day session to complete an Equalities Impact Assessment (EQIA) of all the documentation was undertaken on 26 August 2022 with input from the Equalities Team, the Individual Patient Funding Team, the Public Health Team and invitations were sent to the Staff Networks as an opportunity to consider how the policies could impact on different groups of people. **The QSE Committee resolved that:** a) The refreshed INNU policy and INNU list was adopted.	
QSE 22/08/017	**Unpaid Carers Charter** The Unpaid Carers Charter was received. The Executive Director of Strategic Planning (EDSP) advised the Committee that unpaid carers played a very important role in supporting individuals and that without them, there would be a huge impact in terms of the amount of care that would be provided to individuals. The population needs assessment produced had identified that there were just over 50,000 unpaid carers in the system. It was noted that pre-pandemic, there was a Regional Carers work stream which sat under the Regional Partnership Board (RPB) to oversee and support work around unpaid carers. As part of the group's action plan a draft Unpaid Carers Strategy had been developed. However, due to the pandemic the board was paused, and the Unpaid Carers Strategy was never published.	

	It was noted that since January 2022, the group had reconvened as the Unpaid Carers Board, acting as a programme board for the RPB work in relation to unpaid carers and to develop the strategy into what became the Unpaid Carers Charter. The EDSP advised the Committee that she would take the paper as read and welcomed any questions. The Ageing Well Programme Manager (AWPM) advised the Committee that at the core of the Unpaid Carers Charter was a set of commitments for the Health Board to provide support to unpaid carers with the hope to also identify more unpaid carers and to help them recognise that they were indeed, unpaid carers. The EDSP advised the Committee that there were 4 priorities identified within the Charter which included: • Priority One - Identifying and valuing unpaid carers – all unpaid carers to be valued and supported to make an informed choice about the care they provide and to access the support they needed whilst caring and when the caring role came to an end. • Priority two - Providing information, advice and assistance – it would be vital that all unpaid carers had access to the right information and advice at the right time and in an appropriate format. • Priority three - Supporting life alongside caring – all unpaid carers must have the opportunity to take breaks from their caring role to enable them to maintain their own health and well-being and have a life alongside caring. • Priority four - Supporting unpaid carers in education and the workplace – employers and educational / training settings should be encouraged to adapt their policies and practices, enabling unpaid carers to work and learn alongside their caring role. **The QSE Committee resolved that:** a) The RPB Unpaid Carers Charter was endorsed.	
QSE 22/08/018	**Exception Reports (Verbal)** The END advised the Committee that there were no further reports to add. **The QSE Committee resolved that:** a) The Exception Reports item was noted.	
QSE 22/08/019	**Minutes from Clinical Board QSE Sub Committees:** **Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 22/08/020	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The DCG advised the Committee that a lot of the risks had been identified in the issues discussed during the meeting and noted that 15 out of the 20 risks on the CRR were linked to, or had patient safety elements associated with them. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates, were noted.	

QSE 22/08/021	**Items to bring to the attention of the Board / Committee** The DCG advised the Committee that the Board should be informed around Patient Safety and the Health Board's challenges moving into the Winter period.	**DCG**
QSE 22/08/022	**Agenda for Private QSE Meeting** *i) Minutes of the Private Committee Meeting held on – 12.04.22* *ii) Pandemic Update & Any Urgent / Emerging Themes – Verbal* *iii) Cardiac Surgery Report Update* *iv) DNAR Orders at St David's Hospital – Update*	
QSE 22/08/023	**Any Other Business** The Executive Medical Director (EMD) advised the Committee that Dr Rajesh Krishnan had been appointed as Deputy Medical Director for Swansea Bay University Health Board. She thanked him for all of his hard work and wished him well in his new role.	
	Date & Time of Next Meeting: Special Meeting - Tuesday, October 11th 2022 via Teams	

Minutes of the Special Quality, Safety & Experience Committee
Held on 11 October 2022
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authority / Chair of the Committee
Present:		
Gary Baxter	GB	Independent Member – University
Akmal Hanuk	AH	Independent Member – Local Community
Mike Jones	MJ	Independent Member – Trade Union
Ceri Phillips	CP	Vice Chair of Cardiff and Vale University Health Board
In Attendance		
Stephen Allen	SA	Chief Officer of the Community Health Council
Tina Bayliss	TB	Director of Operations for Surgical Clinical Board
Paul Bostock	PB	Chief Operating Officer
Jayne Catherall	JC	People Experience Lead - Digital Narrator
David Scott-Coombes	DSC	Clinical Board Director - Surgical
Emma Cooke	EC	Clinical Director of Allied Health Professionals
Daniel Crossland	DC	Director of Operations – Mental Health Clinical Board
Mark Doherty	MD	Director of Nursing – Mental Health Clinical Board
Nicola Foreman	NF	Director of Corporate Governance
Michelle Fowler	MF	Patient Experience Lead
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Andy Jones	AJ	Director of Nursing – Children & Women's Clinical Board
Fiona Kinghorn	FK	Executive Director of Public Health
Suzanne Rankin	SR	Chief Executive Officer
Jason Roberts	JR	Interim Executive Nurse Director
Clare Rowntree	CR	Clinical Board Director Women and Children's
Alex Scott	AS	Assistant Director of Quality Safety
Vicky Stuart	VS	Complaints Manager
Clare Wade	CW	Director of Nursing for Surgical Clinical Board
Observing		
Tara Cardew	TC	Interim Head of Patient Safety and Quality
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Marcia Donovan	MD	Head of Corporate Governance
Neil Jones	NJ	Clinical Board Director – Mental Health

QSE 22/10/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 22/10/002	**Apologies for Absence** It was noted that the Executive Director of Therapies & Health Sciences would need to leave the meeting before it concluded and that the Clinical Director of Allied Health Professionals would join in her place. The Vice Chair of the University Health Board (Vice Chair – UHB) advised the Committee that he would need to leave the meeting early.	
QSE 22/10/003	**Declarations of Interest** No declarations of Interest were noted.	

QSE 22/10/004	**Chair's Action taken since the last meeting** No Chair's Actions had been taken since the last meeting.	
QSE 22/10/005	**Thematic Reviews** The CC advised the Committee that 4 presentations would be received which consisted of: • Maternity / Neonatal • Mental Health • The Five Harms • Emergency Department The Assistant Director of Patient Experience (ADPE) advised the Committee that each of the Clinical Boards would present their Thematic Reviews which would include their biggest challenges and some of the assurance that could be given around the mitigation measures which had been put in place. **Maternity / Neonatal:** The Maternity / Neonatal Thematic Review was received. The Director of Nursing – Children & Women's Clinical Board (DNCW) advised the Committee that the Thematic Review would cover a number of areas that had been looked at over the past 12 months. Those included: • Quality & Safety data. • The Ockenden and National Investigation Maternity/Neonatal Reports. • A summary of the baseline position against recommendations. • Areas of Good Practice • Areas in progress • Live areas that required resolution • The Clinical Board's approach and next steps It was noted the Children and Women's Clinical Board (CWCB) had ten open Nationally Reportable Incidents (NRIs) with 4 being overdue and 2 closed with the Delivery Unit (DU) in September 2022. The DNCW added that of the 4 overdue NRIs, 3 would be closed in October 2022. It was noted that 7 of the 10 NRIs related to Obstetrics and 3 to Neonates. The Committee was advised that in terms of concerns and complaints received by the CWCB the most significant number related to Clinical treatment and assessment, but it was noted that the majority of concerns were resolved through an early resolution mechanism. It was noted that 86% of concerns were closed within 30 working days. The DNCW advised the Committee that in relation to Redress (which meant cases where there was or could be a qualifying liability), the CWCB had 6 open cases between August 2021 and August 2022. He added that the main theme of the Redress cases was in relation to the documentation challenges within Obstetric theatres. Those had been driven by a rise in instrumental assisted birth deliveries. It was noted that new National Institute for Health and Care Excellence (NICE) guidance was released in 2021. That had resulted in the vast majority of births requiring assisted delivery which put additional complexities into the system. The DNCW advised the Committee that there had been a number of standardised reviews. One of those included the National Perinatal Mortality Review which had identified that the	

Health Board had 24 intrauterine deaths in 2021 which were reviewed and noted that 23 out of 24 had demonstrated good care.

It was noted that a number of themes had been identified from the Review which included:

- 68% of births had been identified as small for gestational age (SGA).
- 29% of stillbirths were black and minority ethnic backgrounds
- The total number of pregnant smokers was 11%, of which 2% had a stillbirth
- Inconsistent writing of discharge letters.

The Committee was advised that actions had been put in place or had been planned which included:

- The CWCB had worked with the Sands Charity, a charity that supported parents with bereavement.

- The CWCB looked at how the Welsh Government (WG) Maternity Neonatal Safety Improvement Network would impact and help with improvement.

The DNCW advised the Committee that mortality data had not deviated significantly and that the Health Board was not an outlier in relation to mortality.

He added that during 2022 there had sadly been 3 maternal deaths, but noted that they did not appear to have significant learning at present as investigations were still underway.

It was noted that Committee Members would be aware of various national reports, such as the Ockenden Report, and the Cwm Taf Report which had looked at difficulties in Maternity and Neonatal care.

The DNCW noted that the Health Board had looked at where Maternity services stood in relation to those reports and identified that changes in Clinical Practice with rising Caesarean and instrumental delivery rates in line with NICE guidance would drive resource and operational context.

He added that in relation to the Ockenden Report, 89 recommendations were identified. The Health Board had undertaken a self-assessment exercise and had drawn up a compliance plan. That plan identified the required resource across Maternity and Neonatal services in order to bring the Health Board in line with the recommendations.

Areas of good practice were presented to the Committee and included:

- Digital Midwife
- Work to improve culture recognised by HEIW since 2020
- Quarterly reviews of local assurance against Cwm Taf framework
- Joint Chairs of Maternity Professional Forum –Consultant Midwife and Obstetrician
- Prompt programme informed by local incidents and updated annually
- Pre-term birth support

The DNCW advised the Committee of good practice in respect of safety which included:

- Clinical Supervision of midwives
- A good reporting culture
- MDT working and learning from events
- Joint (maternity and neo-nates) Risk and Governance Forum and Q and S Forum
- Patient involvement in investigations

He added that there were some gaps against the recommendations from the Ockenden Report which included:

- Lack of full-time risk Midwives
- Corporate Safety Team cover required extension
- Learning from events needed to happen within 6 months

- There was no pre-conceptual service for women with pre-existing medical disorders – NICE hypertension guideline
- The flow of neonatal Transitional Care

The DNCW advised the Committee of good practice regarding Quality and Experience which included:

- Staff Voices and Sharepoint
- Staff wellbeing and Patient Communication

He added that there were some gaps against the recommendations which included:

- The need for Psychology support – NICU and Obstetrics
- Inequity of bereavement support across the Maternity and Neonatal system
- Transitional Care/NICU –Capacity, flow and Patient experience.

The Committee was advised of areas that required resolution:

- Lack of Consultant sessions to extend to resident labour ward presence 12 hours per day and review within 14 hours of emergency admissions.
- Lack of Job Planned time for maternity governance- RCAs and NRIs in Obstetrics, Neonates and Midwifery
- Investment into Senior Midwifery Workforce - Development of core team of senior Midwives trained in HDU care.
- Psychology Support
- Development of a Consultant Led Neonatal Transitional Care Service

The DNCW concluded that the approach that would be taken by the CWCB and next steps included:

- Establishment of an Ockenden Oversight Group
- Resource requirements had been recognised and were live but were currently unresolved
- MatNeo Safety Programme Welsh Government programme was new and was being launched with champions throughout each Health Board in Wales.
- Workforce challenges being improved upon.

The Independent Member – University (IMU) noted that workforce challenges had been noted as part of the next steps presentation and asked what the challenges were in relation to recruitment, retention and turnover.

The DNCW responded that the CWCB were not out of line with any other area within the Health Board, but noted that there was only one outturn of student Midwives per year which was never enough.

He added that the Health Board had just recruited 29 Midwives which was an over establishment. That was also replicated in Paediatric Nursing which should help with challenges being faced.

It was noted that due to the Covid-19 pandemic a number of people had left the Midwifery profession and that resilience had reduced.

The IMU noted that he had concerns around Senior Midwifery staff.

The DNCW responded that the challenges being seen covered all levels of experience, but agreed that Senior Midwifery staff were vitality important in terms of training new and unqualified staff as well as other MDT members.

It was noted that to help with those challenges, a number of recruitment events had been held and more were due to be held.

The Independent Member – Trade Union (IMTU) advised the Committee that he had been interested to see that 'Staff Voices' had been set up and he asked how much input staff had on that and how the CWCB fed back to those staff.

The DNCW responded that a QR code was available to all staff who could leave feedback and comments either publicly or anonymously.

He added that the data and information was collected and reviewed regularly and it was fed back on the CWCB Sharepoint page which could be accessed by all staff.

The END advised the Committee that he would work with the Executive Director of People & Culture (EDPC) to look at a wider piece of work regarding Midwives and retention.

He added that assurance could be provided with regards to Maternity services. The Ockenden Review Panel was in place and he would oversee the gap analysis which would be taken to the Senior Leadership Board for review and then to the QSE Committee for further scrutiny.

The Clinical Board Director for Women and Children added that in relation to the loss of Senior Midwifery staff, the Health Board had managed to recruit a number of senior staff from England. She added that retention issues were more challenging in NICU than in Maternity and added that a strategy was being implemented to support staff.

Mental Health:

The Mental Health Thematic Review was received.

The Director of Nursing – Mental Health Clinical Board (DNMH) advised the Committee that 6 months ago Members had been informed of the challenges encountered in the Mental Health Clinical Board (MHCB).

He added that a thematic review had been conducted at the time by the Consultant Nurse for Complex Clinical risk. That review had generated a suite of actions within the MHCB and was called the Inpatient Safety and Stability Programme.

It was noted that Clinical Risk in Mental Health did not just exist within the inpatient setting but due to the position 6 months ago, the thematic review was mainly based around the inpatient setting due to what was described as a "cluster of suicides".

The DNMH presented the Committee with a summary of the thematic review of inpatient suicides.

He described the personal factors involved which included:

- Perception of lack of social support
- Stressful life events –relationships and abuse
- Substance use
- Access to lethal means/method
- Previous self-harm
- Escalating help-seeking or disengagement from services
- Distressing Insomnia
- Suicidal ideas worsening or a well-formed plan and preparation

Organisation / Care factors to the inpatient suicide rate were highlighted and included:

- Recent change in medication
- Assessed as low or no apparent risk at time of death
- Ward staff vacancies
- Significant amount of experienced staff with more than 2 years' experience. Trained in WARRN
- Junior doctors staffing – continuity

The DNMH provided the Committee with the suite of actions identified during the thematic review and noted that each action had a MHCB sponsor attached to it. Those actions included:

- Returning to the Hafan Y Coed footprint
- Review of Sentinels and associated processes
- Suicide Prevention Training
- MDT inpatient reviews
- Cluster response plans
- Implementation of WARRN as a baseline assessment
- Royal College of Psychiatrists Review
- Observations Policy
- Staff Communication and Support.

It was noted that within the MHCB there were 9 NRIs open, of which 7 were overdue.

The Committee was advised that the MHCB were quite assiduous in reporting events and it was noted that a lot of the events turned into NRIS because they were high profile and complex.

It was noted that 2 NRIs were closed in September 2022.

The DNMH advised the Committee of concerns received by the MHCB.

It was noted that there were 48 open concerns with a number of those outside of compliance. However, the DNMH advised the Committee that the MHCB had done a lot of work in relation to the complicated concerns and had brought those concerns to a close.

The DNMH thanked the Concerns team for providing a member of staff to the MHCB who had attended Hafan Y Coed and who had worked through the complexities of the concerns and had progressed them quickly.

The Committee was advised that in relation to Redress, the MHCB had 2 cases that were being considered in redress and it was noted that no particular themes had been identified.

It was noted that Redress cases were often to do with the physical healthcare that the MHCB was able to provide in the Mental Health setting and that some service users had comorbidities and a lot of physical complexities.

It was noted that during the Covid-19 period, Patient feedback had declined and the MHCB had been working with colleagues to develop alternative and more creative ways of gathering service user feedback.

The Director of Operations – Mental Health Clinical Board (DOMH) presented the Committee with the MHCB Performance data. That date had identified that during the Covid-19 pandemic the MHCB had seen challenges but had managed to balance the targets and had achieved 100% compliance for the past three months in part 1a and 1b of the Mental Health Measure.

It was noted that the demands around Attention-deficit/hyperactivity disorder (ADHD) within the CAMHS service had impacted on the quality provision as well as a large number of complaints that related to ADHD diagnosis and referral.

The Committee was advised that the numbers noticed in recent years around ADHD referrals had increased exponentially and that in some months 30% of referrals were singularly for an ADHD diagnosis.

The DNCW added that from the CWCB point of view it was very challenging around ADHD and noted that the CWCB had looked to put additional resources in to address the long waits for neurodevelopment input.

The DNMH concluded by presenting the Committee with the MHCB Clinical Response, Improvement and Mitigations to the thematic review which included:

- The MHCB continued to learn and recalibrate following a difficult 2020/21. The processes which supported that included Sentinels oversight of cases integrated with a regular, supportive lessons learned process and considerable work on interrogating untoward events through RCAs / NRIs

- There had been no inpatient suicides since the “cluster”.

- The next “headlines” in terms of quality, safety and patient experience for MHCB were:

- Physical security (fences, doors) etc
- What concerns were telling the MHCB
- Maintaining and improving the skill set of staff in terms of clinical risk assessment (WARRN) and suicide mitigation training
- Moving to WARRN as the default risk assessment approach from December 2022
- Commencement of the Royal College of Psychiatry Review of MHCB functional services.

- NRIs continued to come down at a slow but steady rate
- Concerns were coming down at a slow and steady rate
- A well developed, successful “lessons learned” process

Challenges to the MHCB were presented which included:

- Specific ongoing clinical scenario presented a significant challenge to staffing resources and resilience
- It was anticipated that the MHCB would see a difficult Winter in terms of staffing: recruitment and retention.
- Reputational issues for Mental Health services

The Chief Officer of the Community Health Council (COCHC) noted that it would be useful to receive detailed information around the WARRN process and the DOMH advised the COCHC that he would contact them.

The Five Harms

The Five Harms presentation was received.

The Director of Nursing for Surgical Clinical Board (DNS) reminded the Committee of the Five Harms:

- Harm directly arising from SARS-CoV2 infections

- Indirect Covid-19 harms due to surge pressures on the Health and Social Care system and changes to healthcare activity, such as cancellation or postponement of elective surgery and other non-urgent treatments and delayed management of long-term conditions.

- Harms arising from population-based health protection measures such as, educational harm, psychological harm and isolation from shielding and other measures

- Economic harms such as unemployment and reduced business income arising both from Covid-19 directly and population control measures like lockdown.

- Harms arising from the way Covid-19 had exacerbated existing, or introduced new, inequalities into society.

It was noted that the most action had been taken around harm number 2 (the indirect Covid-19 harms due to surge pressures on the Health and Social Care system and changes to healthcare activity, such as cancellation or postponement of elective surgery and other non-urgent treatments and delayed management of long-term conditions).

The DNS advised the Committee that her presentation would include an update on the changes made by the Surgical Clinical Board (SCB) with regards to the way that Surgical Patients were treated when they required urgent same day care.

She added that the plan had been to open a Same Day Emergency Care (SDEC) centre at the University Hospital of Wales and it was noted that the Committee would be updated as to:

- What was SDEC and how could the SCB do it well.
- Where was the SCB in relation to the timeline
- What needed to be developed.

The Committee was advised that in 2019, prior to Covid-19 the SCB had already identified that it needed some same day emergency care or a different system in place within the Health Board for Surgical Patients.

It was noted that this was due to a lot of Surgical Patients presenting via GPs or the Emergency Department which had caused a lot of pressures in the system. In 2019 a small assessment unit was being used with a small footprint which saw around 40 to 50 patients a day.

The DNS advised the Committee that with the help of NHS elect and networking, the SCB put together a project group which consisted of Surgeons, Nurse Practitioners, Lead Senior Nurses, Managers and Informatics and a strategy was developed for SDEC.

It was noted that 6 themes had been identified within the strategy which included:

- Advice and Guidance
- Turning Unplanned Care into Planned Care
- Same Day Emergency Care as Default
- Creating the Right Environment
- Reducing Variation
- Managing Frailty in Acute Surgery

The key messages for the SDEC were presented to the Committee which included:

- The SDEC aimed to minimise and remove delays in the emergency Patient pathway
- The SDEC would cover Medicine, Surgery, Frailty and sub specialities, such as Paediatrics, Gynaecology and Early Pregnancy.
- The SDEC model should be adopted across the Emergency Floor.
- All providers with a type 1 Emergency Department (ED) would need to deliver SDEC for Medical and Surgical Patients for a minimum of 12 hours a day, 7 days a week.

The DNS advised the Committee that since November 2019, the SCB had achieved quite a lot with regards to the SDEC.

She added that the clinical conversations and the connections between Health Board Clinicians, GPs, the ED, NHS 111 and the Welsh Ambulance Service (WAST) and WAST had started and had made a good difference to Patient pathways.

The Committee was informed of what the SDEC had already achieved, which included:

- Surgical lists - it was noted that the SDEC Surgical lists had relieved pressure from Emergency theatres and had allowed Clinical teams to treat Emergency Surgical Patients in a planned way.

- Perioperative Care of Older People undergoing Surgery (POPS) service

- Emergency General Surgery (EGS) Workforce Expansion

The Clinical Board Director for Surgical (CBDS) advised the Committee that the SDEC had opened in July 2022.

He added that the unit consisted of:

- 45 chairs in waiting room
- 2 triage rooms
- 2 observation rooms
- 4 clinical assessment rooms
- 8 reclining/ambulatory chairs
- 3 Procedure Rooms

It was noted that the SDEC was attached to the Surgical Admissions Care unit (SACU) which consisted of:

- 10 beds (2 side rooms) which were used for Patients having short stay emergency surgery
- Dedicated SDEC lists

The CBDS advised the Committee that digital transformation had been a key enabler within the SDEC and had included:

- Notes facility with digital dictation
- Electronic Discharge Summary
- Virtual Patient Management
- E-Whiteboard

It was noted that the E-Whiteboard allowed the SDEC to have internal referral management so that there would be no confusion as to which set of Nurses and Doctors was caring for Patients at any particular time.

It was noted that it also allowed the SCB to have a much better idea of where Patients were on the pathway and that it provided for better data collection.

It was noted that the introduction of the SDEC process had seen a reduction in acute attendances by 22% and that 63% of all Surgical Emergency attendances were being seen via the SDEC compared to 43% pre-SDEC.

The Committee was advised of the impact seen from the SDEC in relation to the data which included:

- A reduction in Acute Attendances from 180 per week to 140.
- An increase of 60 Patients per week seen in SDEC compared to the Surgical Assessment Unit
- A 47% reduction in Surgical ED attendances
- Time from arrival to the Decision to Admit (DTA) had reduced by 150 minutes
- The median time from Arrival to Discharge had reduced by 7 hours.

The CBDS concluded that there were still a number of areas to develop around the SDEC and those included:

- Acute Surgical Ward
- Virtual inpatient system/ early supported discharge
- SDEC Flow Coordinator in EU which would minimise missed opportunities for SDEC.
- Acute Oncology/ Palliative Care pathway
- In-house data viewers. It was noted that the SCB had previously been reliant on 3rd party Data reporting.

	The COCHC thanked the SCB for the presentation and queried how long Patients were waiting in the reclining chairs before they were moved on into the system or moved back to their homes. The CBDS responded that if a Patient was going to be admitted, they would not even arrive onto the reclining chairs because they were not an alternative to an inpatient bed. **Emergency Department** The Emergency Department presentation was not received during the meeting because the Medicine Clinical Board (MCB) had recorded their presentation and it was agreed that the presentation would be shared with Committee members outside of the meeting. **The QSE Committee resolved that:** a) The three thematic reviews: Maternity / Neonatal, Mental Health and The Five Harms were noted.	
QSE 22/10/006	**Quality, Safety and Experience Themes and Trends August 2021 – August 2022** The Quality, Safety and Experience Themes and Trends August 2021 – August 2022 were received. The ADPE advised the Committee that they would be shown a series of presentations around QSE themes and trends and noted that a background paper had been received for Members to read. She added that the only item which required noting from the background paper was the Health and Social Care Act which placed both an enhanced Duty of Quality and an organisational Duty of Candour which would strengthen the approach to high quality and safe care. **Concerns, Claims, Compliments, Inquests and Redress.** The Committee was presented with a recording from the Head of Concerns & Redress (HCR). The HCR advised the Committee that there had been a continued increase in concerns received in the current year and noted that, as of 30th September 2022, the Concerns team had received 4,557 concerns with an average of 400 a month. It was noted that in response to the increase in concerns and in order to improve the experience of complainants accessing the concerns process, the Concerns team was restructured. That restructure had involved the setting up of an Early Resolution team to support Clinical Boards to resolve concerns in a timely manner and to ensure an appropriate level of investigation and resolution for complainants. It was noted that “communication” continued to be a recurring theme throughout concerns, and had overtaken Clinical care and treatment in a number of concerns received by a primary subject. The Committee was advised that despite the increase in concerns, the unprecedented demands on the service and limited resources available to commence investigations and respond to complainants, the Health Board had still reviewed and closed 83% of concerns within 30 working days. The HCR advised the Committee that during the past year, the Health Board had received 150 compliments. She added that various departments also received a significant number of compliments via cards in person and via social media which were not captured formally. It was noted that all concerns received by the Health Board were considered under the “Putting Things Right” regulations and that investigations included the following: • Whether there had been a breach in the duty of care	

- What level of harm had been caused.

It was noted that if a breach of duty and harm caused were identified in an investigation, Redress would be considered.

The Committee was advised that the Health Board currently had 33 active Redress cases.

It was noted that themes had been identified in Redress which included:

- Failure to diagnose or appropriately manage fractures
- Pressure damage
- Issues related to consent
- Inappropriate discharges from the Emergency Unit
- Inadequate cannula care

It was noted that many of the Redress cases were settled with solicitors' fees capped at £1920 or where Patients represented themselves no such fees were payable.

Clinical Negligence

The Committee were presented with a recording narrated by the ADPE. It was noted that the slides had been prepared by the Head of Clinical Negligence Claims (HCNC).

It was noted that the Health Board had received 76 new Clinical Negligence claims in 2021/22.

The ADPE advised the Committee that in all claims where the decision was made to concede the claim, a "learning from events" form was completed and submitted for approval by the Welsh Risk Pool.

The National Learning Advisory Panel (LAP) reviewed the learning presented by Health Bodies in NHS Wales following a Clinical Negligence claim.

The Committee was provided with the Clinical Negligence Costs during the past 12 months and was advised that there had been multiple learnings from those claims. An example was provided in relation to avoidable pressure ulcers where a piece of work was undertaken by the Director of Nursing in Surgery Clinical Board who re-established the collaborative to look at the themes that were identified in any cases where there had been avoidable pressure ulcers.

Personal Injury

The Committee were presented with a recording from the Head of Personal Injury Claims (HPIC).

The HPIC advised the Committee that there had been a consistent number of new claims compared to previous years and noted that 35 new claims had been made, 2 of which had been compensated under the Alternative Compensation Scheme which did not attract legal fees.

It was noted that the number of active Personal Injury (PI) claims during the year remained at around 104 being open, with 48 PI claims being closed during the same period.

It was noted that during 2021, most new claims remained as "probable" until the investigations could be completed.

The Committee was advised there were no concerning categories in comparison to the All Wales information received from Legal and Risk Services.

It was noted that the Health Board had successfully defended 2 PI claims at Court.

Inquests

The Committee were presented with a recording from the Head of Inquests (HI).

The Committee was advised that the Coroners had started opening investigations where there would be a request for statements and clinical information.

It was noted that some investigations then proceeded to inquest whereas others were closed and no inquest was opened.

It was noted that (i) the Medicine Clinical Board (MCB) had 123 open inquests, of which 11 were NRIs, (ii) the SCB had 11 open inquests with 3 NRIs, (iii) Specialist Services had 51 open inquests with 4 NRIs, (iv) MHCB had 62 open inquests with 20 NRIs, (v) PCIC had 11 open inquests with 7 NRIs and, (vi) CWCB had 11 open inquests, of which 7 were NRIs.

It was noted that the role of Inquest Team was to:

- Provide support for staff
- Communicate with Clinical Boards
- Communicate with other teams.

The Committee was advised that positive feedback had been received from staff regarding the Inquest Team and future objectives were presented which included:

- Development of videos in collaboration with the Legal and Risk Services.
- Improvement of communication with each Clinical Board

Patient Safety, Quality and Improvement

The Committee was presented with a recording from the Interim Head of Patient Safety and Quality (HPSQ).

The Committee was advised that the Health Board had gone “live” with a new “once for Wales” Datix system in March 2022.

It was noted that no major change in Incident Reporting figures had been reported during the change to the new system.

It was noted that Pressure Damage and Falls continued to be the highest reported category within Datix and that that it was reassuring to see that most of the incidents were reported as no or low harm.

The Committee was advised that the new reporting process for NRIs was implemented across all Health Boards in June 2021 and that since that time, the Health Board had reported 159 NRIs.

It was noted that the implementation was deemed as “phase one” and that “phase two” had not been implemented yet. Phase two would consist of special report arrangements for key areas of focus on thematic reviews which would include:

- Pressure Damage
- Falls
- Unexpected deaths in the community known to Mental Health services
- Safeguarding
- Abuse/suspected abuse
- Commissioned Services
- Externally reportable incidents.

It was noted that 34 out of 54 NRIs were overdue for a number of reasons which included that the Health Board was a high reporting Organisation due to the complexity of services which meant that some investigations could take longer than planned.

The Committee was advised of actions that would be undertaken to improve closure targets which included:

A monthly RAG rated NRI report to Clinical Boards regarding open and overdue NRIs which would include outstanding actions required.

- A monthly meeting with the Clinical Boards to review open NRIs and to agree closure targets for the following month
- A new investigation tool to be piloted
- Ongoing review of the use of a Rapid Review Tool for investigations that did not require a full RCA investigation.

Mortality – Medical Examiner Purpose

The Committee was informed of the purpose of the Medical Examiner and what the service would provide, which included:

- Greater safeguards through proper, independent scrutiny of all non-Coronial deaths.
- Ensuring of appropriate direction of deaths to the Coroner.
- An opportunity for the bereaved to raise any concerns
- Improvement of the quality of death certification
- Improvement of the quality of mortality data.

It was noted that since March 2021, the Health Board had been sending scanned case notes to the Medical Examiner Office for independent scrutiny.

It was noted that if the Medical Examiner identified any concerns in the care and treatment of Patients and/or the bereaved family raised concerns, then the Health Board would receive a letter detailing the issues which would then start a Concerns process which would be escalated to the relevant Clinical Board.

The Committee was presented with a graph that showed (i) the number of letters received from the Medical Examiner Service and (ii) possible concerns by the Medical Examiner and/ or the bereaved family. It was noted that whilst the number of deaths per month was fairly stable, the number of letters being received was increasing proportionately to the number of cases sent to the Medical Examiner Service.

It was noted that for independent scrutiny, it was expected that the number would at least double by the time that all hospital deaths were scrutinised.

It was noted that the Health Board was working with the Medical Examiner Service to steadily increase the amount of case notes sent for scrutiny and that there was an expectation that all hospital deaths would be scrutinised by April 2023.

It was noted that a mortality review group was set up to support the requisite changes, which could not be underestimated and that the Chief Medical Examiner for Wales had been very complimentary about the way the Health Board was approaching learning from deaths and had repeatedly thanked Medical Records staff and bereavement staff for their contribution.

The Committee was presented with emerging concerning themes identified by the Medical Examiner which included:

- Management of high risk patients
- Discharge / re-admission
- Communication
- Nutrition
- Pressure Damage
- Falls
- Covid
- Nurse staffing
- Early diagnosis

Actions for issues were presented to the Committee which included:

- Falls – A Falls prevention programme and Falls review panel was established.

- Pressure Damage – Pressure Damage Collaborative
- DNA CPR/Inappropriate resus – Focus on post graduate training
- Coroner referral criteria – Focus on post graduate training
- Communication – Development of a communication tool to inform relatives during Covid
- Accurate Death Certification – Liaising with the Medical Examiner to agree causes of death
- Management of High-Risk Patients – Prehabilitation, Surgical Diabetes pathway
- Covid – Covid Investigation team established

The CEO asked which deaths the Health Board was reviewing because she had assumed all deaths were being looked at.

The Assistant Director of Quality Safety (ADQS) responded that at present the Medical Examiner did not have the capacity to review all deaths, and so they were dictating the proportion of the Health Board's inpatient deaths that they would review.

The CC asked if the Medical Examiner was looking at community deaths.

The ADQS responded that they were not at present but were expecting to by Autumn 2023.

Clinical Effectiveness

The Committee was presented with information regarding Patient Safety, Quality Assurance and Clinical Effectiveness.

It was noted that in January 2021, the Clinical Effectiveness Committee was established to provide strategic direction for the Health Board's national and local clinical audit programme and NICE and Health Technology Wales implementation and provided assurance to the Quality, Safety and Experience Committee.

It was noted that in June of 2021, an internal audit was undertaken of the Health Board's Clinical audit arrangements and that the report gave a classification of limited assurance.

It was noted that there were eight recommendations in total and an action plan was developed.

The Committee was advised that there were four high priority actions that were identified which included:

- The recognised absence of a Health Board approved Clinical Audit strategy
- The lack of Clinical audit policy procedures,
- Inadequate staff resources for monitoring Clinical audits
- Limitations of the current systems to effectively monitor Clinical audits and their outcomes.

It was noted that a business case was developed for quality, safety and experience (QSE) to implement the new QSE framework resource for Clinical audit and that assurance was also included.

Funds allocated from the business case allowed for a number of resources which included:

- Audit Management and Tracking (AMaT) - it was noted that the Health Board had commenced a pilot of AMaT in the CWCB and that a Health Board Clinical Policy and Strategy had been developed.

- Team Investment – it was noted that new appointments had been made to the Health Board which included;

- Clinical Effectiveness Lead
- Clinical Effectiveness Facilitator
- AMaT Officer
- Senior Clinical Audit Co-Ordinator had been promoted to Clinical Audit Manager

	The Committee was advised of a number of actions for the year ahead relating to Clinical Effectiveness which included: • Implementation of AMaT throughout the Health Board • Gaining of oversight of all audit activity • Maximising AMaT functions • Development of meaningful clinical and audit plans • Review of the Clinical Effectiveness Committee's Terms of Reference • Establishment of Clinical Safety Group that would report to the QSE Committee ensuring that there were leads and clear Terms of Reference. • Evaluation of workplans and resources to secure funding for AMaT • Consideration of requirements to deliver Duty of Quality. The CC concluded that a lot of information had been received for the Committee to process and noted that a number of presentations had not been received by the Committee which were: • Emergency Unit Presentation • Covid Presentation • Feedback presentation She added that those presentations should be shared with the Committee at a future QSE Committee meeting. **The QSE Committee resolved that:** a) The Quality, Safety and Experience Themes and Trends August 2021 – August 2022 were noted.	
QSE 22/10/007	**Items to bring to the attention of the Board / Committee** The CEO advised the Committee that in conversations held with the Chair of the Health Board he had expressed concerns that the Board needed more understanding around the Ockenden Report and Maternity Services. She added that once the Executives had a really good understanding of it, it would need to be taken to Board early in 2023.	
QSE 22/10/008	**Review of the Meeting.** The Director of Corporate Governance advised the Committee that the QSE Committee concerned scrutiny, challenge and providing assurance to Members and then referring that to the Board. She added that the content needed to be more about themes, trends and benchmarking and noted that due to the style of the presentations it was difficult for Members to do the scrutiny and challenge required. She felt the presentations had been more about education in relation to Quality and Safety and if Committee Members felt they required further education, it could be obtained outside of the meeting. The Independent Member – Local Community (IMLC) advised the Committee that a lot of the content felt rushed and no real time was given to be able to provide the assurance needed. The IMU advised the Committee that the agenda needed to be more curated for the meeting because time was needed to secure assurance required and due to the size of the agenda, a lot of the discussion had been curtailed. The CC concluded that it was crucial to be able to distil the assurance for onward assurance to the Board. The ADPE concluded that too much information had tried to be covered within the meeting and she noted that she hoped by the next Special QSE Committee meeting live demonstrations from the relevant databases would be able to be provided to the Committee.	
	Date & Time of Next Meeting:	

	Tuesday, 29 November 2022 at 9am	

Action Log

Quality, Safety & Experience Committee

Update for meeting 29 November 2022
(Following the meeting held on 11 October 2022)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 22/10/005	**Thematic Reviews**	The Emergency Department presentation, Covid presentation and feedback presentation were not received and it was agreed that the presentations would be shared with Committee members via email.	**29.11.2022**	Jason Roberts/Meriel Jenney	**COMPLETED** Circulated to Committee members via email.
QSE 22/10/005	**Thematic Reviews**	The Chief Officer of the Community Health Council noted that it would be useful to receive detailed information around the WARRN process and the DOMH advised the COCHC that he would contact them.	**29.11.2022**	Daniel Crossland	**COMPLETED** Information sent to CHC
Actions in Progress					
QSE 22/06/006	**Clinical Diagnostics & Therapies Clinical Board Assurance Report**	The CBDCDT to meet offline with the IMTU to discuss mitigation measures in relation to the risk rating of 16 for the backlog and waiting lists.	**29.11.2022**	Meriel Jenney/Sue Bailey	**Update on 29 November 2022** On agenda - item 2.7
QSE 22/06/008	**Mortality Indicators**	Update to be provided to the Committee in November, to include RAMI in Intensive Care.	**29.11.2022**	Meriel Jenney	**Update on 29 November 2022** On agenda – item 2.10

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 22/06/008	**Mortality Indicators – format of report paper**	The Executive Medical Director to consider the format of the RAMI report paper in time for the next RAMI update to the Committee.	**29.11.2022**	Meriel Jenney	**Update on 29 November 2022** On agenda – item 2.10
QSE 22/06/010	**HIW Activity Overview**	HIW Report from visit to Stroke Centre	**29.11.2022**	Jason Roberts	**Update on 29 November 2022** On agenda – item 2.5
QSE 22/06/010	**HIW Activity Overview**	Committee to receive copy of the HIW Report regarding Cardiothoracic services	**29.11.2022**	Jason Roberts	**Update on 29 November 2022** On agenda – item 2.5
QSE 22/08/008	**HIW Activity Overview**	HIW Report from visit to EU	**29.11.2022**	Jason Roberts	**Update on 29 November 2022** On agenda – item 2.5
QSE 22/08/013	**Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response**	Progress had been made and would be presented to the Committee.	**10.01.2023**	Nicola Foreman	**Update on 10 January 2023**
Actions referred to Board / Committees					
QSE 22/06/008 **QSE 22/02/008**	**Board Development**	The Chair asked for a future Board Development to have sight on the information discussed on: • Healthcare Standards • Duty of Candour • National Quality Framework • Annual Quality Statement	15 December 2022	Jason Roberts/ Nicola Foreman	**Update on 15 December 2022** Original Board Development Session date of 25 August has been postponed. Now scheduled to go to the Board Development Session on 15 December 2022.

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 22/06/008	**Mortality Indicators/ RAMI Board Development**	The Chair asked if a Board Development Session could be arranged in relation to Mortality Indicators/RAMI.	25 August 2022	Meriel Jenney/Nicola Foreman	**Completed** Presented to Board Members at the Board Development Session on 25 August 2022.
Actions referred FROM Board / Committees					
UHB 22/09/011	**Integrated Performance Report**	The IMU asked at the Board meeting for the management approach to mitigating the pressure damage issues be explored further, at the Quality, Safety and Experience Committee.	10 January 2023	Jason Roberts	**Update on 10 January 2023**

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

COMMITTEE CHAIR'S ACTION REQUEST

Date of Request	Details of Request	Date of Authority	Independent Members Supporting the Action
13 October 2022	To seek authority to formally approve the Research Governance Policy (UHB 099) (copy enclosed) on behalf of the QSE Committee. The policy has recently been reviewed and has undergone a consultation exercise with no comments being received. The minutes of the Research Governance Group dated 6 July 2022 (copy enclosed) set out further details and also record the decision of the Research Governance Group to recommend the policy to the QSE Committee to approve. Unfortunately, the Corporate Governance team missed the instruction to put this on	13/10/2022	Not applicable

	the QSE meeting agenda in August. The next QSE meeting is scheduled for 29 November 2022. Approval of the policy has now become urgent, hence the request to authorise approval of the Research Governance Policy (UHB 099) by way of a Chair's Action. The request is for the Chair of the QSE Committee to formally approve, by way of a Chair's Action, the Research Governance Policy (UHB 099) (as attached).		

Signed 

Susan Elsmore,
Chair of the Quality, Safety and Experience Committee

RESEARCH GOVERNANCE GROUP (RGG) MINUTES
Thursday 6th July 2022 10.00 – 12.00am
Virtual Meeting via Teams

Present	
Name	**Position**
Professor Colin Dayan (CD)	JRO Director
Mr Paul Emmerson (PE)	Finance Manager
Mr Chris Shaw (CS)	Acting Head Research Integrity, Governance and Ethics, Cardiff University
Guru Naik	Primary Care Clinical Board Lead
Judith White (JW)	Deputising for CD&T Clinical Board Lead
Vianne Britten (VB)	Research Delivery Manager, CRF
David Butler (DB)	Deputising for Medicine Clinical Board Lead
Mrs Lucy Jenkins (LJ)	Acting Deputy R&D Manager
Ms Carina Fraser	Deputising for Kate Shires Cardiff University Biobank
Ms Danielle Huckle	Deputising for Julie Cornish Surgery Clinical Board
Mr Ian Tully	All Wales Medical Genomics Service
Claire Johnson (from 11 am)	Clinical Trials Research
Ms Carina Fraser	Deputising for Kate Shires
Ms Jade Cole	Specialist Services Clinical Board
In Attendance	
Name	**Position**
Mrs Pat Tamplin (PT)	HTA Governance Officer
Dr Helen Hughes (HH)(to 10.30am)	Commercial Trials Manager
Ms Rachel Norman	Registrations and Improvement Manage
Mrs Helen Falconer	Research Governance Officer

PART 1	PRELIMINARIES
	1.1 APOLOGIES FOR ABSENCE Aled Rees, Kate Shires ,Julie Cornish, Mrs Kathryn Murray (KM), Dr Rhys Morris (RM) Nicola Foreman, Richard Anderson, Claire Johnson, Zoe Lawrence, Philip Connor, Julia Sanders
	1.2
	1.3 DECLARATION OF INTERESTS ON THE AGENDA ITEMS None
	1.4 MINUTES OF LAST MEETING Professor Colin Dayan (CD) went through the minutes of the last RGG meeting of 21st April and no changes were noted. Minutes of the last meeting were therefore approved.

Minutes confirmed as a true record by: Chair, Research Governance Group

Signed……..…… **Date**……..

	1.5 MATTERS ARISING (NOT OTHERWISE ON THE AGENDA) The updates were noted by the Group.
PART 2	**PAPERS FOR DECISION**
2.1 **2.2**	**POL/016/01 Research Governance Policy** Mrs Lucy Jenkins (LJ) presented the recently revised SOP which has had minor changes throughout, which had been updated to reflect the change from Cardiff & Vale UHB R&D Office to Cardiff Joint Research Office (JRO). LJ advised that the document has been placed on the UHB consultation pages and that she had received no comments. Members agreed to the changes. It was noted that RGG cannot approve UHB Policies and it would therefore need to go to QSE for approval. **Action- Recommend to QSE for approval.** **SOP/001/02 Data Management for Clinical Trials: Standard Operational Procedure** Dr Helen Hughes (HH) presented the recently revised SOP which has had minor changes throughout, which had been updated to reflect the change from Cardiff & Vale UHB R&D Office to Cardiff Joint Research Office (JRO) as well as updating the legislation to the post Brexit GDPR. HH drew attention to the fact that some Sponsors are requesting electronic Trial Site Files, which this UHB is unable to do so at present. It had been agreed that this SOP would be re-issued and the JRO would liaise with IT and IG to resolve this issue. HH advised that the document has been placed on the UHB consultation pages and that she had received no comments. Members agreed to the changes but wished to progress the electronic Trial Site File with IT and IG. **Action- Document approved HH to link with IT and IG to progress with agreement for the electronic Trial Site File.**
PART 3	**GOVERNANCE**
	3.1 R&D GOVERNANCE REPORT **A) Non-Commercial Studies** Ms Rachel Norman presented the governance report for the JRO sponsorship team covering the period of April 22 – 30 June 22 (Q1). In quarter one, seven Cardiff and Vale UHB Sponsored study and two Cardiff University studies have had Capacity and Capability confirmed and opened to recruitment. The JRO Sponsorship team have received 21 new requests for sponsorship in quarter four (11 via Cardiff & Vale UHB and 10 via Cardiff University). Further detail can be seen in the office activity report. **Action – none** **B)Audit** The audit plan for this year will be delayed due to staffing issues.

C)Incident/Breach Summary

Two new breaches have been reported in quarter four for Cardiff and Vale UHB and two or Cardiff University, ongoing breaches are detailed in the report. Four breaches that were open in the last quarter have been closed

The 2 new breaches for Cardiff and Vale UHB are minor and were noted by the group. Helen Falconer advised on the 2 new Cardiff University breaches (as yet not allocated a number)

1. A dermatology trial that CU were sponsoring had ethical approval withdrawn as the Ethics Committee had not received an ongoing update report since 2018. Samples held under the study were immediately brought under the CU HTA licence. HF advised that a joint HTA/Sponsor study monitoring visit will be arranged before the end of 2022 and that REIS would prepare a CAPA.
2. A recent sample audit revealed that completed consent forms were missing for five study samples. The Research Team will seek an amendment to allow CVUHB staff to contact and re-consent affected participants. Improved consent checking and sample management systems to be implemented. Study staff to be retrained in consent processes.

Rachel Norman highlighted NPR143 which involved the flooding of OASIS the archiving storage location. 227 boxes have been deemed non-recoverable (18 belonging to R&D). R&D have emailed the Sponsors of the impacted boxes. The UHB are awaiting a full report from OASIS, in order to develop a CAPA. Lucy Jenkins informed the group that the UHB has taken the decision to move the contract to 'The Maltings' and the contract is being negotiated by Procurement. She is in regular contact with procurement to progress with this option.

D) Commercial Studies

The Rutherford Cancer Centre has gone into administration and is no longer able to provide imaging services for C&V UHB commercial clinical trials. This effects 4 Haematology oncology trials and 4 cardiology trials. Discussions are ongoing with RCC to organise transfer of archived images to C&V UHB and also the adoption by C&&V UHB of the services previously provided RCC.

Action A further update will be provided at the next meeting.

E) Human Tissue Act

See item 4.5

F) Clinical Research Facility

Nothing to report

G) Training needs identified

Nothing to report

	H) EUDRACT Reporting, 60% of Cardiff and Vale University Health Board sponsored CTIMPs that are due to have results reported on the EU Clinical Trial register, now have reported results. There are nine trials remaining for which reporting of trial results is overdue. 86% of Cardiff University's sponsored CTIMPs that are due to have results reported on the EU Clinical Trial register have reported results. There are five trials remaining for which reporting of trial results is overdue. Cardiff University have shared knowledge with Cardiff and Vale colleagues and Cardiff and Vale are working on increasing their reporting percentage. **I) NHS Digital Audit** NHS Digital undertook a routine audit of a closed CU-Sponsored CTIMP (AML 15) from 03/05/22-09/05/22. The audit involved staff from the Centre for Trials Research (CTR), staff from the CU RIGE Team and staff in the University of Birmingham Clinical Trials Unit (CTU), where the data is currently held. The draft Audit Report has been released to the CTR for review and full feedback will be provided to RGG when the audit outcome has been confirmed by NHS Digital. **J) MHRA report** The MHRA have conducted an inspection in March 2022 of an archived commercially Sponsored CTIMP at CVUHB. This was predominantly an inspection of the Sponsor organisation. There were two major and four other findings identified and the report will be sent directly to the commercial Sponsor for action. It was noted that access to scans was an issue in this inspection. Rhys Morris advised that images undertaken at C&V would remain on the PACs system and that imaging undertaken at other sites were available for 6 months under image sharing and neither are included in the medical record. Helen Hughes advised that accessibility of imaging if required for inspection purposes is included in the contract with CUBRIC and noted that PETIC is reported on the PACs system. The C&V contracts team have looked at the model site agreement for non-commercial studies and confirmed that the contract does enable the images to remain accessible for inspections The full report has been received from the MHRA and the study team have completed the actions and discussed this with the Sponsor. The R&D office will follow up on these if appropriate. **Action – Philip Connor to provide further update at the next meeting.**
	3.2 RESEARCH GOVERNANCE ISSUES AND ADVISING OF SAE IN CLINICAL BOARDS IN SPECIFIC AREAS • **Women and Children Clinical Board –** no representative • **Specialist Services –** not discussed • **CD&T**- Judith White reported on the difficulties that CEDAR had encountered in trying to use online services software for a study that did not involve patients, not UHB staff, only staff in a different UHB in their own time. They had to resort to MS forms despite the software being used in a number of institutions. Helen Falconer advised that the software is used extensively in Cardiff University but

users firstly have to complete training modules on IG. Judith White to link with Helen Falconer and then with IT to provide assurances and diligence.

- **Medicine** David Butler reported that there are long delays with the early phase team in reviewing capability and capacity, which could lead to reputational damage for the UHB. He also reported that there are delays in uploading images to a 3rd party site for commercial studies. Although time has been costed into the study for this activity, there is still no time for staff to undertake this. Paul Emmerson reported that the commercial income would have been allocated to the Board and possibly it was a performance issue that the service was not being provided. He would e mail Rhys Morris regarding the issue.
- **Primary Care** nothing to report
- **Mental Health** not discussed
- **All Wales Medical Genomics Service** – Ian Tully advised that the service had been approached by a private company regarding them offering patients, a free genetic test, related to obesity but in return they would keep the data. The governance issues related to this were
  - ❖ Knowing who had undertaken the test
  - ❖ What the result was
  - ❖ Managing the outcome of the result

  The group felt that the testing ought to be undertaken as part of a commercial research study, with ethical approval.
- **Surgical Services** nothing to report

Action – PE to email RM regarding uploading of radiological images.
Judith White to link with Helen Falconer and then with IT to provide assurances and diligence.

3.3 UHB PHARMACY REPORT

Kathryn Murray was unable to attend the meeting and her report was noted in her absence

Action – none

3.4 CLINICAL TRIALS IN NON-NHS PREMISES

Neither Aaron Fowler nor Nicola Foreman were able to attend the meeting. It was noted that the work of inspecting non NHS premises, where research activity with NHS patients took place, had been started by Peter Welsh some years ago but an established documented process, incorporating a review had not been formalised within the UHB. The duty of care to these patients was noted.

It had previously been agreed that we need a system in place to assess the vendor, confirm it has been done and confirmation of its' suitability. Lucy Jenkins advised that there had been little progress to establish a process. Helen Falconer advised that there may be some national work on this theme, which she was aware of as member of the Non- Commercial sponsorship Group and agreed to share slides with the group.

Action – HF to share slides with group and liaise with AF to discuss establishing a process or incorporating this into the Memorandum of Understanding which is being re-drafted.

Minutes confirmed as a true record by: Chair, Research Governance Group

Signed……..…… **Date**……..

PART 4	PERFORMANCE AND ASSURANCE
	4.1 DELIVERY STAFF REPORT VB gave a verbal update with regards to the delivery service. VB stated the largest risk at present is staffing pressures, as a number of staff are on long term sickness, secondments as well as maternity leave. There are a number of vacancies out to advert and bank staff are being utilised. The picture is very similar in relation to administration staff. The capability and capacity delays in the early phase team area consequence of the absences. There are so many new trials waiting to open, that need prioritisation. VB advised that she has appointed a training and quality team lead, but she will need to cover 8 weeks planned sick leave for another member of staff. **Action – none**
	4.2 RESEARCH DELIVERY MANAGEMENT BOARD (RDMB) VB advised that no RDMB meeting had taken place since the last meeting. **Action – none**
	4.3 FINANCE UPDATE Paul Emmerson (PE) presented a brief finance update. He reported the expenditure of the R&D budget is in line with the projected position. The UHB position is £4M overspent at end of month 2. **Action – none**
	4.4 JOINT R&D OFFICE WITH CARDIFF UNIVERSITY CD delivered an update with regards to the development of the JRO. • Process for early warning sponsorship process established. 30 requests to date. Feedback has been that it is a positive process, and useful in terms of expectation management and better preparation of the study. DH advised that she raises the early warning sponsorship process at her local meetings and felt that the web platform a=was a good idea. • Website has now been procured. • Research Professionals Group is being established. • CD and CS have a meeting with RCDS regarding training. **Action –.none**
	4.5 CARDIFF UNIVERSITY BIOBANK **4.5.1 Report** Carina Fraser advised that she was deputising for Kate Shires CUB Biobank Manager. She advised that the biobank had approved 2 new paediatric cystic fibrosis studies that would complement the adult collection. There are 2 more in the pipeline • Duncan Cole – blood stream infections in inherited metabolical disease. CD noted that this had arisen from an early awareness sponsorship meeting, that signposted the applicant to CUB. • Jonathon Underwood. Carina Fraser advised that there is external interest in HS samples from the commercial sector where there is potential to get funding support to fund staff time to consent and take samples.

	4.5.2 Incident Carina Fraser advised that CUB had identified that it is holding data for the Cystic Fibrosis (CF) Collection that was not initially agreed in the approved New Prospective Collection application (CUB-19/0005) – the initial CF application. This has arisen due to researchers requesting samples from donors with particular characteristics, in this case, current treatments and a particular infection. The data was requested by CUB and provided by the clinical team at CVUHB to enable the supply of the requested samples to the researchers (but the data has not been provided to anyone else). To place this in context, the data items agreed by CVUHB when the application to set up the CF collection was agreed, were very specific and included only demographic data about the patient, antibiotic use and the results of specific tests undertaken related to CF. In subsequent collection applications the data items agreed with CVUHB have been much broader, such as treatment data, diagnostics data and test result data rather than specific test results. Had this broad approach been taken with the initial CF collection application (CUB-19/0005) the data requested would have fallen into these categories and this situation would not have arisen. Carina Fraser advised that both corrective and preventative actions and a CAPA had been put in place. **Action –none**
	4.6 PROVISION OF TRAINING It was noted that Zoe Lawrence (nee Boult) was unable to attend the meeting but it was noted that she had returned to work and was recommencing the lunch and learn sessions. Prof Dayan welcomed her back to work and advised she wanted to set up a meeting with her and Chris Shaw to discuss training in relation to governance. **Action – Marietta Clavo to arrange a meeting for CD, CS and ZL.**
PART 5	**PAPERS FOR NOTING**
	5.1 R&D OFFICE ACTIVITY REPORT The report was noted. **5.2 R&D PEFORMANCE** **REVIEWED DOCUMENTS FOR NOTING** The papers were noted **New None** **Revised** FRM/010/01- Initiation visit report FRM/010/02- Early and routine monitoring visit report FRM/003/06- Label for patient medical notes FRM/010/03- Close down monitoring visit report GUI/003/01- R&D HR arrangements for researchers working in the NHS IS/001/03- Research funding applications involving CVUHB IS/001/06- Researchers information sheet AEs and SAE reporting for interventional research other than clinical CTIMPs

	SOP/003/01- Human tissue in clinical research management procedure SOP/016/02- Research Governance SOP TPL/003/02- Template study delegation log TPL/003/07- File note WI/001/03- Applying for ETC funding for NHS research WI/001/04- R&D review of funding applications
PART 6	**SUMMARY OF RISKS TO RAISE AT QSE** POL/016/01 Research Governance Policy to be taken to QSE for approval**.**
	None raised
PART 7	**FINAL CLOSURE AND FUTURE MEETINGS**
	7.1 ANY OTHER BUSINESS – none discussed
PART 8	**FUTURE FORMAT OF RESEARCH GOVERNANCE GROUP**
	Draft Terms of Reference for Joint Research Governance Group **Proposed Committee Governance Structure** Prof Dayan went through the flow chart (paper 8.2 Joint Research Office Committee reporting structure and operational oversight) which highlighted by solid lines where groups report to and by dotted lines where info was required. It was noted that 2 groups will report directly to the Joint Research Governance Group: • Quality Assurance group which would develop SOPs • Clinical Trial Governance Group (formerly CTIMP-GG) which would look at the governance perspective of CTIMPs, preparation for MHRA inspections which would encompass CU or C&V sponsored studies as well as CTR management of trials. Discussion arose on the role of CEDAR and whether they needed to feed into this group, but the consensus was that they did not need to. Discussion arose on finance not being part of the governance structure and PE agreed it sat more with RDMB and that CD and PE ought to meet separately to discuss the R&D budget. Prof Dayan went through the draft Terms of Reference for Joint Research Governance Group (paper 8.1) which were well received by the group. A vote was taken to resolve to dissolve the UHB Research Governance Group and encompass the activity as outlined in the draft Terms of Reference for Joint Research Governance Group. The vote was that all were in favour. The draft Terms of reference were accepted by the group.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board	**Reference Number: UHB099** **Version Number: 4** **Date of Next Review: 06/07/2025** **Previous Trust/LHB Reference Number: 296**

RESEARCH GOVERNANCE POLICY

Policy Statement

Research Governance can be defined as the broad range of regulations, principles and standards of good practice that ensure high quality research. Cardiff and Vale University Health Board (UHB) considers the governance of research and development (R&D) activity involving its patients, staff and resources to be of paramount importance. We are committed to high quality, relevant research that is managed appropriately to ensure patient dignity, rights, safety and wellbeing. We will ensure that all research complies with the law and that financial probity is maintained.

Policy Commitment

The UHB is committed to providing a framework for research which complies with the law and good practice, without unnecessarily restricting the freedom of individual researchers to develop ideas which can improve clinical care.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedures listed below aim to

- Ensure that R&D is of the highest quality and that researchers operate within the same quality framework as the services which the research is aimed at improving
- Ensure that all R&D is carried out lawfully, properly and sensitively respecting the rights, dignity, wellbeing and safety of patients
- Clearly identify the responsibilities of individuals involved in R&D

Other supporting documents are:

Research Governance Procedure (UHB 457)
Governance & Compliance Audit of Human Tissue For Research Purposes (UHB 134)
Financial Procedure for supporting Non-Commercial Research (UHB 487)
Archiving of Clinical Trial and Research Study Data SOP (UHB 121)
Informed Consent in Clinical Research (UHB 147)
Investigating and Handling Allegations of Research Misconduct Procedure (UHB145)
Research Audit SOP (UHB 236)
Managing Breaches of Good Clinical Practice or the Study Protocol SOP (UHB 235)
Oversight and Monitoring in Research SOP (UHB 247)
Data Management for Clinical Trials SOP (UHB 449)

Safety Reporting in CTIMPs SOP (UHB 253) Clinical Research Training requirements including Good Clinical Practice (GCP) Training – SOP (UHB 317) Applying for Cardiff and Vale UHB NHS Sponsorship SOP (UHB 453) Reporting requirements for Cardiff and Vale UHB Sponsored Research SOP (UHB 406) Managing amendments for Sponsored Research SOP (UHB 302) Obtaining Capacity and Capability Confirmation for Research to Start (UHB 448) UK Policy Framework for Health and Social Care Research
Scope The scope of this Policy extends to all research activity, both commercial and non-commercial, involving the UHB including: • Research using patients, carers, volunteers and members of staff at the UHB and in Primary Care settings; • Research using patient tissue, organs or data; • Research taking place on UHB premises, satellite sites and authorised external organisations, or involving UHB resources, including non-clinical and laboratory based research; • Research being undertaken as part of an educational qualification.

Equality and Health Impact Assessment	An Equality Impact Assessment (EqIA) was completed on Version 1 and 2 and this found there to be no impact. This EqIA has been updated with new references to form an EHIA. The changes to the Policy (see below) would not impact on the outcome of the EHIA.

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Research Governance Group
Accountable Executive or Clinical Board Director	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 Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
2	Review by Research Governance Group 26/04/2016	1/11/2016	The document has been updated to reflect the current Clinical Board and committee structure of the UHB, the changes to Health and Care Research Wales and updated internal UHB documents. The Mental Capacity Act has been highlighted in certain sections. The Audit section has been changed to reflect alignment with the current Research Audit SOP
3	Review by QSE Committee	26/09/2019	In line with UHB requirements, this Policy now follows the Policy template of UHB. UHB Policy has been replaced by a Policy and a Procedure and has been updated to reflect the replacement of the Research Governance Framework for Health and Social Care in Wales with the UK Policy Framework for Health and Social Care Research.
4	Review by Research Governance Group		EHIA assessment reviewed and no issues noted to be changed. All references to the R&D office have been updated to JRO. Links checked and updated.

Equality & Health Impact Assessment for

Research Governance Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Research Governance Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Joint Research Office, Medical Director's Office, Executive Clinical Board Research and Development Manager, Joint research Office, Floor 2, Old Lakeside Building
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To: • Ensure that R&D is of the highest quality and that researchers operate within the same quality framework as the services which the research is aimed at improving • Ensure that all R&D is carried out lawfully, properly and sensitively respecting the rights, dignity, wellbeing and safety of participants • Clearly identify the responsibilities of individuals involved in R&D

4.	Evidence and background information considered. For example • population data • staff and service users 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 Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	Previous EQIA performed on the previous version of the Research Governance Policy. Comments from those involved in the designing and development stages Good practice guidelines Based on content of the UK Policy Framework for Health and Social Care Research which underwent extensive consultation at the UK wide level at staff and service user level.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Staff and service users involved in Research and Development

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

6. 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.
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in		

	respect of information governance management. The evidence suggests that it has no impact on this equality group.		
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	Yes Documents are not automatically published in Braille or languages other than English. The primary source of circulation is via the intranet. Software which will read the policy for the reader is now very common therefore documents should generally be accessible to those with a visual impairment. The Disability Discrimination Act requires that information should be made accessible for those with disabilities. In addition, recommendations on accessibility in terms of reading age, form part of the ethical review undertaken of all research taking place within the NHS and are contained in the NRES guidance referenced at the end of this section. Where specific groups with a particular disability are part of a research group under study then as part of the ethical review, arrangements for taking informed consent in an appropriate way and with appropriate skills/tools will be a mandatory part of the review and approval process. The Health Research Authority together with the Medical Research Council 'Consent and Patient Information Sheet preparation Guidance' http://www.hra.nhs.uk/resources/before-you-apply/consent-and-participation/consent-and-participant-information/ highlights the requirement for information to be made available in appropriate ways to allow equality of access to research studies for all.		

	Governance arrangements for Research Ethics Committees available at Governance arrangements for Research Ethics Committees - Health Research Authority (hra.nhs.uk)		
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	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		

6.4 People who are married or who have a civil partner.	The policy applies equally to all research participants. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		
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 are potential risks to the unborn child in including women of child bearing age in early phase drug studies. In the past this meant that only men were recruited. However, women are now included in these studies with very careful control of pregnancy testing before during and after the study and follow up and reporting of all pregnancy outcomes to the Medicine and Healthcare products Regulatory Agency. As part of the ethical review that all research studies undergo aspects of equality of access will be closely examined Governance arrangements for Research Ethics Committees available at Governance arrangements for Research Ethics Committees - Health Research Authority (hra.nhs.uk)		

6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group. Issues around cultural and language are dealt with extensively as part of the ethical review that all research projects undergo before getting approval to be undertaken. Evidence has been gathered from the National Research Ethics Service(NRES) website guidance document http://www.hra.nhs.uk/resources/before-you-apply/consent-and-participation/consent-and-participant-information/. In particular it is a requirement as part of ethical approval that if translation is required to enable an individual to consider taking part in a research project then translation must be provided by an independent translator provided by the organisation. There is a specific section in the NRES/IRAS application which highlights the fact that family members must not be used to ensure that there is no coercion. Governance arrangements for Research Ethics Committees available at		

	Governance arrangements for Research Ethics Committees - Health Research Authority (hra.nhs.uk)		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in		

	respect of information governance management. The evidence suggests that it has no impact on this equality group. Evidence has been gathered from the NMC which highlights the responsibility of all nurses/midwives to treat [people] fairly irrespective of race, disability, age, sexual orientation, religion or belief and gender. Available at http://www.nmc-uk.org/About-us/Equality-and-diversity/Equality-and-diversity-about-us/		
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	In respect of communication the UHB will need to ensure that people who wish to communicate in the Welsh medium have a means to do so as referred to in our Welsh Language Scheme. This can be found on the UHB website Welsh Language in Healthcare - Cardiff and Vale University Health Board (nhs.wales)		
6.10 People according to their income related group:	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application		

Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		
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	The policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content. The guidance available from NRES (HRA) ensures that vulnerable adults and children have special protection and the oversight provided by monitoring and audit by sponsors ensures that this is implemented. Its application requires strict adherence to legal obligations, regulations and guidance in respect of information governance management. The evidence suggests that it has no impact on this equality group.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	No further additions required		

7. 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 policy applies equally to all research participants and all those involved in the research study. The strict regulatory framework which governs the conduct of research within the NHS has at its heart equality of access to research for all potential participants. This is enshrined in the application process and the guidance for information sheets and their content.		

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
7.2 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 (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	There is potentially a positive impact in this area as some research conducted in accordance with this policy may address how various interventions relating to changing lifestyle to more healthier choices can improve well being		

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
7.3 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 Well-being Goal – A prosperous Wales	This policy has little impact in this area		
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,	This policy has little impact in this area. However some research conducted under this policy may produce results which show that certain interventions on physical environment may have a positive impact on health and well-being.		

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
exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces 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	Researchers are encouraged to seek input from the lay community/patient support groups when designing research studies. This can have a positive impact on the sense of belonging and 'community' identity.		

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	High quality relevant research as outlined in this policy can have a positive impact on influencing government policy and guidelines		

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	A policy which commits to the UHB carrying out high quality research in a safe and lawful manner has the potential to positively impact on the patient community by providing opportunities for patients to receive new and innovate treatments and diagnostic procedures and ensure UHB retains a positive reputation for undertaking high quality research

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	On reviewing the previous policy and writing the latest policy and procedure and completing the EHIA, there appear to be no negative impacts of the Policy. Therefore no key actions have been identified.			

	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 no negative impact has been identified, it is considered unnecessary to undertake a more detailed assessment.			

	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 and rewriting as a policy and procedure in line with UHB guidelines, the EQIA has been revisited and an EHIA now completed. The policy and procedure have been approved by Research Governance Group. When this policy is next reviewed, this EHIA will form part of that consultation exercise. This EHIA will be reviewed 3 years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required			

Report Title:	QSE Medicine Clinical Board Assurance Report				Agenda Item no.	2.1	
Meeting:	QSE Committee Meeting		Public	x	Meeting Date:	29th November 2022	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Executive Nurse Director Jason Roberts						
Report Author (Title):	Quality and Governance Lead Katherine Prosser						

Main Report
Background and current situation:

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

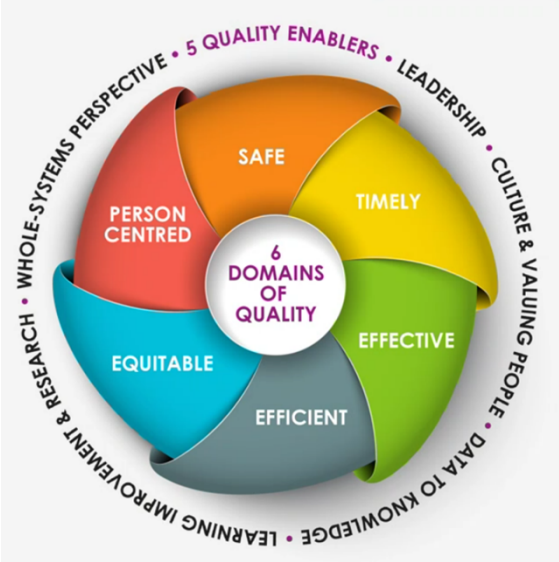
Medicine Clinical Board offers high quality clinical care for people with multiple, complex health needs, minor injuries and serious disease. The services provide for the wider regional and Welsh population eg, Infectious Diseases, Welsh Gender, Stroke, Diabetes, Dermatology and Gastroenterology. The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

The Clinical Board for 2022/23 has an annual budget of £140.9m, and a current workforce establishment of 1765 WTE staff in post which includes 810 WTE Registered Nurses, 441 WTE Health Care Support Workers, 187 WTE Admin and Clerical, 298 WTE Medical and Dental staff 7.4 WTE Additional Prof Scientific and Technic, 7.06 WTE Additional Clinical Services, 8.92 WTE Allied Health Professionals, and 5.05 WTE Health Care Scientists. It has an inpatient bed base of 502, three Day Units and several outpatient suites. In addition, there are currently 224 additional un-commissioned inpatient beds open which include, C7, East 2, Glan Ely, Lakeside Wing and Heulwen North.

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

The aims of the Medicine Clinical Board in summary are:

- Ensuring there is a process in place to continually monitor and review the quality and safety risk register, acting to mitigate risks on an ongoing basis;
- Maintaining an open culture of improving quality, safety and patient experience across all teams and all staff; and
- Promoting a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care.



Quality, Safety and Experience (QSPE) is the highest priority for the Clinical Board and the governance and oversight has developed significantly. Both Clinical Board Director and Director of Nursing lead the agenda.

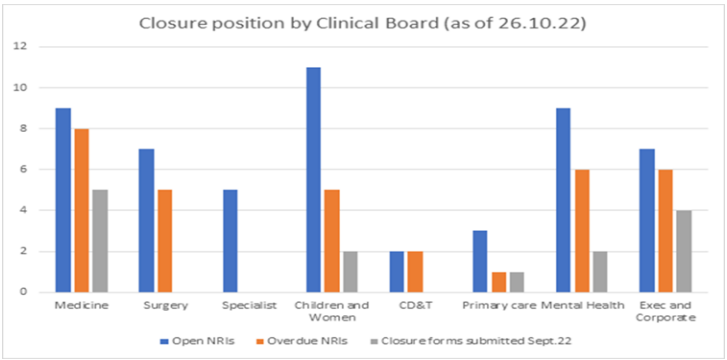
QSPE meetings are planned every month, which are well represented by medical, nursing and managerial staff across all Directorates, as well as other multi-disciplinary colleagues from other areas taking an active part in the meetings and shaping the overall agenda. Terms of Reference and Work Plan are reviewed annually. QSE has previously been considered in line with Health and Care Standards but for the purpose of this report is being considered under each of the six domains of quality which will form the priorities for the Duty of Quality.

Safe Care

Patient Safety Alerts/Internal Safety Notices

The Clinical Board has a robust management system in place for Patient Safety Alerts working in conjunction with the Patient Safety Team. An identified member of staff is responsible for all alerts received, and is responsible for the dissemination and actions were applicable. These are shared at both Clinical Board and Directorate QSPE meetings. The Clinical Board is 100% compliant of all Patient Safety Notices issued over the last year.

NRI Management



The Clinical Board are currently investigating the following National Reportable Incidents:

- Omission of prescribed Hydrocortisone for a patient with known Addison's Disease

- Post Stroke VTE prophylaxis
- The deterioration of a post thrombectomy Stroke patient in recovery
- Wrong Site pleural tap reported as a Never Event
- Delay in Ulcerative Colitis surveillance Endoscopy
- Delay in diagnostic cancer diagnosis
- One unexpected death (awaiting final PM report as no cause of death identified)
- Missed Stridor/delay in treatment

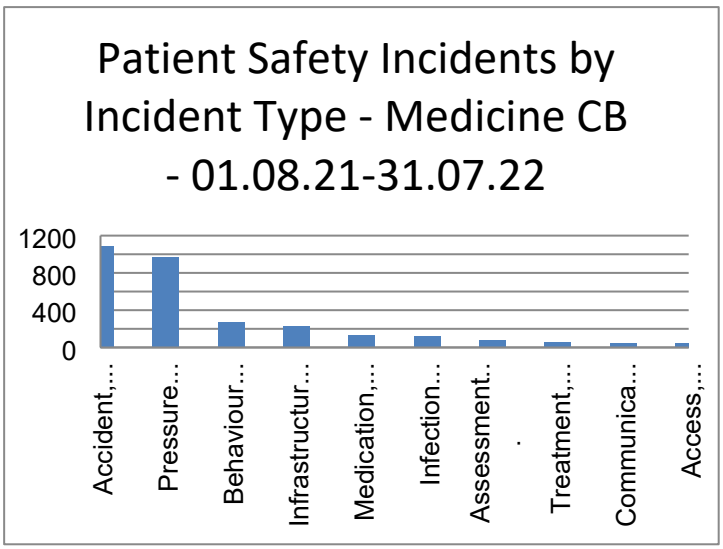
5 of these investigations are being progressed for closure over the next two months, 3 are subject to His Majesties Coroners inquests. Overdue NRI closures are being escalated for completion, balanced against competing operational demands.

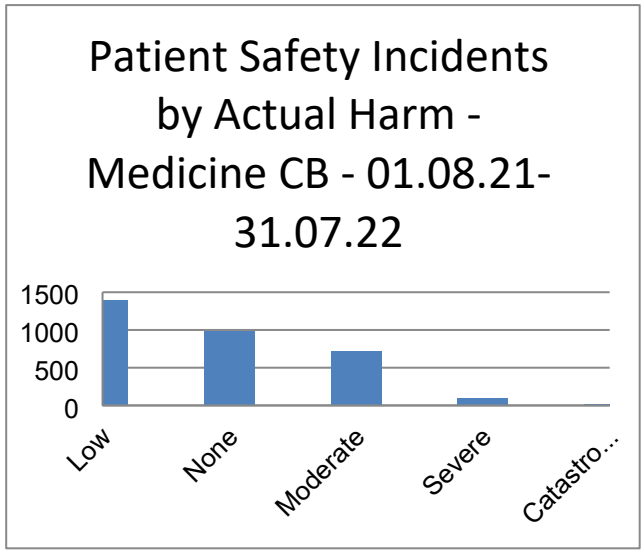
The omission of prescribed Hydrocortisone for a patient with known Addison's disease immediately prompted the recirculation of Patient Safety Notice PSN057/June 2021 Emergency Steroid Therapy Cards: Supporting Early Recognition and Management of Adrenal Crisis in Adults and Children.

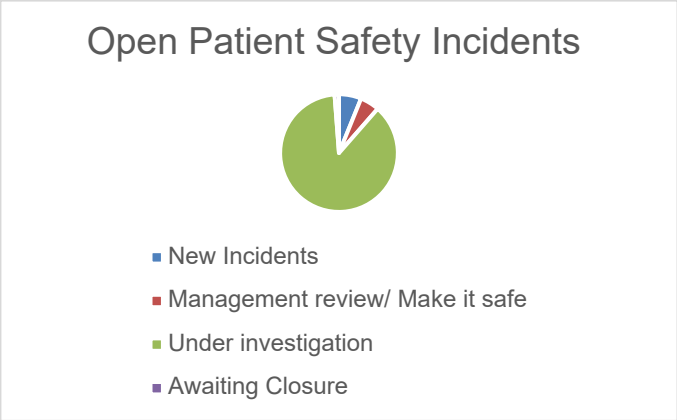
The omission of post Stroke VTE prophylaxis relates to the use of intermittent pneumatic compression stockings in accordance with NICE NG89 (2019) Section 1.4.2. All staff across the Stroke pathway have now been trained with the use of intermittent pneumatic compression stockings as a means of preventing DVT/PE.

The missed Stridor and delay in treatment resulted in the pathway for post-operative surgical patients being reviewed on presentation to the Emergency Department. At point of triage a direct referral can be immediately made to the relevant surgical specialty. In addition, the post-operative tonsillectomy patient information sheet needs to be updated to reflect signs/symptoms of shortness of breath.

Patient Safety Incident Management



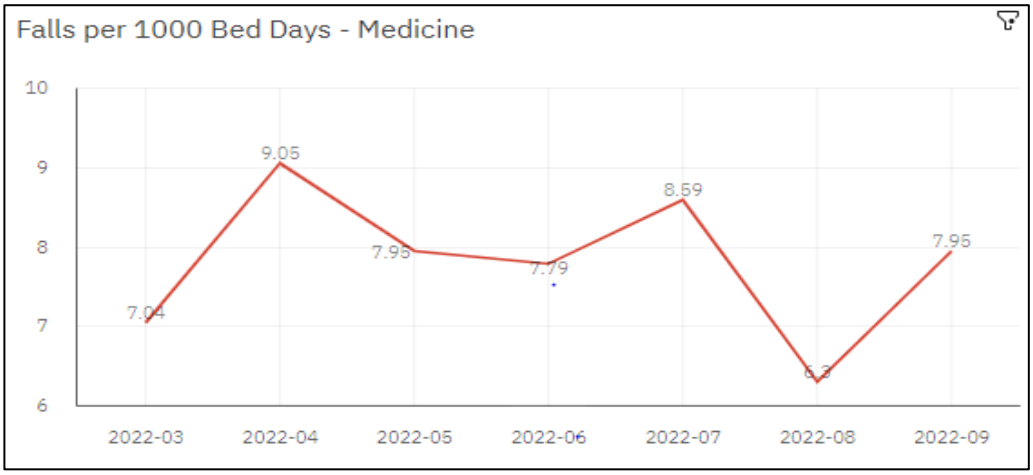




The Clinical Board demonstrate an open reporting culture with high number of incidents reported, with the vast majority of incidents leading to no or minor harm. The Clinical Board acknowledges the challenges for timely closure of Datix, and is currently focusing on those reporting severe or catastrophic harm. In addition, bespoke individual support is being provided to those incident managers with significant Datix queues.

Falls

Falls remain one of the most reported incidents within the Clinical Board via Datix Cymru. The Clinical Board reported between 127 – 180 falls per month for the period 01st March 2022 to 30th September 2022.

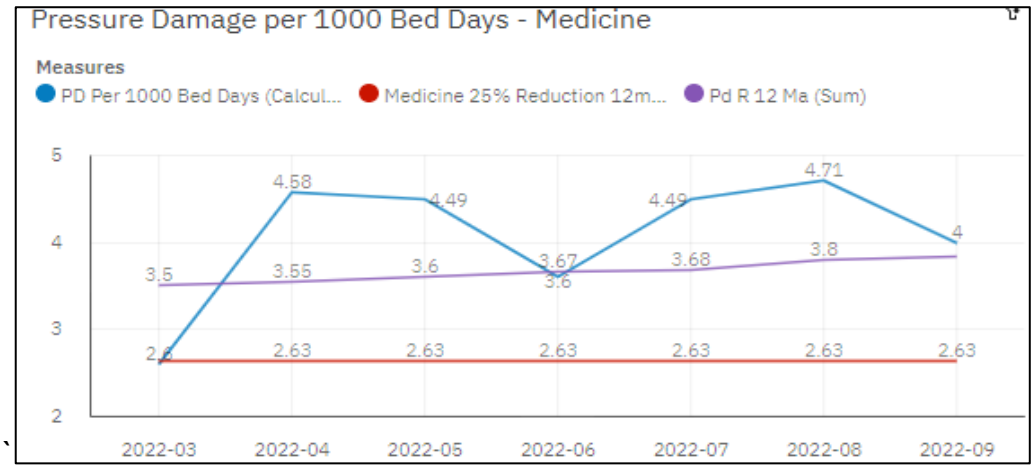


For this time period the Clinical Board reported 44 injurious injuries. For investigations completed to date, they either did not meet the criteria set by the Delivery Unit for NRI reporting, or concluded that no acts or omissions contributed towards the fall and injury, with the exception of one fractured neck of femur. The Falls Focus Review identified the patient as a high falls risk and was not monitored as per Enhanced Supervision Framework and instruction.

The Clinical Board is extremely supportive of the UHB falls review panel, and welcomes the feedback provided to improve pre and post falls procedures. A common theme identified from Falls Focus Reviews are around the completion of lying and standing blood pressure for all patients aged over 65 years. This now forms part of the Clinical Boards Education and Learning Plan which supports identifying specific learning points from NRI's and other incidents. The Clinical Board is represented in the UHB Falls Delivery Programme.

Pressure and tissue damage reduction and prevention

The Clinical Board continues to learn from all avoidable and unavoidable healthcare acquired pressure damage. The Clinical Board have recently introduced a Pressure Damage Learning and Scrutiny Panel which supports Ward Sisters/Senior and Lead Nurses to engage in the decision making, and identification of learning to share more widely across the Clinical Board. This also forms part of the Clinical Board Education and Learning Programme.



From 01st March 2022 to 30th September 2022 the Clinical Board reported 10 avoidable healthcare acquired pressure damage as NRI's. 5 Category 3, 4 Unstageable and 1 Category 4. The Focused Pressure Damage reviews and subsequent discussions at the Learning and Scrutiny panel identified areas of learning relating to documentation to support prescribed intentional rounding, and appropriate mattress selection. As a result, the current mattress selection algorithm is being reviewed by the UHB Tissue Viability Nurses and UHB Pressure Damage Task and Finish Group to support timelier escalation for mattress upgrades. In addition, preventative pressure damage interventions/documentation has been included in the Core Standard Tendable Audits to support timely, safe and clinically effective care.

Safeguarding

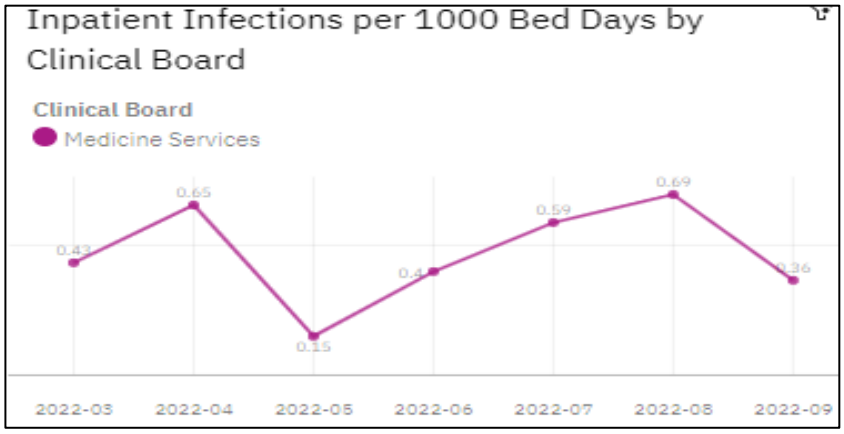
All safeguarding referrals relating to community concerns, or raised against staff working within the Clinical Board are subject to the required level of investigation and scrutiny to ensure safe care is provided. Investigations are led by Health Lead Professionals, with appropriate actions taken and shared more widely if required. The Clinical Board are currently investigating 56 safeguarding referrals, 13 of these relate to avoidable healthcare acquired pressure damage. The Clinical Board has key links with the Safeguarding Team to ensure openness and transparency, and remains a standing agenda item on the QSPE agenda.

A Vulnerability and Safeguarding Hub has been created within the Emergency Department to support patients with complex, multifactorial needs resulting in frequent attendances, or for conditions that create vulnerability or risk in their lives. Within the Hub is co-located the Violence Reduction Unit, the Frequent Attenders Service, the IDVA's, Psychiatry Liaison Teams, CAMHS and Red Cross, with the additional benefit of further hot desking space for other expert teams as required. The Hub supports complex discharges from Emergency Medicine, helps to reduce frequent attendances, support staff with safeguarding concerns, and ensures high standard, expert care is provided to an often-overlooked cohort of patients.

Infection, Prevention and Control

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

From 01st March 2022 – 30th September 2022 the Clinical Board reported 66 healthcare acquired infections.



Clostridium Difficile

17 incidents of C. *Difficile* were reported for the Clinical Board from 01st March 2022 – 30th September 2022, this is an improvement for the same time period the previous year where 21 incidents were reported. The investigations and discussion with Infection, Prevention and Control identified the increased use of anti-biotics and acuity of patients being a significant contributory factor.

MSSA

13 incidents of MSSA were reported for the Clinical Board from 01st March 2022 – 30th September 2022, which is a slight deterioration for the same time period the previous year where 11 incidents were reported. The investigations and discussion with Infection, Prevention and Control identified causes secondary to a lung empyema, skin contamination and sources unknown. Focused work is being undertaken with Practice Development Nurses and Infection, Prevention and Control to improve PVC compliance and VIP scoring.

MRSA

Two incidents of MRSA were reported for the Clinical Board from 01st March 2022 – 30th September 2022. The incident reported in March identified this was attributed to a line infection. The remaining investigation reported in July has been escalated for completion.

E Coli

23 incidents of E Coli were reported for the Clinical Board from 01st March 2022 – 30th September 2022. Investigations and discussion with Infection, Prevention and Control have identified these to be 13 urinary, 3 abdominal, 1 biliary, 1 osteomyelitis and 5 unknown sources. CAUTI audits

continue with the urinary sources predominately related to patients presenting with long term catheters that required replacement.

Klebseilla

12 incidents of Klebseilla were reported for the Clinical Board from 01st March 2022 – 30th September 2022. This is a slight improvement for the same time period the previous year where 13 incidents were reported. The investigations and discussion with Infection, Prevention and Control identified these were predominately urinary and biliary sources.

Psuedomonas

2 incidents of Psuedomonas were reported for the Clinical Board from 01st March 2022 – 30th September 2022.

The Clinical Board continues to see clusters of patients and staff testing positive for Covid-19 resulting in Covid Outbreaks and Incidents. As a Clinical Board we continue to work in partnership with other Clinical Boards and OPAT to ensure patients are admitted, or moved to appropriate 'Red' capacity. The Clinical Board is well represented at the Covid-19 investigation scrutiny panel meetings, and embedded the framework for safe patient placement. To date, investigations have highlighted care provided was reasonable with no major concerns highlighted. One case has been escalated to Legal and Risk regarding the movement of a patient into a Covid-19 area secondary to a lack of documentation. Staff wellbeing measures continue with feedback at Clinical Board QSPE meetings.

Infection, Prevention and Control, the Clinical Board and Estates have recently introduced post outbreak learning meetings to identify potential themes/learning and actions to improve key Tier 1 performance indicators.

Staffing

Nurse staff remains one of the highest Clinical Board risks with a score of 25. Mitigation includes posts advertised in a timely manner with the authorisation of vacancies reviewed efficiently. Bimonthly recruitment events are undertaken, with ongoing overseas recruitment, adaptation programmes, student streamlining and staff return to practice. A staff risk framework is completed daily by the Clinical Board and shared at daily OPAT UHB meetings. Focused work on staff exit questionnaires and engagement with established staff to protect establishment is ongoing.

Medicine Clinical Board consists of 1765 WTE staff. The Clinical Board currently has a 10% turnover rate. Cumulative sickness reported for September was 8.3% which has improved from 10.8%. The current Registered Nurse vacancy position across the Clinical Board is 66 WTE. There has been active, ongoing recruitment alongside generic recruitment, student streamlining and overseas nurses. A further 7 overseas nurses will be in post by December. These numbers factor the closure of Ward C5 with staff moving to Wards C7 and Heulwen North.

The current staffing position is having a significant impact on the ability to provide consistently good standard of care which is reflected in an increase in the number of Datix Cymru reporting staffing shortfalls. This staffing position is also having a negative impact on staff health and wellbeing which is reflected in 25% of our sickness relating to anxiety and stress. The Clinical Board are committed to ensure staff feel supported, and have the required resources to enable them to deliver the care required by our patients. The Clinical Board has implemented a workforce and Nurse retention plan supported by Workforce and Organisational Development.

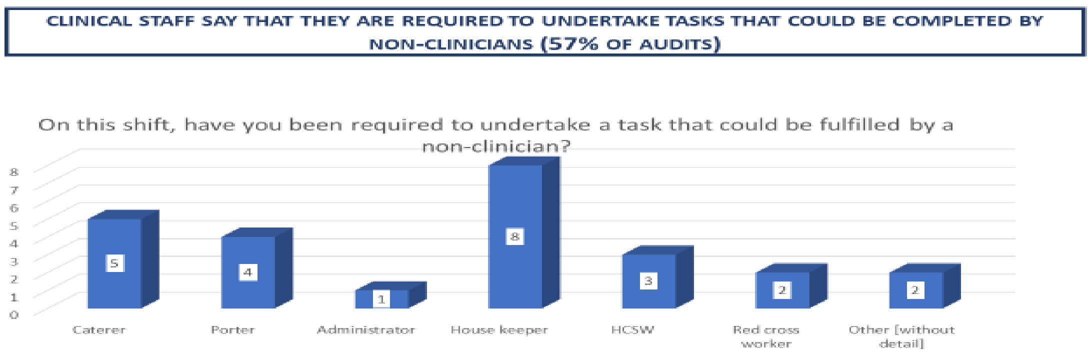
Some examples of staff experience feedback in Tendable include:

1. 96% (n=27) colleagues reported that they could take a break during their last shift
2. 89% (n=25) colleagues reported that they had enough clinical items/equipment available to do their jobs effectively
3. 85% (n=24) colleagues report that they were satisfied with the standards of care that they provided during their most recent shift.

The Clinical Board inpatient wards are reviewed against the All Wales Nurse Staffing acuity data, and triangulated with quality indicators and professional judgement; to ensure the Clinical Board inpatient wards have the right number of Registered Nurses and the right skill mix to ensure the delivery of a high quality and standard of care for our patients.

An Emergency Paediatric Nursing Establishment paper has been developed to align the nursing workforce in line with current recommendations to provide consistent, safe, high quality care to children and families. The Paediatric Emergency Unit has seen significant redesign and transformation, with an increase in the local Paediatrics population, and increased volume of attendances. Unlike current workforce models and tools, the calculation of nursing establishment is based on the number of physical trolleys within the department, rather than attendances or acuity of patients in the department. This is resulting in national standards for emergency care often not being met.

A recent Tendable audit taken within our Emergency Department showed that Registered Nurses were undertaking a number of roles that could have been undertaken by non Registered Nurses:



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

Senior Medical staffing within Medicine Clinical Board benefits from the attraction of Cardiff as a capital city and the excellent reputation of Cardiff & Vale now as a progressive provider of secondary and tertiary care, together with a team of dynamic and open-minded Clinical Directors intent upon growing and evolving services with likeminded colleagues.

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

The importance of staff appraisal cannot be underestimated. The Clinical Board and Directorates are working hard to improve compliance with Values Based Appraisal and pay progression. This is

currently being reviewed by the Clinical Board to improve compliance. The current position is as follows:

Emergency and Acute Medicine	25.88%
Integrated Medicine	20.56%
Specialised Medicine	24.34%
MCB Non Medical	4.29%
Clinical Board Total	**22.20%**
Medical Staff Appraisal	**78%**

Staff engagement

The Clinical Board has long recognised the importance of listening and engaging with staff. The engagement of staff in the development of the Clinical Board is inherit to its values. In order to support our staff across all disciplines away days have been undertaken and continue, which has been extremely valued by Ward Sisters/Managers highlighting the importance of peer support.

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

- Dr Hasan Haboubi winner of Moondance Cancer awards for his inspiring leadership and the implementation of Transnasal Endoscopy.

- Tina Jones Gastroenterology Clinical Nurse Specialist successfully completed her training in less than 14 months to become an accredited Colonoscopist.

- Senior Nurse Carly Simpson was honoured by Her Majesty the Queen in the summer for her outstanding contribution to nursing.

The Clinical Board recognise and celebrate success in the form of Celebration Events. Our next celebration event is planned for November which allows the Clinical Board to share so many excellent examples of innovative practice, making improvements in the quality and safety of the care we provide. Words cannot describe how thankful the Clinical Board are for the sheer determination, enthusiasm, commitment and above all courage our staff continue to demonstrate. Working as united teams, sharing both good and bad times, learning to work in different ways in order to ensure patient safety, quality and experience is maintained.

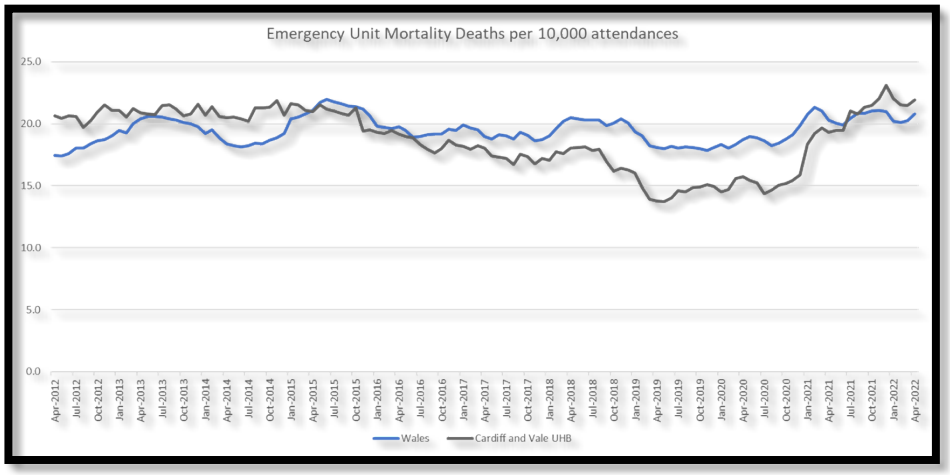
Effective Care

Mortality reviews

Mortality reviews are routinely undertaken as part of Directorate QSPE meetings in line with the All Wales Checklist. Mortality Level 2 reviews are undertaken with a proportion shared at Directorate QSPE meetings as a means of discussion and shared learning. The Clinical Board is fully engaged and supportive of the Independent Medical Examiner reviews and form part of the UHB Mortality Group with feedback shared at Clinical Board QSPE meetings.

ED Mortality

ED mortality reported as deaths per 10 000 attendance has tracked the national rate with increased mortality noted from the outset of Covid-19 across and Wales and in Cardiff and Vale.



National Audit
Processes to oversee the results performance and improvements relating to:
National COPD audit
National Asthma Audit
National Early Inflammatory Arthritis Audit
National Lung Cancer Audit
Sentinel Stroke National Audit Programme

Each Directorate has a Clinical Lead and forms part of the Clinical Board Director's responsibilities. The Clinical Board welcomes the implementation of AMaT from 7th November 2022 which will enable clinical audit, quality improvement and service evaluation projects to be registered electronically with NICE guidance automatically uploaded once published.

Examples of some clinical research/audits undertaken are noted as:

The Parkinson's Team have started Sialorrhoea injections as per NICE recommendations for severe drooling in Parkinson's. The data analysed has been overwhelmingly positive and improved patient care and cost saving.

A recent NICE guidance Stroke compliance audit demonstrated an overall good compliance. Key areas for development were identified as; Emergency Department Stroke assessment and admission pathway, TIA clinic reconfiguration, imaging pathway for Stroke and TIA, development of an intracerebral haemorrhage pathway and development of a stroke-surgical pathway.

The Memory Team undertook a QIP project 'Barriers in accessing memory services' which was a National Award Winner at the 2022 Dementia Masterclass. There are around 5,773 patients living with Dementia in Cardiff & Vale. By 2030 the number of patients is expected to increase by more than 30%. The Memory Team see an average of 130-150 new patients per month, and support 3,500 patients overall. The aim of the QIP project was to recognize possible barriers in accessing memory support and care in Cardiff & Vale, to detect any delays in the diagnostic pathway of dementia patients, if any trends were detected, and to formulate possible solutions or additional support that could be implemented by the memory service. The QIP project concluded there appears to be an underrepresentation of ethnic minority population presenting to Cardiff & Vale MAS

(ethnic minorities represent 20.1% of overall Cardiff & Vale population). The majority of patients presented to their GP's after more than six months of experiencing symptoms, with patients in the Vale more likely to present earlier. Covid-19 had an adverse effect on both patient presentation to their GP as well as in accessing specialist memory assessments in secondary care. Ethnic minority patients reported more barriers in accessing memory assessments in secondary care. Overall there were good levels of satisfaction with the Memory Service, with scope for improvement. Interventions following the QIP project included education programmes within communities to improve awareness, targeting cultural and religious establishment to improve awareness and education amongst the minority population groups. Formal GP sessions to improve recognition and need for early referrals to MAS, and enhance the role of memory link workers to support patients and carers in the community.

Undertaken by two independent auditors, the Do Not Attempt Resuscitation Audit within St Davids Hospital, which is reviewing whether patients DNACPR decision making was appropriate, and was there any bias during the Covid-19 pandemics has nearly concluded. A review of 30 sets of notes pre Covid, during Covid and post Covid has assessed where the DNACPR decision was made and documented, was the DNACPR appropriate for those patients, and the quality of the DNACPR documentation.

Tendable allows clinical areas, Senior/Lead Nurses and Infection Prevention and Control, to undertake Core Standard Audits. This is linked to a Nursing Dashboard within Business Intelligence System providing the Clinical Board and Directorates with key Quality and Safety, Patient Experience, Staff Experience/Workforce and Improvement data. Examples include the deteriorating patient; a review of over 30 patient records indicated NEWS charts were fully completed, calculated correctly and reviewed in line with protocols/timings. Patient Checks; 100% patients had a drink to hand; 100% patients had a working call bell within reach and 93% of patients were wearing an ID band. Areas of improvement are required to support patients knowing their predicted discharge date, and what is required to get home, or to their next destination. In addition, further education is required relating to the completion of the Learning Disabilities pack.

A Deprivation of Liberty compliance audit has recently been completed for the Clinical Boards inpatient areas to understand the number of patients who met the criteria for a DOLS application, and of those patients eligible, how many patients had a DOLS submitted, and the process wards have to monitor and track DOLS applications. The audit identified variation across ward areas as to how DOLS applications are managed and tracked. Immediate actions were undertaken to address areas with lower performance to ensure all eligible patients had a DOLS submitted. Monthly spot check audits are undertaken to ensure ongoing management and compliance of DOLS. There is a need to establish local methods of managing DOLS, review and transfer between wards. Consideration is being given to add to Tendable to support compliance monitoring and the exploration of complimentary electronic solutions to DOLS traceability and tracking. Teaching sessions with the DOLS team focused for both medical and nursing workforce is being explored.

Sam Davies Ward in Barry was one of the first wards to use Welsh Nursing Care Records in August 2022. The ward was really excited and motivated by the implementation of this change and immediately saw how it would improve documentation standards. Staff reported it was much easier to use than initially believed, saving time throughout busy shifts.

Dr Hasan Haboubi, the clinical lead for a Moondance cancer initiative piloted the use of Transnasal Endoscopy (TNE). The benefits were identified as better patient outcomes as the procedure is less evasive and therefore more comfortable. The pilot improved efficiency as TNE can take less time with fewer resources, and showed a reduction in the use of aerosols. The pilot identified 94% patients were satisfied with their TNE, 33% had no discomfort, 64% a little, and 3% a lot. 98% stated it was easy to communicate during the procedure. As a result, Phase 2 has commenced at Cwm Taf with positive media feedback.

Virtual Ward is a means by which we can safely care for patients in Acute Medicine who would otherwise have an inpatient stay. Working collaboratively with Acute Medicine, Diagnostics and Integrated Medicine over 1,000 patients to date have been able to stay at home to receive care with 1,500 medical bed days saved and 250 medical same day emergency visits avoided. Patients are referred to Medicine and seen by an Acute Physician, and then referred to Virtual Ward. The Virtual Ward MDT plan the patients' package of care, and discharge the patient home, before deploying wraparound support to enable patients to access speedy diagnostics, virtual clinics, daily check ins, and treatment plans all from the comfort of their home

Person centred Care

Happy or Not Machines
Patient experience surveys

Concerns

Concerns between 01st March 2022 – 30th September 2022

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

The Clinical Board aims to resolve all concerns by early resolution with contact from the relevant Ward Sister/Manager, Senior/Lead Nurse or clinician. From 01st March 2022 – 30th September 2022 the Clinical Board responded to 926 concerns. The top three themes received for concerns relate to clinical assessment/treatment, communication and attitude and behavior. Case reviews are undertaken as part of Directorate QSPE to share any potential learning and themes. 'Learning from Events' and feedback from Welsh Risk Pool are shared at Clinical Board QSPE to inform shared learning and outcomes.

Compliance with the timescale for formal concerns has shown improvement from August to September. The current position for the Clinical Board is 82%. This is discussed at all Directorate Performance Reviews and Clinical Board QSPE to help drive the continued improvement required.

Patient Experience
All areas of the Clinical Board are engaged with the Patient Experience Framework. Paediatrics Emergency Unit launched a patient feedback initiative earlier this year and received hundreds of

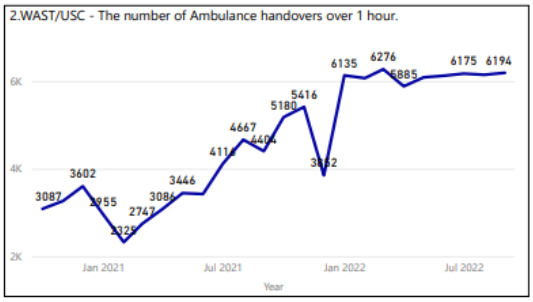
responses. These have been used to bring about improvements in the environment with an application submitted to CAV Health Charity to refurbish the department and facilities.

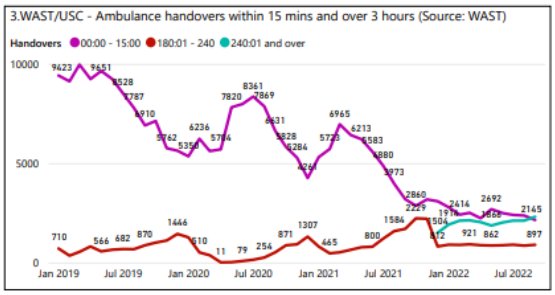
The Clinical Board share a patient story and compliments at Clinical Board QSPE each month to share good practice, areas for improvement and learning outcomes such as Learning From Events for patients in our care. An example of a compliment recently shared at QSPE:

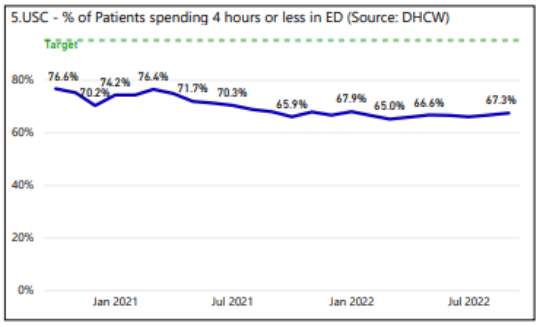
> *'I would like to thank you all for the care and attention you gave to John during his long stay in hospital. I can honestly say Lakeside Ward 2 was the best ward he has ever been on. Special thanks to the medical team for giving me 'the talk' on end of life care with such dignity, tact and compassion. All the nurses who cared for him did an excellent job, but I must express my deep gratitude to the nurse who was with John at the time he passed away. John could not have been in better hands and deserves a special mention for his compassion and tender care'*

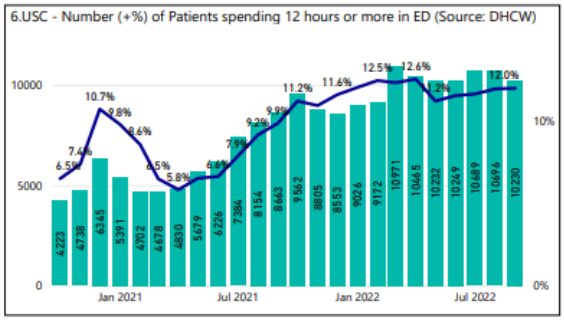
The Parkinson's Team have developed My Parkinson's, a web-based application for people with Parkinson's, their families and carers. This was introduced through clinics and local groups. Feedback from the service users has been positive, surprised by its ease of use. Self-rated scores for confidence in self-management increased. All users advised they would recommend My Parkinson's to others.

Timely Care









Health Inspectorate Wales (HIW) made an unannounced visit to the Acute and Emergency Medicine Department in June 2022 with the report published 30th September 2022. The majority of patients advised staff had treated them with respect, and had taken measures to protect their privacy whilst being seen in the Emergency Unit or Assessment Unit. Generally, patients agreed staff provided them with enough information to help understand their healthcare and medical conditions. A summary of the recommendations included:

- Infection Prevention and Control and decontamination
- Medicines Management and storage

- Restocking of Resuscitation Trolleys
- Completion of Mandatory Training
- Promotion of Privacy and Dignity
- Promotion of Welsh Language Act
- Feedback to staff of actions undertaken in relation to Putting Things Right
- Audit follow up
- Leadership and management

Following the recommendations an immediate improvement plan was completed and included a meeting with the UHB estates team to determine a schedule of work to address the environmental issues. The Directorate and Estates are meeting 11th November to take this work forward. A formal daily checklist has been developed to ensure Tier 1 performance indicators are maintained in line with best practice and added to Tendable audit schedule, which also includes medical equipment audits. Support from Infection, Prevention and Control colleagues to undertake full IP&C audits, with dedicated cleaning schedules and review of housekeeping service within the Acute and Emergency Footprint. Capital bid for installation of TDSI system access to the medication room in ACU areas with all doors/cupboards broken repaired. Senior management staff are working collaboratively with Pharmacy and staff to ensure awareness of their legal responsibilities regarding medicines management standards. Documentation in line with Healthcare Standards are being audited, with educational boards implemented. Educational plans have been established including a trajectory to improve the required mandatory training.

In addition to the immediate actions, the Directorate are reviewing the current health promotion advise displayed across the department. To ensure the privacy, dignity and confidentiality of patients, all patients receive their consultations and assessments in dedicated examination rooms. Business cases are being developed to improve the environment across the Directorate. The current footprint of the Acute Medicine Unit is being reviewed to evaluate how the area can be used for maximum benefit. All Welsh speaking staff have the Welsh Language symbol on their uniform with posters placed within the department advising patients of the significance of the Welsh Language Symbol. The audio band system in the department is bilingual. A full review of signage in the department is being undertaken. Information boards are being implemented which includes information on Putting Things Right. The Executive Director of People and Culture and Executive Nurse Director, have met with the senior leadership team along with Workforce and Organisational Development, to coordinate a programme of development as requested by the Clinical Board

In order to improve the service to our frail older patients a project was undertaken to understand the reasons for low referral numbers to the Elderly Care Assessment Unit (ECAS) from the Emergency and Acute Medicine footprint. ECAS provides a full complex geriatric assessment and has a significant benefit in avoiding hospital admission. To improve the number of referrals the ECAS triage process has changed so patients in the Emergency and Acute Medicine footprint are prioritised, following engagement with both EU clinicians, Lead/Senior Nurses and EU Transformation Team. A Geriatric SpR also attends the EU Huddle as a means of identifying patients who could be pulled by ECAS. Early results suggested this multi-faceted intervention had a significant impact on increasing referral numbers. The engagement of the Emergency Department resulting in this change has been very encouraging. This project is ongoing and aims to continue directing frail patients away from A&E to appropriate intermediate services whenever possible

Overcrowding in the Emergency department remains on the Clinical Board Risk Register and scored as 20. Controls in place include the development of a UHB and local escalation policy and implementation led by the Clinical Board and OPAT. All vulnerable patients are escalated to ensure appropriate oversight and mitigation and there are Standard Operating Procedures in place for all ambulatory areas. The Clinical Board is engaged with and supportive of ‘on boarding’ and ‘full

capacity protocol' to facilitate flow. Change in Emergency Unit footprint to support flow. Introduction of two Band 7 nurses to support flow and OPAT.

Likewise, WAST handover ambulance delays remains on the Risk Register with a score of 20. Mitigation includes WAST hospital avoidance initiatives with some evidence this has reduced ambulance transfers. Protection of Resus capacity when possible including one buffer space. Standard Operating procedure in place within Emergency Unit to support immediate release requests. Joint Clinical Board/WAST partnership meetings to focus on improvement. Engagement with NRI process for reporting incidents were WAST delays have resulted in harm. Working with OPAT and supportive of 'on boarding and FCP' when ambulances have been held for 3 hours. Transformational work within EU, eg RATZ, Virtual Ward and Speciality Hub.

The Clinical Board in conjunction with the Improvement and Implementation team are committed to improving patient flow. To reduce congestion at our front door services, and patients allocated the right bed, first time, in a timely manner. Ward A1 has been reset to ensure patients with a predicted length of stay under 72 hours are admitted. In conjunction with this the Clinical Board are committed to providing 3 beds by 08:00am to support timely flow within the Emergency and Acute footprints. This supports the zero tolerance for 4 hour WAST ambulance delays.

Rapid assessment and treatment (RATZ) by a senior clinical decision maker within Emergency Medicine was deemed a priority for the ambulant stream of patients within the department. This enables patients to see an Emergency Department consultant early in their journey to ensure they are streamed to the most appropriate place for their needs, a prudent and value-based plan commenced for any investigations and/or treatments, reducing the risk of iatrogenic harm and the early recognition of those patients who could return home without further investigations. A pilot RATZ service commenced in November 2021, and deployed an iterative and agile learning process, before being launched in March 2022. Data since March has shown 30% of all patients who went through RATZ were discharged home, with no requirement to go further into the hospital system. 15% of patients were referred directly to specialties, reducing the significant waits they would have faced to see an ED clinician outside of RATZ. A further 55% entered the Emergency Department system with a plan in place to ensure only necessary investigations and treatments were commenced.

Dermatology
Within Dermatology the use of Teledermoscopy imaging enables consultants to diagnose low risk patients without the need for an outpatient appointment first. 60% of patients are discharged from the service without needing to attend clinic. To improve the pathway for urgent suspected cancers within Dermatology joint monthly meetings are undertaken with cancer services, and weekly USC meetings to monitor and review the waiting times and escalate as appropriate, supported by a USC coordinator. In addition to improve the diagnostic waiting times, CA62 stickers are added to the pathology forms to highlight a histopathology report is urgent. Waiting list initiative outpatient clinics have been implemented with additional theatre sessions to ensure patients are treated within target.

The Acne Service have introduced Virtual Group Clinics to reduce the current RTT position. By running one Virtual Group clinic of 15 new patients per week, all patients waiting more than 36 weeks will be seen by November 2022.

Efficient Care

Rheumatology
Rheumatology have implemented a Patient Initiated Follow Up/SOS service based on their symptoms and individual circumstances. Feedback has been positive with 100% of patients

reporting they received an appointment much sooner than expected following initial contact, and were extremely confident with their treatment plans.

Paediatrics Emergency Department introduced electronic results sign off via Welsh Clinical Portal well in advance of the UHB roll-out. This has shown improvement in signing x-rays with reductions in missed results.

As part of Right Bed First Time C5 introduced a clinical led flow model with respect to board rounds. The small change in the timings of board rounds has seen a big impact on communication and team working in relation to patient discharges and flow.

Maintaining safe and timely patient flow across the Clinical Board continues to be a significant challenge. To support discharge and reduction in the number of DTOC's, focused deep dives are undertaken across ward areas with multi-disciplinary involvement to promote timely discharge.

Equitable Care

Gender Services

The Welsh Gender Service has been working with colleagues to develop satellite clinics across Wales to improve accessibility for more individuals. The clinics staffed by Welsh Gender clinicians allows patients based upon where they live, to choose a location be that virtual or in person. The first satellite clinic has been set up in North Wales seeing their first patients in September. The aim is to continue expansion provision across Wales. To support Welsh Gender Services making informed changes to their services, patient reported experience measures questionnaires (PREMs) are now live bilingually with a QR code included on patient letters from 01st November being used to assess the quality of healthcare experiences, focusing on patients. Within Welsh Gender Services a PrEP (Pre-Exposure Prophylaxis) referral pathway is now in place. This is a new HIV strategy in which HIV-negative people use HIV antiretroviral drugs, usually used to treat HIV infection, to reduce their risk of becoming infected with HIV.

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

Nursing workforce: The Clinical Board is proactively reviewing nursing establishments with a view to remodelling the nursing workforce to ensure safe staffing levels are maintained in our clinical areas. It is however recognised this work will take time, and may not support the current gaps we have within our staffing establishments. This is impacting on our ability to provide safe care to our patients and is currently the Clinical Boards highest risk on our Risk Register. The current Registered Nurse vacancy position across the Clinical Board is 66 WTE. There has been active, ongoing recruitment alongside generic recruitment, student streamlining and overseas nurses. A further 7 overseas nurses will be in post by December. These numbers factor in the closure of Ward C5 with staff moving to Wards C7 and Heulwen North. In order to open additional winter capacity further staffing will be required which potentially may impact on an already fragile workforce.

Medical workforce: Frailty consultants recruited with a 6 day frailty service in the Assessment Unit commencing November 2022. Acute Medicine Consultant posts are out to rolling advert with recruitment efforts ongoing. There is a new round of F3 recruitment planned early in new year to offset locum use, particularly in traditionally non-commissioned capacity.

Emergency Department pressures and overcrowding: Plans discussed for Medical teams to support specialty patients whilst they are held in the Emergency and Acute footprint. There are a large number of patients (up to 80, average approximately 40) with a decision to admit across this footprint. There is a plan for those patients to receive daily input from appropriate specialty teams

whilst awaiting a ward bed; a principle enshrined within a new document under review to describe expectations of specialist teams and their input to patients within the Emergency Department and Assessment Unit footprint. Successes in offloading ambulances and marked reduction in ambulance waits on the Emergency Department forecourt is a major recent achievement of our system. We must not under-estimate the extra efforts of our ward areas who despite staffing challenges of their own are supporting onboarding, and enactment of the full capacity protocol, that ultimately enables the offloading of our patients from ambulances, and facilitates WAST returning their ambulances to patients in need within our community settings.

Recommendation:

The Committee is requested to:

a) **NOTE** assurance provided by the Medicine Clinical Board Report Medicine Clinical Board QSE assurance report; and
b) **AGREE** the mitigation being taken to improve quality, safety and experience and reduce harm.

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

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

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

Prevention		Long term		Integration		Collaboration		Involvement	

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

Risk: Yes
Noted within document
Safety: Yes
Noted within document
Financial: Yes
Noted within document
Workforce: Yes
Noted within document
Legal: No
Reputational: Yes
Noted within document

Socio Economic: No	
Equality and Health: Yes	
Noted within document	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Quality Indicators – Progress Report				Agenda Item no.	2.2	
Meeting:	QSE		Public	✓	Meeting Date:	29/11/2022	
			Private				
Status *(please tick one only):*	Assurance	✓	Approval		Information		
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Assistant Director of Patient Experience						

Main Report

Background and current situation:

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

There have been significant operational pressures across the Organisation, made more challenging with the ongoing staffing pressures.

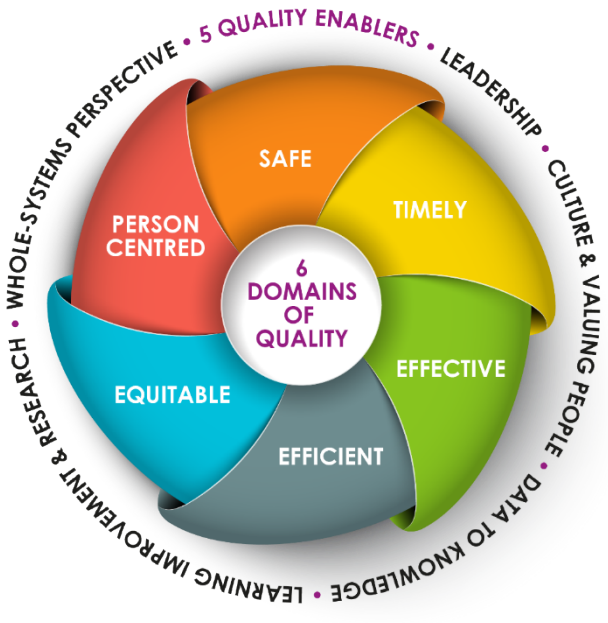
We are seeing an increased presentation of patients with complex mental health and behavioral needs within Adult and Paediatrics care which is adding additional pressures.

Maternity services also continue to be under pressure with increased volume and complexity of maternity cases coupled with ongoing staffing pressures.

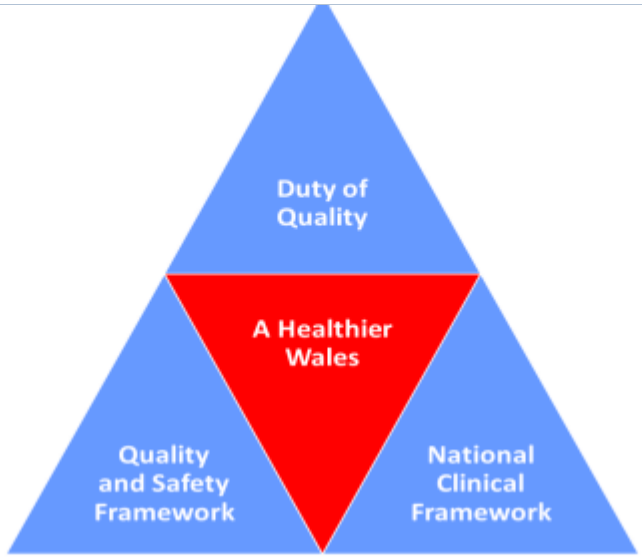
In particular, we are receiving a number of concerns relating to the EU Department. In the main, people are complimentary about the staff, the key issues are the environment, the experience and the waiting times.

The QSE framework continues to be embedded and the committees/groups will all be in place in 2022 with a workplan. The Stakeholder Reference Group will be established in 2022.

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



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



Key messages

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

Cardiff and Vale University Health Board Quality, Safety and Experience Committee and Group Structure

Board

QSE Dashboard/Signals from noise

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

- High Impact Topics
- IP&C
- Safeguarding
- Clinical Board Deep Dive Assurance Reports
- HIW
- Significant National QSE Reports

Organisational Learning Committee (Chairs-Executive Medical and Nurse Director)

Terms of Reference to be agreed

Clinical Safety Group (Chair: Executive Medical Director)

Pressure Damage	Medicines Management
Medical Devices	Dementia
Falls	Nutrition and Hydration
Consent	Cleanliness
Decontamination	Research
Patient Information	Blood Transfusion
Resuscitation (RADAR)/NEWS	Sepsis
VTE	Patient Safety Solutions
NatSSIPs	Suicide Prevention
POCT	Transition
Organ Donation	JAG
IRMER	Learning from Deaths

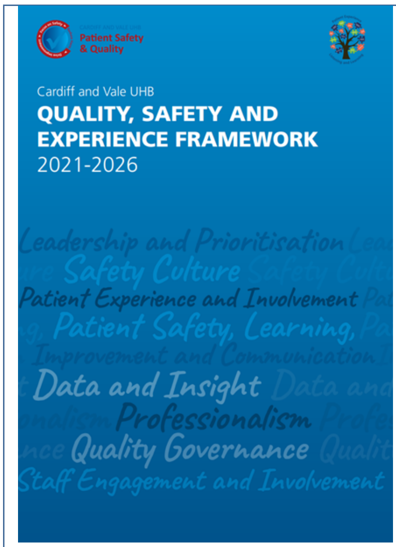
Clinical Effectiveness Committee (Chair AMD for Quality and Safety)

- Local Clinical Audit
- National Clinical Audit
- NICE
- CEPOD
- Accreditation
- External Peer Reviews
- Consent
- CAVQI

NRI/ Concerns (Chair: Executive Nurse Director)

- Complaint/Claims
- Serious Incidents
- Patient Experience and Involvement
- Never Events
- Inquests
- Once for Wales Concerns Management System
- Covid Investigations
- Joint Investigations with other organisations
- Being Open/Duty of Candour
- QSE Dashboard

Clinical Board/Directorate/Site-Based Leadership Quality, Safety and Experience Groups



The structure above is our QSE framework - the final committee being established is the Learning Committee to progress the whole systems approach to learning across Cardiff and the Vale.
We believe that in focusing on these 8 key priorities, we can aspire to provide safe, effective services, that deliver an excellent user experience, equal to the best healthcare organizations in the world.

These eight key areas are:

• Safety Culture
• Leadership and the Prioritization of QSE
• Patient Experience and Involvement
• Patient Safety Learning and Communication
• Staff Engagement and Involvement
• Data and Insight
• Professionalism of QSE
• Quality Governance Arrangement

Traditionally, we have focused on things that go wrong, and of course this is important and something to which we will always be committed. However, to really become one of the safest, high quality organisations in the UK where people and patients experience great care, we recognise that there are a number of key enablers that we have to address. We are now ready to move away from current approaches which focus on harm (Safety 1) to more contemporary methods which align with other safety critical industries (Safety 11). Our approach to safety needs to move from ensuring that 'as few things as possible go wrong' to ensuring that 'as many things as possible go right'. We need to achieve a whole system shift in which our QSE priorities in Community and Primary Care carry equal attention to that in our secondary and tertiary care services

For many years each of the Clinical Boards have active QSE meetings where concerns are discussed and where cases are presented for shared learning, peer review and discussion. The governance structure described in our framework will facilitate the whole system learning approach embedded in the Duty of Quality with the constant strive to improvement.

The Health and Social Care (Quality and Engagement) (Wales) Act 2020, introduces a Statutory Duty of Quality and a Duty of Candour and we look forward to working with colleagues across Wales, to implement the Quality and Safety Framework: Learning and Improving.

Our vision is ambitious and needs to be achieved while recognising the work that is required to deliver the 'four harms approach' to our Covid-19 recovery plans. We also need to focus on how we most effectively contribute to the reduction of health inequalities. There is increasing evidence of the

differences in healthcare outcomes and access to services experienced by different ethnic and cultural groups within our communities. We know that socioeconomic status and where someone lives, also impact on mortality and morbidity. The pandemic has magnified these inequalities.

The last committee to be established will be the Learning and Improvement committee, as we needed to have all of the other groups in place and these have been established in the weekly NRI/concerns meeting, The Clinical Effectiveness Committee, Clinical Safety Group and then the Learning Committee

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

Safe

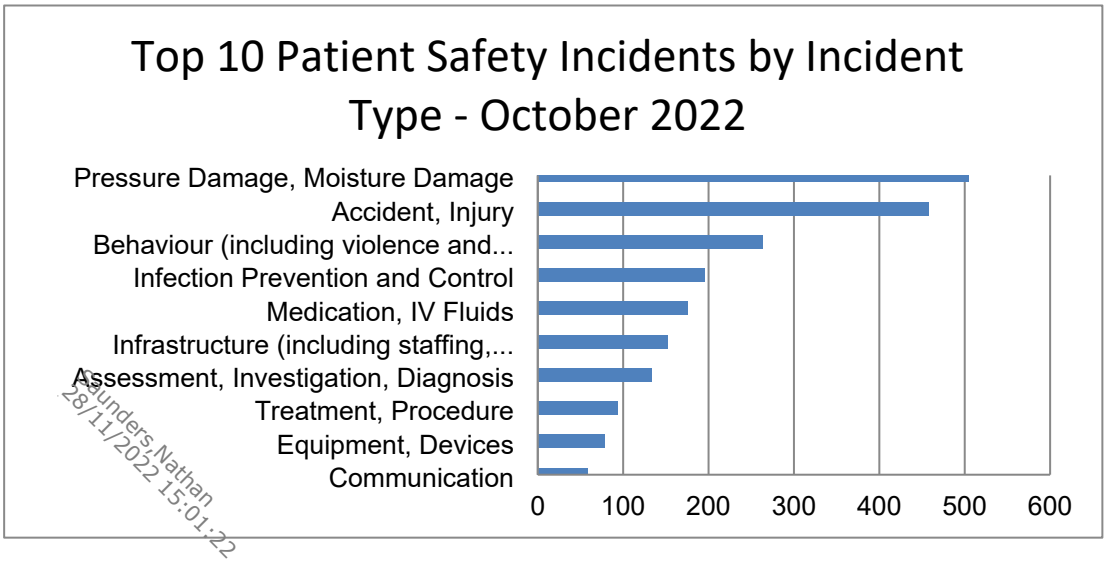
Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce,

Incident reporting

The chart below illustrates patient safety incidents reported in October 2022 by incident type. A total of 2403 incidents were reported in October 2022, again, the most commonly reported incident relating to the development of pressure or moisture damage.

Pressure damage is subject to investigation to establish if there were any modifiable elements or omissions in healthcare. Pressure damage that is deemed to be associated with healthcare provision are subject to national reporting requirements.

Accident/Injury (falls) is the second most commonly reported incident; these 2 categories often alternate in terms of most prevalent.



Pressure Damage

Whilst there was a reduction in apparent pressure damage between May 2021 and March 2022, it is not known if this reduction was due to a genuine improvement or simply less reports completed on Datix. We are aware that there were significant operational staffing pressures during this period.

From April 2022 however, the incidence of reported pressure damage increased and peaked in July - a marked increase in Pressure Ulcers to 3.41 per 1000 bed days. We know that short staffing incidents also peaked in July 2022 over the summer holidays, when it was more difficult to fill shifts with temporary staff.

There is also consideration that this potential increase in pressure damage in Spring 2022 may be a result of long waits for ambulances in the community and the long waits on an ambulance outside of EU as well as delays in admission to beds on wards for patients with “decision to admit”. The Welsh Ambulance Service are now starting to collate information relating to community/handover delays, so that a more informed assessment can be made when assessing pressure damage risk.

Looking at short staffing incidents, the chart below shows the peak in the summer months, the usual impact of the summer holidays on the ability to fill unfilled shifts was exacerbated by the ongoing staffing pressures being experienced across the Health Board. As already mentioned, July (which shows the peak in short staffing incidents reported) also recorded the peak in pressure damage.

The figures reported whilst high, undoubtedly reflect an under-reporting.

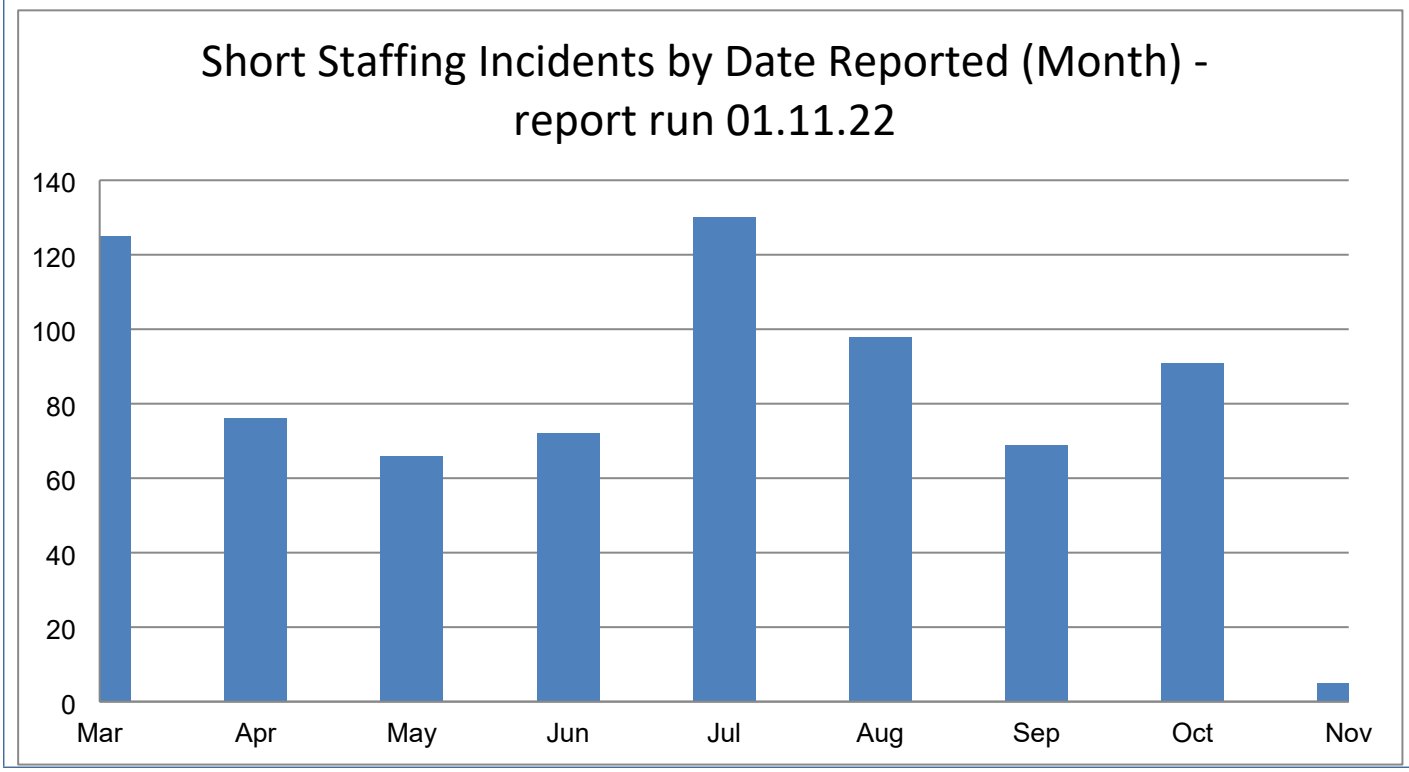
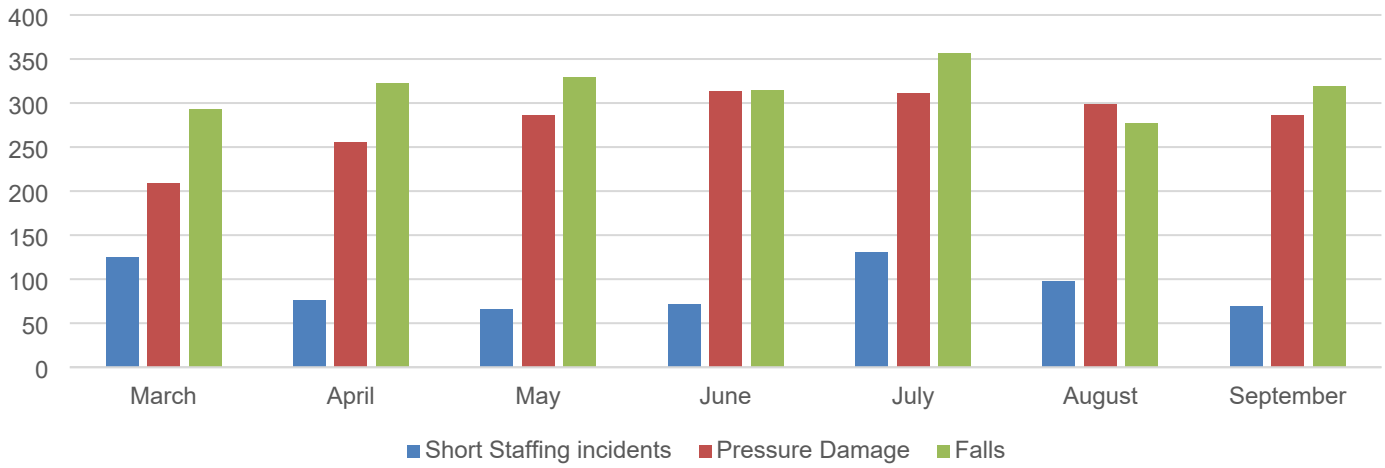


Fig. 8 Staffing/pressure damage/falls incidents by month (from March 2022)

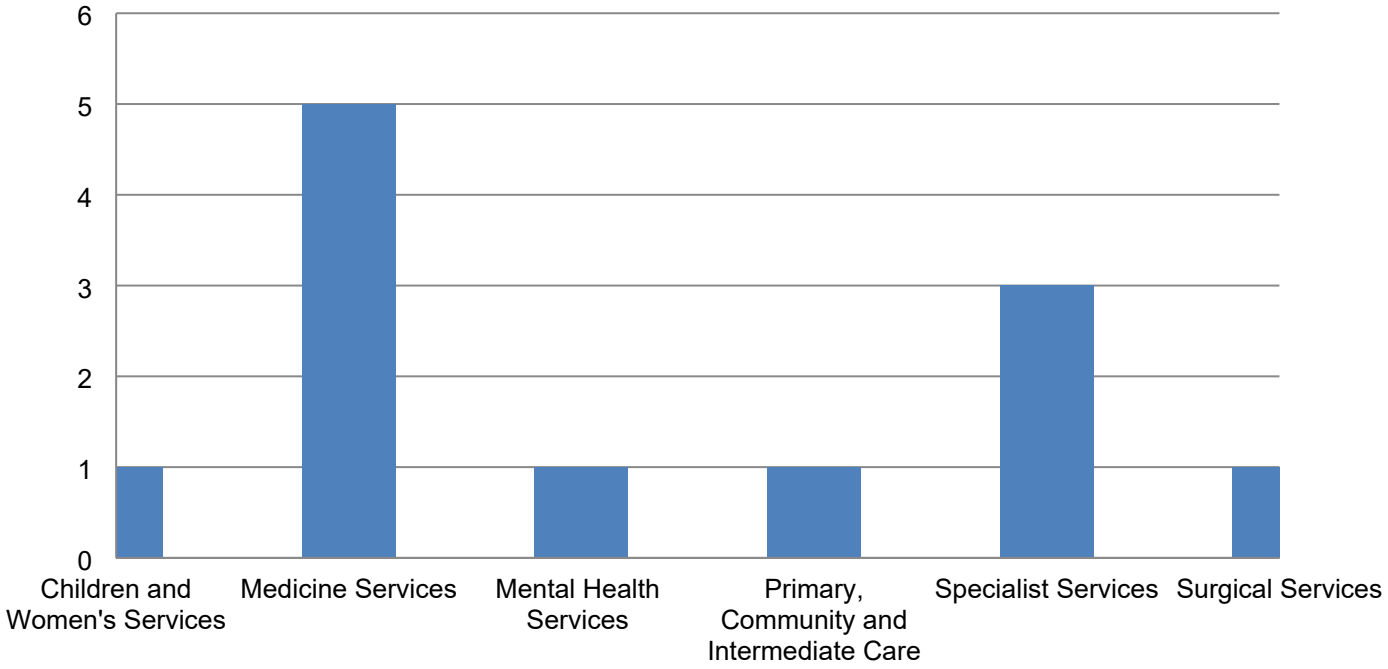


The tables are used to examine whether there was any correlation between short staffing incidents and pressure damage and falls reporting. Specifically, to examine the theory that short staffing incidents leads to a reduction in falls, as there are not the staff to mobilise the patients, and therefore an associated increase in pressure damage as a result. This is not suggested above, however, this data does not account for rates per 1000 bed days. July shows a peak in falls at the time when there was also a peak in short staffing incidents. We do know however that staffing is under reported so the true position of staffing may not be determinable from the above.

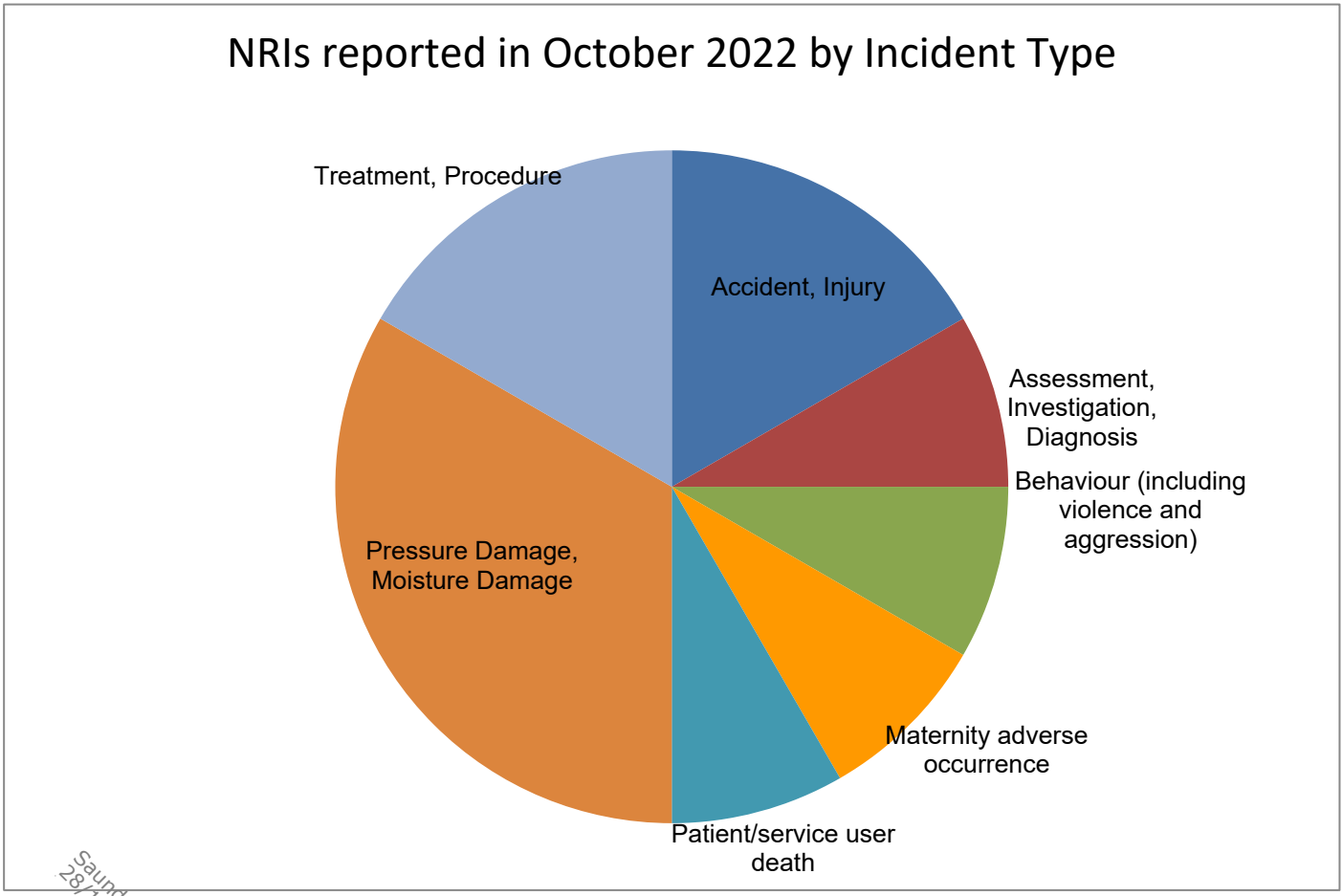
Nationally Reportable Incidents (NRIs)

The table illustrates performance of Nationally Reportable Incidents until 31st October 2022. The position has improved over the last month, the open NRIs have reduced, as have the number of overdue NRIs. In September there were 53 open and 34 overdue, an approximate reduction of 10%. The two areas which have significantly reduced their overdue position are Mental Health, who had 7 overdue NRIs in September compared with 4 as of the end of October and Exec and Corporate, which has reduced from 6 in September to 3 in October, a reduction of 50%. The Exec and Corporate incidents relate to delays in ambulance conveyance (Appendix Bs).

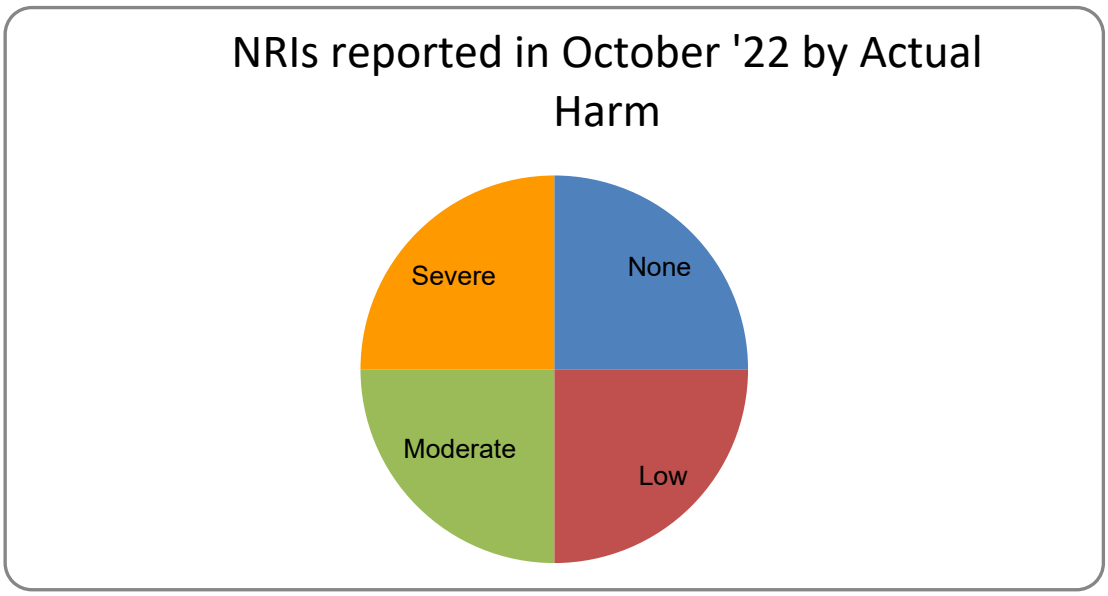
Clinical Board	Open NRIs as of 31.10.22	Overdue NRIs as of 31.10.22
Children and Women	11	5
CD&T	2	2
Executive	4	3
Medicine	9	8
Mental Health	7	4
Surgery	7	5
PCIC	3	2
Specialist	5	0
Total	**48**	**29**



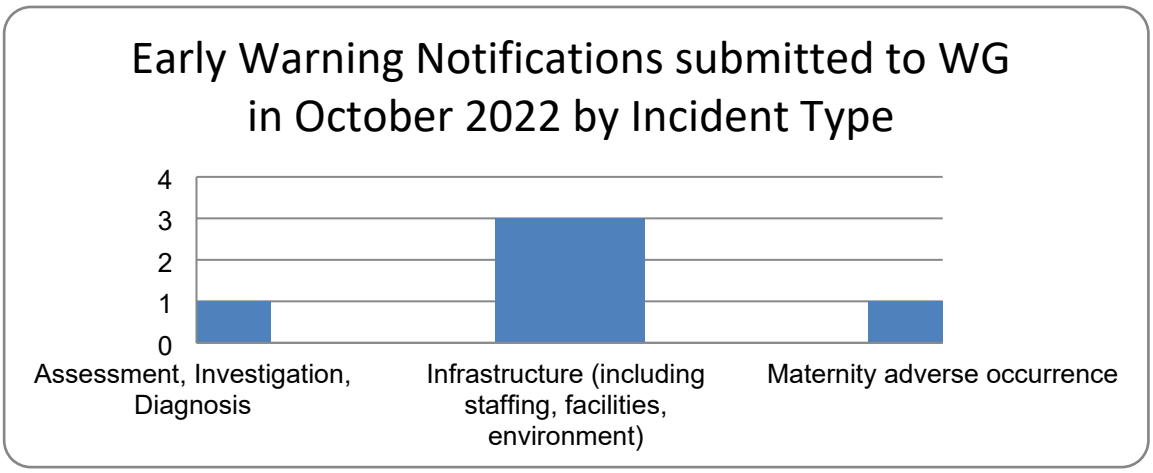
Twelve NRIs were reported in October by C&V, compared with six in September.



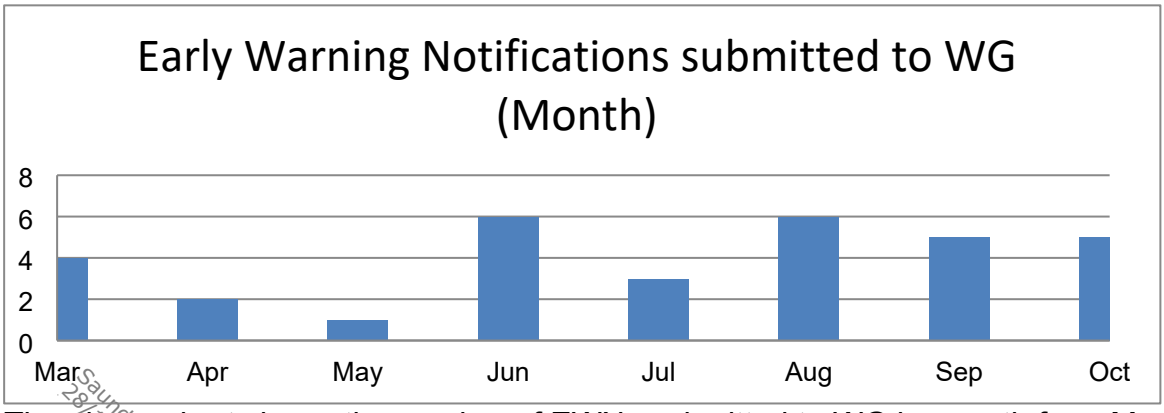
80% of the NRIs reported in September related to care acquired avoidable pressure damage, in October there were more NRIs and a wider scope of incidents reported, 67% of the total were attributable to avoidable pressure damage in October.



The above shows a more even distribution of assessed harm from the NRI, in September, 50% was attributed to moderate harm, 30% to severe and 20% to low harm.



The above illustrates the Early Warning Notifications reported to Welsh Government in October by incident type. This is the same number as last month.



The above chart shows the number of EWNs submitted to WG by month from March 2022.

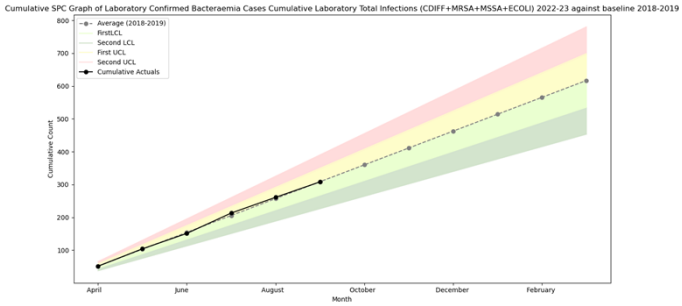
No Never Events were submitted during October 2022.

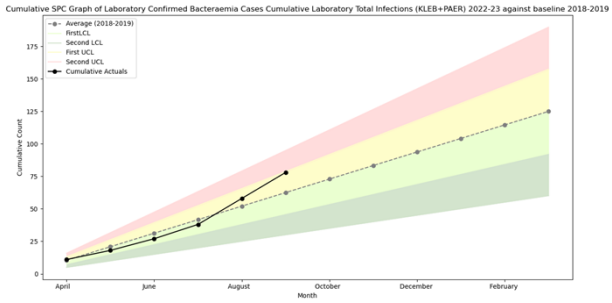
Infection Control

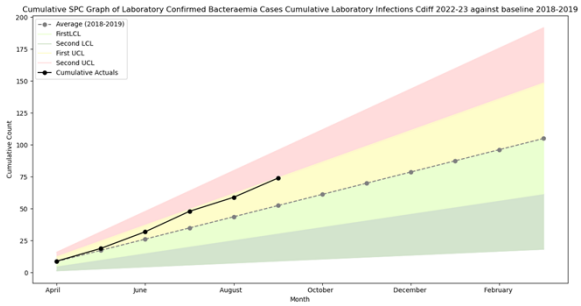
Hospital Infections – the grouped total Cdiff, Ecoli, MRSA and MSSA infections, is showing no in-year improvement against the 2018/2019 baseline. However, Ecoli, MRSA and MSSA are demonstrating an in-year improvement, whereas Cdiff in-year has increased, compared to baseline of December 2018.

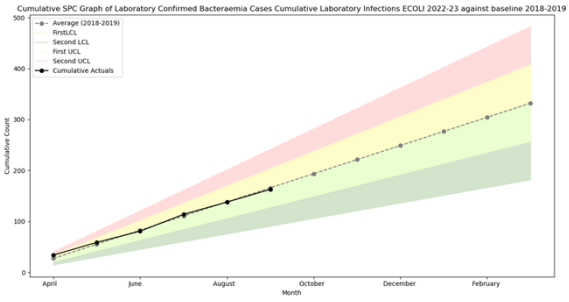
Cdiff rates were observed to be high across the UK after the first and subsequent waves of Covid, all community cases are now subject to investigation to understand the cause of the infection.

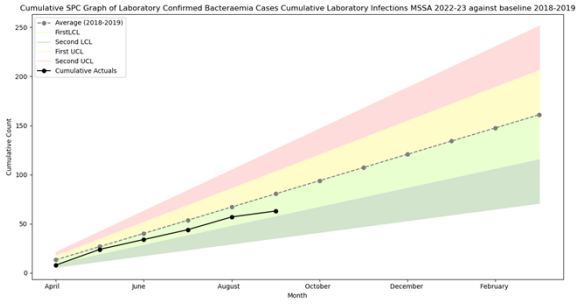
There has been significant investment in the IP&C team in the past 2 years, which has enabled increased audit and review of infections and supports a bespoke approach to supporting wards and primary care reviews.

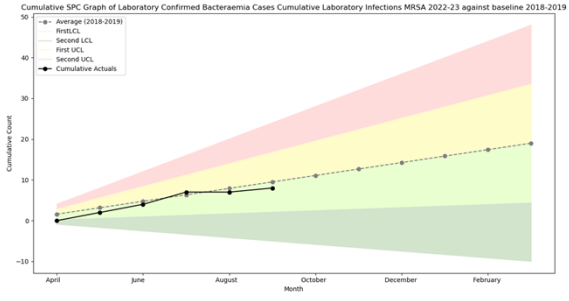


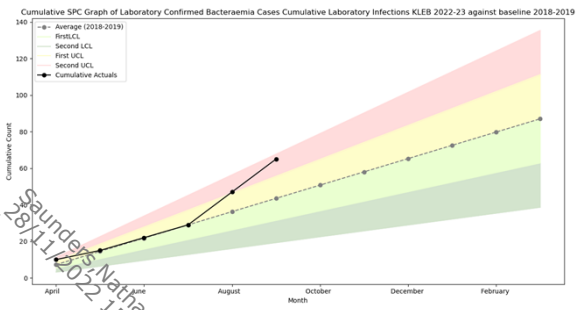


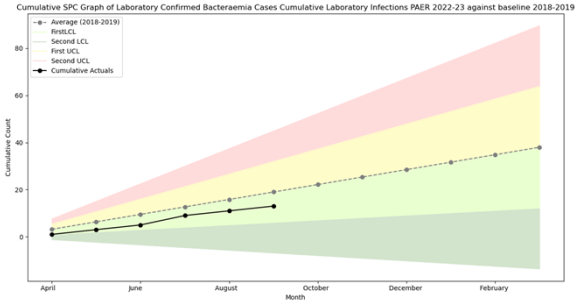


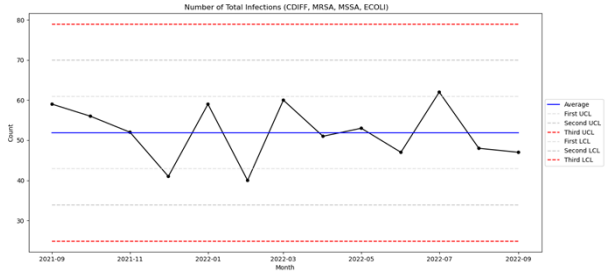


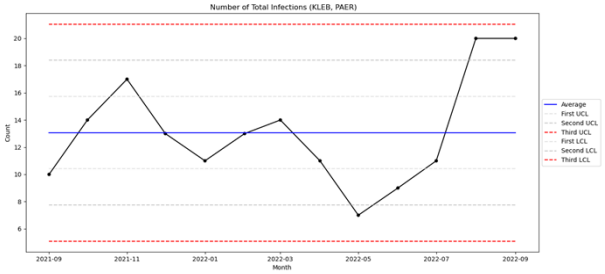


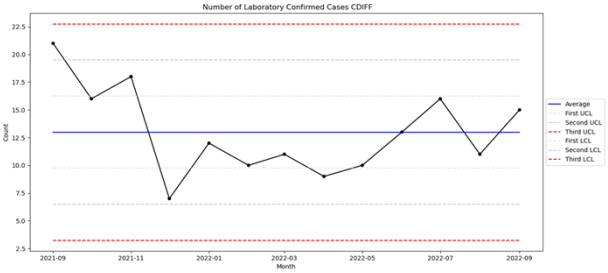


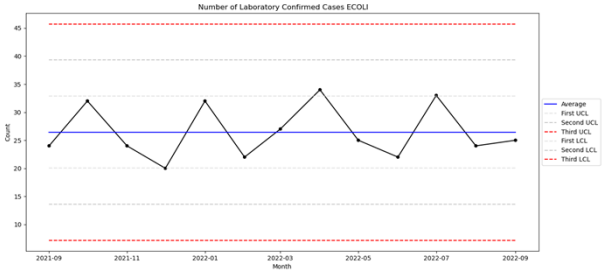


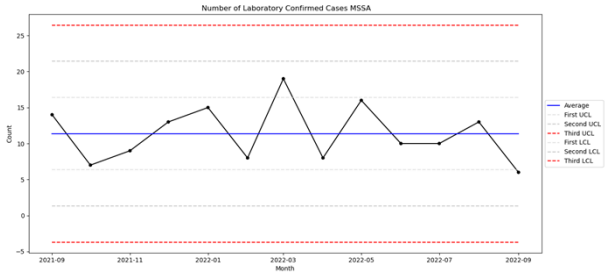


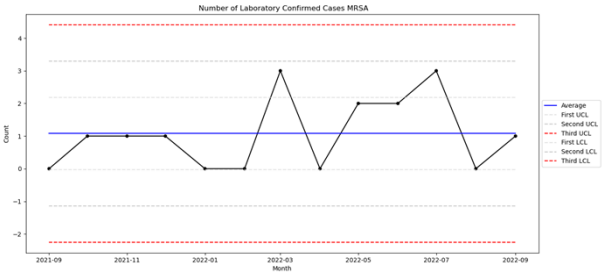


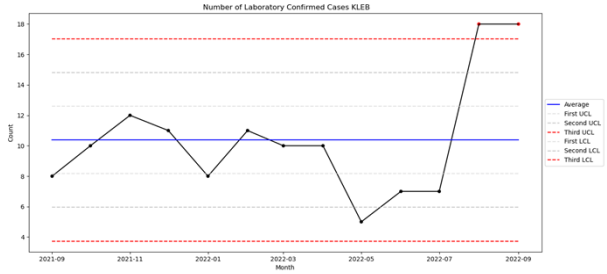


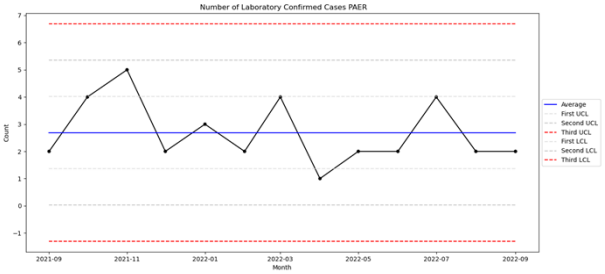










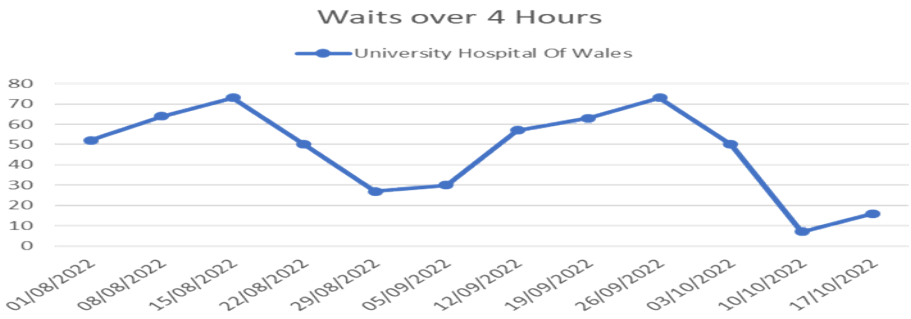


Actions to progress the improvement trajectory

- Weekly Cdiff/SAUR meeting with IP&C, Micro, AMR specialist pharmacists ongoing
- Plan to reinstate MDT review rounds with the above
- MRSA RCA review meetings with the EMD, EDON, IP&C and clinical teams
- IP&C audit plan for 2022/23 includes increased audits of PCV/CVC bundle compliance and insertion pack usage
- ICNET SSI surveillance to begin within the next month
- Working with clinical teams to further standardize products/procedures including IV access teams
- Regular audits of clinical environments and equipment
- Working with Capital/Estate/Facilities teams to improve clinical environments
- Build on the existing Education programme to widen staff groups included

Timely

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



The Health Board is currently developing the – RELEASING TIME 2 CARE

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

Key principles of the framework include:

1. Identifying problems.
2. Developing solutions.
3. Testing ideas.
4. Using visual queues to focus performance.
5. Embedding strong communication between teams.

- **Expected benefits** of the approach:
  - Improve experience for staff working on wards.
  - Better organisation of ward processes.
  - Smoother discharge planning and organisation – reducing length of stay.

Following the pandemic, the long waits for treatment etc. have worsened.

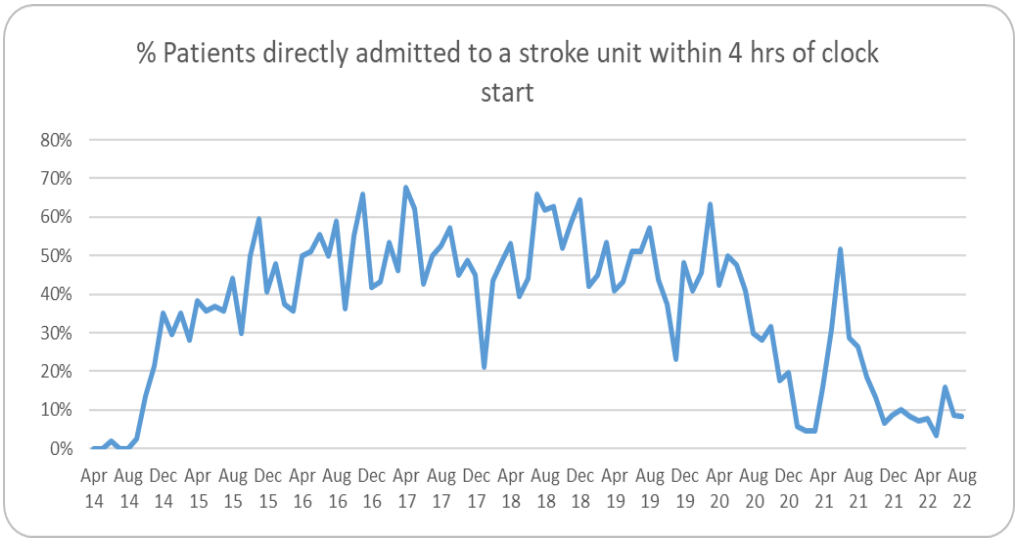
Addressing the Challenges

50 Winter Beds - Acute Sites	Increase bed capacity by 50 beds across A5; Heulwen South and UHL
1000 beds	38 additional nursing and care home beds have been commissioned
Step Down	St Davids redesign (Enablement) and MFFD Ward on Lakeside
Frailty	Expansion of the frailty model to provide more capacity and revised pathways
Acute Medicine Model	Expand virtual wards, strengthen SDEC model and increase acute care physicians
Mental Health	Additional capacity for third sector organisations to help support dementia patients and their families
Primary Care	Urgent Primary Care Centres, Cardiff and Vale Health Inclusion Service, CRT/VRCS, CAV 24/7
Third Sector	Additional third sector projects including care and repair
Imaging	Additional imaging capacity for inpatients, diagnostics day unit
Patient At Risk Team (PART)	Commission PART team 24/7 to mitigate unmet need which is currently 10-15% of all referrals to ICU
Supporting Our Teams	Staff wellbeing, supporting each other and working together

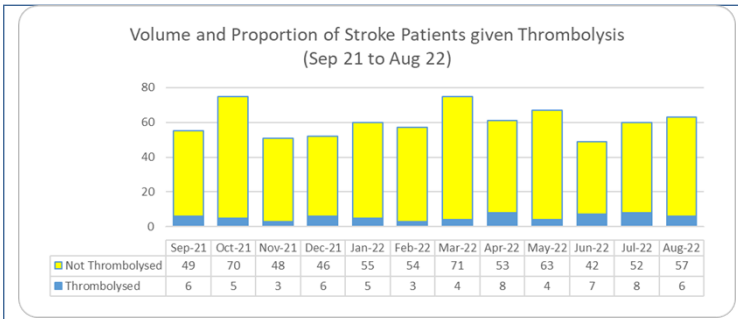
Effective

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

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



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



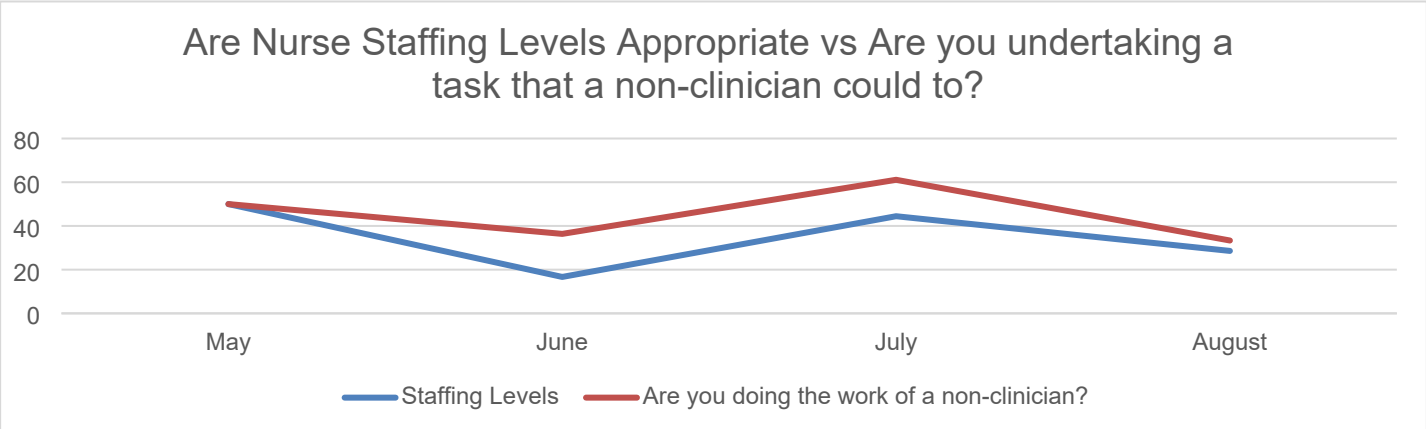
There is ongoing work to improve the service:

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

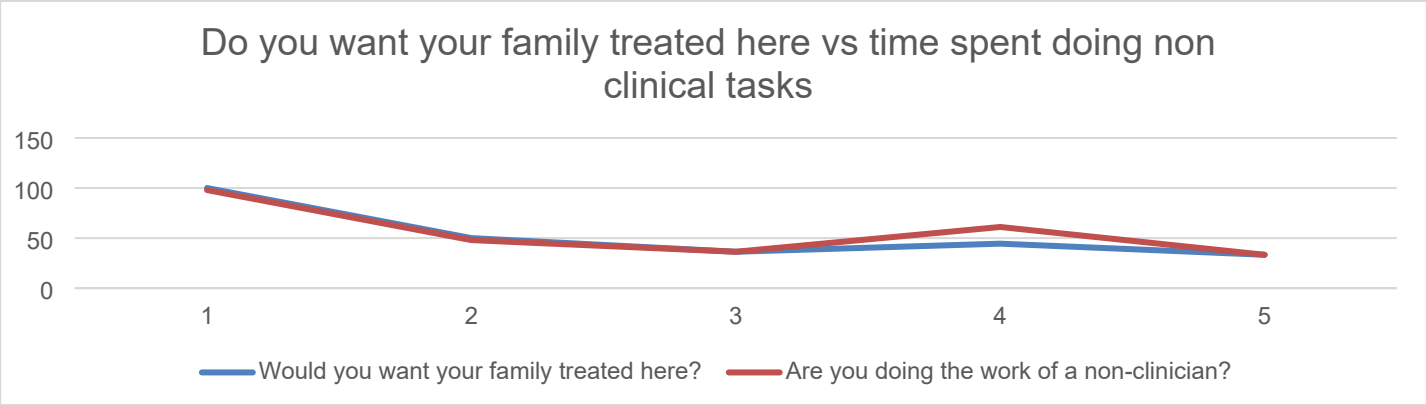
Efficient

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

Some of our information collated through the tendable platform, enables us to analyses some of the best use of resources questions



The more nurses feel that staffing levels are inappropriate, the more they report doing tasks that could be undertaken by a non-clinician. This correlation is, in part, contributing to the consistent reduction in staff wellbeing scores



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

Equitable

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

This is an area of focus in the Health Board. We are aware that both ethnicity and socio-economic status has a direct causal link to poor outcomes and significant chronic health conditions. The health board is working with partners to develop effective partnership models to address health inequalities experienced by ethnic minority communities, including the identification and implementation of policy and service interventions and regular engagement with relevant statutory, voluntary and private sector stakeholders and communities, on issues relevant to health equity.

Person-centred

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

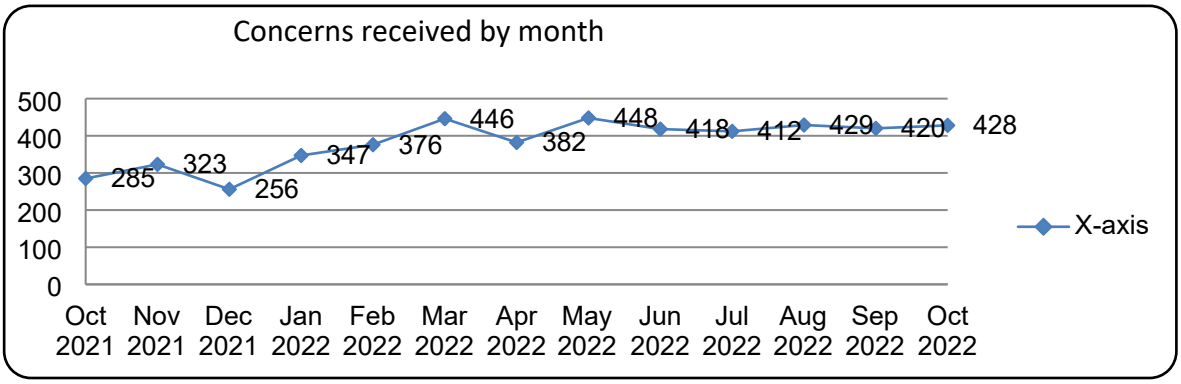
We have maintained an overall 30 working day response time for all concerns, of 85% (*to 28 October*). This is despite a significant increase in the numbers of concerns being received (see Figure 1).

August 30 day performance 80%
September 84%
October 85%

In August and September, we processed **64%** of concerns in line with Early Resolution (*this process can be utilised dependent upon the nature of the concern*). It is pleasing to note that in October we closed **69%** of concerns under Early Resolution, this ensures that a response is received within 2 working days, if however, we cannot issue a satisfactory response to a concern, then the formal process must be used.

It should be noted that previously we have been able to process up to 80% of concerns via the Early Resolution route but it is dependent upon timely response to enquiries and ensuring that a satisfactory resolution for the complainant is achieved.

However, the volume of concerns is increasingly challenging and it is appreciated that failure to answer concerns in a timely way is not acceptable and we continue to be focused upon improving the response times whenever possible and addressing the underlying themes.



We currently have 417 active concerns. Surgery and Medicine Clinical consistently receive the highest number of concerns. This is in line with the number of patient contacts and complex care both Clinical Board's provide, the number of necessary cancellations and delays due to Covid and the significant increase and demand on services like EU.

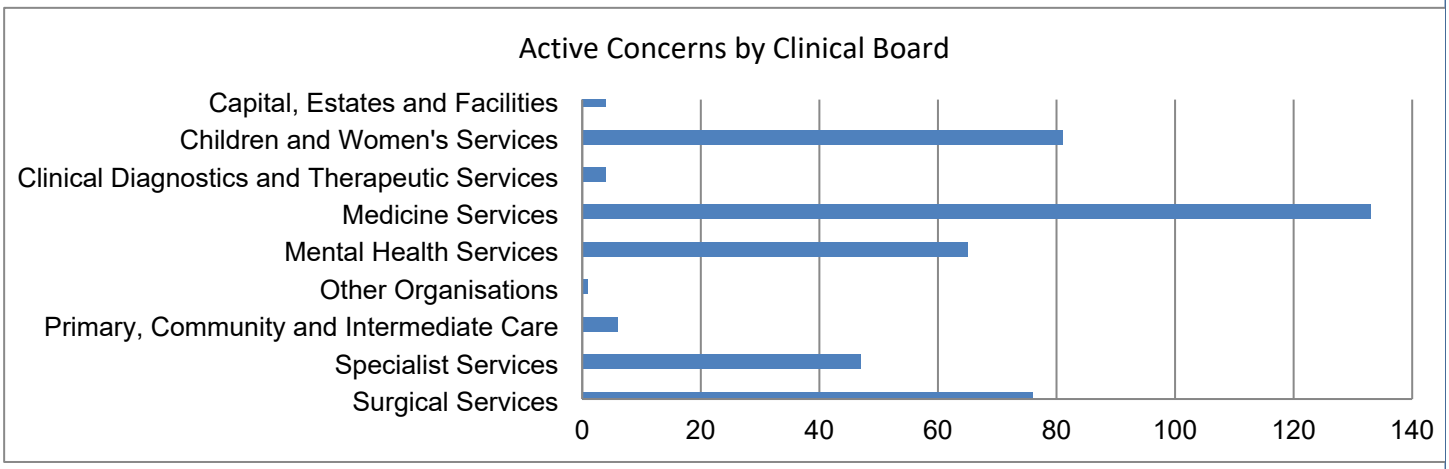
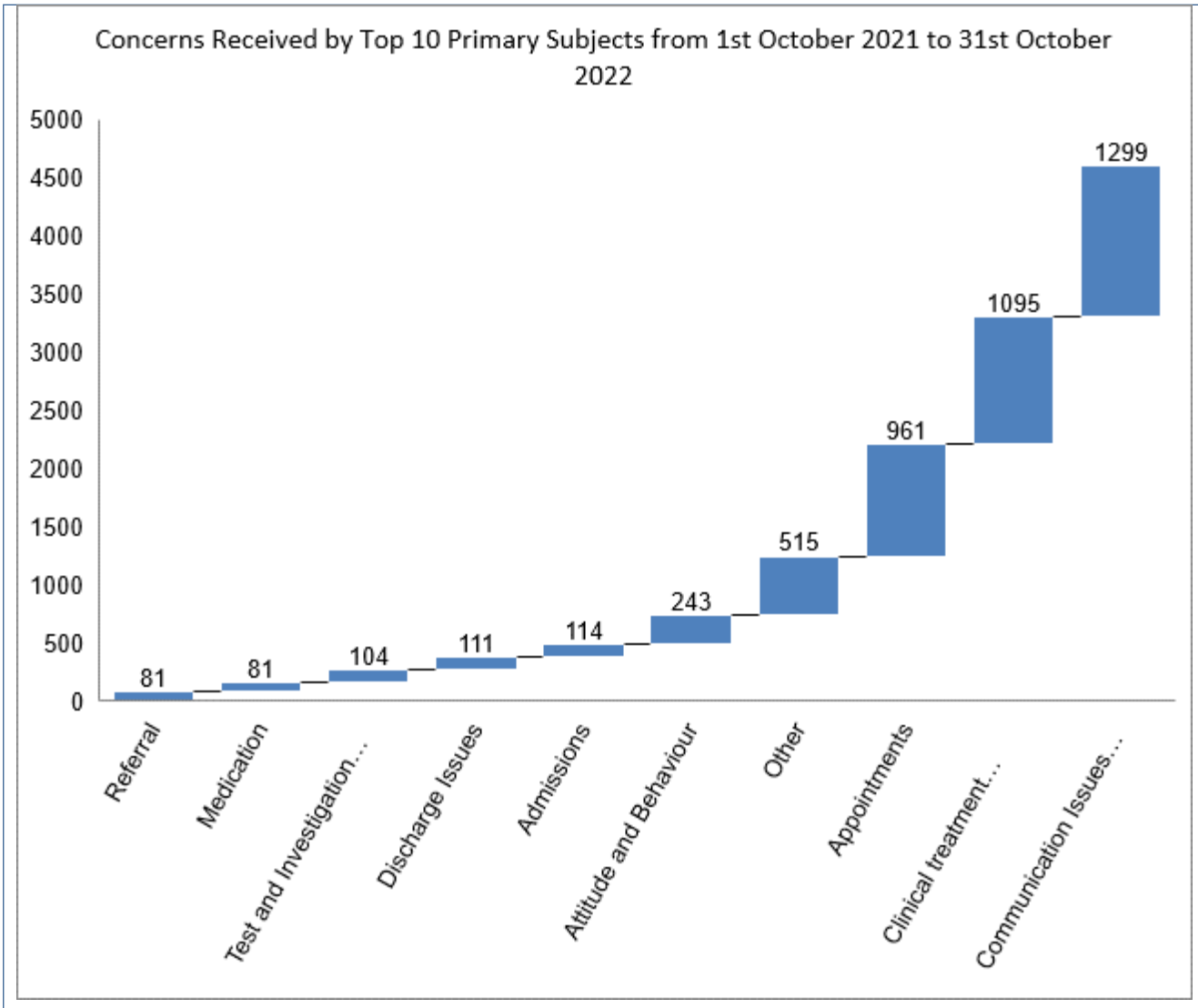


Figure demonstrates the 10 main themes noted in Concerns. Communication continues to be a recurring theme in Concerns, however, it should be noted that the number of concerns relating to Clinical treatment and attitudes and behaviours is rising. Whilst not showing highly on the chart above, we have noted a significant increase in concerns that mention Environment.



Feedback **HappyOrNot feedback** (All locations)

In relation to the 'HappyOrNot' feedback, those reported as being satisfied are respondents who when asked: "How would you rate the care you have received?" chose the 'Very happy' or 'Happy' button options i.e. gave a positive response.

A breakdown of the feedback for August, September and October is:

Summary values	August	September	October
Surveys completed	**2513**	**2252**	**1810**
Response: Very happy button (Excellent/Very positive)	56%	64%	64%
Response: Happy button (Good/Positive)	9%	7%	9%
Response: Unhappy button (Fair/Negative)	6%	4%	5%
Response: Very unhappy button (Poor/Very negative)	30%	25%	22%
Respondents satisfied	**65%**	**72%**	**73%**

Fig 4. Gives the October feedback, broken down by which day of the week the feedback was received:

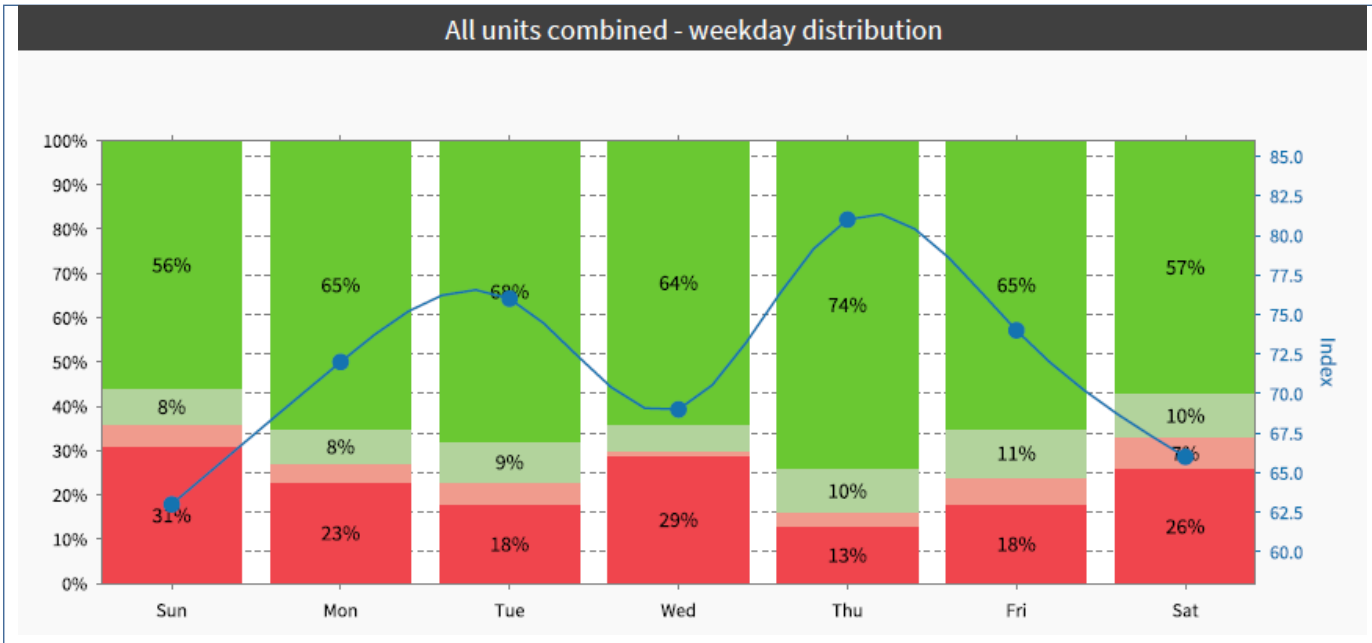
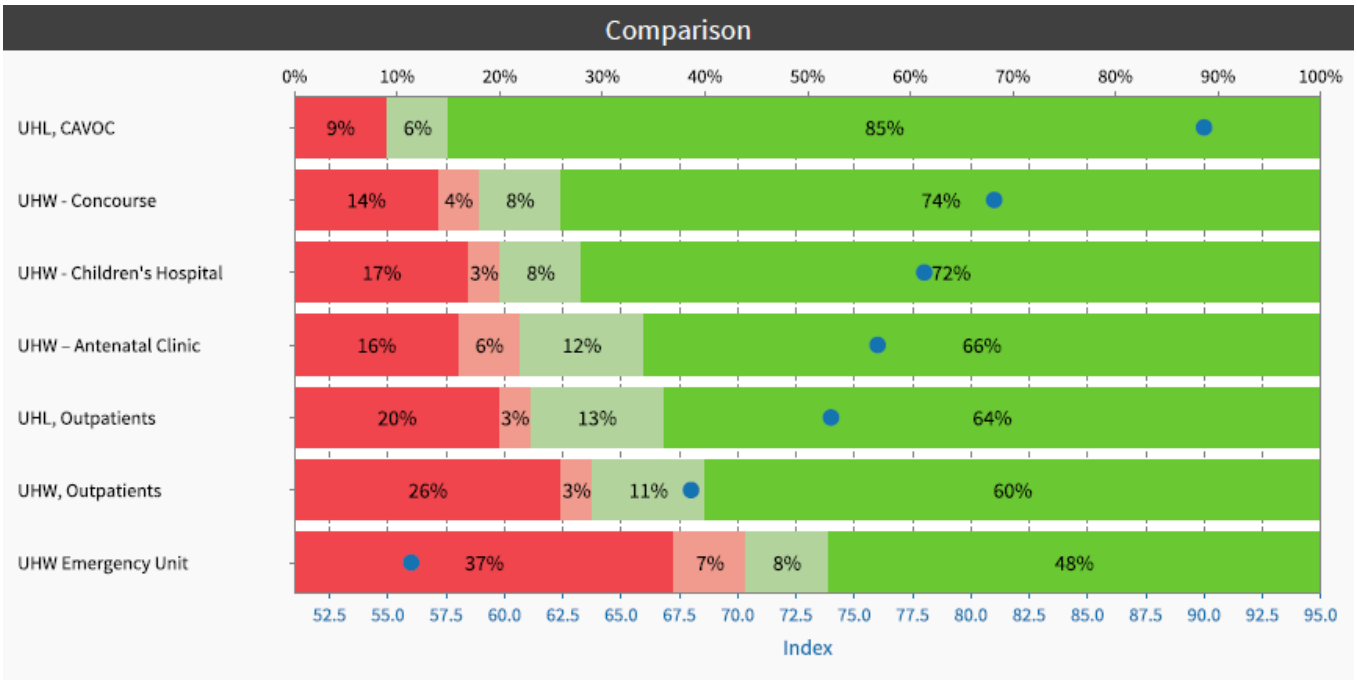


Fig 5. Gives the October feedback, broken down by kiosk location:



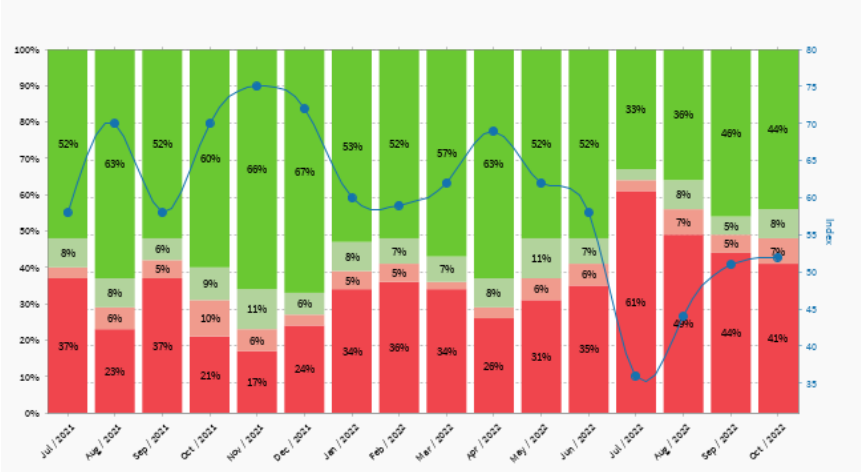
<u>HappyOrNot feedback</u> (EU areas only)

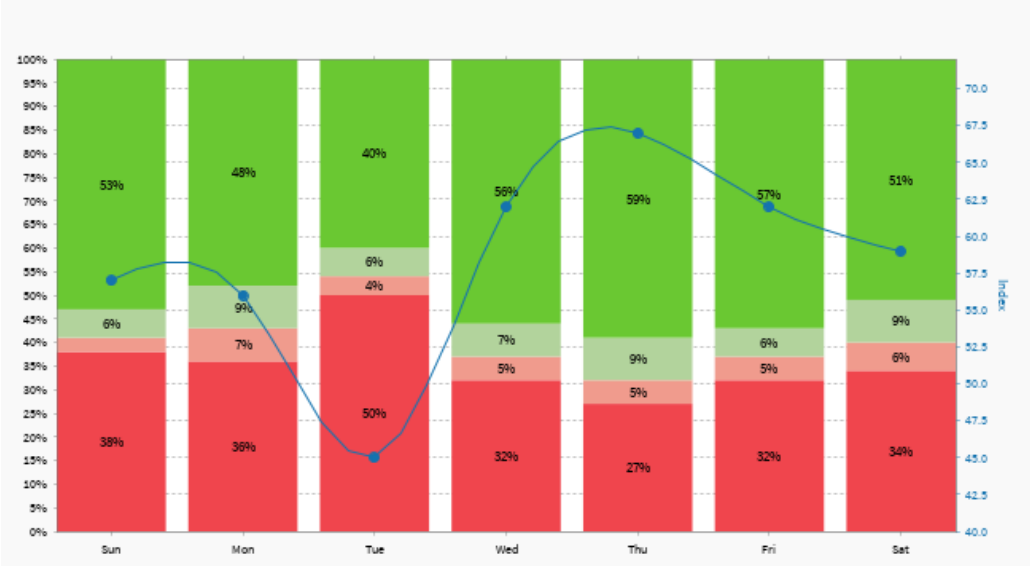
The table below is a basic summary of the information received from the HappyOrNot EU feedback:

Summary values	**August**	**September**	**October**
Surveys completed	914	631	515
Respondents satisfied	**44%**	**50%**	**57%**

Please note, the number of surveys completed has dropped in September and October, as two kiosks located in the EU reception and MAECU are no longer in use.

6. Monthly distribution - July 2022 significant decrease inpatient experience rating:





7. Weekday distribution - Consistently Tuesday is when the lowest score is noted.

Bespoke project examples

We are also currently involved in numerous bespoke projects, for example:

- SOS and PIFU survey
- CMHT (Physical health pack) survey
- Prehabilitation survey

Civica 'Once for Wales' platform

The CIVICA 'Once for Wales' software platform enables Health Boards to collect and report on feedback. This could be feedback from patients, staff or the wider public. This initiative is currently being implemented across all Welsh Health Boards.

For our UHB, the system went live on Friday 28th October and we are currently surveying up to 600 patients daily via SMS.

Patients receive their text 3 days post discharge/appointment and the text includes a link to a survey. Once completed, their feedback is available straight away to users of the system. As of Monday 31st October, we have received 259 survey completions. For the next Board report, we will produce a more detailed breakdown of those sent and returned.

It is hoped that we will eventually use the system as our main 'hub' to collect and collate feedback from various sources e.g. electronic links, tablets and kiosks. The system will also enable users to create and deploy their own survey designs and analyse their feedback.

Key messages

- Quality is defined as continuously, reliably, and sustainably meeting the needs of the population that we serve
- Welsh Ministers and NHS bodies will need to ensure that health services are **safe, timely, effective, efficient, equitable and person-centred**
- These quality dimensions (so-called STEEEP) provide a framework to assess quality and guide improvement
- Quality enablers have been identified which underpin and influence a blueprint to ensure a system-wide approach to improving quality
- The quality enablers are **leadership; culture and valuing people; data to knowledge; learning, improvement and research and whole-systems perspective**
- Maturing and embedding the quality management system takes time, vision, ambition, and an active commitment to learning and improving

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

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

Recommendation:

The Committee is requested to:

a) Note the content of the report and the developing process to monitor Quality Indicators.

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

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration		Collaboration	✓	Involvement	✓

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Quality indicators should help to identify areas of concern.
Safety: Yes
Delays in investigations presents a delay in identified learning and mitigation being put in place at the earliest opportunity the Quality Indicators should help when viewed collectively to pre-alert to areas of concern.
Financial: Yes
Failure to identify learning from themes will lead to increased harm and litigation.
Workforce: No
Legal: Yes
We need to adhere to the relevant legislation.
Reputational: Yes
There is media interest in QSE.
Socio Economic: Yes/No
Consideration of socio-economic disadvantage needs to be further explored through interrogation of the quality indicators to the level of low super output areas of social deprivation in comparison to areas of affluence.
Equality and Health: Yes
Many quality indicators when reviewed in detail demonstrate equality and health inequalities.
Decarbonisation: No

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

Saunders,Nathan 28/11/2022 15:01:22

Report Title:	Healthcare Inspectorate Wales Activity				Agenda Item no.	2.4	
Meeting:	Quality, Safety & Experience Committee		Public	x	Meeting Date:	29 November 2022	
			Private				
Status *(please tick one only)*:	Assurance	X	Approval		Information		X
Lead Executive:	Jason Roberts, Executive Nurse Director						
Report Author (Title):	Angharad Oyler, Head of Quality Assurance and Clinical Effectiveness						

Main Report
Background and current situation:

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the reviews and inspections carried out by Healthcare Inspectorate Wales (HIW). The paper seeks to assure the Committee that action is already being implemented in response to the findings of inspections and that appropriate monitoring of progress against the actions is being undertaken.

HIW is the independent inspectorate and regulator for health care in Wales. The core role of HIW is to review and inspect the NHS and Independent Healthcare organisations in Wales so that assurance can be given to patients, public, Welsh Government (WG) and healthcare providers that services are safe and of good quality.

Inspections are a means of providing assurance that services are meeting the Health and Care Standards (2015) and are meeting any other relevant professional standards and guidance. Inspections are a structured process and are underpinned by the view of Francis (2013), who emphasised the importance of undertaking direct observations of a service and care provided. Unannounced inspections undertaken by HIW allow them to see services in the way they usually operate and focus on the following themes:

- Quality of the patient experience
- Delivery of safe and effective care
- Quality of management and leadership
- Delivery of a safe and effective service

<u>Unannounced Inspections</u>

Cardiothoracic Services – UHL – Unannounced Visit

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Cardiac Surgery Ward (also known as West 6) at the University Hospital Llandough, on the 1 and 2 March 2022. No immediate concerns were identified.

An update has been provided to HIW on completion of the Improvement plan. All actions have been completed with exception of relocating cardiothoracic surgery to UHW.

The relocation of cardiothoracic services is planned for May 2023. However, the relocation of cardiac services back to UHW service is complex and dependent on the relocation of specialist services including critical care and medical wards on the UHW footprint to accommodate cardiac surgery. There is no direct risk to patients receiving cardiac surgery in UHL, however there are logistically challenges for consultants delivering care on two sites and accessing other specialist services.

Emergency Unit and Assessment Unit UHW

An unannounced visit took place in EU at UHW on the 20th, 21st and 22nd of June. HIW acknowledged that staff were working extremely hard in very challenging circumstances and welcomed the inspection team. A number of immediate Improvements were identified by HIW, and an action plan was developed and submitted to provide immediate assurance.

Good progress has been made with regards to the implementation of the improvement plan, however some actions remain in progress. EU have been working collaboratively with Pharmacy, Estates, Medical Engineering and Human Resources to address the issues identified.

The Tendable digital ward audit system is being utilised to monitor compliance with IP&C, medicines management, cleanliness etc. Additional roles have been appointed to support medical devices and IT systems, and staff to coordinate cleanliness and ordering of equipment which are having a positive impact.

See appendix 1 for updated Improvement plan.

Stroke Services
A national review of patient flow in the stroke pathway commenced in 2021 with field work beginning in March 2022. Throughout the review HIW are considering how health organisations in Wales address access to acute care at the right time and consider if care is received in the right place. The report and associated recommendations and improvements will be reported to the committee on publication.

Maternity Services
Maternity Services were subject to an unannounced Inspection by HIW on the 9th, 10th 11th November 2022. A number of immediate assurances recommendations were issued following the inspection. The report and associated improvements will be presented to the committee on publication by HIW.

Nuclear Medicine Department UHL

An IRMER compliance inspection was undertaken in UHL on the 11th and 12th of October, Initial verbal feedback was overall positive, there were no immediate concerns identified. The report and any associated improvements will be presented to the committee on publication by HIW.

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

All actions relating to the HIW cardiothoracic inspection have been completed with the exception of relocating the department back to UHW. Plans are in place to complete this by May 2023, however success is dependent on the relocation of a number of services.

Good progress has been made in relation to the Emergency Unit improvement plan. Work continues in partnership with Organisational Development. Significant improvement of the estates and facilities are being planned. The use of the Tendable audit platform is support ongoing assurance around the sustained improvements.

A recent unannounced inspection of Maternity service in UHW has identified a number of immediate assurance. The full report will be reported to committee on publication.

Recommendation:

The Committee is asked to:

a) NOTE the assurance provided by the progress made against the improvement plans; and
b) NOTE the recent inspections in Maternity and Nuclear medicine that are yet to be published.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration	X	Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes, HIW provide oversight of services around four themes including quality and patient safety. The outcomes of reviews and the development of improvement plans support the delivery of high quality and safe care
Safety: Yes, HIW provide oversight of services around four themes including quality and patient safety. The outcomes of reviews and the development of improvement plans support the delivery of high quality and safe care
Financial: No
Workforce: HIW include a number of workforce considerations including competency and training and workforce establishments
Legal: No
Reputational: HIW inspections are reported in the public domain and are therefore subject to external scrutiny including press coverage
Socio Economic: No

Equality and Health: No
Decarbonisation: No

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

Appendix 1 - Improvement plan

Service: University Hospital of Wales - Emergency Unit and Assessment Unit

Date of inspection: 20, 21 and 22 June 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to make relevant and consistent health promotion information and advice available to patients within the Assessment Unit.	Standard 1.1 Health Promotion, Protection and Improvement	The directorate is reviewing the current health promotion advice that is displayed in all areas of the department, to ensure consistency and accessibility of patient information throughout the department. Update November 22 - leaflet racks in all waiting rooms of ED with public health advice. These will be monitored for replenishment by directorate and patient experience.	Lead Nurse	Complete Complete

		Display boards currently being put up within department with public advice and information.		Complete
The health board is required to provide HIW with details of the action to promote the privacy and dignity and comfort of patients in both the Emergency Unit and the Assessment Unit.	Standard 4.1 Dignified Care	Reclining chairs have been removed from the south side of the assessment unit and these have been replaced by beds To ensure the privacy, dignity and confidentiality of patients, all patients will receive their consultations and assessments in one of the dedicated examination rooms next to this area. The directorate have acknowledge and actioned:- • Capital bids have been submitted for estate work within the department. The requirement for an additional patient shower facility is being progressed as a priority but will require design works	Directorate team Director of Capital Planning and Estates	Complete 30th November 2022

		• Other works identified will be reviewed with options developed and costed. Funding sources will need to be identified to progress the works	Director of Capital Planning and Estates	Feasibility report 31st October 2022
		• Increase linen ordered to meet demand	Lead Nurse EU	Complete
		• Order placed for further new high back chairs (20)	Lead Nurse EU	Complete
		• Order placed for new waiting room seating	General Manager EU	Welsh Government bid has been confirmed which will support new waiting room seating, decoration and flooring throughout the department. Start date to be confirmed New showers to be completed end November 22.

				New high back chairs now in place. Old chairs are being re-upholstered
		• A business case is currently being developed for artificial sky lights for the clinical areas with no natural light to improve the environment which will be submitted to Capital Estates and Facilities	General Manager and Lead Nurse EU	December 2022
		• The current footprint of the acute medicine unit is currently being reviewed to evaluate how best the area can be utilised for maximum benefit. This will be an agenda item in the Q&S forum and discussed through the Clinical Board Structure.	Head of Service Planning/ General Manager and Lead Nurse EU	December 2022

The health board is required to provide HIW with details of the action taken to promote the use of the Welsh language within the Emergency Unit and the Assessment Unit.	Standard 3.2 Communicating Effectively	• All Welsh speaking staff have the Welsh language symbol on their uniform to indicate they are able to converse in welsh.	General Manager and Lead Nurse for EU	Complete
		• A poster has been put in place within the department advising patients of the significance of the Welsh Language Symbol.	General Manager and Lead Nurse for EU	Complete
		• The audiobant system in the department is in the Welsh and English language.	General Manager and Lead Nurse for EU	Complete
		• A full review of signage in the department will be undertaken. The department will ensure that all signage throughout the department is in Welsh and English	General Manager and Lead Nurse for EU	The directorate have mapped the department given the changes and currently agreeing new signage wording. SDEC signage complete.

		• Staff members aware of requirement to answer phones in Welsh as well as English. Welsh Language action card have been placed by telephones and reception areas to remind and support staff of the appropriate greeting in Welsh when answering the phone and in person.	General Manager and Lead Nurse for EU	Complete
The health board is required to provide HIW with details of the action taken to make patients and their representatives aware of 'Putting Things Right'.	Standard 6.3 Listening and Learning from Feedback	To ensure accessibility to information on 'Putting things right' is accessible to patients and their representatives the following action are being taken; • The directorate have ordered information boards whereby information about how to raise concerns will be displayed, the department is working closely with the concerns team for display items.	Directorate Team	Complete

		• UHB Link to Putting Things Right information added to introductory information on bespoke EU online survey.	Patient Experience Team	Complete
		• Survey posters will have link/QR Code for the Putting Things Right information (Putting Things Right - Cardiff and Vale University Health Board (nhs.wales))	Patient Experience Team	Complete
		• PTR Leaflets redesigned and updated with QR code linking to UHB Concerns page.	Patient Experience Team	Complete
		• Updated PTR Leaflets and posters distributed for display	Patient Experience Team	Complete
		• EU Volunteers having access to updated Putting Things Right leaflets and information on the UHB complaints process to enable them to signpost	Patient Experience Team	Complete

		patients and their representatives. • Place QR Code, linking to UHB Putting Things Right information, on Happy or Not Machines when based in EU QR codes now on new posters that have been developed	Patient Experience Team	Complete
The health board is required to provide HIW with details of the action taken to share patient feedback with staff and to demonstrate this has been acted upon. Saunders,Nathan 28/11/2022 15:01:22	Standard 6.3 Listening and Learning from Feedback	• The directorate are creating a 'dashboard' for staff to share feedback from patients, Concerns and National Reportable Incidences. Compliments are also shared with staff for learning • Discussions are taking place with the communications team to	Lead Nurse Lead Nurse	3 November 2022 30 November 2022

		develop a communications strategy for the Directorate. Compliments are also shared with staff for learning		Meeting Director of Communication to discuss a communication strategy to better share learning and information amongst staff
		• The directorate is working closely with the patient safety team to utilise DATIX system functionality to extract themes from reported incidents that can be shared with staff.	Lead Nurse	30 November 2022
The health board is required to provide HIW with details of the action taken to ensure the environment of the Emergency Unit and the Assessment Unit is maintained to a sufficient standard and to improve the facilities in both units.	Standard 2.1 Managing Risk and Promoting Health and Safety	The directorate have supported 2 initiatives to support the improvements of standards within the department:- • Dedicated time for a member of staff to undertake internal IP&C audits. Declutter areas and	Lead Nurse	Complete

		resolve actions that arise from the clinical audits • A new post is being developed as a pilot, to ensure that there is a dedicated staff member to review and maintain all equipment within the department to ensure it is in good working order and reported faulty equipment is escalated and resolved as quickly as possible	Directorate, service manager	Complete
The health board is required to provide details of the action taken to respond and address the less favourable staff comments in relation to the availability of equipment. Saunders,Nathan 28/11/2022 15:01:22	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	• A Job description has been developed to pilot a new post to support maintenance and availability of equipment within the department. The JD is currently with job matching. • A Meeting has been arranged between Medical Engineering, Mechanical	Directorate, service manager Head of Clinical Engineering/ EU General Manager and Lead Nurse	Complete Meeting arranged 23/11/23

		Engineering and EU to ensure a collaborative approach to undertake a baseline assessment to evaluate the requirements and risks of the department related to accessibility of equipment.		
The health board is required to provide details of the action taken to respond to staff comments in relation access to ICT systems.	Standard 3.4 Information Governance and Communications Technology	The Directorate team have audited IT equipment in the department and identified the following actions: • Additional PCs have been placed into areas as well as mobile carts. • A scoping exercise will take place to review current UHB management systems in place/being implemented and evaluate IT system in place in the EU and establish a dedicated IT support system.	Directorate Management Team Directorate Management Team	Complete 30th November 2022

		• The Job Description for the dedicated role for equipment maintenance will also include oversight of IT systems within the department to resolve or escalate IT issues in a timely way within the department	Directorate Management Team	Complete
The health board is require to provide HIW with details of the action taken to seek assurance that audit activity and follow up processes are effective.	Governance, Leadership and Accountability	The directorate is moving to an internal digital audit tool. • Actions that arise from this will be collected on a database whereby problems can be allocated for resolution and can be tracked for progression and completion	Directorate team	Complete
The health board is required to provide HIW with details of the action taken to respond to the less favourable staff responses to some of the questions as noted in the	Standard 7.1 Workforce	The senior team have scheduled the following to support staff and improve communication: - • Monthly senior team meeting		

Quality of Management and Leadership section of this report.		• Band representation meeting alternate months • Developing a dashboard to include patient feedback/NRI/concern themes/workforce report • small task and finish groups to improve care of patients within the directorate involving frontline staff • operational improvement plan has been drafted	Lead Nurse	Completed
		Lead Nurse has met with the Operational Department Lead to consider supporting specific work around retention/team working/UHB communication:- • Drop in Q&A sessions for staff 'a conversation with' - this will be in themes eg recruitment	Lead Nurse EAMD, DoN Medical Clinical Board,	Complete

		• Workshops for all staff - OD facilitated • QR codes are in use for any time feedback • HR led exist interviews		First drop in Q&A took place specifically for ED on 26th Oct. with plans for further regular sessions. First workshop facilitated by Organisational Development on 9th November for Senior Management Team, 7th December for clinical senior team and consultant body. Plan will be formulated from the outcome of these to guide future workshops. HR has undertaken exit interviews and

		• Review of educational process and development opportunities		engaged with the SMT. Secondment agreed for senior nurse for professional development to support the development of an educational framework and ongoing staff education.
The health board is required to provide details of the action taken to improve compliance with mandatory training and staff appraisals. Saunders,Nathan 28/11/2022 15:01:22	Standard 7.1 Workforce1	The directorate have taken the following actions to improve compliance with staff appraisals and mandatory training • Team leaders have been given a protected day to meet with their team to complete Values Based Appraisals.	Lead Nurse EU	Complete The Staffing pressures and vacancies continues

		• Staff have been booked on e-learning support sessions with the Education Team • Compliance of staff mandatory training and appraisals will be monitored on a monthly basis through the senior management team meetings.		to be a constraint in timely progression of this action, however, VBA compliance has increased to 26% in October and further team VBAs have been scheduled throughout November. compliance will be monitored through monthly Quality and Safety meetings and senior management meetings

Report Title:	**South Glamorgan Community Health Council Activity Review**			Agenda Item no.	**2.6**
Meeting:	**Quality, Safety & Experience Committee**	Public	x	Meeting Date:	**29/11/2022**
		Private			
Status *(please tick one only):*	Assurance	x	Approval		Information
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Interim Deputy Executive Nurse Director**				

Main Report
Background and current situation:

The purpose of this report is to provide a review of South Glamorgan Community Health Council (CHC) activity within Cardiff and Vale UHB. The CHC work closely with the UHB to plan and deliver services and represent the patient and public voice. The CHC engagement and feedback with the UHB consists of:

- Announced Scrutiny Visits
- Unannounced Scrutiny Visits
- Service Reviews

The CHC have the opportunity to engage directly with patients and staff or via surveys, videoconferencing and social media, throughout their reviews.

Feedback to the UHB is provided by reports which includes improvement recommendations.

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

The CHC suspended announced scrutiny visits during the pandemic and recommenced in Quarter 2.

Appendix 1 to this report provides a list of CHC Q2 and Q3 Announced Scrutiny Visits.

To date the CHC have provided the UHB with the final reports and recommendations to the following areas:

- Midwife Led Unit, UHW - CHC Visit Final Report. **Appendix 2 under supporting documents**
- Island Ward Childrens Hospital for Wales, UHW - CHC Final Report. **Appendix 3 under supporting documents**
- East 4 Medical, UHL - CHC Final Report. **Appendix 4 under supporting documents**
- B4 Neuro, UHW – CHC Final Report **Appendix 5 under supporting documents**
- Spinal Rehabilitation UHL – CHC Final Report **Appendix 6 under supporting documents**

The main themes highlighted by the reports include:

- Lack of Day Room and TV facilities
- Improvement to showering facilities for patients with mobility issues
- Improved storage facilities
- Improve Parking availability
- Improve signage
- Improve Menus Meal Time Choices

- Encourage Carers to support patient care

The Clinical Boards are progressing the required actions and all improvement plans are approved by the Executive Nurse Director and Executive Director of Planning and signed off by the Chief Executive, prior to submission to the CHC.

The following reports of services have been received during Q2 and 3, the full reports are within **Appendix 7 (under supporting documents)**:

- Mental Health Services
- Veterans Survey Report
- The Impact of Covid restrictions on people receiving care & their families and care for people living with long Covid

The Clinical Boards respond to the recommendations within each Service Report via formal letter, which is approved by the Executive Director of Planning and appropriate Executive Director, dependent on the Service Report and signed off by the Chief Executive before submission to the CHC.

Recommendation:

The Quality, Safety and Experience Committee is requested to:

a) **NOTE** the contents of the report and the CHC feedback and recommendations.

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

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

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

Prevention		Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓

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

Risk: No

Safety: No

Financial: No

Workforce: No

Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

APPENDIX 1

Date	**Type of Visit**	**Location**	**Site**
Tuesday 28th June	Secondary Care - Announced	Ward B1 Cardiology	UHW
Wednesday 6th July	Secondary Care - Announced	Stroke Rehabilitation Unit	UHL
Friday 15th July	Secondary Care - Announced	Lakeside Unit	UHW
TBC – Awaiting UHB Dates	Secondary Care - Announced	Maternity Midwifery Led Unit/Clinician Led Unit	UHW
TBC – Awaiting UHB Dates	Secondary Care - Announced	Spinal Rehab Unit (Ward West 8 & 10)	UHL
Wednesday 3rd August	Secondary Care - Announced	St Barruc's Ward	Barry Hospital
Monday 8th August	Secondary Care - Announced	Jungle Ward / Island Ward	CHfW
Thursday 18th August	Secondary Care - Announced	Ward East 4	UHL
Tuesday 23rd August	Secondary Care - Announced	Ward West 1	UHL

Date	**Type of Visit**	**Location**	**Site**
WC 10/10/22	Secondary Care - Announced	SSSU / SSDEC Short	UHW
WC 24/10/22	Secondary Care - Announced	Emergency Unit	UHW
WC 31/10/22	Secondary Care - Announced	Poison Beds	UHW
WC 07/11/22	Secondary Care - Announced	Hafan Y Coed, Cedar Ward	UHL
02/12/22	Secondary Care - Announced	Alcohol Treatment Unit	Cardiff

Report Title:	**Board Assurance Framework – Patient Safety & Workforce**			Agenda Item no.	2.7
Meeting:	Quality, Safety and Experience	Public	x	Meeting Date:	29th November 2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Director of Corporate Governance				

Main Report
Background and current situation:

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee with the opportunity to review the risks on the Board Assurance Framework (BAF) which impact upon Patient Quality, Safety and Experience.

At the Board Meeting held on the 24th November 2022 the following risks were reported on the BAF which impact upon said areas:

- Patient Safety
- Maternity
- Critical Care
- Cancer
- Stroke
- Urgent and Emergency Care
- Planned Care.

With the exception of Patient Safety and Urgent and Emergency Care these were all new risks to the BAF.

These risks will be reported to each meeting of the Quality, Safety and Experience Committee going forward to ensure that they are being appropriately managed and/or mitigated, so the Committee can provide assurance to the Board that this is the case.

The highest scoring net risks (which is after controls are in place) from the above are Patient Safety (20), Maternity (20) and Critical Care (20). Further details including cause, impact, controls and assurances are also detailed in the attached risks.

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

The Board Assurance Framework provides the Board with information on the key risks impacting upon the delivery of the Strategic Objectives of Cardiff and Vale University Health Board.

The attached Patient Safety, Quality and Experience Risks (last considered by the Board in November 2022) are considered to be key risks to the achievement of the organisation's Strategic Objectives.

There are also a number of risks on the Corporate Risk Register which relate to Patient Safety.

Recommendation:

The Quality, Safety and Experience Committee are requested to:

Review the attached risks in relation to Patient Safety, Quality and Experience to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
Safety: ~~Yes~~/No
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: ~~Yes~~/No
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No
Approval/Scrutiny Route:

Committee/Group/Exec	Date:
Board	24th November 2022

1. **Patient Safety – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)**

Patient safety should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.

Risk	There is a risk to patient safety: Due to post Covid recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list. Due to increased demand, post Covid 19, of unscheduled care of patients with higher acuity and more complexity which is adding to the pressure within the Emergency Unit (EU). Due to a sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care in a larger clinical footprint in relation to post Covid 19 recovery. Due to the ability to balance within the health community and the challenge in transferring patients to EU. Due to the current pressure in EU and inability to segregate patients due to the volume in the department.		
Date added:	April 2021		
Cause	Patients not able to access the appropriate levels of planned care since the onset of the COVID 19 pandemic creating both longer waiting lists for planned care. Resources re directed to address planned care demand leaving unplanned care/unscheduled care pathways with lower staffing		
Impact	Worsening of patient outcomes and experience, with an impact on patient outcomes Post Covid recovery sickness is having a significant impact on staff availability (see separate risk on workforce).		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Recovery Plans being developed and implemented across all areas of Planned Care • Maintaining Training/Education of all staff groups in relation to delivery of care • Use of Private Partner facilities. • In-house and insourcing activity • Additional recurrent activity taking place • Recruitment of additional staff • Workforce hub in place with daily review of nurse staffing by DoN in Clinical Boards to manage the risk • Hire of additional mobile theatres • Quality and Safety and Experience Framework Implementation underway • health and social care actions to assist the current risk in the system with work continuing to be embedded and implemented •		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (3) • CAHMS position reviewed at Strategy and Delivery Committee (1)		

	• Mental Health Committee aware of more people requiring support (1) • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives (1)(2) • . (1) • Recent Executive review with Clinical Teams for understanding and review of front door pressures. (1)		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes and domiciliary care settings. Deterioration of quality of care provided to patients due to the availability of staff in some key clinical environments.		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions	Lead	By when	Update since Sept 2022
1. Review of hospital acquired COVID 19 and COVID deaths (wave 1) being undertaken and monitored through Nosocomial C&V Programme Board.	Jason Roberts	30.04.23	Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan Review of deaths continues in line with WG requirements with oversight from Nosocomial National Programme Board
2. Choices framework being utilised due to the quality of care and ability to provide safe care with current demand and pressures	Paul Bostock	31.03.23	Choice framework continues to be utilised
3. Programme of work in place and being led by the Chief Operating Officer, supported by Operational Teams to address the backlog	Paul Bostock	31.03.23 Review October 22	Programme currently been reviewed by COO

Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 High)**

2. Maternity Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

The recommendations of the Ockenden Review into maternity services in England were published at the end of March 2022. The Ockenden review and its recommendations is very much in the public domain and attracted significant coverage from the media. Becoming compliant with the Ockendon requirements also brings opportunity benefits such as full compliance with the Cwm Taf and other formal reviews recommendations and achieving BAPM compliance in the Neo-Natal Unit.

The background to, and summary of the Ockenden report, is best understood in the quote from Donna Ockenden below

> **"This final report of the Independent Maternity Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve, and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives. "**

The report details 89 recommendations that should be enacted to improve maternity services across the UK. An immediate self-assessment of the service was undertaken against the requirements, which noted that 45 of the requirements were already met, 27 partially met, and 17 not met at all. The detail of where we are currently not meeting recommendations and the proposal to close that gap has been completed (appendix 1). The recommendations that we currently fail to meet can largely be grouped into 3 categories, patient safety, quality and experience, training, and workforce.

Whilst underlying actions to progress the plans to achieve the recommendations have developed and presented to Execs, UHB agreement of circa £2M recurrent funding is required to deliver progress.

In addition, the service has sustained pressure across Obstetrics and Maternity care system, mainly due to reduced workforce availability, increased interventional birthing as a result of NICE guidance, backlogs on critical incident investigation etc

Risk	We are currently unable to demonstrate compliance against a number of recommendations against the various external reviews and reports. We have a backlog of investigations, RCA's and concerns and as a result LFE delays Workforce concerns and adverse media
Date added: 3/11/22	

Cause	• In England 180 million pounds of funding was released to support each Trust in complying with all of the Ockenden Recommendations. Welsh Government have invested £1 million in to the Mat Neo Safety Programme across Wales, which is currently in its Discovery phase for circa 12 months, next steps of which are yet to be communicated. The operational view is that it is unlikely any further investment will be made available by Welsh Government to support implementation of the recommendations. • NICE clinical guidance Intrapartum care for healthy women and babies resulting in increased instrumental birthing practices. Patients presenting and subsequently admitted have a higher acuity and complexity, particularly in light of NICE guidance. • We continue to experience challenges in our ability to deploy sufficient workforce to cover community, Midwifery-Led and Obstetric-Led care setting services. We struggle with sustained workforce challenges from sickness, maternity leave, resignations, retirement and challenges of retention and recruitment. • One out-take of newly Qualified Midwives and Paediatric Nurses each year from Welsh Universities causing a limited flow of Midwives/Paediatric Nursing staff • Restricted Neonatal capacity continues to add an increased layer of complexity in managing patient flow. • T2 new area opened during Pandemic, but with no increase in staffing (loss of 6 beds on Delivery Suite, 14 opened on T2). • Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and MSWs. Reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives are undertaking the New-born and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home. • With the publication of the latest NICE guideline on Antenatal Care that recommends that all women be 'booked' by 12 weeks' gestation, more women are meeting their midwife earlier than previously happened before 10 weeks. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal. In most maternity services approximately 10% of women are 'booked' and then have no further contact with the midwife. • Constraints accommodating the increased number of Inductions of Labour (IOL) and instrumental deliveries within current footprint. • Good level of incident reporting but insufficient resources to complete investigations, action plans and learning from events actions. • Independent external Birth-rate+ re-assessment has been undertaken and verbal findings are circa 16 Midwives short.
Impact	• Closure of Community Home Birth Services and Maternity Led Unit due to lack of staff. • Delays in allocating IO's to investigations, subsequent delays in completing investigations, action plans and LFE • Rise in instrumental deliveries • Delays in IOL and constraints in accommodating elective caesarean sections due to lack of NICU capacity • Congested department and long waits for IOL & ECS • Insufficient consultant cover for labour ward, NCEPOD readmission reviews • Lack of specialist roles; labour ward leads, Foetal surveillance, bereavement, transitional care nursing. • Lack of training in Human factors, CTG, labour ward coordinator leadership. • Poor staff morale and retention due to the sustained pressures in the system

	• Worsening patient experience and outcomes (see separate risk on patient safety) and run of adverse incidents.		
Impact Score: 5	Likelihood Score:5	Gross Risk Score:	**25 (Extreme)**
Current Controls	• Induction of 27 Newly qualified Midwives (NQM) and 43 Newly Qualified Paediatrics nurses from Student Streamlining • Introduction of daily clinical huddles between each days Lead Midwife, Lead obstetrician, lead neonatologist and lead neonatal nurse each day • Rollout of 3 extra consultant sessions for obstetric governance and 1 extra consultant session Neonatology governance to enable allocation of IO's to investigations • RAG rating of position against national report recommendations, presentation of gap analysis to executives and to senior Leadership Board for support of required resources • Continued recruitment actions • Escalation of concerns to HEIW re single out-turn of midwives and paediatric nurses • Establishment of Ockenden Oversight group meeting on fortnightly basis • Team continue to support recruitment and retention, submission of request for oversea recruitment. • Daily SiteRep reporting introduced into maternity and Neonates and DoNM/HoM daily catch up		
Current Assurances	• Operational position reported into Management Executive (Daily) (1) • Mechanisms in place to monitor key measures being strengthened into visible dashboard.(1) • Key operational performance indicators and progress against plans reported into the Maternity/Neonatal oversight Group being led by Executive Nurse Director. (1)		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	• Confirmation of additional funding resource to fill gaps in assurance mapping • Recruitment strategies to sustain and increase multidisciplinary teams (appendix 1). • Developing an effective, high quality and sustainable model of managing intrapartum care and current constraints • Several incidents out of time		
Gap in Assurances	• Data and benchmarking information • Resources to meet the national recommendations		

Actions	**Lead**	**By when**	**Update since September 2022**
1. Ongoing recruitment above establishment, increasing training places	AJ	31/03/23	New action
2. Reviewing current obstetric practice in line with NICE guidance	CR/SZ	01/01/23	New action

3. Senior daily oversight of obstetric /Neonatal capacity and escalation to Executives		AJ	31/03/23	New action
4. Continued maternity / Neonatology oversight meetings with Executive lead		JR/AJ	31/03/23	New action
5. Ongoing review of job planning and consultant establishment		CR/AT	31/03/23	New action
Impact Score: 5	Likelihood Score: 3	Target Risk Score:		**15 (high)**

3. **Critical Care Capacity – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)**

For a sustained period prior to the COVID19 pandemic there were recognised critical care capacity challenges in CAV. The sustainability of Critical Care Services in Cardiff is reported in the 2014 unmet needs study WG, and the 2019 FICM external review. Following the COVID19 pandemic these challenges remain and still needs to be addressed. Critical care department capacity is not in a position to deliver a sustainable service to the population it serves.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable critical care capacity.		
Cause	• There is a progressively deteriorating problem with access for critically ill patients to ICU in Cardiff as a direct result of capacity. This now means patients who would benefit from ICU admission and care are not able to have this. • Gap of 15 ICU beds in CAV (2014 unmet needs study WG) • Funded increase in tertiary workload has increased the overall demands on critical care services in CAV • Poor infrastructure within the critical care unit – limited access to cubicles • Patient at Risk Team (PART) only operate during daytime hours (7am-7pm)		
Impact	• Adverse impact upon the Emergency Department and theatre flow • Untimely patient access • Inequity of patient access • 15% of referrals not admitted to critical care • Impact other operationally e.g. anaesthesia and theatres • Impact tertiary development e.g. ECMO • Patient outcomes worse • Reputation, Professional & Legal risk • Workforce - Reduced Recruitment & Retention • Poor staff morale and retention due to the sustained pressures in the system • Delayed admission and discharge from critical care leading to poor patient experience and outcomes		
Impact Score: 5	Likelihood Score:5	Gross Risk Score:	**25 (Extreme)**
Current Controls	• Strengthened site-based leadership and management • Strengthened OPAT oversight and support for DTOCs • Workforce plans in place to support recruitment and retention • Registered nursing recruited to establishment • Local escalation plan in place and utilised when appropriate to support operational pressures • PART team provide daytime support patients not admitted to critical care • Ringfenced PACU to protect elective urgent and cancer surgery • Winter escalation plan in place to support delivery of critical care to the sickest patients during the winter months		
Current Assurances	• Operational position reported into OPAT (1) • Key operational performance indicators and progress against plans reported into the clinical board 6 weekly (1) • ICNARC audit to provide assurance on outcomes (2) • Plans in development to increase level 3 bed capacity by three beds during 2023/24.(1) • Project team established to address medium term infrastructure constraints.(1)		

Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	Development and implementation of a capacity plan to address the 15-bed gap Achievement of standard to step down patients from ICU within 4 hours to improve efficiency and patient flow 24/7 PART team Development of a fit for purpose critical care unit (UHW2)		
Gap in Assurances	Able to meet the needs of the sickest or highest priority cases. Un-met not fully understood across the organisation.		

Actions	Lead	By when	Update since September 2022
1. Secure funding and develop implementation plan for further three ICU beds	PB	30/11/22	Funding not confirmed as at 03/11/22. Focus remains on utilising existing resource to rollout out to further clusters
2. Implementation of 24/7 PART team	PB	31/03/23	Plan developed. Funding not confirmed as at 03/11/22 and implementation on hold.
3. Implementation of the UHW site masterplan and critical care infrastructure programme a. Medium term development of additional cubicles and support facilities b. Development of a new unit as part of UHW2 development. c. Transfer of LTiV services to a bespoke facility in UHL	AH / PB	31.03.23	Implementation of de-escalation plan commenced – but behind timescale due to ongoing operational pressures and recent increase in covid admissions. Awaiting decision from WG on funding of stage 1 of the infrastructure programme
4. Ongoing development of recruitment and retention strategies	JR / RG	31.03.23	

Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

4. Cancer Services – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

One of the Health Board's Strategic Objectives is to have sustainable cancer services that deliver the single cancer pathway standard to treat patients with a confirmed diagnosis of cancer within 62 days. To achieve this, the system needs to ensure sufficient capacity is prioritised to meet the predicted weekly demand for cancer patients at the outpatient, diagnostic and treatment stages of the pathway whilst also being sufficiently flexible to respond to peaks and troughs in demand. The recently published Welsh Government Planned Care Plan, the Wales Cancer Network's Quality Statement and the emerging Wales Cancer Network's Improving Cancer Services and Outcomes Action Plan reflect the high priority of cancer services.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments to see elective patients in a timely manner has also impacted on those waiting on a cancer pathway. • Referral demand for cancer is now greater than pre-Covid levels and our planned care system has struggled to respond to this increase in demand and carve out sufficient capacity for cancer at outpatients, diagnostics, and treatments stages • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff • Weaknesses in the central cancer team in terms of changes of leadership, structure, vacancies and temporary staffing leading to lack of clarity and consistency		
Impact	• Long waiting times for first contact and diagnostics contributing to lengthening of the overall pathway for cancer patients • Overall PTL has grown 3-fold since pre-Covid • Significant volumes of patients now waiting >62 days and >104 days • Potential for harm e.g. missing the window of opportunity for surgical intervention, delays to starting chemotherapy/radiotherapy • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety)		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**
Current Controls	• Strengthened governance and oversight • COO is now Executive Lead for Cancer • Cancer is one of the delivery programmes in the 2022/23 Operational Plan • SOP in place to support tracking process • Roles and responsibilities redefined • Training being rolled out to refresh understanding of SCP guidance • Workforce team continue to support recruitment and retention • Ambition clearly stated – first contact by day 10, diagnosis by day 28, treatment by day 62 • Two cancer summits held with senior leadership teams, directorate management teams and tumour site clinical leads • Demand/capacity work commenced		

Current Assurances	• Operational position reported into Cancer Oversight Meeting weekly tracking improvements[1] • Executive Cancer Board meets quarterly[1] • Mechanisms in place to monitor key schemes in Cancer as part of the Operational Delivery Plan [1] • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee [1] • Breach reports produced for every patient treated >62 days [1] • Harm reviews conducted for every patient treated >146 days [1] • Cancer reported as part of the Board Integrated Performance report [1]		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	• Continuation of demand/capacity work to inform how much capacity needs to be carved out for cancer • Undertake pathway work to streamline the journey for cancer patients and reduce the downtime between steps on the pathway • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Whilst a Cancer Oversight Meeting is in place, there is a need to establish a weekly PTL tracking meeting with General Managers/Directorate Managers • Breach reports need to be shared with the Directorates for validation and themes (e.g. risks/issues/constraints) need to be fed through a continuous improvement loop to ensure mitigation/solutions are put in place • The Cancer Strategy needs to be finalised and a workplan developed		

Actions	Lead	By when	Update since September 22
1. Continue to develop and iterate the demand/capacity work	HE/JC	31.3.23	D&HI team are engaged in the work
2. Undertake a review of the key tumour site pathways with a view to removing constraints and delays in the patients' journey	RL	31.3.23	Support from the WCN to undertake a number of deep dives – focus on lung and urology initially
3. Establish a weekly PTL meeting with General Managers/Directorate Managers	JC	30.11.22	Terms of reference being drafted
4. Finalise the Cancer Strategy and develop a workplan	RL/BW	31.3.23	Draft strategy completed and is on the agenda for Exec Cancer Board in November
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 5 / Likelihood Score: 2	Target Risk Score:		**10 (High)**

5. Stroke Services – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

Stroke services within C&V UHB have declined since the COVID pandemic, caused by a reduction in clinical services, but an increase in demand, most noticeably in patients self-presenting to the Emergency Department. There has been a real drive to improve this service for the patients and improvement has been seen in thrombolysis rates, achieving >10% since June 22 and now at 10.9%. Challenges include patients self-presenting to ED, dilution of stroke cases within the very busy ED leading to delay in recognition of stroke, scanning and treatment. Despite increased thrombolysis rates, door to needle times are not improving to pre-pandemic performance. There is often no dedicated Stroke medic at the front door meaning Medics are faced with competing given the capacity constraints within the footprint.

In addition to thrombolysis treatment rates, there has been improvement in thrombectomy assessment, referral and procedures delivered both internally and referred to Bristol. There has also been focused training for acute medics on stroke assessment, thrombolysis and thrombectomy. The Stroke CNS role is being protected where possible; recognised that this team are the drivers and facilitators of the thrombolysis pathway.

Investment is needed for increased Stroke resource at the front door – allowing patients to be seen, diagnosed and treated in a timely manner, ultimately reducing mortality and improving outcomes for patients. The aims are to improve Tier 1 performance and most importantly, safer care for our Stroke patients

Risk **Date added:** **01/11/2022**	Poor compliance with SSNAP – currently a D grade centre.
Cause	• An increasingly busy ED (double the number of patients) has seen a high demand upon the Stroke Service. Patients are often self-presenting which may result in an initial delay to be triaged resulting in (i) delays to Stroke calls being put out (ii) delays to patients receiving CT scans within 1-hour (iii) delays in the recognition and subsequent delivery of thrombolysis to patients. • The Stroke Unit at UHW regularly runs at 100% occupancy. Every effort is made to ensure there is a bed available for new stroke admissions. The large volumes of patients in the ED mean there is often a delay in patients being triaged and assessed within 4 hours, making it difficult to get the patients to the acute ward within a timely manner. Patients awaiting admission to the stroke unit in September between them spent almost 70 days in the ED. • Pressures across the system mean that Stroke beds are often used for non-Stroke patients. These short-term gains have long term impact on Stroke affecting the ability to admit new stroke patients within 4 hours, which has knock-on impact on specialist MDT assessments, commencement of rehabilitation and supportive discharge planning. • Since additional capacity beds which were collocated with stroke closed in August 22, performance against the 4 hours admit target improved to 20% in September. Support is needed to protect stroke beds for patients on the stroke pathway • Stroke CNS being pulled into ward numbers due to poor staffing levels

Impact	• Delays in patients receiving their CT scans within 1 hour • Delays in patients being recognised as potential Stroke patients • Delays in patients receiving timely treatment such as thrombolysis • Delays in patients being recognised as potential thrombectomy patients • Patients not receiving swallow screening in a timely manner (<4 hours) • Delays in patients being admitted to the acute Stroke ward in a timely manner (<4 hours) • Delays in patients leaving the acute Stroke ward (long lengths of stay, non-stroke patients being admitted due to ambulance waits) • Poor patient outcomes • Lack of available CRT slots or inappropriate CRT slots meaning patients in SRC are unable to be discharged in a timely manner		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20**
Current Controls	• Awareness raising on the importance of early swallow screen assessment – investment in training over the summer needs reinforcement with the timing of swallow screen and its urgency. • Taking any golden opportunities, we can – whenever there is capacity on the stroke unit, the stroke team are driving and pushing the ED stroke pathway to achieve the 4 hours admit wherever we can. The stroke team are real champions of the principles of 'Think Thrombolysis, Think Thrombectomy' and are pushing the imaging pathway to reach diagnosis as early as possible and ensure all patients are considered and assessed for urgent treatments which could reduce the disabling impact of the stroke. • Stroke Service Manager in post since July; Clinical Director for stroke in post from October. Dedicated resource for focused work with ED, radiology and medicine to ensure the optimal stroke pathway is in place and applied for all patients. • Seeking investment for uplift of CNS resource and dedicated stroke medical resource to support the front door for stroke. • Wider programme of works is needed to continue momentum of a stroke service improvement programme, particularly given future requirements for regional network service delivery and for UHW to become the regional thrombectomy centre		
Current Assurances	• Operational position reported into MCB (Monthly) (1) • Mechanisms in place to monitor key schemes in Stroke Operational Group and MCB SMT/IM DPR (1) • Monthly touch point meeting with the Delivery Unit (1)		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	Lack of consistent cover to the ground floor by a dedicated Stroke Medic CNS cover not 7/7 Stroke beds not ringfenced SRC capacity		
Gap in Assurances	Competing demand on regional, thrombectomy and clinical board priorities		

Actions	Lead	By when	Update since September 2022
1. Recruit and appoint a dedicated Service Manager for Stroke (8a) to form part of the triumvirate to lead the service	SB	01/07/2022	Completed and member of staff now in place

2. Recruit and appoint a new dedicated Clinical Director for Stroke Services	AR/NT/SB	01/10/2022	Completed and member of staff now in place
3. Nursing Uplift Stroke CNS cover to 12 hour shifts 7 days per week. **Benefits** Increased out of hours CNS support to Code Stroke, facilitation of thrombolysis and thrombectomy treatment pathways, 4 hours admit target and nurse assessments. **Interdependencies / Risks** Capacity and flow, medical support	DP/NW/NT/TH	31/01/2023	
4. Medical Extend locum SHO for SRC in backfill of specialist middle grade moving to UHW front door (Mon-Fri 9-5) Collaboration with other specialities (e.g. neurology) to improve stroke junior doctor out of hours cover. May incur cost to medicine. Contribute 4 locum consultant sessions to a new post with ITU for a neuro critical care specialist with 4 stroke sessions **Benefits** Cross speciality working - more sustainable OOH model and offers training opportunities. Reviewing the structure of the out of hours rota will offer further support to the medical on call team. Specialist middle grade and uplift of consultant sessions would support TIA clinic reconfiguration and front door senior decision making. Improved selection of patients for C4 beds, improved management of mimics in ED, acceleration of stroke assessment and diagnostics, improvement in 4 hours admit. This model offers the service an interim solution for winter demands, reducing the urgency of consultant uplift, allowing for planned succession and recruitment. **Interdependencies / Risks** Uplift is needed both in and out of hours. Locum posts are expensive but it is unknown if the workforce is there for external middle grade or consultant recruitment.	TH/NT/SB	31/01/2023	Locum SHO secured which will allow 6 sessions of front door Stroke cover (likely beginning middle of November)

5. Capacity C4 beds only to admit those patients on the stroke pathway with a protected minimum of 4 beds. Until additional capacity Winter beds open the ask is to cap medical outliers to 4 on the ward at any one time. **Benefits –** median number of admissions per day = 3 in September. 4 beds protected should offer admission capacity for most new stroke patients and we would hope to see the 4 hours admit performance >50%. When necessary to relieve pressure across the system medical outliers would be admitted; the cap would attempt to minimise the impact of these admissions on stroke performance. **Interactions/Risks** – Ability to create 4 beds each day once used is uncertain. Exit strategy needed for any medical outliers and stroke mimics. Flow needed across whole stroke pathway; community services to be approached re options to prioritise stroke beds in CRT slot allocation if possible.	NT/DP/NW/SB	31/01/2023	SOP being produced for the ringfencing of beds Agreement being sought at Clinical Board and Health Board level for ringfencing of beds "Golden days" where beds are available at the beginning of the day to show the art of the possible
6. Diagnostics Daily imaging 'hot slots' for carotid dopplers/ MRIs/ CTA for stroke patients. **Benefits –** Timely diagnoses and treatment for both stroke patients and stroke mimics. Improved discharge profile to support protection of beds. **Interactions and Risks –** hot slots may not be needed every day (would be booked by 10am and released back to radiology if not needed). Ideally would operate over 7 days.	NT/TH		Ongoing discussions with radiology to create slots Use of the CD&T escalation email to prioritise Stroke patients for discharge dependent MRIs, etc.
Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

6. **Urgent & Emergency Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)**

One of the Health Board's Strategic Objectives is to have a sustainable unplanned (emergency) care system that provides the right care, in the right place, first time. To achieve this, a whole system approach is required with health and social care working in partnership – both together and also with independent and third sector partners. The recently published Welsh Government Six goals for Urgent and Emergency Care span the whole pathway and reflect priorities to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration. The impact of the covid pandemic has had many consequences. This includes sustained pressure across the urgent and emergency care system and, whilst underlying actions to progress the plans to achieve the strategy have progressed, covid-19 has impacted on the speed of ongoing action and implementation of plans. The Sustainable Primary and Community Care risk reported in 2021/22 has been incorporated into this newly reported risk for 2022/23.

Risk **Date added: 09/05/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable urgent and emergency care as close to home as possible.
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the urgent and emergency care system. Five factors have combined to cause current operational challenges: (i) Non-covid occupancy remains at a high level and we continue to experience challenges in our ability to achieve timely discharge of patients (ii) Covid continues to add an increased layer of complexity in managing patient flow (iii) Patients presenting and subsequently admitted have a higher acuity and complexity (iv) We have sustained workforce challenges (v) Social Care are experiencing similar workforce and demand challenges • Sustained pressure in Primary and Community Care, including an increased number of GP practices operating at a higher level of escalation, temporary list closures and practice closures • Poor consistency in referral pathways, and in care in the community leading to significant variation in practice • Rollout of multi-disciplinary team cluster models only in limited number of clusters • Lack of co-ordination and / or streamlined services across Health and Social care to ensure a joined-up response is provided and the patient gets the right care, in the right place, first time • Poor response times in the community from WAST due to significant delays in ambulance handovers • Longer length of stay for both medically fit patients and clinically unfit patients, significantly above pre-covid levels
Impact	• Long waiting times for patients to access a GP • Patients attend the Emergency Department because they cannot get the care or timely care they need in Primary and Community Care • Referrals and admissions into hospital because there are no alternative options or staff are unaware of alternative options • Congested ED department and long waits for patients to be seen • Increase in ambulance handover delays and challenges in timeliness of ambulance response to community demand • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety)

Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**

Current Controls	• Development of Primary Care Support Team to provide proactive support to fragile practices • Plans agreed and implemented for contract resignations and list closures • Rollout of MDT cluster model to further 2 clusters (1 already implemented) • Urgent Primary Care hubs in the Vale – c.2500 appointments per month • Cardiff CRT and Vale CRT support people to remain at home, avoid hospital admission and be discharged from hospital – but challenges do remain on capacity and timeliness • Implementation of CAV24/7 and transition to NHS Wales 111 • Strengthened site-based leadership and management • Urgent & Emergency Care is one of the five delivery programmes in the 2022/23 Operational Plan. Delivery Group in place. Urgent and Emergency Care System Plan developed, aligned to the National six goals – see actions. • Ambulance handover improvement plan developed and being implemented • Workforce team continue to support recruitment and retention • Local Choices Framework governance in place and utilised when appropriate to support operational pressures
Current Assurances	• Operational position reported into Management Executive (weekly) (1) • Mechanisms in place to monitor key schemes in Urgent & Emergency Care Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee. Specific focus on Six Goals for Urgent & Emergency Care on 12th July 2022. (1) • Urgent and Emergency Care reported as part of the Board Integrated Performance report (1)

Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**

Gap in Controls	Actively scale up multidisciplinary cluster models Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce) Developing an effective, high quality and sustainable Acute Medicine model Reconfiguring our in-hospital footprint to improve efficiency and patient flow
Gap in Assurances	Whilst an Urgent & Emergency Care Delivery Group is in place, the Six Goals Integrated Urgent & Emergency Care Transformation Board is yet to be established

Actions	Lead	By when	Update since Sept 2022
1. Secure funding and develop implementation plan for further MDT cluster rollout and Urgent Primary care Centre in Cardiff	LD	30.11.22	Utilisation of CAV 24/7 funding to support interim model as larger scale redesign developed for Health Board
2. Development and implementation of one Urgent and Emergency Care Plan, aligned to the National six goals Saunders,Nathan 28/11/2022 15:01:22	PB	31/10/22	Clinical Director appointed. Associated director for transformation and delivery appointed. Support for key urgent and emergency models of care developed and to be implemented in Quarter 3.

3. Introduce Medical Same Day Emergency Care Unit moving to new area whilst introducing senior clinical triaging and hot clinics	PB	30.11.22	New action
4. Introducing frail assessment service in emergency and assessment area UHW	PB	30.11.22	New action
5. Develop SOP for A1 (medical short stay ward) and SOP for Zero four-hour ambulance handovers	PB	30.11.22	New action
6. Develop cohesive Winter Plan that introduces 150 beds or bed equivalents 7. Develop acute admission protocols	PB PB	30.11.22 30.11.22	New action New action
8. Continued development of joint Health and Social Care strategies to allow seamless solutions and services for patients with health or social needs	AH / PB	31.03.23	Partnership working continues. Joint action plans in place. Work progressing through RPB, SLG and JME with new IMT introduced bi-weekly chaired by SR to increase focus on actions
9. Introduce integrated care assessment unit as part of the Winter Plan to discharge patients into UHW Lakeside for focused social care intervention whilst maintaining care.	PB	31.10.22 - 31.01.23	New action
10. Implementation of the UHW site masterplan, including de-escalation of additional capacity and reconfiguration of the EU	PB	31.03.23	Implementation of de-escalation plan commenced – but behind timescale due to ongoing operational pressures and recent increase in covid admissions.
11. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 5 / Likelihood Score: 2	Target Risk Score:		**10 (high)**

7. **Planned Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)**

One of the Health Board's Strategic Objectives is to have sustainable planned care services that deliver the ministerial measures of no-one waiting >52 weeks for a new outpatient appointment by December 2022 and no-one waiting >104 weeks for treatment (all stages) by March 2023. To achieve this, the system needs to ensure sufficient capacity to meet recurrent demand and to increase capacity and activity sufficiently above pre-Covid levels to make inroads into the backlog. The recently published Welsh Government Planned Care Plan reflects the high priority of planned care services.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable planned care services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments for urgent/emergency care has impacted on those waiting to access the system for planned care. • Referrals for planned care are at pre-Covid levels overall, however there is significant variation between specialities. Whilst our planned care system (outpatients, diagnostics, treatments) is almost back to full capacity, it has been challenging to achieve activity levels significantly above pre-Covid activity. • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff		
Impact	• Significant volumes of patients waiting for new outpatient appointments, diagnostics and treatment • Some patients are tipping over into waits of more than 3 years, some of these are still at the outpatient stage • Potential for harm in terms of clinical deterioration whilst patients are waiting, particularly at the outpatient stage where patients have yet to be seen by a secondary care clinician and priority determined • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety) • Organisational/reputational harm due to political and media interest and scrutiny		
Impact Score: 4	Likelihood Score:4	Gross Risk Score:	**16 (Extreme)**
Current Controls	• Planned Care is one of the delivery programmes in the 2022/23 Operational Plan • Demand/capacity work undertaken to model expected delivery against the ministerial measures • Additional capacity schemes funded through WG planned care monies are in place and delivering e.g. independent sector, mobile ophthalmology theatres, 2nd gynae treatment room commissioned, spinal unit commissioned, mobile endoscopy unit in place • Workforce team continue to support recruitment and retention • Suite of reports and dashboard created by the Digital and Healthcare Intelligence team to support Directorate teams and Clinical Board in terms of managing the planned care position		

Current Assurances	• Current position against 52/104weeks monitored via weekly Planned Care Performance meeting [(1)] • Operational position reported into daily/weekly 'hot' reports[(1)] • Elective Care Delivery Group in place monthly; suite of metrics reviewed at every meeting [(1)] • Monthly meeting with the Delivery Unit on Planned Care[(1)] • Mechanisms in place to monitor key Planned Care schemes as part of the Operational Delivery Plan [(1)] • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee [(1)] • Planned Care reported as part of the Board Integrated Performance report [(1)]		
Impact Score: 4	Likelihood Score: 3	Net Risk Score:	**12 (High)**
Gap in Controls	• Further demand/capacity work required together with an indication of the ministerial targets to inform the plan for 23/24 and assess deliverability • Availability of planned care funding may mean that choices need to be made in terms of delivery • Further work required to maximise treat in turn • Solutions required to ensure all specialities can access sufficient capacity to enable a return to pre-Covid levels of activity • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Since the Operational Plan Delivery Group meeting has been stepped down, there is a need to consider the governance mechanisms by which key risks and messages from the Elective Care Delivery Group are escalated • Whilst a sub-group on supporting patients whilst they are waiting has been established, the group is in its infancy and needs to progress at pace		

Actions	Lead	By when	Update since Sept 22
1. Continue to develop and iterate the demand/capacity work for 23/24 to inform the IMTP	AW/JC	31.1.23	D&HI team are engaged in the work
2. Establish key priorities and a work plan for the supporting patients sub-group	EC	31.12.22	Group is meeting fortnightly initially
3. Continue to progress plans to maximise activity and monitor via the Planned Care Performance group	JC	Weekly	Meetings in place
4. Agree formal reporting mechanisms from the Elective Care Delivery group through to SLB	PB/HE	31.12.22	Under consideration as part of review of COO meeting structures
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 4 / Likelihood Score: 2	Target Risk Score:		**8 (High)**

Report Title:	**Corporate Risk Register**			Agenda Item no.	2.8
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	29/11/2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

The Corporate Risk Register ('the Register') has been developed to enable the Cardiff and Vale UHB (the Health Board) Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates. Whilst the Register and the overarching Board Assurance Framework and Risk Management Policy ("the Policy") were embedded in practice and consistency in application developed, the Register included those risks which were rated 15 and above to provide the Board and it's Committees with an overview of the Health Board's extreme Operational Risks.

Since the July 2021 Board meeting, where an updated version of the Policy was agreed, the Register has recorded only those risks scoring 20 and above.

Each of these risks are linked to a Committee of the Board and the Board Assurance Framework. Those risks which are linked to the Quality, Safety and Experience Committee are attached at Appendix A for further scrutiny and to provide assurance to the Committee that relevant risks are being appropriately recorded, managed and escalated.

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

The Risk and Regulation Team continue to work with clinical and corporate colleagues to refine risk descriptors, controls and actions within Risk Registers. Since the September 2021 Board meeting the Risk and Regulation Team have undertaken a 'Check and Challenge Process' with all Clinical Board and Corporate Directorate risk leads to ensure that those risks recorded within the Register are correctly recorded in line with the Risk Scoring Matrix detailed within the Policy.

This ensures that the Board and its Committees can take assurance that the risks detailed in the Register are consistent with agreed procedures and are a true reflection of the operational risks that the Health Board continues to manage.

Alongside this process the Risk and Regulation Team continue to provide ongoing support and training to risk leads across the Health Board. During October and November 2022, the Head of Risk and Regulation has also met with Risk Leads within all Clinical Board Triumvirates and Corporate Directorates to provide additional support and guidance in advance of submission of updated risk registers for the November 2022 Board meeting.

At the Health Board's November 2022 Board meeting a total of 17 (from a total of 22 risks scoring 20 or above) Extreme Risks reported to the Board related to Patient Safety and are linked to the Quality, Safety and Experience Committee for assurance purposes.

Details of those risks are attached at Appendix A but can be summarized as follows:

Risk Score (1 to 25) - Clinical Board	20/25	25/25
CD&T		
Medicine	6	1
PCIC		
Specialist Services	4	
Surgery		
Digital Health		
Estates		
Children and Women	2	
Mental Health		
Capital Estates and Facilities	**4**	
Workforce and OD		
Total:	**16**	**1**

Of those risks recorded the following should be noted:

- A discussion has taken place with the Specialist Services Clinical Board regarding the Extreme Risks that they are holding, specifically aged risk 21. Given the nature and age of this risk the Clinical Board and appropriate directorates were asked to reconsider the risk presented in advance of the November Strategy and Delivery Committee meeting so that an updated position was provided. At the November Strategy and Delivery Committee it was confirmed that whilst the risk had remained on the Haematology Risk Register since 2010, it is certainly not the case that the risk had been left unmanaged.

  In an effort to work towards continued JACIE accreditation the Haematology, Immunology & Metabolic Medicine Directorate have, with the support of the Clinical Board, Strategic Planning and Capital and Estates colleagues, worked through a number of solutions to mitigate this risk. Since 2010 a wide variety of improvement plans and proposals have been developed but have, unfortunately, not been successfully implemented. These include, but are not limited to the following.

  - Re-location to the 7th Floor at University Hospital for Wales ("UHW")
  - A new purpose-built construction between the Dental Hospital and C Block (UHW)
  - Re-location to the top floor of the Lakeside Wing

  These plans have not been successfully implemented due to a variety of factors which include, prohibitive capital expenditure, logistical difficulties and clinical risk. By way of example, it has not been possible to re-locate to the Lakeside Wing as it is not clinically appropriate to convey immunocompromised patients from the main hospital to the Lakeside Wing via available routes.

  The Committee can be re-assured that a large-scale refurbishment of the Clinical Area was undertaken in 2019 following a Bacterial Infection outbreak which went some way to addressing JACIE accreditation concerns. Notwithstanding this work, the Directorate and Clinical Board continue to explore options for the improvement and/or relocation of this clinical area.

  The area is currently being considered within the Health Board's Acute Sites Master Plan (alongside Critical Care which is referred to at Risk 20 of Appendix A) with plans being worked up to relocate the department within the current UHW Outpatients footprint. This work will form part of a staged process and is conditional upon a number of factors including Welsh Government Funding, capacity to undertake the relocation exercise for all areas within the Master Plan and sequencing of the moves required. Whilst these plans will take time to be approved and implemented, it is hoped that ongoing work in this area will provide the Committee with reassurance that the described risk continues to be managed and mitigated by the Health Board's Operational teams.

It should also be noted that despite the articulated risk the outcomes from the Bone Marrow Transplant programme are excellent and the service continues to perform well in terms of waiting times and activity.

An updated Register will be shared with the Board at its January 2022 meeting. It should also be noted that each Clinical Board shares the detail of their Extreme Risks with Executive and Operational colleagues bi-monthly at Clinical Board Operational Meetings to ensure that they are continually monitored and proactively managed.

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The programme of education and training that continues to be rolled out by the Risk and Regulation Team ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.

Recommendation:

The Committee is requested to:

NOTE the Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work which is now progressing with Clinical Boards and Corporate Directorates.

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

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

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

Prevention	x	Long term		Integration		Collaboration		Involvement	

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

Risk: Yes/No

Yes – The ongoing management and review of the Health Board's Corporate Risk Register involves a review of all Extreme Risks held by Clinical Boards and Corporate Directorates.

Safety: Yes/No

n/a

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board	28/07/2022

CORPORATE RISK REGISTER NOVEMBER 2022

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Capital and Estates	1	Mar-21	**Obsolete Medical Gas and Air Delivery Equipment and Plant** **Risk/Issue**: Medical Gas (Oxygen) Manifold is obsolete at UHW Maternity (manifolds 1&7), In addition the UHW Medical Gas Pressure reducing set is obsolete. Helipad and Ambulatory Care Medical Air Plant areare non compliant to HTM02-01 MGPS Standards. **Impact:** Equipment failure leading to Loss of Service and interruption of supply. This would adversely impact on patient safety. quality of service and HTM regulatory compliance.	5	4	20	Regular inspection and maintenance	5	4	20	New manifolds and pressure reducing sets required	5	1	5	Dec-22	Quality, Safety & Experience Committee	Patient Safety Capital Assets
	2	Mar-21	**Risk/Issue**: UHW Tunnels corroded Main O2 Pipeline due to building leakage **Impac**t: Equipment Failure leading to Loss of Service and Interruption of oxygen supply to whole of UHL - impacting on patient safety and failure to meet HTM regulations.	5	4	**20**	Regular inspection and maintenance.	5	4	**20**	Repair building leak and renew section's of corroded pipework.	5	1	**5**	Dec-22	Quality, Safety & Experience Committee	Patient Safety Capital Assets
	3	Mar-21	**Risk/Issue**: UHL Main Boiler F&E TANKS are badly corroded and require renewing **Impact**: Corrosion causing tanks to leak and loss of Heating throughout Hospital	5	4	20	No controls in place as cleaning tanks may result in leakage	5	4	20	Renew or reline tanks to prevent leaks.	5	1	5	Dec-22	Quality, Safety & Experience Committee	Patient Safety Capital Assets
	4	Jun-21	**Risk/Issue:** Ventilation verification of critical systems has identified UHW ITU A3N, UHW ITU B3N North, UHW Cardiac ITU C3 Link does not comply with HTM's for Ventilation. **Impact:** Adverse impact on the safety of staff working in these areas, faiulre to comply with HTM regulations.	5	4	20	System is subject to statutory testing and inspection in line with legislation and HTM regulations. Regular maintenance.	5	4	20	Preparing plans to renew the AHU. Look at improving the sytem to comply with current HTMs	5	1	5	Dec-22	Quality, Safety & Experience Committee	Workforce Patient Safety Capital Assets Staff Wellbeing
	6	08/2022	There is a risk of physical and emotional harm to patients and staff due to the number of nursing vacanies across the Clinical Board. Secondary to this is the risk of failure to comply with regulatory staffing requirements (Nurse Staffing Levels (Wales) Act 2016).	5	5	25	Posts advertised in a timely manner. Authorisation of vacancies reviewed efficiently. Maximsation of medical ward float staff. Dedicated recruitment officer in post. Bimonthly recruitment events held. Engagement with Project 95, overseas recruitment, adaptation programmes, student streamlining and staff return to practice. Risk staff framework completed daily by the Clinical Board and shared at daily OPAT UHB meetings	5	5	25	Ongoing support and escalation via OPAT. Overseas nurses coming on board October 2022 to support staffing shortfalls. Focused work on staff exit questionairres and engagement with established staff to protect establishment.	5	3	15	Dec-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Workforce Patient Safety Staff Wellbeing Urgent and Emergency Care
	7	08/2022	Patients with suspected (Basal cell carcinoma) BCC are added to a routine waiting list, due to this there is a risk that these patients may actually be unusual presentation of a higher risk Squamous cell carcinoma (SCC). Secondary to existing RTT waiting times for routine referrals (target 36 weeks) there is a risk that increased waits could impact on a patients prognosis.	5	5	25	Ongoing work within the Directorate with Clinical Board oversight to reduce waiting times	5	4	20	Waiting list initiatives ongoing as part of recovery plan to reduce overall waiting position. Triage system in place for referrals: teledermatology review of photographs to support clinical prioritisation	5	1	15	Dec-22	Quality, Safety and Experience Committee	Patient Safety Cancer Planned Care
	8	08/2022	There is a risk of patient harm due to delays to patient treatment and flow following a speciality referral from the Emergency Unit.	5	5	25	Engagement across Clinical Board specialities to review patients within 30 minutes of referral and make a plan within 60 minutes. Implementation of internal escalation cards within Emergency Medicine. Delays documented within EU Safety Huddles Report.	5	4	20	To facilatate seven day 12 hour per day presence of an Acute Medicine Consultant as per Royal College of Physician guidelines	5	3	15	Dec-22	Quality, Safety and Experience Committee	Patient Safety, Urgent and Emergency Care
	9	08/2022	There is a risk of Patient Harm due delays in the delivery of patient care and subsequently NRI's reported to the Delivery Unit for delayed cancer diagnosis secondary to the accumulation of therapeutic and surveillance backlog for Endoscopy and due to Covid restrictions. Change in the local lower GI pathway has shifted all USC priority CT pneumocolon requests into secondary care. Implementaton of FIT stool testing into pathway now requires result for some patient groups delaying decision making and waiting times for USC referral.	4	5	20	Clinical validation of lists. Corporate risk stratification cub available in BIS to pull through surveillance patients based upon individual risk vs chronological waiting times. NEP also provided documentation for risk stratification. High risk surveillance patients started to be listed for procedures.	4	5	20	Directorate to utilise BIS risk surveillance to prioritise patients and reduce potential harm. Administrative team to send patient risk letters for delayed surveillance cases to manage patient risk. Directorate to consider use of FIT stool test as per BSG to manage risk of overdue lower GI surveillance. Clinical validation continues risk assessing using a clinical tool recommended by steering group. Table top exercises undertaken to ensure all actions aligned and updated and will continue to be reviewed.	4	2	8	Dec-22	Quality, Safety and Experience Committee Strategy and Delivery Committee	Patient Safety Planned Care Cancer

Medicine Clinical Board	10	01/03/2019	There is a risk to patient safety and wellbeing due to patients remaining on WAST ambulances for above the agreed 15 minute Welsh Government turn around time secondary to lack of capacity within the Directorate and UHB. This results in delays for patient assessment and treatment with the potential to cause patient harm.	5	5	**25**	When patient arrives by WAST, patient is booked in and major assessment nurse (MAN) is alerted to immediately triage patient and handover taken. If there is any change in the patients condition, the WAST crew will immediately inform the MAN. All non paramedic crews are assessed by the Triage Nurse/MAN to ensure a patient clinical assessment is conducted. Concern by either party about the length of any dealy or volume of crews being held is escalated to the Senior Controller/EU nurse in charge to Patient Access for usual UHB escalation procedures, or by WAST via Silver Command. WAST have introduced a number of hospital avoidance initiatives with some evidence this has reduced ambulance transfers. Protection of Resus capacity when possible including one buffer. Standard operating procedure in place within EU to support 'immediate release' requests by WAST. Joint CB/WAST partnership meeting in place to focus on improvement. The CB is engaged with the NRI process for reporting incidents where WAST delays have resulted in major harm. The Clinical Board work with OPAT and the completion of 'on boarding' and FCP when ambulances have been held for 3 hours. Transformational work undertaken across Acute and Emergency Medicine to support flow including RATZ, virtual ward and speciality hub. The appointment of two Band 7 registered nurses to work with Patient Access to support patient flow.	5	4	**20**	Daily review and risks noted within Safety Huddles and EU controller reports. Escalation via MCB HUB and Patient Access Services. Evaluation of Standard Operating Procedure to reflect changes required. WAST immediate release Standard Operating Procedure in use to support 'red' calls in the community. OPAT across both UHW and UHL sites to support WAST and patient flow.	5	2	**10**	Dec-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety Urgent and Emergency Care
	11	01/01/2021	There is a risk of patient and staff harm due to an inability to safely provide medical cover across all Specialities and disciplines across the Clinical Board secondary to ongoing Covid pressures and overall recruitment, resulting in the delay of assessment for patients which could result in clinical risk and poor patient experience.	5	5	**25**	Ongoing recruitment of medical staff including Consultant body. Review of Consultant Job Plans. Engagement with the Workforce Hub. Electronic rota database.	5	4	**20**	Medical staffing reviewed as part of the daily OPAT meeting with ongoing planning to ensure safe staffing. Work ongoing with Medi Team and Locums to support the Emergency footprint. Ongoing recruitment into F3 posts	5	2	**10**	Dec-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patienty Safety Staff Wellbeing Workforce
	12	01/12/2021	There is a risk of patient harm due to overcrowding within the Emergency and Acute Medicine footprint secondary to no flow or lack of UHB capacity. This results in the inability to provide and maintain key quality standards as patients are being nursed in inappropriate areas affecting timely access to treatment and discharge.	5	5	**25**	UHB and local escalation policy and implementation led by MCB Hub and Patient Access Services working in partnership with the EU Controller and Senior Floor cover to improve flow. Escalation of all constraints to all Directorates. Internal escalation to key clinicians/staff to assist with flow across the department. All vulnerable patients escalated to ensure timely bed allocation. Standard Operating Procedure in place for all ambulatory areas. Clinical Board engaged and supportive of 'on boarding' to facilitate flow. Change in the Emergency Unit footprint to support flow, eg speciality hub.	5	4	**20**	Appropriate escalation and discussion with MCB HUB, Patient Access Services and OPAT regarding safe and timely patient flow. Introduction of two Band 7 nurses to support flow and patient access.	5	3	**15**	Dec-22	Quality, Safety & Experience Committee	Patient Safety Capital Assets
Children and Women Clinical Board	15		Due to Fetal Medicine capacity shortfall and breach of ASW 5 day referral standard, there is an increased risk of harm to compromised fetuses and reduced options for termination of pregnancy if delayed beyond 21+6 weeks	5	5	**25**	Fetal medicine lead is keeping accurate data regarding breach figures, along with demand and capacity data. Clinics are being overbooked to absorb urgent referrals and active triage to allow joint shared care with local delivery where possible.	5	4	**20**	The fetal medicine service is actively triaging on a daily basis and managing patients locally where possible and declining to accept referrals when safe to do so. A locum consultant with appropriate experience is providing 2 clinic sessions a week. Extra additional clinics are being put on where possible and will continue to be explored, however this is not always possible due to consultant availability and there still not being enough sessions available to meet the demand on the service. The fetal medicine service will continue to try manage the risk by vigilant triaging to pick off the highest risk cases and trying to manage joint care with local units when possible. Additional clincial space (current antenatal phlebotomy room) is being prepared to reduce crowding in clinics and improve efficiency.	5	1	**5**	Dec-22	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety Maternity
	16	01.05.22	Due to staffing levels within Maternity services there is a risk that: - there will be delay and interruption to induction of labour and the potential risk of poor patient experience and poor outcomes for mothers and babies. Home Birth Services will be withdrawn resulting in the loss of choice for women. This has the potential for reputational harm to the Health Board. - the Midwifery Led Unit will have to close resulting in the loss of choice for women. This has the potential for reputational harm to the Health Board	5	5	**25**	1.Undertaking an in depth review of our that there is continued assurance that sickness is being managed according to the policy. 2. Introduced a weekend planning meeting each Friday at 12pm so that we have assurance that weekends are covered 3. Introduced a postnatal / newborn spot screening clinic at UHW on the weekends. This means that women will attend ANC at UHW or UHL for their care rather than a midwife visiting. This will release a community midwife to come in to support the hospital setting but keep the home birth service going. 4. Midwives offered bank / additional hours and overtime Enhanced overtime approved	5	4	**20**	1.Band 6 vacancies to be filled. Band 5 vacancies have been filled. On going request to PHW to facilitate rapid Covid testing for maternity staff. Improved sickness review in place. Weekend planning meetings continue.	5	2	**10**	Dec-22	Quality, Safety and Experience Committee	Patient Safety Workforce Maternity
	18	Sep - 21	**Critical Care - Nursing Workforce** There is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner due to insufficient Critical Care Nursing Capacity resulting in patient safety risks including serious harm and death, staff burnout and a failure to adhere to national standards and guidelines. This risk is currently exacerbated by the consequences of the Covid19 pandemic due to staff absences due Covid19 infection, sheilding & self-isolation requirements, and the significant associated impacts upon staff wellbeing.	5	5	**25**	Block booking of temporary staffing is ongoing; Recruitment strategies in place (ongoing recruitment events); Increased our educational team from 2.64 WTE to 5.04 WTE to support the junior workforce; Relying on the availability of an additional clinical area to admit patients; Working collaboratively with patient access to identify beds in a timely manner for Level 1 patients (not currently effective) Robust implementation of the CC escalation plan; Implement the smaller pod-focused initiative.	5	4	**20**	Develop a strategy to attract prospective employees to work in C&V CC; Develop further cross- Health Board working; Develop a staff feedback opportunity to generate ideas to support Point 1. Gain support from HR and Recruitment to have an open CC recruitment advert; Implement the Leadership Programme developed for senior staff Identify a more robust process for discharging patients within the 4 hour target; Robust implementation of the CC escalation plan; Develop a staff feedback opportunity to generate ideas to support Point 2. Initiate Workforce Task & Finish Group	5	2	**10**	Dec-22	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety Staff Wellbeing Workforce Critical Care

Specialist Services Clinical Board	19	08/2022	**Critical Care - Bed Capacity** Lack of physical Emergency Critical Care beds at UHW to admit current and predicted Critical Care Demand to 2030. Delays in Emergency admission to Critical Care present a risk of avoidable deaths and impaired functional outcomes. Emergency Critical Care has 35 Level 3 commissioned beds. Due to its specialist nature, the majority of Critical Care work undertaken at Cardiff and Vale cannot be undertaken anywhere else in Wales.	5	5	**25**	Currently the directorate are occupying the use of a surge ICU area (C 3 Link) to provide 10 additional physical beds. Capital Planning are in the design process for refurbishment and expansion of Critical Care.	5	4	**20**	Undertake Design work to produce an outline cost for refurbishment and expansion of Critical Care beds, overseen by Program Board.Seek funding for expansion and refurbishment. Clarify commissioning arrangements	5	2	**10**	Dec-22	Quality, Safety and Experience Committee Strategy and Delivery Committee	Patient Safety Critical Care
	20		**Critical Care - Estates** There is a risk of patient and staff harm due to aging and obsolete estates and equipment coupled with reduced capacity within the Critical Care Directorate. Aggragated Risk following risk of harm in the following areas: - HCID Level 2 and 3 (Reduced Capacity) - Sub-standard Heating, Ventilation and Air Circulation - Isolation Facilities - LTV unit	4	5	**20**	Prioritisation of clinical need, use of neighbouring facilities and acquiing temporary mobile structures.	4	5	**20**	Business cases to be developed to secure renovation and replacement funding.	4	2	**8**	Dec-22	Quality, Safety and Experience Committee Strategy and Delivery Committee	Capital Assets Patient Safety Critical Care
	21	Jan - 2010	**Haematology and Immunology - Clinical Environment** There is an inadequate clinical environment for the care of Haematology Patients (including Bone Marrow Transplant). This creates a risk of cross infection for patients particularly vulnerable to infection. There is a potential impact on patient morbidity and mortality, quality of service and reputation. Despite the controls and assurances currently applied, it is extremely likely that the clinical environment will not meet the minimum required standard at the next JACIE accreditation assessment and the ensuing consequences of this cannot currently be prevented.	5	5	**25**	Risk specific policies, protocols, and guidelines. Cleaning schedules. Installation of air pressure gauges outside BMT cubicles to measure positive air pressures. Patients admitted to ward C4 North (amber) for triage prior to admission to B4 (green). HCAI monitored monthly. Positive air pressure gauges outside the BMT cubicles are monitored daily to ensure appropriate air pressures are maintained. Air pressure system validated by Estates Dept. High C4C scores consistently achieved. A number of options for the relocation of the service have been explored over the past 10 years but have not been successfully adopted. The directorate and Clinical Board are currently working with Estates and Operational Colleagues as part of the Health Board's Acute Sites Master Plan work to develop plans for relocation to the current Outpatient site at UHW.	5	4	**20**	New dedicated Haematology facility required. Escalated to Clinical Board, estates and WHSSC. Bid for Lakeside Wing is to be submitted for consideration.	5	1	**5**	Dec-22	Quality, Safety and Experience Committee Strategy and Delivery Committee	Patient Safety Capital Assets

Report Title:	Safeguarding Children and Adults at Risk Annual Report 2021/2022				Agenda Item no.	2.9	
Meeting:	QSE	Public	X		Meeting Date:	29 November 2022	
		Private					
Status *(please tick one only):*	Assurance		Approval		Information		X
Lead Executive:	Jason Roberts, Executive Nurse Director						
Report Author (Title):	Linda Hughes Jones, Head of Safeguarding						

Main Report
Background and current situation:

The purpose of this paper is to present the Safeguarding Children and Adults at Risk Annual Report 2021/22 to the Committee.

The UHB have continued to make progress in ensuring a range of processes are in place to safeguard children and adults and these are outlined in the attached Annual Report.

Since April 2014 the National and International safeguarding landscape has broadened. It has seen the introduction of two significant Acts of law in Wales which has impacted on the safeguarding workstream across the UHB and requiring significant changes in process, additional training and supervision as well as relocation of existing resources. Further legislation from the Home Office has also defined the need to raise awareness of Domestic Homicide and FGM. The Modern Slavery Act (2015) is another area whereby the safeguarding team need to work with partner agencies to raise staff and public awareness.

The Cardiff and Vale University Health Board Safeguarding Team will strive to continue to meet all of the demands set by the UHB and Welsh Government to ensure the safety and safeguarding of children and adults at risk that become known to us. This will only be achieved by continuing to work collaboratively with our strategic partners ensuring that communication and decision making is embedded in open, honest and transparent practice.

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

The implementation of the Social Services and Well-being Act (Wales) 2014 (SS&W-bA) and the Violence against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) has determined much of the safeguarding work undertaken across Wales.

Ensuring that both Acts are implemented within the organisation has been a priority due to the duty to report and investigate, provide awareness raising training, supporting all staff to undertake their duty, recognise their responsibility and encourage partnership working with other statutory agencies.

The 2021/22 Safeguarding Report considers the workstream from April 2021 to March 2022, demonstrating and evaluating the breadth of the safeguarding agenda and the progression made across the UHB.

Recommendation:

The Board / Committee are requested to: **NOTE** the assurance provided by the Annual Report 2021/22

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a
Decarbonisation: Yes/No
n/a

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

Saunders,Nathan
28/11/2022 15:01:22

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

Cardiff and Vale University Health Board

Safeguarding Children and Adults at Risk

ANNUAL REPORT 2021/2022

Contents Page

1. Introduction

The 2020/21 Cardiff and Vale University Health Board (UHB) Safeguarding Report portrayed a forecast for the coming year that considered the work to be undertaken by the integrated corporate Safeguarding Team. Areas highlighted formed part of the work plan for the team to ensure that progress has been made and projected development is maintained. The forecast areas are shown, to demonstrate advancement made:

	Action	Outcome
1.	Launch an updated Risk Assessment for Young People on Adult Wards	***Completed Green***
2.	Complete an aligned Patient Safety/Safeguarding pathway for reporting Pressure Damage within the UHB to report to Local Authority and Serious Incident to Welsh Government	***Completed Green***
3.	Embed Domestic Abuse, Routine Enquiry pilot in to practice within Emergency Unit at UHB University Hospital of Wales	***Completed Green***
4.	Undertake an internal UHB Pressure Damage audit across all Clinical Boards	***Completed Green***
5.	Introduce and update current UHB Safeguarding Standard Operational Procedures	***Completed Green***
6.	Provide safeguarding advice and training as required by the newly launched Regional Major Trauma Centre (MTC) at UHW	***Completed Green***
7.	Launch a Routine Enquiry for Child/Adult Sexual Abuse within the Midwifery Service	***Completed Green***
8.	Complete a Standard Operational Procedure for Midwives and Health Visitors on the law around overlay for infant victims of Sudden Infant Death Syndrome (SIDS)	***Completed Green***
9.	Complete an induction training programme for Band 5 nurses employed within the Health Visitor Service	***Completed Green***
10.	Incorporate the Cardiff Multi-Agency National Transfer Scheme and National Referral Mechanism processes	***Completed Green***
11.	Update the UHB Medical Illustration Protocol for sharing images with South Wales Police and staff guidance whilst dealing with Child Protection cases	***Completed Green***
12.	Children and Women (C&W) Clinical Board will audit the effectiveness of the Children Looked After Service during 2021	***Completed Green***
13.	Department of Sexual Health (DoSH) will complete an audit during 2021 of the use of child exploitation information in the department proforma	***Completed Green***
14.	Successfully implement a South Wales Police, Access to medical records at Emergency Department (ED) during “out of hours” through the introduction of the Streamlined Forensic Reporting (SFR) process	***Completed Green***

15.	Participate in a PhD study around facilitating safeguarding group supervision	***On-going Amber***
16.	Consider a new logo for the UHB Safeguarding Team designed by the Youth Board	***On-going Amber***
17.	Provide the Executive Team with a monthly Informatics Dashboard on Safeguarding activity across the UHB	***On-going Amber***
18.	Introduce a new multi-agency approach to reviews through the Single Unified Safeguarding Review (SUSR)	***On-going Amber***
19.	Improve the safeguarding dashboard recording of Deliberate Self-Harm and Suicide in Young People	***On-going Amber***
20.	Safeguarding recovery plan for school nurses to consider the impact of lockdown on children during COVID-19 and service provision available	***On-going Amber***
21.	Report the data of health workload within Cardiff Multi-Agency Safeguarding Hub (MASH)	***On-going Amber***
22.	All Clinical Boards recognises that improved mandatory training compliance is required post COVID-19 - measures to be introduced to improve the current situation	***On-going Amber***
23.	Prioritising a targeted increase in mandatory safeguarding training, to achieve a UHB level of 75%	***On-going Amber***
24.	Introduce a standardised proforma to be completed by GPs, Practice Nurses and DoSH when sexual concerns are indicated	***On-going Amber***
25.	Launch an additional Level 3 Safeguarding Training Day "Learning from Child/Adult Practice Reviews" and "Domestic Homicide Reviews"	***Deferred Red***
26.	Work in partnership with the Royal College of Nursing to gain accreditation for UHB Safeguarding Training	***Deferred Red***
27.	Demonstrate partnership working to engage with communities in relation to anxieties around Female Genital Mutilation (FGM) reporting	***Deferred Red***

Forecast Population Growth within the Cardiff and Vale University Health Board (UHB) Region

To continue to improve and develop, the UHB Safeguarding Team will consider the growing population of the region to guarantee that the local Public Health plan for 2020-23 is respected and provides a benchmark for safeguarding service delivery. The current report states that the population of Cardiff is growing at nearly 1% per year, or around 37,000 over the next 10 years. The population of Cardiff and Vale is nearly 500,000 at present with a forecast of 400,000 in Cardiff alone by 2028. The average age of people in the region is increasing and expected to increase for those over 85 years by 20% over the next five years in the Vale and nearly 50% over 10 years. The region is recognised as one of the most ethnically diverse populations in Wales, with one in five people from a Black, Asian and Minority Ethnic background. These statistics, as well as health inequalities identified in specific neighbourhoods across Cardiff and the Vale of Glamorgan, impact on safeguarding and well-being of individuals and families, resulting in targeting services to meet demand.

The emergence of COVID-19 expedited identified cases of substance misuse, emotional and mental health well-being and unhealthy relationships. Social isolation and loneliness had been identified prior to COVID-19 measures as affecting a quarter of vulnerable people within the region. Isolation restrictions during this period may be the result of increased cases reported, requiring a multi-agency safeguarding response.

Cardiff and Vale Corporate Nursing Safeguarding Team Structure

To promote the safeguarding agenda the corporate team consists of:

- Head of Safeguarding
- Named Doctor for Safeguarding Children
- Senior Nurse Safeguarding
- Seven Safeguarding Nurse Advisors
- Safeguarding Nurse Advisor (Flying Start)
- Safeguarding Nurse Advisor (Midwifery Services)
- Safeguarding Trainer/Nurse Advisor
- Specialist Safeguarding Liaison Nurse
- Health Independent Domestic Violence Advocate (IDVA)
- Violence Prevention Team, one Band 6 nurse and one Band 6 advocate
- Liberty Protection Safeguards (LPS), Project Manager
- Deprivation of Liberty Safeguards (DoLS), Manager
- Mental Capacity Act Lead, advisor
- Administration Team

The safeguarding governance structure sits within the portfolio of the Executive Nurse Director and the Deputy Executive Nurse Director. A bi-monthly Safeguarding Steering Group meeting is held within the UHB and is attended by representatives from each Clinical Board (CB). The CBs consist of Mental Health, Specialist Services, Children and Women, Medicine, Surgery, Primary Care Community and Intermediate Services and Clinical Diagnostics & Therapeutics. More recently South Wales Police has been represented at the meeting, Cardiff and Vale Local Authorities are invited and have receipt of minutes. This reflects the ethos of safeguarding being everybody's business and provides assurance to the UHB Board that the safeguarding agenda is being progressed in line with legislative duties and best practice.

The Safeguarding Team locations are: the Noah's Ark Children's Hospital at the University Hospital of Wales, Cardiff Multi Agency Safeguarding Hub (MASH) and the main office for advice and queries based at Woodland House, Heath, Cardiff. The Cardiff MASH was launched in July 2015, hosted by South Wales Police at Cardiff Bay Police Station. Agencies located within the MASH include Cardiff Local Authority (LA) Children and Adult services, South Wales Police, Cardiff Local Authority Education, Health and Probation services. The purpose of the MASH is to ensure that safeguarding of children, adults at risk and domestic abuse has a timely, appropriate multi-agency response and approach. By co-locating agencies to share information immediately that a concern is raised, safeguarding measures are considered and put into place immediately or within 24 hours. Two safeguarding nurse advisors work within the MASH, sharing appropriate health information to ensure the safety of children and adults at risk across the UHB locality.

The Safeguarding Team continues to work to provide assurance to the Executive Board that the UHB is discharging its duties in line with Health Care Standards (2.7 Safeguarding). The current corporate assessment for the UHB is: *Leading the Way.* This is unchanged from the

previous year and demonstrates the collective progression made by all Clinical Boards (CBs) during the year.

Significant Legislation that Informs the Wales Safeguarding Agenda

The implementation of the Social Services and Well-being Act (Wales) 2014 (SS&W-bA) and the Violence against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) has determined much of the safeguarding work undertaken across Wales. Ensuring that both Acts are implemented within the organisation has been a priority due to the duty to report and investigate, provide awareness raising training, supporting all staff to undertake their duty, recognise their responsibility and encourage partnership working with other statutory agencies. The Welsh Government (WG), National Training Framework five-year plan for Groups 1, 2 and 6 has been submitted and reflects the UHB's commitment to deliver the raising awareness training across the organisation in line with WG expectation. The UHB has worked with Public Health Wales, National Safeguarding Team to produce a training package aimed at Group 2 training following agreement by WG for Health organisations to deliver a single agency package. This has been implemented within the UHB from September 2019. Delivering the training for Group 2 in accordance with WG recommended staff groups is a challenge for the safeguarding team as it is estimated that a figure of approximately 11,000 staff will require this additional training. Group 3 multi-agency VAWDASV training is expected to commence in 2022.

In addition to the Acts, there has been the introduction of Home Office Mandatory Reporting of Female Genital Mutilation (FGM) in October 2015 and Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) under section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The Well-being of Future Generations (Wales) Act 2015 requires the development of Public Service Boards (PSBs) in each Local Authority area; the Boards are in place within the region. PSBs are responsible for assessing the well-being of the local population, the Board agree for a Domestic Homicide Review (DHR) to be commissioned. The DHR responsibility is likely to be transferred to the RSB in the coming year.

The Wales Safeguarding Procedures (2019) incorporating Children and Adults at Risk has been implemented since October 2019. The Deputy Executive Nurse Director and the Head of Safeguarding have participated in the workshops held by Cardiff Local Authority who are commissioned by WG to deliver and implement the updated procedures. The procedures replace the previous All Wales Child Protection Procedures (2008) and reinforce the instructions within the Social Services and Well-being Act (2015) Wales.

Meeting the demands of the growing activity surrounding the depth of safeguarding is a constant challenge for the Executive and Deputy Nurse Directors and the corporate Safeguarding Team. Ensuring that the UHB is compliant with the legislation is a priority area; however, maintaining the ethos of the UHB's values and behaviours must be considered when work is undertaken with individuals, families and UHB staff.

Effective safeguarding relies on good working partnerships with other agencies utilising an open and transparent approach. This is reflected by the corporate Safeguarding Team working within the UHB; in addition to the work undertaken with GPs, Local Authority, Police, Education, Probation and Third Sector agencies. Since the introduction of the Cardiff MASH the safeguarding referral process across the UHB has been restructured and is transferred to the appropriate LA and Police by the Safeguarding Team electronically via secure e-mail. Safeguarding referrals continue to be more complex resulting in additional staff time in support and supervision of cases, involving more strategy discussions/meetings, multi-agency investigations and often legal advice. Team members

report an increase in violence related referrals through MASH and patient's presenting at Emergency Department.

The 2021/22 Safeguarding Report will consider the workstream from April 2021 to March 2022, demonstrating and evaluating the breadth of the safeguarding agenda and the progression made across the UHB. A summary of the collective safeguarding work undertaken with the Cardiff and Vale Regional Safeguarding Board (RSB), the VAWDASV Regional Strategy and Public Health Wales, NHS National Safeguarding Team validates the enormity of the safeguarding agenda across the region and Wales.

It is appropriate to mention at this point that the UHB, like every other establishment worldwide, has been gripped by the pandemic of COVID-19 since the early part of 2020. Planning and implementing the UHB response to the operational difficulties of ensuring the appropriate resources and provisions being in place when inevitably the pandemic struck the region, understandably took priority over other routine work. This included training, meetings such as UHB Safeguarding Steering Group and multi-agency meetings not directly associated with COVID-19 planning being affected. Arrangements were made to either temporarily discontinue or shorten time spent at meetings.

The initial United Kingdom lockdown commenced on the 23 March 2020, a change that affected us all on a personal and professional basis. Adaptions in the way in which the UHB approached safeguarding commenced immediately. This involved home working facilities to allow the safeguarding team to rotate between home and office base, providing additional support to clinical staff by completing safeguarding reports for children and adults as required, completing adult at risk case management on behalf of Health Lead Practitioners (HLP). The pandemic did not affect the operational resources available for day to day safeguarding; however, attendance at the Emergency Department (ED) dropped by 50%, outpatient clinics and attendances were cancelled, other than in areas such as Midwifery. The impact on services became evident almost immediately. Domestic abuse disclosures in ED increased, likely to be due to no visitors or people accompanying patients allowed in the department. This provided staff with the ability to ask routine enquiry questions without the patient feeling coerced or intimidated by another person. Data shown in the report must be viewed with these circumstances in mind. The impact remains evident in all services across the UHB with recovery and transformation slowly progressing.

2. Training

The safeguarding team are responsible for developing, planning and delivering a range of training events throughout the year. The aim of safeguarding training is to ensure all staff have the skills, knowledge and understanding to inform the ways in which they engage with people at risk of abuse, harm or neglect. Training will ensure that all staff know how to respond to concerns in line with local and national requirements in a confident and competent manner.

Training is developed to reflect guidance from training competencies as identified in the National Intercollegiate Documents:

- *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019,* and
- *Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018*

Online Safeguarding training at Level 1 and Level 2 is available through Electronic Staff Records (ESR) and forms part of staff mandatory training requirements. The safeguarding

team deliver classroom-based training sessions and TEAMS training at Level 2, Level 3 training is classroom based. These sessions run regularly throughout the year and are advertised in the UHB training prospectus and are booked through the Education, Culture and Organisational Development (ECOD). Additionally, the safeguarding team deliver a number of bespoke training session with identified staff groups. During this time period staff training across the UHB was considerably reduced in line with COVID guidance and significant reduction in staff resources in clinical areas for a period of time. This is reflected in the data.

Data collated demonstrates a reduction in staff completing training in all areas. This will need to be a priority for the coming year in line with COVID guidance to ensure UHB compliance is focused. Safeguarding training provides service users and staff with a level of protection against harm through the knowledge gained and the understanding correct processes to follow.

Online Safeguarding Training Data

Training data for safeguarding training completed/ attended up to and including 31 March 2022.

Table 1: Safeguarding Level 1 training (online)			
Number and percentage of staff compliant with Safeguarding Children training at **31 March 2022**			
Level of training	**Headcount** (UHB Total)	**Number trained**	**% trained**
Safeguarding Children Level 1*	16743	2849	17%
Safeguarding Adults Level 1 * *Online training only*	16743	2899	17%
VAWDASV (Domestic Abuse) Group 1 *Online Training Only*	16495	10198	61.09%
***NOTE**:* All staff working in Health Services are required to complete **Level 1** safeguarding training, this package is delivered online via ESR. Relevant staff can also access **Level 2** training material via ESR.			

Table 2: Safeguarding Children and Safeguarding Adults (3-Year refresher) *available online and face to face classroom sessions*			
Number and percentage of staff compliant with Safeguarding Adults training as at **31 March 2022**			
Level of training	**Headcount** (UHB Total)	**Number trained**	**% trained**
Safeguarding Children Level 1	All Employees approximately 16,000	12100	Mandatory Training for all employees **72.7%**
Safeguarding Adults Level 1	All Employees approximately 16,000	12285	Mandatory Training for all employees **73.37%**
Safeguarding Children Level 2	Only specified staff groups require this level of training -	5289	Only specific staff groups require this level of training -

	see notes section below		see notes section below **67.24%**
Safeguarding Adults Level 2	Only specified staff groups require this level of training - see notes section below	5332	Only specified staff groups require this level of training - see notes section below **69.38%**
VAWDASV Group 2	Only specified staff groups require this level of training - see notes section below	550	This training is organised and delivered exclusively by the safeguarding team
VAWDASV Group 3 Multi-Agency training (Champions)	Only specified staff groups require this level of training - see notes section below	13	This training is delivered through a multi-agency trainer team
NOTE: Level 2 safeguarding training and Group 2 VAWDASV training, is relevant for the following staff to attend/complete i.e., all practitioners who have regular contact with patients, their families or carers, or members of the public. ECOD are in the process of including the VAWDASV Group 2 training to the UHB Mandatory field.			

Please Note: More detailed safeguarding training compliance data is available for each Clinical Board through Education, Culture and Organisational Development (ECOD) and Electronic Staff Records (ESR).

<u>Classroom Based Training Data</u>

Throughout the year, the Safeguarding Team would usually provide a number of classroom-based training sessions and study days which are open for all relevant staff groups. Feedback from staff evidences that training through virtual means inhibits fully active two-way engagement and interaction between the audience and trainer. It is fair to say that technical issues affect some elements of the training flowing freely.

Source: VAWDASV pre/post feedback forms 2021.

Level 2 safeguarding children training session is relevant for the following staff to attend:

Non-clinical and clinical staff who, in their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children (Source: Inter Collegiate Document Safeguarding Children, January 2019)

********Level 2 safeguarding adults training is relevant for the following staff to attend all practitioners who have regular contact with patients, their families or carers, or the public. (Source: ICD Adult Safeguarding, August 2018)*

Level 3 Training Sessions

Event	Audience/Subject delivered	Number of attendees
Child Sexual Exploitation	Level 3	Not held during this time period
Current Themes in Safeguarding Children	Level 3	54
VAWDASV multi-agency training	Group 3	Training to commence from April 2022
Parental Mental Health and the Impact on Children	Level 3	Not held during this time period
Legal Aspects of Safeguarding	Level 3	Not held during this time period
Safeguarding Adults Study Day	Level 3	34
Current Themes in Safeguarding Adults	Level 3	Not held during this time period
Bespoke Training		
Health Visitor Preceptorship Induction	Induction	30
Dental Training	Qualified Staff and Students	113

Safeguarding Training Meetings Attended

To ensure a robust evidence-based training programme is delivered within Cardiff and Vale UHB, key members of the Safeguarding Team would usually attend local and National Training meetings:

UHB Mandatory Training Steering Group Meeting

The Safeguarding Team attends this meeting to inform the mandatory training agenda and has been involved in work to promote safeguarding children, safeguarding adults training and VAWDASV training.

Cardiff and Vale Regional Safeguarding Board (RSB) training sub-group meeting

This training sub-group reports to the RSB Board and has previously completed a safeguarding training mapping exercise to consider the different levels and types of safeguarding training partner agencies currently deliver. Recent work has focused on the implementation and embedding training for the Wales Safeguarding Procedures.

Safeguarding Training Network Meeting

This training sub-group meeting meets bi-monthly, reports to the Wales Safeguarding Network Meeting and is facilitated by the National Safeguarding Team, Public Health Wales.

National Training Programme – Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) Regional Training Group

The aim of this multi-agency regional training group is to share best practice and discuss current training compliance for VAWDASV training. The meeting is also driven by the five-

year regional VAWDASV training programme, which includes the development and delivery of VAWDASV training for Groups 2, 3 and 6.

During this time period some meetings were stood down.

3. Safeguarding Activity

All referrals for safeguarding children, adults and domestic abuse are sent electronically by practitioners to a central UHB safeguarding referral e-mail address, the referrals are not screened and are sent directly to Cardiff MASH, Vale of Glamorgan Local Authority teams and Police as appropriate, on the same day as it is received. The referral pathway and referral forms are available on the UHB Safeguarding Children and Adult web pages. This process is unique to Cardiff and Vale UHB and allows the safeguarding team to collate the activity across the UHB to target service areas that may require additional training, supervision or advice.

Safeguarding Children Activity

Activity is collated on a monthly basis across the UHB and presented to the Safeguarding Steering Group as a Run Rate Report. The report exhibits activity from 1 April 2021 to 31 March 2022 across all CBs.

Table 1:

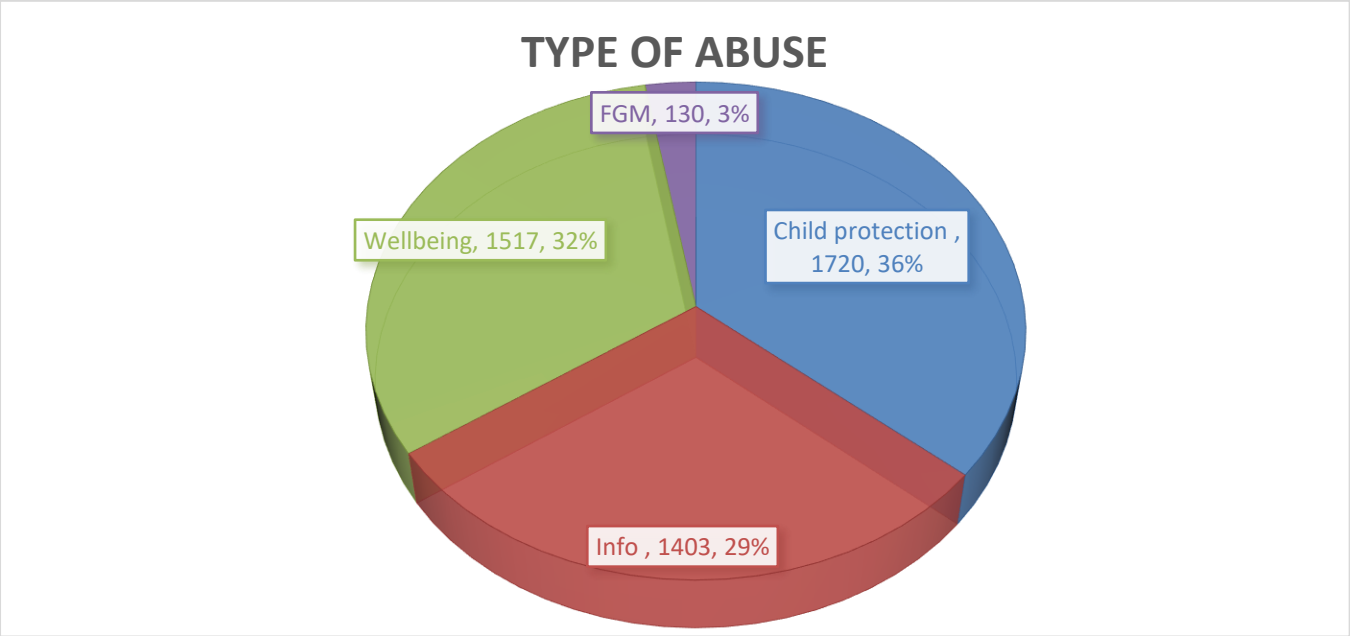
Clinical Board 2021/22	04	05	06	07	08	09	10	11	12	01	02	03
Medicine	212	208	206	171	134	143	123	157	60	147	115	174
Surgery	0	1	2	2	5	1	6	3	1	6	3	8
Specialist	2	1	0	4	0	2	1	2	1	2	0	0
Mental Health	29	25	26	34	31	30	38	32	14	22	41	33
Children and Women	113	89	137	160	120	113	152	142	47	118	124	134
PCIC	17	19	12	10	10	9	8	8	7	2	13	20
CD&T	0	1	1	0	2	0	2	0	1	7	5	0
Corporate	54	55	61	62	43	53	45	44	33	43	77	82
WAST	0	1	1	0	0	1	0	0	1	1	3	8
Unknown	0	9	0	0	2	0	0	2	0	0	4	6
Total	**427**	**409**	**446**	**443**	**347**	**352**	**375**	**390**	**165**	**34**	**385**	**465**

The referrals made by the Medical CB are generally generated in Paediatric Emergency Department (EU). Children and Women CB referrals are predominantly made by community-based staff such as Health Visitors and School Nurses; however, disciplines within the acute sector make a proportionate number of referrals. PCIC referrals will be submitted by GPs and District Nurses. It is noticeable that at the beginning of COVID lockdown in April 2020 a reduced number of referrals were made coinciding with less footfall in to EU and far fewer visits made to children in the community by health practitioners. Referrals increased gradually from June 2020 onwards. In non COVID times an increase in referrals would not be associated to any particular event although historically it would be considered that increased awareness training and media coverage will heighten professional accountability and alertness. A total of 4/548 referrals were made by UHB staff and submitted to Cardiff, Vale of Glamorgan Local Authority or a Local Authority out of area by the safeguarding team during this period. There is an increase from the same period the year before when 3,759 referrals were submitted, a difference of 789 in total.

Categories of Abuse

Table 2 represents the type of referral captured on some of the referrals received by the safeguarding team. A number of referrals submitted lack information for the administration team to determine the category of abuse when collating information.

Table 2:



Identifying that a large proportion of referrals to Children's Services distinguish the concern raised, has improved within the UHB through training and supervision. The implementation of the Early Help Hub in Cardiff during 2019 identifies referrals that are to be progressed to MASH and those that will be signposted to other services for additional support.

Categories of referrals

Table 3:

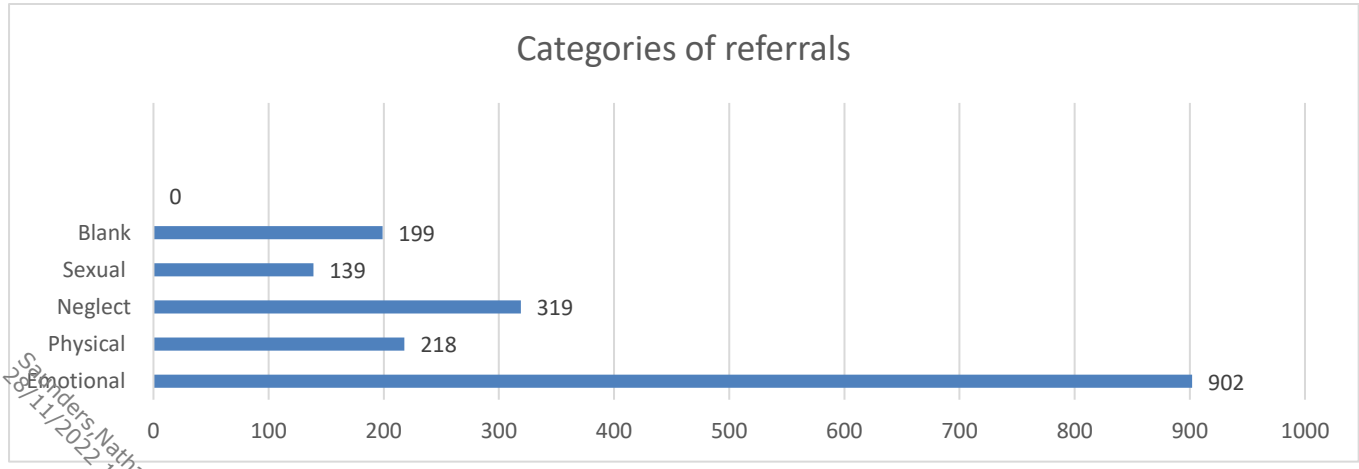


Table 3 recognises the known categories of concern acknowledged on the referral form by the UHB referrer. Once the referral has been reviewed and assessed by Children's Services the category may change.

Table 3a:

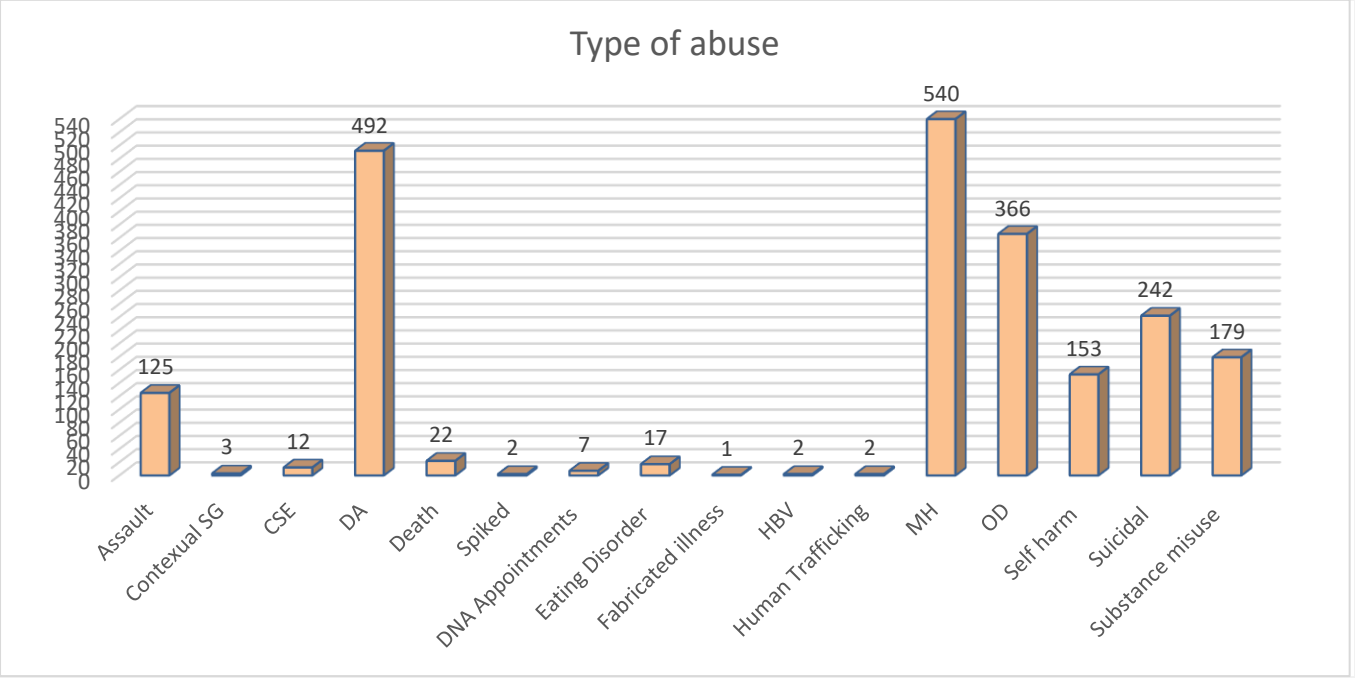


Table 4:

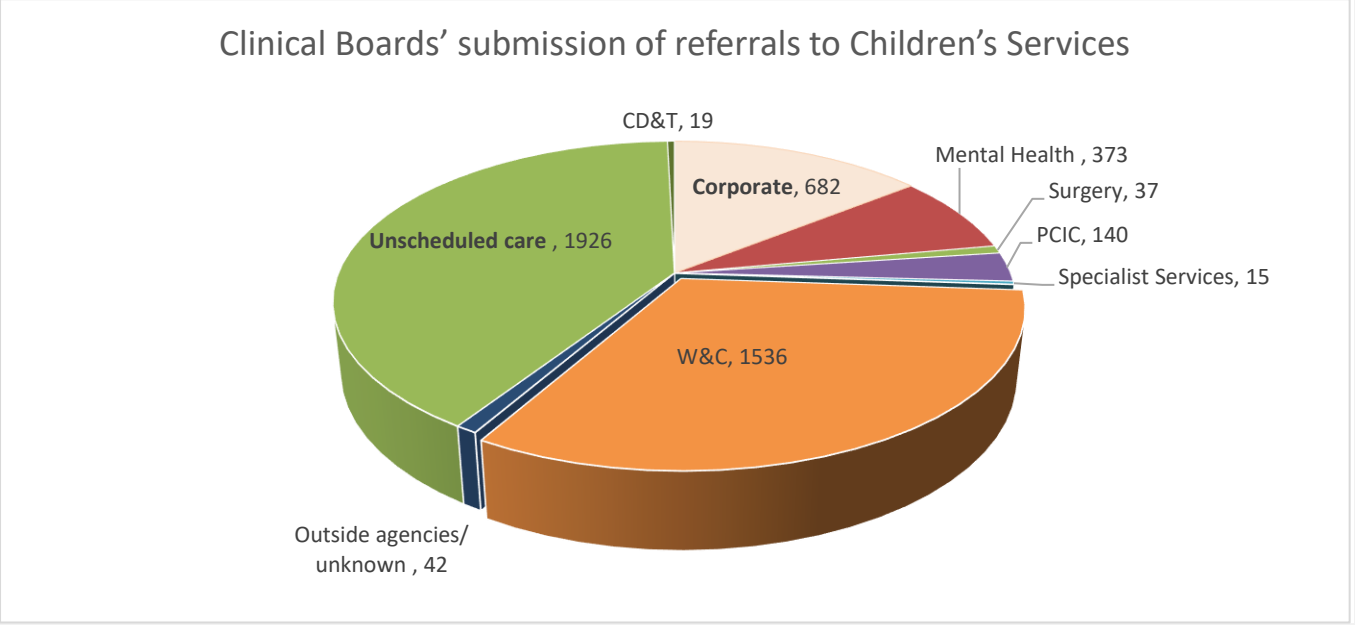
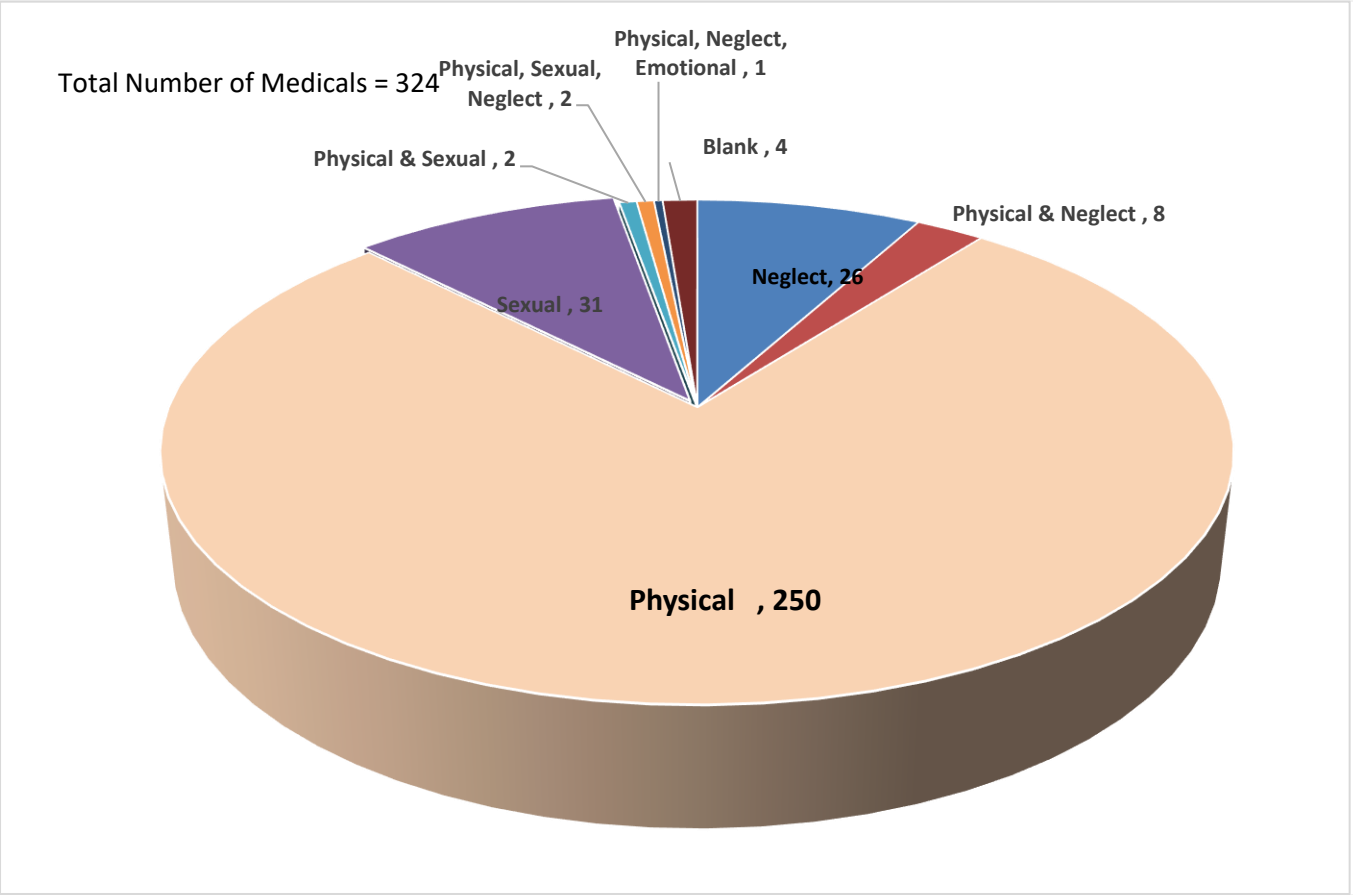


Table 4 indicates the Clinical Boards' submission of referrals to Children's Services.

Table 5:

Total of 324 Child Protection Medicals Undertaken



Child Protection medicals are undertaken by the Community Paediatricians based at St David's Children's Centre during normal working hours. The table below illustrates the reason for the medical and total percentage. In total there were 324 medicals undertaken. Physical assault represents the greatest category with 250 cases reported, 26 neglect cases and child sexual abuse accounted for 31 cases. Table 5 represents these figures

Safeguarding Adult at Risk Activity

Activity is collated on a monthly basis across the UHB and presented to the Safeguarding Steering Group as a Run Rate Report. The report exhibits activity from 1 April 2021 to 31 March 31 2022 across all CBs.

Table 1:

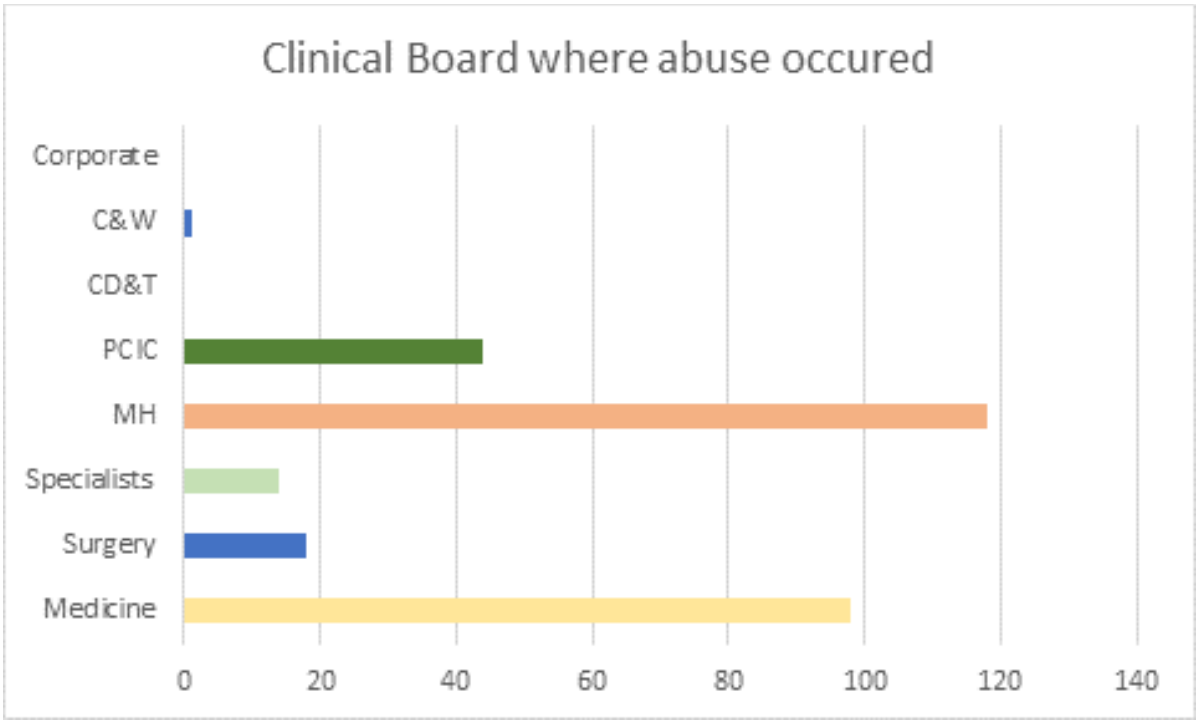
Clinical Board 202/22	04	05	06	07	08	09	10	11	12	01	02	03
Medicine	7	2	11	10	5	6	7	7	12	13	9	7
Surgery	1	2	0	2	0	1	0	1	1	1	3	6
Specialists	1	1	0	0	2	1	2	2	1	0	4	0
Mental Health	10	7	9	4	8	14	11	15	8	11	6	3
Children and Women	0	0	0	0	0	0	0	0	0	0	1	0
PCIC	2	4	7	7	3	5	4	1	5	3	2	1
Corporate	0	0	0	0	0	0	0	0	0	0	0	0
CD&T	0	0	0	0	0	0	0	0	0	0	0	0
Total	21	16	27	23	18	27	24	26	27	28	25	17

A total of 289 referrals were made by health professionals to the local authority during this period, in comparison 267 referrals were made during the same period in the previous year. This is an increase of 22 referrals during COVID-19 and lockdown measures in place.

This safeguarding adult data is collated by the number of health-led referrals across the UHB. Each CB has a Health Lead Practitioner (HLP) that take responsibility to lead on the Adult at Risk process for their own area; HLPs are usually Lead Nurses, Senior Nurses or Advanced Nurse Practitioners. HLPs are given additional bespoke safeguarding adult at risk training by the Head of Safeguarding or Senior Nurse to undertake this role. An electronic shared drive has been established to enhance the process allowing HLPs in each clinical area to be aware of cases in their CB to ensure that cases are maintained and progressed should the named HLP be on annual leave or sick leave. There are 49 active HLPs across the UHB. The process has evolved since the implementation of the SS&W-b Act (2014) and since the launch of Cardiff MASH. This may not be a true reflection of all referrals made, it has been noted that health staff based in integrated community teams are sometimes making referrals directly to the Local Authority and bypassing the UHB Safeguarding Team. This is complicated due to the fact that health staff are working from LA computers and facilities, plus their email address is Local Authority. Measures to ensure that this practice is discontinued are being introduced to ensure that health staff are following the UHB referral process.

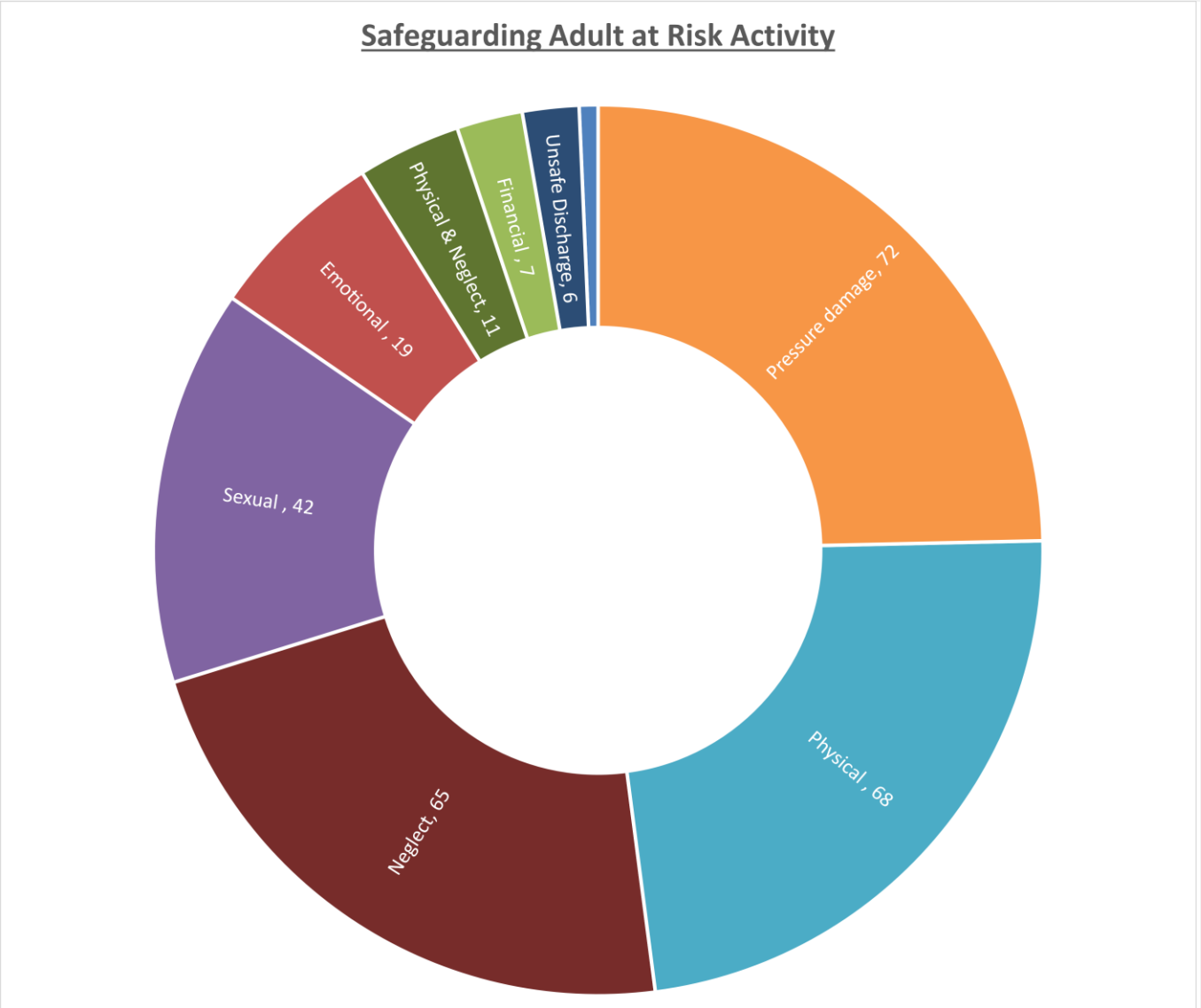
Table 2: captures the number of health-led referrals made by each Clinical Board for this period.

Table 2:



Categories of Abuse:

Table 3:

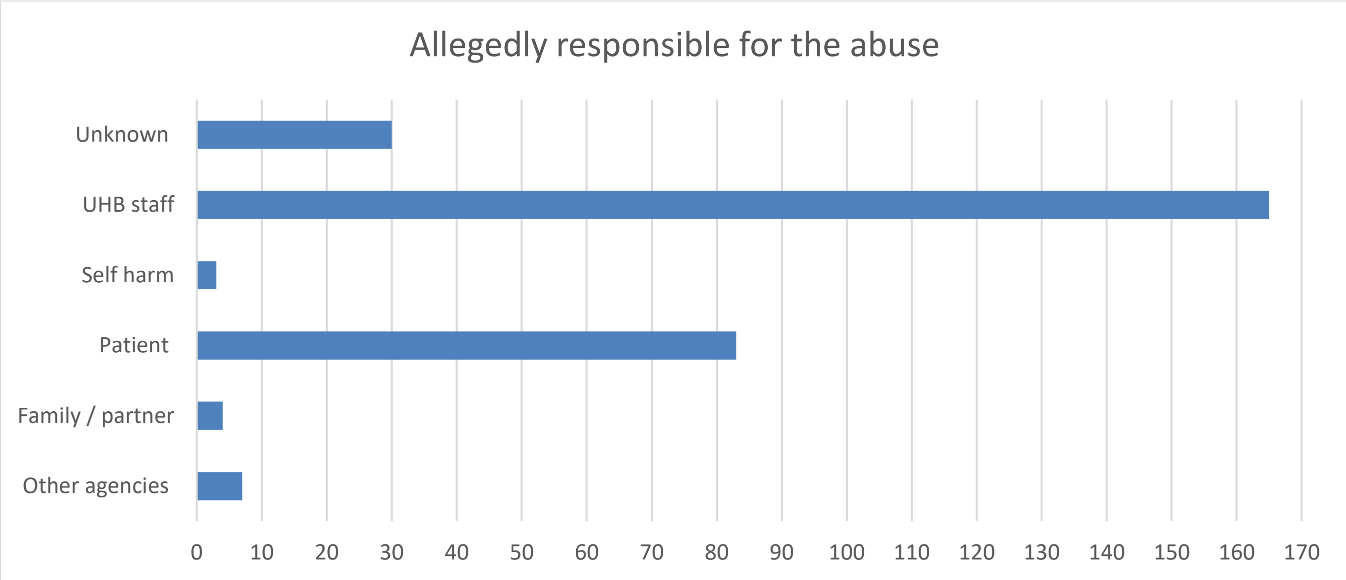


Categories of abuse are easier to capture on the current Adult at Risk referral form as opposed to the Children's referral form, as there are tick boxes for practitioners to choose. Highlighted in table 3 are the areas considered by practitioners to be the reason for submitting the referral to the LA. The most commonly used category is Pressure Damage, possibly reflecting neglect by a clinical area within the UHB.

Adult cases often prove to be complex, determining the main issue at the point of disclosure or reporting is often difficult for referrers; this is often not established until further fact finding is undertaken. This may be in the shape of a criminal or non-criminal investigation. The HLP will lead on the case if the situation involves a clinical area within the UHB. Cases, where individual staff members are deemed as the alleged perpetrator of abuse, are managed by the Head of Safeguarding/Senior Nurse since February 2020 to ensure that a consistent approach is in place that aligns with the UHB and RSB Professional Allegation/Concern process. The HLP is central to gathering fact finding statements and keeping in touch with the staff member during this process. The UHB acknowledges that any allegation involving a member of staff will raise anxiety and often results in the employee taking sick leave. The UHB works closely with Human Resources (HR) and the line management team to ensure

that a proportional risk assessment is in place to support and protect staff members from further accusations whilst this process is in place.

Table 4:



Often practitioners from the UHB or from an outside agency will not have the information to determine who the alleged perpetrator is, this is evidenced in table 4, as no person responsible has been identified on the referral. 165 of the cases sites the Hospital or Hospital staff exclusively as being responsible for the abuse. 83 of the cases are alleged abuse from another patient, more often these are cases in Mental Health clinical areas.

Pressure Damage

A health-led pressure damage six-month pilot study was introduced in December 2018 following agreement by the RSB. This involved the UHB referring pressure damage of grade 3/4 to the LA following completion of an All Wales Risk Assessment tool determining that the pressure damage is deemed to be avoidable. The pilot study was undertaken in the Medicine and PCIC CBs. The pilot study was presented at the RSB meeting in January 2020, recommendations were agreed and the improved referral pathway implemented in the UHB from February 2020. This has resulted in only avoidable pressure damage of grade 3/4 or unstageable damage reported to LA. This has decreased the number of pressure damage referrals to LA. This is in alignment with recent Welsh Government, Serious Incident Reporting and in compliance with the Social Services and Well-being (Wales) Act (2014).

Professional Allegations/Concern Strategy Meetings

The UHB Professional Allegation/Concern guidance updated in 2021 has formalised the approach to address concerns of employees' behaviour in or outside of work. The process is in alignment to the Wales Safeguarding Procedures (2019). UHB employee line management, Police, UHB Safeguarding and LA are invited to each meeting to share information and ensure that the UHB is open and transparent in the approach. Concerns include arrest and police investigation around domestic abuse, sexual assault, physical assault etc, outside the workplace. Some cases will proceed through the disciplinary process following closure by police and/or the Court process.

Period	Number of Professional Meetings
2021-2022	**Professional allegation/ concern identified in: 210** cases, in addition 48 domestic abuse cases were discussed with managers whereby a member of staff has been identified as a “high risk” Domestic Abuse victim or issues around Mental Health. This is a remarkable increase from the previous year (186) and (43) respectively. This is likely to be due to a number of issues: lockdown measures, Domestic Abuse, Routine Enquiry for all attendees at Emergency Unit- this process also includes staff. Improved communication with police and UHB Concern Team and Workforce will also factor in the progress made.

Issues raised with UHB employees relate to allegations made against them by family members, patients or a criminal investigation by police. All employees are notified of the concern raised as appropriate and an immediate risk assessment is completed by the line manager and the People Service Manager (Human Resources) representative to ensure that safeguarding measures are in place. This certifies the protection and support of the member of staff if further allegations are made and gives the UHB assurance that appropriate and proportional measures are in place to protect the public accessing care and services from the UHB. The Head of Safeguarding and the Senior Nurse will provide advice and support to the line manager to achieve a manageable response ensuring that the employee is directed to the well-being service, Occupational Health or General Practitioner (GP) as required.

In the case of commissioned service providers (independent practitioners – GPs, dentists, optometrists, pharmacists), they will be contacted by the Community Director for Quality and Safety/Deputy Clinical Board Director of PCIC, by the Dental Practice Adviser, or Primary Care Optometric Adviser. If the allegation relates to a member of staff as perpetrator advice will be given to the employer and proportionate measures will be put in place. The circumstances are more complicated regarding Optometric Practices and Pharmacies as many of the practitioners are employed by major multiple organisations (eg Boots, Well, Specsavers) as they are guided by their corporate requirements in addition to Health Board expectations.

There has been an increase in reporting nationally of survivors disclosing domestic abuse during lockdown and easing of restrictive measures. Admissions of people and children <18 years of age presenting with mental health or emotional well-being concerns has also increased. This is corroborated in a recent draft report from the Public Health Wales, Violence Prevention Team analysing data. The report is not yet released for publication.

4. Audit, Survey, Professional Presentations and Publications

Public Health Wales Safeguarding Maturity Matrix (SMM)

The purpose of collating the information is to assess quality improvement, compare compliance against agreed standards and to demonstrate the learning from incidents and reviews. Organisations completed self-assessments along with improvement plans that were submitted to the National Safeguarding Team to assemble a National picture and to report the findings. The aim being to provide assurance, share practice and drive improvements. Cardiff and Vale University Health Board (C&V UHB) fully participate, drawing on information from across all Clinical Boards to inform the UHB self-assessment and provide a true reflection of the current situation. Overall the UHB acknowledges that there are always improvements to be made in an ever-evolving field such as safeguarding.

Implementing the recommendations is monitored with CBs and reported through the Safeguarding Steering Group. The peer review report demonstrates that C&V UHB is operating in line with other organisations across Wales.

All Wales Domestic Abuse Routine Enquiry for Midwives and Health Visitors

Routine Enquiry (RE) questions asked by Midwives and Health Visitors (HV) relating to domestic abuse; has been maintained, this involves specific questions asked twice to women accessing services in Midwifery and once to women accessing services in Health Visiting. The results for 2021-22 are:

Routine Enquiry Asked:	Asked Once	Asked Twice
Midwifery Service	98.9%	94.9%
Health Visiting Service	30.20%	Not recorded

In total 10% of the number of birth (544) notes were manually checked in Midwifery to calculate the data enclosed.

In addition, 306 positive domestic abuse disclosures were made by women in this period. All survivors were signposted appropriately for expert support and counselling.

The Health Visiting percentage is disappointing and actions are in place to improve data collection. Often HV are unable to ask the RE questions at the birth visit as it is deemed to be unsafe if the partner is in attendance. Another mitigating factor during this period would be that HVs were unable to make usual home visits due to COVID19. Most birth visits were made initially over the phone and visits undertaken outside the home. HVs were also aware that a number of partners were working from home which increased the risk of disclosure for survivors if overheard by the partner. A total of 37.84% of RE opportunities were recorded as reason given for questions not being asked.

Paediatric Emergency Department (PED) Safeguarding Meeting

The Paediatric Emergency Department (PED) Safeguarding Meeting is held weekly and involves multi-disciplinary practitioners. The meeting identifies and highlights cases where additional referral or information is required.

The PED experienced an increase in attendance during this time period to 31,000 compared to 21,317 during the previous 12 months. An explanation for this increase may be an indication of the challenge families encounter trying to access medical services in the community. This is demonstrated by the increase of frequent attendances reported to Health Visitor (HV) and School Nurse (SN) via documentation on PARIS (community electronic health record); 417 notifications made, (210 of which are infants <12 months of age). Frequent attendances at PED is an ongoing challenge to the department as it is not designed to provide care for recurrent problems and exposes the child to hospital acquired infections. The demand placed on the department leads to prolonged waiting times to be seen by a professional. This often results in families leaving the department without being seen after the triage process. 58 PARIS notifications for families who “self-discharged” were sent to HV or SN for information purposes and possible follow up. A new “Did not Wait” pathway has been developed by PED to safeguard children as there is the potential that the number of children not seen is much greater. The pathway will be implemented during the coming months.

The number of referrals made by PED concerning behavioural concerns, overdose or other methods of self-harm may reflect the effects of COVID-19 and the impact on children and young people's mental health. **A total of 591 referrals were submitted to Children's Services, HV and SN. Parental behaviours or anxiety contributed to a further 197 referrals**.

The safeguarding meeting remains a feature within the PED governance and Safeguarding Steering Group agenda. A total of 49 meetings were held during this time period. This included discussion of Major Trauma Centre cases which were introduced in February 2021. The following table summarises the activity of the meeting:

Injuries <12 months old	489 (452 in previous year)
Fractures <2 years old	95 (94 in previous year)
Thermal Injuries	333 (344 in previous year)
Major Trauma Centre Cases	116
Health Visitor/ School Nurse Referrals generated from this meeting	235 HV and 43 School Nurse
Total Cases Discussed	**1033 (890 in previous year)**

The safeguarding meeting provides a means of assurance that vulnerable children and young people are identified within the PED and referred to other agencies or disciplines appropriately. The annual audit demonstrates PED completes 67.5% of necessary PARIS notifications after the initial ED attendance with the outstanding referrals completed retrospectively at the meeting. This suggests improvements can be made, particularly with regards to fractures in infants under 2 years of age (40%) and MTC patients (61%).

PED submitted 33 MARFS last year for concerns of maltreatment of child/young person under 16 years of age. A further 748 MARF notifications were submitted for information sharing with Children's Services. Indications for the notification include assessment of a 'Child Looked After' or for families consenting for additional support. In total, 2,689 PARIS notifications were completed by the PED team representing 9% of all PED attendances over the past 12months.

A total of 120 notifications for assault were documented on PARIS during this period however, it is recognised that not all children or young people are referred to the Violence Prevention Team. An audit will be undertaken in the next 12 months of the assault activity to consider if cases should be discussed at the PED meeting.

A health team consisting of: General Paediatrician, Paediatric Consultants ED and Professor within Dental have been monitoring responses to children injured in community violence. Children and families have been signposted to services and provided with information on bullying. Improvements to the child's experience following attendance at ED has been demonstrated; however, further exploration is required to effectively share information with police and schools to map areas of concern. The information is currently shared with the School Nursing Service, however, greater links with education is required. A pilot initiative with Action for Children looking at ways of engaging young people and minimising community and school related violence has been delayed however, this will be explored during this coming year.

Adolescent Safeguarding Meeting

This meeting commenced in September 2018, following a pilot scheme in Cardiff and Vale UHB which gathered the opinions of over 300 children and highlighted that 16 and 17-year

olds were seen in the adult ED and not paediatrics. This identified gaps and areas for development. The findings dictated that the aim of the initiative was to 'Improve the Safeguarding processes in the Adult ED and introduce a holistic assessment tool for 16 and 17-year olds'. The meeting is held on a fortnightly basis. Attendees are Consultant and Lead Nurse from ED, Violence Prevention Unit, Safeguarding Team, Department of Sexual Health (DOSH), Children's Rights Advocate/Children's Charter & Youth Board, CAMHS and Child Looked after Team (CLA).

The following are areas which require improvement and additional staff training:

- Only the physical symptoms identified and treated
- Not seen as children
- Safeguarding documentation missing
- Referrals to social services not completed
- Warning signs not noticed (CSE, DA)
- No School noted
- No School Nurse referral
- No signposting
- Missing an opportunity for an intervention

This approach aims to empower staff working particularly in health services, but also partner organisations, to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease.

A casualty card which incorporates the HEADSS (Home, Education, Activities, Drugs/alcohol, Sexuality, and Suicide) and SERAF (Sexual Exploitation Risk Assessment Framework) indicators is used. Questions around these areas are asked when red flag attendances occur.

This table identifies the safeguarding cases:

Total number of adolescent attendances in the period March 2021-April 2022	2968
Number of cases discussed at safeguarding meeting	727
Attendance average with safeguarding needs	24%
Average number of actions required following meeting	12 actions per meeting
Average retrospective referrals	43%

Retrospective Referrals:	
Violence Prevention Team	25
CAMHS Referrals	30
DOSH	4
Child Looked After (CLA) Notifications	12
School Nurse Notifications	28
Safeguarding Referrals	206

Indications highlighted are an increase in overdose since the pandemic. The EU department are planning to update the current casualty card which will be used with children > 12 years of age. The updated card will also incorporate a red flag alert for children suspected of being trafficked or at risk of Female Genital Mutilation (FGM).

5. Safeguarding Supervision

The Public Health Wales All Wales Safeguarding Best Practice Supervision Guidance (2018) states that:

"*The aim is to provide guidance on the implementation and utilisation of supervision and support within the context of safeguarding. It sees safeguarding supervision as a priority to which staff are actively supported to have the time to attend*"

This approach has been adopted with safeguarding children and adults at risk within the UHB.

The Safeguarding Team successfully introduced a new way of providing group safeguarding supervision with the HV service in 2015 by working with the Executive Team and service managers. This was the first pilot in Wales around safeguarding supervision of HVs and raised much interest from other Health Boards across Wales. The aim of the pilot is to ensure a safe supervision pathway exists that reduces the allocated time required of the Safeguarding Team to provide supervision to the HV service on a 1:1 basis.

The pilot idea advanced and progressed through the UHB Leading Innovation in Patient Safety (LIPS) headed by the Head of Safeguarding and joined by two team managers from the HV service. The pilot pathway commenced in October 2015 and was overseen by a Lecturer in Cardiff University to provide an independent view, accreditation to the pathway and to undertake group forums with the HVs involved. Practitioners report to their supervisor that the learning element of the session is interesting and effective and that transitional skills are adopted through peer discussion around complex cases. The HV supervision groups are working well. 1:1 safeguarding supervision is also available for newly qualified HVs, long term sickness returns or, by request. Safeguarding Nurse Advisors (SNA) have undertaken additional training with Public Health Wales to prepare for the role of facilitator in group supervision. The C&V UHB Pathway has been discussed with other Health Boards through the NHS Network meeting and has been presented as a poster presentation at the Chief Nursing Officer Conference in May 2018 by Cardiff University. Work in this area continues with Cardiff University, arrangements are in place to continue the study through PhD research.

Group Safeguarding Supervision is provided to Midwives, Health Visitors (HV), School Nurses, Cardiff and Vale Health Inclusion Service (C&VHIS) Nurses, Department of Sexual Health (DOSH), Multi-disciplinary staff in Special Schools and Community Therapists and more recently Child and Adolescent Mental Health Service (CAMHS). Safeguarding supervision is provided to other groups such as doctors and acute nurses as required. The aim of supervision is to support staff, facilitate learning and promote best practice.

Adult safeguarding supervision is provided by the Senior Nurse for Safeguarding to the HLPs as required and through arranged sessions within each Clinical Board and/or through Development Day sessions. The supervision is ideally provided on a three-monthly basis in group supervision sessions using the same agenda as the children's safeguarding supervision. However, during this period there has been a lapse due to the pressures on staffing due to COVID. All open adult at risk safeguarding cases are reported to the Executive Nurse Director and Deputy on a monthly basis and discussed at Nurse Director Professional Performance Review. Cases involving staff are reported through the bi-monthly Executive Quality and Safety meetings.

Signs of Safety" training has been introduced in Cardiff Children's Services since 2016-17. The training has been shared with the Safeguarding Team and rolled out to some areas within the Health Visitor and School Nurse service to enhance cohesive partnership working with partner agencies and families. The Signs of Safety approach is used in supervision sessions.

Peer Review

Within Cardiff and Vale UHB, medical staff peer review is held on a monthly basis. It is made available to all doctors involved in child protection work in order that doctors undertaking in this difficult area of work are well supported and have the opportunity to receive peer review and clinical supervision in order to feel confident and competent. Pragmatically, the peer review process encourages paediatricians to meet the expected standards and prevents practitioners working in isolation.

Peer reviews are held for suspected cases of physical abuse at St David's hospital; additionally, a separate peer review is held at the Sexual Assault Referral Centre (SARC) for cases of suspected sexual abuse.

The meeting is chaired by the Named Doctor for safeguarding children or the Medical Lead for Sexual Assault Referral Centre (SARC).

Attendance is consistently good. All child protection cases from the previous month are presented to ensure the management of the case meets the expected standard of practice. The process involves review of the medical report, photo documentation and the multi-agency working. It is an opportunity for professional development and learning within an appropriate environment and allows staff to debrief following difficult cases.

6. Expert Advice

Partnership Working

The implementation of the SS&WB (Wales) (2014) Act and VAWDASV (Wales) (2015) has encouraged partnership working across strategic partner organisations and third sector agencies. Ensuring that compliance, knowledge and awareness raising is understood within each agency has required joined up thinking through shared training and guidance from the Cardiff and Vale Regional Safeguarding Children and Adult Board.

Cardiff and Vale UHB (C&V UHB) has close strategic and operational links with both the Regional Safeguarding Children and Adult Board. There is representation at the amalgamated RSB.

The meeting is attended by the Executive or Deputy Executive Nurse Director, Named Doctor for Safeguarding Children or the Head of Safeguarding. Minutes for the meeting are shared with Clinical Boards through the UHB Safeguarding Steering Group meeting. Sub-groups of the main Board include Practice Improvement & Development, Case Review Group, Children and Adult Quality Assurance, Communication and Engagement, Monitoring Group, Policy & Procedures, FGM are attended by the safeguarding team who participate fully in the work involved with each group.

Meeting the demand of the workflow within Cardiff Multi-Agency Safeguarding Hub (MASH) is a daily challenge for the two Safeguarding Nurse Advisors (SNA) representing the UHB in the MASH. It is true to say that all agencies within the MASH report an increase in the number of referrals and calls made to the MASH in each consecutive year. Two SNAs from

the safeguarding team rotate on a daily basis into the MASH working area. Day to day work consists of attending daily discussions for up to six to ten domestic abuse cases requiring immediate safety planning action, this is in addition to the cases discussed at the fortnightly Cardiff Multi-Agency referral Assessment Conference (MARAC) which a SNA attends. Attending child and adult at risk strategy meetings, which are called immediately a concern is reported and ensuring that all documentation is recorded appropriately on PARIS to make certain that community practitioners meeting with families are alert to the concerns raised, is a feature of the daily work in MASH. An increase of cases discussed has been apparent during this period with up to 10 child strategy meetings per day, 10 high risk daily discussions per day as well as up to three adult strategy meetings held.

The Cardiff MASH demonstrates valued multi-agency working, it has evidenced respect and an understanding of roles amongst the different organisations and broken-down barriers to working in partnership.

Partnership working is evident in the RSCB/RSAB training and audit sub groups; agencies are brought together to consider available training resources and to undertake specific audits from Child Practice Reviews (CPR) or Adult Practice Reviews (APR) and develop action plans.

The UHB works in partnership with the Regional Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) group; to ensure compliance with the training programme in line with the Welsh Government, National Training Framework. The work involves sharing training figures for Mandatory Group 1 training and Group 2. There is the expectation that Group 3 training will be rolled out in the coming year.

The UHB is represented at all Public Health Wales, National Safeguarding Team meetings by the Deputy Executive Nurse Director, Named Doctor for Safeguarding Children and/or the Head of Safeguarding. The meetings bring together Health Boards and Trusts from across Wales, the aim is to maintain standards and to share learning. There are subgroups covering VAWDASV, Training and Child Looked After (CLA). There is representation from the safeguarding team in all meetings, the CLA team attend the sub group for their service.

Female Genital Mutilation (FGM)

The United Kingdom (UK) Government and UNICEF hosted the first “Girl Summit” in July 2014 aimed at mobilising National and International efforts to end FGM as routine practice in some countries across the World. The UK Government also made a number of commitments for new legislation to tackle FGM.

In 2015 a number of amendments were made to the Female Genital Mutilation Act 2003 through the Serious Crime Act 2015. Section 4 of the 2003 Act specifies that extra-territorial jurisdiction extends to prohibit acts done outside the UK *by* a UK national or a person who is resident in the UK. Considered with that change, section 70 (1) also amends section 3 of the 2003 Act (offence of assisting a non-UK person to mutilate overseas a girl’s genitalia) so that it extends to acts of FGM done *to* a UK national or a person who is resident in the UK. This has placed a mandatory reporting duty on all health professionals to report “known” cases of FGM in under 18-year olds to the police, this duty has been instigated since 31 October 2015.

The All Wales Clinical Pathway for FGM was created and completed by a task and finish group in October 2015 and ratified in July 2016. Work has been on-going within Public Health Wales to update the pathway.

Specific mandatory training for midwives has been in place since 2014, 300 midwives receive the training during the year. Additional sessions were introduced to other health professionals through an introduction in Level 3 Safeguarding Current Themes and the Level 2 VAWDASV safeguarding training.

A continued drive to raise awareness across the UHB has been maintained by the safeguarding team. Midwifery training has been facilitated by the FGM Lead Midwife with additional training across the UHB delivered by members of the safeguarding team.

Online FGM training is also available, endorsed by the Home Office; this is accessible to UHB staff.

Welsh Government requested quarterly updates from all Health Boards across Wales identifying FGM from October 2016 this also included referrals made to Children's Services where mothers of female children are identified as having experienced FGM. The data collection has since been commissioned to Public Health Wales. The reason for referring children to Children's Services ensures that professionals are aware of an increased risk that the female children may experience FGM in the future.

Numbers of women identified has decreased during this period, possibly due to restrictions in worldwide travel and relocation.

Quarter during 2021-2022	Number of Women Identified	Child Protection Referral Made	Mandatory Reporting
Q1	21	13	2
Q2	19	6	1
Q3	8	4	0
Q4	18	8	1

The referral process for suspected cases of FGM has been reviewed within the UHB, an example child protection referral is available on the UHB's intranet (CAVweb), and an FGM Risk Assessment (RA) tool has been added to the Multi Agency Referral Form (MARF) this has been agreed with police and local authority. An increase in recognition has been apparent as a result of the FGM working party training, staff have presented at both a South Wales Police (SWP) Conference and the Chief Nursing Officer Conference. A Leading Innovation in Patient Safety (LIPS) project in September 2018 brought Health, SWP and the National FGM centre together considering the referral pathway and outcome within the Cardiff and Vale region. Neither of the LAs were able to attend the LIPS study days although consultation from them was sought.

An FGM service model, the Women's Well-being clinic continues across the UHB, the clinic opened in May 2018 following funding secured from the Police for the psychosexual element and from the Iolanthe award.

The Women's well-being clinic consists of a service held weekly (1 all day session) within the Cardiff Health Access Practice (CHAP) in Cardiff Royal Infirmary, which is centrally placed for easy access, has already been secured at no additional costs.

The first year saw a total of 147 women referred to the Women's Wellbeing clinic, 102 young people/women have been reviewed in this time. The majority of referrals are from UHW maternity. There are varying reasons for referral including gynaecological and psychological issues with the predominant reason being pregnancy. One family attended clinic to seek refuge due to risk of FGM. Country of origin has been collated with the

majority of women reviewed being from the Sudanese community. Self-referrals at the clinic are accepted.

The Clinic has completed its 4th year and numbers remained steady. A total of 106 women have been referred for assessment, the average number of consultations with women presenting with type 3 FGM requiring de-infibulation is n=3.

In 2018 and 2019 all women were offered Psychosexual counselling at the women's wellbeing clinic, funding for this service ceased in 2019. In 2020 and 2021 the clinic has referred women to 3rd sector agencies for support such as BAWSO, OASIS, the Birth partner project, the Orchid project, Red cross, Welsh refugee council and Trinity church. Future plans are in place to offer psychological support to prepare for birth at the women's wellbeing clinic.

The Women's Well-being clinic has demonstrated a need for this service within the community and is evidenced by the numbers of women that have been reviewed, future plans include: to continue with the clinic including outsourcing of psychosexual service and to further engage with the local communities to promote the services within the clinic. Training for community de-infibulation is also being explored as service development.

Procedural Response to Unexpected Death in Childhood (PRUDIC)

The process was first introduced across Wales in 2010 with the aim to "*ensure that the multi-agency response to unexpected child deaths is safe, consistent and sensitive to those concerned and that there is uniformity across Wales".*

The National Safeguarding Team in Public Health Wales revised the document in 2018. The procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

The process within the UHB is established; the Head of Safeguarding liaises with police to arrange a multi-agency meeting within 48 working hours of the child's death, the meeting is chaired by police, and attendance includes representatives from Children's Services, Education when appropriate, Welsh Ambulance Service Trust, appropriate representation from health professionals involved with the child. The purpose of the meeting is to ensure that there are no suspicious circumstances surrounding the child's death and to make certain that a robust bereavement package is in place for the family.

C&V UHB are fortunate to have a Bereavement Nurse that liaises directly with the family and supports them through this extremely difficult time by discussing with them any pathology information, arrangements for visiting the child in the morgue and registering the death. Referrals are made to charitable organisations to support the family long term and a memory box is created. The table below identifies the number of child deaths of children residing in the Cardiff and Vale of Glamorgan locality.

Period	Number of Child Deaths
2021-2022	4 (2) cases Young People Suicide

Child and Adult Practice Reviews (CPR and APR)

Guidance for Child and Adult Practice Reviews were updated and came into force from 6 April 2016 following the implementation of the SS&WB (Wales) Act 2014. The guidance is addressed at the Safeguarding Children and Adult Board meetings involving all partner

agencies. The purpose of the review is to promote a positive culture of multi-agency child and adult protection learning and reviewing in local areas when there are serious incidents resulting from abuse or neglect, there is a system of multi-agency concise and extended practice reviews. The criteria for child practice reviews are laid down in the *Safeguarding Boards (Function and Procedures) (Wales) Regulations 2015.* The outcome is expected to generate new learning to support continuous improvement in inter-agency protection practice.

The process involves agencies, staff and families reflecting and learning from what has happened to improve practice with the focus on accountability and not culpability. This will potentially develop more competent and confident practice, better understanding of knowledge base and perspective of different professional's role and responsibility.

The Head of Safeguarding and Named Doctor for Safeguarding Children participate in the Regional Safeguarding Board sub-group for Child and Adult Practice Reviews when consideration is given to new referrals and the commissioning of a new review. SNAs participate as panel members to individual reviews and complete a health chronology of each health contact to inform the timeline of events that will notify the reviewers preparing the report once collation of each agency's information has been submitted. There has also been representation from the team as a reviewer and Chair for Child Practice Reviews.

Recommendations and learning from the reviews will be identified in action plans or from the learning event. Organising a multi-agency approach for the learning event allows professionals to consider the case in detail, reflect on their own practice and to take learning back to each organisation to prevent the same situation happening again. One Child Practice Review was published in this reporting period. Five CPRs on-going, one Multi-Agency Professional Forum (MAPF) commenced, three Internal Management Reviews (IMR) undertaken. There are no outstanding Adult Practice Reviews in this period.

Child Practice Review	Adult Practice Review	Internal Management Review	Multi-Agency Professional Forum (MAPF)
5	0	3	1

Domestic Homicide Review (DHR)

Completed DHR	On-Going Awaiting Publication
5	**7**

DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). The provision came in to force on 13 April 2011. The Home Office Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews has been updated in 2016. Domestic violence includes physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members. In 2009/10, domestic violence accounted for 14% of all violent incidents and affects both men and women. A domestic violence incident which results in the death of the victim is often not a first attack and is likely to have been preceded by psychological and emotional abuse. It is likely that many people within agencies may have known of these attacks and circumstances. This can sometimes make serious injury and homicide preventable with early intervention.

A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect. Similarly, to CPR and APR, the DHR will consider what lessons can be learnt by professionals and

organisations to safeguard victims, what change can be identified, update policies and procedures, make every attempt to prevent domestic homicide by improving services to individuals and their children through improved inter-agency working.

The DHRs are commissioned through Partnership Boards in Cardiff and the Vale of Glamorgan localities. Referrals are received from South Wales Police and consideration is given at the Partnership Boards to undertake a DHR. The UHB Executives are formally notified of the commissioning of the DHR; the Head of Safeguarding attends a multi-agency meeting to agree the Terms of Reference for cases.

As with CPR and APR, safeguarding nurses are identified within the team to collate information from each health contact and develop a timeline to inform the DHR report. Representatives from the safeguarding team attend all DHR meetings and participate in the development of the report. There has been nine DHRs undertaken in Cardiff since 2015 and one case in the Vale of Glamorgan. This process is likely to transfer to the RSB in 2021-22 and called a Single Unified Safeguarding Review (SUSR).

Domestic Abuse

The implementation of the Violence against Women, Domestic Abuse and Sexual Assault (Wales) Act 2015 has seen a change in the referrals, training and width and breadth of the domestic abuse agenda within the UHB as indeed across Wales.

The Regional Multi-Agency Domestic Abuse Strategy for Cardiff and Vale of Glamorgan has been completed, the strategy incorporates a plan to address service need and training actions across the locality of Cardiff and Vale of Glamorgan council area. Welsh Government (WG) has provided guidance for all organisations to consider a five-year plan to meet the National Training Framework expectations to raise awareness with all employees within each organisation. Different levels of training are identified with compliance within each organisation expected to be at 100%. No additional resources have been identified by Welsh Government to achieve this target. Group 2 training commenced within the UHB during this time period, Group 6 training will be completed within 2022. The UHB has provided WG with a forecast of the number of staffs completing training over the next five years.

The UHB is fortunate to have a Health Independent Domestic Violence Advisor (IDVA) this is the only post within Health across Wales.

The Health Independent Domestic Violence Advisor (IDVA) came in to post in October 2016 with a role to deliver advocacy support within Cardiff and Vale University Health Board to clients who have experienced domestic abuse in Cardiff and the Vale of Glamorgan. During the period April 2021 to March 2022 the Health IDVA has continued to raise awareness of domestic abuse and raise the profile of the IDVA role within the UHB. In line with the Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015 the Health IDVA has continued to deliver VAWDASV, Group 1 training which is mandatory for all staff. In addition, The UHB Safeguarding Team has commenced the roll out VAWDASV group 2 training in line with the Welsh Government National Training Framework. There is a requirement within the VAWDASV Act that all professionals working with the public in any capacity must undertake this additional training. A broad estimate of 11,000 staff within the UHB will be expected to complete this training. In addition to this, within the reporting period, the Health IDVA has co-delivered UHB Level 3 VAWDASV training days and has also been a guest speaker on other UHB Level 3 safeguarding study days. The Health IDVA has continued to provide ad hoc awareness raising sessions to departments including Dentistry.

As an organisation we continue to support the White Ribbon Campaign. Several ambassadors and champions within the UHB have completed online training within their roles and departments to promote awareness and support for patients experiencing these types of abuse.

In addition to providing training and raising awareness the Health IDVA continues to provide support to survivors of domestic abuse. During the period April 2021 to March 2022, 632 Ask and Act (A&A) referrals were received. This has shown a continued increase in referrals with an average of 53 per month compared with 17.6 referrals per month in 2018-2019. Following these referrals, safety planning has been completed with 290 clients either over the phone or face to face and initial assessments have been completed with 231 of the clients, 125 of these were assessed to be at high risk of domestic abuse. In cases where assessments have been completed, individualised safety plans have been developed with support including: markers and security measures on properties, assistance to report to the police, support at Court, Clare's Law Disclosure requests, signpost referrals for counselling and referrals to specialist support services. Furthermore, 10 clients have been supported to access refuge directly from hospital. In addition, the Health IDVA has made 61 referrals to MARAC.

During this reporting period a pilot Domestic Abuse, Routine Enquiry (RE) commenced in Emergency Unit (EU). The pilot coincided with the first and second wave of COVID-19 lockdown measures. The safeguarding team recognised the opportunity to assess all attendees to EU and complete the A&A when presenting with injuries and them not being accompanied by another person due to social distancing.

The result of the pilot introduction was phenomenal, with a large increase in positive disclosures made. The pilot has now become part of the practice in EU with staff maintaining the RE with all patients >16 years of age. The table below demonstrates the increase in positive disclosures:

Month	Total number of Ask and Act referrals	Positive Ask and Act referrals	Ask and Act referrals from other departments within UHB	Ask and Act referrals with disclosures from ED	Ask and Act referrals with non-disclosures from ED
Apr-21	**592**	44	10	34	548
May-21	**750**	52	11	41	698
Jun-21	**751**	66	17	49	685
Jul-21	**622**	62	14	48	560
Aug-21	**682**	43	9	34	639
Sep-21	**578**	47	13	34	531
Oct-21	**462**	58	19	39	404
Nov-21	**695**	52	18	34	643
Dec-21	**523**	46	18	28	477
Jan-22	**306**	53	19	34	253

Month	Total number of Ask and Act referrals	Positive Ask and Act referrals	Ask and Act referrals from other departments within UHB	Ask and Act referrals with disclosures from ED	Ask and Act referrals with non-disclosures from ED
Feb-22	**751**	56	17	39	695
Mar-22	280	49	22	27	231

Once it became clear that the number of positive referrals were exceptionally increased additional resources and training were sourced to target the areas of impact. The UHB worked in collaboration with the Regional VAWDASV group to successfully bid for additional funding from WG. The funding from November 2021- March 2022 provided an administrator to manage the regional training programme and the equivalent of additional full-time Health IDVA service for the UHB. In addition, funds within the corporate safeguarding team were allocated to provide an additional Health IDVA to cover Maternity Leave of the substantive IDVA post. The additional Health IDVA services have evaluated extremely well with improved services provided across the UHB.

Domestic abuse and other forms of violence can impact negatively on an employee's health and wellbeing and staff morale. In addition, in England and Wales domestic abuse has economic costs of £14 billion arising from lost output due to time off work and reduced productivity (The Home Office, 2019). The Health IDVA supports staff members experiencing domestic abuse, within the reporting period has received 45 referrals. The Health IDVA has supported the staff by completing regular risk assessments and working in a client led way to develop safety plans for them at home and in work. This includes working closely with managers, the UHB Health and Safety Team and UHB Security. The Health IDVA has also worked closely with the Health and Safety Team to put in a successful bid to the Health Charity for lone worker devices for staff experiencing domestic abuse and stalking.

Violence Prevention Team (VPT)

This multi-agency project launched in October 2019 in Cardiff, hosted by the Wales Violence Prevention Unit (VPU) and funded by the Home Office. Cardiff and Vale University Health Board (UHB) were invited to be part of the unit as the Emergency Department (ED) is situated in the University Hospital of Wales (UHW), which is one of the biggest and busiest in the United Kingdom. Every year thousands of people find themselves within an ED as the victim of serious violence (National Violence Surveillance Network 2019). The Violence Prevention Team (VPT) consisting of two staff members, a seconded qualified nurse and an advocate embedded alongside clinicians and trauma practitioners within the ED at UHW. This is the first model of its kind in the UK. Together the VPU comprises of members from South Wales Police, the Police and Crime Commission, Public Health Wales, Her Majesty's Prison and Probation Service, Home Office Immigration and Third Sector support services. Together they take a Public Health approach to prevent all forms of violence across Wales.

The health team based within the ED meet with patients of any age attending with Violence with Injury (VWI). Initially the project concentrated on knife related injuries, however this expanded to include all violence which incorporates Domestic Abuse. The health team approach the patient to provide support, advice and guidance as soon as it is appropriate. The focus is on building a rapport, providing personalised, holistic and integrated support, enabling patients to make informed decisions. The aim is to enable empowerment to

improve the patient's well-being and then encourage patients to make informed, long-term positive plans to break away from cycles of violence. With the patients consent the team will refer to external agencies, for continued support in the community, if required following hospital discharge.

The programme objectives are:

- Assessment of all VWI and identifying appropriate pathways of support.
- A reduction in violence.
- A reduction in repeat attendances to the Emergency Department as a result of violence.
- Enabling clinical staff within Emergency Departments in being more equipped to support vulnerable people.
- Increasing incident reporting to the Police
- Improved safeguarding mechanisms for those at risk
- Improving safeguarding procedures for adolescent patients.
- Data collection

Violence Prevention Team Training

The VPT training is developed and delivered by its members in a variety of methods, including classroom- based presentations, drop-in sessions, 1-1 on the spot teaching, and recorded/online sessions. ED teaching sessions are arranged by the Emergency Unit Practice Educator often during the departments study days. All levels of staff within the department have received some form of training, including reception staff, doctors and nurses since October 2019.

It has become apparent, that due to staff rotation and turnover of staff within the department, education sessions need to be consistent and regular. The team are also visible in ED to answer staff questions and encourage engagement.

ED staff education entails:

- Raising awareness of the service and its provisions
- Identifying the VPT referral pathway
- Use of referral forms and processes
- Reporting of all knife related admissions
- Encouraging paediatric referrals
- Encouraging all safeguarding measures are met

The team has also conducted educational sessions on the Level 3 UHB Safeguarding study days. Including the Current Safeguarding Themes full day training, since November 2019, reaching a variety of different UHB staff members.

Raising awareness has been a key part of the VPT, and contributes to the quality of service that the team provide. Within the UHB the team has liaised with other specialities, such as Major Trauma, Poisons, Drug and Alcohol Liaison Nurses and Psychiatry. The VPT have provided training and support to specialist nurses and health care assistants working in the Major Trauma Centre (MCT), and have developed a clear, robust referral mechanism between the MTC and the VPT. The VPT have recently developed a training package for the Radiology Led Discharge Team to support them in their new role within the ED.

The VPT have developed a number of service links externally to the UHB with both statutory and third sector agencies. Since the beginning of this project, work with third

sector agencies have assisted, developed and enhanced the service now being provided to ED patients. Work streams have been formed allowing the team to make seamless referrals into these services; continuing support for patients from hospital and into the community. To develop external links, the VPT has presented at the Serious Youth Violence in South Wales Seminar outlining their role to a wider range of professionals and developing new operational networks. The VPT have also joined the National Violence Reduction Network, which is a bi-monthly meeting of violence reduction specialist sharing knowledge, practice and learning.

The VPT have recently been mentioned in an international publication – Slazburg Global Seminar – Global innovations on youth violence, safety and justice. Highlighting the work of the VPT and its benefits in supporting young people in Wales

COVID-19 measures and restrictions have disrupted the team's training programme, however face to face training sessions are now being resumed.

Training and Networking: April 2021 to March 2022

UHB Training Sessions	
ED Dr introduction	3 sessions (23 people in person + 8 online)
Student Nurse induction	3 individual sessions
1-1 opportunistic teaching	Not recorded (however occurs daily)
Emergency Dept drop in Session	21 Persons in person
Level 3 Current Themes	Level 3 Current Themes
External Training	
Faculty of Nursing Conference	1 Session (28+ Recorded for members)
4 Nations National Conference	1 Session (50+ Recorded for delegates)
Serious Youth Violence Champions – South Wales Police	25 online

Patient Outcomes: April 2021 to March 2022

Knife Related Injuries	117 patients	81 engaged	52 accepted ongoing support after discharge
Violence Related Injuries	697 patients	602 engaged	302 accepted ongoing support after discharge
Self-Harm Punch Injuries	102 patients	67 engaged	25 accepted ongoing support after discharge
Retrospective MARFS or AS1 submitted	337 patients		

Evaluation

The Violence Prevention Team will work together with Public Health Wales in 2021 to evaluate the programme and services provided. The primary objectives of the evaluation are:

1. To understand the role of the NHS Violence Prevention Team (VPT) in supporting victims of violence-related injury;
2. To assess the efficacy of the VPT in addressing the needs of patients and preventing future violence related injuries;
3. To assess the effectiveness of the implementation and delivery of the VPT within the ED, and identify any developments to further enhance the role of the team;
4. To explore the value of the VPT, and consider sustainability of the model, potential for scale up, and roll-out of the intervention to other health settings in Wales.

Due to the positive outcome from the VPT evaluation, additional funding has now been provided by the Home Office to expand the VPT and develop a similar provision in Morriston Hospital A&E. The C&V VPT are working to support this team and assist them in their development.

CONTEST

Contest is the UK Government's counter-terrorism strategy. Part of the strategy, PREVENT is designed to tackle the problem of terrorism at its roots, with the aim of preventing vulnerable people from becoming radicalised. The Safeguarding Team, working directly with the Head of Emergency Preparedness Resilience & Response (EPRR) have developed a UHB referral pathway for UHB employees to follow when they have a concern that a service user or a member of staff maybe at risk of radicalisation. Training in this area is disseminated to UHB employees via a workshop designed to help make staff aware of their contribution in preventing vulnerable people from being exploited for terrorist purposes. The Safeguarding Team play a key role in this agenda, working closely with Clinical Boards and the UHB EPRR Team. The UHB are expected to report the number of staff attending the workshop to Welsh Government on a quarterly basis. A small working group from the safeguarding team, the EPRR team and a practice educator from Emergency Department have an on-going annual work plan to ensure that the Prevent Awareness training is delivered to key groups working with members of the public and/ or families in the community.

Contextual Safeguarding

The contextual safeguarding agenda continues to evolve within adult and child safeguarding practices. Contextual safeguarding seeks to identify and safeguard young people against abuse not just within the home but within the wider environment, this is termed extra-familial abuse (Firmin 2017). Contextual safeguarding seeks to identify how professionals can safeguard children on a wider scale within the community. The way in which individuals can be safeguarded is to disrupt the environment where the abuse is occurring. Contextual safeguarding is important as family members have little influence over these contexts, the only way to access these contexts is through interagency working. Examples of contextual safeguarding are as follows:

- Criminal exploitation/county lines/sexual exploitation
- Peer on peer abuse
- Radicalisation
- Modern Slavery
- Trafficking
- Online abuse

Within the UHB this means increased multiagency partnership working to share information and establish innovative actions to safeguard individuals or a group of individuals within the community. High risk panel meetings within Cardiff driven by Children's Services, have

been established to help address contextual safeguarding, these meetings take place once weekly. Young people aged under 18 years are referred into the high-risk panel meeting that are identified as being at imminent or high risk of serious harm. The high-risk panel identifies risks outside of the family home within the community. The safeguarding team have been involved in attending high risk panel meetings to share information and jointly agree a risk management plan with agencies such as children's services, youth offending services, adult services, police, children's services legal team and education. These meetings are complex and at times a group of young people at risk are discussed where there can be numerous risk factors present.

Child Sexual Exploitation continues to be a priority for Welsh Government, Regional Safeguarding Children Board (RSCB) and the National Safeguarding team in Public Health Wales. A National action plan has been introduced to ensure that all statutory agencies and Third Sectors consider how to Prepare, Prevent, Protect and Pursuit (police) will be driven through each organisation. The RSCB endorsed a CSE Strategic Group to consider the prevalence of CSE across Cardiff and the Vale of Glamorgan by undertaking a mapping study and each agency identifying the training that is delivered and sharing the resources available. This challenges the effectiveness of the activity undertaken by the Board to safeguard and promote the welfare of the children who are at risk of, or being harmed by, child sexual exploitation across the region. This is particularly pertinent as a Child Practice Review Multi-Agency Professional Forum presented a CSE case in 2016 whereby a number of children were exploited by the same perpetrator. This group has now been replaced by an Exploitation Thematic Group which is in the process of developing an Exploitation Strategy with the purpose "*to develop a robust multi-agency response to prevent and address exploitation, developing effective services to support victims of exploitation and improve the identification of victims of exploitation across Cardiff and the Vale of Glamorgan".*

Within the UHB an increase in the workload associated with CSE has continued during 2020-21 following the introduction of additional staff in Children's Services and police to tackle the problem in Cardiff. This has led to regular weekly CSE strategy meetings for individual children suspected to be at risk of CSE. Health professionals involved or working with the age group, such as school nurse, Department of Sexual Health (DOSH) or Children Looked After nurses, Sexual Assault Referral Centre (SARC) nurses and Paediatric Emergency Department nurses are expected to contribute to the meetings to share information that may be available within Health to support the concern raised. As with all strategy meetings held through the Wales Safeguarding Procedures (2019), a plan is implemented to support the child and an attempt made to prevent the child from risk of harm through abuse or neglect. No additional resources are available within the Children and Women Clinical Board, Primary Community & Intermediate Care Clinical Board or the safeguarding team to assist with the increase in workload; this has been identified as a continued cause for concern. In an attempt to reduce the risk associated with this type of abuse, alert flags in Emergency Department at University Hospital of Wales are placed on identified children and young people, considered to be at risk.

In addition, the safeguarding team have developed a new CSE/CCE (Child Criminal Exploitation) Multi Agency Strategy Meeting Pathway which commenced 6th November 2019, to ensure that all relevant health information is shared by a health professional at each MASM, whilst reducing the commitment required of each team in attending. This is covered on a rotational basis between five identified health teams who present a health report for each young person. These reports are collated from information provided by all involved health professionals. Outcomes and actions are documented on the electronic record system by the attendee and all people involved are notified. There will be ongoing review and evaluation to measure the effectiveness of the new process.

Modern Day Slavery

Modern slavery is a serious crime in which people are treated as commodities and exploited for criminal gain. The true extent of modern slavery in the UK is unknown. Modern slavery, in particular Human Trafficking, is an international problem. Modern slavery includes human trafficking, slavery, servitude and forced and compulsory labour. Exploitation takes a number of forms, including sexual exploitation, forced manual labour and domestic servitude; victims come from all walks of life. The Modern Slavery Act 2015 outlines frontline staff responsibility to identify potential victims of modern slavery and human trafficking, refer potential victims and ensure that victims have access to services to which they are entitled. UHB employees are identifying victims and are following the Multi-Agency Response Pathway for suspected cases. Human Trafficking Multi-Agency Risk Assessment Conferences (HT MARAC) are held in Cardiff on a monthly basis, the Safeguarding Team represent the UHB at the meeting. Training for Modern Slavery is incorporated in to the Level 3 Current Themes (adult) Study Days provided by the Safeguarding Team. The training is available for UHB and GP employees. The process has been disrupted during COVID-19 and will require a recovery plan in the coming year.

The National Referral Mechanism (NRM) is the framework for identifying victims of modern slavery. Cardiff and Vale UHB Safeguarding team are part of a pilot in which the outcome of NRM referrals for children residing within Cardiff are no longer decided by the home office but through a multiagency decision, decision makers being police, children's services and health. The Home Office will review decisions as part of the pilot. The decision is made whether there are reasonable grounds to believe the individual is a victim of modern slavery and a further meeting is held to determine whether there are conclusive grounds a child is a victim, if this cannot be established at the initial meeting. The reasonable grounds decision is a relatively low threshold – "I suspect but cannot prove the person is a victim". Conclusive grounds decision is whether on the balance of probabilities a child is a victim of modern slavery. The conclusive grounds decision is a higher threshold than reasonable grounds decisions. NRM panel meetings take place weekly and safeguarding nurse advisor attends these meetings. Safeguarding nurse advisors have attended additional training to enable effective decision making. Attendance at these meetings has increased multiagency working and increased awareness of concerns within the community, prior to this health would not have information on NRM referrals submitted for children within Cardiff and would not routinely be aware of the outcomes of the referral. This increase in knowledge is shared throughout the UHB via safeguarding documentation in records and updating training to increase awareness.

There is a newly developed Safeguarding Adolescents from Exploitation (SAFE) model in place within Cardiff introduced by the Local Authority Children's Services. This model has established additional multiagency meetings to share information and discuss strategies to obtain a multiagency response to contextual safeguarding risks.

High Risk Panel Meetings have been established as part of the SAFE model, Cardiff and Vale UHB Safeguarding team have been representing health at these meetings the meetings take place weekly. The purpose of the panel meetings is to discuss children/young people that are considered at immediate risk of harm in relation to contextual safeguarding, these involve complex criminal exploitation and child sexual exploitation cases. The meetings aim to establish if a young person is at high risk of exploitation and to maintain oversight of the case. Involved agencies jointly agree a risk management plan and have a collective responsibility. Agencies will look at a form of disruption for the individual or group of young people that are being exploited. Many of the young people discussed, have difficulties with engagement, are frequently deemed as

missing. This often requires ongoing strategies to try and locate and engage with the young person. We have approximately three to four high risk panel meetings taking place weekly.

SAFE Locality Operational Groups is a further multiagency meeting that has been developed as part of the SAFE model. A pilot for this group has been taking place within North Cardiff. The health Violence Prevention Team (VPT) represent health at these meetings. The group involves a wide range of professionals within the area – head teachers from local schools, local police in the area for example - PCSOs, children's services managers in the area, Media Academy Cymru, Neighbourhood Housing, Early Help, PA Service. The purpose of the operational group is to focus on areas of concern within Cardiff and share information amongst agencies. Information and local intelligence relating to contexts/locations where harm is being seen within the area is shared with partner agencies and information on peer networks. The group will discuss strategies to disrupt the context/environment that the abuse is taking place.

County Lines

County Lines is a national issue that poses a significant threat to communities and exploits the most vulnerable members of society. Vulnerable local residents will be exploited, coerced and forced to participate. Their properties are targeted and occupied (cuckooing); vulnerable people including children are groomed, intimidated and/or threatened into transporting and hosting drug related activity. The emerging themes for children and adults at risk with this activity is exploitation and abuse in all its forms, human trafficking and any associated criminal action.

Information and training has been shared by South Wales Police (SWP) to raise awareness of the growing issue identified as County Lines. Resources have been provided to partner agencies, to cascade training within their own organisations to frontline staff who are likely to see people presenting with injuries or sickness associated with the culture and crime surrounding County Lines.

The nature of any person presenting at C&V UHB is likely to be a child under the age of 18 years old or an adult deemed to be vulnerable. The threat linked to County Lines is not only a drug problem but is exacerbated by how the criminality is carried out. SWP are reporting an increase in knife crime connected to the gang culture.

Bespoke training from the safeguarding team has been provided to specific areas within the UHB most likely to come into contact with county lines activity - these areas include ED, Maternity Unit, Mental Health, GPs, DOSH, HVs and school nurses. This has informed and reinforced existing reporting arrangements to ensure raised awareness and cascading of information to all UHB staff to be alert to this emerging phenomenon. The safeguarding team are working with police and social services to provide assurance that the effects of county lines activity is addressed by health services.

Deprivation of Liberty Safeguards (DoLS)

The Cardiff and Vale UHB DoLS team operate the supervisory responsibility on behalf of Cardiff and Vale UHB, Vale of Glamorgan Council and Cardiff Council through a Partnership Management Board consisting of senior representatives of each supervisory body.

The DoLS team provide advice to Care Homes, hospital wards and Health and Social Care staff across the sector in relation to Mental Capacity Act (MCA) and DoLS.

Monthly awareness training sessions are provided at UHW and UHL sites.

There has been an increase in requests for assessments since March 2014 when a Supreme Court Judgement clarified DoLS. This is evidenced in the table below, during 2013-2014 pre- judgement there were 55 requests made:

Period	Number of health requests made	Number of Assessments Completed
2021-2022	1199	974

The DoLS coordinator is a Band 7 nurse employed by the UHB and supervised/ professionally managed by the Head of Safeguarding. DoLS/MCA training is delivered by the DoLS team throughout the year. The training is incorporated into existing safeguarding training however, bespoke sessions are also provided to individual wards, dietician's and physiotherapists as requested.

Liberty Protection Safeguards

Consultation on the Regulations for the Liberty Protection Safeguards and updated MCA Code of Practice ended on 14th July 2022. We are still awaiting a new target date for implementation; the UK Government have advised that this will be announced once they have had an opportunity to review the feedback from the Consultation.

The new Safeguards will change the assessment process for a deprivation of liberty from an external team undertaking assessments to provisions being written within the person's care plan. This will have significant implications for the UHB and a staff training programme will be introduced to ensure that all appropriate staff are able to complete the necessary assessments. Each individual that completes the assessments for the LPS will need to ensure that they have a good working knowledge of the Mental Capacity Act and its principles in order to reach the required standard of legal scrutiny.

The UHB have appointed a Project Manager to commence the transition and phased implementation project plan, working in collaboration with partner agencies.

Sexual Assault Referral Centre (SARC), Ynys Saff

Cardiff and Vale UHB hosts Ynys Saff, the multi-agency Sexual Assault Referral Centre (SARC), in Cardiff Royal Infirmary. The service delivers a comprehensive quality service for victims of sexual assault for adults and children in Cardiff and the Vale of Glamorgan; it also offers a provision for children across South and Mid Wales region who are victims of an acute assault.

Ynys Saff sits within the governance framework of the Children and Women Clinical Board. The UHB Safeguarding Team support the service in relation to safeguarding activity with the Safeguarding ISVA/IDVA linking in with SARC ISVAs and making the appropriate referrals to SARC to ensure a wrap- around service for the client.

The number of referrals to Ynys Saff during the last 12 months have increased significantly. 726 referrals received during this time period in comparison to 464 in the previous year.

Ynys Saff SARC has remained open throughout the pandemic, with appropriate infection control measures in place. The service continues to provide interview facilities for the police. The Independent Sexual Violence Advocate (ISVA) and Child and Young Person Sexual

Violence Advocate (CYPSVA) service has continued, but has adjusted to providing mainly remote support over the phone or virtual consultations. This generally has been accepted by clients. Where a client is felt to require face to face appointments, these have been offered, with infection control measures in place.

Children's counselling has continued over the phone with limited spaces available for face to face counselling when COVID restrictions were lifted. Face to face counselling waiting times remain a priority with the current waiting time around 18 months. Adult counselling has been via the telephone or face to face. Increased funding from Welsh government has allowed a reduction in the waiting list for counselling from around 12 months, to 3 months.

The SARC Project Board has moved into the NHS collaborative. Progression with the project was impacted by the Covid-19 pandemic. A new project manager was appointed in June 2021. Work has been continuing to ensure that Ynys Saff will be able to meet ISO Forensic Accreditation standards by October 2023. Phase 1 included an extension to the current SARC building with the addition of two forensic medical exam suites and is almost complete. Phase 2 is due to start April/May 2022 which will involve changes made to an existing examination room to meet the ISO Forensic Accreditation Standards. The increased capacity from South East Wales will be completed in stages, whilst waiting for the required workforce.

Ynys Saff SARC hosts the interim Paediatric regional service for children across the whole of the South and Mid Wales region. In the previous year, 58 sexual assault medicals took place for children under the age of 14 years within Ynys Saff. This remains a vast under representation number of children who are experiencing sexual assault, and work is continuing to work with multiagency teams to increase disclosures and ensure clear pathways are in place to ensure all medical needs are met. The interim model offers five afternoon clinics (Monday to Friday) with provision for:

- Acute service for children and young people up until their 14th birthday who may have experienced rape or sexual abuse
- Historic cases requiring a medial assessment of children residing in Cardiff and Vale UHB, and Cwm Taf Morgannwg UHB (comprising Bridgend, Merthyr Tydfil, Rhondda Cynon Taff)
- Ongoing evaluation of this interim model continues to inform the development of the regional service for children

Work will continue to progress to a more sustainable two-site model with Swansea identified as the second site, but remains challenging due to staff resources. However, there continues to be a commitment from all Health Boards in Wales to achieve the two-site model, work is ongoing within the Welsh Sexual Assault Services Regional Board (WSASRB) to achieve this. Regular peer review is held within Ynys Saff for Cardiff Paediatricians. A wider regional peer review is being set up this year to meet the needs of doctors providing cold case sexual assault medical examinations outside Cardiff.

Out-of-hours cover for the regional service continues to be covered by the Cardiff and Vale community paediatric safeguarding rota. Development of a robust 7- day regional service is still required and work towards this is being supported by the WSASRB. Work is underway to establish the training framework for clinicians to meet RCPCH/ FFLM standards for undertaking paediatric sexual assault medical reviews.

Ongoing discussions are in place for funding to support the capital plan to relocate the SARC from its current position to a larger self-contained refurbished accommodation in Houses 54-56 on the Cardiff Royal Infirmary (CRI) site. The Outline Business case for the

wider CRI development is due to be submitted to Welsh Government at the end of May 2022.

Children Looked After Team

Children Looked After represent one of the most vulnerable groups of children in modern society. It is well evidenced that these children and young people have adverse health outcomes owing to their early life adversity. Cardiff and Vale UHB have both corporate parenting responsibilities as well as statutory obligations to perform health assessments aimed at identifying unmet health needs, improving health outcomes and reducing health inequalities. A small but dedicated team of staff are employed to fulfil these requirements. Within 5 working days, the UHB should receive notification from the Local Authority that a child has become Looked After. The initial health assessment must be completed within 28 days of the child entering care with review assessments required annually for children over the age of 5 years, and 6-monthly for children under 5 years of age. An audit looking at the delays in completing the statutory health assessment was completed in 2021. This audit looked at the delays in receiving the notification and the delays in completing the initial health assessment. This highlighted significant delays in both the notifications being received (26% compliant) and the health assessment being completed (2.4% compliant). Additional work has been undertaken to consider the delays between receiving the notification and the completion of the health assessment. Whilst this demonstrated an improvement in compliance with the statutory regulations, the overall outcome established that the UHB is significantly non- compliant (19.4% in 2021).

The current working model within the UHB is that Children Looked After under the age of 10 have their health assessments undertaken by the paediatricians and those aged 10 years and over are undertaken by the specialist nurses; however, this model is under review with proposals submitted to the Clinical Board and will hopefully change within the next few years in an attempt to improve performance but also to better meet the needs of the population. A new data transfer system has been trialled with the aim of aiding the notification process and work is starting with the electronic PARIS system to create a Children Looked After module to improve both data capture, clinical efficiency and recording.

There has been a consistent increase in children in care in Cardiff and the Vale of Glamorgan rising from 840 in 2017, to 1070 in 2019, and 1275 in March 2022. Cardiff and Vale UHB also undertake health assessments for children from other Health Boards placed within our area, and are responsible for ensuring that children from Cardiff and Vale placed elsewhere have their health needs met in their host Health Board. In May 2022 there were 1620 children and young people that the team were involved with. Of these 190 children were under adoption regulations. It is clear that whilst the numbers are increasing, the complexity of the cases and difficulties faced by these young people are also rising.

Historically, Cardiff and Vale UHB have always received unaccompanied asylum-seeking children who fall under the remit of Children Looked After being cared for by the Local Authority. In 2021 the team were involved in the National Transfer Scheme pilot for unaccompanied asylum seekers which has now completed and the scheme has been implemented across Wales. During the pilot, 39 unaccompanied asylum-seeking children were received with a plan for more than 50 to be dispersed within Cardiff and the Vale region. This is in addition to the unaccompanied asylum-seeking children received in the previous process. No additional resources have been received to meet this increased demand.

In addition to the health needs of the children and young people, the paediatricians are responsible for reviewing the health needs of all adults applying for positions as foster carers, kinship carers and adopters and attend adoption and fostering panels.

Learning Disability

Learning from three Serious Incident reviews in 2015 and a Safeguarding an Adult at Risk case in 2016 highlighted the need for service improvements required for Learning Disability (LD) patients within the UHB. Progress has been made to improve the quality of care provided to patients with LD. This has been achieved through the "1000 Lives" care bundle launch and implementation development of a "flagging" system of immediate alerting across acute areas, modification of NEWS escalation of deteriorating condition response, risk assessment of immediate need and reasonable adjustments required to care. 250 resource files giving staff advice on implementing the care bundle has been obtained and distributed across Adult, Mental Health and Children and Women service areas. In addition, a daily Business Intelligence System (BIS) report gives notification of all in-patients with LD allowing prompt review of this vulnerable group. There is also a weekly report of mortality within LD patients, allowing level 2 mortality reviews to be chased for learning. Easy read qualitative feedback questionnaires are automatically sent out to patients with LD and also to family and carers after an admission or an outpatient appointment in order to enable learning has been introduced.

The launch in November 2018 of UHB LD Champion Roles, identified staff from all wards and departments to take the lead and raise awareness within their clinical area. Over 150 staff have been trained to date, training is provided on a six-monthly basis (COVID-19 permitted). This will enhance dissemination of available resources and share good practice across the breadth of C&V UHB. An additional Level 3 Safeguarding Themes (Adults) training session incorporates information for practitioners, this event was launched in November 2019. We have worked with Hijinks Drama Company to produce 4 film clip learning from real life situations which challenge staff to appropriately care for patients, with LD. The UHB continues to work in partnership with Swansea Bay Health Board for LD services that are commissioned in community settings. In addition, we now have two UHB Acute Liaison Nurses since June 2020. The posts support all areas with training and advice when individuals with LD are admitted to hospital. The post was identified as a priority within the joint LD commissioning strategy developed for the region. The priorities also include the progression of LD primary care liaison targeted at raising awareness and training on management of individuals and to improve the uptake of an annual health check. An action plan to progress work in this area is in place, both Cardiff and Vale of Glamorgan Local Authorities as well as the UHB are committed to this workstream.

Cardiff and Vale UHB Youth Board

The Youth Board was introduced in 2018 following a recruitment process within the Children and Women CB. This aligned with the launch of the UHB Children's Charter, which was developed from the participation via focus groups of approximately 200 children and young people from Cardiff and Vale of Glamorgan. The focus groups included participants from a wide range of backgrounds, educational levels, ethnicities, genders and sexualities. A representative from the safeguarding team attends appropriate meetings to offer safeguarding advice as appropriate. Safeguarding training has been delivered to the Youth Board to raise awareness of safeguarding matters, how to recognise a concern and to report appropriately. They have created an animation for use in Safeguarding training, which informs learners about the UNCRC (United Nations Convention on the Rights of the Child), from the perspective of a child.

The Youth Board assisted with the questions for the safeguarding audit of "Risk Assessment of Young People Admitted to Adult Wards" to ensure the language was suitable for children and offered the opportunity for honest feedback. They continue to offer meaningful contributions to UHB decisions, ensuring a Children's Rights approach is a constant consideration. Youth Board members complete online mandatory safeguarding training as part of the volunteer service agreement.

In addition, the Youth Board are consulted in relation to numerous interventions such as:

Public Health:

Healthy Weight Healthy Wales (multiple meetings)
Energy drinks consultation
Teenage Immunisations (multiple meetings)
Smoking strategy

Emotional Well-being:

Reviewing CAMHS documentation and letters home
Input into new CAMHS pathways
Design of, development of and then population of new UHB website
Writing of and voicing or starring in 'help' videos for other young people
Input into 'Empower', including naming and logo

Interviewing:

For our new CEO
For our director of nursing
Many CAMHS nurse roles
Many clinical psychologists' roles
Community Connectors (new social prescribing roles)
Included as panel members for the commissioning of a new service for young people
Child Friendly Cities/UNICEF
Feedback consultation
Video content

Comms:
Support with UHB TikTok account
Videos for TikTok on 'back to school advice'
Six-month update interview with Suzanne Rankin (Chief Executive)
Celebration of South Asian month

7. Safeguarding Team Achievements

- Launch of Group 3 multi-agency VAWDASV training
- Two Group 3 Trainers identified within the safeguarding team
- Completion of Group 6 VAWDASV training to the UHB Executive Board
- Safeguarding Nurse Advisor participation in the Home Office NRM process for Cardiff
- Annual twice a year safeguarding education for District Nurses delivered as a full day session
- Successful secondment of a UHB Safeguarding Nurse Advisor to the LA Adult safeguarding team for 6 months
- Implementation and awareness training across the UHB in relation to Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020

- Paediatricians publication in the Royal College of Paediatricians and Child Health Conference: "Do we Need to brush up on our dental documentation"?
- Band 7 secondment from Medicine Clinical Board to safeguarding team for 6 months
- Band 6 secondment from Acute Paediatrics to safeguarding team for 9 months

Audits Undertaken or Commenced:

- Pressure Damage deemed as unavoidable and not reported to LA
- Survey with staff on how best to deliver mandatory safeguarding training to ensure optimum attendance

Safeguarding Audits undertaken by 3rd/ 4th Cardiff University Medical Students:

- Project looking at the patterns of child protection referrals over the course of the pandemic and contribution to all Wales (study presented at WPS) and UHB Safeguarding Steering Group meeting
- Project looking at our documentation of dental neglect during child protection medicals and developing a referral pathway to dental services
- Project evaluation in collaboration with Public Health Wales of the Cardiff Violence Prevention Team
- Project evaluating timeliness of statutory Children Looked After assessments
- Project evaluating dental registration of Children Looked After population
- Project evaluating multiagency working within Cardiff MASH model

Regional Safeguarding Board Safeguarding Nominations 2021-2022:

- Diana Wakefield
  Category 1: *Exceptional commitment to the safeguarding of children*
  Category 4: *Excellent contribution to safeguarding practice*
- Casey Keegans and staff on Cedar Ward
  Category 1: *Exceptional commitment to the safeguarding of children*
- ELAN team midwives:
  Category 6: *Exceptional commitment to practice demonstrated during COVID restrictions*
- Helen Gray and Sandy Sandburg - Health Independent Violence Advisors
  Category 6: *Exceptional commitment to practice demonstrated during COVID restrictions*

8. Forecast 2022-2023

Continuing with the achievements made, sustaining and maintaining the safeguarding agenda workload is challenging for the UHB safeguarding team. This is an area that continues to evolve with emerging themes such the overarching Contextual Exploitation. Ensuring that the UHB staff are prepared and aware of their professional duty to report, through providing specific training has been considered and discussed with all appropriate clinical areas. Additional training resources from within the team will be required through 2022-22 and onwards to provide Group 2 Domestic Abuse Training across the UHB, in line with WG expectation. The safeguarding team has proved that it is an innovative team that demonstrates the ability to adapt to contemporary situations. Ensuring that staff resources are available to cover three sites is often demanding, particularly considering the amount of work generated within Cardiff MASH, the multi-agency commitments to the RSB and Public Health Wales. The team will strive to resume the energy demonstrated to address the safeguarding agenda and ensure that staff and the public are safeguarded appropriately by the UHB.

Further work during 2022-2023 will include:

Action	Service Delivery
IDVA RE pilot in ED for children aged 13-16 years old addressing potential relationship difficulties	Corporate Safeguarding Team & Police and Crime Commissioner
Introduce a new multi-agency approach to reviews through the Single Unified Safeguarding Review (SUSR)	Regional Safeguarding Board
Demonstrate partnership working to engage with communities in relation to anxieties around FGM reporting *incomplete due to COVID-19 restrictions*	Regional Safeguarding Board
Introduction of the Home Office driven Offensive Weapons Homicide Reviews as a pilot in South Wales region	South Wales Police Region
Improve the safeguarding dashboard recording of Deliberate Self-Harm and Suicide in Young People	Corporate Safeguarding Team & Public Health Wales
Provide the Executive Team with a monthly Informatics Dashboard on Safeguarding activity across the UHB	Corporate Safeguarding Team: Executive Team
Work in partnership with the Royal College of Nursing to gain accreditation for UHB Safeguarding Training	Corporate Safeguarding Team: Training
Launch an additional Level 3 Safeguarding Training Day "Learning from Child/ Adult Practice Reviews and Domestic Homicide Reviews	Corporate Safeguarding Team: Training
Participate in a PhD study around facilitating safeguarding group supervision	Corporate Safeguarding Team: Training
All CBs recognises that improved mandatory training compliance is required post COVID-19, measures to be introduced to improve the current situation	Corporate Safeguarding Team: Training
Update PREVENT slides on safeguarding training pack	Corporate Safeguarding Team: Training
MARF teaching for staff in Children's Hospital of Wales	Corporate Safeguarding Team: Training
Update Level 2 training package for Volunteers	Corporate Safeguarding Team: Training
Report evaluation of HV preceptorship training	Corporate Safeguarding Team: Training
Raise awareness of multi-agency learning following the publication of The Child Safeguarding Practice Review Panel "Child Protection in England" National Review of the death of two children and a local child death case	Corporate Safeguarding Team: Training
Expansion of the Routine Enquiry for Child/ Adult Sexual Abuse within the Midwifery Service, in addition consider evaluation of the pilot in collaboration with Centre of Excellence for child Sexual Abuse	Corporate Safeguarding Team & Children & Women Clinical Board

Update of ED Casualty Card to include Human Trafficking and FGM	Corporate Safeguarding Team & Medicine Clinical Board
Ensure Domestic Abuse ED markers are in place following discussion at MARAC/ Daily Discussions	Corporate Safeguarding Team & Medicine Clinical Board
Audit of assault cases referred to Violence Prevention Team in Paediatric Emergency Department	Corporate Safeguarding Team & Medicine Clinical Board
Safeguarding recovery plan for school nurses to consider the impact of lockdown on children during COVID-19 and service provision available	Corporate Safeguarding Team & Children & Women Clinical Board
Pilot in Paediatric Emergency Department with Action for Children to consider engagement with children and young people in the community to minimise school related violence	Corporate Safeguarding Team & Medicine Clinical Board
Introduce a standardised proforma to be completed by GPs, Practice Nurses and the Department of Sexual Health (DOSH) when sexual concerns are indicated	Corporate Safeguarding Team & Primary Care Clinical Board
Introduce Safeguarding Documentation to be used by GP practices across the Cardiff and Vale region. Collaborative work with Children's Services	Corporate Safeguarding Team & Primary Care Clinical Board
Undertake an annual internal UHB Pressure Damage audit across all Clinical Boards	Corporate Safeguarding Team, Patient Safety & Clinical Boards
Audit of young people placed on Acute Adult Mental Health wards	Corporate Safeguarding Team & Mental Health Clinical Board
Update of the UHB Professional Allegations/ Concerns process	Corporate Safeguarding Team & Peoples Service Team
Audit of safeguarding cases discussed in supervision	Corporate Safeguarding Team
Audit of the use of the safeguarding chronology documentation in acute paediatrics	Corporate Safeguarding Team
Audit the effectiveness of the multi-agency contextual safeguarding pathway within health	Corporate Safeguarding Team
Report the data of health workload within Cardiff MASH	Corporate Safeguarding Team
Consider a new logo for the UHB Safeguarding Team, designed by the Youth Board	Corporate Safeguarding Team
Resume UHB Safeguarding Team Newsletter	Corporate Safeguarding Team
Update UHB Domestic Abuse policies and procedures	Corporate Safeguarding Team

Survey with HVs to evaluate knowledge and use of PRUDiC process and Overlay	Corporate Safeguarding Team: Supervision
Survey of Mental Health staff in relation to safeguarding support from UHB team	Corporate Safeguarding Team: Supervision

9. Summary

Since April 2014 the National and indeed International safeguarding landscape has broadened. We have seen the introduction of two significant Acts of law in Wales which has impacted on the safeguarding work stream across the UHB requiring significant changes in process, additional training and supervision as well as relocation of existing resources. Further legislation from the Home Office has also defined the need to raise awareness of Domestic Homicide and FGM. The Modern Slavery Act (2015) is another area whereby the safeguarding team need to work with partner agencies to raise staff and public awareness.

Workstreams from January 2020 were disrupted on a national basis throughout all organisations due to the pandemic outbreak of COVID-19. This forced the safeguarding team like all other departments to consider how services are appropriately and effectively delivered to ensure staff are supported, given appropriate timely advice and ensuring that safeguarding measures are in place. Planning and changes commenced in early February 2020 when it became clear that rapid changes were taking place in clinical areas and mass recruitment in the NHS. The UHB safeguarding team responded to the changing climate by providing direct support to staff by completing safeguarding reports for children and adults at risk as required, attending virtual child protection conferences on behalf of practitioners as required and introducing a team rota for home working to ensure the well-being and safety of staff members within the team.

During this time period the NHS has experienced significant issues in recruitment and retention of staff across all areas. The use of agency staff has been widespread across clinical areas. This has identified learning around staff mandatory training and increased professional concerns due to care provided to patients. This has been addressed appropriately at the time however it is fair to say that the increase in advice and management of safeguarding cases has impacted on the UHB Safeguarding Team. The team workplan reflects how we are able to map targeted training and supervision of staff. Through staff surveys and audit of the team service delivery we aim to provide a good quality safeguarding service within the UHB.

The Cardiff and Vale University Health Board Safeguarding Team will strive to continue to meet all of the demands set by the UHB and Welsh Government to ensure the safety and safeguarding of children and adults at risk that become known to us. This will only be achieved by continuing to work collaboratively with our strategic partners ensuring that communication and decision making is embedded in open, honest and transparent practice.

Acknowledgement is given to all UHB professionals who contributed to this report, thank you.

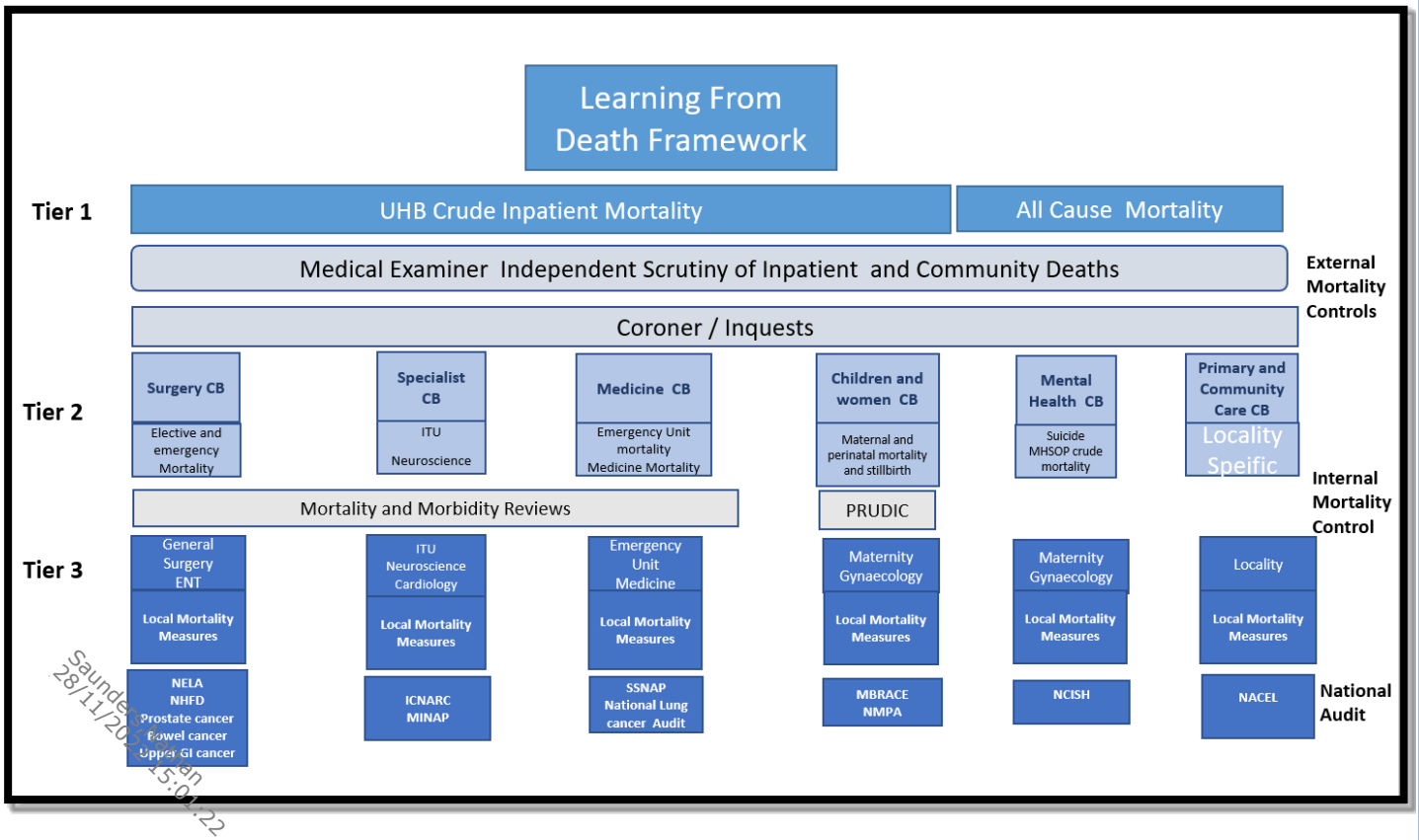
Report Title:	Mortality Indicators			Agenda Item no.	2.10
Meeting:	Quality, Safety & Experience Committee	Public	x	Meeting Date:	29 November 2022
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Executive Medical Director				
Report Author (Title):	Assistant Director of Quality and Patient Safety				

Main Report
Background and current situation:

Approximately 1% of the UK population will die each year and the majority of these deaths will be predicted and are observed in the 75 years and older age range. There are however occasions when health care is a contributory factor in an individual's death and it is Important that health organisations in wales take every opportunity to understand these events and ensure the necessary learning and requisite improvements are in place to optimise patient outcomes and reduce the risk of untoward events.

The Medical Examiner Service in Wales will provide independent scrutiny of all inpatient deaths by spring 2023 and all inpatient and community deaths by Autumn 2023. The learning from these reviews will allow the Health Board to triangulate learning with others sources of mortality information including health board mortality data and national clinical audit data. Fig 1 shows the Learning From Death Framework illustrating the interrelationship between mortality data, clinical audit and the external and internal mortality scrutiny processes.

Fig 1



To support an approach of systematic ward to board reporting and monitoring of mortality, robust and accurate mortality data needs to be made readily available. This will allow the identification of trends and the subsequent triangulation of condition specific mortality data with information from the Medical Examiner. A stratified model of mortality data sub divided into three tiers will allow oversight at:

- Tier 1 -Organisational Level
- Tier 2- Clinical Board Level
- Tier 3- Speciality level

Tier 1 mortality Indicators

It is proposed that the health Board adopts crude all cause and inpatient mortality as a tier 1 mortality indicators.

Crude mortality may hide significant differences between subgroups eg. Age, gender or ethnicity that can be important indicators of inequalities in health. In addition, crude mortality might not be sensitive enough to identify changes in mortality rates in a single specialty, however crude mortality can provide assurance as part of a stratified approach an is an effective measure of significant population everts including, the impact of Covid or influenza and seasonal changes in mortality.

Crude mortality, as illustrated below, compares the number of deaths across the entire population to the average for the same reporting period over the previous 5 years and supports identification of trends above or below this average. The measurement of all cause crude mortality was useful from the outset of covid as a measure of excess deaths relating to the pandemic. Figure 2 illustrates crude all-cause mortality in Cardiff and the Vale of Glamorgan as well as deaths where covid-19 was mentioned on the death certificate.

Fig 2

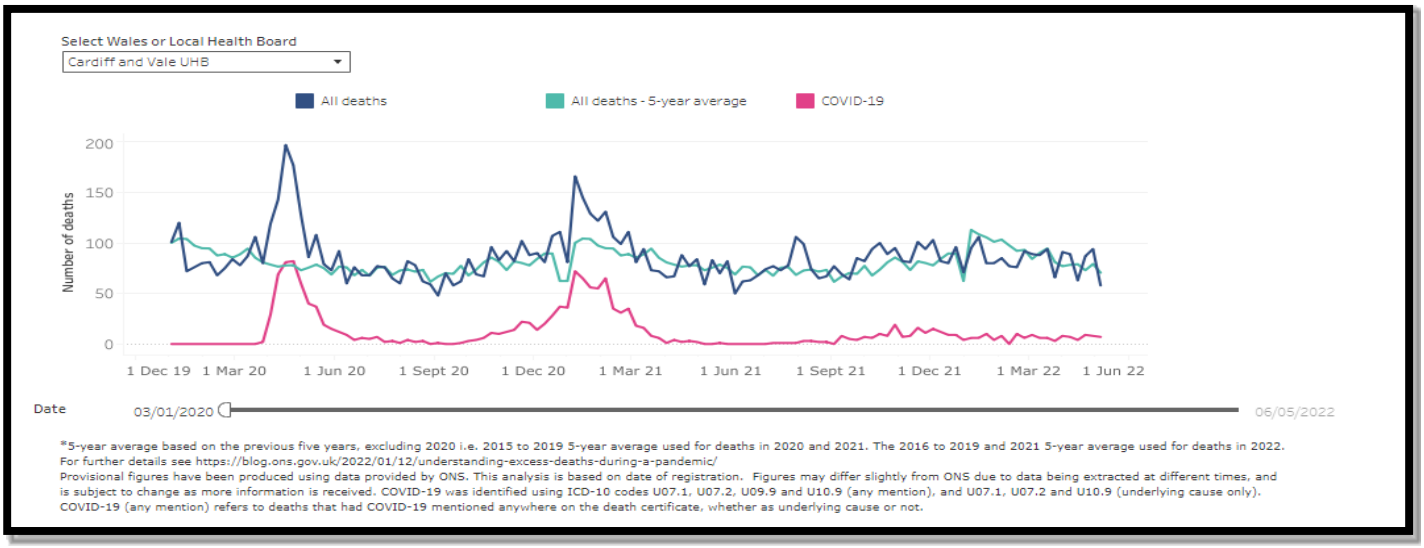
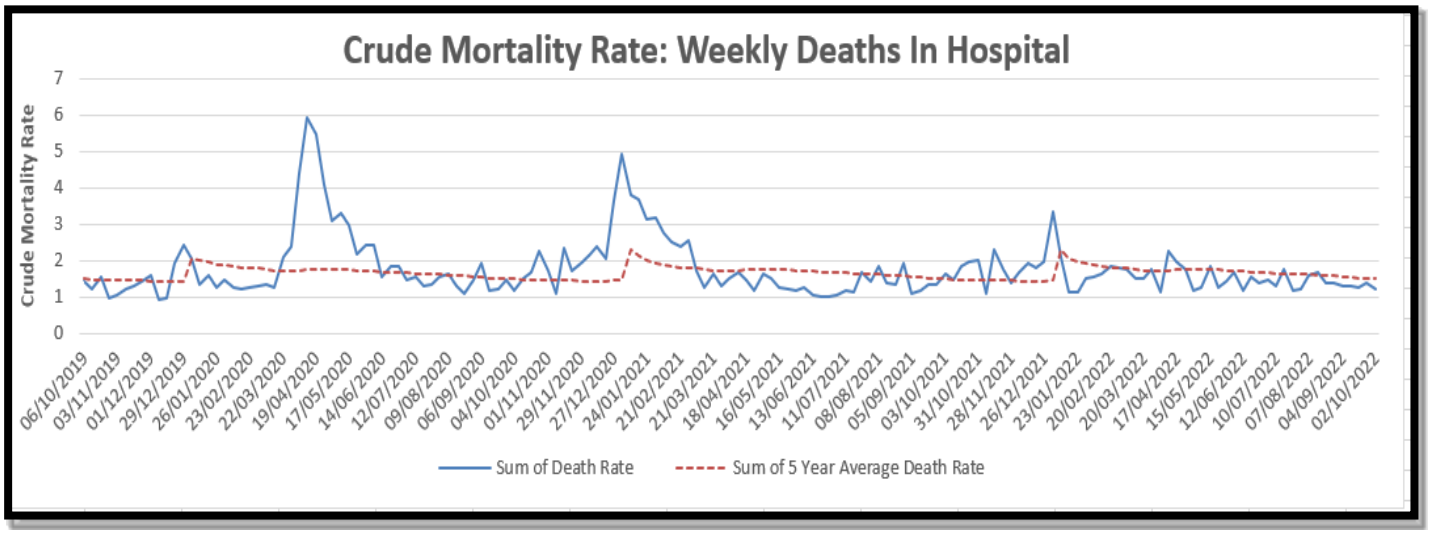


Figure 3 illustrates crude inpatient mortality per 1000 bed days where the denominator is all inpatients in the UHB. The measure illustrates seasonal variation in the five-year average rates with deaths increasing each January.

Figure 3



Tier 2 Mortality Indicators

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

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

Figure 4 illustrates the proposed mortality indicators identified in collaboration with the clinical boards and the Information Department that will allows reporting of Tier 2 mortality data.

Fig 4

Children and Women	Medicine	Mental Health	PCIC	Specialist	Surgery
Maternal mortality	Emergency Department / 10000 attendance	Inpatient Suicide (population measure)	Locality specific mortality	ITU mortality	30 day post elective surgery inpatient mortality
Perinatal Mortality / 1000 births	Stroke Mortality	Learning disability deaths	Preferred place of death	Cardiothoracic mortality	30 post non-elective surgery inpatient mortality
Still Birth / 1000 births	Medicine Crude Mortality	MHSOP Crude mortality		Neurosurgery Mortality	
PICnet (Paediatric ITU)					

Tier 3 Mortality Indicators

Once Tier 2 indicators are established, work will progress to identify appropriate indicators in each Directorate. There are multiple clinical databases in use across the organsiation and mortality data is included in many of these resources. Specialties that benefit from these resources include:

- Emergency laparotomy surgery
- Neonatal Unit
- Intensive Care
- Interventional cardiology
- Renal
- Trauma and orthopaedics

Where an existing mortality measure is not in place, the directorate and quality and patient safety team will work together to develop bespoke measures from CHKS (a health care intelligence system procured by the UHB).

A governance framework will be developed as part of the Learning From Death Framework to support a systematic approach to considering condition / procedure specific mortality in each directorate which will include:

- Systematic reporting of mortality data through directorate quality and patient safety meetings
- Triangulation of mortality data with the medical examiner reviews and Mortality and Morbidity (M&M) reviews and Inquests
- Formal assurance and escalation reporting system from M&M reviews
- Assurance and exception reporting to the Clinical Board Quality and Patient safety meetings.

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

The Learning from Death Framework sets out three tiers of mortality indicators

- Organisational Mortality
- Clinical Board Mortality
- Speciality Mortality

This approach will support proportionate and specific scrutiny of mortality at every level of the organsiation and a system wide approach to learning from death.

Recommendation:

The Committee is asked to:

a) **NOTE** the approach proposed as part of the Learning From Death Framework and the assurance it will provide; and
b) **APPROVE** the proposed Tier 1 Mortality Indicators and to **NOTE** the proposed Tier 2 Indicators

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care	

		sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration	X	Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation : No

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

Saunders,Nathan
28/11/2022 15:01:22

Report Title:	Policies for Ratification			Agenda Item no.	3.1
Meeting:	Quality & Safety Committee	Public	X	Meeting Date:	29/11/2022
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Jason Roberts, Executive Nurse Director and Fiona Jenkins, Executive Director of Therapies and Healthcare Sciences.				
Report Author (Title):	Jason Roberts, Executive Nurse Director				

Main Report
Background and current situation:

A number of policies and procedures have passed their review date. These include;

1. Concerns, Complaints, Claims Policy (UHB 332)
2. Medical Equipment Policy and Procedure (UHB 082)
3. Ionising Radiation Policy (UHB 344)
4. Exposure of Patients to Ionising Radiation Procedure (UHB 345)
5. Radioactive Substances Risk Management Policy (UHB 463) and Procedure (UHB 464)
6. Exposure of Staff and Public to Ionising Radiation Procedure (UHB 465).
7. Venepuncture for non-clinically qualified research staff Policy (UHB 364) and Procedure (UHB 365)

Each of the above policies has been reviewed within the relevant professional meetings and have been agreed there.

Schedule 1 of the Health Board's Standing Orders (paragraph 20 of the Schedule of Matters Reserved to Board) states that the following matter is reserved to full Board *"Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements*". Whilst approval of the Concerns (Complaints) and Claims (Clinical Negligence, Personal Injury and Redress) Policy rests with the Board, the updated Policy is being presented to the QSE Committee for review and to seek recommendation from the Committee for Board approval.

Aside from the Concerns, (Complaints) and Claims (Clinical Negligence, Personal Injury and Redress) Policy (UHB 332), the other Policies and Procedures referred to above are now being submitted to the Quality and Safety Committee for final ratification.

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

No significant changes have been made to these policies / procedures. However, a verbal briefing will be provided in the Quality, Safety Committee for each of the policies by the relevant Executive Director.

Recommendation:

The Committee is requested to:

a) **Ratify** the following attached policies / procedures:-

(i) Medical Equipment Management Policy (UHB 082) and Management of Medical Equipment Procedure (UHB 082);

(ii) Radioactive Substances Risk Management Policy (UHB 463);
(iii) Radioactive Substances Risk Management Procedure (UHB 464);
(iv) Exposure of Staff and Members of the Public to Ionising Radiation Procedure (UHB 464).
(v) Ionising Radiation Risk Management Policy (UHB 344);
(vi) Exposure of Patients to Ionising Radiation Procedure (UHB 345); and
(vii) Venepuncture for non-clinically qualified research staff Policy (UHB 364) and Procedure (UHB 365).

b) **Recommend to Board** that the Concerns, (Complaints) and Claims (Clinical Negligence, Personal Injury and Redress) Policy (UHB 332) be approved.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration		Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
None
Safety: Yes/No
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No
Socio Economic: Yes/No
Equality and Health: Yes/No
Decarbonisation: Yes/No
Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Reference Number: UHB 332 **Version Number:** 3	**Date of Next Review: December 2023** **Reference Number:** T/3

Concerns (Complaints) and Claims (Clinical Negligence, Personal Injury and Redress) Management Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will manage all concerns/claims in accordance with the policy.

Policy Commitment

To provide a transparent, equitable and proactive approach to the management of concerns (Complaints and Claims) to ensure that learning is identified and actioned at the earliest opportunity**.**

Supporting Procedures and Written Control Documents
Other supporting documents are:
Responsibilities & Accountability Framework

Scheme of Delegation
Claims Handling Escalation Procedure
Standing Orders and Standing Financial Instructions
WHC (97) 17 - CN & PI : Claims Handling
WHC (97) 7 - CN & PI: Structured Settlements
WHC (98) 8 – NHS Indemnity – Arrangements for Handling CN Claims against NHS staff
WHC (99) 128 – Handling CN Claims: Pre-Action Protocol
WRP Claims Management Standards (April 2007)
WRP Reimbursement Procedure & other Procedures
Civil Procedure Rules 1998
Putting Things Right Regulations 2011 (Guidance amended November 2013)
Public Service Ombudsman Model Complaints Handling Policy

Scope

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

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has / has been completed and this found there to be a positive. No key actions have been identified

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 Concerns Department

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	13/09/2016	11/10/2016	New Policy superseding UHB 107,108,109
2	*18/12/2020*	*tbc*	Review following PSOW model complaints handling Policy WRP changes

1. POLICY STATEMENT

1.1 This document describes the Policy of the Cardiff and Vale University Health Board for the management of concerns (Complaints and Claims) made against the Health Board.

1.2 Both the human costs of things going wrong and the financial costs of providing redress are powerful incentives for effective risk management. It is acknowledged that funds that are spent on addressing and compensating could otherwise contribute to the continuous improvements of healthcare services and working environments. Therefore, this Policy forms an integral part of the Health Board's Risk Management Strategy and is intrinsically linked into the Health Board's systems for managing and learning from adverse incidents and complaints.

1.3 The Health Board aims to deal with all concerns made against it proactively, in an equitable, efficient and timely manner.

1.4 The Health Board will adopt a common and standardised approach in dealing with complaints, litigation claims for both clinical negligence and personal injury. The Health Board aims to gather all evidence as quickly as possible and, where liability is admitted, will seek to negotiate settlement in the shortest possible time therefore minimising unnecessary legal costs.

For complaints refer to appendix A for process

Claims

1.5 The Health Board will defend claims where appropriate. It will make every effort to resolve a claim before the issue of court proceedings and will explore the option of alternative dispute resolution methods when appropriate. However, where formal legal action or Court proceedings is required the Health Board will ensure that it conducts its defence of the Claim in a fair and timely manner, ensuring that legal costs are incurred appropriately and proportionately.

1.6 The Health Board acknowledges the importance of the claims management process within its organisation and will ensure that the process is supported by a robust escalation policy. The weekly executive meetings enable the timely consideration of identified legal cases.

1.7 The Health Board will comply with the Pre-Action Protocols laid down by the Civil Procedure Rules in dealing with all legal claims ensuring a constructive and open approach to claims that reduces delays and costs and the need for formal legal proceedings.

1.8 The Health Board is committed to learning lessons from claims to ensure the continued improvement in standards of patient and staff safety and services.

2. INTRODUCTION

2.1 This Policy has been produced in accordance with the references contained in Appendix 1 for the management of the following:

- clinical/medical negligence claims;
- personal injury claims;
- Redress claims

It does not cover Employment or Estates issues.

2.2 The Health Board has a legal duty of care towards those it treats, together with members of the general public and its staff. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the Health Board.

2.3 For a claim to be successful, a claimant must prove:

- that he/she was owed a duty of care;

- that the duty was breached;
- that the breach of duty caused, or contributed materially to, the damage in question; and
- that there were consequences and effects of the damage.

2.4 The Limitation Act 1980 requires that claims be made within three years of the date of the incident or three years from the date a claimant became aware that he/she had suffered from an episode of negligence. With minors, the three-year limitation period becomes effective once they have reached the age of 18. However, there are no time limits for people with a disability who cannot manage their own affairs. Claims exceeding the three-year limitation period can, however, still be brought against the Health Board at the discretion of the Court or by prior agreement to a moratorium of the three year limitation period

3. DEFINITIONS

The following provide definitions for clinical negligence, personal injury.

3.1 Clinical/ Medical Negligence

"A breach of duty of care by members of the health care professions employed by NHS bodies or by others consequent on decisions or judgments made by members of those professions acting in their professional capacity in the course of employment, and which are admitted as negligent by the employer or are determined as such through the legal process."

3.2 Personal Injury

"Any disease or impairment of a person's physical or mental condition."

4. RESPONSIBILITIES

4.1 The Chief Executive is the Board member with overall responsibility for issues relating to clinical negligence and personal injury and for keeping the Health Board informed of major developments. This responsibility has been delegated to the Executive Director of Nursing.

4.2 All Executive Directors and Clinical Board Directors, Directors of Nursing and Directors of Operations have delegated accountability and responsibility within their designated areas for the implementation and adherence to this policy.

4.3 The Concerns Managers are accountable to the Executive Nurse Director via the Assistant Director of Patient Experience for the management of claims for ensuring

compliance with the policy, including compliance with delegated authority limits and for securing the most cost-effective resolution of claims.

4.5 All members of staff are encouraged to report adverse incidents, including those that may lead to claims for compensation, in line with the Health Board's promotion of a just, blame free culture and in line with the new duty of candour coming into force in 2023

4.6 Staff also have a duty towards the Health Board in the investigation and, where appropriate, defence of all claims and will assist all claims staff, as necessary during the claims management process.

4.7 Approval of this strategic Claims Management Policy will rest with the Health Board or delegated committee; although the approval of subsequent claims management procedures setting out the detailed operational arrangements for complying with this policy will be delegated by the Health Board to the appropriate committee.

5. DELEGATED LIMITS

Delegation of Out of Court Settlement

5.1 The Health Board acknowledges that the Welsh Assembly Government has delegated its responsibility for the settlement of claims to a limit of £1 million to the Health Board and that the Health Board continues to exercise this discretion subject to satisfaction with minimum requirements and standards:

- That it adopts a clear policy for the handling of claims which satisfies the requirements of WHC(97)17
- That the requirements of WHC(97)17 form the basis of the procedure for the day to day management of claims.

Internal Delegated Limits

5.2 The Health Board has formal delegated responsibility from the Welsh Assembly Government for the management of clinical negligence and personal injury claims valued up to £1 million.

5.3 The levels of delegated authority within the Health Board are those contained within the Health Board's Scheme of Delegation.

6. USE OF LEGAL ADVISORS

6.1 The Health Board will use legal advisors in the defence or settlement of significant clinical negligence and personal injury claims. Small to moderate value claims of modest complexity may be managed in-house by the Health Board's Redress Team/Concerns/Claims Managers. The legal process of claims will be managed by NWSSP: Legal and Risk Services.

6.2 Where external legal advice is sought, the Health Board will retain the responsibility to direct its solicitors in respect of liability admission, defence, settlement and general strategy. However, the Health Board will always take due account of qualified legal advice in making such decisions. Legal advice will cover:

- Liability and causation; with the exception of some redress cases
- An assessment of the strength of the available defence and probability of success;
- The likely valuation of quantum of damages including best and worst case scenarios; and:
- Estimates of legal costs for claimant and defendant

6.3 For claims managed in-house, advice will be provided by the Health Board's Concerns Managers. In all such cases, advice will be recorded on the case file satisfying the same requirements for the provision of legal advice as are set out in paragraph 6.2 above.

6.4 The decision to settle a claim or to continue with its defence will be on the basis of legal advice of Counsel and/or Legal and Risk Services, in conjunction with Concerns Managers.

7. THE ROLE OF THE CONCERNS/ CLAIMS MANAGERS

7.1 The Health Board will employ dedicated Concerns Managers, who can demonstrate sufficient experience in the management of Clinical Negligence and Personal Injury claims.

7.2 The Concerns Managers will be required to demonstrate on-going updating and continuing professional development in the area of claims management.

7.3 There must be demonstrable communications, as necessary to achieve the objectives of WHC(97)17 for effective claims management.

7.4 The Concerns Managers will ensure that all members of staff and/or their line managers involved in a claim are kept informed of the progress and outcome of the claim.

8. REPORTING REQUIREMENTS

8.1 The Health Board delegates its responsibilities to the Concerns, Claims and Compliments assurance group, the duly authorised committee. The group will receive and review quarterly progress reports on the management and status of claims against the Health Board, in the format specified by WHC (97)17.

8.2 The delegated committee will receive a quarterly report, reporting upon comparative issues.

8.3 The Terms of Reference of the delegated committee as the duly authorised Committee will reflect its role in relation to claims.

8.4 The Executive Nurse Director retains responsibility for claims management within the Health Board and will ensure that the Health Board is kept informed of significant and major developments.

8.5 It is acknowledged that where a claim has been identified as a Patient Safety Incident but that it was not previously reported through the incident reporting process, the Health Board will ensure that a procedure exists which is set out in the Claims Management Written Control Document, to support the objective that the person with responsibility for Risk Management within the Health Board, is informed, and a retrospective report is sent to the National Patient Safety Agency by the National Reporting and Learning System as appropriate following a review.

8.6 The reporting requirements relating to the reimbursement process managed by the Welsh Risk Pool

8.7 The reporting requirements to the Welsh Assembly Government are set out in this policy.

9. CLAIMS MANAGEMENT WRITTEN CONTROL DOCUMENT

9.1 The Health Board will ensure that a Claims Management Written Control Document is developed which supports and embraces the objectives contained in this Policy and WHC(91)17.

10. INVOLVEMENT OF STAFF

10.1 The Health Board recognises that the co-operation of all staff involved in the incident leading to a claim is crucial to the early collation of information to that case. The Health Board will ensure that staff are encouraged to support the Concerns Managers and any duly appointed legal advisors, in the handling of that claim. All staff are required to fully and openly co-operate with the investigation of any legal claims and to comply with this Policy and the Claims Management Written Control Document.

10.2 Once a claim has been received, the Concerns Managers will establish an objective account of the original incident at the earliest available opportunity.

10.3 Unless there are exceptional circumstances, any member of staff asked to do so should provide the Concerns Managers with a witness statement and information regarding the investigation of the relevant claim in a timely manner.

10.4 The Health Board recognises that providing a statement and giving evidence can be a stressful experience and will ensure that full support and guidance is provided to members of staff who are asked to give evidence on behalf of the Health Board.

10.5 The Health Board will support an escalation procedure to be contained in the Health Board's Claims Management Written Control Document to secure this objective.

10.6 The Health Board will take full responsibility for managing and, where appropriate, settling claims in clinical negligence cases, meeting all its financial obligations and will not seek to recover any costs from health professionals. In very exceptional cases, where the health professional was legally found to be acting outside of his/her remit, the matter will be referred to the appropriate Clinical Board or Executive Director.

11. NUISANCE CLAIMS

11.1 The Health Board will not settle claims of doubtful merit, however small, purely on a 'nuisance' value basis. Similarly claims will not be inappropriately defended.

11.2 The decision to settle a claim will always be based upon an assessment of the Health Board's legal liability and the risks and costs associated with the defence of that claim, including the prospects of recovering those costs in the event that the defence is successful.

12. REPORTING OF CLAIMS TO WELSH ASSEMBLY GOVERNMENT

12.1 **Novel, Contentious or Repercussive Claims**

The Concerns Managers will monitor the nature and type of claims received to highlight any claims which are considered to be novel, contentious or repercussive. In such cases the Concerns Managers will liaise with the designated Solicitors/Legal Advisors, to ensure that the Welsh Assembly Government are duly made aware or advised. The Director of Governance and Communications will be kept informed throughout.

12.2 **Claims Exceeding the Delegated Authority**

The Concerns Managers will ensure that any claims with damages estimated to exceed the Health Board's delegated authority of £1 million are reported to the Welsh Assembly Government and prior approval is obtained in advance of liability being conceded and the claim being settled.

12.3 The Annex form will be signed by the Clinical Board lead, Executive Nurse Director and /or Chief Executive prior to the matter being reported to the Welsh Assembly Government and a copy will be presented to the Quality and Safety Committee for information purposes only.

13. DATABASES

13.1 The Health Board will maintain a Claims Handling database via datix :

- The Health Board's claims data-base will contain the information given in the Claims Management Written Control Document. All Clinical Negligence and Personal Injury claims will be entered onto the database by the Legal Services Manager or by an authorised member of staff.

- The Health Board will ensure that patient and staff confidentiality is maintained.

14. LINKS BETWEEN CLAIMS, COMPLAINTS, INCIDENTS AND OTHER RISK INFORMATION

14.1 The Health Board recognises the need for close connections between risk management, complaints, incidents and the management of claims. It appreciates

the need for close and co-operative working between these functions and will ensure that appropriate linkages are in place to facilitate this objective.

Linkages

14.2 Adverse incidents or outcomes which could lead to a claim for negligence should be identified and reported to the Concerns Managers at the earliest possible opportunity, either through the provision of a serious incident report sent to the Welsh Assembly Government or Regional Office or by the provision of the relevant documentation.

14.3 The Concerns Managers will work together to identify complaints which involved potential breaches of the legal duty of care by the Health Board. An appropriate investigation will be undertaken to enable the Health Board to adopt a pro-active stance to the management and resolution of potential claims identified through the complaints procedure. Never events will be discussed with the concerns team to establish if redress is appropriate for early and effective litigation resolution.

14.4 Appropriate systems will be established by the appointed deputy, to enable the lead members of staff for complaints, risk and claims to meet on a regular basis through an appropriate forum to ensure the identification of any trends and remedial action that may be required. Appropriate and relevant staff will then implement any recommendations arising from complaints, claims, experts' reports and investigations.

14.5 The Claims Handling Database system identifies where a potential claim has previously been reported as an incident or complaint. This facilitates the gathering of information to comply with the relevant Pre-Action Protocols.

Committee Structure

14.6 Summaries of claims and trends will be routinely provided for information and management action as necessary to such committees as requested.

14.7 The special losses panel will routinely report the value and incidence of Claims, payments to the Audit Committee.

Controls Assurance

14.8 The Concerns Managers are the Lead Officers for the Welsh Risk Management Standard for Claims Management and are responsible for provision of the evidence against this standard which relates to matters within their jurisdiction.

15. LEARNING LESSONS FROM CLAIMS AND IDENTIFYING CLAIMS FROM INCIDENTS AND COMPLAINTS

15.1 The Health Board is committed to learning lessons from claims, complaints and adverse incidents.

15.2 It is important that wherever possible lessons are learnt following an incident. It is the responsibility of Concerns manger to ensure that any lessons learnt from claims are communicated to the relevant staff in the Clinical Board structure and that any action plans are implemented and monitored in a timely manner.

15.3 The Health Board, via the Clinical Boards, will ensure that a formal process and procedure to support the learning of lessons, monitoring of implementation of lessons learned, evaluation of the efficacy of lessons learned and thereafter the auditing of each component, is developed.

15.4 The Concerns Managers will identify the potential for 'learning lessons' from claims. This information will be routinely reported to the appropriate committee in accordance with the formal procedure for learning lessons as set out in the Claims Management Written Control Document.

15.5 The Concerns Managers will identify the potential for the use of alternative dispute resolution before considering litigation. In addition, the established NHS Complaint's procedure will be used to ensure that patients receive, where appropriate, an apology and a full explanation of what went wrong to reduce the potential for complainants to take legal action to achieve such a remedy.

15.6 The Concerns Managers will produce an Annex form Checklist and an associated Action Plan for all claims exceeding the Health Board's excess of £25,000. This will be used as the basis for learning, monitoring and evaluating the efficacy of the lessons learned from claims.

16. LIAISON WITH THE WELSH RISK POOL

16.1 The Health Board is assessed annually against the Welsh Risk Pool Standard for Claims Management.

16.2 The Health Board will comply with the various rules and procedures of the Welsh Risk Pool. The Concerns Managers will ensure the Health Board's adherence to the same.

16.3 The Concerns Managers will report details of claims settled with a quantum of under £25,000 to the Welsh Risk Pool using the LFER (Learning from events report)

form or such other format as may be required by the Welsh Risk Pool. For matters of Redress, all matters where a qualifying liability has been established a LFER will be due, regardless of quantum.

16.4 In order to be reimbursed by the Welsh Risk Pool, the Health Board is required to submit a CMR (case management report), Costs Schedule and Annex form Checklist, in a format consistent with that set out in the Welsh Risk Pool reimbursement procedures.

16.5 The Health Board acknowledges that the Welsh Risk Pool will periodically undertake reviews of claims managed by the Health Board. The Health Board will ensure the co-operation of its members of staff with such reviews through the development of a formal review process to be contained in the Claims Management Procedure.

17. NHS REDRESS ACT 2006

17.1 The Health Board appreciates and is committed to the objectives of the NHS Redress Act 2006 which provides for the development of a small value clinical negligence scheme for Wales.

17.2 The Health Board will undertake such action as it deems appropriate to support the introduction of such a scheme following the development of detailed regulations and which will be included in its Claims Management Procedure.

REFERENCES

This Policy complies with the following references:-

- The Civil Procedure Rules 1998
- WHC(97) 7 – Clinical Negligence and Personal Injury Litigation: Structured Settlements
- WHC(97)17 – Clinical Negligence and Personal Injury Litigation: Claims Handling
- WHC(98)8 - NHS Indemnity – Arrangements for Handling Clinical Negligence Claims against NHS Staff
- WHC(99)128 – Handling Clinical Negligence Claims: Pre-Action Protocol
- The Welsh Risk Pool Claims Management Standard (April 2007)
- The Welsh Risk Pool Reimbursement Procedure and other Procedures
- The Health Board's Standing Orders and Standing Financial Instructions

Documents to be read alongside this policy:

- UHB Claims Handling Statement of Intent
- UHB Claims Handling Policy & Procedure
- UHB Scheme of Delegation
- Claims Handling Escalation Procedure
- Standing Orders and Standing Claims Handling
- UHB Responsibilities & Accountability Framework
  Financial Instructions
- WHC (97) 17 - CN & PI : Claims Handling
- WHC (97)17 CN & PI: Structured Settlements
- WHC (98) 8 – NHS Indemnity – Arrangements for Handling CN Claims against NHS Staff
- WHC (99) 128 – Handling CN Claims: Pre-Action Protocol
- WRP Claims Management Standards (April 2007)
- WRP Reimbursement Procedure & other Procedures
- Civil Procedure Rules 1998

Review CLAIMS HANDLING PROCEDURE INDEX

1. PRE-LITIGATION PROCEDURE

1.1 Reporting and investigation of incidents (see Appendix 1: Flowchart – Claims Procedure)

The principal benefit of untoward incident reporting is that it provides a means of identifying claims at an early stage. In practice, years can pass between the date of medical treatment, giving rise to a claim or accident and a letter of claim, or a request for disclosure of medical notes and records. In the interim, key witnesses could have moved away or have little recollection of any particular case over and above the contents of a note or usual practice.

Early investigation into circumstances surrounding an alleged breach of duty is essential if the chances of successfully defending a claim are to be increased. In addition, work carried out at this stage is an investment if viewed as a means of identifying problem cases where an early conclusion would minimise legal costs.

Completion of the incident report should be undertaken as soon as practicable after the incident occurs and all the requisite documentation should be completed as comprehensively as possible, signed by the reporting officer and providing all relevant information and details of witnesses.

All witnesses should be asked to provide a statement to include those named in the incident report and other relevant parties. The manager should not simply rely on the names of witnesses given by the injured person but should make their own investigations to find out whether or not other witnesses exist. Brief statements should be taken from the witnesses and should include details of the witnesses name, address and job description and all information relevant to the allegation. There should be an investigation of the site of the incident, for example in slipping/tripping cases the location of the incident should be considered along with the floor surface or ground in question. Investigations should be carried out as to

whether or not there have been previous incidents or complaints and consideration should be given to obtaining photographs of the area at an early stage.

In relation to manual handling claims or incidents the risk assessment, injured persons training record and availability of other staff to assist with the manoeuvre should be obtained and considered. Particular note should be made of exactly who was on duty at the time and who could have been contacted.

The patient's details should be considered if injury were caused as a result of lifting or assisting a patient, with details of the patient's dependency level at the time of the incident should also be considered.

Consideration should be given to any possible element of contributory negligence on the part of the injured person.

The Concerns Manager should be notified immediately of any reported incidents or complaints that could potentially result in a claim.

2. DEFINITIONS

2.1 Timescale for bringing a claim

A patient contemplating an action must act relatively promptly. The general rule is that all actions for clinical negligence or personal injury must be brought within three years of the infliction of the relevant injury or the date of knowledge of the injury.

This is known as the limitation period and is laid down in the Limitation Act l990. In the case of a minor the three-year period runs from the date that the child attains the age of l8. The claimant must demonstrate that it is more likely than not that his or her deterioration in health or the injury complained of, resulted from the negligence of the defendant.

2.2 Clinical Negligence

Clinical negligence is defined by the Welsh Risk Pool (hereinafter referred to as the WRP) as: -

"A breach of duty of care by members of the Healthcare Professions (including medical practitioners, nurses and midwifes, professions allied to medicine, laboratory staff and relevant technicians) or by others consequent on decisions of judgments made by members of those professions acting in their professional capacity on relevant work, and which are admitted as negligent by the employer or are determined as such through the legal process."

In as much as a breach of duty of care is alleged, the Health Board will need to seek legal advice in individual cases. In general terms however, the following must apply before liability for negligence exists: -

- There must have been a duty of care owed to the patient by the relevant professional(s)
- The standard of care appropriate to such duty must not have been attained and therefore the duty breached whether by action or inaction, advice given or failure to advise
- It must be demonstrated that the breach caused the injury and therefore the resulting loss about which the patient complains
- The loss must have been reasonably foreseeable

2.2.1 Private work

Consultants providing care under private arrangements with their patients, or Consultants or other clinical staff treating patients in connection with voluntary work or "Good Samaritan" act, are not covered by these arrangements or the WRP. Instead, consultants or other clinical staff should take out their own medical defence insurance. However, the WRP cover does apply where medical or other staff working under their NHS contract provide care for a consultant's private patients.

Any incident arising as a result of private work, which involves other staff, facilities or equipment, must be reported in the usual way.

2.3 Personal injury

Personal injury litigation can be defined as action taken (often through solicitors) by an individual who has sustained an accident or contracted a condition as a consequence of alleged exposure to a harmful substance and **not** as a result of clinical intervention, treatment or lack of treatment. The Health Board receives such claims from staff, visitors and patients who have suffered an injury related to the premises. The majority of cases brought against the Health Board are union funded and the union solicitors will inevitably advise the claimants. In the absence of legal advice a claimant can of course bring a claim without legal assistance, known as a 'litigant in person'. This occurs rarely. For the purpose of this document, reference will be made to claimants who are being represented by solicitors. Not every incident gives rise to litigation, but for those incidents that do, it is essential that the Health Board have in place a co-ordinated system that firstly examines issues of liability and causation which ultimately results in a claim being settled or defended. If the claimant is unable to adduce sufficient evidence to prove his or her case, a further possibility is that the claim may be discontinued.

To be successful, the claimant must prove, on the balance of probabilities (i.e.>51%) the following three things:

- That the Health Board had a duty of care to staff, visitors or patients to ensure that every precaution is taken to prevent personal injury
- That the duty of care had been breached by not complying with any standards set to safeguard the person

- That the breach of duty caused the damage to the person

2.4 Pre Action Protocols

The claimant or his/her solicitors should provide full details of the intended claim pursuant to the Pre Action Protocols contained in the Civil Procedure Rules, which arose from Lord Wolf's Access to Justice Report (July 1996). The Pre-Action Protocols were introduced on all proceedings that commenced after 26 April 1999 and impose challenging targets for the Health Board. The only way to avoid increased litigation costs and court imposed financial penalties is to ensure that a clear view about any alleged incident is reached quickly and effectively. This requires commitment from all staff involved to report adverse incidents and to respond quickly and clearly to allegations.

A detailed response to the letter of claim must be given within 4 months. These Protocols encourage early exchange of and full information to be given about a claim, with a view to trying to avoid litigation by agreeing a settlement before the commencement of proceedings. If the claim cannot be agreed, proceedings are issued and a claim form and particulars of claim are served upon the Health Board (unless an extension is agreed for service of the particulars of claim). This document sets out the details of the allegations against the defendant/Health Board, together with a medical report as to the claimant's condition and statement (or schedule) of special damages (financial loss said to have been suffered as a consequence of injury and future losses). The Protocols support efficient management of proceedings where litigation cannot be avoided.

2.5 Methods of reaching a settlement

Every effort should be made to discuss and negotiate settlement prior to court proceedings. This may include:

- Mediation/face to face discussion with the claimant regarding the claim
- Early evaluation of the claim by legal expert
- Internal arbitration
- Determination by an expert
- Alternative Dispute Resolution

3. HANDLING CLINICAL NEGLIGENCE CLAIMS

3.1 Notification of a claim

There are several ways in which the Health Board may be notified of a claim:

- Letter of claim
- Letter of Notification
- Request for medical records from a solicitor where it is stated that action against the Health Board is contemplated
- Verbal

- During the complaints process
- Direct contact

3.2 **Initial stage of the claim**

When notification of a claim is received, usually in the form of a letter of claim, and it is stated that there is a potential or actual threat of litigation as a result of negligence; certain action will then need to be undertaken immediately. An assessment of the claim is required to ascertain what information will be required.

The claim will be acknowledged in an appropriate manner within 14 days, using the standard form letter available for use at the relevant time. The Health Board's solicitors are also notified, and formally requested to act on behalf of the Health Board, usually by sending to them a copy of the letter of claim.

3.3 First steps

Upon receipt of the claim for compensation, the details must be entered onto the Claims database. The database is the Health Board's own record of new and ongoing claims and must be maintained and updated throughout the life of the claim.

The following information is recorded:

- Name of claimant
- Name of second person, if the claim is on behalf of a child or patient who has died
- Unique reference number
- Type of claim
- Whether it is a Health Board or Health Authority claim
- Whether the claim has previously been the subject of an internal complaint
- Whether a clinical adverse incident form was completed at the time of the event
- Date of incident
- Date of letter of claim
- Directorate and specialty
- Ward or department
- Consultant
- Other Consultant or named staff
- Allegations
- Injury sustained
- Claimant's Solicitors
- Stage of the claim
- Quantum damages
- Quantum costs
- Compensation recovery unit
- Estimated date of settlement
- Compensation paid including interim payments

- Actual costs - claimant and defendant
- Additional costs

The former Health Authorities were abolished on the 31st March 2003. Powys Local Health Board has responsibility for accounting for the residual liabilities arising from legal claims against the former Health Authorities. Management is directly by the WRP on behalf of Powys HB.

Any queries in relation to these procedures should be directed either to the WRP's Senior Claims Support Officer or Finance Development Officer.

A file is then created to keep the documentation relevant to the claim such as:

- Correspondence to/from the Health Board's solicitors
- Risk management issues
- Copies of proceedings and expert opinions
- Witness statements
- Internal correspondence
- Financial documents

3.4 Information required at the start of the claim
The standard information required at the start of the claim and the reasons for this, are detailed below:

a) Full names and titles of all staff involved
It is useful at the outset if the consultant/manager in charge of the patient's care can list the staff involved so that statements can be obtained from all necessary parties.

b) Identity of the Doctors' defence organisations and membership numbers
Doctors no longer need to subscribe to a recognised defence organisation following the guidance given in circular WHC (89) 70. However, many doctors still pay a lower rate subscription to a defence organisation for personal advice. It is often found that the junior medical staff involved in treatment, which is later the subject of a legal claim, are no longer in post. If the Health Board has no forwarding address, the defence organisation can be engaged to locate Doctors and obtain statements when required.

c) Two copies of the case notes
When considering whether the claimant has a claim in respect of negligence, the patient and his legal advisors will clearly benefit by gaining access to the patient's notes, reports and X-rays and other test records. Disclosure of the records can be mutually beneficial to the other side and the Health Board, as a claim is often found to have no merit or an individual's actions may be exonerated. Money and effort can be saved by prompt disclosure.

Upon receipt of the medical records, the Concerns/Claims Managers shall check that the records are complete. Once copied, the notes shall be checked to ensure that the standard of photocopying is satisfactory and that the information is appropriate.

At the start of a claim, two copies of the claimant's case notes are required for use by the Health Board's solicitors - disclosure to the "other side's" solicitors (if an authority to disclose has been obtained) and for a nominated expert adviser. The copy notes should be made available within 40 days of the letter of claim, if practicable to do so.

Delays in the initial investigation of a claim are often caused by the poor standards of photocopied case notes, which are disclosed to the "other side", and criticism is often aimed at the presentation, clarity and format of copy case notes. It is therefore helpful if staff could ensure that they make comprehensive legible entries in the case notes, use a black pen at all times and ensure that case note sheets are filed in chronological order.

d) One copy of any relevant X-rays

X-rays form part of the medical records and are usually asked for in the list of documents requested from the claimant's solicitors. These will be disclosed through the Health Board's solicitors. Additional sets may be required depending on how many expert reports are commissioned.

e) View of the Consultant concerned upon the disclosure of the case notes to the other side's expert advisors

The Consultant will need to give his/her views upon the disclosure of case notes as soon as possible. If disclosure is not given promptly the claimant may apply for a court order requiring the Doctor or the Health Board to disclose any records or notes likely to be relevant in forthcoming proceedings under Section 33 of the Supreme Court Act l981 or under the Access to Health Records Act 1990 / Data Protection Act 1998. If an application is made for pre-action disclosure then additional costs may be incurred.

However, in view of the effects of the Access to Health Records Act 1990 / Data Protection Act 1998 and subsequent Welsh Assembly Government clarification, objections to disclosure of the case notes can only be made where there is something in the notes that could cause serious mental or physical harm to the patient or a third person, as defined in the relevant legislation.

f) Initial statements from the identified staff regarding their involvement in a claim

The Health Board will require co-operation if cases are to be defended. Statements will therefore be required to assist in investigating or defending a claim. Failure

without good cause to provide a statement could result in the Health Board being unable to defend an allegation of negligence.

At the start of each claim it is necessary that good preliminary reports be obtained from **all** the staff involved. Such statements, if adequate, provide invaluable information as to whether a claim has any foundation and its future management can be assessed. Until such statements are received it is difficult to proceed past the investigatory stage of a claim.

It is necessary, therefore, that the staff concerned, are informed of a claim as soon as possible and a copy of the claimant's solicitors letter outlining allegations is made available to them.

g) Member of staff with primary involvement
The member of staff who has primary involvement will need to be identified so that s/he can provide a detailed report.

h) Views of the clinical board as to whether he/she considers the claim to have any merit.
The Clinical Director and Consultant responsible for the patient should be informed about the claim by way of notice, with relevant documents attached. The Clinical Director and/or the Consultant will need to provide a preliminary report outlining the background of the case, involvement of his/her department as a whole, guidance on any areas of importance, identify the staff involved and finally offer any views as to whether the claim has any merit.

i) Any other background information
Any additional information available surrounding a legal claim, such as previous documentation at a complaints stage or untoward incident report should be considered.

3.5 Escalation procedure
Should the Concerns/Claims Managers encounter difficulties in obtaining comments from any members of the Health Board's staff, the matter shall be escalated to the attention of the, Clinical Board Director, Director of Nursing or Director of Operations If there is still difficulty in obtaining comments, the Concerns/Claims Managers will escalate matters initially to the assistant director of patient experience and ultimately the lead Executive will be informed.

3.6 Progress of the claim – expert advice
The claimant's claim will be reliant upon expert testimony to prove negligence. Expert medical evidence can be obtained to comment on many issues including causation, condition and prognosis and life expectancy. When a suitable expert has

been determined, the lead Clinician involved in the litigation claim will be invited to approve the appointment.

The Health Board may also wish to commission its own expert reports, particularly in relation to multi-track claims, which may lead to conflicting accounts as to the proper standard of care in the procedure in issue. In certain circumstances the Health Board may agree to the use of a joint expert. Given the complexity of clinical negligence claims, reports from Counsel are sometimes sought by the Health Board's legal advisors to consider the future management of the claim and to comment specifically on issues relating to liability and quantum.

The Clinical Board and lead Clinician shall be kept updated as to the progress of the claim at all times.

3.7 Assessment of the claim

An assessment of the claim will need to be made by the Concerns Manager and Health Board's solicitor, by examining expert legal and medical reports and the views of the staff involved. Although the views of the staff directly involved are considered, it is not appropriate that they are involved in the decision making process as this requires an independent role. These will need to be authorised by the concerns team staff, a second Executive Director, and Chief Executive.

Health Board approval will be sought as required. A broad guideline to the information usually required is:

- An objective account of the incident
- An explanation of the basis and background of the claim
- The views of the Welsh Government if the case involves novel, contentious or precedent setting issues
- A balanced view of the likely defence, including legal and medical opinion when available
- Clarification of the basis on which damages have been estimated
- A legal opinion of the likely outcome of any court hearing
- Assessment of quantum including, if applicable, the reason for the proposed settlement
- An estimate of the possible savings for the public purse if a payment is made
- Details of the proposed approach to negotiations with the claimant, including the initial offer and proposed upper limit
- Details, where applicable, of structured settlements/periodical payments
- Details of any systematic failings on the part of; the clinical or other front line staff, operational or risk management procedures, claims handling staff or claims handling procedures. If so, what action is intended to remedy the identified deficiencies, including the timetable for implementation of any

changes or improvements and identify how the proposed improvements will be monitored

3.8 Settle or defend

Upon receipt of the Health Board's instruction, the Health Board's solicitors will either prepare the case for Court or attempt to secure a settlement, which can either be accompanied by an admission of liability on a "without prejudice" basis.

4. HANDLING PERSONAL INJURY CLAIMS

4.1 Notification of a claim

There are several ways in which the Health Board may be notified of a claim:

- Letter of claim
- Verbal
- During the complaint process
- Direct contact

4.2 Initial stage of the claim

When notification of a claim is received, usually in the form of a letter of claim, and it is stated that there is a potential or actual threat of litigation as a result of an alleged breach of duty of care, then certain action will need to be undertaken immediately. An assessment of the claim is required to ascertain what information will be required. The claim will be acknowledged in an appropriate manner within 21 days, using the standard form letter available for use at the relevant time. The Health Board's solicitors are also notified, usually by sending to them a copy of the letter of claim.

4.3 First steps

Upon receipt of the claim for compensation, the details must be entered onto the claims database.

The database is the Health Board's own record of new and ongoing claims and must be maintained and updated throughout the life of the claim.

The following information is recorded:

- Name of claimant
- Name of second person if the claim is on behalf of a child or patient who has died
- Unique reference
- Type of claim
- Date of letter of claim
- Whether a clinical adverse incident form was completed at the time of the event

- Date of incident
- Date of letter of claim
- Department
- Location of incident
- Head of department
- Witness names
- Brief description of incident
- Injury sustained
- Claimant's solicitors
- Stage of the claim
- Quantum damages
- Quantum – claimant's and defendant's costs
- Compensation recovery unit
- Estimated date of settlement/closure
- Compensation paid including interim payments
- Actual costs - claimant and defendant
- Additional costs

A file is then created to keep the documentation relevant to the claim such as:

- Correspondence to/from our solicitor
- Risk management issues
- Copies of proceedings and expert opinions
- Witness statements
- Internal correspondence
- Financial documents

4.4 Action to be taken and information to be gathered

The standard action and information required at the start of the claim and the reasons for this are detailed below:

a) Notify the appropriate Clinical Board lead requesting, amongst other things:

- Incident documentation (report and check list)
- Accident book entry
- RIDDOR form
- Initial witness statements
- Documented training (if member of staff)
- Initial investigations
- Details of the patient (if involved)
- Photographs and plans
- Documentation re: repairs, staffing levels etc.
- Details of previous similar incidents
- Risk assessment
- Local procedures and protocol

- Personnel file (if member of staff)
- If the action concerns a member of staff, write to the Payroll Department, seeking details of the claimant's earnings and statutory sickness details
- Establish contact with the Head of Risk Management, seeking details as to any investigation or review undertaken in respect of the incident, establishing an objective account of the original incident, ascertaining the incident has been duly reported:
- Adverse Incident Report
- All meetings with complainants/Claimants can be audio recorded and a copy of the recording provided to all parties

Documentation to be accessed to include, but not limited to;

- Datix
- RIDDOR
- Ad Hoc Reports
- Risk Register

If not so reported, the Concerns/Claims Managers will link with the Risk Manager to ensure that a retrospective report is presented to the NPSA upon any and all Claims/Incidents as of 1st January 2004.

b) Notify the Compensation Recovery Unit, if the case is being dealt with internally.

c) Obtain Emergency Unit cards.

d) Ask the claimant to sign a form of authority for the release of his/her GP notes, Medical Notes, X-rays and Occupational Health Records

e) If the claimant's solicitors request copies of the A&E, hospital notes or X-rays, obtain the claimant's signed form of authority for the disclosure of these notes to the solicitors and check the quality and accuracy of the photocopied records before sending them to the solicitors (see 3.4.c).

f) Review the Directorate's response to the standard letter, payroll information and further information from the claimant's solicitors and obtain any further comments/statements required.

g) Establish an objective account of the original incident, which gives appropriate weight to the recollection of the staff originally involved.

h) At this stage, a decision will be made by the Executive Nurse Director or Concerns/Claims Managers regarding the handling of the claim internally or by reference of the file to one of the firms of solicitors duly appointed by the Health

Board. For the purpose of this document, reference will be made to the Health Board's solicitor.

4.5 Gathering the evidence

Staff should be aware that certain type of information is subject to confidentiality. In the past, statements have been received from staff, which makes reference to patients and their medical conditions. This is of course confidential to the patient.

In cases where staff have injured themselves when lifting a patient, it is usual for the claimant's solicitors to seek information in respect of the patient, normally the care plan, giving details as to weight and medical condition. The Health Board's legal **advisor** will ensure that any information will be subject to the removal of the patient's identification details thus anonymising the records.

It is a legal requirement, once legal action has been initiated, that we are bound to disclose any notes, memoranda etc. that relates to a specific incident that were in existence prior to the commencement of an action. It is therefore essential to instigate and maintain a system, which will ensure the ability to file and recall appropriate records.

The claimant's solicitors may request access to an area where their client allegedly sustained their accident. Whilst this request cannot normally be denied, it is important to place the request in the context of the proceedings. For example, if the Health Board's position in respect of liability and causation is a foregone conclusion in favour of the claimant then an inspection of the site in question would be an unnecessary addition to the costs of the action.

Where a site inspection has been agreed, the name of the appropriate contact officer should be given to the Concerns/Claims Managers or Health Board's solicitors, who will relay this information to the claimant's solicitors.

Should equipment be involved in an accident, this will have to be retained for inspection, if practicable, and if not, appropriate steps should be taken to provide a brief note as to its reason for disposal. Although not every accident leads to litigation, some incidents will prompt the senior manager responsible to ask for photographs to be taken, which of course will aid the Health Board, should the claim be initiated at a future date.

4.6 Expert evidence

Expert advice, such as engineer or medical evidence can be obtained to comment on many issues including liability, causation, condition and prognosis and life expectancy.

The Health Board may also wish to commission its own experts reports, particularly in relation to multi-track claims, which may lead to conflicting accounts as to the

proper standard of care in the procedure in issue. In certain circumstances the Health Board may agree to the use of a joint expert. Given the complexity of some claims, in particular clinical negligence claims, the Health Board's solicitors to consider the future management of the claim and to comment specifically on issues relating to liability and quantum and will seek advice from Counsel when appropriate. The Clinical Board shall be kept updated as to the progress of the claim at all times.

4.7 Assessment of a claim

Following the receipt of the evidence, the Health Board's solicitors will provide an initial assessment and valuation of the claim, together with recommendations for future management within four months of the notification of the claim if possible. Although the views of the staff directly involved are considered, it is not appropriate that they are involved in the decision making process. This requires an independent assessment of the available evidence and a consideration of the Health Board's position on the balance of probabilities.

The Health Board's solicitors will then prepare a summary of the claim by examining expert legal and medical reports and the views of the staff involved. A broad guideline as to the information usually required is:

- An objective account of the incident
- An explanation of the basis and background of the claim
- The views of the Welsh Government if the case involves novel, contentious or precedent setting issues
- A balanced view of the likely defence including legal and medical opinion when available
- Clarification of the basis on which damages have been estimated
- A legal opinion of the likely outcome of any court hearing
- An assessment of quantum including, where applicable, the reason for the proposed settlement
- An estimate of the possible savings for the public purse if a payment is made
- Details of the proposed approach to negotiations with the claimant (Including the initial offer and proposed upper limit)
- Details, where applicable, of structured settlement/periodical payments
- Details of any systematic failings on the part of clinical or other front line staff, operational and risk management procedures, claims handling staff, claims handling procedure. If so, what action is intended to remedy the identified deficiencies, including the timetable for implementation of any changes or improvements. It should also be identified how the proposed improvements will be monitored

4.8 Settle or defend

Depending on each individual case, the Health Board's Solicitor may be able to conclude the matter swiftly or else seek further expert opinion from suitably qualified

experts. If the Health Board's solicitors advise that the allegations cannot be defended, then authorisation for an out of court settlement will be sought within

delegated limits and agreed levels of authority. Alternatively, the Health Board's solicitors will prepare the case for court.

5. COURT PROCEEDINGS

Should court proceedings be commenced in relation to clinical negligence or personal injury claims, the Health Board's solicitors shall take the following actions:

5.1 The procedure

a) Claim form and particulars of claim

The claim form and particulars of claim will be served either directly on the Health Board or the Health Board's solicitors, together with the acknowledgment of service. The acknowledgement of service must be filed within 14 days, indicating whether the claim is to be defended. If the claim is to be defended a defence must be filed within 28 days of service of the particulars of claim.

Therefore, it is essential that any information requested is supplied promptly and forwarded without any unnecessary delays to the Concerns/Claims Managers for onward transmission to the Health Board's solicitors.

b) Development of a case

Court proceedings will be run in accordance with the Civil Procedure Rules and directions given for the conduct of the action at any Case Management Conferences.

c) Directions

- **Disclosure**

The parties to an action will have to serve Lists of Documents giving details of all documentary evidence relevant to the claim, not including those documents, which are privileged. Such documentation would include incident reports, risk assessments, claimant's training records, occupational health records etc.

- **Exchange of evidence**

The parties to the action will have to exchange witness evidence, to include lay witness and medical or other expert evidence prior to the trial.

Exchange of witness evidence is carried out on a simultaneous basis so each side receives the others evidence at the same time. The court at a Case Management Conference determines the time frame.

d) Trial/settlement

Following the completion of the above stages, the claimant will seek to push the matter towards trial, unless a decision is made by the Health Board to settle the

claimant's case or, on rare occasions, the claimant discontinues his/her action against the Health Board.

In readiness for the final hearing, the Concerns/Claims Managers shall arrange for the Health Board's witnesses to attend court and ensure that they have been briefed about court procedure.

The Health Board's position is determined after careful consideration of the evidence by the Health Board's solicitors, backed up by an opinion from Counsel, if necessary. The Health Board will request advice as to the likelihood of successfully arguing, on the balance of probabilities, that the Health Board was not liable for the claimant's injuries. At this stage it may be necessary to arrange a conference to include officers of the Health Board, usually the Concerns/Claims Managers, with the required level of Executive authority, the Health Board's legal advisors, experts, Counsel and witnesses in order to consider the available evidence and make a decision on the best options available to the Health Board.

Depending upon the level of quantum, the decision as to whether or not to proceed to trial or negotiate a settlement will be made by the Executive Nurse Director or the Board itself, depending on the level of delegated authority required. Upon receipt of the Health Board's instructions, the Health Board's solicitors will either prepare the case for final hearing or attempt to secure a settlement which can either be accompanied by an admission of liability or on a without prejudice basis. Once a decision is taken to settle a claim, the Health Board is committed to payment of those damages to the claimant, whether or not the Health Board admits liability.

On the advice of the Health Board's solicitors, the Health Board may wish to make a payment into court (Part 36 payment). This would protect the Health Board's position should the claim proceed to Trial.

6. CLAIMS HANDLING - GENERAL INFORMATION

6.1 The role of the Health Board's Solicitors

Once the Health Board's solicitors have been notified of a claim, they will then act on the Health Board's behalf in conducting the claim as set out above. They will keep in regular contact with the Concerns/Claims Managers and give an expert opinion of the strengths and weaknesses in the Health Board's defence. The solicitor shall also keep the Concerns/Claims Managers fully briefed on all stages of the claim throughout its lifetime.

6.2 Authorisation

a) To take certain action

Authorisation may be requested at any time during the life of a claim. This may be for:

- Authority to admit liability

- Authority to take certain action
- Authority to make an offer of settlement
- Authority to settle damages or costs for a certain amount

To obtain authority to take certain action, all the authorised signatories must sign an 'Authorisation Request Form' which is supported by evidence and then retained on the Health Board's claim file. All claims of £1 million and over have to be submitted to the Welsh Assembly Government for approval.

b) To make payments
Payments may be requested at any time during the life of a claim. These may include:

- Fees to expert witnesses
- Fees to Counsel
- Payments into court
- Interim/full and final settlements of the claimant's damages and costs
- Legal fees to the Health Board's solicitors (Personal Injury Cases)

A request for authority to make a payment is made on a 'Finance Request Form' to which the invoice/request for payment is attached. All the authorised signatories must sign this form. The form is then handed to the Finance Analyst who arranges for the cheque to be issued and then forwarded to the Concerns/Claims Managers for distribution. The Health Board's file must have a copy of the finance request form showing all required signatures.

6.3 Delegated financial limits
It is the responsibility of the Board to agree the circumstances, including delegated financial limits, in which various requests may be approved by authorised signatories being:

a) The Chief Executive,
b) The Board itself
c) The Executive Directors
d) Other

6.4 Structured settlements/periodical payments
At times, it may be appropriate for alternatives to a single lump sum payment to be considered.

In the event of a lump sum award, it is assumed that the claimant invests the money in a suitable mix of equities, gilts and cash and pays for the care costs out of these investments. These investments are subject to taxation and professional fees. A lump sum, prudently invested, will provide regular income for the claimant. However, there is also the possibility that the money awarded runs out before the claimant

dies. In this case it is assumed that the claimant falls back on the State who pays for their care costs although it is recognised that Free State care may not compare with that purchased by the claimant.

A structured settlement (which is a periodical payment funded by an annuity) is an alternative to a lump sum payment made to a claimant. A structured settlement involves a number of payments at different times in the future. The amount of money required at the present time to provide these payments in the future is known as the present value of the future payments. A structured settlement allows for part of the damages to be paid in the form of annual tax free instalments for the duration of the claimant's life.

The courts are now able to order structured settlements for future loss and care costs without the consent of the parties. It also gives the Lord Chancellor a power to enable such awards or agreements to be varied under specified circumstances, and prevents the assignment of the right to receive payments unless the court is satisfied that there are special circumstances, which make this necessary.

The structured settlement may be for the life of the claimant, for a specified period or of a specified number or minimum number or include payments of more than one of those descriptions. If the recipient of a structured settlement dies, the payments will cease. Therefore, there is a chance that the next payment may not be made. Each year, there is a chance that the recipient of the periodic payment could die. In high value claims a large proportion of the compensation is associated with future loss as a result of the injury. The Health Board will provide these payments either by means of an Annuity backed structured settlement or a self-funded structured settlement. Welsh Assembly Government guidance (WHC (97) 17) states that structured settlements must be considered for any settlement of £250,000 or more.

The Health Board will depend upon the guidance of its legal advisors and the finance department as to whether to enter into a structured settlement.
In the event that a structured settlement is considered/may be made, the Health Board should notify the WRP as soon as possible. This is essential as the WRP is responsible for setting up and maintaining the structured settlement schedule of payments once agreed by the Court. Once the claim has been settled and the Court has approved the structured settlement, the court order should be submitted to the WRP within 14 days of the order being approved.

Structured settlements are administered in the main by the Health Board's solicitors, Legal and Risk Services.

6.5 Quantum reports

On a quarterly basis the Concerns/Claims Managers shall prepare an up to date quantum report, which shall be forwarded to the WRP and to the finance department. The report will give quantum figures to enable the finance department to calculate

the Health Board's total liabilities and also probability of loss. The quantum may change during the course of the claim. The following information will also be noted by reference to the numbers 1-5.

Probability of loss

1 - 95%-100% certain
- The Health Board has been proven negligent and will have to compensate

2 - 50%-94% Probable
- There is evidence of negligence, but the Health Board may be able to prove some contributory negligence on the part of the Claimant or extenuating circumstance

3 - 06%-49% Possible
- The Health Board has a good defence and may be able to defend the claim

4 - 0%-06% Remote
- The Health Board has not been found to be negligent and the Claimant has no case

5 – 0%-06% Remote
- The Health Board has not been found to be negligent and the Claimant has no case

6 - TETA – (Too Early To Assess) – a new claim that is too early to assess

On receipt of quantum reports the Concerns/Claims Managers shall confirm the current status of the claim to ensure that it is active. Consideration should be given to the closure of a file if it has been inactive for a period of 18 months.

7. WELSH RISK POOL (WRP) REQUIREMENTS

The WRP requires notification of any claim that is estimated to cost more than the Health Board's excess (£25,000). On receipt of the quantum reports from the Health Board and solicitors, on a quarterly basis, the WRP will be updated as to any revaluation or new claims handled by external or in-house solicitor other than the Legal and Risk Services that may result in a claim against the WRP.

The Concerns/Claims Managers have a duty to:

- Notify the WRP of all claims that are settled
- Claim reimbursement from the WRP within 4 months of the final payment on the file being made with the minimum of delay

All claims on the WRP should be made on the appropriate forms. On receipt of the form, the WRP may request additional information. It should also be noted that the claim file might be requested by the WRP for audit purposes.

Claims against the WRP can only be made after the claim has been concluded and the full costs have been paid. However, following an interim payment in excess of £100,000, an immediate claim can be made against the WRP.

The Concerns/Claims Managers and Finance Analyst will work together to ensure that the Health Board complies with the calendar and financial requirements of the WRP, thereby aiming to ensure the efficacy of the Health Board to validate dates, payments made, and reimbursement requests as accurate, appropriate and within the required time parameters.

Welsh Risk Pool Assessments

The WRP periodically undertakes detailed reviews of a sample of claims received by the WRP Advisory Board for reimbursement. The purpose of these reviews is to consider the way in which the claim has been managed with emphasis placed upon the lessons learned and the local procedures that are now in place. The WRP will share the lessons learnt via the networks within the NHS organisations in Wales.

The Concerns/Claims Managers will ensure that upon any request from the WRP for a detailed file review, that access is available, but not limited to, the following:

- Claims File
- Clinical Records
- Policies and Procedures
- Site visit if required
- Directorate staff
- Any or all parties involved in the Claim
- Audit Reports
- Health Board Report etc.

The Concerns/Claims Managers will ensure that all parties are involved in the Claim. All clinical Boards are notified of the Assessment, date, time and venue, and are available for interview if so required. You must ensure that any documentation or any changes instigated since the claim are available for the Assessors review.

Upon conclusion of the Assessment, the WRP Assessor will provide a draft report for comment; the Concerns/Claims Managers will review the said report, consult with Directorate staff and will provide the WRP Assessor with any comments or further information as required, prior to the finalisation of the WRP report.

7.1 Financial Limits and the requirement of an LFERform

a) Claims not exceeding £1,000 and discontinued claims

There is no obligation to complete an LFER form in relation to claims where quantum **(damages, claimant's and defendant's costs combined)** does not exceed £1,000

or on claims that have been discontinued. The completion of a LFERin relation to these claims is at the Concerns/Claims Managers' discretion.

b) Claims exceeding £1,000 but not exceeding £25,000
LFERs are to be undertaken on all concluded claims where quantum has exceeded £1,000.00.

c) Claims exceeding £25,000
Detailed LFER's are required whenever quantum on a case exceeds £25,000 on acceptance of liability. These are to be submitted to WRP no later than 60 working days after acceptance of liability.

The Finance Analyst must be informed of the commencement of the LFER.

7.2 Procedure for the reimbursement of claims exceeding £25,000
The following documentation should be completed by the Concerns/Claims Managers Litigation, in conjunction with the Finance Analyst, special losses and submitted to the Welsh Risk Pool (WRP) for claim reimbursements:

- WRP1 claim form
- CMR
- U2
- Schedule of Costs

a) **WRP 1** claim –

This form should be

- An original form
- Signed by an authorised signatory
- Completed in typeface as handwritten forms will not be accepted
- All areas of the claim form should be completed including
- The Claimant's full name including fore name and surname to enable a full search for previous payments
- The name of the lead clinician involved in the claim
- Identify correctly the health body who is the Defendant to the claim especially where the claim relates to a former health authority

b) LFER/Category 7 Checklist

In accordance with WHC (97) 17, Health Boards and Local Health Boards are required to complete a LFERdetailing the nature of the incident, its context, the manner in which it was handled as a claim and changes that have been made to reduce future risk. This is the LFER. The key areas of the LFER that are reviewed include the remedial action taken to prevent future occurrences and areas where

lessons may be learnt. The nature of the alleged negligence should therefore be suitably detailed, as should the breaches of duty of care, to enable the sufficiency of the remedial action to be assessed.

The LFER should satisfy the following conditions:

- It must be typed, as handwritten LFER will not be accepted
- It must be signed by authorised signatories, one of whom must always be the Chief Executive

c) Schedule of Costs

A detailed schedule of the costs incurred by the Health Board or health body (i.e. pre Health Board claims), should be attached to the completed WRP 1 claim form.

The schedule should include the following:

- The date that the payment was made
- To whom the payment was payable
- The description of the payment i.e. what it was for
- Where a former health authority has previously managed the claim, the health body that incurred the costs should be specified.

It is also recommended that schedules should have a cumulative running total of expenditure. To ensure compliance of the WRP reimbursement procedures, the Health Board will be required to make a declaration that all items are net of recoverable VAT on each schedule presented.

7.3 Authorised Signatories

Claims for reimbursement can only be considered for approval if authorised signatories have signed the WRP 1 claim form, LFER and CMRThe WRP stipulate that member organisations must supply the WRP manager with sample signatures of at least 3 officers with delegated responsibility for authorising such claims in accordance with the organisation's standing financial instructions. It is the responsibility of all member organisations to update authorised signatories in the event of personnel changes and to ensure that the schedules supplied to the WRP are in accordance with their own standing financial instructions and schemes of delegation. The Chief Executive must always be one of the signatories on the LFER. Where a health body is aware that its Chief Executive is not going to be available for any reason in the long term, and appoints an Acting Chief Executive, the Acting Chief Executive can complete the signatories forms indicating that he/she is acting up and thereafter may sign the LFER as Acting Chief Executive.

7.5 Reimbursable Costs – Health Board excess is at £25,000.00

Costs associated with losses will be reimbursed by the WRP subject to compliance with the WRP reimbursement procedures.

Any VAT incurred on costs that can be reclaimed by the Health Board, interest earned from payments into Court or any costs recovered from a claimant, should be deducted from the amount claimed for reimbursement.

Where the WRP has reimbursed the Health Board, any monies returned to the Health Board by either the Courts or the Compensation Recovery unit must be paid back to the WRP within 14 days of its receipt.

7.6 Timing of Reimbursement Claims

Requests for reimbursement must be presented to the WRP Advisory Board, notification of the meeting dates are provided periodically by the WRP. It is preferable that reimbursement claims are submitted 10 days before the due WRP Advisory Board meeting date. Any claims received later than the cut off date will be submitted to the next Advisory Board meeting.

Again, the Concerns/Claims Managers Litigation will contact the WRP by e-mail, within 7 days of forwarding, to confirm their receipt of the said request. WRP acknowledgements to be retained on file accordingly.

7.7 Interim Claims

The Health Board is obliged to submit an interim claim for reimbursement for any claim on which the cumulative balance of all payments, disbursements, costs etc associated with the claim, total £100,000.

The interim claim must be submitted within 56 days of this figure being reached, even where this precedes the resolution of costs. The excess for interim claims for all NHS Health Boards is £50,000.

In the event that a claim is received by the WRP, after 56 days of the expenditure totalling £100,000.00, a penalty will be imposed.

When the unclaimed balance (including the interim excess) again reaches £100,000, a further interim claim should be made. This should continue until the claim is finally concluded.

The excess reverts to the standard £25,000 upon conclusion of any claim.

The Health Board must submit a final claim for reimbursement within 4 months of the case being resolved and the costs being paid in full. Any claims for reimbursement submitted outside of this timescale will be penalised in accordance with WRP provisions.

Claims subject to an outstanding appeal to the Compensation Recovery Unit (CRU) should be considered as a final claim, rather than await determination of the CRU appeal. Following a successful CRU appeal any monies received should be remitted back to the WRP as a Post Closure item.
This is to be monitored by both the Finance Analyst and Concerns/Claims Managers to ensure compliance.

Once again, the Concerns/Claims Managers is to contact the WRP by e-mail, within 7 days of forwarding, to confirm their receipt of the said request. WRP acknowledgements will be retained on file accordingly.

7.9 Penalties
Where a claim for reimbursement is submitted outside of the timescale, will not be paid and the if the delay has been with the Clinical Board thy will be liable for the full cost of the settlement

7.10 Concluded claims: accepted date of closure
The above 'trigger point' practice is also adopted when claims reach their conclusion. The date considered as the final 'done date' is the date of the last cheque request for payment of costs etc., (irrespective of whether they are claimant or defence costs).

The date of settlement is the date the Health Board agreed the terms of the settlement and a cheque request for the amount agreed is prepared and duly authorised. The settlement date is not to be considered as the date when cheques are received from the finance department.

7.11 LFER process
The Concerns/ Claims managers will complete the appendix form within 60 working days of making an admission of liability. The Clinical Board will be given time to complete the lesson learned and provide the supporting evidence. The form will then be checked, finance information provided and shared with the Welsh Risk Pool.

7.12 Request for further information and resubmission of rejected claims If insufficient information is provided in the LFER form, the Advisory Board will request further information. This can delay reimbursement to the Health Board and the Board could reject the claim.

7.13 Post closure payments and receipts
The Health Board may receive late invoices in respect of expert fees and other costs after a claims file has been closed and a final reimbursement has been made by the WRP.

For payments made, the WRP will reimburse the additional amount, provided it is satisfied that all reasonable steps were taken by the Health Board to complete all financial transactions prior to submitting a final claim.

The Health Board will need to make a claim using the following documentation:

- WRP 1 claim form
- Updated Schedule of Costs
- Photocopy of the original LFER

7.14 Notifying the WRP of other claims
In accordance with WHC (2000) 12, the Concerns/Claims Managers is obliged to notify the WRP Manager of the following:

a) WRP 2 Forms
Any existing claim which is likely to become subject to a claim for reimbursement. The WRP acknowledges that it now has available to it, financial information relating to the value of claims from Legal and Risk Services,therefore, this requirement now only relates to claims, which are handled by either external or in-house solicitors, i.e. those other than Legal and Risk Services. In all such claims, which are likely to exceed excess, the Health Board must lodge a WRP 2 form with the WRP. Failure to notify the WRP of the existence of such a claim, may result in the WRP Advisory Board rejecting the claim.

b) WRP 3 Forms
All claims settled below excess should be notified to the WRP on WRP 3 Forms.

c) WRP4 Forms
WRP 4 forms must be completed and submitted to the WRP by the Legal Services Manager on all claims in excess of £1,000.00 to £30,000.00. The Legal Services Manager sends a hard copy of the signed WRP 4 form to the Finance Analyst.

8. CONCLUSION OF THE CLAIM

8.1 Closed files
There are several ways in which a claim may be closed:

- Discontinued
- Formally withdrawn
- Statute barred
- Settlement
- Nothing further heard

Where settlement has been made, the closure of a claim will include settlement of the claimant's costs. It will also include payment of the Health Board's defence costs

and any other outstanding fees. The database should be updated to show the date of closure and the outcome of the claim.

8.1 Closure of files

The Finance Analyst must be advised of the closure of all claims with a monetary value. An Annex form is e-mailed to the Finance Analyst, to enable this information to be recording onto LASPAR. The Finance Analyst also receives a copy of the WRP 4 form.

8.2 Notification to the relevant parties to the claim

At the conclusion of a claim, the Concerns/Claims Managers shall advise the others involved in the Claim, of the outcome of the claim; that the claim is to be closed and thank them for their kind assistance.

8.3 Reviewing files at conclusion

a) Lessons learnt

When the Concerns/Claims Managers identifies or is notified that a claim has been closed, a decision will be made upon whether the preparation of a further LFER is appropriate. This decision is based upon Welsh Risk Pool requirements as set out above or, if LFER is not required in accordance with WRP requirements, whether it is felt that the matter has progressed to a stage that a LFER is justified.

The Concerns/Claims Managers will review all closed files. Once the LFER has been completed or a decision has been made to close the file without a further, the following actions will be undertaken:

a) The Concerns/Claims Managers will review the file and decide whether to prepare an action plan, identifying the failures, lessons learnt, action to be taken, evidence and audit.

b) If an action plan is appropriate, the Concerns/Claims Managers will then speak to the Clinical Board or other relevant member of staff with conduct of the claim to review the action plan in relation to the failures identified, lessons learnt, action to be taken, evidence and audit.

c) The member of staff with conduct of the claim will then provide the Legal Services Manager with the name of the individual who is responsible for the action and due date.

d) The Concerns/Claims Managers will then finalise the action plan and send a copy to the individual with responsibility for the action, noting the due date.

e) The Lead Officers Group shall consider the action plan and further recommendations may be made. If this is the case, the Legal Services Manager

f) Shall discuss these with the member of staff with responsibility for the claim, as set out above.

g) The Concerns/Claims Managers will enter the action plan into a bring forward system with a view to monitoring compliance with the due date and collating evidence in relation to each action.

h) Once each action has been addressed and evidence in relation to each action has been collated, the Concerns/Claims Managers will then provide the member of staff with conduct of the complaint with a completed action plan for display/circulation to all staff within the Directorate.

- Facilitating and promoting change within the organisation through the development of the lessons learnt process
- Receiving progress reports on current and recently closed litigation reports
- Receiving annual litigation reports

At every meeting the group will consider in detail the failures identified, lessons learnt, actions to be taken and relevant audits in relation to all relevant claims that have been concluded within the period since the Group last met.

In relation to each claim the Group shall consider the following documents:

- Case Synopsis
- Action Plan
- Concluded action plan together with any relevant documentation in relation to actions taken
- Concluded audits

Having considered the case synopsis and action plan, the group shall:

- Decide whether the failures identified, lessons learnt and actions to be taken are satisfactory
- Decide whether any additional failures, lessons learnt and actions can be identified and make recommendations for amendments to the action plan
- Consider whether the claim should be referred to the Clinical Audit Department for consideration and if so, identify the nature of the audit to be undertaken

It will be noted on all claims files whether a claim has been referred to the Lead Officers Group and if so, the outcome of that referral.

9.2 Compensation Recovery Unit

The rules concerning the repayment of benefits to the Compensation Recovery Unit (CRU) have recently changed under the provisions of the Social Security (Recovery of Benefits) Act l997.

The main points from the Act are as follows: -

- The new rules apply to all claims settled on or after the 6th October l997, including claims arising out of accidents prior to 1st January 1989 which were not covered by original Compensation Recovery Scheme
- The current small payment exemption for compensation of £2,500 or less will no longer apply from the 6th October l997, and the CRU must be informed of all claims and a Certificate of Total Benefit obtained before settlement.
- The Health Board repays the full amount of recoverable benefits to the CRU
- No benefits may be taken from the claimant's general damages i.e. those damages paid for compensation for pain and suffering, loss of amenity, loss of congenial employment
- The Health Board will only be able to reduce the compensation payable to a claimant where DSS benefits have been paid for the same reason that compensation has been awarded e.g. Statutory Sick Pay and Sickness Benefit may be deducted from the compensation award for loss of earnings resulting - from the relevant accident

The new legislation will remove the possibility of a small nuisance settlement in cases where a large amount of benefits has accrued. Further, should the benefits to be repaid to the CRU exceed the special damages claim, the Health Board will have to repay the full amount of benefit to the CRU as well as general damages awarded to the claimant, which will remain ring fenced. This will increase the Health Board's outlay from the present position whereby any benefits to be recovered in excess of special damages would be recouped from general damages. The Director Governance & Communications' role in this process is limited. Any documentation received will need to be sent to the Health Board's legal advisor for action.

9.4 Criminal Injuries Compensation Authority

The Board entertains applications for payments of compensation where the applicant has sustained personal injury attributable to a crime of violence. As with personal injury claims these will only be considered if made within three years of the incident, giving rise to injury. Minor injuries are excluded (i.e. where awards would be less than £1,000 after the deduction of benefits received). A person can simultaneously pursue the Health Board and the Compensation Board, but the individual will not recover a payment in duplicate.

Appendix A

Complaints Standards Authority – Wales
Concerns and Complaints Policy for Public Services Providers in Wales

This model policy is designed for public services providers in Wales. It represents a minimum standard of complaint handling for public bodies in Wales.

The Policy is fully compatible with the Welsh Language Standards Regulations of 2018.

Please note that NHS bodies in Wales adhere to the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, known as 'Putting Things Right'.

When the content of this policy conflicts with the Putting Things Right regulations, the Putting Things Right regulations will take precedence, including when references are made to timescales.

Also, the Social Services Complaints Procedure (Wales) Regulations 2014 outline the procedure for handling complaints about Social Services issues in Wales.

A Model Concerns and Complaints Policy Cardiff and Vale UHB has reviewed our process in line with the Model Concerns Policy

Cardiff and Vale UHB is committed to dealing effectively with any concerns or complaints you may have about our services. We aim to clarify any issues you may be unsure about. If possible, we'll put right any mistakes we may have made. We will provide any service you're entitled to which we have failed to deliver. If we did something wrong, we'll apologise and, where possible, try to put things right for you. We aim to learn from our mistakes and use the information we gain from complaints to improve our services.

When to use this policy

When you express your concerns or complain to us, we will usually respond in the way we explain below. However, sometimes you may have a statutory right of appeal so, rather than investigate your concern, we will explain to you how you can appeal. Sometimes, you might be concerned about matters that are not covered by this policy *[e.g. concerns relating to other organisations, matters which are not related to direct or indirect Patient Care, employee relation matters, issues which are best managed via the police]* and we will then advise you about how to make your concerns known.

This policy does not apply to 'Freedom of Information' or data access issues. Please contact *[insert relevant contact details]*.

Complaints Team staff can advise on the type and scope of complaints they can consider.

Asking us to provide a service?

If you are approaching us to request a service, this policy doesn't apply. If you make a request for a service and then are not happy with our response, you will be able to make your concern known as we describe below.

Informal resolution

If you are unhappy with the treatment or care you are receiving, we would encourage you to raise your concerns as soon as possible, preferably to senior staff on duty at the time of the incident or the appropriate ward, hospital or community manager. Alternatively, please contact a member of the Concerns Department and they will be happy to discuss your concerns with you and pass them on to the relevant department.

How to express concern or complain formally

You can express your concern in any of the following ways:

The Concerns Office is open between the hours of 9 am to 5 pm (7 days per week) Please call on the following telephone numbers in office hours if you wish to speak with a member of the Concerns Team.

- **029 218 36318**
- **029 218 36319**
- **029 218 36323**
- **029 218 36340**

For BSL users the phone line is accessible via sign live https://youtu.be/Ygxdvhl9X4E please see the video explaining the service.

You can also fill in our **Concerns Form**, e mail the team at concerns@wales.nhs.uk or write to us at Chief Executive, Cardiff and Vale University Health Board, Maes y Coed Road, Llanishen, Cardiff CF14 4HH.

Other than in exceptional circumstances, a complaint should be made as quickly as possible in relation to the problem arising. If there is a good reason why the complaint cannot be made sooner, it may still be possible to investigate your concerns, as long as no more than a year has passed. We may exceptionally be able to look at concerns which are brought to our attention later than a year. However, you will have to explain why you have not been able to bring it to our attention earlier and we will need to have sufficient information about the issue to allow us to consider it properly. In any event, we will not consider any concerns about matters that took place more than three years ago.

Concerns Form - Manylion am y pryder.doc (*Word, 130Kb*)

Once the complaint form has been completed you can either send it by email to: concerns@wales.nhs.uk (you will receive an e mail acknowledgement within two working days), or by post to:

Chief Executive
Cardiff and Vale University Health Board Headquarters

Woodland House
Maes y Coed Road
Cardiff
CF14 4HH

You may submit a complaint on behalf of someone else. However, the Health Board will have to ask for permission/consent from the person involved (if they are aged over 18 and have capacity) to investigate the issues raised.

We would encourage you to contact the Complaints Department in the first instance to try and achieve a timely and informal resolution to your concerns. If you are not happy with any informal course of action, then you will still be able to submit a formal complaint.

You will receive an acknowledgement letter within two working days of receipt of your formal complaint. This letter will provide you with contact details of the Complaints Co-ordinator who is processing your complaint. If you have any questions, please feel free to contact this person.

The aim is for you to receive a written response to your complaint within 30 **working** days. However, if a more in-depth investigation is required, the Health Board can take up to 6 months to complete its investigation.

In exceptional circumstances an investigation may take longer than 6 months. On occasions, we may ask you if you wish to meet with members of the clinical team who will discuss your complaint with you. This can be prior to, during or following the investigation.

We place great importance on any feedback we receive and the way in which we manage and investigate concerns you may have. By understanding why our patients have cause to complain, we can improve the quality of care and treatment provided to anyone using our services.

If you would like to provide feedback following raising a concern with us please complete the form below and send in an email to the above address.

Concerns Feedback Form.doc (*Word, 98Kb*)

We aim to have concern and complaint forms available at all of our service outlets and public areas and also at appropriate locations they are available with leaflets in all of our Information Centres in the main entrance of the hospitals and at our main reception desks.

What if there is more than one body involved?

If your complaint covers more than one body (another Health or social care provider) with your consent *we* will usually work with them to decide who should take the lead in dealing with your concerns. You will then be given the name of the person responsible for communicating with you while we consider your complaint.

If the complaint is about a body working on our behalf you may wish to raise the matter informally with them first. However, if you want to express your concern or complaint formally, we will look into this ourselves and respond to you.

Investigation

We will tell you who we have asked to look into your concern or complaint. If your concern is straightforward, we'll usually ask somebody from the relevant service area to look into it and respond to you. If it is more serious, we may also use someone from elsewhere. We will set out our understanding of your concerns and ask you to confirm that we are right. We'll also ask you to tell us what outcome you're hoping for.

The person looking at your complaint will usually need to see the files we hold relevant to your complaint. If you don't want this to happen, it's important that you tell us.

If there is a simple solution to your problem, we may ask you if you're happy to accept this. For example, where you asked for a service and we see straight away that you should have had it, we will offer to provide the service rather than investigate and produce a report. We will aim to resolve concerns as quickly as possible and expect to deal with the vast majority within 30 working days *[if appropriate, bodies may wish to insert a shorter timescale here]*. If your complaint is more complex, we will:

• Let you know within this time why we think it may take longer to investigate.

• Tell you how long we expect it to take.

• Let you know where we have reached with the investigation, and

• Give you regular updates, including telling you whether any developments might change our original estimate.

The person who is investigating your concerns will firstly aim to establish the facts. The extent of the investigation will depend upon how complex and how serious the issues you have raised are. In complex cases, we will draw up an investigation plan.

In some instances, we may ask to meet with you to discuss your concerns. Occasionally, we might suggest mediation or another method to try to resolve disputes.

We'll look at relevant evidence. This could include information you have provided, our case files, notes of conversations, letters, emails or whatever may be relevant to your particular concern. If necessary, we'll talk to the staff or others involved and look at our policies, any legal entitlement and guidance.

Outcome

If we formally investigate your complaint, we will let you know what we find. If necessary, we will produce a report. We'll explain how and why we came to our conclusions.

If we find that we made a mistake, we'll tell you what happened and why.

If we find there is a fault in our systems or the way we do things, we'll tell you what it is and how we plan to change things to stop it happening again.

If we make a mistake, we will always apologise for it.

Putting Things Right

If we didn't provide you with a service you should have had, we'll aim to provide it now, if that's possible. If we didn't do something well, we'll aim to put it right. If you have lost out as a result of a mistake on our part, we'll try to put you back in the position you would have been in if we'd done things properly.

If you had to pay for a service yourself, when we should have reasonably provided it for you, we will try to refund the cost.

The Ombudsman

If we do not succeed in resolving your complaint, you may complain to the Public Services Ombudsman for Wales. The Ombudsman is independent of all government bodies and can look into your complaint if you believe that you personally, or the person on whose behalf you are complaining:

• Have been treated unfairly or received a bad service through some failure on the part of the service provider.

• Have been disadvantaged personally by a service failure or have been treated unfairly.

The Ombudsman normally expects you to bring your concerns to our attention first and to give us a chance to put things right. You can contact the Ombudsman by:

• Phone: 0300 790 0203

• Email: ask@ombudsman.wales

• The website: www.ombudsman.wales

• Writing to: Public Services Ombudsman for Wales

1 Ffordd yr Hen Gae, Pencoed CF35 5LJ

There are also other organisations that consider complaints. For example, the Welsh Language Commissioner's Office deals with complaints about services in Welsh. We can advise you about such organisations.

Learning lessons

We take your concerns and complaints seriously and try to learn from any mistakes we've made. Our senior management team considers a summary of all complaints quarterly and is made aware of all serious complaints. Our Learning committee also considers our response to complaints at least twice a year. We share summary (anonymised) information on complaints received and complaints outcomes with the Ombudsman as part of our commitment to accountability and learning from complaints.

Where there is a need for significant change, we will develop an action plan setting out what we will do, who will do it and when we plan to do it. We will let you know when changes we've promised have been made.

What if you need help?

Our staff will aim to help you make your concerns known to us. If you need extra assistance, we will try to put you in touch with someone who can help. You may wish to contact *[insert examples appropriate to the service provider here e.g. advocacy services, Age Cymru, Shelter etc.]* who may be able to assist you.

Advocacy

Community Health Council

Community Health Councils (CHCs) were set up originally by Act of Parliament in 1974 as **independent "Watchdogs"** to monitor and review services provided by the NHS.

The South Glamorgan members are recruited from the general public and appointments are made by the Welsh Assembly Government, the Local Authorities and also from established voluntary organisations. The members are unpaid and receive out-of-pocket expenses only and are supported by paid support staff.

The CHC provide a free independent advocacy service should you wish to raise a concern in any part of the NHS. They can:

- advise you on available health services
- help you to find further information
- help you to deal with other health bodies
- Listen to your comments. If you feel that you need to complain about any aspect of the Health Service, we can help you by:
    - providing information about NHS Complaints Procedures
    - making enquiries on your behalf
    - Acting as a Patient's Friend at meetings with Health Service Managers.

Contact Details

South Glamorgan CHC,
Pro-Copy Business Centre (Rear)
Parc Tŷ Glas
Llanishen
Cardiff
CF14 5DU

Telephone: 02920 750112

Email: SouthGlam.Chiefofficer@waleschc.org.uk

Advocacy Support Cymru (ASC)

ASC is a specialist advocacy provider currently delivering independent advocacy services in parts of South and Mid Wales.

ASC believe independent advocacy is important because it seeks to give a voice to people who can't make themselves heard. Advocacy helps to ensure that people are

as involved as they can be in the things that affect them, and are able to communicate their needs and wishes to others who may have influence or power over their lives.

Contact Details
ASC
Charterhouse 1
Links Business Park
Fortran Road
St Mellons
Cardiff CF3 0LT

Telephone: 02920 540444
Fax: 029 2073 5620

E Mail: info@ascymru.org.uk

Advocacy Support Cymru is the new service provider for the Independent Mental Capacity (IMCA)

You can also use this concerns and complaints policy if you are under the age of 18. If you need help, you can speak to someone on the Meic Helpline:

• Phone 0808 802 3456

• Website www.meiccymru.org

or contact the Children's Commissioner for Wales. Contact details are:

• Phone 0808 801 1000

• Email post@childcomwales.org.uk

• Website www.childcom.org.uk

What we expect from you

In times of trouble or distress, some people may act out of character. There may have been upsetting or distressing circumstances leading up to a concern or a complaint. We do not view behaviour as unacceptable just because someone is forceful or determined.

We believe that all complainants have the right to be heard, understood and respected. However, we also consider that our staff have the same rights. We therefore expect you to be polite and courteous in your dealings with us. We will not tolerate aggressive or abusive behaviour, unreasonable demands or unreasonable persistence. We have a separate policy to manage situations when we find that someone's actions are unacceptable.

Appendix 1

Cardiff and Vale University Health Board Concerns form

Section A: Your Details

Title:

Name:

DOB:

Address:

Contact Details

Telephone:
Mobile:
Email:

Are you the Patient?

Y / N

Section B: a concern on behalf of someone else

Title:

Name:

DOB:

Address:

Section C: Details about the concern

If you are raising this concern on behalf of someone else, what is your relationship to the patient?:

Date event/incident occurred:

Have you already put your concern to the frontline staff responsible for delivering the service? If so, please give brief details of how and when you did so:

Summary of your concerns/key issues

In your opinion, what went wrong?

Specific questions you would like answered:

Details of what you would like to happen as a result of your complaint.

To be completed where the person raising the concern is not the patient.

I hereby authorise

Name of person raising the concern:	
Address:	

To act on my behalf and to receive any and all information that may be relevant to the concern.

I hereby agree that the health records and any personal information can be used in the investigation of the concern. I understand that access to records and personal information will be limited only to those who need to see them in order to investigate the issues raised and, only those sections of the health records relevant to the investigation will be used.

Signature of patient:	
Date:	

Please return to:

Concerns Department
Woodland House
Maes-y-Coed Road
Cardiff
CF14 4HH concerns@wales.nhs.uk

Equality & Health Impact Assessment for

{insert title of strategy/ policy/ plan/ procedure/ service}

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	**Concerns (Complaints) and Claims (Clinical Negligence, Personal Injury and Redress) Management Policy**
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Patient Experience
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will manage all concerns/claims in accordance with the policy.

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

4.	Evidence and background information considered. For example • population data • staff and service users 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 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].	Duties under the Equality Act 2010 As public authorities the Health Board is required to pay "due regard" to the three aims of the general equality duty to: • Eliminate discrimination, harassment, victimization and any other conduct that is prohibited by or under this Act • Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it Foster good relations between persons who share a relevant protected characteristic and persons who do not share it . Having "due regard" for advancing equality involves: • Removing or minimising disadvantages people encounter due to their protected characteristics • Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people • Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low. We are legally bound to demonstrate that we are taking action to promote equality in relation to policy making, development of policies and procedural documents, alongside the delivery of services, service developments and employment. Within the Act, we also have a legal duty to show that we have given due regard to the nine protected characteristics below: • Sex • Ethnicity • Gender • Disability • Religion / belief • Sexual orientation • Gender reassignment • Marriage or civil partnership • Pregnancy / maternity • Age. The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to. The Act sets human rights in a series of 'Articles' and each Article deals with a different right. There are 16 Articles; details of which are at: www.equalityhumanrights.com/en/human-rights/human-rights-act.

[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		This policy draws particular attention to the following Article, although all Articles are important to apply to assessments. Article 14: Right to freedom from discrimination (which in effect means protection from discrimination for any other reason that is not one of the protected characteristics e.g. socio economic status) The Health and Social Care Act 2012 – Health Inequalities The Health and Social Care Act 2012, states that each CCG must, in the exercise of its functions, have regard to the need to: • Reduce inequalities between patients with respect to their ability to access health services • Reduce inequalities between patients with respect to the outcomes achieved for them. Sussex NHS Commissioners have incorporated health inequalities considerations into the assessment template to ensure these requirements are considered. 2.4. The Brown Principles Case law known as the Brown Principles sets out a broad indication of what public sector organisations need to do to in respect of the aims set out in the general equality duties and they provide useful insight into how courts interpret the duties although they are not additional legal requirements. In summary, the Brown principles say: • Decision-makers must be made aware of their duty to have “due regard” to the three aims of the general equality duty • Due regard is fulfilled before and at the time a particular policy that will or might affect people with protected characteristics is under development and consideration, as well as at the time a decision is taken • Due regard involves a conscious approach and state of mind. A body subject to the duty cannot satisfy the duty by justifying a decision after it has been taken as this is unlawful. Attempts to justify a decision as being consistent with the exercise of the duty, when it was not considered before the decision, are not enough to discharge the duty • The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision • The duty has to be integrated within the discharge of the public functions of the body subject to the duty. It is

		not a question of “ticking boxes” • The duty cannot be delegated and will always remain on the body subject to it • It is good practice for those exercising public functions to keep an accurate record showing that they had actually considered the general equality duty and pondered relevant questions. If records are not kept it may make it more difficult, evidentially, for a public authority to persuade a court that it has fulfilled the duty imposed by the equality duties.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Anyone raising a concern

6. 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 18; • between 18 and 65; and • over 65	This policy does not have an impact on people because of their age. Each claim is assessed on its own merits in accordance with legislation, such as the Civil Procedural Rules, regardless of gender.	Nil required	
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	This policy is predominantly intended to be an internal facing document. There is potential however for service users to request copies The policy is not routinely produced in alternative formats such as Braille. The policy may not be understood by those who have difficulty deciphering or	Large print, Braille or audio versions could be provided on request. Consideration should be given to producing a separate document which is aimed at service users. The Welsh Government are currently revising the 'Putting things Right' leaflet and this may be an option for including an	

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
	reading the written word, for example, dyslexia	explanation of the claims management process. Further explanations and support to understand the policy will be provided as required. We have a redress information leaflet provided on acknowledgement of concerns	
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	This policy does not have any negative or positive effects on people of different genders. Each claim is assessed on the basis of facts and in accordance with the law. We have a legal obligation to provide all information it holds relating to the claim in accordance with the law		

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
referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	As in 6.3		
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.	As in 6.3		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Each claim is assessed on the basis of facts and in accordance with the law. Discrimination to people of a different race, nationality, colour, culture or ethnic origin is unlikely to occur. There may however be a negative impact for individuals who do not understand written English or for whom English is not their first language. We can explore the option of using an		

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
	interpretation service. The negative impact could be mitigated via the use of plain English. The policy can be explained to individuals who are able to understand English.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief			
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	Negative – existing policies are not routinely translated into Welsh. Welsh speakers who wish to pursue a claim through the medium of Welsh will be supported in doing so. Consideration should be given	Negative – existing policies are not routinely translated into Welsh. Welsh speakers who wish to pursue a claim through the medium of Welsh will be supported in doing so. Consideration should be	

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
Well-being Goal – A Wales of vibrant culture and thriving Welsh language	to publishing this policy in Welsh.	given to publishing this policy in Welsh.	
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	People on low incomes may be dissuaded from pursing a legal claim due to the cost involved. However, for low value clinical negligence claims (below £25,000), the individual can pursue the 'Putting things Right' route. Individuals who pursue this avenue as a form of redress will be entitled to free legal advice, where a qualifying liability in law exists. We can explain the process to individuals and support them to pursue this route. Public Health Wales also advises every service user, who raises a concern, of their right to access independent and free advocacy and support	None required	
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or			

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
health indicators, people unable to access services and facilities			
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

7. 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	This policy is an administrative document which has no direct impact on the health of the population, the addressing of inequalities in health or the delivery of services. Please refer to section 6.10		
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 (eg immunisation and vaccination, falls prevention). Also consider			

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
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 Well-being Goal – A prosperous Wales	This policy does not have an impact in the area (although please refer to Section 6.10)		
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			

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
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 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			

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			

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	This policy is predominantly intended as an internal facing policy which describes the staff responsibilities and the organisational structures needed to support the claims management process. The policy is intended to make the claims management process as quick and as fair as possible, with claim being assessed on the basis of facts and in accordance with the law. It is therefore felt that the impact is largely positive. The positive effect could be enhanced with perhaps a document which is aimed at service users and explains the claims process in plain English. This option will be explored with the Welsh Government who are currently reviewing the 'Putting things Right' leaflet. The screening process did however identify some potential for negative impacts, for example, for service users whose first language is not English.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Explore the option of producing a separate document on the claims management process which is specifically aimed at Service Users. Consider the implications of the Welsh Language Standards on this policy Lead for Putting things Right/ Claims Manage	Explore the option of producing a separate document on the claims management process which is specifically aimed at Service Users. Consider the implications of the Welsh Language Standards on this policy Lead for Putting things Right/ Claims Manage		

	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?				

	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	Following consultation with QSE present the policy to the Public Health Wales Bo for approval. Publish updated version of the policy on the website. Consider translating and publishing the policy in Welsh Explore the option of linking with Welsh Government, as they are producir a universal leaflet on the Putting things Right Scheme. It may be possible to include an explanation of the claims process. It is likely that the leaflet on the PTR Scheme will be translated into a number of languages. Monitor and review compliance with poli throughout the claims management process			

Appendix 1

Equality & Health Impact Assessment

Developing strategies, policies, plans and services that reflect our Mission of 'Caring for People, Keeping People Well'

Guidance

The University Health Board's (the UHB's) Strategy 'Shaping Our Future Wellbeing' (2015-2025) outlines how we will meet the health and care needs of our population, working with key partner organisations to deliver services that reflect the UHB's values. Our population has varied and diverse needs with some of our communities and population groups requiring additional consideration and support. With this in mind, when developing or reviewing any strategies, policies, plans, procedures or services it will be required that the following issues are explicitly included and addressed from the outset:-

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)[4]

This explicit consideration of the above will apply to strategies (e.g. Shaping Our Future Strategy, Estates Strategy), policies (e.g. catering policies, procurement policies), plans (e.g. Clinical Board operational plans, Diabetes Delivery Plan), procedures (for example Varicella Zoster - chickenpox/shingles - Infection Control Procedure) and services /activity (e.g. developing new clinical services, setting up a weight management service).

Considering and completing the Equality & Health Impact Assessment (EHIA) in parallel with development stages will ensure that all UHB strategies, policies, plans, procedures or services comply with relevant statutory obligations and responsibilities and at the same time takes forward the UHB's Vision, 'a person's chance of leading a healthy life is the same wherever they live and whoever they are'. This process should be proportionate but still provide helpful and robust information to support decision making. Where a more detailed consideration of an issue is required, the EHIA will identify if there is a need for a full impact assessment.

Some key statutory/mandatory requirements that strategies, policies, plans, procedures and services must reflect include:

[4] http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)[5]
- Equality Act 2010[6]
- Well-being of Future Generations (Wales) Act 2015[7]
- Social Services and Well-being (Wales) Act 2015[8]
- Health Impact Assessment (non statutory but good practice)[9]
- The Human Rights Act 1998[10]
- United Nations Convention on the Rights of the Child 1989[11]
- United Nations Convention on Rights of Persons with Disabilities 2009[12]
- United Nations Principles for Older Persons 1991[13]
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance[14]
- Welsh Government Health & Care Standards 2015[15]
- Welsh Language (Wales) Measure 2011[16]

This EHIA allows us to meet the requirements of the above as part of an integrated impact assessment method that brings together Equality Impact Assessment (EQIA) and Health Impact Assessment (HIA). A number of statutory /mandatory requirements will need to be included and failure to comply with these requirements, or demonstrate due regard, can expose the UHB to legal challenge or other forms of reproach. This means showing due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups.

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (ie their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues. They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

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[5] http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en
[6] https://www.gov.uk/guidance/equality-act-2010-guidance
[7] http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
[8] http://gov.wales/topics/health/socialcare/act/?lang=en
[9] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782
[10] https://www.equalityhumanrights.com/en/human-rights/human-rights-act
[11] http://www.unicef.org.uk/UNICEFs-Work/UN-Convention
[12] http://www.un.org/disabilities/convention/conventionfull.shtml
[13] http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx
[14] http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf
[15] http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en
[16] http://www.legislation.gov.uk/mwa/2011/1/contents/enacted

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently on the basis of where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

The **EHIA** brings together both impact assessments in to a single tool and helps to assess the impact of the strategy, policy, plan, procedure and/or service. Using the EHIA from the outset and during development stages will help identify those most affected by the proposed revisions or changes and inform plans for engagement and co-production. Engaging with those most affected and co-producing any changes or revisions will result in a set of recommendations to mitigate negative, and enhance positive impacts. Throughout the assessment, 'health' is not restricted to medical conditions but includes the wide range of influences on people's well-being including, but not limited to, experience of discrimination, access to transport, education, housing quality and employment.

Throughout the development of the strategy, policy, plan, procedure or service, in addition to the questions in the EHIA, you are required to remember our values of *care, trust, respect, personal responsibility, integrity and kindness* and to take the Human Rights Act 1998 into account. All NHS organisations have a duty to act compatibly with and to respect, protect and fulfil the rights set out in the Human Rights Act. Further detail on the Act is available in Appendix 2.

Completion of the EHIA should be an iterative process and commenced as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

For further information or if you require support to facilitate a session, please contact Susan Toner, Principal Health Promotion Specialist (susan.toner@wales.nh.uk) or Keithley Wilkinson, Equality Manager (Keithley.wilkinson@wales.nhs.uk)

Based on

- Cardiff Council (2013) Statutory Screening Tool Guidance
- NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools and templates[17]
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide[18]

[17] http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf (accessed 4 January 2016)
[18] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782 (accessed on 4 January 2016)

Appendix 2 – The Human Rights Act 1998[19]

The Act sets out our human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights':

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, issues of patient restraint and control
3. Article 4 Freedom from slavery and forced labour
4. Article 5 Right to liberty and security. NHS examples: issues of patient choice, control, empowerment and independence, issues of patient restraint and control
5. Article 6 Right to a fair trial
6. Article 7 No punishment without law
7. Article 8 Respect for your private and family life, home and correspondence. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, the right of a patient or employee to enjoy their family and/or private life
8. Article 9 Freedom of thought, belief and religion. NHS examples: the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person solely because of their age, patients presented with health options without the use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home
13. Protocol 1, Article 1 Right to peaceful enjoyment of your property
14. Protocol 1, Article 2 Right to education
15. Protocol 1, Article 3 Right to participate in free elections
16. Protocol 13, Article 1 Abolition of the death penalty

[19] https://www.equalityhumanrights.com/en/human-rights/human-rights-act

Appendix 3

Tips

- Be clear about the policy or decision's rationale, objectives, delivery method and stakeholders.
- Work through the Toolkit early in the design and development stages and make use of it as the work progresses to inform you of those most affected and inform mitigating actions
- Allow adequate time to complete the Equality Health Impact Assessment
- Identify what data you already have and what are the gaps.
- Engage with stakeholders and those most affected early. View them as active partners rather than passive recipients of your services.
- Remember to consider the impact of your decisions on your staff as well as the public.
- Record which organisations and protected characteristic groups you engaged with, when you engaged with them and how you did so (for example, workshop, public meeting, written submission).
- Produce a summary table describing the issues affecting each protected group and what the potential mitigations are.
- Report on positive impacts as well as negative ones.
- Remember what the Equality Act says – how can this policy or decision help foster good relations between different groups?
- Do it with other people! Talk to colleagues, bounce ideas, seek views and opinions.

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

Reference Number: UHB 082
Version Number: 5
Date of Next Review: 31 Mar 2023
Previous LHB Reference Number: UHB 082

MEDICAL EQUIPMENT MANAGEMENT POLICY

Policy Statement

Cardiff and Vale University Health Board is required to set out a Policy for the management of Medical Equipment it deploys in the care of its patients and services users. This requirement is established by a number of national standards and regulatory bodies including the Medicines and Healthcare Products Regulatory Agency (MHRA) and is necessary to assure compliance with the Medical Device Regulations 2002 (as subsequently amended) and other relevant legislation.

The Medical Equipment Management Policy establishes a clear governance framework for the management of Medical Equipment used in the care of UHB patients and service users. The Policy and associated Procedures covers the life cycle management of all Medical Equipment in use in the UHB. It establishes a minimum set of quality standards which are applicable to all Medical Equipment irrespective of whether the Medical Equipment is owned, loaned, leased or used by commissioned external service providers.

The Medical Equipment Group (MEG) is responsible for maintaining and reviewing the Medical Equipment Management Policy and its associated Procedures. The MEG will oversee a network of Medical Device Safety Officers (MDSOs) who will have delegated responsibility for the implementation of the standards for the management of Medical Equipment contained within the Medical Equipment Management Policy and its associated Procedures.

Equipment management encompasses the whole life cycle process that applies to all equipment from critical evaluation, selection / in-house design, procurement / in-house manufacture, commissioning, training, use, maintenance, repair, upgrade, decommissioning through to final disposal. Inappropriate management of Medical Equipment at any stage of its life will lead to increased risks (unintended harm to patients, harm to professional users, statutory regulatory non-compliance, Welsh Risk Pool indemnity etc.) and poor value for money.

Cardiff and Vale UHB aims to provide the most effective Medical Equipment to support the delivery of high quality patient care and deliver the best possible health and financial outcomes. This is to be achieved by managing Medical Equipment effectively and efficiently in order to reduce risk, meet all statutory regulatory requirements, ensure that all staff and, where appropriate, patients know how to operate the equipment safely and ensure that equipment is maintained to its optimum standard. To this end, the following 15 principles will be applied:

1. Medical Equipment must be selected taking account of the following factors:

- fitness for purpose as judged against a duly considered specification which references, where appropriate, NICE and other national evidence based standards,
- future proofing in terms of both predicated demand and technology evolution including the impact of known disruptive technologies in that clinical sector,
- prudent healthcare principles; Medical Equipment must be selected to support the minimum appropriate intervention agreed on the patient pathway,
- strategic alignment including national, regional and local clinical service planning where the selection and procurement of Medical Equipment may be a strategic enabler for change,
- known risks to sustainable delivery of high quality and affordable clinical services,
- best life cycle value for money including whole life revenue costs (consumables, maintenance, training etc.)

- demonstrable clinical benefits to deliver outcomes which matter to patients and service users,
- standardisation with other similar types of equipment already in use,
- the training needs of users of the equipment,
- the needs of the UHB as a teaching / training organisation and a leading research and development organisation, to include needs highlighted by strategic partnerships,
- maintenance implications, i.e. cost of maintenance, warranty terms, availability of in- house technical support, quality of support from the supplier etc.
- reliability, based on experience in this UHB and other organisations,
- any need for decontamination of the equipment and the availability of suitable decontamination facilities at the UHB,
- any implications for the UHB's IT infrastructure,
- any Estates enabling works,
- Medicines and Healthcare Products Regulatory Agency (MHRA) safety alerts, safety standards, Health & Safety Regulations and other relevant regulatory requirements and external quality accreditation standards and guidance,
- the UHB's Standing Orders, Policies and Procedures.

2. In planning for the replacement of Medical Equipment the following equipment criteria should be considered. Is the existing Medical Equipment:

   - worn out beyond economic repair,
   - damaged beyond economic repair,
   - unreliable,
   - clinically or technologically obsolete,
   - supported on 'best endeavours' as spare parts are no longer available,
   - unable to be cleaned effectively prior to disinfection/sterilisation.

   If replacement needs are identified then the availability of better alternatives on a regional or national network level should be considered rather than 'like for like' replacement. This may also enable health system level pathway or service redesign.

3. Procurement of Medical Equipment will be undertaken via NHS Wales Shared Services Partnership (NWSSP) Procurement Services, in collaboration with the Medical Equipment users, the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to the Artificial Limb and Appliance Service (ALAS)), the Health & Safety Department, the Estates Department and others as required.

4. There must be a site visit and survey carried out before any item of Medical Equipment that will be fixed to the floor, ceiling or to a wall is ordered to ensure that there is sufficient space to use and maintain the equipment in a safe and effective manner, and that all necessary enabling works can be undertaken. This site visit must be undertaken in collaboration with the UHB's Estates Department.

5. Certain types of Medical Equipment, as designated from time to time by the Medical Equipment Group (MEG), will be 'owned' and managed corporately through the Medical Equipment Loan Service.

6. Before submitting a requisition for Medical Equipment of capital or revenue value, Directorates and Clinical Boards must seek advice from the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to the Artificial Limb and Appliance Service (ALAS)) to confirm that all aspects of clinical risk, standardisation, technical specifications and maintenance arrangements are taken into account at the start of the procurement process.

7. Medical Equipment (whether purchased or on loan) must not be put into clinical use until it has been commissioned by the appropriate technical department or, in approved cases, by the supplier. Specific provisions apply for equipment manufactured, modified or repaired in-house (please refer to the UHB In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure).

8. Appropriate maintenance arrangements must be considered and agreed before Medical Equipment is put into clinical use. Where appropriate, external maintenance contracts will be technically monitored by the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to the Artificial Limb and Appliance Service (ALAS)).

9. Professional Users must have received appropriate training and be competent, before Medical Equipment is put into clinical use.

10. End Users of Medical Equipment must be appropriately trained and given suitable written instructions before equipment is issued to them.

11. Records of all Medical Equipment as designated from time to time by the Medical Equipment Group (MEG), will be kept on a database held and maintained by the UHB's Clinical Engineering Department.

12. The Clinical Engineering Department will hold a database of all Medical Equipment prioritised by risk to inform the UHB's Medical Equipment replacement programmes.

13. Disposal of Medical Equipment must be done in consultation with the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to the Artificial Limb and Appliance Service (ALAS)) and adhere to UHB waste disposal policies and protocols.

14. The Policy and Procedures apply to all acquisitions of Medical Equipment from whatever source, e.g. directorate budgets, capital allocation, capital schemes, Welsh Government, National Service Frameworks, lease, loan, voluntary organisations, endowment funds, charitable funding allocation, in-house manufacture, etc.

15. This liability extends to all Medical Equipment brought onto UHB premises by external contractors. The same level of assurance must be provided through contractual arrangements for Medical Equipment used to deliver subcontracted or hosted clinical services for the population served by the UHB.

16. The Medical Equipment Group (MEG) will maintain overarching governance of all Medical Equipment (and Devices) within the Health Board. The MEG will be chaired by the Executive(s) that is responsible for Medical Equipment (and Devices) as part of their portfolio. Ultrasound Medical Equipment will be primarily overseen by the Ultrasound Clinical Governance Group (USCGG) with any governance issues escalated to the MEG when necessary.

Policy Commitment

Cardiff and Vale UHB is committed to adopting a standard, evidence based and systematic approach to the specification, acquisition/in-house manufacture, deployment, maintenance (preventive maintenance and performance assurance), repair and disposal of medical devices (noting that software used to inform clinical decision making may also be a medical device under relevant legislation) and Medical Equipment training.

The aim of the policy is to ensure that Cardiff and Vale UHB provides the most effective Medical Equipment support the delivery of high quality patient care and deliver the best possible health and financial outcomes and to assure compliance with relevant legislation. It sets minimum standards which are applicable across all sectors of the UHB's healthcare services and includes equipment which is deployed by partner organisations and contractors to care the UHB's patients. It also enshrines through Medical Equipment selection criteria strong alignment to UHB started and the overarching principles of prudent healthcare.

The Medical Equipment Management Policy establishes a clear framework within which the UHB can;

- Effectively and actively manage its Medical Equipment so as to reduce risk,
- Meet its legal obligations to comply with legislation,
- Meet its governance obligations, both clinical and financial,
- To the requirements of the relevant Health and Care Standards,
- Demonstrate that it is taking account of MHRA guidance,
- Meet external accrediting body quality standards covering Medical Equipment
- Report medical device adverse incidents in line with MHRA Yellow Card reporting

Supporting Procedures and Written Control Documents

This Policy, the Medical Equipment Management Procedure and the In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure describe how the UHB will discharge it duties in respect of statutory legislation and its obligations to meet external quality standards set out by health service accreditation bodies.

Other supporting documents are:

- Cardiff and Vale UHB Policies:
  - Decontamination of Reusable Medical Devices Policy
  - Safe Use of Ionising Radiation Policy
  - Safe Use of Non-Ionising Radiation Policy
  - Waste Disposal Policy
  - Ultrasound Clinical Governance and Risk Policy
- Provision and Use of Work Equipment Regulations (PUWER), 1998
- Medical Device Regulations 2002 (as subsequently amended).
- Managing Medical Devices, Guidance for healthcare and social services organisations, MHRA, January 2021.
- Best-practice guidance for the in-house manufacture of medical devices and nonmedical devices, including software in both cases, for use within the same health institution (IPEM January 2021)
- Yellow Card | Making medicines and medical devices safer (mhra.gov.uk)

Scope

This policy applies to all of Cardiff and Vale UHB staff in all locations including those with honorary contracts. It applies to all Medical Equipment used by Cardiff and Vale UHB services irrespective of whether the Medical Equipment is owned, loaned, leased or used by commissioned external service providers.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be a positive impact.
Health Impact Assessment	A Health Impact Assessment is not required for this policy.
Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Medical Equipment Group
Accountable Executive or Clinical Board Director	Director of Therapies and Health Science.

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 Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1			
2	15 Sep 2015	25 Sep 2015	UHB policy reviewed and updated to reflect new organisational structures and life cycle management framework for medical equipment. This is in response to the rapidly evolving regulatory landscape in which medical equipment is now used, and to keep pace with innovative, novel and emergent medical technologies. The Policy and Procedure are now contained in separate documents.
	18 April 2019	01 Jul 2019	Outcome of the review by UHB MEG of the UHB Medical Equipment Management Policy / UHB Management of Medical Equipment Procedure that the content should remain unchanged at this time and a new review date set at 31.03.20 in order that the policy / procedure may be revised

			in response to updated MHRA guidance due to be published in the next few months
3	25 Mar 2020	15 April 2020	Review and interim update by UHB MEG of the UHB Medical Equipment Management Policy / UHB Management of Medical Equipment Procedure / UHB In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure in response to likely delay of publication of updated MHRA guidance until after the MDR 2017 full implementation date of 26th May 2020. The Policy and Procedures will be further updated following publication of pending updated MHRA guidance.
4	17 Mar 2021	4 April 2021	Review and interim update by UHB MEG of the UHB Medical Equipment Management Policy / UHB Management of Medical Equipment Procedure / UHB In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure in response to the publication of Best-practice guidance for the in-house manufacture of medical devices and nonmedical devices, including software in both cases, for use within the same health institution (IPEM January 2021) and likely introduction of Medical Devices (Amendment etc.) (EU Exit) Regulations 2020 during 2021.
5	02 March 2022	14 April 2022	Review and interim update by UHB MEG of the UHB Medical Equipment Management Policy / UHB Management of Medical Equipment Procedure / UHB In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure pending the outcome of the MHRA consultation on medical device regulation in the UK and subsequent introduction of new legislation.

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

Reference Number: UHB082
Version Number: 5
Date of Next Review: 31 Mar 2023
Previous Trust/LHB Reference Number: UHB082

THE MANAGEMENT OF MEDICAL EQUIPMENT PROCEDURE

Introduction and Aim

The aim of the Medical Equipment Management Policy and this associated Procedure is to ensure that Cardiff and Vale UHB provides the most effective Medical Equipment support the delivery of high quality patient care and deliver the best possible health and financial outcomes. The Medical Equipment Management Policy sets minimum standards which are applicable across all sectors of the UHB's healthcare services and includes Medical Equipment which is deployed by partner organisations and contractors to care for UHB patients and service users. It also enshrines through Medical Equipment selection criteria strong alignment to UHB started and the overarching principles of prudent healthcare.

This Procedure has been developed so as to facilitate the consistent application of the Medical Equipment Management Policy, as part of an overarching governance framework. It expands on the 15 governance principles established by the Medical Equipment Management Policy and describes in detail the UHB's Medical Equipment Governance Framework. The In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure has been developed to assure compliance with relevant legislation, standards and guidance in relation to in-house design and manufacture of medical devices (including software) put into service within the UHB.

Objectives

The Medical Equipment Management Policy establishes a clear framework within which the UHB can;

- Effectively and actively manage its Medical Equipment so as to reduce risk,
- Meet its legal obligations to comply with legislation,
- Meet its governance obligations, both clinical and financial,
- To the requirements of the relevant Health and Care Standards,
- Demonstrate that it is taking account of MHRA guidance,
- Meet external accrediting body quality standards covering Medical Equipment

Scope

This Procedure applies to all of Cardiff and Vale UHB staff in all locations including those with honorary contracts. It covers all Medical Equipment used by Cardiff and Vale UHB services irrespective of whether the Medical Equipment is owned, loaned, leased or used by external service providers commissioned by the UHB.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be a positive impact.
Documents to read alongside this Procedure	Cardiff and Vale UHB Policies: o Decontamination of Reusable Medical Devices Policy o Safe Use of Ionising Radiation Policy o Safe Use of Non-Ionising Radiation Policy o Waste Disposal Policy Provision and Use of Work Equipment Regulations (PUWER), 1998 Medical Device Regulations 2002 (as subsequently amended). Managing Medical Devices, Guidance for healthcare and social services organisations, MHRA, January 2021 Best-practice guidance for the in-house manufacture of medical devices and nonmedical devices, including software in both cases, for use within the same health

	institution (IPEM January 2021) Yellow Card | Making medicines and medical devices safer (mhra.gov.uk)
Approved by	Quality, Safety and Experience Committee
Accountable Executive	Director of Therapies and Health Science.
Author(s)	*Head of Clinical Engineering / Deputy Director of Therapies and Health Science.*

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 Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
2	15/09/2015	25/09/2015	The Policy and Procedure are disaggregated. Greater clarity on Medical Equipment life cycle management principles including more robust governance of the procurement of Medical Equipment and strengthened alignment to UHB strategy Significant specific amendments include: • Roles, responsibilities and lines of accountability are transparent. • There are more robust governance arrangements covering the procurement of Medical Equipment. • The procedures explicitly cover the activities of the Artificial Limb and Appliance Services hosted by Cardiff and Vale UHB.
3	25/03/2020	15/04/2020	Review and interim update by UHB MEG of the UHB Medical Equipment Management Policy / UHB Management of Medical Equipment Procedure / UHB In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure in response to likely delay of publication of updated MHRA guidance until after the MDR 2017 full implementation date of 26th May 2020. The Policy and Procedures will be further updated following publication of pending updated MHRA guidance.
4	17/03/2021	04/04/2021	Review and interim update by UHB MEG of the UHB Medical Equipment Management Policy / UHB Management of Medical Equipment Procedure / UHB In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure in response to the publication of Best-practice guidance for the in-house manufacture of medical devices and nonmedical devices, including software in both cases, for use within the same health institution (IPEM January 2021) and likely

			introduction of Medical Devices (Amendment etc.) (EU Exit) Regulations 2020 during 2021.
5	02/03/2022	14/04/2022	Review and interim update by UHB MEG of the UHB Medical Equipment Management Policy / UHB Management of Medical Equipment Procedure / UHB In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure pending the outcome of the MHRA consultation on medical device regulation in the UK and subsequent introduction of new legislation.

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1. INTRODUCTION

1.1 This Procedure covers the life cycle management of all Medical Equipment (including Software as a Medical Device) in use at Cardiff and Vale University Health Board (UHB) irrespective of the source of funding for the equipment or whether it is owned, loaned, leased or used by commissioned service providers. This includes Medical Equipment provided under managed service contracts. It also covers the use of Medical Equipment by contractors to deliver UHB commissioned clinical services to Cardiff and Vale UHB's patients and service users. For the purposes of this Procedure, 'Medical Equipment' refers to medical devices (including software) that aid diagnosis, monitoring, treatment and rehabilitation in relation to medical conditions (some examples of which are given in Appendix 2). As a defined term, MEDICAL EQUIPMENT is placed in SMALL CAPITALS throughout the rest of this Policy.

1.2 Equipment management encompasses the whole life cycle process that applies to all MEDICAL EQUIPMENT from critical evaluation, selection procurement, commissioning, training, use, maintenance, repair, upgrade, decommissioning through to final disposal (Appendix 1).

1.3 Inappropriate management of MEDICAL EQUIPMENT at any stage of its life will lead to increased risks (unintended harm to patients, harm to professional users, statutory regulatory non-compliance, Welsh Risk Pool indemnity etc.) and poor value for money.

1.4 Therefore, relevant legislation, standards and guidance including Health and Care Standards, requires the UHB to have in place a Policy and Procedures to cover this activity.

1.5 This Procedure has been developed so as to facilitate the consistent application of this Policy, as part of an overarching governance framework and will be kept under review.

1.6 The philosophy of the Policy and associated Procedure is that there must be co-operation and collaboration between Clinical User Departments, Clinical Engineering, NHS Wales Shared Services Partnership (NWSSP) Procurement Services and other relevant parties in order for the UHB to maximise the benefits and minimise the risks of its use of MEDICAL EQUIPMENT. A slogan that has been suggested and modified by the Medical Equipment Group (MEG) for use in this context is;

"Choose it right; Buy it right; Use it right; Keep it right"

1.7 PROFESSIONAL USERS and END USER. These terms are used in Policy and Procedures and have the following meaning;

PROFESSIONAL USERS: Professionally qualified health care workers who use MEDICAL EQUIPMENT as part of their job.
END USERS: Patients or clients of the UHB or their carers, who use MEDICAL EQUIPMENT in the treatment or care of themselves or those whom they look after

2. POLICY AND PROCEDURE STATEMENT

Cardiff and Vale UHB aims to provide the most effective MEDICAL EQUIPMENT to support the delivery of high quality patient care and deliver the best possible health and financial outcomes. This is to be achieved by managing MEDICAL EQUIPMENT effectively and efficiently in order to reduce risk, meet all statutory regulatory requirements, ensure that all staff and, where appropriate, patients know how to operate the equipment safely and ensure that equipment is maintained to its optimum standard. To this end, the following principles will be applied:

2.1 MEDICAL EQUIPMENT must be selected taking account of the following factors:

- fitness for purpose as judged against a duly considered specification which references, where appropriate, NICE and other national evidence-based standards,
- future proofing in terms of both predicated demand and technology evolution including the impact of known disruptive technologies in that clinical sector,
- prudent healthcare principles; Medical Equipment must be selected to support the minimum appropriate intervention agreed on the patient pathway,
- strategic alignment including national, regional and local clinical service planning where the selection and procurement of MEDICAL EQUIPMENT may be a strategic enabler for change,
- known risks to sustainable delivery of high quality and affordable clinical services,
- best life cycle value for money including whole life revenue costs (consumables, maintenance, training etc.)
- demonstrable clinical benefits to deliver outcomes which matter to patients and service users,
- standardisation with other similar types of equipment already in use,
- the training needs of users of the equipment,
- the needs of the UHB as a teaching / training organisation and a leading research and development organisation, to include needs highlighted by strategic partnerships,
- maintenance implications, i.e. cost of maintenance, warranty terms, availability of in-house technical support, quality of support from the supplier etc.
- reliability, based on experience in this UHB and other organisations,
- any need for decontamination of the equipment and the availability of suitable decontamination facilities at the UHB,

- any implications for the UHB's IT infrastructure,
- any Estates enabling works,
- Medicines and Healthcare Products Regulatory Agency (MHRA) safety alerts, safety standards, Health & Safety Regulations and other relevant regulatory requirements and external quality accreditation standards and guidance,
- the UHB's Standing Orders, Policies and procedures.

Whilst user preference or supplier preference based on past experience are key considerations they must not take primacy over the factors listed above. As a principle the UHB must never adopt MEDICAL EQUIPMENT where there is evidence that is unreliable, but the issue of unplanned MEDICAL EQUIPMENT downtime should be discussed with suppliers and included as contractual performance indicators. The critical evaluation and selection phase is pivotal to ensure that the UHB achieves its objectives of delivering prudent healthcare and reducing waste, variation and harm. Therefore the MEG will support this phase to ensure a degree of impartiality and transparent decision making when selecting MEDICAL EQUIPMENT for use within the UHB. CEDAR provide access to contemporary critical assessments of novel MEDICAL EQUIPMENT and Medical Technologies and must be included in the evaluation phase for any MEDICAL EQUIPMENT which is new to the UHB.

2.2 In planning for the replacement of MEDICAL EQUIPMENT the following equipment criteria should be considered. Is the existing MEDICAL EQUIPMENT:

- worn out beyond economic repair,
- damaged beyond economic repair,
- unreliable,
- clinically or technologically obsolete,
- supported on 'best endeavours' as spare parts are no longer available,
- unable to be cleaned effectively prior to disinfection/sterilisation.

If replacement needs are identified then the availability of better alternatives on a regional or national network level should be considered rather than 'like for like' replacement. This may also enable health system level pathway or service redesign.

2.3 Procurement of will be undertaken via NHS Wales Shared Services Partnership (NWSSP) Procurement Services, in collaboration with the user, Clinical Engineering, the Health & Safety Department, the Estates Department and others as required.

2.4 There must be a site visit and survey carried out before any item of MEDICAL EQUIPMENT that will be fixed to the floor, ceiling or to a wall is ordered to ensure that there is sufficient space to use and maintain the equipment in a safe and effective manner, and that all necessary enabling works can be

undertaken. This site visit must be undertaken in collaboration with the UHB's Estates Department.

2.5 Certain types of MEDICAL EQUIPMENT, as designated from time to time by the Medical Equipment Group (MEG), will be 'owned' and managed corporately through the Medical Equipment Loan Service.

2.6 Before submitting a requisition for MEDICAL EQUIPMENT of capital or revenue value, Directorates and Clinical Boards must seek advice from Clinical Engineering (or the Rehabilitation Engineering Unit in relation to the Artificial Limb and Appliance Service (ALAS)) to confirm that all aspects of clinical risk, standardisation, technical specifications and maintenance arrangements are taken into account at the start of the procurement process.

2.7 MEDICAL EQUIPMENT (whether purchased or on loan) must not be put into clinical use until it has been commissioned by the appropriate technical department or, in approved cases, by the supplier. For equipment manufactured, modified or repaired in-house please refer to the UHB In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure.

2.8 Appropriate maintenance arrangements must be considered and agreed before MEDICAL EQUIPMENT is put into clinical use. Where appropriate, external maintenance contracts will be technically monitored by the UHB's Clinical Engineering Department.

2.9 PROFESSIONAL USERS must have received appropriate training and be competent, before MEDICAL EQUIPMENT is put into clinical use.

2.10 END USERS of MEDICAL EQUIPMENT must be appropriately trained and given suitable written instructions before equipment is issued to them.

2.11 Records of all MEDICAL EQUIPMENT as designated from time to time by the Medical Equipment Group (MEG) will be kept on a database held and maintained by the UHB's Clinical Engineering Department.

2.12 The UHB's Clinical Engineering Department will hold a database of all MEDICAL EQUIPMENT PRIORITISED by risk to inform the UHB's Medical Equipment replacement programmes.

2.13 Disposal of MEDICAL EQUIPMENT must be done in consultation with the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS) and adhere to UHB waste disposal policies and protocols.

2.14 The Policy and Procedures applies to all acquisitions of MEDICAL EQUIPMENT from whatever source, e.g. directorate budgets, capital allocation, capital schemes, Welsh Government, National Service Frameworks, lease, loan, voluntary organisations, endowment funds, in-house manufacture, etc.

2.15 This liability extends to all MEDICAL EQUIPMENT brought onto UHB premises by external contractors. The same level of assurance must be provided through contractual arrangements for MEDICAL EQUIPMENT used to deliver subcontracted or hosted clinical services for the population served by the UHB.

2.16 Issues regarding Ultrasound MEDICAL EQUIPMENT should first be raised with the Ultrasound Clinical Governance Group (UCGG). Issues can then be escalated to the Medical Equipment Group (MEG) where deemed necessary by UCGG chair.

For further details and explanations, see Appendix 3 of this Procedure.

3. AIM

The aim of this Procedure is to provide a clear framework within which the UHB can;

3.1 effectively and actively manage its MEDICAL EQUIPMENT so as to reduce risk,

3.2 meet its legal obligations to comply with legislation,

3.3 meet its governance obligations, both clinical and financial,

3.4 respond to the requirements of the relevant Health and Care Standards[14],

3.5 demonstrate that it is taking account of MHRA guidance

3.6 meet external accrediting body quality standards covering MEDICAL EQUIPMENT.

4. OBJECTIVES

4.1 To establish a robust Procedures to underpin the Medical Equipment Management Policy , to cover the evaluation, selection, procurement, commissioning, maintenance, use and disposal of the UHBs MEDICAL EQUIPMENT.

4.2 To ensure that the true life-cycle costs, including maintenance costs, consumable costs and other revenue costs are taken into account in the selection process.

4.3 To ensure that PROFESSIONAL USER training and where applicable, END USER training are considered as part of the process.

4.4 To ensure robust competence assessment programmes are available for all MEDICAL EQUIPMENT USERS.

4.5 To ensure best value for money in the overall management of the UHBs MEDICAL EQUIPMENT assets.

4.6 To ensure predictable and well understood systems are available to support consistent and auditable capital MEDICAL EQUIPMENT procurement activities.

5. ROLES and RESPONSIBILITIES

5.1 The Excecutive Director of Therapies and Health Science is the Executive Director with responsibility for MEDICAL EQUIPMENT.

5.2 The Assistant Director of Therapies and Health Science is the UHB lead for MEDICAL EQUIPMENT.

5.3 The Medical Equipment Group (MEG) is responsible for maintaining and reviewing the Medical Equipment Management Policy and Procedures.

5.4 The Medical Equipment Management Policy and this Procedure will mainly impact on the activities of Clinical Board teams, Clinical Directors, Directorate Managers and Clinical Teams when they are considering the management and use of MEDICAL EQUIPMENT and the procurement of new MEDICAL EQUIPMENT. The MEG will oversee a network of Medical Device Safety Officers (MDSOs) who will have delegated responsibility for the implementation of the standards for the management of MEDICAL EQUIPMENT contained within the Medical Equipment Management Policy and Procedures.

5.1 The UHB's Head of Procurement for NHS Wales Shared Services Partnership will ensure that all MEDICAL EQUIPMENT is procured in keeping with UHB policies and standing instructions. Procurement Services will have a UHB 'gatekeeper' function and bring all requests for MEDICAL EQUIPMENT to the attention of the Executive Director of Therapies and Health Science and the MEG to ensure that the correct authorisation pathway has been followed before proceeding to purchase (Appendix 6).

5.2 The UHB's Head of Discretionary Capital and Systems will coordinate and log any capital MEDICAL EQUIPMENT ordering activities including projects or schemes.

5.3 The Assistant Director of Planning, Capital, and Estates & Operational Services holds the capital budget and ensures that all capital MEDICAL EQUIPMENT replacement or development proposals are within allocated budget.

5.4 All capital MEDICAL EQUIPMENT requests have to be agreed by the Major Capital Group. The Executive Director of Planning provides final signed authorisation to any capital purchase request.

5.5 This hierarchical capital MEDICAL EQUIPMENT procurement process will be coordinate and signed off using the "Project Outline for Major Capital Medical Equipment Replacement" template (Appendix 5). A deputising subgroup of the MEG will be convened to sign urgent MEDICAL EQUIPMENT purchases in the absence of the Executive Director or Deputy Director for Therapies and Health Science.

5.6 Clinical Engineering (or the Rehabilitation Engineering Unit in relation to ALAS) will monitor the application and implementation of the Medical Equipment Management Policy and Procedures.

6. RESOURCES

6.1 There are no changes to the resource implications resulting from the revision of the Medical Equipment Management Policy and Procedures.

7. TRAINING

7.1 The Medical Equipment Management Policy and Procedures requires that the users of MEDICAL EQUIPMENT are appropriately trained and competent in the correct and safe use of the equipment (see 2.8 and 2.9). This is particularly important for MEDICAL EQUIPMENT which due to type, or mode of use, presents higher risks. The UHB has already identified infusion devices in this category and put in place a specific policy dealing with such equipment. On behalf of the UHB, the Medical Equipment Group (MEG) will continue to identify further UHB wide training needs and put in place mechanisms to meet them.

8. IMPLEMENTATION

8.1 Medical Equipment Management Policy and Procedures should be implemented following approval by Medical Equipment Group (MEG) and the UHB's Quality, Safety and Patient Experience Committee.

9. AUDIT

9.1 The Policy and Procedures will be monitored by the Medical Equipment Group (MEG).

9.2 The application of the Policy and Procedures will be audited by the Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS).

10. DISTRIBUTION

10.1 The Policy and Procedures will be available via the UHB Intranet and Internet Sites. Where staff do not have access to these resources the line manager must ensure that they are aware of the contents where appropriate.

11. REVIEW

11.1 The Policy and Procedures will be reviewed to reflect any changes in guidance or legislation. As a minimum it will be reviewed 3 years after the date of approval.

Appendix 1

Equipment life cycle management can be defined as:

"A life-cycle approach to the critical evidence based evaluation, purchase, use, maintenance, and disposal of equipment."[7, 8]

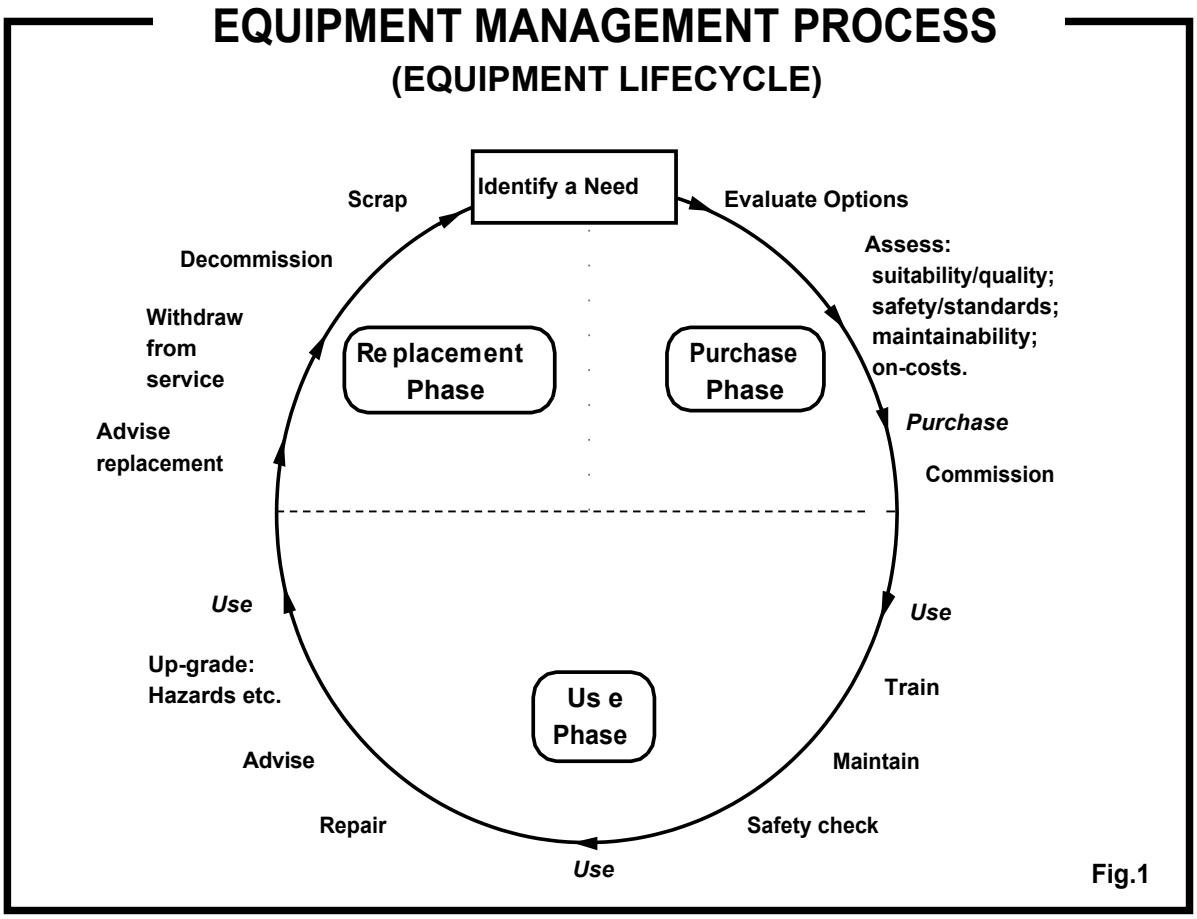


Fig.1

Ref: Equip Lifecyc le 2

Appendix 2

EXAMPLES OF MEDICAL EQUIPMENT

Anaesthetic machines Apnoea Monitors Audiometers **B**lood Flow Meters Blood Pressure Monitors **C**ardiotacographs **D**efibrillators Dialysis Equipment Diathermy **E**CG Monitors EEG Equipment Electronic Assistive Technology Electro-Surgical Units Endoscopes **F**eed Pumps Foetal Monitors **I**nfant Incubators Infant Radiant Warmers Infusion Pumps ➢ Ambulatory ➢ Anaesthesia ➢ Patient Controlled Analgesia (PCA) ➢ Syringe ➢ Volumetric ➢ ICU/ITU Central Station and Monitoring Equipment	**L**asers **N**erve Stimulators NIBP Machines **P**atient monitors Patient Hoists Patient Plinths Posture and Mobility Equipment (including wheelchairs) Pressure Transducers Prosthetics and Orthotics Pulse Oximeters **S**urgical diathermy Surgical Saws Suction apparatus **T**elemetry Equipment Temperature Monitors Treatment Couches / plinths **U**rology Equipment **V**entilators Vital Signs Monitors **W**eighing Scales for patients
*This list of types is NOT exhaustive and is given as guidance only. Contact the UHB's Clinical Engineering Department at UHW or the Rehabilitation Engineering Department at ALAS for detailed advice.	

Appendix 3

Procedural advice to support the implementation of the Medical Equipment Management Policy.

Choosing the right equipment for the right prudent intervention:

Critical Evaluation

The CEDAR service at UHW supports decision making in healthcare by providing information and recommendations on:

•Emerging health technologies

•Medical devices

•Diagnostic tests

•Healthcare interventions

CEDAR representatives form part of the core membership of the MEG. CEDAR provides access to contemporary assessments of novel MEDICAL EQUIPMENT and Medical Technologies. CEDAR must be consulted before making decision to adopt MEDICAL EQUIPMENT or Medical Technologies which are new to the UHB

Specifications

Equipment suitability for the job required can best be determined by careful consideration and preparation of a technical specification. In many cases Clinical Engineering (or the Rehabilitation Engineering Unit in relation to ALAS) is in a position to provide advice on the options available and assist in the preparation of the specification.

Standardisation

If like for like technology replacement is being considered, e.g. another patient monitor or another pulse oximeter, then the need for standardisation of equipment to a restricted range of types throughout the UHB **must** override the personal preferences of individual users. The prudent benefits given by standardisation are a significant contribution to the reduction of clinical risk, the effectiveness of user training and the cost of procurement and maintenance.

Training

The costs of and arrangements for training both PROFESSIONAL USERS and technical maintenance staff need to be taken into account. Significant savings can be made if training arrangements are agreed as part of the procurement process. Robust training and competence programmes and competence assessment must be a critical dependency of implementation plan. This will ensure that all clinical and safety risks associated with the introduction of new medical technology are appropriately managed.

At times there may be a requirement to procure equipment to meet the training obligations of the UHB. Examples would be additional defibrillators for the Resuscitation Department's training programme, or a teaching attachment for endoscopy equipment.

Maintenance Implications

Maintenance implications of the procurement of new equipment are often overlooked. If same or similar equipment is procured then maintenance implications are minimised. In addition, experience gained regarding the overall reliability and performance of and support for various equipment types will inform decisions about which equipment to continue buying.

When new types of MEDICAL EQUIPMENT are being considered then the maintenance implications need to be considered and arrangements agreed at an early stage and any negotiations carried out with the potential supplier before the procurement order is finalised. Significant clinical and operational risks arise when the first time maintenance implications are thought about is as the equipment fails for the first time.

Reliability

Previous experience with the same or similar equipment from a given manufacturer or with a given manufacturer's equipment in general may be advantageous when making decisions. Networking with colleagues in other Health Boards, Trusts and Shared Service partner organisations can be helpful as can reference to guidance publications from the NICE Medical Technologies Evaluation Programme. Whilst MEDICAL EQUIPMENT which is known to be unreliable must never be adopted by the UHB, previous experience must be considered in the round with other MEDICAL EQUIPMENT life cycle criteria. Failure to do so may stifle innovation, depart from agreed prudent health care principles, fail to deliver outcomes that matter to patients and may not provide the best value for money option.

Decontamination

Some types of MEDICAL EQUIPMENT e.g. endoscopes, will require decontamination after each use. Some models may be more easily and effectively decontaminated than others. Some equipment may need highly specialised decontamination facilities and this may add significantly to the cost of a new purchase. These issues must be considered with expert advice from the UHB's 'Decontamination User' (Hospital Sterilisation and Decontamination Unit (HSDU) Manager), the Authorising Engineer (Decontamination) (Senior Decontamination Engineer, NHS Wales – Shared Services Partnership - Facilities Services, (NWSSP-FS, AE(D)) and the UHB's Decontamination Group. Please see Cardiff and Vale UHB's 'Decontamination of Reusable Medical Device Policy' for detailed advice.

Impact on the IT infrastructure

Some MEDICAL EQUIPMENT is networked either locally within a unit e.g. a Coronary Care Unit, or UHB wide, e.g. a Radiology Information System. Telemetry systems may interfere with wireless IT networks. All such

implications need to be considered prior to purchase and discussed with the UHB's IM&T and Clinical Engineering departments.

Impact on existing Estate.

If Medical Equipment is not 'plug and play' and requires modifications to the fabric of buildings, then enabling works can be costly and contribute significantly to overall project costs. Detailed project costs must be viable in advance of nay decision to purchase Medical Equipment. A Project Outline for Major Capital Medical Equipment Replacement template must be completed in collaboration with the Estates department.

Whole life costs

The whole life cost of equipment can be significantly altered if the costs of disposables are included. This is particularly so for infusion devices. Conversely, the nature and quality of disposables may affect the performance of the equipment. These clinical and technical issues need to be taken into account as part of the procurement process.

Regulations

CE/UKCA marking of all Medical Devices 'placed on the market' under the Medical Devices Regulations 2002 (as subsequently amended) is a legal requirement. However, problems arise with equipment supplied not being marked or marked but exhibiting characteristics that raise concerns. It is therefore prohibited for the UHB to purchase/loan and then put into use MEDICAL EQUIPMENT that is not CE/UKCA marked without explicit agreement from the UHB's Medical Equipment Group which may be granted under exceptional circumstances, for example, in line with a formally agreed MHRA humanitarian exemption together with agreement from the Welsh Risk Pool.[1]

Any urgent requests for the exceptional use of non-CE/UKCA marked devices (including for research purposes) may be made to the Chair of the UHB'S Medical Equipment Group who, in consultation with the Clinical Board Medical Devices Safety Officers and having received all relevant assurances, may take Chair's action to allow use under specific conditions.

Suppliers are required to submit a Pre-Procurement Questionnaire (PPQ). This is then reviewed by a technically competent person in the NWSSP Procurement Service prior to raising the purchase order.

Risks

Purchasing MEDICAL EQUIPMENT without due regard to the standards articulated in the Medical Equipment Management Policy can put patients at risk e.g. purchasing a non-standard anaesthetic machine. Indiscriminate purchase of equipment e.g. not taking account of expensive disposables or installation costs can put the UHB at financial risk.

Standing Orders

The UHB has in place Standing Orders regarding such things as limits above which formal tenders must be issued. Standardisation to limited lists may lead to prospective procurements of certain types of equipment exceeding these limits and presents the opportunity for tendering and thus cost reduction.

Replacement Criteria

The replacement status of all MEDICAL EQUIPMENT should be continually reviewed. In many cases, the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS) will be in a position to review and provide advice based on one or more of the criteria given. Any application for funds to replace equipment will be strengthened by clear arguments based on these criteria. Advice must be sought from CEDAR to determine whether contemporary critical assessments of MEDICAL EQUIPMENT or Medical Technologies are available.

Formal Procurement Arrangements

NWSSP Procurement Services have the responsibility to raise procurement orders and the expertise to advise on issues around Standing Orders, EC rules for large procurements, leasing options etc. NWSSP Procurement Services will work collaboratively with the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS) and the user departments to ensure that the principles of this policy are applied to the best advantage of the UHB.

Medical Equipment Loan Service Equipment

The UHB has established a Medical Equipment Loan Service with equipment libraries at UHW and University Hospital Llandough. For infusion pumps and defibrillators the UHB has already developed mechanisms to decide on the restricted range to be procured. Further consultative work will be carried out to extend the standard types agreed. (National Audit Office (NAO) Report, Recommendation 16)[2]

Requisitioning equipment through Clinical Engineering

Clinical Engineering (or the Rehabilitation Engineering Unit in relation to ALAS) have the expertise to deal with or advise on most of the issues raised above and the experience to co-ordinate all the factors that should be considered. They are in a position to take an overview of the reliability, suitability and performance of most devices based on the fact that they have contact with all users in the UHB of particular types of equipment.

Unless Clinical Engineering is involved on every occasion (other than in relation to ALAS), the opportunities for standardisation, cost saving, arranging appropriate maintenance, training etc. are likely to be lost with consequent risk to the UHB.

Commissioning new equipment

MHRA advice is clear that all MEDICAL EQUIPMENT should go through an appropriate acceptance check procedure.[3] In addition, MHRA guidance[3] states that all devices on loan from manufacturers should be subject to a written agreement which defines the device management requirements, responsibilities and liabilities (noting that delivery receipt and pre-use procedures for loan device should be the same as those for purchased device, unless otherwise specified in this written agreement). Technical support for most MEDICAL EQUIPMENT is provided by one of the Clinical Engineering teams

and they will carry out the commissioning process in most cases. They are in a position to advise in all cases. In certain situations the most appropriate arrangements are for the supplier to carry out the commissioning but input from a UHB technical team is still required so that equipment is logged on asset registers, safety test results recorded etc. User instructions will be issued as part of the commissioning process. There is also detailed specialist advice on commissioning decontamination equipment contained in the UHB's Decontamination of Reusable Medical Devices Policy.

If MEDICAL EQUIPMENT is manufactured in-house, or modified in any way, in addition to being required to demonstrate compliance with the relevant legislation, standards and guidance, the UHB takes on all of the associated civil law risks. Such activities must only be carried out in accordance with the UHB In-house Adaption, Modification, Manufacture and Repair of Medical Equipment Procedure.

If such in-house manufactured or modified equipment is passed on to other organisations e.g. another UHB, then they are likely to have been 'placed on the market' under the Medical Devices Regulations 2002 (as subsequently amended) in which case advice must be taken from the UHB Medical Equipment Group prior any such activity.

Maintenance of MEDICAL EQUIPMENT

Maintenance of all work equipment is a statutory requirement.[4] The details of maintenance arrangements will depend on the nature of the equipment and the risks posed to employees and others who might be affected. Poorly maintained MEDICAL EQUIPMENT may pose a risk to the UHB's employees but more likely a risk to patients. Clinical users have a responsibility to ensure that maintenance arrangements are in place. Agreement on the arrangements and on the funding of those arrangements must be made before equipment goes into use. It should be noted that with some equipment there will be routine maintenance requirements even in the warranty period. The manufacturer's warranty will not cover these, just as routine servicing on a new motor car is not covered by the warranty.

Detailed guidance has been issued by the MHRA[3] covering this and all other aspects of equipment management. This includes a recommendation that cannibalising old equipment is not an acceptable option for acquisition of equipment. The National Audit Office (NAO) Report[2] also provided opinions on best practice. This includes consideration of sharing maintenance with external suppliers, regularly reviewing contracts for value for money and reviewing preventive maintenance schedules in the light of experience and risk assessment.

The UHB also has to demonstrate that it is meeting the requirements of the Health and Care Standards[5]. The requirements of this policy are designed to ensure that these issues are addressed and agreed at an early stage. It is unacceptable for Directorates to assume that the relevant technical support team can simply take on the maintenance of additional equipment without any additional resource.

A register of maintenance providers for various types of MEDICAL EQUIPMENT is given in Appendix 4. This is current but is subject to change as more effective

methods of equipment maintenance become available. The UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS) is always available to give advice.

Training Issues: PROFESSIONAL USERS

Training in the proper and safe use of work equipment is also a statutory requirement.[6] Regulation 9 of the Provision and Use of Work Equipment Regulation (PUWER) [3] states that,

'Every employer shall ensure that all persons who use work equipment have received adequate training for the purposes of health and safety, including training in the methods which may be adopted when using work equipment, any risks such use may entail and precautions to be taken.'

The extent and level of training can be proportionate to the risks to patients and employees. The obligation to provide adequate training extends not only to those who use work equipment but also to those supervising or managing them. An assessment of competence must form part of MEDICAL EQUIPMENT training programmes.

For these reasons, PROFESSIONAL USERS must not put MEDICAL EQUIPMENT into use unless they have had appropriate and adequate training and an initial assessment of competence and an on-going programme of competence assessment.

Training Issues: END USERS

The END USERS of equipment may be patients or carers. When the UHB issues equipment for use by END USERS the same legal principles outlined above apply, as well as a duty of care liability. Therefore, it is vital that appropriate training is given and that the equipment is accompanied by suitable written instructions. If possible these should be agreed with the manufacturer of the equipment but in any event must be peer reviewed and signed off by a responsible person. An assessment of competence must form part of MEDICAL EQUIPMENT training programmes. For End Users this could be a visual assessment of use following training.

MEDICAL EQUIPMENT inventory data base

Inventory information regarding all assets of Medical Equipment (other than in relation to ALAS) are held on the UHB's Clinical Engineering Department's data base which is accessible UHB wide in read only form. Departments that have holdings of equipment not on the Clinical Engineering data base must establish their own systems. The UHB is working towards a single data base for all MEDICAL EQUIPMENT including those items under £5,000 in value which are not assets.

Disposal of Equipment

Before MEDICAL EQUIPMENT is disposed of it is important that it is recorded on the database as having been removed from service. In addition, new

regulations coming into force and the attendant risk to the UHB of not complying mean that certain component parts of equipment e.g. VDU screens, batteries, may need to be made safe or removed and disposed of separately. This requires technical knowledge and facilities. Therefore the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS) must be consulted prior to disposal and the Capital & Asset Management must be informed to update the UHB's Asset register.

Application of the Policy and Procedures to all MEDICAL EQUIPMENT Acquisitions

All the long term implications of controlling and making use of MEDICAL EQUIPMENT apply whatever the source of funding. Therefore the Medical equipment Management Policy and Procedure must be followed for all MEDICAL EQUIPMENT purchases.

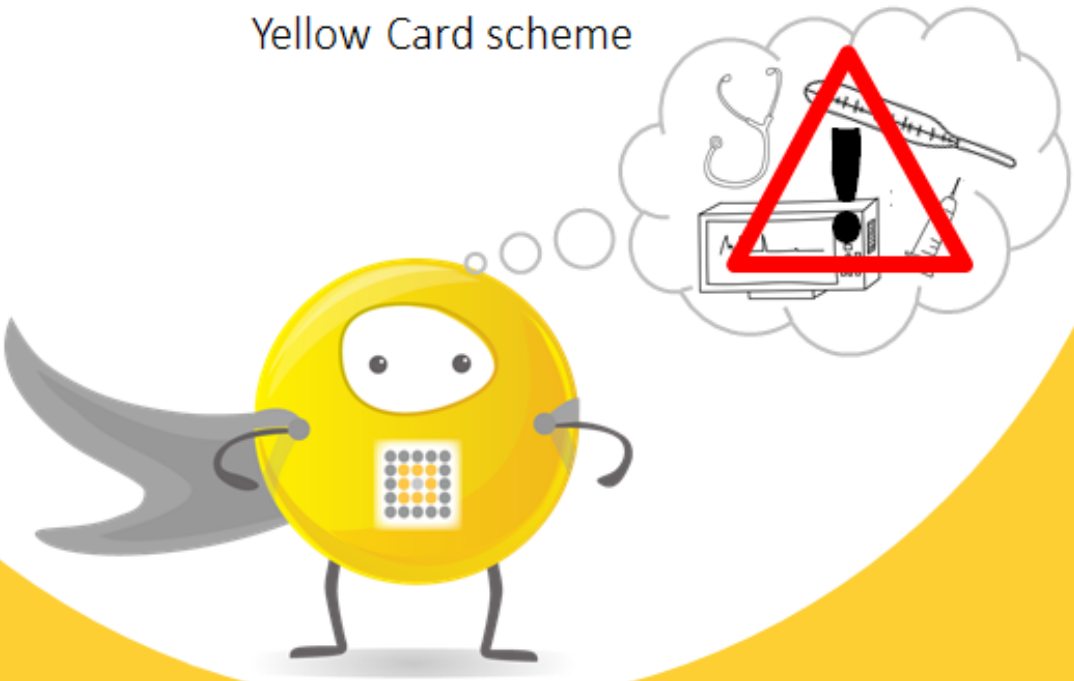
Medical Equipment – Incident Reporting

It is vital that all incidents involving MEDICAL EQUIPMENT are reported appropriately via both the internal Datix reporting system and the MHRA Yellow Card reporting scheme (please see below). The UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS) should also be informed so that appropriate action can be taken which may include referring the incident to the MHRA (NB – only equipment managed by Clinical Engineering will be reported to the MHRA by Clinical Engineering, therefore, all other equipment should be reported to the MHRA directly by those raising/managing the internal Datix report). Internal Datix incident reports must always be completed to include the 'medical equipment' flag in order that Clinical Engineering are alerted to the incident. All equipment that is the subject incident reporting should be taken out of service and quarantined pending an investigation further advice on which may be obtained from the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS).

Equipment and accessories including disposable items must be retained securely for examination during an investigation. Information regarding MEDICAL EQUIPMENT incidents will be collated and reviewed at MEG meetings.

Problem with a medical device?

Did you know you can help make medical devices (including disposable items) safer by reporting suspected problems to the Yellow Card scheme



Examples of problems to report

- Faulty brakes on a wheelchair
- Faulty batch of test strips for a blood glucose meter test giving wrong readings
- Unclear labelling or instructions on the device
- Unsafe design
- Quality issues that impact safety

To report

- Visit **mhra.gov.uk/yellowcard**
- Use the free app

iPhone Android

For further information about the Yellow Card scheme go to **www.awttc.org/YCCWales** or contact Yellow Card Centre Wales on:

Phone: 029 2074 5831 **E-mail:** CAV_YCCWales@wales.nhs.uk

For more information or support please contact Clinical Engineering on 029 20745678

YCC Wales
Yellow Card Centre Wales
Canolfan Cerdyn Melyn Cymru

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

Medicines & Healthcare products Regulatory Agency

Appendix 4

Register of maintenance providers for MEDICAL EQUIPMENT

Type of MEDICAL EQUIPMENT	Maintenance arrangements through:
General MEDICAL EQUIPMENT • Patient monitors • Infusion devices • Defibrillators • Blood pressure monitors • Pulse oximeters • Foetal monitors • Infant incubators • Infant warmers • Physiotherapy equipment (electronic) • Surgical diathermy • Temperature measuring equipment • Patient warming equipment • etc.	Clinical Engineering Technical Services
Anaesthetic equipment • Anaesthetic machines • Patient ventilators • Suction equipment • Oxygen therapy equipment • Nebulisers • Medical gas and suction flowmeters and regulators etc.	Clinical Engineering Technical Services
Dialysis equipment	Clinical Engineering – DTS
Patient handling equipment • Treatment couches and plinths • Patient trolleys • Chiropody equipment • Wheelchairs for short term loan/ transfers • Patient hoists • Operating tables	Clinical Engineering – Mechanical Engineering Clinical Engineering – Mechanical Engineering Clinical Engineering – Mechanical Engineering Contract via Estates Services
Radiology equipment • X-Ray equipment • CT equipment • MRI equipment	Contact Radiology Department

<u>Other imaging equipment</u> • Gamma cameras • Ultrasound scanners • Lasers	 Contract; first line Medical Physics Contract; first line Medical Physics Contract; first line Medical Physics
<u>Disability equipment</u> • Posture and Mobility equipment (including wheelchairs) • Prosthetics and Orthotics • Electronic Assistive Technology	 ALAS ALAS ALAS
<u>Laboratory equipment</u>	Contact Laboratory Medicine Directorate.
If there is any doubt please contact the Clinical Engineering Department at UHW or the Rehabilitation Engineering Department at ALAS.	

Appendix 5

CAPITAL MEDICAL DEVICE BIDDING PROCESS

Appendix 6

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

CAPITAL MEDICAL DEVICES BIDDING FORM

(Medical, Laboratory & Imaging Devices)
Please *complete and submit electronically*

BID FOR

Number of items Date bid was submitted

Clinical Board
Department/Specialty
Project Lead/Contact
Email Phone
Alternative Contact
Bid Amount £ (excl. VAT and Revenue Costs)

Have you contacted Procurement, your Clinical Board's MDSO[1] and Clinical Engineering to discuss this bid?

1. Statement of Need

Provide a short summary pitch or attach an SBAR of why the equipment should be purchased i.e. Statement of Need.

- *What does the equipment do?*
- *What are the issues with the current equipment? E.g. age, reliability, fit for purpose.*
- *What are the benefits of the new equipment?*
- *Are there Local and National drivers for change?*
- *How does the new equipment support delivery of WG, UHB, Point of Care Testing Policy, Clinical Board and Partner Organisation(s) objectives and priorities e.g. Audits, IMTP, Medical Equipment Management Policy etc.*

2. Primary reason for Bid

- ☐ Routine replacement
- ☐ Standardisation of equipment
- ☐ Expiry of lease arrangements
- ☐ Unreliable and/or maintenance support withdrawn
- ☐ Equipment failed or no longer fit for purpose
- ☐* Newer equipment saves its extra cost within in a specified time-frame
- ☐ New or additional equipment

*Please provide evidence/calculations of cost savings in section 1

3. Risk scoring

Please refer to Risk Assessment and Risk Register Procedure

Is this risk captured on the Department, Clinical Board or Corporate Risk Register? Yes ☐ No ☐

Please attached the risk assessment in the box below,

The UHB's template can be found here

Highlight the largest risk* of the **old equipment/current situation**:

*This should be the risk score on the risk register

Likelihood (1-5)	**x**	**Consequences** (1–5)	**=**	**Risk**
.....	x	.....	=	.....

4. Details of equipment being replaced (if appropriate)

If you have a detailed equipment replacement plan or list of identified equipment attach this instead, indicating which items are to be replaced and the original funding source.

Extend the table as necessary.

Manufacturer	Model	Age (yrs)	Asset Number*	Who services/ maintains the equipment?
				Choose an item.
				Choose an item.

*Preferably the Asset Number, B or R Number. Provide the serial number if the other numbers are not available.

5. Disposal of existing equipment

Equipment should be disposed of through Clinical Engineering. Alternative routes must be agreed.

Clinical Engineering ☐
Manufacturer (of existing or new equipment) ☐
Other (please specify)

	Yes	**No**	**Approximate amount**
Are there decommissioning or disposal costs for the old equipment?	☐	☐	£

s there confidential information stored on the **old** equipment e.g. patient ata? Yes ☐ No ☐

6. Medical Device being Considered

1. Device Details

What category is the equipment?

Medical ☐
Laboratory ☐
Point of Care Testing (POCT) ☐*
Imaging ☐

Ionising ☐
Non-ionising ☐

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*Consideration of POCT equipment must be signed off through POCT's procedure

Approved By	**Role**	**Evidence of Approval****
.....	.....	

**Add the email (drag and drop) containing the approval

Who will own the equipment?

Please list all departments if equipment numbers will be divided.

Will this equipment be regularly used by users outside of the department which owns it? Yes* ☐ No ☐

*if **YES**, Who will pay for recurring costs? E.g. maintenance, consumables etc.
Please seek appropriate authorisation from the clinical board and head of finance, Section 8.

2. Quotation Examples

Provide at least two quotations of equipment that would meet the identified requirements

Option	Preferred Option	Manufacturer / Supplier	Model	Quote for one item Excl. VAT	Total Cost Excl. VAT	Quote**
A	☐			£	£	
B	☐			£	£	

*Highlight the preferred option and preferably add reasoning to the Risk Assessment, Appendix A

What is the lead time for delivery of the equipment? ..... Months

Is this equipment or a similar type that is not being replaced, already used in your area or elsewhere in the UHB? Yes* ☐ No ☐

***If Yes**, please specify where:

Has an equipment trial been undertaken? Yes ☐ No ☐

Will the new equipment require changes to consumables? Yes ☐ No ☐

New consumables ☐

Consumables no longer required ☐

3. Estates and Infrastructure

Does the equipment require Estate-enabling works? Yes* ☐ No ☐

Equipment may require construction work which includes supplying utilities.

Yes, have you contacted Estates to discuss feasibility and costs? Yes ☐

Will the purchase require space reallocation or reconfiguration? Yes ☐ No ☐

Newer equipment may have a larger floor-footprint than older equipment such that it may not fit in the space previously used for that equipment.

4. I.T. Network and Data

Can the equipment be connected to a network? Yes ☐ No ☐

Will the equipment be connected to a network? Yes* ☐ No ☐

***If yes, have toy contacted the relevant team (IT or PACS) to discuss feasibility and costs** Yes ☐

	Initial Cost	Annual Cost

Networking setup/ management £ £

Central data storage/ server £ £

oes the new equipment store confidential information? Yes ☐ No ☐

an the new equipment output patient identifiable information via a port e.g. USB, Ethernet etc.)? Yes ☐ No ☐

5. Maintenance

Who will maintain the equipment?

		Annual Cost
Clinical Engineering	☐	£
ALAS	☐	£
Manufacturer or Supplier	☐	£
Third-party maintenance service	☐	£

6. User Training

What training is required to use this equipment?

Manufacturer ☐

UHB-led training ☐

What department/service provides this training? .....

ost of training £ ..... Per ..... places

low many staff require training (approximately)? .....

7. Decontamination

this equipment is new to the UHB, have you contacted HSDU nd/or IP&C to discuss feasibility and costs? Yes ☐

oes the UHB have the facility to effectively decontaminate this quipment? Yes ☐ No* ☐

If NO, please explain approved decontamination plan with additional costs

8. Radiation Safety

Does the equipment use any of the following?

	Yes	No	Approval required	Approved by	Evidence of Approval
Ionising radiation	☐	☐	Radiation Protection Advisor	.....	
Ultrasound	☐	☐	Ultrasound Protection Advisor	.....	
Laser technology	☐	☐	Laser Protection Advisor	.....	
MRI	☐	☐	MRI Protection Advisor	.....	

Page Break

7. Estimated Cost Summary

Total Cost of Medical Device* £

Additional Capital Costs* £

Total Cost of Bid* £

*Prices excluding VAT

Include any quotations for equipment, 6.2 Quotation Examples

1. Revenue Impact/ Annual Costs

These costs are the responsibility of the department that has agreed to pay for recurring costs and requires authorisation by the respective Clinical Board's Head of Finance.

What are the expected annual financial changes (revenue)?

	Increase	Neutral	Decrease	Approximate amount
Staffing costs	☐	☐	☐	£
Training cost	☐	☐	☐	£
Consumable costs	☐	☐	☐	£
Maintenance costs (**AFTER** warranty period)	☐	☐	☐	£
Other Costs	☐	☐	☐	£
Service Income	☐	☐	☐	£

Page Break

8. Authorisation

Proposal Completed By	Role	Date

Clinical Board Authorisation	Role	Date

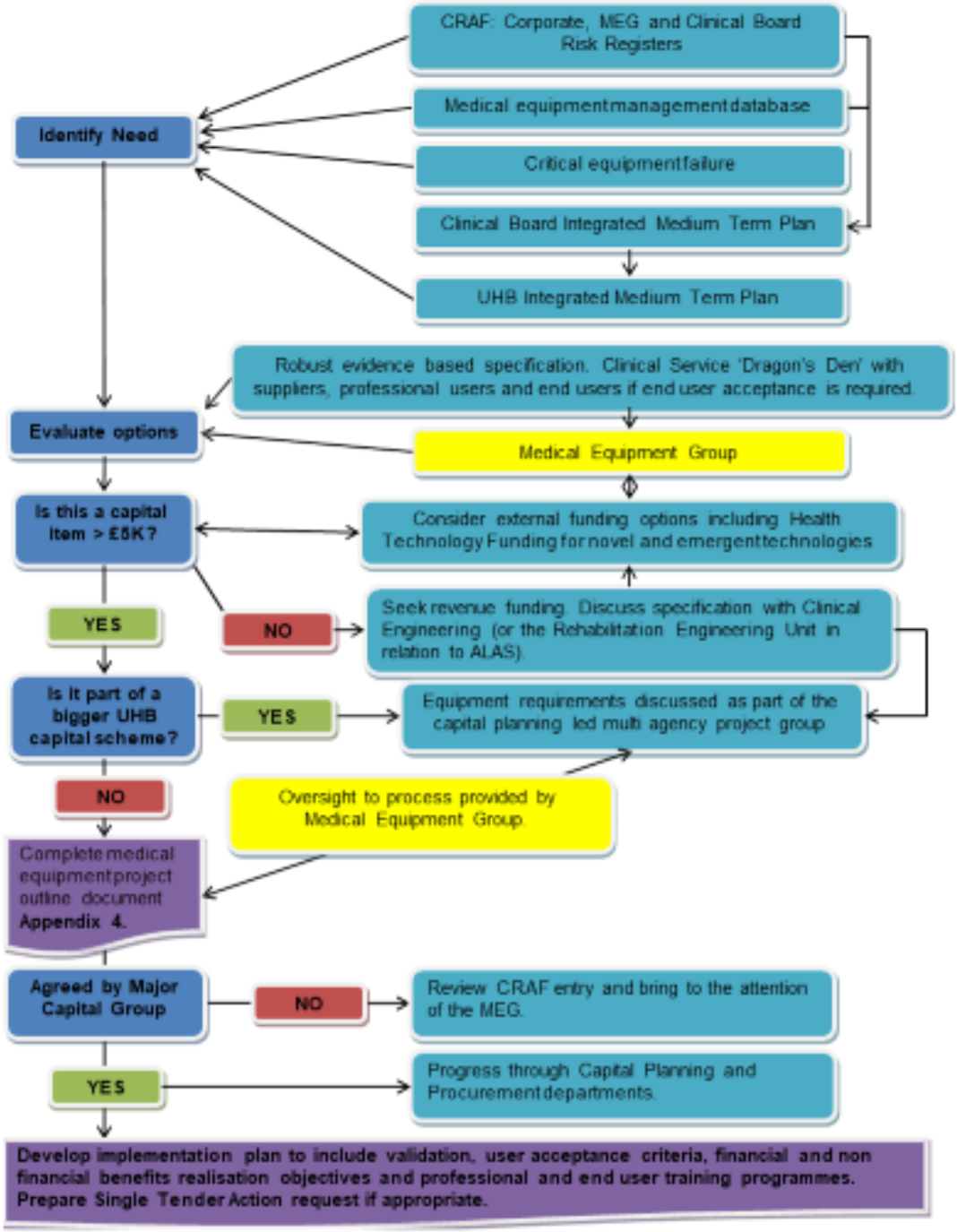
Clinical Board Head of Finance Authorisation	Role	Date

MDSO Authorisation	Role	Date

Executive Authorisation	Role	Date

Appendix 7

Medical Equipment Procurement Pathway



REFERENCES

[1] Medical Devices Regulations 2002 (as subsequently amended)

Medical Devices are defined as follows and include a huge range of devices from sticking plasters to MRI scanners. The definition also encompasses disposables such as syringes, and accessories such as electrocardiograph leads:

A medical device is defined as:

Any instrument, apparatus, appliance, software, implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings for one or more of the following specific medical purposes:

— diagnosis, prevention, monitoring, prediction, prognosis, treatment or alleviation of disease,

— diagnosis, monitoring, treatment, alleviation of, or compensation for, an injury or disability,

— investigation, replacement or modification of the anatomy or of a physiological or pathological process or state,

— providing information by means of *in vitro* examination of specimens derived from the human body, including organ, blood and tissue donations, …

An 'accessory for a medical device' are regulated as if it is a medical device.

[2] National Audit Office, *The Management of Medical Equipment in NHS Acute UHBs in England,* HC 475Session 1998-99, HMSO, London, 1999

[3] Managing Medical Devices, Guidance for healthcare and social services organisations, MHRA, April 2015

[4] Health and Safety at Work Act 1974

- Provision and Use of Work Equipment Regulations (PUWER) 1998

[5] Health and Care Standards, Welsh Government, January 2021

[6] Keay, S. *Policy for Parenteral Infusion Pumps Issue 2.0* Cardiff and Vale NHS UHB, Policy No 77, Cardiff, August 2003

[7] McCarthy J.P., *Health Service Equipment Management; the Engineers View* Presented to a Welsh Medical Technology Forum Seminar; *Medical Devices - the User's View.* Treforest, South Wales, October 1994

[8] McCarthy J.P., *Equipment Management: A Current Perspective* Presented to an NHS conference; *The Way Ahead for Equipment Procurement in the NHS,* Eastwood Park, June 1998

Reference Number: *UHB 344* **Version Number:** 3	**Date of Next Review: 30/Oct/2025** **Previous Trust/LHB Reference Number:** N/A

Ionising Radiation Risk Management Policy

Policy Statement

To ensure that the Cardiff and Vale University Health Board (UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will manage our use of use ionising radiation in a safe manner and in such a way as to protect the health and well-being of patients, staff and members of the public.

Policy Commitment

We will:

- Provide a robust framework for the management and use of ionising radiation
- Ensure that management of the use of ionising radiation is safe and compliant with current legislation, standards and guidance in order to protect the UHB, patients, staff and members of the public
- Ensure that managers and staff are aware of their roles in the safe use of ionising radiation
- Keep radiation doses and dose rates as low as reasonably practicable (ALARP)
- Restrict the use of ionising radiation to practices that are justified and ensure that each intentional exposure of a human subject is individually justified
- Optimise exposure to ionising radiation in order to reduce radiation dose, provided that this is consistent with any desired clinical or related outcome
- Keep radiation doses to staff and members of the public within statutory dose limits
- Manage radiation equipment in accordance with accepted best practice
- Entitle duty holders associated with the exposure of human subjects to ionising radiation
- Demonstrate compliance through record keeping and audit
- Appoint Radiation Protection Adviser(s), Medical Physics Expert(s) and Radiation Protection Supervisors, Dangerous Goods Safety Adviser(s) and Radioactive Waste Adviser(s)

Supporting Procedures and Written Control Documents

This Policy is supported by two procedures:

- Exposure of Patients to Ionising Radiation Procedure
- Exposure of Staff and Members of the Public to Ionising Radiation Procedure

They describe the following with regard to the safe use of ionising radiation:

- Procurement and use of radiation equipment, particularly for medical applications
- Management of the use of ionising radiation with emphasis on the safety of those who are affected or may be affected by its use
- Demonstration of compliance with regulatory requirements and dealing with instances of non-compliance
- Duties associated with the safe use of ionising radiation

Other supporting documents include:

- Health and Safety Policy
- Medical Equipment Management Policy
- Risk Management and Board Assurance Framework
- Radioactive Substances Risk Management Policy
- Radioactive Substances Risk Management Procedure

Scope

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

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has not been completed, this policy is a requirement to meet current ionising radiation legislation
Health Impact Assessment	A Health Impact Assessment (HIA) has not been completed, this policy is a requirement to meet current ionising radiation legislation
Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Radiation Protection Group

Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	Medical Physics Experts, Clinical Scientist, Director of M.P.C.E.

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 Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	13/01/2016	04/01/2017	Supersedes UHB 031 and T299
2	25/07/2019	04/09/2019	Amendment
3			Add DGSA to list of appointed personnel, minor grammatical amendments

Reference Number: UHB 345 Version Number: 3	Date of Next Review: 30/Oct/2025 Previous Trust/LHB Reference Number: N/A

Exposure of Patients to Ionising Radiation Procedure

Introduction and Aim

The Cardiff and Vale University Health Board (UHB) uses ionising radiation for a variety of clinical and other applications and this use presents a potential hazard to a range of people including patients, staff and members of the public.

The UHB has an Ionising Radiation Risk Management Policy the aim of which is to ensure that we manage the use of ionising radiation in such a way as to minimise adverse effects on people, provided that this is consistent with any desired clinical or related outcome.

This Procedure supports the Policy and translates its aim into practical implementation measures as regards the safety of patients.

Objectives

We will achieve our aim by:

- Providing a robust framework for the management and safe use of ionising radiation
- Ensuring that management of the use of ionising radiation is safe and compliant with current legislation, standards and guidance in order to protect the UHB, patients, staff and members of the public
- Ensuring that managers and staff are aware of their roles in the safe use of ionising radiation
- Keeping radiation doses and dose rates as low as reasonably practicable (ALARP)
- Restricting the use of ionising radiation to practices that are justified and ensure that each intentional exposure of a human subject is individually justified
- Optimising exposure to ionising radiation in order to reduce radiation dose, provided that this is consistent with any desired clinical or related outcome
- Managing radiation equipment in accordance with accepted best practice guidelines and manufacturer recommendations
- Entitling duty holders associated with the exposure of human subjects to ionising radiation
- Demonstrating compliance through record keeping and audit
- Appointing Radiation Protection Advisers, Medical Physics Experts and Radiation Protection Supervisors

Scope This procedure applies to all of our staff in all locations including those with honorary contracts.	
Equality Impact Assessment	An Equality Impact Assessment (EqIA) has not been completed as this procedure is a requirement to meet current legislation.
Health Impact Assessment	*A Health Impact Assessment (HIA) has not been completed*
Documents to read alongside this Procedure	• Ionising Radiation Risk Management Policy • Exposure of Staff and Members of the Public to Ionising Radiation Procedure • Health and Safety Policy • Medical Equipment Management Policy • Risk Management Policy • Radioactive Substances Risk Management Policy • Radioactive Substances Risk Management Procedure
Approved by	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	Medical Physics Experts, Clinical Scientist, Director of M.P.C.E.

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 Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	13/12/2016	04/01/2017	New Document
2	25/07/2019	04/09/2019	Amendment
3			Legislation updated

Contents

1 Definition of terms

Absorbed dose
The fundamental type of radiation dose defined as the energy deposited by ionising radiation in unit mass of irradiated material.

Alpha radiation
Particulate ionising radiation in the form of helium-4 nuclei (a combination of two protons and two neutrons) emitted by nuclei during radioactive decay.

Beta radiation
Particulate ionising radiation in the form of electrons or positrons emitted by nuclei during radioactive decay.

Deterministic effect
An effect of ionising radiation on living tissue in which the severity of the effect increases with radiation dose above a threshold dose (below which the effect does not occur).

Diagnostic Reference Level (DRL)
Value of radiation dose, or administered activity in nuclear medicine, for typical diagnostic examinations in groups of standard-sized patients for broadly defined types of radiation equipment.

Dose constraint
A restriction on the prospective radiation dose to an individual that may result from a given radiation source.

Effective dose
The sum of the product of equivalent dose and tissue weighting factor taken over all irradiated tissues and organs.

Electron
A negatively charged particle that is one of the constituents of the atom.

Equivalent dose
The product of absorbed dose and radiation weighting factor for a particular irradiated tissue or organ.

Gamma rays (gamma radiation)
Ionising radiation in the form of photons emitted by nuclei during radioactive decay.

Gy
The gray, which is the unit of absorbed dose (equal to 1 joule of energy per kg).

Ionising radiation
Radiation that is sufficiently energetic to cause ionisation through the release of inner electrons in atoms of high atomic number.

Neutron
An uncharged particle that is one of the constituents of the atomic nucleus.

Particle
A unit of radiation that has mass e.g. electron, beta particle, proton, alpha particle and neutron.

Photon
A unit (quantum) of electromagnetic radiation such as infra-red, visible, ultra-violet, x and gamma radiation.

Proton
A positively charged particle that is one of the constituents of the atomic nucleus.

Radiation
A stream of energy, usually in the form of photons or particles, emitted from a source, moving through a material and interacting with it to deposit energy in the material.

Radiation dose
A measure of the energy deposited by ionising radiation in a material and its potential harmful effects.

Radiation employer
An employer who in the course of a trade, business or other undertaking carries out, or engages others to carry out, work with ionising radiation.

Radiation weighting factor
A quantity that indicates the relative harmfulness of different types of ionising radiation to living tissue.

Radioactive decay or disintegration
The transformation of one nuclide (a radionuclide) into another with the emission of ionising radiation.

Radioactive substance (material)
Substance (material) that contains one or more radionuclides.

Radioactive waste
Any material that is either radioactive in its own right or is contaminated by radioactive substances and for which no further use is envisaged.

Radioactivity
The phenomenon associated with radioactive decay or disintegration.

Radiopharmaceutical
A radioactive medicinal product that is administered to human subjects for medical diagnosis or treatment or a related purpose such as medical research.

Radiosensitivity
The sensitivity or susceptibility of different tissues and organs to the harmful effects of radiation.

Stochastic effect
An effect of ionising radiation on living tissue in which the probability of the effect occurring increases linearly with radiation dose without a threshold.

Sv
The sievert, which is the unit of equivalent dose and effective dose.

Tissue weighting factor
A quantity that indicates the relative sensitivity or susceptibility of different tissues and organs to the harmful effects of ionising radiation.

Tissue reaction
This is the same as a deterministic effect.

X-rays (x-radiation)
Ionising radiation in the form of photons emitted by electron interactions in atoms, possibly as a consequence of radioactive decay.

X-ray tube
An evacuated chamber in which electrons are accelerated towards a target to produce x-rays.

2 Use and harmful effects of ionising radiation

Ionising radiation takes the form of either high energy photons (such as x-rays and gamma rays) or high energy particles (such as alpha radiation, beta radiation, electrons, protons and neutrons). It is produced by electrical radiation generators (such as x-ray tubes) and by radioactive substances.

Ionising radiation has a wide range of beneficial applications but it also has the potential to cause harm.

The UHB uses ionising radiation at Barry Hospital, Cardiff Royal Infirmary, St David's Hospital, University Hospital Llandough (UHL), the University Hospital of Wales (UHW) (including the Children's Hospital and the Dental Hospital) and at community medical and dental sites in the following practices:

- Production of radioactive products (including radiopharmaceuticals and radioactive sources)
- Application of radioactive tracers (for medical and biological techniques)
- Diagnosis (medical)
- Treatment (medical)
- Medical and biomedical research
- Examinations performed for insurance or legal purposes without a medical indication
- Teaching including further and higher education and training
- Ionising radiation metrology
- Transport of radioactive material

All these practices are justified [1-3] i.e. they produce sufficient benefit to individuals exposed to ionising radiation or to society in general to offset the detriment that they cause. Justification is one of the basic tenets of radiation protection, the others being optimisation and dose limitation [4].

The majority of the above practices are associated with radiology (diagnostic and interventional) and nuclear medicine (diagnostic and therapeutic). In radiology, human subjects are exposed to x-rays from an external source (x-ray tube). Radiology is practised widely throughout the UHB. Nuclear medicine, on the other hand, involves the administration of radioactive substances (in the form of radioactive medicinal products or radiopharmaceuticals) to humans such that the subjects are irradiated internally by beta and gamma radiation. Nuclear medicine is practised only at UHW and UHL.

The potential of ionising radiation to cause harm is usually expressed in terms of radiation dose, which is a measure of the energy deposited by radiation and its impact on living tissue [4]. The basic quantity is absorbed dose, which is an expression of the energy deposited by ionising radiation per unit mass of the material which it irradiates; its unit is the gray (Gy). Absorbed dose is used to quantify the energy deposited by ionising radiation in tissues and organs.

The same absorbed dose delivered to living tissue by different types of ionising radiation causes biological damage to different extent. This variation

is expressed by the radiation weighting factor, which is unity (one) for x, beta and gamma radiation (since they are equally harmful) and greater for alpha radiation and neutrons (because they are relatively more harmful for the same absorbed dose). The equivalent dose is given by the absorbed dose multiplied by the radiation weighting factor. It is indicator of harm to a particular tissue or organ due to ionising radiation irrespective of the type (and energy) of the radiation; its unit is the sievert (Sv).

In addition, some living tissues and organs are more sensitive or susceptible to the harmful effects of ionising radiation. This variation is expressed by the tissue weighting factor, which is relatively larger for those tissues and organs which are most radiosensitive (i.e. most susceptible to the harmful effects of radiation). The effective dose is the sum of the equivalent dose multiplied by the tissue weighting factor for all irradiated tissues and organs. It is an indicator of harm to the whole body from either total or partial exposure to radiation regardless of the number of tissues and organs exposed; it is also expressed in Sv.

There are two broad types of harmful effect of ionising radiation: deterministic effects (also called tissue reactions) and stochastic effects [4]. Deterministic effects occur in the irradiated individual and are characterised by a threshold absorbed dose (below which the effect does not occur) and the fact that the severity of the effect increases with absorbed dose (above the threshold). An example would be erythema (reddening) of the skin with a threshold of 2-5 Gy and progression to blistering and ulceration as absorbed dose increases.

For stochastic effects, the probability of the effect occurring increases in proportion to effective dose; there is no threshold. Stochastic effects may occur in irradiated individuals and in future generations. The most important stochastic effect is the induction of cancer in an irradiated individual. For a general population, the risk of fatal cancer is about 5% per Sv, although the risk varies with age and is greater for children than for adults [4].

Irradiation of the embryo and foetus may cause both deterministic and stochastic effects [4].

3 Regulation of ionising radiation

The use of ionising radiation is governed by legislation that is designed to control its adverse effects on people and the environment. This involves keeping radiation doses as low as reasonably practicable (ALARP). The legislation is supported by codes of practice and guidance and compliance is assessed through a programme of inspections by statutory external agencies.

The exposure of patients to ionising radiation is governed by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 and a subsequent amendment to the regulations [5,6]. The regulations are supported by official and professional body guidance [7,8]. They apply to the deliberate exposure of human subjects to ionising radiation as follows:

- To patients as part of their medical diagnosis or treatment
- To individuals as part of health screening programmes
- To patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes
- To carers and comforters
- To asymptomatic individuals
- To individuals undergoing non-medical imaging using medical radiological equipment

For the purposes of this Procedure, those subject to exposures in these categories are collectively called ‘patients’. Practices that involve the deliberate exposure of humans under circumstances other than the above do not fall within the scope of IR(ME)R 2017. Such practices are permitted only if their justification is confirmed by the most recent version of the national Justification Register [1-3,9]. The regulations specify the responsibilities of employer, referrer, practitioner, operator and Medical Physics Expert (MPE)

The regulations are enforced by Healthcare Inspectorate Wales (HIW), which reports on its activities. In England, similar reports are published by the Care Quality Commission (previously Healthcare Commission) [10-11].

In nuclear medicine, radiopharmaceuticals may be administered to humans only by a person who holds a licence from Health Ministers or someone acting under the authority of such a person. In addition, a separate licence is required by the employer at each site where such administrations take place [12]. Radiopharmaceuticals are prepared in a specialised radiopharmacy at UHW under a regime [7, 13-15] that is regulated by the Medicines and Healthcare products Regulatory Agency (MHRA).

The Ionising Radiations Regulations (IRR) 2017 [16] address all aspects of work with ionising radiation. They are made under the Health and Safety at Work Act 1974 [17] and are supported by an Approved Code of Practice (ACOP) and official guidance [18] as well as professional body guidance [9]. IRR 2017 deal with the radiation protection of workers and the members of the public who are exposed as a result of work with ionising radiation. They are not concerned directly with the radiation protection of patients. The regulations specify the responsibilities of a radiation employer; these include making risk assessments, appointing a Radiation Protection Adviser (RPA)

and one or more Radiation Protection Supervisors (RPSs) and writing Local Rules. IRR 2017 are enforced by the Health and Safety Executive (HSE).

Radioactive material is kept on UHW and UHL premises only, in accord with the stipulations of the Environmental Permitting (England and Wales) Regulations (EPR) 2016 [19-20] and under conditions that are specified in Environmental Permits issued by Natural Resources Wales (NRW). The same applies to the accumulation and disposal of radioactive waste. The permits are site-specific for UHW and UHL. In addition, there is a requirement [21] to appoint a suitable Radioactive Waste Adviser (RWA). Radioactive materials are transported in a manner [22-23] that is consistent with the requirements of the Office for Nuclear Regulation, which includes the appointment of a Dangerous Goods Safety Adviser (DGSA). Regulations governing the keeping and transportation of radioactive substances and the management of radioactive waste do not have a direct impact on the radiation safety of patients.

4 General arrangements for the protection of patients against the harmful effects of ionising radiation

For the deliberate irradiation of patients, the goal of radiation protection is to achieve the desired clinical outcome while restricting radiation exposure as much as possible i.e. keeping radiation doses ALARP. The mechanisms for achieving this goal are the justification of individual exposures and the optimisation of processes. For diagnostic and interventional procedures this means minimising the risk of stochastic effects and avoiding deterministic effects. For therapeutic procedures, doses to non-target volumes should be as low as reasonably practicable consistent with the intended therapeutic purpose. IR(ME)R [5-6] provide a regulatory framework within which the UHB works to achieve these goals.

The exposure of patients to ionising radiation is mainly carried out in three Clinical Boards within the UHB: Specialist Services, Clinical Diagnostics and Therapeutics and Surgery.

The Employer as defined in the regulations is the UHB and the Chief Executive takes overall responsibility for compliance with legislation on behalf of the UHB. The Chief Executive has delegated the task of ensuring compliance with radiation safety legislation to the Executive Director of Therapies and Health Science (DoTH). The DoTH has further delegated this task to individuals throughout the UHB's line management structure. This includes the identification and entitlement of various duty holders and the appointment of Medical Physics Experts to provide expert advice regarding the medical exposure of patients.

The UHB has established a Radiation Protection Group (RPG) that reports to the Quality, Safety and Patient Experience Committee and onwards to the Executive Board. The RPG discusses all aspects of radiation safety including the exposure of patients and its work includes what would otherwise be done by a Medical Exposures Committee.

5 Specific arrangements for the regulation of medical exposures to ionising radiation

The UHB must provide standard operating procedures (SOPs) for all aspects the medical exposure of patients to ionising radiation. These include the following employer's procedures (IR(ME)R Schedule 2):

(a) to identify correctly the individual to be exposed to ionising radiation;
(b) to identify individuals entitled to act as referrer or practitioner or operator within a specified scope of practice;
(c) for making enquiries of individuals of childbearing potential to establish whether the individual is or may be pregnant or breastfeeding;
(d) to ensure that quality assurance programmes in respect of written procedures, written protocols, and equipment are followed;
(e) for the assessment of patient dose and administered activity;
(f) for the use and review of such diagnostic reference levels as the employer may have established for radiodiagnostic examinations falling within regulation 3(a), (b), (e) and (f);
(g) for determining whether the practitioner or operator is required to effect one or more of the matters set out in regulation 12(4) including criteria on how to effect those matters and in particular procedures for the use of dose constraints established by the employer for biomedical and medical research programmes falling within regulation 3(c) where no direct medical benefit for the individual is expected from the exposure;
The
(i) providing that wherever practicable, and prior to an exposure taking place, the individual to be exposed or their representative is provided with adequate information relating to the benefits and risks associated with the radiation dose from the exposure;
(j) for the carrying out and recording of an evaluation for each exposure including, where appropriate, factors relevant to patient dose;
(k) to ensure that the probability and magnitude of accidental or unintended exposure to individuals from radiological practices are reduced so far as reasonably practicable;
(l) to ensure that the referrer, the practitioner, and the individual exposed or their representative are informed of the occurrence of any relevant clinically significant unintended or accidental exposure, and of the outcome of the analysis of this exposure;
(m) to be observed in the case of non-medical imaging exposures;

(n) to establish appropriate dose constraints and guidance for the exposure of carers and comforters.

Those procedures that apply throughout the UHB, especially at corporate level, are addressed in this document. More detailed procedures are tailored to the work of individual services. The content of these procedures may vary considerably from one service to another, reflecting the diversity of the UHB's clinical and research work.

The UHB as employer should pay special attention to the following:

- Exposures that have no direct health benefit to the exposed individuals including setting dose constraints for research
- Medical exposure of children because of their relatively high radiosensitivity compared with adults
- Medical exposure for health screening, which can involve large numbers of symptomless individuals
- Medical exposures involving high radiation dose to patients because of the increased stochastic risk and the possibility of tissue reactions
- Medical exposures to individuals of childbearing potential in whom pregnancy cannot be excluded, in particular if pelvic or abdominal anatomic regions are involved, considering the exposure of both the expectant individual and the unborn child, the urgency of the exposure and the relatively high radiosensitivity of the foetus
- Radiopharmaceutical administrations in nuclear medicine to individuals who are breast feeding, considering the exposure of both the individual and the child and the urgency of the exposure

The UHB should perform other duties imposed upon the employer; these include ensuring that:

- Referral criteria, such as those developed by the Royal College of Radiologists for diagnostic investigations [24], are made available to referrers, together with the appropriate radiation doses
- Research involving radiation exposure has been approved by the appropriate Ethics Committee
- Individuals who administer radiopharmaceuticals in nuclear medicine hold appropriate licences issued under advice from officials of the Administration of Radioactive Substances Advisory Committee (ARSAC) on behalf of the Licencing Authority.
- In nuclear medicine, the role of practitioner is undertaken by an ARSAC licence holder
- Duty holders are identified for each exposure, with particular attention to the use of portable radiation equipment and exposures conducted in multi-disciplinary settings (such as an operating theatre or a catheterisation laboratory)

- Adequate training, including that for new techniques, and continuous professional development (CPD) is provided for practitioners and operators
- Records of training are kept and made available for inspection by HIW
- Duty holders (including referrers, practitioners and operators) carry out the duties assigned to them in Section 6 of this Procedure
- The radiation exposure of individual patients is justified and authorised and different types of exposure are optimised
- Practitioners and operators comply with SOPs
- Written protocols are provided for each type of standard radiological practice for each item of equipment
- The expertise of Medical Physics Experts (MPEs) as specific operators is used as appropriate, depending upon the hazards and radiation doses associated with the particular type of exposure
- Appropriate clinical audit is carried out
- An inventory is kept of equipment used for medical exposure
- Incidents involving radiation doses to patients much greater than intended or are clinically significant [25] are reported to HIW

6 Duties

To ensure the implementation of its Ionising Radiation Risk Management Policy as regards the exposure of patients, the UHB assigns the duties described here.

The duties of the Executive Director of Therapies and Health Science include:

- Ensuring that the UHB provides suitable management arrangements, including sufficient resources and competent persons, to comply with legislation and guidance governing the safe use of ionising radiation
- Providing assurance to the UHB Board that the use of ionising radiation is managed in compliance with the UHB's policies and procedures
- Informing the UHB Board about issues related to the use of ionising radiation
- Ensuring that Clinical Board Directors have arrangements in place for the entitlement of referrers, practitioners and operators for services provided within their Clinical Boards
- Appointing suitably qualified and experienced MPEs in writing
- Maintaining a list of appointed MPEs including their scope of practice
- Delegating duties to other managers as appropriate
- Ensuring that the UHB holds licences for the sites at which radiopharmaceuticals are administered

The duties of Clinical Board Directors include:

- Providing assurance to the Executive Director of Therapies and Health Science that the use of ionising radiation is managed in compliance with policies and procedures and regulatory requirements
- Ensuring that Directorate Clinical Directors have arrangements in place for the entitlement of referrers, practitioners and operators for services provided by their Directorates
- Communicating and liaising with the Chair of the Radiation Protection Group, Practitioners, MPEs, Clinical Directors and other managers about issues related to the use of ionising radiation
- Reporting confirmed incidents of exposure much greater than intended to HIW in a timely manner
- Disseminating information about reported incidents within the UHB as appropriate
- Delegating duties to other managers as appropriate

The duties of Directorate Clinical Directors include:

- Ensuring that members of staff are aware of their roles and duties as regards medical exposures
- Entitling registered healthcare professionals as referrers, defining their scope of practice (with due regard to their qualifications and training) and making referral guidelines available to them
- Entitling registered healthcare professionals as practitioners and defining their scope of practice (e.g. in terms of type of medical exposure)
- Entitling operators and defining their scope of practice (e.g. in terms of operator tasks, including making and recording a clinical evaluation of each exposure)
- Withdrawing entitlement for persistent non-compliance with policies and procedures
- Maintaining a list of referrers, practitioners and operators
- Ensuring that practitioners and operators are qualified, adequately trained, receive update training as appropriate and participate in continuous professional development
- Maintaining training records and making such records available for inspection
- Providing SOPs and exposure protocols for their services and reviewing these documents at appropriate intervals
- Ensuring that a record is kept of all medical exposures including the names of the referrer, practitioner and operator(s) and an estimate of radiation dose for each individual exposure
- Providing procedures to ensure that a clinical evaluation is made and recorded for each exposure and that the record (report) is received by the referrer in a timely manner

- Ensuring that medical exposures and associated procedures are subject to suitable clinical and other types of audit
- Investigating suspected incidents of accidental, unnecessary or unintended exposure in association with the appropriate MPE and reporting confirmed incidents of exposure much greater than intended to the Clinical Board Head of Operations and Delivery
- Keeping records of incidents for the appropriate time
- Delegating duties to duty holders and other managers as appropriate

In nuclear medicine:

- Ensuring that practitioners hold ARSAC licences for the administrations of radiopharmaceuticals for procedures that they wish to undertake and that there is an employer licence to cover the required procedure(s).

The duties of the Chair of the UHB Radiation Protection Group include:

- Providing advice on the implementation of relevant UHB policies and procedures
- Receiving compliance reports with respect to relevant UHB policies and procedures
- Reviewing relevant UHB policies and procedures at least every three years and ensuring that they are amended and updated as necessary
- Reviewing reports from Medical Physics Experts and taking action as necessary
- Liaising with members of the Radiation Protection Group and others as necessary

The duties of the Medical Physics Expert (MPE) include:

- Being involved as appropriate in clinical exposures with external radiation beams
- Working closely with practitioners as regards the justification of medical exposures
- Working closely with operators, maintenance engineers and others as regards the optimisation and practical aspects of medical exposures
- Measuring radiation dose and providing calibrated systems for radiation dose measurement
- Estimating radiation dose and assessing radiation risk to patients and, where appropriate, embryo or foetus, in cases of both intended and unintended exposure
- Providing advice to patients as regards radiation risk including individuals of child bearing potential who are or may be pregnant
- Providing advice and assessing the radiation dose implications of introducing new equipment and techniques
- Setting and reviewing diagnostic reference levels (DRLs) for clinical exposures and dose constraints and target doses for research exposures

- Monitoring and reviewing patient radiation doses and developing dose reduction strategies
- Evaluating image quality in relation to patient dose
- Providing a quality assurance programme for equipment and liaising with other operators as regards routine equipment quality control
- Reviewing and communicating the outcome of equipment quality assurance
- Advising on equipment management including the specification, selection and purchase of clinical and related radiation equipment and the maintenance of an equipment inventory
- Advising on the application and quality assurance of clinical software for the purpose of recording and optimising dose
- Performing acceptance testing and participating in commissioning new equipment including communicating with equipment supplier applications specialists
- Advising on the suspension of the use of existing equipment
- Reviewing equipment replacement policies and processes
- Developing and performing suitable audits for medical exposures and participating in multi-disciplinary clinical audit programmes
- Investigating incidents including making patient radiation dose assessments
- Advising on the radiation protection of comforters and carers in association with the RPA
- Participating in inspections by statutory authorities
- Contributing to the development, implementation and quality assurance of employer's procedures, SOPs and exposure protocols
- Providing training
- Participating in multi-disciplinary clinical audit and review
- Liaising with the RPA as regards the design and construction of clinical and related radiation facilities
- Liaising with the RPA and agreeing on the demarcation of duties associated with radiation safety and compliance with legislation
- Communicating with practitioners, operators, managers and other employees as appropriate

In nuclear medicine

- Being available for diagnostic investigations and standard radionuclide therapies
- Being present and closely involved with all therapeutic administrations of radiopharmaceuticals that are non-standard or being undertaken for the first time
- Supporting applications for ARSAC licences by the UHB and by practitioners.
- Providing advice as regards radiation risk to infants in the case of individuals who are breast feeding

- Working closely with practitioners and others as regards the development and implementation of protocols for the diagnostic and therapeutic administration of radiopharmaceuticals
- Providing radiation protection advice to patients leaving hospital after radiopharmaceutical administration and to those who care for or come into contact with such patients, in liaison with the RPA
- Measuring radioactivity and providing calibrated systems for radioactivity measurement
- Liaising with the RWA and DGSA as regards the storage and transportation of radioactive substances and the accumulation and disposal of radioactive waste

The duties of the Radiation Protection Adviser (RPA) include:

- Liaising with MPEs and agreeing on the demarcation of duties associated with radiation safety and compliance with legislation
- Liaising with MPEs as regards the design and construction of clinical and related radiation facilities

In nuclear medicine:

- Providing radiation protection advice to patients leaving hospital after radiopharmaceutical administration and to those who care for or come into contact with such patients, in liaison with MPEs

The duties of the Referrer include:

- Providing the practitioner with accurate and legible information to permit unambiguous identification of the patient and a decision on justification (i.e. whether a net benefit is associated with the exposure)
- Ensuring that referrals or medical exposure are made within their scope of practice, in accordance with referral guidelines and after discussion with the practitioner where appropriate
- Ensuring that in the case of referrals made for clinical purposes, the required information has not already been provided by previous diagnostic investigations
- Assessing and acting upon reports and clinical evaluations in an appropriate and timely manner
- Identifying exposures that are requested for research purposes
- Ensuring that in the case of referrals made for research purposes, the research protocol has received ethics approval and that outcomes are included in the data analysis

The duties of the Practitioner include:

- Justifying individual exposures taking account of information supplied by the referrer, the specific objectives of the exposure, the characteristics of the patient, the benefit of the exposure vs. the nature and risk of potential detriment and the usefulness of alternative techniques

- Paying special attention to the justification of exposures on children and individuals of childbearing potential in whom pregnancy cannot be excluded, with due regard to the urgency of the exposure and the possible irradiation of an unborn child
- Paying special attention to the justification of exposures to carers and comforters and those who derive no direct health benefit from the exposure
- Authorising individual exposures (by physical or electronic signature) and delegating authorisation to operators under written Delegated Authorisation Guidelines (DAGs) as appropriate
- Liaising with referrers regarding referrals that may not be justified i.e. ones for which there is insufficient net benefit
- Returning referrals when there is insufficient or incorrect information to unambiguously identify the patient
- Ensuring that radiation doses for research exposures are consistent with dose constraints (where there is no health benefit to the individual) or target doses (where there is such a benefit) as specified in the research protocol
- Co-operating with operators, MPEs and others as regards practical aspects of exposures to keep radiation doses ALARP, consistent with the intended purpose
- Discussing incidents of accidental, unnecessary or unintended exposure with patients
- Engaging in continuous professional development and keeping a personal record of such activity

In nuclear medicine:

- Obtaining an ARSAC licence for clinical administrations of radiopharmaceuticals and ensuring that research administrations are authorised if relevant.
- Paying special attention to the justification of an exposure to individuals who are breast feeding, taking account of possible radiation dose to the infant
- Prescribing administered activities and routes of administration for diagnostic and research investigations that are in accord with ARSAC recommendations and trial protocols.
- Making an individual assessment of each patient referred for radionuclide therapy and prescribing an administered activity and route of administration that takes account of professional guidance

The duties of the Operator include:

- Selecting equipment and methods to keep doses ALARP, consistent with the intended diagnostic, therapeutic or other purpose
- Paying special attention to quality assurance, assessment of radiation dose and adherence to DRLs

- Paying special attention to the restriction of radiation dose and the optimisation of exposures for children and individuals of childbearing potential in whom pregnancy cannot be excluded
- Paying special attention to the optimisation of exposures made for health screening purposes and those that impart a relatively high radiation dose
- Co-operating with practitioners, MPEs and others as regards practical aspects of exposures
- Authorising individual exposures (by physical or electronic signature) under written Delegated Authorisation Guidelines (DAGs) from the practitioner
- Making and recording a clinical evaluation of each exposure including diagnostic findings and therapeutic implications as appropriate within the scope of practice
- Engaging in continuous professional development and keeping a personal record of such activity

In nuclear medicine

- Taking care to administer an appropriate activity of the correct radiopharmaceutical through the correct route of administration
- Paying special attention to the optimisation of an exposure to an individual who is breast feeding, taking account of possible radiation dose to the infant

The duties of all individual members of staff include:

- Following SOPs and protocols for medical exposure
- Reporting suspected incidents of accidental, unnecessary or unintended patient exposure to the Directorate Clinical Director through the line management structure

7 References

1. The Justification of Practices Involving Ionising Radiation Regulations 2004. Statutory Instrument 2004 No. 1769.

2. The Justification of Practices involving Ionising Radiation (Amendment) Regulations 2018. Statutory Instrument 2018 No. 430.

3. The Justification of Practices Involving Ionising Radiation Regulations 2004: Guidance on their Application and Administration.

4. The 2007 Recommendations of the International Commission on Radiological Protection (ICRP Publication 103).

5. The Ionising Radiation (Medical Exposure) Regulations 2017. Statutory Instrument 2017 No. 1322.

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9. Justification Register – Applications and Decisions made under Regulations 9,10 and 12 of the Justification of Practices involving Ionising Radiation Regulations 2004. Updated January 2022

10. Ionising Radiation (Medical Exposures) Regulations 2017: Enforcement policy. CQC 2019

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12. Notes for Guidance on the Clinical Administration of Radiopharmaceuticals and Use of Sealed Radioactive Sources. Administration of Radioactive Substances Advisory Committee 2022.

13. The Medicines Act 1968. Chapter 67.

14. The Human Medicines Regulations 2012. Statutory Instrument 2012 No. 1916.

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17. The Health and Safety at Work etc. Act 1974. Chapter 37.

18. Work with Ionising Radiation: Ionising Radiations Regulations 2017 Approved Code of Practice and guidance. Health and Safety Executive (HSE) 2018.

19. The Environmental Permitting (England and Wales) Regulations 2016. Statutory Instrument 2016 No. 1154.

20. The Environmental Permitting (England and Wales) (Amendment) (No. 2) Regulations 2018. Statutory Instrument 2018 No. 428.

21. Environment Agencies Statement on Radioactive Waste Advisers. Environment Agencies 2018.

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23. Accord Européen relatif au Transport International des Marchandises Dangereuses par Route (ADR) (European Agreement Concerning the International Carriage of Dangerous Goods by Road). United Nations Economic Commission for Europe (UNECE) 2021.

24. iRefer - Making the Best use of Clinical Radiology. Royal College of Radiologists 2018 (version 8).

25. Ionising Radiation (Medical Exposure) Regulations - Significant accidental and unintended exposures under IR(ME)R Guidance for employers and duty-holders. Version 2, August 2020

Reference Number: UHB 463 **Version Number:** 2	**Date of Next Review: 30/Oct/2025** **Previous Trust/LHB Reference Number:** *N/A*

Radioactive Substances Risk Management Policy

Policy Statement

To ensure the Cardiff and Vale University Health Board (UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will manage our use of radioactive substances and exposure to radon in a safe manner and in such a way as to minimise their impact on people and the environment.

Policy Commitment

The UHB will:

- Provide a robust framework and use best available techniques (BAT) to manage radioactive substances
- Ensure that radioactive substances management is safe and compliant with current legislation, standards and guidance in order to protect the UHB, patients, staff, members of the public and the environment
- Ensure that managers and staff are aware of their roles in the safe management of radioactive substances
- Keep radiation doses and dose rates as low as reasonably practicable (ALARP)
- Minimise the amount of radioactive material kept on our premises by only procuring material for work that is justified
- Optimise radioactive substances management processes in order to reduce the amount of radioactive waste that we produce
- Where practicable, reduce the amount of radioactive waste disposed to the environment by accumulating and storing it securely and allowing it to decay
- Dispose of radioactive waste in compliance with Environmental Permits issued by Natural Resources Wales and other statutory and regulatory requirements
- Ensure that arrangements for the transport of radioactive materials satisfy the requirements of the Office for Nuclear Regulation
- Monitor the concentration in air of naturally-occurring radioactive radon gas on its premises and take remedial action to limit exposure where necessary
- Demonstrate compliance through record keeping and audit
- Appoint a Radioactive Waste Adviser(s), a Dangerous Goods Safety Adviser(s), a Radiation Protection Adviser(s) and Radiation Protection Supervisors

Supporting Procedures and Written Control Documents

This Policy is supported by:

- Radioactive Substances Risk Management Procedure (UHB 464)

They describe the following with regards to safe and effective management of radioactive substances:

- Duties associated with the management of radioactive substances
- Procurement and use of radioactive substances
- Transport of radioactive materials
- Management of radioactive waste including its generation, accumulation, disposal and recording
- Arrangements for monitoring and limiting exposure to airborne radon
- Demonstration of compliance with regulatory requirements and dealing with instances of non-compliance

Other supporting documents include:

- Ionising Radiation Risk Management Policy (UHB 344)
- Exposure of Patients to Ionising Radiation Procedure (UHB 345)
- Exposure of Staff and Members of the Public to Ionising Radiation Procedure (UHB 465)
- Health and Safety Policy (IMS 01-01)
- Waste Management Policy (UHB 038)
- Radioactive Materials Management Review for the Management of Radioactive Materials by Best Available Techniques
- Local Waste Management Operational Procedures

Scope

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

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has not been completed as this policy is a requirement to meet current radioactive substances legislation.

Health Impact Assessment	A Health Impact Assessment (HIA) has not been completed
Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	Medical Physics Experts, Clinical Scientist, Director of M.P.C.E.

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 Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	25/07/2019	04/09/2019	New document
2			Reviewed – added UHB policies numbers and minor amendments

Reference Number: UHB 464 Version Number: 2	Date of Next Review: 30/Oct/2025 Previous Trust/LHB Reference Number: N/A

Radioactive Substances Risk Management Procedure

Introduction and Aim

The Cardiff and Vale University Health Board (UHB) uses radioactive materials for a variety of clinical and other applications; this use results in the production of radioactive waste. The radiation emitted by radioactive substances (including radioactive waste) has the potential to present a hazard to people and to living organisms in the environment. In addition, individuals may be exposed to airborne naturally occurring radon gas on the UHB's premises.

The UHB has a Radioactive Substances Risk Management Policy whose aim is to ensure that we manage our use of radioactive substances and exposure to radon in a safe manner and in such a way as to minimise their impact on people and the environment.

This Procedure supports the Policy and translates its aim into practical implementation measures.

Objectives

The UHB will achieve its aim by:

- Providing a robust framework and using best available techniques (BAT) to manage radioactive substances
- Ensuring that radioactive substances management is safe and compliant with current legislation, standards and guidance in order to protect the UHB, patients, staff, members of the public and the environment
- Ensuring that managers and staff are aware of their roles in the safe management of radioactive substances
- Keeping radiation doses and dose rates as low as reasonably practicable (ALARP)
- Minimise the amount of radioactive substances kept on our premises by only procuring material for work that is justified
- Optimising radioactive substances management processes in order to reduce the amount of radioactive waste that is produced
- Where practicable, reducing the amount of radioactive waste disposed to the environment by accumulating and storing it securely and allowing it to decay
- Disposing of radioactive waste in compliance with Environmental Permits issued by Natural Resources Wales and other statutory and regulatory requirements
- Ensuring that arrangements for the transport of radioactive materials satisfy the requirements of the Office for Nuclear Regulation
- Monitoring the concentration in air of radioactive radon gas on its premises and taking remedial action to limit exposure where necessary

- Demonstrating compliance through record keeping and audit
- Appointing a Radioactive Waste Adviser, a Dangerous Goods Safety Adviser, a Radiation Protection Adviser and Radiation Protection Supervisors

Scope

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

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has not been completed, this procedure is a requirement to meet current radioactive substances legislation.
Health Impact Assessment	*A Health Impact Assessment (HIA) has not been completed*, this procedure is a requirement to meet current radioactive substances legislation.
Documents to read alongside this Procedure	• Radioactive Substances Risk Management Policy • Ionising Radiation Risk Management Policy • Exposure of Patients to Ionising Radiation Procedure • Exposure of Staff and Members of the Public to Ionising Radiation Procedure • Health and Safety Policy • Waste Management Policy • Radioactive Materials Management Review for the Management of Radioactive Materials by Best Available Techniques • Local Waste Management Operational Procedures
Approved by	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	Medical Physics Experts, Clinical Scientist, Director of M.P.C.E.

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 Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments

1	25/07/2019	04/09/2019	New Document
2			Updated with current legislation and minor amendments

Contents

1 Definition of terms

Activity
The rate of decay or disintegration of a radionuclide (i.e. the number of nuclei decaying in unit time).

Alpha radiation
Particulate ionising radiation in the form of helium-4 nuclei (a combination of two protons and two neutrons) emitted by nuclei during radioactive decay.

Aqueous waste
Liquid radioactive waste in a continuous aqueous phase with any entrained solids, gases and non-aqueous liquids.

Atomic number
The number of protons in the nucleus of an atom of an element.

Becquerel (Bq)
The unit of activity (equal to one decay or disintegration per second).

Beta radiation
Particulate ionising radiation in the form of electrons or positrons emitted by nuclei during radioactive decay.

Flood-field source
A large area radioactive source that is used to test the uniformity of a gamma camera.

Gamma camera
A device that produces an image of the distribution of a radiopharmaceutical within an individual.

Gamma radiation
Ionising radiation in the form of photons emitted by nuclei during radioactive decay.

GBq
Giga becquerel (10^9 Bq).

Half-life
The time taken for the activity of a radionuclide to decrease to half its original value.

Ionising radiation
Radiation that is sufficiently energetic to cause ionisation through the release of inner electrons in atoms of high atomic number.

kBq
Kilo becquerel (10^3 Bq).

Low Level Waste (LLW)
Solid radioactive waste, including any immediate packaging, with a maximum activity of 4 GBq per tonne (equivalent to 4 kBq per gram) of alpha emitting radionuclides and 12 GBq per tonne (equivalent to 12 kBq per gram) of all other radionuclides

MBq
Mega Becquerel (10^6 Bq).

Nuclide
A particular nuclear species in which all the atomic nuclei are identical (i.e. they contain the same number of protons and the same number of neutrons).

Open source
A radioactive source that is not in the form of a sealed source.

Organic liquid waste
Liquid radioactive waste, not being aqueous waste, containing one or more organic chemical compounds.

Photon
A unit (quantum) of electromagnetic radiation.

Radioactive decay or disintegration
The transformation of one nuclide (a radionuclide) into another with the emission of ionising radiation.

Radioactive source
An object that comprises or contains radioactive substances and is the origin of ionising radiation emitted by radionuclides.

Radioactive substance (material)
Substance (material) that contains one or more radionuclides.

Radioactive generator
A device that produces a short-lived radionuclide from a longer-lived parent radionuclide.

Radioactive waste
Any material that is either radioactive in its own right or is contaminated by radioactive substances and for which no further use is envisaged.

Radioactivity
The phenomenon associated with radioactive decay or disintegration.

Radionuclide
A radioactive nuclide.

Radon
A naturally occurring radioactive gas that is present in air.

Sealed source
A radioactive source whose structure is such as to prevent, under normal conditions of use, any dispersion of radioactive substances to the environment.

Very Low Level Waste (VLLW)
Solid radioactive waste in which each 0.1 m^3 total volume of waste contains a total activity less than 400 kBq and an activity of any single item less than 40 kBq.

X-radiation
Ionising radiation in the form of photons emitted by electron interactions in atoms, possibly as a consequence of radioactive decay.

2 Use and regulation of radioactive substances

Radioactive substances pose a hazard as a result of the ionising radiation that they emit. The UHB as an employer uses radioactive substances at the University Hospital of Wales (UHW) and at University Hospital Llandough (UHL) only

The UHB uses or may use radioactive substances in the following practices:

- Production of radioactive products (including radiopharmaceuticals and radioactive sources)
- Application of radioactive tracers (for medical and biological techniques)
- Diagnosis (medical)
- Treatment (medical)
- Medical and biomedical research Examinations performed for insurance or legal purposes without a medical indication
- Teaching including further and higher education and training
- Ionising radiation metrology
- Transport of radioactive material

All these practices are justified [1-3] i.e. they produce sufficient benefit to individuals exposed to ionising radiation or to society in general to offset the detriment that they cause. Justification is one of the basic tenets of radiation protection [4].

The majority of the above practices are associated with nuclear medicine, which involves the administration of radioactive substances (in the form of radioactive medicinal products or radiopharmaceuticals) to humans, usually for medical diagnosis, medical treatment or medical or biomedical research. Nuclear medicine is practised at UHW and UHL. In addition, radioactive substances are used for the quality control and calibration of radiation equipment and for teaching and training in radiation sciences.

Radiopharmaceuticals are prepared in a specialised radiopharmacy at UHW under a regime [5-9] that is regulated by the Medicines and Healthcare products Regulatory Agency (MHRA). These products are transported to UHL (and other sites in south-east Wales) in a manner [10-11] that is consistent with the requirements of the Office for Nuclear Regulation (ONR), which includes the appointment of a Dangerous Goods Safety Adviser (DGSA).

Radioactive sources are kept and used as sealed sources or open sources in accord with the stipulations of the Environmental Permitting (England and Wales) Regulations (EPR) 2016 [12-13] and under conditions that are specified in separate Environmental Permits issued by Natural Resources Wales (NRW). These permits are also site-specific for UHW and UHL and EPR require the appointment of a Radioactive Waste Adviser(s) (RWA).

Sealed sources are solid objects and typically they are used for equipment quality control or calibration. Open sources, on the other hand, are usually in liquid or gaseous form (although they may be solid). If treated inappropriately, they may release radioactive substances to the environment causing radioactive contamination. Open sources are typically used for administration to patients as part of nuclear medicine tests or treatments.

By their very nature, radioactive substances and their applications are governed by general legislation and guidance [14-17] that apply to the use of ionising radiation, in particular the Ionising Radiations Regulations (IRR) 2017 [17]. This is enforced by the Health and safety Executive (HSE) and requires the appointment of a Radiation Protection Adviser(s) (RPA) and one or more Radiation Protection Supervisors (RPSs) and the writing of Local Rules.

3 General arrangements for the management of radioactive substances

The majority of the UHB's work with radioactive substances is done by the Radiology, Medical Physics and Clinical Engineering (RMPCE) Directorate. In addition, radioactive waste is also generated in theatres. The UHB's use of radioactive substances is subject to formal consent from the HSE. Their management is co-ordinated by Medical Physics and Clinical Engineering (MPCE), (RMPCE Directorate) in association with the RWA(s), the RPA(s) and the DGSA(s).

The UHB procures radioactive materials for specific purposes. Most are purchased for clinical use in nuclear medicine as radiopharmaceuticals; in this case, the majority of the radionuclides have relatively short half-lives ranging from several seconds to several days. In some cases, the radionuclide that is procured (the parent) is not used directly and it is the daughter radionuclide that has clinical application. The most widely used example takes the form of a radioactive generator in which molybdenum-99, decays to the clinically useful technetium-99m. Some clinical radionuclides and most radionuclides obtained for test and calibration purposes have relatively long half-lives ranging from weeks to years.

On receipt, radioactive materials are recorded and securely stored e.g. in a locked safe or a locked cupboard in a controlled access locked room. During storage, the materials are kept in shielded containers made of a suitable material of a suitable thickness and the store is labelled to indicate its contents. Records are kept of the removal of radioactive sources from the store and their return to the store. When a radioactive source is no longer required, its residual activity (following clinical or other use and/or radioactive decay) becomes radioactive waste.

It is inevitable that the use of open radioactive sources produces some radioactive contamination on surfaces and protective clothing. There are routine monitoring programmes to detect such contamination and procedures for decontamination where necessary.

Radiation Risk assessments are made of all aspects of the use of radioactive substances [15,16]. In addition, there are contingency plans to deal with incidents such as a spillage of liquid radioactive material and the loss of a radioactive source. If the activities are sufficiently great, such incidents are reported to the HSE.

The UHB has established a Radiation Protection Group (RPG) that reports to the Quality, Safety and Patient Experience Committee and onwards to the Executive Board. The RPG discusses all aspects of radiation safety including the management of radioactive substances.

4 Transport of radioactive materials

In the course of its work, the UHB transports radioactive materials by road. This poses a potential hazard to staff, members of the public and the environment and in the governing regulations [10- 11], radioactive materials are categorised as Class 7 dangerous goods. These regulations are enforced by Office of Nuclear Regulations (ONR).

Radiopharmaceuticals are transported from UHW to a number of other hospitals each working day for clinical nuclear medicine procedures (including UHL). Sometimes radioactive waste is transported for storage and disposal at another site, radioactive patient samples (such as blood or tissue) are transported for analysis to UHW and to other hospitals, and radioactive calibration and other sources are transported from one site to another. Patients to whom radioactive substances have been administered are not subject to the road transport regulations. It is also the case that the transport regulations do not apply to radioactive materials that are moved from one place to another within a single site (such as a hospital). The material is usually transported in a vehicle designated for this purpose, although a private car may be used under some circumstances; public passenger transport may not be used.

Radioactive materials are packaged in such a way as to minimise the external radiation hazard and the risk of damage to the contents or radioactive contamination. In order of increasing hazard, the packages used by the UHB are designated as exempt, excepted or Type A. Packages are labelled to indicate their contents and there are written procedures to ensure package security, minimise the risk of untoward events and mange incidents if they arise. Transport vehicles carry placards and a fire-proof cab notice to indicate the radioactive nature of the goods and what to do in the event of an accident.

Specific duties are assigned to the consignor (sender of the goods), the carrier (transporter), the vehicle driver and the consignee (recipient). Typically, the UHB is the consignor and the carrier and a member of its staff is the driver; the consignee may the UHB or another organisation. Shipments are accompanied by documents and records such that they are traceable to the consignor. Furthermore, there are training and quality assurance systems for the staff (vehicle drivers in particular), equipment and processes associated with the transport of the materials. There are also contingency plans that are tested periodically either in the field or as a ‘desk-top’ exercise.

5 Generation and regulation of radioactive waste

The use of radioactive substances by the UHB inevitably generates radioactive waste which, in general, may be solid, liquid or gaseous. In addition, the UHB receives radioactive waste from Cardiff University's Heath Park site.

Solid radioactive waste mainly takes the form of items (such as vials, syringes and test tubes) that contain residual radioactive substances and items (such as gloves, swabs, linen and clothing) that are contaminated by radioactive substances. These items are mainly produced as a result of:

- Radiopharmaceutical preparation
- Nuclear medicine tests and treatments
- Radio-Immuno-Assay (RIA)

Solid radioactive waste also includes sealed sources that have reached the end of their useful life.

The UHB produces solid radioactive waste as Low Level Waste (LLW) and Very Low Level Waste (VLLW).

The UHB produces aqueous liquid radioactive waste mainly in the form of:

- Unused radiopharmaceuticals, RIA ingredients and related products
- Gamma emitting nuclear medicine and RIA samples that have been measured
- Human excreta following nuclear medicine tests and treatments

Organic liquid waste is mainly produced as a result of the measurement of beta emitting samples in nuclear medicine using the method of liquid scintillation counting. This type of waste takes the form of liquid in a closed vial or other container.

The UHB does not produce gaseous radioactive waste. Radioactive gas (Krypton-81m) is used in nuclear medicine for lung ventilation imaging but its half-life (13 seconds) is so short that no waste is produced. In addition, Xenon-133 gas is produced as a by-product from Iodine-131 however this is exempt from the Natural Resources Wales Environmental permit.

The receipt, accumulation and disposal of radioactive waste are subject to the same legislation (EPR) [12-13] and regulatory framework as the keeping and use of radioactive substances. These aspects of radioactive waste management are incorporated into the same Environmental permit as applies for the keeping and use of open sources. In addition, there is a requirement [18] to appoint a suitable RWA.

6 General arrangements for the management of radioactive waste

The majority of the UHB's radioactive waste is generated by the work of the RMPCE Directorate; some waste is also generated by the work of the Laboratory Services Directorate. Other directorates may be involved with radioactive waste, especially those who deal with nuclear medicine in-patients and day cases.

In UHW, the management of radioactive waste is co-ordinated by the MPCE department (RMPCE Directorate) in association with Waste Management (Facilities Directorate). This includes the provision of a dedicated secure room that can be used as a radioactive waste store. It is located in Medical Physics at UHW. In UHL, Radioactive waste is co-ordinated by Nuclear Medicine department. This includes the provision of a dedicated secure storage boxes. Radioactive waste is discussed by the RPG.

The UHB uses Best Available Techniques (BAT) for the Management of Radioactive Waste in order to minimise its impact on people and the environment. This includes keeping radiation doses and dose rates as low as reasonably practicable (ALARP) and optimising processes to reduce the amount of radioactive waste produced. There is a separate BAT procedure. The keeping of radioactive substances and the accumulation, storage and disposal of radioactive waste by the UHB should be in accordance with the conditions of the relevant Environmental Permits. Incidents involving non-compliance with Environmental Permits should be reported to NRW.

7 Accumulation, segregation and disposal of radioactive waste

Solid radioactive waste containing short-lived radionuclides (half-lives less than 7 hours) should be placed in a suitable container as it is produced. The container should not be the same as that used to keep long-lived waste and it should be labelled to indicate that it contains radioactive substances.

At the end of the period of waste accumulation, containers of short-lived solid waste should be sealed and placed in the dedicated radioactive waste store or other suitable location. After a period of one week the radioactivity has decayed to such an extent that the waste may be classified as out of scope and/or VLLW. It should be disposed of as contaminated non-radioactive waste after the removal of all labels indicating the presence of radioactivity.

Organic liquid waste and solid radioactive waste containing long-lived radionuclides (half-lives equal to or greater than 7 hours) should be placed in suitable separate containers as it is produced and should be labelled to indicate that they contain radioactive substances. A record should be made of the accumulation of waste in the containers.

After an accumulation period of no longer than three months, containers of organic liquid waste and long-lived solid waste should be sealed and transferred to the dedicated radioactive waste store together with the record of accumulated waste. The contents of the radioactive waste store should be kept securely at all times [19].

At the end of their period of storage, containers of organic liquid waste and long-lived solid waste should be suitably packaged and transferred to a contractor for removal and disposal by incineration (or possible burial at a designated land-fill site) as LLW. A record of the transfer should be made.

Small-sized sealed sources that are no longer required should be regarded as solid radioactive waste. They should be immediately disposed of as VLLW [20] or placed in the radioactive waste store and disposed of as LLW.

In general, large area sealed sources (gamma camera flood-field sources) and radionuclide generators that are no longer required should not be treated as radioactive waste by the UHB. By prior arrangement, they should be transferred as radioactive sources to the provider of a replacement source or generator at or near the time of delivery of the replacement. A record of such transfers should be made.

If transfer as radioactive sources is not possible, large area sealed sources and radionuclide generators that are no longer required should be taken to the dedicated radioactive waste store and disposed of as LLW or VLLW [20].

Individuals to whom radiopharmaceuticals have been administered will excrete some of the administered activity, mainly in urine. While they are on UHB premises, such individuals should be instructed to use designated toilets. These toilets should be identified by notices indicating that they may be used for this purpose.

The excreta are regarded as aqueous liquid waste which eventually reaches the sea via drains, sewers and sewage works. Much of the radioactivity in this waste will decay before it is diluted in sea water. A record should be made of the estimated activity of aqueous waste disposed of in this manner.

Aqueous radioactive waste that is produced in clinical and laboratory settings should be stored wherever possible until out of scope. Alternatively, if storage is not possible, should be disposed of by pouring down designated sinks or sluices and flushing with a copious amount of water. Such sinks, pipes and sluices should be identified by notices indicating that they may be used for this purpose.

The waste eventually reaches the sea via drains, sewers and sewage works and some of the radioactivity in this waste will decay before it is diluted in sea

water. A record should be made of aqueous waste disposed of in this manner.

Since the UHB does not produce gaseous radioactive waste, it does not make any disposals of radioactive waste to air.

8 Exposure to radon

The element radon is a naturally occurring noble gas that only exists in radioactive form [21]. In common usage, the term radon means its most abundant isotope, radon-222, which decays with the emission of alpha radiation. Although its half-life is relatively short (3.8 days), it originates from uranium-238 in the natural environment. This radionuclide is much longer-lived, which means that radon is continuously produced.

Radon mixes with air and is therefore inhaled by all organisms including humans. It is colourless, odourless and tasteless and therefore its presence cannot be detected by human senses. Outdoors, the concentration of airborne radon is very small but it is possible for indoor concentrations to represent a radiation hazard. The main concern is the exposure of the lungs to alpha radiation and the associated risk of lung cancer. The air concentration of radon tends to be greatest in basements and other poorly ventilated areas. It also tends to be greater in winter than in summer, when buildings are better ventilated.

The concentration of radon in a specific room or location is usually measured with a passive detector, which is left in situ for a three-month period, and a risk assessment of radon exposure is made based on the results. If the annual average activity concentration of radon in air exceeds 300 Bq m^{-3}, remedial action should be taken [15-16]. The UHB's premises are not located in radon-affected areas and so it is unlikely that measures need to be taken to reduce radon concentration. However, radon concentration is monitored every ten years and risk assessments updated as appropriate.

9 Duties

Responsibility for implementing the Radioactive Substances Risk Management Policy and its supporting procedures lies with the UHB as radiation employer, with the Executive Director of Therapies and Health Science being the responsible officer. This responsibility is fulfilled by assigning the duties described here.

The duties of the Executive Director of Therapies and Health Science include:

- Taking overall responsibility for the management of radioactive substances on behalf of the UHB as the holder of Environmental Permits relating to radioactive substances and radioactive waste
- Providing assurance to the UHB Board that radioactive substances are managed in compliance with the UHB's policies and procedures and relevant Environmental Permits issued by Natural Resources Wales
- Ensuring that the UHB provides suitable management arrangements, including sufficient resources and competent persons, to comply with relevant Environmental Permits
- Providing assurance to the UHB Board that radioactive materials are transported in accordance with legislation and guidance
- Informing the UHB Board about issues related to radioactive substances management
- Appointing the UHB's RWA and RPA in writing
- Delegating duties to other managers as appropriate

The duties of Clinical Board Heads of Operations and Delivery include:

- Providing assurance to the Executive Director of Therapies and Health Science that radioactive substances are managed in compliance with policies and procedures and regulatory requirements
- Communicating and liaising with the RWA, RPA, Clinical Directors and other managers about issues related to radioactive substances and radioactive waste
- Appointing RPSs in writing
- Delegating duties to other managers as appropriate

The duties of the Chair of the UHB Radiation Protection Group (RPG) include:

- Reviewing relevant UHB policies and procedures at least every three years and ensuring that they are amended and updated as necessary
- Reviewing reports from the RWA, RPA and other members of the RPG and taking actions as necessary

The duties of the Head of Health Safety include:

- Report incidents of regulatory non-compliance with respect to radioactive substances (other than those associated with Environmental Permits) to the appropriate external regulatory body such as NRW, the Health and Safety Executive or the Office for Nuclear Regulation with the guidance of the radioactive waste advisor.
- Ensuring that the Executive Director of Therapies and Health Sciences, the Chair of the UHB Radiation Protection Group and the relevant Clinical Director and Clinical Board Head of Operations and Delivery are aware of all reports made to external regulatory bodies .

- Ensuring that the UHB's premises are monitored for radon every ten years, reviewing the results of such monitoring and updating radon risk assessments
- Liaising with the Head of Estates informing of remedial work required to reduce the concentration of airborne radon

The duties of the Radioactive Waste Adviser (RWA) include:

- Acting as the UHB's primary contact with NRW as the regulator for the keeping of radioactive substances and the accumulation and disposal of radioactive waste.
- Preparing applications for relevant Environmental Permits from NRW
- Liaising with NRW as regards radioactive waste management and matters such as site inspections and environmental permit variations
- Providing NRW with an annual inventory of the disposal of radioactive waste
- Reporting incidents to Directorate Clinical Directors and/or Professional Heads, incidents involving non-compliance with Environmental permits and liaise with NRW as requested.
- Performing, reviewing and updating environmental impact assessments for the discharge of aqueous liquid waste
- Promoting the use of BAT for the management of radioactive substances including radioactive waste
- Advising on the optimisation of processes to reduce the amount of radioactive waste produced
- Advising on the commissioning, calibration and quality assurance of contamination monitors and other equipment for the measurement of radioactivity
- Undertaking regular audits of compliance with relevant policies, procedures and Environmental Permits (to include the accumulation and disposal of solid and organic liquid waste and the disposal of aqueous liquid waste) and recommending remedial actions as necessary
- Providing quarterly reports to the Executive Director of Therapies and Health Science, the Chair of the Radiation Protection Group and relevant Clinical Board Heads of Operations and Delivery
- Providing advice to managers, Radiation Protection Supervisors and members of staff as regards compliance with relevant UHB policies and procedures and the stipulations of Environmental Permits

The duties of the Dangerous Goods Safety Adviser (DGSA) include:

- Giving direct advice on all aspects of the transport of radioactive materials
- Visiting sites to conduct safety audits and to review regulatory compliance as regards the transport of radioactive materials

- Giving assistance with matters such as packaging, labelling, consignment procedures, documentation and vehicle marking
- Advising on the carriage, loading, unloading and handling of radioactive materials and associated safe working practices
- Developing procedures and emergency arrangements if required
- Providing safety training for staff if required

The duties of the Radiation Protection Adviser (RPA) include:

- Providing advice on the safety of staff and the public as regards exposure to ionising radiation from radioactive substances and radioactive waste
- Providing advice on the safety of staff and members of the public as regards exposure to radon

The duties of the Head of Estates include:

- Co-operating with the Head of the Health, Safety and Environment Unit in performing monitoring for radon every ten years
- Undertaking any remedial work that is required to reduce the concentration of airborne radon at identified locations on the UHB's premises

The duties of Directorate Clinical Directors include:

- Ensuring that all aspects of the management of radioactive substances and radioactive waste (including procurement, storage, security, transport and disposal) comply with policies and procedures and regulatory requirements
- Ensuring that quality management system exists for all aspects of radioactive substances and radioactive waste
- Identifying and ensuring the appropriate training of individual members of staff as RPSs
- Ensuring that Local Rules and Standard Operating Procedures (SoPs) are written to implement the requirements of this UHB procedure
- Ensuring that relevant members of staff are adequately trained and have the resources to comply with the Local Rules and SoPs
- Maintaining records of staff training
- Putting in place measures to monitor staff compliance with SoPs
- Liaising with and seeking advice from the RWA, RPA and DGSA
- Making risk assessments and taking mitigating action as necessary
- Liaising with the Clinical Board Head of Operations and Delivery about the appointment of RPSs and issues related to the management of radioactive substances
- Reporting incidents of regulatory non-compliance (including those associated with Environmental Permits) to the Head of the Health, Safety and Environment Unit and informing the Executive Director of

Therapies and Health Science, the Chair of the UHB Radiation Protection Group and the Clinical Board Head of Operations and Delivery
- Delegating duties to other managers as appropriate

The duties of the Director of MPCE:
- Writing and updating relevant UHB policies and procedures
- Providing and maintaining a suitable computerised system for recording radioactive substances and radioactive waste
- Ensuring that the transport of radioactive materials to and from the radiopharmacy at UHW complies with policies and procedures and regulatory requirements
- Liaising with the Executive Director of Therapies and Health Science as regards the appointment of RWA and RPA to the UHB
- Delegating duties to members of staff as appropriate
- Reporting incidents or potential incidents involving non-compliance with Environmental Permits and other concerns about radioactive substances management to the RWA and the Clinical Director
- Reporting incidents or potential incidents involving radioactive substances (other than those related to Environmental Permits) to the Clinical Director

The duties of the Head of Waste Management include:
- Procuring the services of an external contractor (see Appendix 1) for the disposal of long-lived solid and organic liquid radioactive waste
- Ensuring that the external contractor has appropriate Environmental Permits for the receipt, accumulation and disposal of radioactive waste
- Delegating duties to members of staff as appropriate

The duties of the manager of the radioactive waste store include:
- Receiving solid and organic liquid radioactive waste into the store from the UHB and Cardiff University on the Heath Park site
- Ensuring the security of the store and its contents
- Retaining records of the disposal of radioactive waste until informed by NRW that records no longer need to be retained
- Maintaining the record of radioactive substances and radioactive waste on the computerised system
- Arranging for the regular transfer of organic liquid waste and solid LLW to the external contractor in association with the Head of Waste Management
- Reporting incidents or potential incidents involving non-compliance with Environmental Permits and other concerns about radioactive waste management to the RWA and the Clinical Director

The duties of Radiation Protection Supervisors include:

- Ensuring compliance with arrangements for radiation safety and supervising the arrangements set out in the Local Rules
- Reporting incidents or potential incidents involving non-compliance with Environmental Permits and other concerns about radioactive substances management to the RWA and the Clinical Director
- Reporting other incidents to the Clinical Director
- Seeking advice from the RWA and RPA as required

The duties of individual members of staff include:

- Placing solid and organic liquid radioactive waste in the appropriate containers as it is produced
- Disposing of aqueous liquid radioactive waste via designated sinks
- Making a record of the production of organic liquid waste and long-lived solid waste and the disposal of aqueous liquid radioactive waste
- Disposing of short-lived solid radioactive waste as VLLW
- Transferring organic liquid waste and long-lived solid waste to the dedicated radioactive waste store
- Packaging and labelling radioactive materials for transport
- Preparing vehicles for the transport of radioactive materials
- Monitoring and recording radioactive contamination and taking remedial action as required
- Following SoPs and Local Rules pertinent to radioactive substances management
- Reporting incidents or potential incidents involving non-compliance with Environmental Permits and other concerns about radioactive substances management to the RPS

10 References

1. The Justification of Practices Involving Ionising Radiation Regulations 2004. Statutory Instrument 2004 No. 1769.

2. The Justification of Practices involving Ionising Radiation (Amendment) Regulations 2018. Statutory Instrument 2018 No. 430.

3. The Justification of Practices Involving Ionising Radiation Regulations 2004: Guidance on their Application and Administration.

4. The 2007 Recommendations of the International Commission on Radiological Protection (ICRP Publication 103).

5. Medical and Dental Guidance Notes: A Good Practice Guide on all Aspects of Ionising Radiation Protection in the Clinical Environment. Institute of Physics and Engineering in Medicine (IPEM) 2002.

6. The Medicines Act 1968. Chapter 67.

7. The Human Medicines Regulations 2012. Statutory Instrument 2012 No. 1916.

8. Good Manufacturing Practice (GMP) Guidelines (EudraLex Volume 4). European Commission 2022.

9. Rules and Guidance for Pharmaceutical Manufacturers and Distributors (Orange Guide) 2022 by Medicines and Healthcare Products Regulatory Agency

10. The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 (and all associated amendments 2011, 2019). Statutory Instrument 2009 No. 1348.

11. Accord Européen relatif au Transport International des Marchandises Dangereuses par Route (ADR) (European Agreement Concerning the International Carriage of Dangerous Goods by Road). United Nations Economic Commission for Europe (UNECE) 2021.

12. The Environmental Permitting (England and Wales) Regulations 2016. Statutory Instrument 2016 No. 1154.

13. The Environmental Permitting (England and Wales) (Amendment) (No. 2) Regulations 2018. Statutory Instrument 2018 No. 428.

14. The Health and Safety at Work etc. Act 1974.

15. The Ionising Radiations Regulations 2017. Statutory Instrument 2017 No. 1075.

16. Work with Ionising Radiation: Ionising Radiations Regulations 2017 Approved Code of Practice and Guidance. Health and Safety Executive (HSE) 2018.

17. The Ionising Radiation (Medical Exposure) Regulations 2017. Statutory Instrument 2017 No. 1322.

18. Environment Agencies Statement on Radioactive Waste Advisers. Environment Agencies 2018.

19. IAEA Nuclear Security Series No. 11-G (Rev.1) Security of Radioactive Material in Use and Storage and of Associated Facilities 2019

20. Scope of And Exemptions From The Radioactive Substances Legislation In England, Wales And Northern Ireland Guidance document 2018 Gov.uk

21. Limitation of Human Exposure to Radon (RCE-15). Health Protection Agency 2010

Appendix 1

External contractor for the disposal of organic liquid radioactive waste and long-lived solid LLW

Contractor: SRCL

Address: Indigo House
Sussex Avenue
Leeds
LS10 2LF

Contact: Customer support
Tel: 0333 240 4400
E-mail: support@srcl.com

Reference Number: UHB 465 Version Number: 2	Date of Next Review: 30/Oct/2025 Previous Trust/LHB Reference Number: UHB 465

Exposure of Staff and Members of the Public to Ionising Radiation Procedure

Introduction and Aim

The Cardiff and Vale University Health Board (UHB) uses ionising radiation for a variety of clinical and other applications and this use presents a potential hazard to a range of people including patients, staff and members of the public.

The UHB has an Ionising Radiation Risk Management Policy the aim of which is to ensure that we manage the use of ionising radiation in such a way as to minimise adverse effects on people, provided that this is consistent with any desired clinical or related outcome.

This Procedure supports the Policy and translates its aim into practical implementation measures as regards the potential adverse effects of ionising radiation on staff and members of the public.

Objectives

We will achieve our aim by:

- Providing a robust framework for the management and safe use of ionising radiation
- Ensuring that managers and staff are aware of their roles in the safe use of ionising radiation
- Keeping radiation doses and dose rates as low as reasonably practicable (ALARP)
- Restricting the use of ionising radiation to practices that are justified and ensure that each intentional exposure of a human subject is individually justified
- Optimising exposure to ionising radiation in order to reduce radiation dose, provided that this is consistent with any desired clinical or related outcome
- Keeping radiation doses to staff and members of the public within statutory dose limits
- Managing radiation equipment in accordance with accepted best practice
- Ensuring that the use of ionising radiation is compliant with current legislation, standards and guidance
- Demonstrating compliance through record keeping and audit
- Entitling duty holders associated with the exposure of human subjects to ionising radiation
- Appointing Radiation Protection Adviser(s), Medical Physics Experts, Radiation Waste Adviser(s) and Radiation Protection Supervisors

Scope This procedure applies to all of our staff in all locations including those with honorary contracts.	
Equality Impact Assessment	An Equality Impact Assessment (EqIA) has not been completed, the procedure aligns to current ionising radiation legislation compliance.
Health Impact Assessment	A Health Impact Assessment (HIA) has not been completed the procedure aligns to current ionising radiation legislation compliance.
Documents to read alongside this Procedure	• Ionising Radiation Risk Management Policy • Exposure of Patients • Radioactive Substances Risk Management Policy • Radioactive Substances Risk Management Procedure • Health and Safety Policy • Medical Equipment Management Policy • Risk Management Policy
Approved by	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	Medical Physics Experts, Clinical Scientist, Director of M.P.C.E.

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 Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	25/07/2019	04/09/2019	New Document
2			Updated with current legislation and minor amendments

Contents

1 Definition of terms

Absorbed dose
The fundamental type of radiation dose defined as the energy deposited by ionising radiation in unit mass of irradiated material.

Alpha radiation
Particulate ionising radiation in the form of helium-4 nuclei (a combination of two protons and two neutrons) emitted by nuclei during radioactive decay.

Beta radiation
Particulate ionising radiation in the form of electrons or positrons emitted by nuclei during radioactive decay.

Deterministic effect
An effect of ionising radiation on living tissue in which the severity of the effect increases with radiation dose above a threshold dose (below which the effect does not occur).

Diagnostic Reference Level (DRL)
Value of radiation dose, or administered activity in nuclear medicine, for typical diagnostic examinations in groups of standard-sized patients for broadly defined types of radiation equipment.

Dose constraint
A restriction on the prospective radiation dose to an individual that may result from a defined source of exposure.

Effective dose
The sum of the product of equivalent dose and tissue weighting factor taken over all irradiated tissues and organs.

Electron
A negatively charged particle that is one of the constituents of the atom.

Equivalent dose
The product of absorbed dose and radiation weighting factor for a particular irradiated tissue or organ.

Gamma rays (gamma radiation)
Ionising radiation in the form of photons emitted by nuclei during radioactive decay.

Gy
The gray, which is the unit of absorbed dose (equal to 1 joule of energy per kg).

Ionising radiation
Radiation that is sufficiently energetic to cause ionisation through the release of inner electrons in atoms of high atomic number.

Neutron
An uncharged particle that is one of the constituents of the atomic nucleus.

Particle
A unit of radiation that has mass e.g. electron, beta particle, proton, alpha particle and neutron.

Photon
A unit (quantum) of electromagnetic radiation such as infra-red, visible, ultra-violet, x and gamma radiation.

Proton
A positively charged particle that is one of the constituents of the atomic nucleus.

Radiation
A stream of energy, usually in the form of photons or particles, emitted from a source, moving through a material and interacting with it to deposit energy in the material.

Radiation dose
A measure of the energy deposited by ionising radiation in a material and its potential harmful effects.

Radiation employer
An employer who in the course of a trade, business or other undertaking carries out, or intends to carry out, work with ionising radiation.

Radiation weighting factor
A quantity that indicates the relative harmfulness of different types of ionising radiation to living tissue.

Radioactive decay or disintegration
The transformation of one nuclide (a radionuclide) into another with the emission of ionising radiation.

Radioactive substance (material)
Substance (material) that contains one or more radionuclides.

Radioactive waste
Any material that is either radioactive in its own right or is contaminated by radioactive substances and for which no further use is envisaged.

Radioactivity
The phenomenon associated with radioactive decay or disintegration.

Radiopharmaceutical
A radioactive medicinal product that is administered to human subjects for medical diagnosis or treatment or a related purpose such as medical research.

Radiosensitivity
The sensitivity or susceptibility of different tissues and organs to the harmful effects of radiation.

Stochastic effect
An effect of ionising radiation on living tissue in which the probability of the effect occurring increases linearly with radiation dose without a threshold.

Sv
The sievert, which is the unit of equivalent dose and effective dose.

Tissue weighting factor
A quantity that indicates the relative sensitivity or susceptibility of different tissues and organs to the harmful effects of ionising radiation.

Tissue reaction
This is the same as a deterministic effect.

X-rays (x-radiation)
Ionising radiation in the form of photons emitted by electron interactions in atoms, possibly as a consequence of radioactive decay.

X-ray tube
An evacuated chamber in which electrons are accelerated towards a target to produce x-rays.

2 Use and harmful effects of ionising radiation

Ionising radiation takes the form of either high energy photons (such as x-rays and gamma rays) or high energy particles (such as alpha radiation, beta radiation, electrons, protons and neutrons). It is produced by electrical radiation generators (such as x-ray tubes) and by radioactive substances.

Ionising radiation has a wide range of beneficial applications but it also has the potential to cause harm.

The UHB uses ionising radiation at Barry Hospital, Cardiff Royal Infirmary, St David's Hospital, University Hospital Llandough (UHL), the University Hospital of Wales (UHW) (including the Children's Hospital and the Dental Hospital) and at community medical and dental sites in the following practices:

- Production of radioactive products (including radiopharmaceuticals and radioactive sources)
- Application of radioactive tracers (for medical and biological techniques)
- Diagnosis (medical)
- Treatment (medical)
- Medical and biomedical research
- Examinations performed for insurance or legal purposes without a medical indication
- Teaching including further and higher education and training
- Ionising radiation metrology
- Transport of radioactive material

All these practices are justified [1-3] i.e. they produce sufficient benefit to individuals exposed to ionising radiation or to society in general to offset the detriment that they cause. Justification is one of the basic tenets of radiation protection, the others being optimisation and dose limitation [4].

The majority of the above practices are associated with radiology (diagnostic and interventional) and nuclear medicine (diagnostic and therapeutic). In radiology, human subjects are exposed to x-rays from an external source (x-ray tube). Radiology is practised widely throughout the UHB. Nuclear medicine, on the other hand, involves the administration of radioactive substances (in the form of radioactive medicinal products or radiopharmaceuticals) to humans such that the subjects are irradiated internally by beta and gamma rays. Nuclear medicine is practised only at UHW and UHL.

The potential of ionising radiation to cause harm is usually expressed in terms of radiation dose, which is a measure of the energy deposited by radiation and its impact on living tissue [4]. The basic quantity is absorbed dose, which is an expression of the energy deposited by ionising radiation per unit mass of the material which it irradiates; its unit is the gray (Gy). Absorbed dose is used to quantify the energy deposited by ionising radiation in tissues and organs.

The same absorbed dose delivered to living tissue by different types of ionising radiation causes biological damage to different extent. This variation is expressed by the radiation weighting factor. A radiation weighting factor of one is used for absorbed dose calculations in x, beta and gamma radiation with a weighting factor of 20 utilised in alpha radiation. [4] The equivalent dose is given by the absorbed dose multiplied by the radiation weighting factor. It is an indicator of harm to a particular tissue or organ due to ionising radiation irrespective of the type (and energy) of the radiation; its unit is the sievert (Sv).

In addition, some living tissues and organs are more sensitive or susceptible to the harmful effects of ionising radiation. This variation is expressed by the tissue weighting factor, which is relatively larger for those tissues and organs which are most radiosensitive (i.e. most susceptible to the harmful effects of radiation). The effective dose is the sum of the equivalent dose multiplied by the tissue weighting factor for all irradiated tissues and organs. It is an indicator of harm to the whole body from either total or partial exposure to radiation regardless of the number of tissues and organs exposed; it is also expressed in Sv.

There are two broad types of harmful effect of ionising radiation: deterministic effects (also called tissue reactions) and stochastic effects [4]. Deterministic effects occur in the irradiated individual and are characterised by a threshold absorbed dose (below which the effect does not occur) and the fact that the severity of the effect increases with absorbed dose (above the threshold). An example would be erythema (reddening) of the skin with a threshold of 2-5 Gy and progression to blistering and ulceration as absorbed dose increases.

For stochastic effects, the probability of the effect occurring increases in proportion to effective dose; there is no threshold. Stochastic effects may occur in irradiated individuals and in future generations. The most important stochastic effect is the induction of cancer in an irradiated individual. For a general population, the risk of fatal cancer is about 5% per Sv, although the risk varies with age and is greater for children than for adults [4].

Irradiation of the embryo and foetus may cause both deterministic and stochastic effects [4].

An inevitable consequence of the clinical use of ionising radiation is the exposure of members of staff as well as those receiving treatment or diagnostic investigations. Staff are also exposed as a result of non-clinical work with ionising radiation. To some extent, the use of ionising radiation also leads to the exposure of members of the public. In this context, members of the public include all those who are not subject to medical exposure or are not regarded as staff (e.g. visitors). The radiation doses received by individual members of staff are much lower than those received by those receiving

clinical investigation or treatment. The doses received by individual members of the public are lower still.

3 Regulation of ionising radiation

The use of ionising radiation is governed by legislation that is designed to control its adverse effects on people and the environment. This involves keeping radiation doses as low as reasonably practicable (ALARP). The legislation is supported by codes of practice and guidance and compliance is assessed through a programme of inspections by statutory external agencies.

The exposure of patients to ionising radiation is governed by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 and a subsequent amendment to the regulations [5,6]. The regulations are supported by official and professional body guidance [7,8]. They apply to the deliberate exposure of human subjects to ionising radiation as follows:

- To patients as part of their medical diagnosis or treatment
- To individuals as part of health screening programmes
- To patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes
- To carers and comforters
- To asymptomatic individuals
- To individuals undergoing non-medical imaging using medical radiological equipment

For the purposes of this Procedure, those subject to exposures in these categories are collectively called ‘patients’. Practices that involve the deliberate exposure of humans under circumstances other than the above do not fall within the scope of IR(ME)R 2017. Such practices are permitted only if their justification is confirmed by the most recent version of the national Justification Register [1-3, 9].

The regulations are enforced by Healthcare Inspectorate Wales (HIW), which reports on its activities. In England, similar reports are published by the Care Quality Commission (previously Healthcare Commission) [10-11].

In nuclear medicine, radiopharmaceuticals may be administered to humans only by a person who holds an ARSAC licence from licensing authority or someone acting under the authority of such a person. In addition, a separate licence is required by the employer at each site where such administrations take place [12]. Radiopharmaceuticals are prepared in a specialised Radiopharmacy at UHW under a regime [7,13-15] that is regulated by the Medicines and Healthcare products Regulatory Agency (MHRA).

The Ionising Radiations Regulations (IRR) 2017 [16] address all aspects of work with ionising radiation. They are made under the Health and Safety at Work Act 1974 [17] and are supported by an Approved Code of Practice (ACOP) and official guidance [18] as well as professional body guidance [7]. IRR 2017 deal with the radiation protection of workers and the members of the public who are exposed as a result of work with ionising radiation. The regulations specify the responsibilities of a radiation employer; these include making risk assessments, appointing a Radiation Protection Adviser (RPA) and one or more Radiation Protection Supervisors (RPSs) and writing Local Rules. IRR 2017 are enforced by the Health and Safety Executive (HSE).

Radioactive material is kept on UHB premises in accord with the stipulations of the Environmental Permitting (England and Wales) Regulations (EPR) 2016 [19-20] and under conditions that are specified in Environmental Permits issued by Natural Resources Wales (NRW). The same applies to the accumulation and disposal of radioactive waste. The permits are site-specific for UHW and UHL. In addition, there is a requirement [21] to appoint a suitable Radioactive Waste Adviser (RWA). Radioactive materials are transported in a manner [22-23] that is consistent with the requirements of the Office for Nuclear Regulation, which includes the appointment of a Dangerous Goods Safety Adviser (DGSA). Regulations governing the keeping and transportation of radioactive substances and the management of radioactive waste do not have a direct impact on the radiation safety of patients.

4 General arrangements for the protection of staff and members of the public against the harmful effects of ionising radiation

For staff and the public, the goals of radiation protection are to restrict exposure as much as possible, i.e. to keep radiation doses ALARP, and to ensure that dose limits are not exceeded. The mechanisms for achieving these goals are the justification of practices and the optimisation of processes and procedures, although additional limitation measures may be necessary under some circumstances. As regards the effects of ionising radiation, this means minimising the risk of stochastic effects and avoiding deterministic effects. IRR [16] provides a regulatory framework within which the UHB works to achieve these goals.

The exposure of patients to ionising radiation is mainly carried out in three Clinical Boards within the UHB: Specialist Services, Clinical Diagnostics & Therapeutics and Surgery.

The Employer as defined in the regulations is the UHB and the Chief Executive takes overall responsibility for compliance with legislation on behalf of the UHB. The Chief Executive has delegated the task of ensuring compliance with radiation safety legislation to the Executive Director of

Therapies and Health Science (DoTH). The DoTH has further delegated this task to individuals throughout the UHB's line management structure. This includes the identification and appointment of Radiation Protection Advisers and Radiation Protection Supervisors.

The UHB has established a Radiation Protection Group (RPG) that reports to the Quality, Safety and Patient Experience Committee and onwards to the Executive Board. The RPG discusses all aspects of radiation safety including the exposure of members of staff and members of the public.

5 Specific arrangements for the limitation of radiation dose to staff and the public

The UHB should put in place a range of procedures to limit radiation dose to members of staff and the public that arise as a result of its work with ionising radiation. Those procedures that apply throughout the UHB, especially at corporate level, are addressed in this document. More detailed procedures are tailored to the work of individual services. The content of these procedures may vary considerably from one service to another, reflecting the diversity of the UHB's clinical, research and other work.

Before undertaking any work with ionising radiation, the UHB should notify the HSE, register that work with the HSE or obtain the HSE's consent for that work as appropriate. In addition, they should carry out a suitable and sufficient radiation risk assessment in order to identify the measures needed to restrict exposure to staff and the public.

While performing work with ionising radiation, the UHB should implement a range of measures to restrict exposure. These include:

- Writing standard operating procedures including Systems of Work for all aspects of work with ionising radiation
- Identifying and designating controlled and supervised radiation areas
- Writing Local Rules for designated radiation areas
- Providing personal protective equipment
- Providing training for radiation workers and RPSs
- Making suitable arrangements for members of staff who are pregnant or breast-feeding
- Making suitable arrangements for outside workers

In general, Local Rules should be provided for all areas where ionising radiation is used. They should be regularly reviewed and available in the locations to which they refer. Controlled areas should be identified in the Local Rules and staff and visitors should only enter in accordance with Systems of Work. Outside workers are members of staff of other employers

who carry out work in a UHB controlled area; they should be subject to special procedures as outlined in Local Rules.

In addition, the UHB should put in place a programme of personal and area radiation dose monitoring. Staff who regularly work with ionising radiation and who have to enter controlled areas should be monitored; the type and frequency of monitoring should be determined by means of a risk assessment. Members of staff who are regularly monitored must wear their dosimeters whenever they enter a controlled area. The dosimeter must be worn in the approved manner. Employees must return any dosimeters supplied to them in a timely manner at the end of each monitoring period.

Doses should be kept under regular review and investigation levels set to minimise the risk of exceeding a dose limit; the investigation levels should be stated in the Local Rules. Dose records must be kept for a minimum of two years. Annual summaries of radiation doses received by staff should be prepared, reviewed by the RPA and reported to the RPG.

Particular attention should be paid to those members of staff who receive relatively high doses and the possibility that they might need to be designated as classified persons. Special procedures, including annual medical investigations, should apply to such persons.

Incidents involving ionising radiation should be promptly and thoroughly investigated and, where appropriate, reported to external agencies; these include incidents involving radiation doses much greater than intended [24].

6 Duties

To ensure the implementation of its Ionising Radiation Risk Management Policy as regards the exposure of members of staff and the public, the UHB assigns the duties described here.

The duties of the Executive Director of Therapies and Health Science include:

- Ensuring that the UHB executive provides suitable management arrangements, including sufficient resources and competent persons, to comply with legislation and guidance governing the safe use of ionising radiation
- Providing assurance to the UHB Board that the use of ionising radiation is managed in compliance with the UHB's policies and procedures
- Informing the UHB Board about issues related to the use of ionising radiation
- Establishing a UHB Radiation Protection Group
- Appointing suitably qualified and experienced RPAs in writing
- Delegating duties to other managers as appropriate

The duties of Clinical Board Directors include:

- Providing assurance to the Executive Director of Therapies and Health Science that the use of ionising radiation is managed in compliance with policies and procedures and regulatory requirements
- Ensuring that Directorate Clinical Directors have arrangements in place for the appointment of RPSs and the writing and implementation of Local Rules and Systems of Work
- Communicating and liaising with the Chair of the Radiation Protection Group, RPAs, Clinical Directors and other managers about issues related to the use of ionising radiation
- Disseminating information about reported incidents within the UHB as appropriate
- Reporting incidents where classified dose limits are exceeded, or likely to be exceed to the HSE
- Delegating duties to other managers as appropriate

The duties of Directorate Clinical Directors include:

- Delegating duties to duty holders and other managers as appropriate
- Ensuring that members of staff are aware of their roles and duties as regards radiation safety
- Ensuring that the radiation dose received by members of staff and other persons are appropriately monitored
- Appointing RPSs in writing and maintaining a list of such appointments
- Ensuring that RPSs and members of staff are adequately trained, receive update training as appropriate and participate in continuous professional development
- Maintaining training records and making such records available for inspection
- Providing SOPs, Systems of Work and Local Rules and ensuring that they are regularly reviewed and updated
- Ensuring that radiation risk assessments are undertaken in association with RPA and that such assessments are reviewed regularly
- Ensuring that radiation equipment is selected, installed, critically examined, commissioned, maintained and replaced in accordance with regulations and guidance
- Ensuring that a risk assessment is made of the working conditions of a members of staff who declares that they are pregnant and that any required changes to working conditions are implemented
- Investigating suspected radiation incidents in association with the RPA and reporting confirmed incidents to the Clinical Board Director and the Head of the Health, Safety
- Keeping records of incidents for the appropriate time

In nuclear medicine:

- Ensuring that a risk assessment is made of the working conditions of a members of staff who declares that they are breast feeding and that any required changes to working conditions are implemented

The duties of the Chair of the UHB Radiation Protection Group include:

- Reviewing relevant UHB policies and procedures related to ionising radiation
- Providing advice on the implementation of relevant UHB policies and procedures
- Reviewing compliance with relevant UHB policies and procedures
- Reviewing relevant UHB policies and procedures at least every three years and ensuring that they are amended and updated as necessary
- Reviewing summary reports from RPAs and taking action as necessary
- Liaising with members of the Radiation Protection Group and others as necessary

The duties of the Head of Health and Safety include:

- Acting as UHB's primary contact with the HSE as appropriate.
- Reporting incidents of regulatory non-compliance to HSE (excluding incidents where individual radiation dose limits have been exceeded).
- Ensuring that the Executive Director of Therapies and Health Science, the Chair of the UHB Radiation Protection Group and the relevant Clinical Director and Clinical Board Head of Operations and Delivery are aware of all reports made to external regulatory bodies ones you deal with.
- Delegating duties to other managers as appropriate.

The duties of the Radiation Protection Adviser (RPA) include:

- Implementing requirements as to controlled and supervised areas
- Examining plans for installations and the acceptance into service of new or modified sources of ionising radiation in relation to engineering controls, design features, safety features and warning devices provided to restrict exposure
- Regularly calibrating equipment provided for monitoring ionising radiation dose and dose rate and checking that such equipment is serviceable and correctly used
- Periodically examining and testing engineering controls, design features, safety features and warning devices and checking Systems of Work including any written arrangements provided to restrict exposure to ionising radiation
- Performing critical examinations of newly installed or repaired equipment or articles for work with ionising radiation
- Estimating radiation dose to members of staff and members of the public
- Participating in inspections by statutory authorities

- Providing radiation protection training
- Liaising with the MPE and agreeing on the demarcation of duties associated with radiation safety and compliance with legislation
- Liaising with MPEs as regards the design and construction of clinical and related radiation facilities
- Advising on risk assessments and contingency plans
- Advising on the form and content of Local Rules for each designated controlled and supervised area
- Advising on the conduct of incident investigations and the content of subsequent reports
- Advising on dose assessment and recoding, including personal and area monitoring
- Advising on the selection and use of appropriate personal protective equipment
- Advising on quality assurance programmes for radiation equipment
- Advising on arrangements for outside workers
- Advising on the designation of classified workers
- Advising on information and instructions for pregnant members of staff
- Advising on training for dealing with emergencies
- Advising on the radiation protection of comforters and carers in association with the MPE

In nuclear medicine:

- Liaising with the RWA and DGSA as regards the storage and transportation of radioactive substances and the accumulation and disposal of radioactive waste
- Advising on radiation protection advice to patients leaving hospital after radiopharmaceutical administration and to those who care for or come into contact with such patients, in liaison with MPEs
- Advising on the design of radiopharmacies and radionuclide laboratories and associated protocols
- Advising on information and instructions for breast-feeding members of staff

The duties of the Radiation Protection Supervisor (RPS) include:

- Exercising close supervision of work with ionising radiation to ensure that it is done in accordance with Local Rules and Systems of Work and in compliance with IRR 2017
- Notifying managers of any proposed changes in or additions to work with ionising radiation
- Notifying managers of any change of equipment usage or conditions, which might affect radiological safety
- Notifying managers of any monitoring instrument used to demonstrate compliance with regulations that has not been calibrated to accepted standards

- Notifying managers of any incident involving or suspected incident resulting in exposure much greater than intended
- Helping to ensure that controls for the restriction of exposure are used in accordance with Local Rules and Systems of Work
- Observing, from time to time, all procedures involving ionising radiation and issuing instructions necessary to maintain radiation doses ALARP
- Attending courses and receiving training as recommended by the RPA
- Promulgating Local Rules and Systems of Work to ensure that necessary safety information and guidance is given to staff, outside workers and any other persons who enter controlled or supervised radiation areas
- Performing additional tasks as agreed with managers

In nuclear medicine

- Notifying managers of any damage to a radioactive source or any spillage, loss or suspected loss of a radioactive substance

The duties of the Director of Medical Physics and Clinical Engineering include:

- Recommending suitably qualified and experienced members of staff and other persons to the Executive Director of Therapies and Health Sciences for appointment as RPAs to the UHB
- Delegating duties to members of staff as appropriate

The duties of all individual members of staff working in radiation areas:

- Following SOPs and Systems of Work and complying with Local Rules
- Wearing personal dosimeter at all times during occupational exposure to ionising radiation
- Making full and proper use of any personal protective equipment that has been provided
- Reporting any defects or suspected faults in radiation and protective equipment to the RPS and the Directorate Clinical Director through the line management structure
- Reporting suspected radiation incidents to the RPS and the Directorate Clinical Director through the line management structure
- Informing the line manager and the Directorate Clinical Director through the line management structure as soon as they know or suspect that they are pregnant

In nuclear medicine:

- Informing the line manager and the Directorate Clinical Director through the line management structure as soon as they are pregnant or start to breast feed

7 References

1. The Justification of Practices Involving Ionising Radiation Regulations 2004. Statutory Instrument 2004 No. 1769.

2. The Justification of Practices involving Ionising Radiation (Amendment) Regulations 2018. Statutory Instrument 2018 No. 430.

3. The Justification of Practices Involving Ionising Radiation Regulations 2004: Guidance on their Application and Administration.

4. The 2007 Recommendations of the International Commission on Radiological Protection (ICRP Publication 103).

5. The Ionising Radiation (Medical Exposure) Regulations 2017. Statutory Instrument 2017 No. 1322.

6. The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018. Statutory Instrument 2018 No. 121.

7. Medical and Dental Guidance Notes: A Good Practice Guide on all Aspects of Ionising Radiation Protection in the Clinical Environment. Institute of Physics and Engineering in Medicine (IPEM) 2002.

8. Guidance to the Ionising Radiation (Medical Exposure) Regulations 2017. Department of Health and Social care 2018.

9. Justification Register – Applications and Decisions made under Regulations 9,10 and 12 of the Justification of Practices involving Ionising Radiation Regulations 2004. Updated January 2022

10. Ionising Radiation (Medical Exposures) Regulations 2017: Enforcement policy. CQC 2019

11. HIW activities and enforcement IR(ME)R annual report 2020/21 - Care Quality Commission

12. Notes for Guidance on the Clinical Administration of Radiopharmaceuticals and Use of Sealed Radioactive Sources. Administration of Radioactive Substances Advisory Committee 2022.

13. The Medicines Act 1968. Chapter 67.

14. The Human Medicines Regulations 2012. Statutory Instrument 2012 No. 1916.

15. Good Manufacturing Practice (GMP) Guidelines (EudraLex Volume 4). European Commission 2022.

16. The Ionising Radiations Regulations 2017. Statutory Instrument 2017 No. 1075.

17. The Health and Safety at Work etc. Act 1974. Chapter 37.

18. Work with Ionising Radiation: Ionising Radiations Regulations 2017 Approved Code of Practice and guidance. Health and Safety Executive (HSE) 2018.

19. The Environmental Permitting (England and Wales) Regulations 2016. Statutory Instrument 2016 No. 1154.

20. The Environmental Permitting (England and Wales) (Amendment) (No. 2) Regulations 2018. Statutory Instrument 2018 No. 428.

21. Environment Agencies Statement on Radioactive Waste Advisers. Environment Agencies 2018.

22. The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 (and all associated amendments 2011, 2019). Statutory Instrument 2009 No. 1348.

23. Accord Européen relatif au Transport International des Marchandises Dangereuses par Route (ADR) (European Agreement Concerning the International Carriage of Dangerous Goods by Road). United Nations Economic Commission for Europe (UNECE) 2021.

24. Ionising Radiation (Medical Exposure) Regulations - Significant accidental and unintended exposures under IR(ME)R Guidance for employers and duty-holders. Version 2, August 2020

Reference Number: *UHB364* **Version Number:** 2.0	**Date of Next Review:** **Previous Trust/LHB Reference Number:** *N/A*

Venepuncture for Non NMC Registered Research Staff Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, this policy will identify the key standards required to ensure the safe practice of venepuncture by research staff without clinical qualifications or prior experience of venepuncture working in research delivery teams within Cardiff and Vale University Health Board.

Policy Commitment

The purpose of this policy is to state the expected standards of care to minimise the associated risk of harm to patients and staff when undertaking venepuncture. To reduce this risk it is imperative to ensure that non clinically qualified research staff have received appropriate training and education, together with a period of supervised practice and assessment to ensure they are competent to undertake this invasive procedure autonomously.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedure describe the following with regard to Venepuncture for Non Clinically Qualified Research

- Staff Roles and Responsibilities
- Limitations
- Training

Other supporting documents are:

UHB Documents

1. UHB452 Labelling of Specimens Submitted to Medical Laboratories Policy
2. UHB200 Hand Decontamination Procedure
3. Patient Identification Procedure
4. UHB019 Infection Control Procedure for needlestick and similar sharps injuries
5. UHB359 Sharps Management Procedure

National guidelines

1. Aseptic Non-Touch Technique (ANTT)
2. Royal Marsden Guidelines
3. Informed Consent in Research as part of Good Clinical Practice training

Scope

This policy is restricted to all non NMC registered staff working in research delivery teams within the UHB, who are required to undertake venepuncture to support the delivery of

research or drug trials. For the purposes of this policy, this includes permanent, temporary, bank and agency staff as well as holders of honorary contracts and letters of access who are working within research delivery teams in the UHB.For the remainder of this document these staff will be referred to as 'Research Delivery Staff' This document serves to outline the conditions under which Research Delivery Staff working within research may be considered suitable to undertake venepuncture training and the limitations that apply.	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and found there to be a no impact

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Research Governance Group
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 Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee 16/10/2018	TBA	New Document
2			Changed title and scope to clarify the staff group to whom this procedure applies. Updated documents to read alongside this policy.

Reference Number: UHB 365 **Version Number:** 2.0	**Date of Next Review:** **Previous Trust/LHB Reference Number:** *N/A*

Procedure for Non NMC Registered Research Delivery Staff to perform Venepuncture

Introduction and Aim

This document supports the UHB Policy for Non NMC registered Research Delivery Staff to perform Venepuncture. The aim of this procedure is to ensure the safe practice of venepuncture by research delivery staff without clinical qualifications or prior experience of venepuncture working within Cardiff and Vale University Health Board (UHB).

Objectives

The objective of this procedure is to

- State the expected standards of care to minimise the associated risk of harm to patients and staff when undertaking venepuncture.
- To reduce this risk by ensuring that non NMC registered research delivery staff have received appropriate training and education, together with a period of supervised practice and assessment
- To ensure that all non NMC registered research delivery staff are competent to undertake this invasive procedure autonomously.
- Identify the roles and responsibilities of UHB staff and limitations on the scope of practice

Scope

This procedure is restricted to all non NMC registered research delivery staff within the UHB, who are required to undertake venepuncture to support the delivery of research projects and clinical trials. For the purposes of this procedure, this includes permanent, temporary, bank and agency staff as well as holders of honorary research contracts and letters of access who are working within research delivery teams in the UHB For the remainder of this document these staff will be referred to as 'Research Delivery Staff'

This document serves to outline the conditions under which research delivery staff working within research may be considered suitable to undertake venepuncture training and the

limitations that apply.	
Equality Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has been completed to support the Policy document implementation (Policy for Non NMC Registered Research Delivery Staff to perform Venepuncture). The Equality Impact Assessment completed for the policy found there to be no impact.
Documents to read alongside this Procedure	**UHB Documents** 1. UHB452 Labelling of Specimens Submitted to Medical Laboratories Policy 2. UHB200 Hand Decontamination Procedure 3. Patient Identification Procedure 4. UHB019 Infection Control Procedure for needlestick and similar sharps injuries 5. UHB 359 Sharps Management Procedure **National guidelines** 1. Aseptic Non-Touch Technique (ANTT) 2. Royal Marsden Guidelines *3.* Informed Consent in Research as part of Good Clinical Practice training
Approved by	Research Governance Group recommended for Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	Executive Medical Director
Author(s)	Senior Manager (R&D) Senior Nurse for Research Education & Training

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1.0	16/10/2018		New Policy and Procedure
2.0			Changed title and scope to clarify the staff group to whom this procedure applies. Updated documents to read alongside this procedure. Changed name of R&D Office to Joint Research Office (JRO). Changed name of LED to Education, Culture and Organisational Development (ECOD). Section 1.0 updated to clarify that research delivery staff should follow the existing training and assessment pathway in the UHB for venepuncture; to reflect current arrangements for access to ESR; to remove reference to appendix 1 which is no longer required. Section 2.1 R&D senior management team replaced with senior management responsible for each research delivery team, as R&D senior team does not have

			management oversight of all research delivery teams in the UHB. Section 2.2 reference to first aid training removed as not available, replaced with clinical safety training and orientation to clinical area. Section 2.3 added nominated line managers of staff with honorary research contracts or letters of access to be made aware of their responsibilities by the JRO; Removed reference to R&D training lead to support staff with HRC/LOA with this training as this is no longer applicable. Appendix 1 removed as staff should follow the standard training pathway in the UHB for venepuncture.

Venepuncture for Non NMC Registered Research Delivery Staff Procedure

CONTENTS **Page No.**

1.0 Introduction

The aim of this procedure is to ensure the safe practice of venepuncture by research delivery staff without clinical qualifications working within Cardiff and Vale University Health Board (UHB).

Cardiff and Vale Joint Research Office (JRO) and Education, Culture and Organisational Development (ECOD) department have stipulated the following training requirements for non NMC registered research delivery staff performing venepuncture as part of their role:

- Research Delivery staff employed by the UHB are able to access ECOD training for venepuncture and must follow the existing pathway for supervised practice, practice based assessments and practice update assessments in the clinical area.

- Research Delivery Staff working under an Honorary Research Contract or with a letter of access from another health board, who are performing venepuncture on CVUHB patients and based with a clinical team (therefore able to undertake supervised practice based assessments), may attend ECOD venepuncture training at an agreed cost if they cannot access it elsewhere. Clinical practice must be supervised by appropriately experienced staff in their clinical team and competence assessed by a member of staff who has been trained as a clinical skills assessor. The responsibility for arranging training, supervision and practice based assessment for this group of staff lies with the nominated line manager within the UHB.

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All research delivery staff who are performing venepuncture will be required to complete the following:

- Aseptic no touch technique (ANTT) e learning and practice based assessment
- UHB Core Mandatory Training (online)
- Basic Life Support (BLS)

In addition to this basic clinical safety training, an orientation to the clinical area in which research delivery staff will be working must be provided. Access to ESR for E Learning can be arranged by a line manager.

A practice based update assessment must be completed every 3 years with a member of staff who has been trained as a clinical skills assessor.

2.0 Roles and Responsibilities

2.1 Senior Management responsible for each research team will ensure that

- Any concerns escalated where staff are not meeting requirements of the UHB to attend training and assessment to perform venepuncture are dealt with appropriately.
- Line managers are supported in monitoring compliance with the venepuncture policy.
- Any incidents related to venepuncture and involving this staff group that are reported using the UHB Datix system are investigated, actioned and followed up.

2.2 Line managers and Team Leads of research delivery staff will ensure that

- Staff required to perform venepuncture as part of their role have had this identified at their PADR, and have completed mandatory training and BLS prior to registering for venepuncture training with LED.

- Non NMC registered staff who are training to perform venepuncture have received basic clinical safety training and orientation to the clinical area prior to attending venepuncture training with ECOD.
- Staff are booked to attend venepuncture training provided by Cardiff and Vale UHB ECOD department, and are supervised and assessed by trained clinical skills assessors to achieve competence within 3 months of attending training.
- Staff trained and assessed as competent to perform this skill are given adequate support and opportunity to maintain this competency following assessment.
- Compliance with the venepuncture policy is maintained.
- Any incidents related to venepuncture are reported using the UHB Datix system, and are investigated, actioned and followed up

2.3 The JRO will ensure that

- Research delivery staff, nominated line managers of staff applying for a letter of access or honorary research contract and Principal Investigators are made aware of this procedure and their responsibilities with regards to compliance with the procedure and training requirements.

2.4 Research Delivery Staff will ensure that

- They are aware of, and are compliant with this procedure and training requirements
- Any concerns about the clinical safety or wellbeing of the patient they are taking blood from are immediately escalated to an appropriately clinical trained and qualified member of staff
- Any concerns about performing the clinical skill or maintaining their competence is escalated to a line manager

- They do not perform any duty outside of the scope of their practice or competence

3.0 Limitations

- Requirement for an individual to gain competence in venepuncture must be made as part of an individual or team PADR by an appropriate Line Manager.
- Research Delivery Staff may only carry out a venepuncture procedure on a patient/client where this responsibility has been appropriately delegated and signed off on the Study Delegation Log by the Principal Investigator.
- Research Delivery Staff may only undertake venepuncture for research samples as outlined in the study protocol. If research participants require standard clinical blood samples to be taken during the same visit, this may be done by research delivery staff to avoid the need for patients to have two procedures. Responsibility for the completion and review of these standard blood samples and results, including the completion of request forms must be undertaken by the clinical team.
- Research Delivery Staff may not take blood samples for any clinical indication where specialist training is required. This restriction includes but is not restricted to blood sampling for transfusion cross matching, blood sampling for blood cultures.
- Research Delivery Staff must not under any circumstances access peripheral venous cannulae, peripheral or central access devices to obtain blood samples. Such devices must only be accessed by clinically trained registered practitioners.
- Research Delivery Staff may only undertake venepuncture within staffed clinically designated areas or appropriately risk assessed non-clinical areas of the UHB where immediate clinically qualified help is readily available.

4.0 Training

The existence of this Procedure and its implications for research delivery staff will be covered during UHB R&D training events, during induction for all research delivery staff and disseminated to managers of research teams.

5.0 Implementation

All staff undertaking Research Delivery within the UHB together with those who have a specific responsibility within this procedure are responsible for its implementation.

6.0 Equality

The UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups. We have not undertaken an Equality and Health Impact Assessment on this procedure but undertook an EHIA as part of the Venepuncture for Non NMC Registered Research Delivery Staff Policy that underpins this procedure and received feedback on the policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment on the policy found that there was no impact to the equality groups mentioned.

7.0 Distribution

The document will be available via the UHB Inter and Intranet and on the R&D Internet pages.

8.0 Review

The Policy underpinning this procedure will be reviewed every 3 years, or more regularly if new legislation so requires.

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**9th August 2022**

Summary of key matters considered by the Committee and any related decisions made

1.0 Mother & Baby Serious Untoward Incident Feedback

An informative presentation was received from Aneurin Bevan University Health Board (ABUHB) on the learning and reflections following a Serious Untoward Incident relating to a Mother and Baby Unit placement that occurred in December 2019. This had been shared with the South Wales Mother and Baby Unit for shared learning in terms of the importance of communication and care and treatment plans for home leave.

2.0 Commissioning Team and Network Updates

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

- **Cancer & Blood**

The Committee was pleased to receive the formal notification that the Neuroendocrine Tumour (NET) Service in Cardiff & Vale University Health Board (CVUHB) had received UK ENET's accreditation. The team were congratulated on their achievement.

- **Cardiac**

The Committee was informed of the improving position in Swansea Bay University Health Board (SBUHB) cardiac services. The level of escalation will be considered once the invited services review report has been received and reviewed by the commissioning team.

- **Neurosciences**

An update was provided on the Artificial Limb Service. It was agreed that it would be beneficial to request an update on patient outcome as part of future work with the service.

- **Women & Children**

An update was provided to the committee regarding Paediatric Surgery, which continued to be monitored with the Clinical Board at CVUHB and through Service Level Agreements (SLA) meetings. It was noted that the SiTREP meetings had been reinstated as a result of ongoing pressures on neonatal cot capacity. This was primarily as a result of workforce issues. Concern was raised regarding the progress in setting up the Welsh Government Maternity & Neonatal Safety programme which would oversee the work. The Committee was made aware of a letter from Welsh Government (WG), dated 14th July, that had been sent to the Neonatal network and copied to WHSSC highlighting growing concerns around neonatal intensive care cot capacity across south Wales. A paper outlining the extent of these issues over the past six months across Wales had been requested, which will be signed off by the EDoN prior to submission to WG. An update regarding the neonatal transport positon was provided to the committee and it was agreed that the neonatal update report submitted to Joint Committee would be shared after the meeting.

- **Intestinal Failure (IF)– Home Parenteral Nutrition**

A verbal update was provided to the committee and a detailed report was requested for the next meeting.

- **Mental Health & Vulnerable Groups**

The committee was provided with a summary of the services in escalation and Members received a presentation from the Cwm Taf Morgannwg University Health Board (CTMUHB) Exec Lead on the progress made at Ty Llidiard, which is currently in Escalation Level 4. It was noted that good progress has been made against the service improvement plan and a further update was requested at the next meeting to ensure a sustained improvement.

Members received a presentation on the recommendations and findings of a coroner's inquest that took place on 22nd February 2022. This was as a result of a serious untoward incident at Arnold Lodge Women's Enhanced Medium Secure Service in July 2018. Whilst no Regulation 28 was issued, a Quality Improvement Plan was put in place that is monitored by Mental Health Specialised Commissioning NHS England Midlands Region. The committee was assured that a joint meeting involving National Collaborative Commissioning Unit (NCCU), WHSSC Health Board and NHS England took place immediately following the inquest and an in-depth Ward Review was undertaken on the 16th June, which will be considered by the commissioning team once published. There were no Welsh placements currently with the NHS provider.

Members were provided with an update regarding service provision for Welsh patients with Eating Disorders. Negotiations with NHS England continue and it is planned that the 'gatekeepers' will visit the two potential units and develop a seamless pathway for patients. This will be an interim arrangement and long-term plans will be considered as part of the Mental Health Strategy. Assurance has been

sought that current patients in Cotswold House will continue with their treatment and be unaffected by any changes to the contract.

The members were provided with an update on the new model and Early Adopter services for the Gender Identity Development Service (GIDS) patients that NHS England announced on 29th July. Dr Cass recommended new regional centres be led by specialist children's hospitals, which are hoped will be operational by Spring 2023. Once operational, these services will take over clinical responsibility for all GIDS patients and those on the waiting list. The London-based service will be formed as a partnership between Great Ormond Street Hospital for Children and Evelina London Children's Hospital, with specialist mental health support provided by South London and Maudsley NHS Foundation Trust. The North West-based service will be formed as a partnership between Alder Hey Children's NHS Foundation Trust and Royal Manchester Children's Hospital, who both provide specialist Children and Young People's Mental Health services.

3.0 Other Reports Received

Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. The status of each service in escalation remains unchanged. However, the Cardiac services are making good progress and it is hoped that WHSSC will be in a position to de-escalate these over the next few months. The North Wales Adolescent Unit is also waiting for the NCCU review and should also be in a position to be de-escalated.

- **CRAF Risk Assurance Framework**

Members noted a new risk relating to neonatal cots and were provided with an updated positon regarding the WHSSC Individual Patient Funding Panel Terms of Reference position and noted the progress made.

- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**

The committee was updated regarding the unannounced inspection that HIW undertook on Hillview Independent Hospital on 15-17 November 2021 and published their report on July 8 2022. Regis Healthcare Ltd is registered to provide an independent hospital for Children and Adolescent Mental Health patients at Hillview Hospital based in Ebbw Vale. The improvement plan will be overseen as part of the NCCU Framework.

The CQC undertook an unannounced inspection of St Mary's Hospital (Elysium Healthcare) focusing on Cavendish and Leo wards on the 21st and 22nd July. This was as a result of recent concerning restraint episodes and the death of a NHS England patient. The commissioning team report will consider the findings once published and WHSSC are a member of the Quality Assurance Board which will oversee the improvement plan.

- **Incident and Concerns report**

A concern was raised by a parent of a child regarding care at Hillview. This is being managed through the NCCU and legal advice has been sought. A copy of the response has been received. The same individual recently featured in a media article and an alternative placement is being actively sought.

- **Policy Group Report**

Received for assurance.

4.0 Items for information:

Members received a number of documents for information only, which members needed to be aware of:

- Chair's Report and Escalation Summary to Joint Committee 12 July 2022,
- Welsh Health Circular – Never Events,
- Welsh Health Circular - National Clinical Audit and Outcome Review Plan,
- Draft Development Day Agenda,
- QPS Distribution List; and
- QPS Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above.

Summary of services in Escalation (Appendix 1 attached)

Matters requiring Committee level consideration and/or approval

There were no specific issues requiring escalation to the committee.

Matters referred to other Committees

None were noted.

Confirmed minutes for the meeting are available upon request

Date of next scheduled meeting:	11th October 2022 at 13.00hrs

1.0 SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of- Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy. • Medical workforce issues improved with further appointments made and the issue of GMC registration resolved for 1 clinician. • Bed panel data submitted electronically. • NCCU undertook Annual Review on 29th June 2022 report yet to be published.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, Exec Lead identified from Health Board. Last escalation meeting 20th July. • Improvement Board established to oversee delivery of an integrated improvement plan. • Emergency SOP has been fully implemented. • Successful recruitment to posts created under a revised nursing workforce model. • All new therapy posts have been advertised and will be completed by end of August. • A new consultant has been appointed to lead the medical staff complement which now includes a further consultant post and a physicians associate grade post. • Completion of a 4C's engagement process.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	• Next escalation meeting proposed July 20th but has been postponed due to lack of IGL availability however written update provided as alternative • Staff proposal approved by BDGB, to increase resilience • Work ongoing to address issues in HMP YOI • Consultant Psychiatrist job description remains with College for approval	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	Continued six weekly meetings in place to receive and monitor against the improvement plan. Although the service was de-escalated on delivery of the immediate actions required by the GIRFT recommendations (per March update), further work is required between SBUHB, C&VUHB and WHSSC to improve the aorto-vascular pathways and develop the preferred options. In the meantime, the pathway will remain unchanged. Escalation level will be reviewed –	

					discussion planned for September 2022 – on provision of six months of data following delivery of GIRFT recommendations and the submission to WHSSC of the recent Royal College of Surgeons of England (RCS England) Invited Service Review report.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
July 2021 April 2022 (from 2-3)	Cardiac Surgery	C&VUHB	3	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report. • In view of continued failure to provide the GIRFT improvement plan and HEIW report the service was re- escalated in April 2022. • Level 3 meetings were held in June and July, and subsequent meetings will be held at six-weekly intervals. • These Executive level escalation meetings supersede bi- monthly meetings previously instituted for	

					monitoring purposes. • The service has now provided the requested GIRFT improvement plan and HEIW report (and action plan), and is has been agreed that WHSSC develop de-escalation criteria based on the recommendations in the GIRFT report and action plans.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
November 2021	Burns	SBUHB	3	• The burns service at SBUHB is currently unable to provide major burns level care due to staffing issues in burns ITU.	• The burns ICU is restored to full capacity (3 beds) with support from general ICU and anaesthetics consultants (stage 1 of the plan). • Mutual assistance is available via the South West and Wales Burns Network and wider UK burns escalation arrangements, should it be required. • The three-stage plan has been agreed following advice and support from the Burns Network and a peer visit to Swansea. • Escalation monitoring meeting arranged for 12th August 2022. • The current timeline	

					for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
February 2022	PETIC	Cardiff University	3	Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. These concerns include: • Recent suspension of production of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotope production failures. • Failure to produce a business case of sufficient quality in a timely manner for	• The next escalation monitoring meeting is arranged for 23rd September 2022. • PETIC is taking forward the agreed actions with regard to increasing management capacity within the service and clarifying the governance arrangements for the service.	⇔

				replacement of the scanner.		

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee
Held On 16th August 2022
Via MS Teams

Present:		
Sue Bailey (Chair)	Chair	Director of Quality, Safety and Patient Experience
Becca Jos	BJ	Deputy Director of Operations
Jenna Walker	JW	Pharmacist, Pharmacy
Robert Bracchi	RB	Medical Advisor to AWTTC
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Edward Chapman	ECh	Head of Clinical Engineering/ Medical Devices Officer
Kim Atkinson	KA	Head of Occupational Therapy
Catherine Evans	CE	Patient Safety Facilitator
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Bolette Jones	BoJ	Head of Medical Illustration
Rhys Morris	RM	CD&T R&D Lead
Rachael Daniel	RD	Health and Safety Adviser (for Jonathan Davies)
Sian Jones	SJ	Operational Service Manager
Judyth Jenkins	JJ	Head of Nutrition and Dietetics
Cath Marshall	CM	Physiotherapy Representative
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Suzanne Rees	SR	Lead Nurse, CD&T
Emma Cooke	ECo	Clinical Director of AHPs
Tracy Wooster	TW	Sister, Outpatients
Secretariat:		
Helen Jenkins	HJ	Clinical Board Secretary
Apologies:		
Sandeep Hemmadi	SH	Clinical Board Director
Matthew Temby	MT	Clinical Board Director of Operations
Seetal Sall	SS	Point of Care Testing Manager
Alun Roderick	AR	Laboratory Service Manager, Haematology
Jonathan Davies	JD	Health and Safety Adviser
Louise Long	LL	Public Health Wales Microbiology
Marie Glyn-Jones	MG-J	Deputy General Manager, Radiology & Medical Physics/ Clinical Engineering
Jo Fleming	JF	Quality Lead, Radiology
Mathew King	MK	Head of Podiatry
Timothy Banner	TB	Clinical Director, Pharmacy
Nia Came	NC	Head of Speech and Language Therapy
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Paul Williams	PW	Clinical Scientist, Medical Physics
Lesley Harris	LH	Head of Radiography UHL

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 22/240	**Welcome & Introduction** The Chair welcomed everyone to the meeting.	
CDTQSE 22/241	**Apologies for Absence** **The Group resolved that:** a) The apologies for absence were noted.	
CDTQSE 22/242	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting held on 21st July 2022 were accepted as an accurate record.	
CDTQSE 22/243	**Matters Arising/Action Log** The Chair thanked AWTTC and Pharmacy for supporting World Patient Safety Day. 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 22/158 NICE Guidance Relating to Rehab Following a Traumatic Injury* SB to discuss with SH the requirement for a risk assessment to be completed for the NICE guidance as this cannot be fully implemented. *CDTQSE 22/213 New CAV Connect App* The Clinical Board to set up a group on the new CAV Connect app when it is launched as a communication tool for senior managers in the event of an emergency. *CDTQSE 22/231 AWTTC Best Practice Day* The video from the AWTTC Best Practice Day on medicines and sustainability has not yet been processed. When finalised it will be placed on their website. RB will send the link to HJ for circulation. RB requested an update on the maintenance required to the lift in Toxicology. SB will obtain an update. **The Group resolved that:** a) An update on the outstanding actions will be provided at the next meeting.	**SB/SH** **HJ** **RB/HJ** **SB**

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CDTQSE 22/244	**Presentation: Occupational Therapy Homelessness Service Development** Sue Bailey welcomed Hayley Baker, Team Lead of the OT Homelessness Service, to the meeting. The service is a new approach to tackling homelessness in Cardiff. It comprises of an MDT of 30 specialists based at the Single Assessment Centre located by St Davids Hospital, which provides a 19-bed emergency accommodation. It is used to house on a temporary basis, those new to homelessness, or those deemed to be very complex and in need of a period of stability before being assessed and moved to frontline hostels. The service was established in 2019 due to the significant numbers of homeless people in Cardiff and Vale at that time. Occupational Therapy joined the service in 2020. Currently Cardiff and Vale has the only OT homelessness service in Wales. Evidence and data have been collated to show that that the service has improved the quality of living for the service users and provided better management of their health and wellbeing. The service addresses the individual's physical, emotional and cognitive health within the context of their environment. It identifies the occupational needs, strengths and barriers to maximise their independence. The benefits of the service are best showcased through patient stories: Case 1: a 31-year-old male who was new to the homelessness service came to the assessment centre following a breakdown in family relationships. The patient was very vulnerable and diagnosed with autism and anxiety. Initial contact and introductory meetings were held to explore his occupational identity, competence and barriers to functioning. The occupational circumstance assessment and interview identified that the individual struggled to meet basic needs. A clear deficit/inability was established in terms of undertaking daily tasks such as personal care and managing environment and also processing new information, problem solving and learning new skills. It was clear that time and opportunities to practice were required. The service identified a risk to self and had great concerns regarding his vulnerability, particularly in terms of developing unhealthy relationships with residents with the potential of taking advantage of him. Using evidence-based practice, the service explored the use of alternative sensory aids and referred the individual to a Complex Needs Case Coordinator to support him. Focus was placed on developing his skills to meet his basic needs and also on medicines management. Activity analysis was used to break down an activity to make this more attainable and meet his needs. He was given opportunity to repeat new learning and build routine to establish new habits.	

	He was referred to social work for a supported placement and package of care. The individual is now well on his way to developing a range of skills in preparation for independent living. Case 2: a 32-year-old male with a queried diagnosis of schizophrenia and a lack of available history. He was socially withdrawn, demonstrated compulsive, repetitive behaviours and cognitive impairment. This individual struggled with communicating and building a rapport was important. A Model of Human Occupation Screen Tool was completed and the OT service worked with him on tasks such as making hot drinks, doing laundry, undertaking community visits and shopping. The assessment established there was a clear cognitive impairment and total neglect of domestic and self-care occupations. There was no pursuit of leisure activities and interests. The individual remained in bed in a darkened room in almost total social isolation. At times he reported visual hallucinations and being scared. The service escalated his case to CMHT and the homeless MDT and created an occupational formulation. It was noted that when prescribed medication the individual showed a marked improvement in his mental health and daily functioning. A joint assessment was undertaken with psychiatrists, CPN and the AMP to explore treatment options and potential for admission. The OT service liaised with his Key Worker to ensure they were monitoring and offering interim support to encourage meeting his basic needs. A management plan was devised to support hostel staff on how to communicate with him. The OT service was able to demonstrate change using the standardised measures tool to make other professionals aware of how far he had come and highlighted that the individual's behaviour was not a result of choice and required regular contact to prevent further neglect in all areas. Looking forward, the future of the OT service is to educate hostel staff and change their perception of the individuals that come into the frontline hostels. There is also a role for OT to offer drop in sessions to speak to individuals who may not have been recognised as needing functional support. From an OT's perspective, they feel valued that their work is making a difference to a marginalised group of society. Going forward the OT service needs a staff structure review as more work can be done to lead change. JJ enquired if there are gaps within the MDT. It was noted that there are gaps in terms of Physiotherapy support, Psychology for intense trauma-based therapy and availability of longer term, permanent accommodation for the individuals. **The Group resolved that:** a) The value of the OT homelessness service and the benefits to its service users was noted	

	b) The Chair suggested that an invitation is extended to the Chief Executive to visit the service. She will contact her with an invitation.	**SB**
CDTQSE 22/245	**Feedback from UHB QSE Committee** **The Group resolved that:** a) The minutes of the meeting held on 15th June 2022 were not yet available.	
CDTQSE 22/246	**Health and Care Standards** **The Group resolved that:** a) There was no update to report.	
CDTQSE 22/247	**Risk Register – Review and Revision** The directorate risk registers have been received and are being reviewed. It was recommended that directorates review the scorings of their risks to ensure their current score is less than their initial score. There are specific themes highlighted across all the directorates such as estates and infrastructure and workforce issues. SB will develop a Clinical Board risk register based on these emerging themes. ECo requested for rehab estate issues to be separated out to ensure they are considered in the planning for UHW 2. Therapies Heads of Service will complete a risk assessment and overall submission for the Clinical Board risk register. **The Group resolved that:** a) Directorates will review the initial and current scorings of their risks. b) Therapies Heads of Service will produce an overall risk for rehab estate issues.	**All** **SB** **ECo/ KA/NC JJ/MK**
CDTQSE 22/248	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** **The Group resolved that:** a) There were no issues from directorates for escalation.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
CDTQSE 22/249	**Initiatives to promote the Health and Wellbeing of Patients and Staff**	

	Vaccination planning is underway in the UHB for the influenza vaccine and Covid boosters in the Autumn. It is not yet clear if both the vaccinations will be delivered at the same time. **The Group resolved that:** a) It was noted that the UHB is putting plans in place for the provision of influenza and Covid booster vaccinations.	
SAFE CARE		
CDTQSE 22/250	**Concerns and Compliments** In July 2022 the Clinical Board reported a Red/Amber status. It received 31 concerns with 42% responded within early resolution timeframes. There were 4 breaches in response times. 15 compliments were received. Physiotherapy reported a Red/Amber status. It received 7 concerns with 57% addressed through early resolution. There were 3 breaches in response times. 3 compliments were received. Dietetics also reported a Red/Amber status, reporting 1 breach in response times. Although it received 1 compliment. Areas reporting a Green status were: Radiology which received 7 concerns. It resolved 14% through early resolution and received 3 compliments. Occupational Therapy which received 7 compliments. Podiatry received 1 concern and resolved this through early resolution. Outpatients/Patient Administration reported an Amber/Green status. It received 3 concerns with 100% addressed through early resolution. The key themes of the concerns received are difficulties relating to arranging appointments and waiting times for test results/scan reports. ECo requested to receive the names of the breaches in the turnaround times within Physiotherapy. HJ will email her the details. The Concerns and Redress Team Newsletter was received. It provides advice on accessing support where there is a breach of duty and submissions to Welsh Risk Pool and demonstrating learning from events. **The group resolved that:** a) The concerns report for July 2022 was noted.	**HJ**

	b) The Concerns and Redress Team Newsletter was noted.	
CDTQSE 22/251	**National Reportable Incidents (NRIs)** The Clinical Board is currently reporting 3 open NRIs: 5456 – relating to the performance of a Radiology trainee. The report is currently being shared for comments and a closure form is being produced. 4123 – incident relating to the breakdown of a Radiology machine during a neuro interventional procedure. The patient experienced ill effect following the procedure and an investigation is underway to determine whether this was related to the breakdown. 5670 – an investigation is being undertaken into a delay to the reporting of a CT scan, where the patient suffered harm as a consequence of the delay. An IRMER incident 9348 has also been reported where the wrong addressograph was attached to a request form. This is being investigated by the clinical service involved. **The Group resolved that:** a) The update on the open NRIs were noted.	
CDTQSE 22/252	**New NRIs** **The Group resolved that:** a) No new NRIs have been reported.	
CDTQSE 22/253	**Patient Safety Alerts (internal/external)** **The Group resolved that** **a)** ISN 2022 Aug 003 Sodium Glucose Co-Transporter 2 was received and noted.	
CDTQSE 22/254	**Medical Device/Equipment Risks** EC noted that an incident was raised relating to a monitor bracket falling from a wall on A1 North. Clinical Engineering is working closely with the Estates team to undertake a UHB wide survey of wall brackets to ensure contractors are using the correct fittings for the wall type. It was suggested that an internal alert is produced. RD will liaise with EC outside of the meeting. It was reported that there is a shortage of Fentanyl and pumps may need to be reconfigured to use Remifentanyl or an alternative drug.	**RD/EC**

	The HIW inspection report has been received in the UHB. EC is awaiting to receive a copy of the report and will feedback at the next meeting. **The Group resolved that:** a) The medical device/equipment risks were noted.	**EC**
CDTQSE 22/255	**IP&C/Decontamination Issues** **The Group resolved that:** a) There were no IPC/decontamination issues to report.	
CDTQSE 22/256	**Point of Care Testing** **The Group resolved that:** a) There were no point of care testing issues to report.	
CDTQSE 22/257	**Safeguarding Update** The Standard Operating Procedure for Professional Concerns was received and noted. The procedure is currently awaiting ratification. The Clinical Board is currently reporting 14 open professional concerns. These are wide ranging issues such as professional conduct, children on child protection registers etc. Any directorates involved in cases need to ensure they are liaising with their HR Lead. **The Group resolved that:** a) The Safeguarding update was noted.	
CDTQSE 22/258	**Health and Safety Issues** **The Group resolved that:** a) There were no health and safety issues to report.	
CDTQSE 22/259	**Regulatory Compliance and Accreditation** The minutes of the Clinical Board Regulatory Compliance Meeting August 2022 were received for information. **The Group resolved that:** a) There were no issues requiring escalation.	
CDTQSE 22/260	**Policies and Procedures** The following policies are out to consultation on the intranet**:**	

	• Employee Wellbeing Policy • Management of Stress Policy • Maternity, Adoption, Paternity and Shared Parental Leave Policy • The Adaptable Workforce Policy • The Recruitment Policy • The Staff Winter Respiratory Vaccination and Covid 19 Policy Within this Clinical Board, the Sonographer Reporting Policy and Ionising Radiation Policy are currently due for review**.** ECo noted that there is a change in the Non-Medical Referrers Policy of who is permitted to refer which will have a significant impact, particularly within Speech and Language Therapy in relation to Video Fluoroscopy. It was noted that LH is the lead for the policy and Eco will discuss this with her outside of the meeting. **The Group resolved that:** a) The policies currently out to consultant and review were noted.	**Eco/ LH**
EFFECTIVE CARE		
CDTQSE 22/261	**NICE Guidance** The Group resolved that: a) No new NICE Guidance has been received.	
CDTQSE 22/262	**National Clinical Audit Plan** The new AMAT auditing tool is being rolled out across the UHB. The official launch date is 12th September. Mike Murphy, Clinical Audit Facilitator is the main point of contact for the tool. **The Group resolved that:** a) The implementation of the new audit tool was noted.	
CDTQSE 22/263	**Research and Development** The minutes of the Clinical Board R&D Group July 2022 were received and noted. **The Group resolved that:** a) There were no issues to escalate.	
CDTQSE 22/264	**Service Improvement Initiatives** SO referred to the improvement work relating to digital therapies and requested an update is presented at a future meeting.	**Eco/ MK**

	A lot of focus is currently being placed in the UHB around planned care and acute outpatient appointments. To address waiting times, the UHB is keen to implement Fully Automated Booking (FAB) for outpatient appointments, however since Covid and the move to virtual appointments, this has affected the functionality around the use of FAB. A 12-week programme of work is therefore being implemented to take this forward. Within this programme there will be the opportunity to also plan for enhancements to utilising FAB and also partial patient participation booking. This involves sending out letters or invites digitally through text messaging but also hard copies of letters to still be sent to patients that do not respond. This will require an active response from patients and if no response is received, then affirmative action will be taken in terms of cancelling appointments. This was a system that worked well prior to the pandemic in terms of reducing DNA rates and improved utilisation. Virtual appointments will also be incorporated into this programme. NR provided an update on Electronic Test Requesting (ETR both in secondary and primary care. ETR uptake is currently at 89.5%, with inpatient work at 97%. The target is 90%. GPTR uptake is at 87.5%. There are 5 GP practices in Cardiff that have not yet gone live with GPTR. 2 of which have shown an interest. A newsletter has been produced and was circulated to GP practices to encourage uptake. The newsletter presented data showing the significant improvements in turnaround times and the rejection rates which are 30% lower when electronically requested. The newsletter also highlighted prudent health care. This looked at the number of tests a practice requests over the practice population. Not only has the request rate reduced but also the range of tests being requested. Practices are also able to view previous results through GPTR and this has led to a reduction in repeat testing. MT has requested for a formal paper to be produced to present as a good news story to the UHB Executive Team. SO noted that the UHB Outpatient Transformation Board, CD Forums and potentially the LMC are mechanisms where uptake can be encouraged for the outliers. **The Group resolved that:** a) A presentation will be delivered to a future meeting on the digital therapies work. b) The programme of work relating to outpatient appointments was noted. c) The update on the uptake of ETR and GPTR was noted.	

CDTQSE 22/265	**Information Governance/Data Quality** SO highlighted IT security issues and the need to report any emails and web links that look suspicious. An internal audit will be undertaken around medical records tracking which is due to commence at the beginning of September. The scope is to investigate the effectiveness of the mechanisms for tracking medical records. There will be significant learning around this for other areas in the Health Board that deal with health records. The audit will also be looking at policies and procedures and the governance and operational arrangements. He also reported that Health Records are in early discussions with the Information Governance Team to identify if Office 365 can be used to receive Subject Access Requests (SARs) centrally and monitor compliance against the 3o day standard. **The Group resolved that:** a) The importance of reporting suspicious emails and weblinks was noted. b) The proposed internal audit around medical records tracking was noted. c) Early discussions around the potential use of Office 365 for SARs was noted.	
CDTQSE 22/266	**Waste and Sustainability** SJ reported that the first meeting of the Clinical Board Green Group was held yesterday. The Group provided an overview of the projects they are undertaking within their departments and a presentation was provided from Pharmacy on the Nitrous Oxide and Entonox project. The Waste Team will be attending the next meeting for a discussion on the appropriate waste disposal and recycling streams that should be utilised within the UHB. It was also reported that the CD&T Waste and Sustainability SharePoint page contains useful information and resources. A memo was circulated across the UHB from Pharmacy advising of the changes to the supplies of pre-filled insulin pens in a drive to reduce expenditure and waste. **The Group resolved that:** a) The feedback from the Clinical Board Green Group was noted.	

	b) The memo from Pharmacy relating to changes to the supplies of pre-filled insulin pens was received and noted.	
DIGNIFIED CARE		
CDTQSE 22/267	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** **The Group resolved that:** a) No reports or improvement plans have been received.	
CDTQSE 22/268	**Any initiatives specifically related to the promotion of dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/269	**Equality and Diversity** SO reported that the Clinical Board Inclusion Ambassadors are not receiving communication from staff within the Clinical Board. A concern from a member of staff was raised via their Trade Union rather than through the Inclusion Ambassador and the Clinical Board has been in discussions with Staff Side to discuss the case and learning from this. One of the outcomes from this discussion is that the Clinical Board will be working with the Clinical Board's Lead Representative to look at developing a Safe Space. SO provided feedback from the UHB Equality and Welsh Language Steering Group. He noted that a Welsh Language Action Plan is being developed and this will be shared with Clinical Boards. Going forward Clinical Boards will be required to submit flash reports and action plans around the equality agenda to the Steering Group. The Chair requested for the minutes of the UHB Equality and Welsh Language Steering Group to be received and noted at this meeting. **The Group resolved that:** a) The work around the development of a Safe Space for staff was noted. b) The feedback from the UHB Equality and Welsh Language Steering Group was noted, with the agreement that the minutes from this Group will be received at this meeting going forward.	**SO**

TIMELY CARE		
CDTQSE 22/270	**Initiatives to Improve Access to Services** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/271	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** The number of patients waiting 8 weeks or more for diagnostics in July was 1043. This was an increase of 62 from the previous month. Whilst an increase was reported this month, steady progress to reduce the waiting times has been made; in December 2021 there were 2351 patients reported. The number of patients waiting 14 weeks for Therapies at the end of July was 1486. Good progress has been made with a reduction of 36 patients from June. **The Group resolved that:** a) The progress being made against the waiting times in Diagnostics and Therapies was noted.	
INDIVIDUAL CARE		
CDTQSE 22/272	**National User Experience Framework** The UHB is not currently circulating user experience questionnaires. 'Happy or Not' data from Outpatients has been collated and overall good feedback has been received. **The Group resolved that:** a) User experience data that is currently available within the Clinical Board is indicating overall good feedback.	
STAFF AND RESOURCES		
CDTQSE 22/273	**Staff Awards and Recognition** **The Group resolved that:** a) Nominations for any national or internal awards are to be encouraged.	
CDTQSE 22/274	**Monitoring of Mandatory Training and PADRs** **The Group resolved that:** a) The monitoring of mandatory training and PADRs is discussed in detail at the Directorate Performance Reviews.	

	b) The simplified paperwork for VBAs has been circulated.	
	ITEMS TO RECEIVE/NOTE FOR INFORMATION	
CDTQSE 22/275	Regulatory Compliance Group Minutes August 2022 CD&T Clinical Board R&D Group Minutes July 2022 *Previously circulated:* CPho/MedsLet/2022/29 – Serious Shortage Protocol for Combisal 125 microgram/25 microgram inhaler CEMCPhA/2022/39 - Class 1 Medicines Recall - Mexiletine hydrochloride 50mg, 100mg and 200 mg Hard Capsules **The Committee resolved that:** a) The above items were received and noted.	
	ANY OTHER BUSINESS	
CDTQSE 22/276	JJ is retiring in September after 45 years' service. SB thanked her for her dedication and commitment to safe and effective care and for the services delivered to patients. **The Group resolved that:** a) The Group wished JJ best wishes for her retirement.	
CDTQSE 22/277	**Date & time of next Meeting** **19th September 2022 at 2pm at via Teams**	

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee
Held On 20th September 2022
Via MS Teams

Present:		
Sue Bailey (Chair)	Chair	Director of Quality, Safety and Patient Experience
Helen Luton	HL	Director of Nursing, CD&T Clinical Board /Multi-professional Teams
Becca Jos	BJ	Deputy Director of Operations
Jenna Walker	JW	Pharmacist, Pharmacy
Robert Bracchi	RB	Medical Advisor to AWTTC
Edward Chapman	ECh	Head of Clinical Engineering/ Medical Devices Officer
Catherine Evans	CE	Patient Safety Facilitator
Bolette Jones	BoJ	Head of Medical Illustration
Rhys Morris	RM	CD&T R&D Lead
Jonathan Davies	JD	Health and Safety Adviser
Sian Jones	SJ	Directorate Manager, Laboratory Services
Cath Marshall	CM	Physiotherapy Representative
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Alun Roderick	AR	Laboratory Service Manager, Haematology
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Chris Cheetham	CC	Head Occupational Therapist
Secretariat:		
Helen Jenkins	HJ	Clinical Board Secretary
Apologies:		
Sandeep Hemmadi	SH	Clinical Board Director
Matthew Temby	MT	Clinical Board Director of Operations
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Emma Cooke	ECo	Clinical Director of AHPs
Tracy Wooster	TW	Sister, Outpatients
Kim Atkinson	KA	Head of Occupational Therapy
Suzanne Rees	SR	Lead Nurse, CD&T
Helen Nicholls	HN	Head of Nutrition and Dietetics
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Seetal Sall	SS	Point of Care Testing Manager
Louise Long	LL	Public Health Wales Microbiology
Marie Glyn-Jones	MG-J	Deputy General Manager, Radiology & Medical Physics/ Clinical Engineering
Jo Fleming	JF	Quality Lead, Radiology
Mathew King	MK	Head of Podiatry
Timothy Banner	TB	Clinical Director, Pharmacy
Nia Came	NC	Head of Speech and Language Therapy
Paul Williams	PW	Clinical Scientist, Medical Physics
Lesley Harris	LH	Head of Radiography UHL

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 22/278	**Welcome & Introductions** The Chair welcomed Helen Luton, Director of Nursing for CD&T Clinical Board/Multidisciplinary Teams to the meeting.	
CDTQSE 22/279	**Apologies for Absence** **The Group resolved that:** a) The apologies for absence were noted.	
CDTQSE 22/280	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting held on 18th August 2022 were accepted as an accurate record.	
CDTQSE 22/281	**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 22/158 NICE Guidance Relating to Rehab Following a Traumatic Injury* SB to discuss with SH the requirement for a risk assessment to be completed for the NICE guidance as this cannot be fully implemented. *CDTQSE 22/213 New CAV Connect App* The Clinical Board to set up a group on the new CAV Connect app when it is launched as a communication tool for senior managers in the event of an emergency. *CDTQSE 22/243 Toxicology Lift* SB is regularly escalating the need for maintenance to the Toxicology lift at the UHB Health and Safety Operational Group. *CDTQSE 22/247 Estates and Infrastructure Risk* The Clinical Board Senior Management Team are meeting later this month to discuss the overarching estates and infrastructure risk that has been collated as a key risk on the Clinical Board risk register.	**SB/SH** **HJ** **SB** **SB**

	CDTQSE 22/247 Therapies Rehab Estates Risk The need for a Therapies rehab risk to be added to the risk register was discussed at the Therapies QSE meeting. CM to remind ECo of the need for the risk assessment to be undertaken and added to the risk register. *CDTQSE 22/254 Wall Brackets* ECh is working closely with the Estates team to address the wall bracket issues across the UHB. This work is almost completed. An update will be provided at the next meeting. *CDTQSE 22/264 Digital Therapies* Eco and MK to provide present an update on the digital work in Therapies at the next meeting. **The Group resolved that:** a) An update on the outstanding actions will be provided at the next meeting.	**CM** **ECh** **ECo/ MK**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CDTQSE 22/282	**Presentation: Blood Transfusion Patient Story** AR presented a story of a lady involved in a serious road traffic collision. She was the front seat passenger in a car and was ejected from the vehicle. She suffered multiple injuries with a massive loss of blood. She was attended at the scene by the EMRTS team. The EMRTS team are supported by the Blood Transfusion Laboratory (BTL) at UHW as part of the Major Trauma Service. The BTL will provide blood and blood products to the EMERTS team which are carried on board in their vehicles under a strictly controlled environment with a replacement system in place. The lady was initially treated at the scene of the accident and blood was administered both at the site of the accident and en-route to UHW. Upon arrival she went straight to theatre for damage control surgery and appeared brainstem dead and the situation appeared hopeless. Whilst she was profoundly hypertensive, given her age, the team engaged in aggressive resuscitation. She was administered with over 100 units of blood and blood products within the first 12 hours and more subsequently. The blood was provided by the BMS staff in the blood transfusion laboratory. This is a serious transfusion amount. For many days ICU staff were unsure if she had any severe brain injury and were unable to assess her. She was eventually roused and after a period of time, she was actually discharged. She is	

	considered an unexpected survivor and although she continues to have complex limb injuries, she is making excellent recovery. To clarify the role of the BTL in this case: • They supply and manage the blood stock carried on board in the EMRTs vehicles under strict MHRA regulatory guidelines. • Responded to the trauma team when the Major Haemorrhage Protocol was enacted . This is an extremely controlled multi-discipline procedure which supplies blood and blood products very quickly to the clinical area and is governed by quality and safety regulations. • Supported the ongoing urgent requirement for blood and blood products over a number of days until the patient was stable. 24/7 cover was provided. Dr Chris Hingston, Consultant, Intensive Care Medicine quoted: "Her survival is testament to you (the BTL) who were able to rapidly supply the necessary blood products to resuscitate her, support her and correct her coagulation abnormalities" (Dr Chris Hingston). SB asked how many units of blood are held in the laboratory. AR responded that generally the laboratory tries to keep stocks as close to 45 units of blood types are day. 2 deliveries are received per day. There is a system to be able to receive blood from the Welsh service very quickly and in an emergency blue lighted with the police. **The Group resolved that:** a) The services provided by the Blood Transfusion Laboratory to support the UHB and beyond was noted.	
CDTQSE 22/283	**Feedback from UHB QSE Committee** The UHB QSE Minutes held on 15th June 2022 were noted. At this meeting, the Clinical Diagnostics and Therapeutics Clinical Board provided its assurance report to the Committee. Also, an update on the Ultrasound Governance position was reported. It was noted that recommendations made from an assurance audit published in August 2021 have been addressed. **The Group resolved that:** a) The minutes of the UHB QSE Committee were noted.	

CDTQSE 22/284	**Health and Care Standards** **The Group resolved that:** a) There was no update to report.	
CDTQSE 22/285	**Risk Register – Review and Revision** **The Group resolved that:** a) There were no new risks to escalate.	
CDTQSE 22/286	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** **The Group resolved that:** a) There were no issues or exception reports to escalate.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
CDTQSE 22/287	**Initiatives to promote the Health and Wellbeing of Patients and Staff** Staff are now receiving invitations to obtain their Covid booster vaccinations. Flu vaccinations will be offered at the same time if available. It was also noted that a series of 'pop-up' sessions for flu vaccinations will be put in place across the UHB. **Health Boards' Responses to the Welsh Government Consultation on Healthy Food Environments** It was noted that Dietetics contributed to the UHB response to the consultation. **The Group resolved that:** a) The start of the Covid and Flu immunisation programme was noted. b) The response to the Welsh Government consultation on healthy food environments was received and noted.	
SAFE CARE		
CDTQSE 22/288	**Concerns and Compliments** In August 2022 the Clinical Board reported a green status with good concerns management across the Clinical Board. 26 concerns were received with 50% resolved through early resolution. 12 compliments were received. All departments reported a green status with the exception of:	

	Laboratory Medicine which reported an Amber/Green status. It received 4 concerns; there were 0 breaches in response times and it resolved 50% through early resolution. Radiology also reported an Amber/Green status. It received 8 concerns; there were 0 breaches in response times and 63% were resolved through early resolution timeframes. Appointment bookings continue to be the main theme of formal concerns but there was a reduction in the number of concerns relating to this issue during August. **The group resolved that:** a) The good concerns management within the Clinical Board for August 2022 was noted.	
CDTQSE 22/289	**National Reportable Incidents (NRIs)** The Clinical Board is currently reporting 3 open NRIs: 5456 – this incident relates to the performance of a Radiology trainee. A closure form is being produced. 4123 – an incident relating to the breakdown of a Radiology machine during a neuro interventional procedure. The patient experienced ill effect following the procedure and an investigation is underway to determine whether this was related to the breakdown. 5670 – an investigation is being undertaken into a delay to the reporting of a CT scan, where the patient suffered harm as a consequence of the delay. SB presented Incident Number In123863 for shared learning. On the 14th April 2018, the patient Mr WC was admitted to University Hospital of Wales (UHW) with abdominal pain. On the 29th May 2018, Mr WC was admitted electively for a cholesystectomy. On the 30th May, Mr WC underwent a Laproscopic Cholesystectomy. It states in the post operative notes “that the gallbladder was covered in adhesions and the cystic duct was not clearly seen”. During the procedure a tissue sample was sent to Pathology. The tissue specimen underwent several different stages of examination as stated in the Histopatology report. The results were reported on the 15th June 2018 via Telepath. These results were also available on clinical portal and a report was printed and posted in the internal mail system to the requesting Consultant Miss JW. Unfortunately, the paper copy report was not received by the Consultant or her secretary. Mr WC attended several hospital appointments between June 2018 and July 2020. On the 27th July 2020, Mr WC was referred	

by his General Practioner (GP) to Gastroentrology UHW. Mr WC had presented with significant weight loss over a six month period with no other symptoms other than a persistant cough. Following a Computerised Tomography (CT) scan, it was revealed Mr WC had metastasis in the liver, with a mass near the Inferior Vena Cava (IVC) likely located at or near to a node. Primary source at this stage was unknown.

On the 28th July 2020, Mr WC was discussed at the Lung Multidisciplinary team (MDT). A CT scan taken on the 11th July 2020 had shown early Usual interstital pnumonia (UIP) changes but no confirmed lung malignancy. The plan following the meeting was to undertake a biopsy of serosal peri–hepatic leison.

On the 4th August 2020, Mr WC met with Consultant Chest Physician Dr Helen Davies to discuss the outcomes following the MDT. It was explained to Mr WC that the appearance from the CT scan was suggestive of metastaic disease although there was no evidence of a primary lung site. During the appointment, Mr WC reported swallowing issues that had been troublesome since he underwent a laproscopic cholesystectomy in May 2018. On review of the histology results from this time, it was noted that the histology from the gallbladder specimen did show a gallbladder adenocarcinoma pT2b with extensive BILIN3 in the background. This information was relayed to Mr WC and his daughter who were very surprised and completely unaware of this result.

Identified problems:

The referrer did not receive the pathology results via the internal post and the electronic system was not checked.

There is currently no process in Cellular Pathology to check the referrer had received the report.

Possible missed opportunity for the histopathology results to have been reviewed at subsequent referrals or hospital appointments.

Executive summary of Datix report In123863 following review by the Clinical Director for Surgery Clinical Board:

1. The pathologist made a definitive diagnosis of gall bladder cancer. There was no delay in the diagnosis being made nor in the report being made available to the requesting surgeon.

2. General Surgeons do not routinely follow up patients up after a cholecystectomy. Nevertheless, it is the responsibility of the consultant surgeon to review all histopathology results issued on patients under their care. A system should be in place to make sure that this happens.

3. There was a failure for this process to be followed by the surgeon in this case.

	4. Whilst some pathologists may informally alert a referring doctor to a result that the pathologist considers to be unexpected, there is no obligation on the pathologist to do so. The Royal College of Pathology is vague about any policy. Currently it is not realistic to have a Standing Operating Procedure that burdens the pathologist with the responsibility of determining what a referring doctor may or may not consider to be an unexpected result or otherwise. 5. The introduction of a system on Welsh Clinical Portal to allow requesting doctors keep track of the results of their requests should be considered. It was noted that a report notification and acknowledgement system for pathology reports has now been implemented in WCP. BJ raised the issue of whether a report showing an incidental finding could automatically be sent to an MDT coordinator as a safety net process, as this would then be identified with the MDT. It was agreed that this option will be explored at the Clinical Board Cancer Meeting. It was noted that the staff involved were distressed by this incident, and by the subsequent management of the RCA process. It was recognised that psychological safety and support were important for all staff involved, those impacted by the incident and the staff undertaking RCA investigations. **The Group resolved that:** a) The update on the open NRIs were noted. b) The Clinical Board Cancer Meeting will consider the option of implementing a safety net process for incidental findings.	**SB**
CDTQSE 22/290	**New NRIs** **The Group resolved that:** a) No new NRIs have been reported.	
CDTQSE 22/291	**Patient Safety Alerts (internal/external)** **The Group resolved that** a) There were no alerts to report.	
CDTQSE 22/292	**Medical Device/Equipment Risks** **Shared Services Audit of the Medical Devices Policy and Procedure** The audit has been completed and a report is being produced. The audit identified that there is adequate assurance and a number of medium priority actions will be recommended.	

	Phillips Medical Device Alert – Phillips MobileDiagnost wDR An update to the instructions for use has been issued which advises that if users overly wet the touchscreen of a device there is a risk of accidentally changing the exposure settings. The safety notice has been signed off and returned to the manufacturer. ECh has advised that when users clean medical devices with Clinell wipes, it is good practice to wipe them over with a damp cloth to remove any residue. He also noted that Arcamed PCA pumps are experiencing a shortage and repairs and warranty replacements are proving challenging. This is a clinical risk and the issue has been raised with the MHRA and on a national level. **The Group resolved that:** a) The Phillips Medical device alert has been actioned. b) The good practice for cleaning medical devices using Clinell wipes was noted. c) The national shortage of Arcamed PCA pumps was noted.	
CDTQSE 22/293	**IP&C/Decontamination Issues** **The Group resolved that:** a) There were no IPC/decontamination issues to report.	
CDTQSE 22/294	**Point of Care Testing** **The Group resolved that:** a) There were no point of care testing issues to report.	
CDTQSE 22/295	**Safeguarding Update** **The Group resolved that:** a) There was no safeguarding update to report.	
CDTQSE 22/296	**Health and Safety Issues** CC has been informed that security arrangements are no longer being provided for Rookwood and Treforest. A list of the services based on these sites is being collated as services are still running. **The Group resolved that:** a) The security issue at Rookwood and Treforest sites was noted.	

CDTQSE 22/297	**Regulatory Compliance and Accreditation** Sue Bailey provided feedback from the Clinical Board Regulatory Compliance Group held on 6th September. It was noted that an action plan to improve the SMPU metrics has been produced. A plan is in place to support the overdue actions and audits reported in Immunophenotyping. HIW will be undertaking an IRMER Inspection in Nuclear Medicine in UHL on 11th and 12th October 2022. **The Group resolved that:** a) The feedback from the Regulatory Compliance Group held on 6th September 2022 was noted.	
CDTQSE 22/298	**Policies and Procedures** **The Group resolved that:** a) There are no relevant policies and procedures out to consultation.	
EFFECTIVE CARE		
CDTQSE 22/299	**NICE Guidance** **2021 National Comparative Audit, NICE Quality Standard Q1378** The document outlines four key areas for auditing clinical and laboratory transfusion practice for safe patient care for the next 5 years. Governance arrangements to improve the metrics will involve the clinical team and through the Blood Transfusion meetings. **The Group resolved that:** a) The audit document was noted.	
CDTQSE 22/300	**Clinical Audits** **Internal Audit on Health Records Tracking** The Internal Audit Team has commissioned an audit on Health Records tracking. The specification of the audit has been agreed and will relate to the acute paper record and also include the impact of digitising records. The audit will identify lessons to be learned for all services that deal with paper and electronic records through this Clinical Board.	

	The Group resolved that: a) An Internal Audit has been commissioned to audit Health Records tracking.	
CDTQSE 22/301	**Research and Development** The next meeting will be held later this week. **The Group resolved that:** a) An update will be provided at the next meeting.	**RM**
CDTQSE 22/302	**Service Improvement Initiatives** A presentation will be requested on Digital Therapies at the next meeting. This will link with the Clinical Board digital work and be an opportunity for shared learning and how the approach to digital services can be adapted and expanded accordingly to other services. Sion O'Keefe provided an update on the uptake of ETR electronic test requesting. GPTR is reporting 87.7% uptake. The target is 90% by the end of this calendar year. A recommendation will be presented to the next Outpatient Transformation Board for a soft mandate i.e. to reject samples from the outstanding GP practices unless these are agreed by exception. The UHB is looking to resume the work around Patient Participation Booking for acute new appointments. As part of this, a large rationalising piece of work will be undertaken around acute appointment letters and ensuring letters are provided in a standardised format that patients will recognise and provided in Welsh. **The Group resolved that:** a) A presentation on Digital work in Therapies and the Clinical Board will be provided at the next meeting. b) The current uptake of GPTR was noted. c) Work is being undertaken to resume the implementation of Patient Participation Booking for acute new appointments.	**SO/ MK/ EC**
CDTQSE 22/303	**Information Governance/Data Quality** A monthly report is being produced on those staff who may have accessed records without the right level of authority. It was noted that triggers not only involved accessing records of family members but also if records are being viewed within the vicinity of where the staff member lives. It was noted that there may quite often be a business need for accessing these records and an agreed approach with HR and the Information Governance Team is being developed which will include the completion of an initial	

	assessment form to identify if there is a good reason for accessing the records. The process will ensure that any further action taken is proportionate and that there is consistency. **The Group resolved that:** a) The new process being developed for staff who may be accessing records without good reason was noted.	
CDTQSE 22/304	**Waste and Sustainability** The CD&T Green Group met last week. The Waste team were in attendance to promote the correct waste and recycling streams and reminding staff to ensure that sharps are disposed of correctly. The next session will promote the trading post for recycling items such as desks and office furniture and Calum Shaw, Programme Manager for the UHB Decarbonisation Strategy and Programme will be presenting. **The Group resolved that:** a) The update from the Clinical Board Green Group was noted.	
DIGNIFIED CARE		
CDTQSE 22/305	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** **HIW Inspection Report for Emergency Unit** ECh noted that staff comments were raised in the report relating to the availability of medical equipment. An action plan will be produced to determine whether surplus equipment from the Covid wards and winter pressure wards can be redirected towards the emergency unit. **The Group resolved that:** a) An action plan will be developed to address the medical equipment issues raised in the report.	
CDTQSE 22/306	**Any initiatives specifically related to the promotion of dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/307	**Equality and Diversity** **The Group resolved that:**	

	a) The minutes from the UHB Equality, Diversity and Welsh Language Sub-Committee will be received at this meeting going forward.	
TIMELY CARE		
CDTQSE 22/308	**Initiatives to Improve Access to Services** **Older Peoples Commissioning for Wales on Accessing Services in the Digital Age Post Covid.** The report was noted. **The Group resolved that:** a) There is shared learning within the guidance from other Health Boards. b) The UHB needs to ensure that patients who cannot access services and information online, have non-digital ways to access the services and information they need. c) The UHB should consider providing help to patients who wish to access services online but require support.	
CDTQSE 22/309	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** In August, the number of patients waiting 8 weeks or more for diagnostics was 1168. This was an increase of 125 from July. In August, the number of patients waiting for Therapies was 1315. This was a reduction of 213 from July. **The Group resolved that:** a) The waiting time position for diagnostics and therapies is monitored in detail in the Directorate Performance Reviews.	
INDIVIDUAL CARE		
CDTQSE 22/310	**National User Experience Framework** Happy or Not Surveys are being undertaken in Outpatient settings. **The Group resolved that:** a) The national questionnaires are not currently being undertaken.	
STAFF AND RESOURCES		
CDTQSE 22/311	**Staff Awards and Recognition** The WAPSU department within AWTTC, was a finalist at the Welsh Pharmacy Awards in the Digital Innovation Award	

	category, as part of the WHSSC Blueteq HCD system implementation for NHS Wales. The Clinical Engineering Network has been nominated in the HSJ Awards. **The Group resolved that:** a) Both teams were congratulated on their nominations.	
CDTQSE 22/312	**Monitoring of Mandatory Training and PADRs** **The Group resolved that:** a) The monitoring of mandatory training and PADRs is discussed in detail with plans to achieve compliance at the Directorate Performance Reviews.	
	ITEMS TO RECEIVE/NOTE FOR INFORMATION	
CDTQSE 22/313	Regulatory Compliance Group Minutes August 2022 **The Committee resolved that:** a) The above item was received and noted.	
	ANY OTHER BUSINESS	
CDTQSE 22/314	**The Group resolved that:** a) There was nothing further to report.	
CDTQSE 22/315	**Date & time of next Meeting** **17th October 2022 at 10am via Teams.**	

Minutes of the Medicine Clinical Board

Quality, Safety & Experience Committee Meeting

Held on 18th August 2022 14:30 – 16:00

Via MS Teams

Present:	
Aled Roberts	Clinical Board Director, MCB (Chair)
Jane Murphy	Director of Nursing, MCB
Diane Walker	Deputy Director of Nursing, MCB
Lyndsey MacDonald	Consultant, Acute & Emergency Medicine
Kath Prosser	Quality & Governance Lead, Medicine
Sam Barratt	General Manager, Integrated Medicine
Derek King	Clinical Nurse Specialist, Infection Prevention & Control
Sam Hughes	Practice Development Nurse, Integrated Medicine
Gemma Taylor	Practice Development Nurse, Integrated Medicine
Barbara Davies	Lead Nurse, Specialised Medicine
Claire Matthews	Deputy Service Manager, Integrated Medicine
Jacqui Westmoreland	Senior Nurse, Covid Investigations
Ruth Cann	Senior Nurse, Integrated Medicine
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Carly Simpson	Senior Nurse, Integrated Medicine
Natasha Whysall	Senior Nurse, Integrated Medicine
Sian Brookes	Senior Nurse, Integrated Medicine
Tracy Williams	Parkinson's Nurse Specialist
Jade Smitherman	Pleural Disease Clinical Nurse Specialist
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Iain Hardcastle	Director of Operations, MCB
Craig Davies	Service Manager, Acute Medicine
Rhiannon Owen	Service Manager, Emergency Medicine
Ceri Richards-Taylor	Lead Nurse, Integrated Medicine
Suzie Cheesman	Patient Safety Facilitator, Patient Safety & Quality Team
Beth Jones	Senior Nurse, Specialised Medicine

Item No	Agenda Item	Action
MCBQSE/ 2022/001	**A1. Welcome & Introductions** – were undertaken.	
MCBQSE/ 2022/002	**1.1 To receive the minutes of the previous meeting** The group resolved: that the minutes were agreed and accepted.	
MCBQSE/ 2022/003	**1.2 Matters arising:** **Support for staff at Inquests** – KP shared how as a UHB and Clinical Board staff giving evidence at a Coroner's Court can be supported. Working with the Inquest Team, work is being undertaken which mirrors Public Health England with the provision of videos that can be shared with staff detailing what the Coroners court looks like, who would be in	

	attendance and the type of questions staff could be asked. As a Clinical Board this must be a Multi-professional approach to support staff. **Diabetes blood sugar audits** – to be carried forward to the next meeting. DP to update at the next meeting. **Presenting DNA CPR Audit from St David's** – this closed action must now be reopened; therefore, the audit has been re-started. AR has asked Ceri Richards-Taylor and Biju Mohammed to have this at least partially reported for Corporate Government in Sept 22. RC recently requested 90 sets of case notes and has been advised that the entire 90 sets will not be released. None received to date. The group resolved: the action below to be followed. **Action from discussion: RC to let AR know of the constraints around this and AR will deal with these. RC will forward the initial request to AR regarding requesting the case notes.** **LP Pro-forma** – AR is awaiting a response regarding this.	Dave Pitchforth Ruth Cann Aled Roberts
MCBQSE/ 2022/004	**1.3 Patient Story** – delivered by Natasha Whysall, Integrated Medicine A lady was admitted to a medical ward following a fall. She had a history of COPD, CCF, PTSD, depression, agoraphobia and chronic pain. She was prescribed regular and PRN analgesia for her ongoing pain. Heat therapy was discussed with the patient who agreed to try this. A nurse then applied a latex glove filled with hot water, wrapped it in a bag and pillow cases to the patient's shoulder. The following day the patient was found to have two blisters, which were reviewed and no infection found. The incident was discussed with the patient and the patient did not raise any concern and felt the nurse was trying to help. The patient had medical photography, there was TVN input, an AS1 was completed, and a safeguarding meeting held. The burn had not healed on discharge and the patient was discharged to District Nurses. Four weeks later, the burn had still not healed. The family submitted a formal complaint, advising the patient's clinical depression had been impacted due to the slow healing of the wound. On 21/6/22 the patient was re-admitted to UHL, however, not due to the burn. **Learning:** the nurse did not intend to cause harm, however, this was poor practice. There was a lack of documentation regarding the heat pack being applied, and a lack of recognition of patient harm. The patient thought a wheat pack had been applied, not a hot water filled latex glove. There was a delay escalating the burn to the doctor; arranging medical photography and referring the patient to the tissue viability nurse. Nurses were unable to access the e-referral as they did not have Nadex identifiers. Submitting a datix was delayed due to the lack of recognition the patient had sustained a burn. The nurse involved was from an agency. Temporary staffing contacted the agency regarding the nurse to ensure they had updated safeguarding training and the learning from the events was discussed with them. All nurses have a Nadex and can complete e-referrals. The need for timely referrals and adequate documentation was discussed with staff. An internal safety notice was distributed across all Medicine Clinical Board wards and also shared with agencies. Medical wards now carry out an audit regarding heat packs on-wards. A formal written response has been sent to the patient and her daughter with breach and qualifying liability agreed.	

	The group resolved: the learning has been appropriately shared. Using a heat pack is not usual practice on wards. A learning from events for the Welsh Risk Pool has been submitted. **Action from discussion: none.**	
MCBQSE/ 2022/005	**1.4 Feedback from UHB QSE Committee** The group resolved: June's minutes will be available in August 2022. **Action from discussion – none.**	
MCBQSE/ 2022/006	**1.5 Directorate QSE minutes – exception reporting** The group resolved: concise, not verbatim, minutes are required. **Action from discussion - SB will update the Integrated Medicine Team advising that minutes should not to be verbatim.**	Sam Barrett
2. HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
MCBQSE/ 2022/007	**2.1 Administration of Prescribed Intravenous Medications in Endoscopy –** a training programme constraint was found, as a person would not be an independent prescriber until they became expert in their field. The majority of endoscopy non-prescribing staff administer by a PGD but specific to colon activity there is a requirement to administer Fentanyl during the procedure. This is a controlled drug and cannot be administered by a PGD. Therefore, the individual would not be able to operate independently. An algorithm and prescription for the titration and administration of bolus intravenous Fentanyl during endoscopy procedures was prepared to check for contradictions. Congratulations were given to all. This has been through all the directorate levels of governance. This has been ratified by the National Endoscopy Programme and the leaders' groups in Gastroenterology fields for Wales. This will be shared across Wales. Brought to MCB QSE for governance. Endoscopist's have all engaged well with the process. The group resolved: this updated procedure was approved. **Action from discussion- BD will ensure this paper is taken to NMB for approval.**	Barbara Davies
MCBQSE/ 2022/008	**2.2 Procedure for T34 and FK use** - paper for ratification, delivered by Tracey Williams, Parkinson's Specialist Nurse This relates to an infusible therapy drug used with Parkinson's. The updated protocol was brought to MCB QSE for approval. The drug is infused via a pump and only used in the community. This is relevant to 3 patients in C&V, however, patients from other Health Boards have been here. The patients carry the protocol. Once the pump is stopped, there is an active drug for 35 minutes and it is out of the patient's system within an hour. The group resolved: the update of the protocol was approved. **Action from discussion - TW will check if there are flags on the system for the patients records and will provide an update.**	Tracey Williams
MCBQSE/ 2022/009	**2.3 Healthcare acquired Covid investigations** Communication with bereaved families has commenced. Contact has been made with six families who were appreciative of the call. Families have a lot of questions. Internal communication has been done. Scrutiny panels are underway. Legal and risk have been contacted	

	regarding one case. Investigations are progressing. The initial call to families is made by non-clinical, experienced concerns co-ordinators. Staff have access to the wellbeing service. Consistent themes when contacting families are communication and visiting. The group resolved: reassurance will be given to families that everything that could have been done was done. **Actions from discussion – none.**	
MCBQSE/ 2022/0010	**2.4 Learning and Education Plan** GT and SH are working on: • Collating core competencies for ward-based staff and will then move onto non-ward-based staff. • A robust induction programme. Focus is on staff retention. • Health Care acquired pressure damage. Action plans are in place for two wards. • Themes of falls resulting in harm, lack of line standing blood pressure. On-going work. • Harm caused to acute stroke patients. • Harm caused by lack of by lack of VTE assessments. • Hospital acquired thrombosis group. The group resolved: work on the plan is ongoing. **Actions from discussion – when the plan is in place, the learning will be shared across the Clinical Board and the organisation.**	Diane Walker
MCBQSE/ 2022/0011	**2.5 Tendable feedback** Go live date awaited. The team have created a dashboard. Feedback has been requested on its usability; how it will be valued in the team; what it will be used for. Future developments are: ongoing acuity audits will be available; Health Roster; Datix; Welsh Nurse Care record. Tendable is assisting with documentation looking at harms The group resolved: the go live date is awaited. **Actions from discussion – all to give feedback on the dashboard to Ceri Dallimore and Helen Bonello.**	ALL
MCBQSE/ 2022/0012	**2.6 Clinical Audit Plan** The group resolved: the formal plan is not completed as yet. **Action from discussion – DW will follow up on preparing a plan.**	Diane Walker
3. SAFE & CLINICALLY EFFECTIVE CARE		
MCBQSE/ 2022/0013	**3.1** There are currently 11 open NRI's, 8 of which are overdue. 1 of these is a Never Event, which relates to a wrong site pleural tap. **NRI's for closure:** **In159285/ID5647** Patient presented to EU on 19/1/22 with anxiety and shortness of breath. Patient disclosed she had taken occasional marijuana and used alcohol. The patient had a history of depression and anxiety, was not known to the Mental Health Team and had only made contact with the Community Psychiatric Nurse the day before admission. The working diagnosis at the time was Atrial Fibrillation with potential sepsis. Following post take review, an ultrasound was suggested. The	

	patient did not wish to stay in hospital and requested to come back the following morning for the USS. The risks of leaving the EU were explained, however the patient was deemed to have capacity to make this informed decision. The patient returned for the USS which reported a normal liver with small ascites, abnormal pulsatile flow within the portal vein which may be in keeping with heart failure given new AF and Cardiomegaly. Further liver screen blood tests and paracetamol levels were requested. The patient was referred for Gastroenterology Speciality retrieval. The patient expressed two further wishes to discharge against medical advice but remained in the department. Following Gastroenterology review the impression was that of acute hepatitis, query viral, query congestive and biliary sepsis was unlikely. At 8.20am on 22/1/22 a HCSW was unable to record the patient's blood pressure using an observations machine and was then asked to take the blood pressure manually. At 9am the patient was given prescribed analgesia, shortly after this the patient was found unresponsive in bed in cardiac arrest. The patient was transferred to purple majors to perform CPR, however, there was a delay getting past obstacles in the corridor enroute. The patient was pronounced dead at 9.45am after attempts of CPR failed to regain a cardiac output. Her death was referred to the Coroner. The post mortem reported the cause of death as 1a Fluoxetine toxicity and liver necrosis with liver failure. An inquest has been opened. **Learning:** The patient did not disclose during their time in the EU they had taken a Fluoxetine overdose. The working diagnosis during the inpatient stay was some form of acute hepatitis possibly congestive related to AF. The patient denied any misuse of Paracetamol and openly disclosed occasional cannabis and had taken some street Zopiclone recently with no other drug causes found. Fluoxetine a selective serotonin reuptake inhibitor is commonly prescribed antidepressants. The majority of Fluoxetine overdoses result in benign clinical course. The largest series of overdoses found the most common effects were tachycardia, drowsiness, tremor, nausea and vomiting. If the working diagnosis was Fluoxetine toxicity the immediate management would be to refer to 'Toxbose' an online information database providing clinical toxicology advice to healthcare professionals. All patient would have a repeat ECG and arterial blood gases to monitor for cardiac abnormalities, seizures and raised CK. Clinicians can also contact specialist poisons clinicians if there are any concerns. Sadly, given the cause of death it was felt that the outcome would have been the same for the patient secondary to the non-disclosure of a Fluoxetine overdose. The post mortem report did not highlight any sign of ischaemic brain injury which would suggest there was not a prolonged delay in commencing CPR. Learning identified there was no evidence of a manual blood pressure following observations being undertaken at 08:20 when a blood pressure could not be recorded. A NEWS score was also not calculated. In addition, the difficulty in transferring the patient from the Assessment Unit to Majors secondary to obstacles in the corridor.	

	All staff were immediately informed of the importance of escalating observations, or the inability to obtain an observation to support patient care and the completion of NEWS score. Immediately following this incident, the corridor was cleared of all obstacles and continues to be monitored daily by the Senior Nurse on floor cover duty. **In160124/ID5636** A 58-year-old man presented to EU via a taxi at 16.09pm. He had been advised by the Welsh Ambulance Service at 15.10pm that due to the long wait for an ambulance, to get a taxi to the EU. On arrival at EU the patient was supported by a HCSW into a wheelchair and taken to the purple stream reception based on symptons of shortness of breath and assisted to book into the department. The patient had difficulty hearing the receptionist, so the HCSW repeated questions to him. Following triage, the HCSW placed the gentleman in a high visibility area. At 20.28pm the patient asked how much longer he had to wait to be seen. When the staff member checked the electronic work station, the patient was not listed as being in the department, so they asked him the reason he was there, recognised he looked unwell, took him to the ambulatory care area to perform an ECG. The patient's responsive levels dropped. He was taken to Resus and was attached to a cardiac monitor which identified ST elevation (a Myocardial Infarction). The EU consultant immediately contacted the Cardiology Registrar with a view for urgent transfer to the cath lab for PCI. ACS treatment commenced. At 21.10pm the patient had a witnessed arrest which responded to treatment immediately. At 21.30pm the patient developed heart block which responded to medication and then went into a full PA arrest. The patient was intubated and placed on an autopulse to continue CPR and transferred to the cath lab. The patient remained in cardiac arrest whilst in the cath lab. A PCI was successfully placed in the right coronary artery but sadly the patient did not regain output and his death verified at 22:45. Further investigation identified that a patient with the same surname, date of birth, with a presenting complaint of chest pain was booked into the department at the same time the patient arrived in the Emergency Unit at 16:14. Staff on triage at the time of the patient's presentation called for this patient on two occasions at 16:50 and 18:30. As this patient did not respond to the call of the triage nurse they were subsequently discharged from the Emergency Unit as a 'did not wait'. Following an expert opinion review, on the balance of probabilities had the patient been correctly booked into the department and responded to the first or second call of triage the patient would not have died. **Learning:** the patient was booked into the Emergency Unit on the UHB's electronic PMS system with the incorrect patient identifiers not using the correct booking in process secondary to a human factors action error. This led to a delay in an ECG being performed and timely treatment for a patient presenting with chest pain. The screens in the reception areas can make it difficult for both staff and patients to hear, particularly when the reception areas are busy. However, the patient was supported to book into the department. There were missed safety netting opportunities for the triage staff to check with reception staff if they could	

point out the patient who had not responded to the call for triage, or to confirm they had left the department. Discussions are ongoing with the family. Trajectory in place for staff to undertake PMS training and this must be 92% compliant by October 2022. There are ongoing audits regarding the PMS booking system. After calling the wrong patient twice, the patient was discharged as 'did not wait'. No-one checked with Reception staff to see if they could point the patient out. The Health Board are exploring a new system for patients to book themselves in if they are able. The meet and greet by Red Cross staff has been reintroduced as an additional welfare check. It is likely that a Regulation 28 will be received for this incident unless the Coroner is happy that a robust action plan is in place so this does not happen again.

ID9121 and ID5829
Both these incidents relate to avoidable category 3 health care acquired pressure damage.
Learning – there is no documentation to support that safe, timely and effective care was provided to the patients, or evidence of required intentional rounding to support pressure area care and prevention.

The group resolved: all agreed these can be closed.
Actions from discussion - none

MCBQSE/ 2022/0014

3.2 Infection Prevention and Control up-date
17 days since last MRSA bacteraemia (UHL E7)
5 days since last MSSA bacteraemia (UHW C5)
9 days since last *C difficile (UHW Heulwen)*
2 days since last E. *Coli* bacteraemia (UHW C5)
130 days since last Pseudomonas bacteraemia (UHW LSGF2)
2 days since last Klebsiella bacteraemia (UHW C5)

- There are 4 ongoing Incidents and outbreaks within the MCB affecting 23 patients, 4 staff and resulting in 2 bed days lost. There is 1 influenza outbreak to date with one patient affected (B7).
- DMT scores – all wards within MCB are compliant for the 4-week period, except for E7 (88%) and E8 (93.18%). SRC achieved 100%.
- Reduction Goals for HCAI's now available for 2022-2023 are:

C.diff	MRSA	MSSA	E.coli	Pseudomonas	Klebsiella
20 cases	0 cases	8 cases	40 cases	0 cases	8 cases

- HCAI position based on the same period 2021-2022: *C. difficile* - 38% reduction, *Klebsiella* 58% reduction. 25% reduction with *E. coli*, 20% increase with SAUR and +1 increase with *Pseudomonas*.
- 25 RCA's remain outstanding.
- Monkey pox. Further cases admitted. Case rates across the UK have plateaued.
- COVID community case rate continues to fall. Influenza remains below baseline threshold.
- Bare Below the Elbow – anecdotal surveillance shows increasing non-compliance. All UHW MCB wards audited yesterday. Results will be available soon.

The group resolved: audits continue, including environmental audits. A lot of work is to be done by Estates on the wards.

	Actions from discussion – MCB would appreciate any training IP&C staff could offer to staff. DK, SH, GT may be able to address some of these issues when pressure drops. DK, SH, GT to discuss further outside this meeting.	Derek King Sam Hughes Gemma Taylor
MCBQSE/ 2022/0015	**3.3 Point of Care testing: any actions required** The group resolved: no issues were raised. **Actions from discussion – none.**	
MCBQSE/ 2022/0016	**3.4 Medical devices/equipment issues** For information, BD is the representative for the Health Board. The group resolved: If there is anything of concern, please let BD know. **Actions from discussion – none.**	
MCBQSE/ 2022/0017	**3.5 Patient Safety Alerts/MDA's/ISN's** • Welsh Resuscitation Forum June 2022: Update on PPE and Cardiopulmonary Resuscitation. • 2022-05-25 – Letter from CNO: Statement on the initial antimicrobial treatment of sepsis and associated 'Clinical decision support frameworks'. • Resuscitation Service Newsletter July 2022. The group resolved: these were noted for sharing. **Actions from discussion – none.**	
4. DIGNIFIED CARE		
MCBQSE/ 2022/0018	**Patients Safety/Quality Care** **4.1** LFE CN/UHW/4294 – the allegations of breach of duty centre around the care afforded to the claimant between 12/3/19 and 11/4/19. Specifically, it is alleged there were failures to consider a differential diagnosis of Amiodarone lung toxicity. Had this been considered, the claimant would have avoided a lower left lobectomy, pneumonectomy and associated sequalae. This matter has been investigated under Putting Things Right. Following which it was agreed the Consultant Histopathologist should have been made aware of the differential diagnosis via the Radiology request for a CT guided biopsy. The Royal College of Radiologists clearly suggests that all forms should be adequately and legibly completed to avoid any misunderstanding. The clinician is required to state the reason for referral as this helps Radiologists better understand the patient's condition; so the required expertise may be utilised to proffer the necessary information to aid proper patient management. Standardised Radiology request forms are not available, and different organisations adopt personalised versions. **4.2 Changing nursing establishment slightly**– more HCSW's, dietetic assistants and non-registered nurses will be brought in. The role of the registered nurse will be reviewed on an interim basis. There are over 80 registered nurse vacancies due to maternity leave, sickness and vacancies equating to half the workforce being off work. Looking at new models and will get these in place quickly. The group resolved: staff wellbeing is of great importance.	

	Actions from discussion – none.	
MCBQSE/ 2022/0019	**4.2 Mortality Group feedback** The group resolved: this should be carried over to next meeting. **Actions from discussion - none.**	
MCBQSE/ 2022/0020	**4.3 HIW feedback Emergency & Acute Medicine** The group resolved: this should be carried over to next meeting. **Actions from discussion - none.**	
5**. TIMELY CARE**		
MCBQSE/ 2022/0021	**5.1 Datix update** The group resolved: the action below should be shared with teams. **Action from discussion** - remind staff that when closing a datix, to go through the management review, review the level of harm to ensure the correct level of harm is noted.	ALL
MCBQSE/ 2022/0022	**5.2 RTT position update – Specialised Medicine** **Dermatology** - backlog of 4,000 patients waiting and significant breach position. An average of 600 referrals are accepted onto the waiting list per month. Total breach position >36 weeks = 1,250 patients 52 weeks = 622 patients breached. 104 weeks = 5 patients breached. Urgent Suspected Cancer (USC) – first appointment booking day 55. **Rheumatology** Total breach position >36 weeks = 748 patients 52 weeks = 555 patients breached 104 weeks = 1 patient breached **Gastroenterology** Total breach position >36 weeks = 1,702 patients 52 weeks = 701 patients breached 104 weeks = 0 patients breached USC – projected breach position =1 **Endoscopy** Total waiting list = 3,976 The group resolved: the report was noted. **Actions from discussion – none.**	
MCBQSE/ 2022/0023	**4.3 4 and 12-hour performance update, Emergency Medicine** The group resolved: to carry this item over to next month. **Actions from discussion – none.**	
6. INDIVIDUAL CARE		
MCBQSE/ 2022/0024	**6.1 National User Experience Framework - Feedback from 2 minutes of your time survey – relevant improvement plans** The group resolved: this is not being done at present. **Actions from discussion – none.**	

MCBQSE/ 2022/0025	**6.2 DTOC's** The group resolved: there are a vast number in the system and a lot of work is on-going to address the long stays. **Actions from discussion – none.**	
MCBQSE/ 2022/0026	**6.3 Safeguarding** The group resolved: to carry this item over to next month's meeting. **Actions from discussion – none.**	
MCBQSE/ 2022/0027	**6.4 Concerns update** Actively trying to close as many as possible. There are currently 93 active concerns. 141 concerns were closed in July 2022. The behaviour of staff is becoming an increasing theme. The group resolved: excellent work is being done closing concerns. **Actions from discussion – none.**	
MCBQSE/ 2022/0028	**6.5 Compliments** **Lakeside Wing 2** – thanks were given from a family regarding the care and kindness shown to their father, making him as comfortable as possible during the last weeks of his life, allowing him to pass away in a dignified way. **Lakeside Wing** – thanks and appreciation were given from a family regarding the care, compassion and support given to their Mum. Their Mum had a challenging but happy stay. **Elizabeth Ward** – thanks were given from a family regarding the support given to them and their family member during the last weeks of their family members life. The family appreciated being kept informed. The group resolved: the compliments above were noted. **Actions from discussion – none.**	
7. STAFF AND RESOURCES		
MCBQSE/ 2022/0029	**7.1 Any updates to share** The group resolved: none were discussed. **Actions from discussion – none.**	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
MCBQSE/ 2022/0030	**7.2 Any other business** The group resolved: no issues were raised. **Actions from discussion – none.**	
MCBQSE/ 2022/0031	**7.3 Date & time of next Meeting –** 2.30pm–4pm on 15 September 2022	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 9:30, Monday 8 August 2022
Teams Meeting
MINUTES

Present:

Claire Main (CMain), Interim Director of Nursing, Specialist Services Board (CHAIR)
Bev Oughton (BO), Senior Nurse, Cardiac Services
Bryony Roberts (BR), Senior Nurse, MTC
Colin Gibson, (CG), Consultant Clinical Scientist, ALAS
Mathew Price, (MP), Directorate Manager, Neurosciences
Sarah Lloyd, (SL), Interim Director of Operations, Specialist Services
Cath Evans, (CE), Patient Safety Facilitator
Jane Morris, (JM), Senior Nurse, PaRT
Ceri Phillips, (CP), Lead Nurse, Cardiac Services
Beth Ingram (BI), Lead Nurse, Haematology
Caroline Murch (CMurch), Health & Safety Adviser
Richard Parry (RP), Q&S Facilitator
Claire Mahoney (CM), CNS Infection Prevention & Control
Gareth Jenkins, (GJ), Interim Directorate Manager, Haematology
Julia Teconi (JT), Senior Nurse, Critical Care
Caroline Burford, (CB), Consultant in Critical Care
Keith Wilson (KW), Consultant Haematologist
Lisa Higginson (LH), Interim Lead Nurse, Nephrology and Transplant
Tracey Skyrme (TS), Head of Inquests, Patient Experience
Jo Clements (JC), Lead Nurse, Critical Care
Guy Blackshaw (GB), Clinical Board Director, Specialist Services Board
Jordan Willmer (JW), Service Manager for non-malignant Haem., Imm. & Metabolic Med.
Kirsty Britton (KB), Senior Nurse, Nephrology & Transplant
Mary Harness (MH), CNS, Haematology
Alex Scott (AS), Assistant Director of Quality & Safety
Nicola Carter (NC), Service Manager for Malignant Haematology

Secretariat:

Mandy McGee

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions C Main welcomed all to the meeting.	
1.2	Apologies for absence Received from Helen Thomas	
1.3	To review the Minutes of the previous meeting 27 June 2022 The minutes of the meeting held 27 June 2022 were agreed as an accurate record. Matters Arising 1.4 Presentation SL reported that she had not received any correspondence relating to IT	

	support required to proceed with transfer of information to the server and asked BI to chase this up within the Department. 3.2 Mortality Review Directorates to let CB know of any alternative reporting systems in place in order to inform the Medical Examiner Service, CB reported that in a recent meeting with the Medical Examiner's Office it probably looks less fundamental that they have access to those systems than originally thought. 3.3 Exception Reports <u>Critical Care</u> Difficulties with storage of documents on Teams, CMain reported that she had an update regarding solutions and ways to store SOPs which she would discuss later in the meeting. KW informed that Haematology currently use a database Q-Pulse to store and share documents on the Intranet but that this will be replaced by SharePoint, a system being adopted on an All Wales basis. CMain confirmed that this was the case and said that she had been meeting with a lead in the Governance Team to understand the options available for central storage and accessibility of documents. CMain will share for review a draft of a policy for writing policies which is currently out for consultation and once adopted will give clarity in terms of the differences between SOP's, ACTION pathways, processes etc. The next step will be a review of where everything is stored so that the team can eventually move the right information into the right platform. It is intended to invite Marcia Donovan to a future meeting to discuss this further. CMain CB added that not everyone's IT is capable of supporting SharePoint. ACTION CMain said that a scoping exercise should be undertaken to determine software capability. CMain	
1.4	<u>Presentation</u> SOP Nurse Led Chemo Assessment and Discharge – Beth Ingram CMain thanked Beth and the Team for all the work involved in producing the document which is a really good example of an improvement piece of work from a patient safety perspective.	
PART 2: SAFE CARE		**Action**
2.1	<u>Open Nationally Reportable Incidents</u> RP provided an update to the group, • Patient HM, Critical Care patient transferred to Nottingham following traumatic brain injury, the patient deteriorated and passed away on arrival, this is an inquest, NRI and Concern. There have been two meetings to date with a third to be ACTION convened early September in order to meet Welsh Government and Coronial deadlines in November. PA ACTION CW reported that going forward a report of potential NRI cases will be presented to the group. CW ACTION CMain reported that arrangements are being made to bring the learning from a recently closed, complex NRI involving ALAS to a future QSE CMain	

	meeting. <u>Open Inquests</u> TS referred to the reports sent through prior to the meeting Ref 805 Patient HN, PIR meeting scheduled for 9 August, statement requested from Dr Craig Spencer. TS reported that communication with the Coroner's Office is limited and confirmed that she will be attending the meeting on 9 August. Ref 391 Patient SB, inquest date is 16 February 2023. Ref 672 Patient AR, no inquest date set, 2 statements outstanding. Ref 744 Patient JY, no inquest date set, outstanding statements and copy notes. TS added that of the 26 inquests for Specialist Services there are dates set for 8. CB reported that there has been a recent change in the Coronial statute whereby not all cases that the Coroner accepts will go to full inquest, which will hopefully address some of the backlog of cases.	
2.2	<u>Closure Forms</u> Nothing further to Report	
2.3	<u>Alerts/Patient Safety Notices</u> The following notices have been disseminated to the Group, nothing further to discuss. • Welsh Resuscitation Forum Update on PPE and CPR • Urgent Field Safety Notice – MDS-22-4427 UPDATED VPS Expansion UKI • CPhO MedsLet 2022 – 28 Alendronic acid 70mg tablets	
2.4	<u>Healthcare Associated Infections</u> • Specialist IP&C Report June / July 2022 completed 3 August 2022 CM referred to the attached report which gives details of the current situation. CM reported that there are 9 potentially 10 cases of C Difficile on Critical Care, currently waiting for typing of the most recent cases. 4 of the 10 cases are the same type, it is encouraging that the last case was 19 July, a meeting has been arranged for later this week to discuss further. West 8 MDRO – since the last QS&E meeting there has been one further case with the same outbreak strain, a meeting to discuss this has been arranged for 15 August. With regards to the Welsh Government expectations of reduction of cases we are only on target for Klebsiella bacteraemia cases and MRSA bacteraemia cases, all others are above trajectory.	

2.5	Health Care Standard 2.9 Medical Devices Prior to the meeting CG had shared the following An urgent field safety notice (attached) has been issued by Medtronic relating to the Gold coated Cobalt CRT-D device (model DTPA2D1) recently approved for humanitarian use locally with a cardiac patient. The issue relates to some of the devices not delivering sufficient energy to the heart under certain circumstances, however, the problem can be averted by reprogramming the device (now underway in relation to the patient concerned).	Medtronic FA122 Urgent Field Safe
2.6 ACTION ACTION	Health and Safety Caroline Murch was introduced as the new H&S Representative for Specialist Services. CMurch reported that there is a new exception report that will be presented to the Operational Group 23 August. There are currently 7 open RIDDOR investigations, CMurch will send through a report after this meeting with details and asked for information back in readiness for the 23 August meeting a review of risk registers will also need to be undertaken by this date. CMain explained that it is intended to have a more focussed attention on H&S at some QS&E meetings, where more time will be allocated for the discussion of RIDDOR incidents etc. Dates to be sent out. CMain reported that there had been a recent incident in Critical Care where a staff member sustained a "sharp's" injury. CMain asked that everyone ensure all are aware of the Sharp's Policy and that this is current and being worked to in all areas. The current policy will be circulated after the meeting.	CMain CMain
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1	Feedback from UHB QSE Committee Nothing specific to report, minutes are available for the meeting held on 22 February 2022, no minutes available for meetings held 12 April 2022 and 15 June 2022.	
3.2	Mortality Review CB reported that the plan is for all cases from UHW to go through the Medical Examiner by September, all UHL cases are already going to the ME. CB said that it was unlikely that this expectation would be realised as the Bereavement Office do not have the capacity to scan sufficient notes for all cases to be reviewed in that timeframe. The plan is to gradually increase the number. Dr Rhian Morse has designed a referral form which will be freely available to all. CB reported that there should be a discussion between the responsible consultant and the junior doctor making the referral to propose a cause of death before the referral is made, this should then be scanned with the medical records. The process will be slightly different in Critical Care. At present the ME is returning approximately 25% of cases for consideration of a Stage 2 review, these are sifted by the Patient Safety Team and about 11 to 12% are taken on to a Stage 2 review. The main themes are concerns regarding care (50%), nosocomial Covid	

ACTION	cases, delays in the process of care and there are smaller number of cases with complications from treatments and procedures. KW asked when the new ME form will be circulated, CB confirmed that if it has not disseminated this before September, CB will circulate the document that the ME is receiving from the HB.	CB
3.3 ACTION	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Haematology</u> KW reported that there are a number of incidents where the H@N doctors are not responding to call for patients who are neutropenic and febrile which is a risk. The risk has been mitigated to some extent by a patient directive which allows them to have 1 of two essential starting antibiotics. CMain asked if there are any Datix's raised from these instances? KW said that he would investigate and report back. Further discussions to be held outside of this meeting. <u>Nephrology & Transplant</u> Nothing to report. <u>Neurosciences</u> Noting to report <u>MTC</u> BR said that the team would like to present at a future meeting on the issues being experienced with TARN and data collection. GB suggested that this would be a good topic to discuss in the Performance Review. <u>Critical Care</u> CMain reported that Critical Care had experienced significant estates issues over the last week resulting in the closure of a number of bed areas. <u>Cardiac Services</u> CP reported that discussions have started to relocate CTS from UHL to UHW. Another risk at present, across the UHB, is that of shortfalls in nursing workforce and the challenges this presents in maintaining services. <u>ALAS</u> Nothing to report <u>PaRT</u> JM suggested that a partial solution to the problem raised by KW would be to extend the PaRT Service to 24/7 which would help offload some of the work from the medics. KW agreed that this was a very good suggestion. KW also reported on positive feedback on the PaRT Team he had received from a consultant colleague. <u>Pharmacy</u> Nothing to report.	

PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	• HIV Action Plan for Wales	
4.2	• July's Medicines Safety Newsletter	
4.3	• Resuscitation Service Newsletter July 2022	
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business CMain welcomed and introduced Alex Scott the Assistant Director of Quality and Patient Safety	
PART 6: DATE OF NEXT MEETING		
6.1	Next Meeting Thursday 1 September 2022 9:30am via Teams	

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 19th July 2022, 08:00-10:00 hours
MS Teams

MINUTES

Present:

Richard Hughes	Consultant Anaesthetist (Chair)
Clare Wade	Director of Nursing
Alexandra Scott	Assistant Director of Quality and Safety
Annabel Green	Work Force Programme Manager
Angela Jones	Senior Nurse RESUS
Antonio Riccioli	Orthopaedics Recovery Manager
Arul Kandan	Deputy General Manager T&O
Barbara Jones	Educational Lead
Carolyn Alport	SCB QSE Lead
Christopher John	Clinical Governance Lead
Debbie Jones	Patient Safety
Denis Williams	Directorate Manager
Hayley Dixon	Director of Operations
Laura Hodges	Lead Nurse T&O
Paul Bracegirdle	Interim Deputy General Manager
Rachael Barlow	Clinical Lead
Rafal Baraz	Consultant Anaesthetist
Sandra Watts	Professional Practice Development Nurse for Surgery
Terry Stephens	Procurement Nurse
Yvonne Hyde	IP&C

In attendance:

Zoe Sweetman	Surgery Clinical Board Secretary
Genessis Viola	Surgery Quality & Safety administrator

PRELIMINARIES *(Chair)*		
SCB/QS: 22/67	**Welcome and Introductions** Members were welcomed to the meeting and introductions were made.	
SCB/QS: 22/68	**Apologies for Absence** Dean Whittle Donna Davies Adrian Turk Ceri Chinn Michelle Ables Vincent Saunders	

SCB/QS: 22/69	**Minutes of meeting held May 2022** The Group approved the minutes of the previous meeting.	
SCB/QS: 22/70	**Action Log** Please see Action Log for update	
SCB/QS: 22/71	**Terms of Reference** The reviewed TOR were approved by the Group. Next review March 2023.	
PART 1: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
SCB/QS: 22/72	**Patient Story – Mr W admitted on the 09.09.2021 for revision of infected knee replacement.** **During procedure September 2021** • During the procedure Alcoholic Chlorhexidine and hydrogen peroxide were used alongside diathermy which caused a spark/fire within the cavity of the knee. • The Two liquids listed above were used by the surgeon to remove biofilm (chemical debridement) within the knee cavity. • This same mixture and process had been documented as being used in the previous revision cases on the same patient, by the same surgeon. • Neither liquids were licensed at the time for use this way. • The fire itself lasted approx. 3 seconds and was extinguished by theatre staff. • No damage to the patient at the time. **Findings** • The surgeon during their statement described the process of using these chemicals to debride the wound. The surgeon's own literature is available to view and he describes this method of operating for the last 5 years. • There is no national or international protocol for chemical debridement during an infected knee revision. • Scrub nurses were unaware of the dangers of pooling alcoholic chlorhexidine • Theatre lead not aware that in this particular case it was being used off licence when used within the knee cavity. • Governance and protocol of using off license medication had not been followed. • **<u>Notable/good Practice</u>** • Incident reported in a timely manner • Theatre team held a de brief soon after the incident, checking staff well being • All of the clinicians with whom this case has been discussed have expressed a strong desire to work together to improve patient safety and clinical outcomes. • **<u>Care delivery/local problems</u>** • Unlicensed use of hydrogen peroxide during adult surgery	

	• Alcoholic chlorhexidine used for the purpose other than skin preparation and in conjunction with diathermy • **<u>Service delivery or organisational problems</u>** • Unregistered and unapproved service evaluation with no progress reports or ongoing governance arrangements • Hydrogen peroxide was not removed from theatres after 2014 MHRA medicines safety alert, and the alert was only shared as part of a monthly update with no monitoring. • Lack of adequate governance arrangements regarding use of unlicensed medications within the trauma and orthopaedic directorate • **<u>Root cause</u>** • Unlicensed use of hydrogen peroxide and alcoholic chlorhexidine in conjunction with diathermy. **Patient outcome** • The patient has been seen several times since the surgery. At this time the patient has fully recovered and is getting back to leading a normal life. A concern was sent in via the legal route.	
SCB/QS: 22/73 SCB/QS: 22/74 SCB/QS: 22/75	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** **DW**- Presented to the group a spreadsheet showing the waiting lists divided by specialities and the majority are waiting for treatment, other bigger part is waiting for investigation prior to be listed for surgery or to be validated to not be there anymore. **DW**- Highlighted that is a team how will be validated 50 persons per week per specialty, expecting this list to be reduce soon. **DW**- Mentioned that this spreadsheet can be shared with anyone how wants to take a better look on it. **VTE Audit June** **BJ** Presented the following report: - An audit was carried out during June 2022 across the Perioperative Care Directorate of Surgery Clinical Board. The audit was facilitated by members of the education team and other staff members within the Perioperative Care Directorate. The audit data was collected by the examination of patients care documentation and observation of practice. <u>The purpose of the audit was to measure the compliance of the following criteria:</u> Question 1. Has the appropriate thromboprophylaxis risk assessment form been completed and signed?	

2. Does the risk assessment indicate chemical and /or mechanical VTE prophylaxis?
3. Has the appropriate chemical and / or mechanical VTE prophylaxis been prescribed on the drug chart?
4. If mechanical is prescribed has an Anti-Embolic stocking record sheet been completed?
5. Has the VTE section on the drug chart been ticked and signed?
6. If prescribed is the patient wearing anti-embolic stockings?
7. Has thromboprophylaxis been completed on the WHO checklist?
8. Has the VTE section on the pre-operative checklist been completed by the ward staff?

Results

Main Theatre UHW

11 sets of notes were audited. Of these 11, the following issues were identified:
A2 – Q2 and Q4 not completed
B4N – Q1,2 & Q4 not completed
PESU Ward – Q4 not completed
T4 - Q4 not completed
B7 – Q1,2 & 7 not completed
A&E – Q1,2,4,6 & 7 not completed
T5 – Q4 not completed
A2 - Q4 not completed
C1 - Q4 not completed

CHfW Theatres

2 sets of notes were audited. Of these 2, the following issues were identified:
OWL Ward – Q1 not fully completed

PESU theatres UHW

5 sets of notes were audited. Of these 5, the following issues were identified:
PESU ward (SSSU) – ON 2 occasions Q1 was not fully completed. On 3 occasions Q2 was not completed and on 3 occasions Q4 was not completed.

UHL Theatres

11 sets of notes were audited. Of these 11, the following issues were identified:
DSU Ward – Q4 not completed
West 5 – Q1,4,5,6,7 not fully completed
West 4 – Q1&2 not completed

Recommendations

- Share audit results with theatre managers / senior management team for dissemination amongst teams. Reinforce the requirement for escalation if issues at point of checking patient into area.

	• Share and discuss results with TaAG group, Directorate Quality and Safety forum, surgery practice educators for dissemination on wards and Surgery Clinical Board Quality & Safety Group • Re-audit in six months **Surgical Diabetes: SGLT2i and Euglycemic Acidosis** **CT** apologises for not been present at the meeting, as requested by CT, RH give an update to the group stating the race profile around clinical board around the issues surrounding the flowzin. New drugs have been introducing on the managing of diabetes also used for heart failure. The patient can have normal glucose but raise ketones and running to major medical problems related to that. Anaesthetics have been on the board and peri-op assessment are implementing a strategy for managing the elective patient coming through but whether or not the incident have relativity elective or not is a big issue and patients can be very sick unless doctor is aware of this a can take care of it. **RB** stated that Catherine Doyle is preparing an update in September or October	
SCB/QS: 22/76	**Feedback from UHB QSE Committee:** AS explained that she hasn't attended to any meeting yet as she is new to her role, but will bring a feedback on the next meeting.	
SCB/QS: 22/77 77.01	**Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities** Directorates Exception reports were received and noted by the Group **Peri-op** The following report was discus by **CJ** with the group **UHW Main Theatres** In155105. Arterial line retained in patient following dressing removal. Investigation completed. Report sent to patient by recorded delivery. ID 8548. Retained swab. Fact finding meeting 07/07/22. Investigation underway. ID 3612. Anaesthetic awareness. Concerns department received complaint. Redress has forwarded cheque in order for patient to receive private phycological support following incident. Patient contacted, may still seek independent solicitor's advice? Anaesthetic Scavenging in theatres 0-6 not functioning properly. Estates looking for weekend to repair with as little disruption to services as possible. Plans recommenced to build new theatres off the back of theatres 5+6. Visits from trade people expected over the coming weeks.	

Escalation plan between Critical Care and Recovery in draft format and out for comments.

UHL

In149722. A patient sustained a burn following the use of Hydrogen Peroxide Solution. RCA complete and awaiting improvement plan completion.

In160082. Never event reported. Wrong side implant used for a primary knee replacement. Investigation and improvement plan in draft. Follow up meeting booked for 15th July.

Lights in CAVOC 1 not working, estates are aware and are planning the repair and logistics as the lights are difficult to access.

HSDU

V2 Surveillance audit (Environment, processes, documentation, non-conformance etc) being conducted 27th + 28th July, work towards providing evidence and preparation ongoing.

Work is in progress regarding staffing shortages to maintain service.

Air handling plant failure last week, resulted in the re-processing of all trays and equipment creating a back log of work. Plant failure fault now resolved and being monitored closely. Work to catch up with re-processing ongoing.

Incident involving gynae probe sterilisation being sterilised at too high a temperature. Investigation ongoing.

CHFW

ID 7106. Child received morphine overdose. Fact finding meeting 11/07/22. Investigation underway. No surprises form submitted to Welsh Government.

Anaesthetic practitioner shortages, could impact upon utilisation of future lists.

Significant improvement of paediatric anaesthetic availability due to support from Swansea anaesthetics teams.

ALL AREAS

Staff sickness increased due to COVID-19. Possible impact upon future theatre utilisation and ability to run lists effectively.

PESU

No new issues/incidents reported.

77.02

General Surgery No report and no representative present at the meeting.

77.03

LH gave an overview of the report for **T&O.** The following was discussed: -

Updates

* Incident in theatres (In 160082) 15.02.22. wrong side implant inserted during total knee replacement. RCA in progress

***** Inquest case COB on 24.5.22. outcome was accidental death

***** New inquest opened MJF May 22, review underway. Concerns response also in progress

* ME enquiries ongoing. 1 closed, discussed at governance.

* Review underway of ?? missed escalation opportunity. Patient DW on A6s likely coronors.

* 1 C.diff reported in the month of June. RCA underway on west 1

* Datix Queues

West 1	20
West 3	10
West 4	1
West 5	29
A6	29

22 open concerns. 10 being about elective surgery dates

* CHC visit booked on west 1 on the 26th July

* Patient safety walk about in Cavoc outpatient's department. On 11th august

77.04

Anaesthetic RB stated no serious incident to be reported.

77.05

Dental report received and noted by the Group. No representative present at the meeting.

77.06

	. **Pharmacy** no representative present in the meeting due to sickness.	
PART 2: HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
SCB/QS: 22/78	**Initiatives to promote health and wellbeing of Patients and Staff:** **SCB H&S/IP&C Meeting – CA** reported the following: - **<u>RIDDORs</u>** • Peri-op manual handling injury when proning a >100kg patient • B6 Patient punched member of staff in stomach • Staff member slipped on wet floor caused by leaking catering trolley **<u>Lifting of COVID 19 restrictions</u>** – It was acknowledged that there had been confusion in some areas over guidance including wearing of masks and distancing – Rachael Sykes recommended staff should contact the IPC Leads in their Directorate for guidance. Pregnancy risk assessment has been updated and is waiting for sign off. HR flow charts will be updated PPE SOPs are being updated and will be available in 3-4 weeks **<u>H&S policy</u>** H&S policy is awaiting sign off. H&S culture plan is being finalised and will go to the Executive Board in July, this will set the scene for the next 3 years, setting out clear systems and processes in line with the People and Culture plan, working towards the best industry standards. NWSSP audit has taken place- assurances were given, next audit planned for 3 years Licenced Audit software – trial to begin shortly **<u>Datix Cymru</u>** Identified challenges with Datix Cymru – incidents not being assigned correctly, manager lists. Particular attention is drawn to incidents relating to staff absence. Currently there is no section to automatically inform H&S if a RIDDOR has triggered a RIDDOR. Managers are asked to inform H&S via the datix email if a staff member is off for more than 7 days following an accident at work. **<u>Lone workers</u>** – people safe devices will be confirmed by 07/06/22 **<u>Risk Register</u>** Document control tab has been added, all risks scoring 16 should be reviewed regularly. **<u>H&S SharePoint</u>** There is ongoing work to develop a H&S share point page, where all H&S documents, guidance and tools can be easily accessed.	

There will be a H&S department information management system (IMS). Clinical Boards will be asked to align to set 1-22 headings, this will be discussed with CB's and rolled out after agreement. Surgery given feedback to H&S advisers. Agreed in its current form the system would not be suitable for use in surgery. Several issues would need addressing before it is fit for purpose, and further input is needed from other CB's.

Future Operation H&S meetings
In all future meetings all CB representatives will be asked to provide a report, template will be sent out by R Sykes two weeks prior to the meeting.
The TOR are currently being updated, this will aim to make meetings structured.

Training Updates
H&S trainers are currently undertaking training for accreditation. External providers have been identified for MH & VA training – there have been updates to VA trainers' course to focus on positive behaviour.
There have been increasing V&A issues raised in the Children's Hospital
LED are updating ESR to update staff MH records as training is now 3 years
49 staff have been trained as workplace assessors.

Current H&S Courses –
H&S working safely, First Aid, & Fire Warden,
train the trainer -fit testing
Fit testing is still being undertaken once a week

H&S Incidents
Calibration cylinder put into wrong waste disposal stream – cylinder was ripped apart, fortunately did not ignite. Reminder to follow correct procedures for waste disposal.
Food waste is being thrown out of windows, specifically this time found on SDEC roof. Managers are asked to remind staff & patients not to throw food out of windows
Doors in car park too heavy for disabled users

Fire Safety
Enforcement notice on A4 – fire service agreement to extend action to 31/03/2023, after this ward will need to be decommissioned for works to be undertaken.
Hafen Y Coed – issues with failure to control ignition. Challenges with Mental Health – to reduce risks there will be a dedicated fire officer for mental health, and possible solutions as installing body scanners.

Decontamination Group update – BJ reported the following: -
Items to Raise/ Risks to note - All actions for HSDU lead to remain on agenda and a representative attend at the next meeting.

	Items to receive or for approval - The HSIB summary of decontamination of instruments was shared and the group agreed it would be looked at from a national perspective to include internal review and audit. **Water Safety Group Update – BJ** discussed the following points: - **Items to Raise/ Risks to Note** - Estates are experiencing significant staffing issues so have asked all clinical boards to be mindful of this as there could be lengthy delays for any estate / maintenance requests. **Ongoing Work / Actions -** Estates requested that if any wards are vacated to inform them so that flushing can still continue	
PART 3: SAFE CARE		
SCB/QS: 22/79	**Patient Safety Incidents** The following report were received and accepted by the Group. • Nationally reportable incidents & No Surprises reported to the Delivery Unit/Welsh Government • Incidents by Location and Approval status • Incidents by Type	
SCB/QS: 22/80	**Patient Safety Alerts (internal/external)** Syringe Driver Infusion Set Potential Leakage from Syringe Driver Set Background: We have been notified by Critical Care that the line at the pump end has leaked. Lot Number 4735076 The item is generally ordered from Lakeside Stores. Can you please check the sets that you currently have in your clinical areas and quarantine. Assessment: All items identified (Lot 4735076) must be removed from clinical areas and quarantined Recommendations: • Clinical Boards are asked to record in their Quality, Safety and Experience that this notice has been received and distributed to all relevant staff. • All clinical boards to ensure affected items are removed and quarantined. (Procurement will arrange collection at a later date) • Replacement stock available from Lakeside Store.	

	• Clinical Areas are requested to only order what is needed, protecting supplies to high usage areas. • Clinical Boards are asked to confirm dissemination and any additional actions taken to Cav.Patientsafetysolutions@wales.nhs.uk by Monday 21st June 2022	
SCB/QS: 22/81 SCB/QS: 22/82	**Health Care Associated Infections** Report received and noted by the Group. The Group discussed the HCAI data for April 2022 • 3 C-Difficile • 0 MRSA • 1 MSSA • 0 E. Coli • 3 Klebsiella • 0 Pseudomonas aeruginosa YH- CNS IP&C informed the Group that the Team were working through the data and updated the Clinical Board on its targets and they are very tight BJones highlighted that she will do audits around the clinical board to revigorated bare below the elbow. **IP&C Report** The SCB IP&C report was circulated to the Group for information. It was noted that this had been submitted to the Corporate IP&C Group for July 2022.	
  SCB/QS: 22/83 SCB/QS: 22/84 SCB/QS: 22/85	**Any key patient safety risks:** **Falls reduction and Pressure and tissue damage reduction and prevention reports** The Falls and Pressure Damage Master Spreadsheets were disseminated to the Group for information. **Medicines Management & Corporate Meds Management Minutes** No representative present at the meeting. **Medical devices/equipment issues** The chair mentioned that room scrubbers how has been implemented in certain clinical areas should now only be use as an emergency, shouldn't be use as routine and they should have a ventilation risk assessment in all clinical areas.	

SCB/QS: 22/86 SCB/QS: 22/87	**Blood management –** Representative to be identified. **Q&S Workplan 2022 -2023** Report received and noted by the Group. It was noted that General Surgery Directorate were due to present on Patient story at the next Meeting in September. Quad audits to be presented by BJ.	
SCB/QS: 22/88	**Mortality data analysis -** No Update. No representative nominated yet.	
PART 4: EFFECTIVE CARE		
SCB/QS: 22/89	**Monitoring of CB Clinical Audit Plan** CW- mentioned that all the audit leads where invited for a presentation on Amat which is the new audit date of base and was well receive, was the first demo and went down very well.	
SCB/QS: 22/90	**NICE GUIDANCE** CW- explained that we are receiving to many but loads of them aren't applicable so they are sent back to the audit team. AS – highlight that Amat would also be used to disseminated nice guidance and would be much easier to do.	
PART 5: DIGNIFIED CARE		
SCB/QS: 22/91	SW – Highlight that POPS team have appointed a band 6 and a band 2 on a 12 months common post based in proac to provide help through the journey making proper referral such like dietitians etc.	
PART 6: TIMELY CARE		
	No Update, to bring back on next meeting	
PART 7: INDIVIDUAL CARE		
	ZS - working on summer news letter Ice Cream van Relaxing on Uniform during hot weather Surveys to ask members of staff how they are and what they need **Compliments** CW – Highlighted a letter received from a patient family thanking all the team involved on the care of their mother, they were very happy and grateful.	

PART 8: Staff and Resources		
SCB/QS: 22/92	**Staff awards and recognition** **CW**- Mentioned Surgery Stars award in been planned and that **ZS** is working very hard to set to this year's event how would take place in October and nominated processes is already ongoing.	
DATES OF NEXT MEETING 20th Sep 2022 – 8-10PM – Ms Teams		

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

Minutes of the SCB Q&S Meeting
Held On 20TH September 2022
Via MS Teams

Present:		
Richard Hughes	RH	Consultant Anaesthetist (Chair)
Clare Wade	CW	Director of Nursing
Alex Young	AY	Speciality Manager T&O Spines
Antonio Riccioli	AR	Orthopaedics Recovery Manager
Barbara Jones	BJ	Educational Lead
Carly Podger	CP	Finance Business Partner CDT Surg
Catherine Evans	CE	Patient Safety Facilitator
Ceri Chinn	CC	Lead Nurse Peri-operative care
Christopher John	CJ	Clinical Governance Lead
Debbie Jones	DJ	Patient Safety
Denis Williams	DW	Directorate Manager
Emma Thomas	ET	Senior Nurse
Gemma Roberts	GR	Interim Senior Nurse
Haley Dixon	HD	Director of Operations
Laura Hodges	LH	Lead Nurse T&O
Naomi Goodwin	NG	Consultant Anaesthetist
Rafal Baraz	RB	Consultant Anaesthetist
Richard Coulthard	RC	Consultant Urology
Rowena Griffiths	RG	Governance & Quality Lead Manager
Sandeep Berry	SB	Consultant Otolaryngologist
Susan Mogford	SM	Senior Nurse
Terry Stephens	TS	Procurement Nurse
Tracy Johnson	TJ	Practice Development Nurse
Yvonne Hyde	YH	Head of Nursing for Infections Prevention & Control
Secretariat		
Genessis Viola	GV	Surgery Quality and Safety administrator
Apologies:		
Carolyn Alport	CA	SCB QSE Lead
Catherine Twamley	CT	Interim Lead Nurse
Julie Cornish	JC	Colorectal consultant and Hon senior lecturer
Michelle Able	MA	CNS Infection Prevention & Control
Rachael Barlow	RB	Clinical Lead
Siene Ng	SN	Ophthalmology Consultant

Item No	Agenda Item	Action
SCB/QS: 22/92	**1. Welcome & Introduction** The Chair welcomed everyone to the meeting.	
SCB/QS: 22/93	**2. Apologies for Absence** a) The apologies given were noted.	
SCB/QS:	**3. Amat**	

22/94	**DJones** presented AMaT verbally to the Group and discuss the followed: - AMaT is an audit management and tracking system; it's an essential system to capture all audit activity. An internal audit took place last year and the result concluded very limited assurance and as a Health Board it raised some governance concerns because all order activity should be registered. A survey identified that members of staff were unsure of how to register it. Equally, members of staff were unsure of who the audit team were or what they did and they weren't sure how to undertake an audit and also trying to understand who the Clinical Audit Leads are. DJ advised that there's three tiers to the audit process, these being: - • Tier one is our national audits. It was noted that these were being captured although there are ongoing and not fully concentrating on those just yet. • Tier two, which are patient safety priorities. It was highlighted that this tier needed focus. • Tier 3, which is the local priority interest so everybody has to focus on patient safety priorities and so anyone with an NHS email will be able to access the system. **The group resolved that:** a) The AMaT System Update was noted and no actions to implement **GOVERNANCE, LEADERSHIP AND ACCOUTABILITY** **4. Patient Story** **ET** presented the following Learning from events Ref: CN/UHW/3786 What Happened? • Patient had a Sub Total Colectomy • The surgeon inserted a Rectal Catheter in theatre • The surgeon requested that the Rectal tube needed flushing, this would be to maintain patency • This was prescribed on the drug chart and nursing staff were informed • This task was never recorded or monitored on a surveillance chart, this form of documentation didn't exist on any of our surgical wards • The only way that we would know if this was carried out, would be if the nursing staff recorded it in the medical notes What was the concern? • The patient highlighted to the nursing staff that she believed that a nurse had incorrectly flushed the wrong port of the tube	
SCB/QS: 22/95		

- It was noted that the nurse had flushed the port that inflates the balloon, which she believed had damaged her remaining Rectal Stump
- Patient stated that she made the nurse aware that she felt that she was doing the procedure incorrectly; however, there was no evidence to support this.
- There was only one entry in the medical notes, whereby a nurse has correctly identified that she has flushed the catheter.

Analysis of events

- It is difficult to assess or prove if the nurse in question did or didn't follow correct procedure
- Without documentation, we cannot correctly assess the events
- At the time of this event, there was no formal education in place to teach this skill
- How often do nursing staff nurse patients with a Rectal Catheter to ensure continuity and safe practice of this skill?
- Did the nursing staff understand the rationale for this practice?

IN CONCLUSION

- Plans to add teaching of this skill to amber areas as well as elective areas
- Discussions around make the care plan available throughout the surgical clinical board
- Looking to make colorectal teaching readily available to staff
- Plans to improve access to teaching resources on our Surgical Training Platform
- Aiming to modernise access to education resources within the surgical clinical board

The GROUP resolved:

a) Followed from the learning from events the group agreed on education and teaching needs to be implemented.

5. BOA Elective Care Review Update

LH reported verbally to the group and shared an Action plan for BOA recommendation.

a) The Actions where discuss and no urgent recommendations were considered necessary to ensure patient safety is protected

	6. Feedback from UHB QSE Committee It was noted that **AS** hadn't attend any meetings yet to be able to give a feed back to the group. a) No actions were implemented.	
SCB/QS: 22/96	**7. Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities** **Peri-operative** **CJ** reported the following and give a verbal update to the group **UHW Main Theatres**	
SCB/QS: 22/97	In155105. Arterial line retained in patient following dressing removal. Investigation completed. Report sent to patient by recorded delivery. Meeting conducted with family to discuss report findings 31/08/22.	
SCB/QS: 22/98	ID 8548. Retained swab. Fact finding meeting 07/07/22. Fact finding Investigation underway. ID 3612. Anaesthetic awareness. Concerns department received complaint. Redress has forwarded cheque in order for patient to receive private phycological support following incident. Timeline and Action Plan uploaded to Datix-Cymru. Concerns department dealing with solicitor regarding incident. Theatre 7 sluice floor needs repairing. Estates aware and dealing with issue. Plans recommenced to build new theatres off the back of theatres 5+6. Visits from trade people expected over the coming weeks. **PESU** No new incidents reported. Several issues with the Vanguard Ophthalmology Theatre units. The ceiling has had several issues with leaks and water ingress causing damage to stock. A list of damaged stock being compiled. Vanguard aware of issues and are repairing leaks as and when identified. **UHL** In149722. A patient sustained a burn following the use of Hydrogen Peroxide Solution. RCA complete, improvement plan nearing completion and sharing of information to take place upon completion.	

In160082. Never event reported. Wrong side implant used for a primary knee replacement. Investigation and improvement plan complete. Follow up meeting conducted 15th July. Incident has been shared for learning. Incident now closed.

Lights in CAVOC 1 not working, estates are aware and are planning the repair and logistics as the lights are difficult to access.

HSDU

Workforce concerns raised, however work is in progress to improve staff shortages in-order to maintain service.

CHFW

ID 7106. Child received morphine overdose. Fact finding meeting 11/07/22. Investigation complete. No surprises form submitted to Welsh Government. Investigation report sent to parent 09/09/2022. Investigation report and outcome sent to mother.

Historic incident involving skin burn following the use of prep solution. Recommendations from Ombudsman put in place and procedure changed to accommodate these changes.

1. Chloroprep (Chlorhexidine 2%) sponges should be used for all CVP and Arterial lines.
2. Chlorhexidine 0.5% spray should be used for all Neuraxial and nerve blocks.
3. Must allow skin to dry before applying drapes.
4. If incontinence pad is used, it must be removed immediately after the anaesthetic procedure.

Ombudsman has now received the relevant information and has closed the incident.

Staffing
Anaesthetic practitioner shortages, could impact upon utilisation of future lists.

Significant improvement of paediatric anaesthetic availability due to support from Swansea anaesthetics teams.

ALL AREAS

Audit for the “5 Steps to Safer Surgery” has been revisited and now completed. All outstanding actions and recommendations have been completed and the audit team are happy with all outcomes. Audit complete and finalised.

Staff sickness increased due to COVID-19. Possible impact upon future theatre utilisation and ability to run lists effectively.

a) No Actions were implemented from the group.

General Surgery & Urology

ET verbally shared the following with the group

It was reported that an injurious fall occurred during the period, within General Surgery - Ward B2. It was noted that the gentleman came in with worsening foot pain and discoloration; and following an X-ray a hip fracture was confirmed which required operating on.

The Group were informed that reports had been completed and an injurious falls investigation was carried out and the patient had been transferred back over to YYF.

The IPC, currently have an outbreak on B2 and it's currently closed, the Ward Manager linking in with and infection control today to try and get at least 1/2 up and running for the network. B6 have also got two confirmed cases as well. In general surgery it's in and COVID is on the increase unfortunately.

It was highlighted that SSSU had ongoing issues with poor lighting; CW reported that CA had agreed to pick this up with patient safety QSE as two incidents had been raised in relation to patients sustaining injuries, within this area

Suite18 Clinic have had a power electrical outage on the weekend, and that is an ongoing and with the water geyser still leaking.

An update was given on ward changes- Heulwen ASW was moving to A5N and A5S would become a medical winter ward staffed and ran by SCB

ENT/H&N

No representative at the meeting

a) No actions to implement

T&O

LH reported the following updates to the group

- Incident on A6, DW. Timeline complete, meeting at end of the month to discuss.
- One case C.difficile reported on West 3, in August. RCA to be completed
- Patient safety alerts shared with teams.
- Injurious fall West 1 10th September. RCA to be completed. High levels of enhanced supervision
- BOA draft action plan under completion.
- LFE for missed Lisfranc fracture
- LFE miss managed fracture

- CHC visit 2 weeks ago on west 1, a/w final report.
- IPC audit plus Tenable app launch

a) No actions were implemented

Anaesthetic

RB reported the following

M+M case presented July 2022: Difficulty measuring BP during surgery of a neonate causing hypoxic damage

•Day 67 Neonate for Tunnelled line and closure of prolapsed stoma

•Complex neonatal course

•Problems measuring BP

•All monitoring satisfactory but not able to get consistent BP reading

•Multiple attempts, size and locations tried to obtain BP reading

•Fluid boluses and adrenaline given once tunnelled line secured

•Proceeded to Laparotomy •BP trending downwards but not worryingly so

•No further issues during laparotomy

•On attempted waking had abnormal movements/fitting therefore MRI arranged: Widespread Hypoxic damage on MRI

•SUI report –something happened under anaesthetic but not due to breach of care

•Recommendations: ensure communication of risk is adequate and explicit.

•Couple of incidents related to CVP line insertion presented in anaesthetic Q+S July 2022

•Incident related to inappropriate catheter length and robust documentation at insertion

•The department aims to standardise lengths. 16cm for RIJ and 20cm for femoral and LIJ veins.

•Recommended use of pre-printed labels to capture all required information.

M+M presented in Sep 2022 anaesthetic Q+S:Chlorhexidine causing skin burns in a baby

•Patient store in July SCB meeting

•RCA following a complaint from a parent of a child (6-week-old)

•Skin burns caused by pooling of chlorhexidine

•Actions:

- Email circulated to the anaesthetic department on 18thAug 2022

- Q+S presentation on 13thSep 2022for shared learning

•Recommendations:

- ChloraPrep 2% sponges for CVC and art lines
- Chlorhexidine Spray 0.5% for neuraxial blocks
- Must be allowed to dry before proceeding
- If incontinence sheet used must be removed as soon as possible

•Paediatrics policy exists from 2017:

- Use an incontinence sheet to avoid pooling
- Then remove the sheet
- This policy could be safely applied to adults

•Further actions:

- Policy needs updating
- RB will update and circulate to anaesthetic department for comments
- RB updated the policy heavily following the anaesthetic Q+S in line with AAGBI recommendations. RB suggested changing the title to include adults. The policy will be reviewed by the pads anaesthetists then will be sent to the general consultants for further review.

-Also, to report: the shortage of the Smith-Medical Epidural minipacks has eased off. However, there is shortage of the Bodyguard Micro set which is a crucial giving se for all epidurals, ESP catheters and rectus sheath catheters. This may cause disruption in both maternity and acute pain service. There is no alternative to this giving set as it is specific to the BD pumps we have in CAV.

Dental

RG had technical problems and wasn't able to present the report.

No actions implemented

Pharmacy

No representative on the meeting

a) No actions were implemented

Prehab

No representative present on the meeting

a) No actions were implemented

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

8. Initiatives to promote health and wellbeing of:

SCB/QS: 22/99	**Patients** **SCB H&S/IPC meeting update** **CA** wasn't present in the meeting; no verbal update was given. Report was noted a shared with the group. a) No actions were implemented **Decontamination group update** **BJ** explained to the group that she hasn't attend any meeting since last Q&S meeting so nothing to report. a) No actions were implemented **Water safety Group Update** **BJ** gave a verbally update to the group, highlighting the main key points raised. It was noted that extra flushing was continuing to be carry out at UHL. BJ reported that concerns were raised around the number of flushing being carried out, but not recoded. Equally, this function was not being picked in the absence of the responsible member of staff when on sick or annual leave. Areas had been asked if this can be looked at and also raised at safety briefings to ensure flushing is on the agenda and the audit tool has changed. a) No actions to record **SAFE CARE** **9. Patient Safety Incidents** **CW** gave a verbal update, reporting that the information provided demonstrated that seven of the long standing NRI had been closed. With eight open and five overdues, which were due to be closed in 60 days, which is a really tight ask, but lot of progression has been made over the last couple of months, so the plan would be to close them over the next month or two hopefully. Action There is a plan in place over the next month to try and support staff in closing some of the non NRIs DATIX. So, some of the Datix queues and supporting managers going forward in closing them in a timely manner. A system is in place within the clinical board that made aware it quite timely if there are any incidents that need to be aware of. **10. Patient Safety Alerts (internal/external)**	
SCB/QS: 22/100		

	RH Discussed about cannulation packs if has been used and what departments. CC to look at possibility of using cannulation packs in Periop and to bring back to next meeting **11. Health Care Associated Infections**	
SCB/QS: 22/101	**HCAI rate** **YHyde** Discussed the rates with the group. It was also discussed the rates in all departments. a) No actions where implemented	
SCB/QS: 22/102	**12. Any key patient safety risks** **Q&S performance data** **CW** shared with the group a data report and discussed the following. this is the data that were shared for last performance review. It was acknowledged that this data was quite limited compared to previous data a) No actions implemented	
SCB/QS: 22/103	**Falls reduction and Pressure and tissue damage reduction and prevention** **CW** show both spreadsheets to the group that highlighted that there had been two injuries falls within the clinical board With regards to hip fracture patients, plans are in place to speed up the new hip fracture pathway. It was noted that, pressure damaging incidents had increased without really understanding the reasons behind it; staffing issues was raised as a constraint, Discussions had taken place around how to track patients prior to admission to check if any damage caused before patient is admitted to the hospital or ward To progress via Pressure damage Collaborative chaired by CW **Medicines management issues/incidents/audit findings** No representative at the meeting to update the group **Medical Equipment Group** **RH** stated the software for medical equipment is becoming more and more complex and linking in as well with the network increasingly.	

	Blood management **CJ** explained to the group that he couldn't attend the last meeting held but he shared that was brought to his attention that staff are returning the white part of the label following blood transfusion and that is an incorrect process, Blood bank actually need the fully completed blue part of the label for traceability **Zero Tolerance Report** . **Q&S Workplan 2022-2023** It was highlighted that ENT/ Ophthalmology is due to present at the next meeting. **13. Mortality data analysis** No representative currently implemented for this group **Effective care** **14. Monitoring of CB Clinical audit plan** **CW** highlighted the importance of AMaT and how implementing it would be very beneficial.	
SCB/QS: 22/104	**15. Implementation of key Nice Guidance** **NICE Spreadsheet** **CW** discussed verbally with the group the following: - A lot of the clinicians get nice guidance sent to the medley from the audit team. This is a function that may well be picked up by AMaT going forward as well.	
SCB/QS: 22/105	Quite a lot of the clinicians are chased regularly with regards to feeding back on NICE guidance. Some of the guidance iis not always sent out to the correct person and some are quite wide ranging covering several CB's	
SCB/QS: 22/106	**16. Research and development update** No representative on the meeting **Dignified Care** **17. HIW/CHC, Deci (dignity and essential care inspections) reports and improvement plans**	

SCB/QS: 22/107 SCB/QS: 22/108 SCB/QS: 22/109 SCB/QS: 22/110 SCB/QS: 22/111	**CW** reported verbally to the group CHC are back visiting areas HIW also recently attend EU and the report is due to be shared shortly with the Health Board **Timely Care** **18. Initiatives to improve access to services/ management of risks** **DW** had to leave the meeting before had the chance to update the group about it. **Individual Care** **19. Concerns news letter** **CW** shared on the screen and invited the group to read through the newsletter **Staff and Resources** **20. Staffing levels** **CW** Mentioned that the senior lead nurses will be going through the processes with the ward managers again now over the next couple of weeks to sign off their safer staffing levels for each inpatient area, which will then come to the Clinical board for sign off and then go to the exec review for sign off. So, this is a triangulated approach which brings together the skills of the ward manager, finance and their quality and safety indicators.	
SCB/QS: 22/112	**4. Date & time of next Meeting** Tuesday 15th November 2022 at 08:00 -10:00	

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 30th August 2022 at 9am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board (Chair)
Clare Rowntree	CR	Clinical Board Director, C&W Clinical Board
Matt McCarthy	MM	Patient Safety Facilitator
Janice Aspinall	JA	Staff Side Lead H&S Representative
Paula Davies	PD	Lead Nurse, CYPFHS Directorate
Alys Gower	AG	Experience Midwife, O&G Directorate
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer (DECLO)
Lois Mortimer	LM	Interim Deputy Head of Midwifery, O&G Directorate
Emma Ward	EW	Interim Risk Midwife, O&G Directorate
Annie Burrin	AB	Interim Governance Support, O&G Directorate
Karenza Moulton	KM	Lead Nurse, CHFW Services Directorate
Martin Edwards	ME	Assistant Clinical Director, CHFW Services Directorate
Secretariat		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Apologies:		
Abraham Theron	AT	Clinical Director, O&G Directorate
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Catherine Wood	CW	Director of Operations, C&W Clinical Board
Becci Ingram	BI	General Manager, CHFW Services Directorate
Ashleigh Trowill	AT	Service Manager, CYPFHS Directorate

Item No	Agenda Item	Action
CWQSE/ 2022/001	**1.1 Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2022/002	**1.2 Apologies for Absence** **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2022/003	**1.3 Minutes of the previous Q&S Meeting held on 26th July 2022** **The CWQSE resolved:** a) The minutes of the meeting held on 26th July 2022 were agreed to be an accurate record.	
CWQSE/ 2022/004	**1.4 To note and update the action log of the meeting of 26th July 2022** Updates were provided on the actions from the last meeting and it was noted that a number of actions have been resolved. The outstanding actions were noted as: **Business Continuity Plans** Business Continuity plan for Obstetrics & Gynaecology is awaited. LM agreed to forward to the Clinical Board as soon as possible for the records.	**LM**

	Guideline for management of constipation in this setting for readmission The guideline is being drafted and will be shared when finalised. LM agreed to follow up. **Health & Safety Management System** Further meeting to be arranged to discuss Clinical Board level overview and progression to implementation. **The CWQSE resolved:** a) An update on the outstanding actions will be provided at the next meeting.	**LM** **AJONES/KH**
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		
CWQSE/ 2022/005	**2.1 CCNS RAG Action Plan – External Review of CCNS Service – Swansea Bay** **The CWQSE resolved:** a) The presentation was deferred to the next meeting.	**PD**
CWQSE/ 2022/006	**2.2 Health & Care Standards Directorate QSE Exception Reporting** **2.2.1 CHFW Directorate Report** • Emergency barcodes for BM Machines for outside (unregistered) visitors collapsing in CHFW areas is a risk and work is ongoing with the POC Team. SBAR is being developed to outline the risk and need for access to the emergency barcodes within the CHFW. • Ongoing issues with regards to temperature control within the Oncology Unit. Longer term solutions are being sourced for resolution going forward. • IP&C MRSA Outbreak within Maternity and NICU is likely to be closed down soon. There have been no further cases reported, some estates work is being taken forward. • RSV numbers are increasing. • Staffing across the CHFW is an ongoing pressure which continues to be monitored. • Monthly Deputy Nurse Forum has been developed to ensure that there is support available across all areas for staff. • ALLOCATE System has been implemented within Gwdihw and Island Wards however concerns have been raised with regards to the ongoing issues/concern relating to rostering meaning that duplication is being undertaken on manual spreadsheets also. Further discussions to take place outside of the meeting. • 213 level 3 patients awaiting surgery with 191 without a date – reduction from last month. There are currently 265 children waiting over 36 weeks of which 141 children have been waiting over 52 weeks. All patients waiting over 52 weeks continue to be reviewed ensuring all quality and safety monitoring is completed for each patient. • For general paediatric and sub specialties there are 273 patients in the outpatient 52-week cohort at the end of August. Of these patients 104 have clinic dates in September. • CHFW Garden has re-opened • Phlebotomy is a continued concern for the CHFW with extended waits for GP appointment. Urgent action plan is required in order to address some of these issues and it was agreed that further discussion would take place outside of the meeting. PD/KM to discuss outside out of the meeting with regards to potential	**KM/AJONES** **KM/AJONES**

	implementation within St David's Hospital Children's Centre with x2 HCSW who are keen to undertake training and the supervision requirement. **The CWQSE resolved:** a) The report provided was noted for information and key highlights and actions were recorded.	**PD/KM**
CWQSE/ 2022/007	**2.2.2 CYPFHS Directorate Report** • Immunisation programme will commence at the end of September 2022, subject to the availability of the vaccine. Risk assessment has been completed with regards to staffing of the programme, and support has been received to over recruit in order to help support the programme. Communications are ongoing with regards to support uptake and education of the Fluenz vaccination programme. Process mapping and workforce requirements exercise is also underway. • Gaps in staffing in Flying Start and Generic Health Visiting is ongoing, and management of risk and safeguarding is continually being monitored. The issue of inability to provide the full components of the programme is an All Wales issue. • Increase in on site staff school provision and special school provision has been requested from Local Authority. Scoping exercise is being completed to understand needs requirements and how to potentially work differently. • Safeguarding processes have been reviewed within School Nursing Service and a standard of practice (SOP) is being developed with regards to documentation of discussion with other practitioners relating to cases. Risk assessments of processes are being undertaken which will inform the SOP • Work ongoing with review and follow up within Complex Needs and Neurodevelopment Service. Review of some cases to be managed externally, via agencies due to vacancies within the CCNS service is being explored to help manage due to current vacancies. • Discussion is ongoing with regards to consideration of acceptance of adult nursing qualifications for children's nursing posts. Further discussions are to take place on an all Wales basis. • PMH waiting lists is reducing and work continues to use additional Helios sessions to help support. • Neurodevelopment Waiting List continues to be a main focus. Work is ongoing to reduce the longest waits and an action plan is being progressed. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2022/008	**2.2.3 O&G Directorate Report** • 22 ongoing RCA's – 6 of which are NRI's, 4 of which have not yet been allocated an IO. X1 NRI is awaiting neonatal input. Ongoing difficulty with Obstetric time for completion of the investigations. Some funding has been received for medical time to help support some of these investigations. • 20 staffing incidents reported in July – many of which relate to delays in commencing inductions or transfers of patients to delivery suite due to acuity. • No further MRSA's reported since the last month. IP&C audits	

	continue, BBE audit has significantly improved and reviewed weekly. • Medical staffing continues to be challenging specifically with regards to trainee workforce. Ongoing recruitment across medical and midwifery services, however there are significant pressures within the workforce which is impacting on provision of services. Enhanced overtime available however issues continue, including midwifery sickness rate of 10-11%. • Elective cancellations have been needed, and number of inductions postponed due to staffing and acuity. • Gynaecology Waiting Times – concerns continue to be received with regards to the increased waiting times for the level 4 patient group (endometriosis). This continues to be monitored. It was noted that some funding has been secured for medical time to address some of the RCA's from Obstetrics and Neonatal. It is anticipated that this will be implemented from September to help support the progression of investigations. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2022/009	**2.3 Waiting Times Update (including Long Waiting Patients)** **The CWQSE resolved:** a) The update was shared as part of the Directorate QSE Exception Reports.	
CWQSE/ 2022/010	**2.4 New Risks to be considered for the Clinical Board Risk Register** **The CWQSE resolved:** a) There were no new risks to be considered from this meeting.	
SAFE CARE		
CWQSE/ 2022/011	**3.1 Update on Serious Incidents** Current position for the Clinical Board, currently 12 open NRI's, 3 of which are now overdue. Work is progressing on these cases. There have been x2 new NRI's submitted since the last meeting – x1 neonatal death with potential issues related to CTG and escalation and x1 baby sustained a skull fracture following a midwife fall. Both cases have had initial fact-finding meetings and the investigations are being progressed. Interviews have taken place for the replacement for the C&W Clinical Board Patient Safety Facilitator. MM will be providing cover whilst this appointment is progressed. **The CWQSE resolved:** a) The update provided by Patient Safety Team was noted.	
CWQSE/ 2022/012	**3.2 To note the DRAFT minutes from the NRI/RCA Governance Sub Group held on 11.08.2022** **The CWQSE resolved:** a) The draft minutes were noted. No exceptions were reported.	

CWQSE/ 2022/013	**3.3 NRI's/RCA's/Closure Forms for NOTING/EXCEPTION REPORTING** **SBAR, RCA Report & Action Plan – LT (Datix Ref 357349)** The case involved a patient who suffered a Term intrauterine death (IUD). Patient had elected to transfer her antenatal care at 32weeks of pregnancy having had consultant led care at Cwm Taf Health Board prior to this. Background of the care provided was shared and noted the patient was booked for consultant led care due to a history of Gilbert Syndrome at 37weeks. At 40weeks the patient attended the Obstetric Assessment Unit due to reported blood loss and reduced fetal movements. Patient was reviewed, fetal movements reported and maternal observations were normal. Patient reports showing the midwife x5 photographs of the PV loss at home prior to admission although midwife only recalls seeing x2 photographs. It was noted that the investigation has been unable to resolve the issue relating to the number of photographs shown. Midwife concluded that the loss was a mucus plug. Patient contacted OAU 13hours later reporting fresh bleeding and was advised to call an ambulance, delivery suite was notified. Concerns were raised with regards to the length of time between the phone call to OAU and patient's subsequent admission by WAST. A separate investigation has been undertaken by WAST with regards to the time delay, and it was noted that the outcome was that the delay was justified as they were preparing for delivery with regular tightening's and the PV loss. Patient was admitted to delivery suite and IUD was confirmed on admission and the following day stillborn baby boy was delivered. Placental histology and examination confirmed a velamentous cord insertion and vasa previa and the root cause noted as ruptured vasa previa at home. ***Lessons learned from the case:*** WAST protocols for pregnant women should specify that if a woman is bleeding, she should be stabilised and then brought to a maternity unit as fast as possible to reduce perinatal and maternal morbidity and mortality, without waiting for a midwife. ***Recommendations were identified as:*** • The department should explore ways to receive and attach women's self-taken photographs to their clinical record. Discussion ensued and it was noted that a scoping exercise is being undertaken as to how this is undertaken in other health boards. MM suggested that contact be made with CD&T as they have responsibility for photoweb and getting images uploaded to this. • All placentas of stillborn babies should be examined macroscopically by the most senior member of medical staff on shift. This clinical examination of the placenta should be added to a new section on the reverse of the examination of the baby, paperwork. This action has been completed. • Where the placenta looks abnormal there should be a system in place for it to be photographed, alongside the baby, before it leaves delivery	

	suite. These photos should be appropriately attached to the clinical record. This action has been completed. • Cancelling of appointments – often out of hours – should be coordinated centrally by one person and include referrals for Covid testing (this is an outside agency). It was noted that the Bereavement checklist has been amended to include covid testing appointments. **The CWQSE resolved:** The report was accepted and the evidence of all actions being completed will be shared with the Clinical Board.	
CWQSE/ 2022/014	**3.4 Learning from Events (LFE) for noting/discussion** **JD - CN/UHL/3975** The case has been reviewed as part of the Directorate Q&S Meeting and learning from the case has been shared widely. Action plan has been reviewed and as part of the development and in-house training, plan is in place for x2 paediatric nurses to attend the NICU/HDU module per year. **FM - CN/UHW/4079** This case is being discussed as part of the Directorate Q&S Meeting in September 2022 and findings/reflections will be shared at the next meeting. **The CWQSE resolved:** a) Updates noted and further update on the case of FM to be discussed at a future meeting.	**EW**
CWQSE/ 2022/015	**3.5 To note the NRI Outcomes Form – IN159076 AE** The outcomes form was shared for information. This has been submitted to Welsh Government for closure. This case involved a patient swallowing a battery whilst on the ward. The key learning from the case was in relation to discussion with parents/carers of highlighting to staff any personal equipment being brought onto the ward so that any risks can be mitigated. It was acknowledged that staff did an excellent job in trying to keep the child safe. **The CWQSE resolved:** a) The outcomes form was noted.	
CWQSE/ 2022/016	**3.6 Infection Prevention Control Update Report** MRSA and MSSA cases are over the required target for the year, others remain within the current targets. IP&C Audits continue across all areas and the new Tenable System is being rolled out. Findings received to date are positive, there have been improvements within Maternity & NICU following recent walkabouts and estates work continues across Maternity & NICU with regards to the recent cases and follow up will be requested from Estates in relation to the required work being undertaken.	**AJONES**

	ANTT update is required from all areas, Directorates were asked to work through. **The CWQSE resolved:** a) The report provided was noted. b) Estates update on necessary actions will be followed up.	**ALL**
CWQSE/ 2022/017	**3.7 Safeguarding** • NHS Wales Safeguarding Network – Communications Bulletin 9 • Child Safeguarding Practice review- Arthur 7 MINUTE BRIEFING • Child Safeguarding Practice review- Star 7 MINUTE BRIEFING • Single Unified Safeguarding Review – 7-minute Briefing • Professional Curiosity Themes from Child and Adult Practice Reviews All documents were shared for information. There were no specific exceptions to note for the meeting. It was requested that these are shared widely across Directorate Q&S processes. **The CWQSE resolved:** a) The safeguarding documents were noted for information b) The documents would be shared widely through Directorate Q&S processes for information	
CWQSE/ 2022/018	**3.8 Patient Safety Alerts (internal/external)/Welsh Health Circulars** • ISN 2022 Aug 003 - SGLT2 Inhibitors and Euglycemic Acidosis • CPhO/MedsLet/2022/29 - Serious shortage protocol for Combisal 125microgram/25microgram inhaler Alerts have been disseminated widely across all areas. There were no specific exceptions to note. **The CWQSE resolved:** a) The alerts were noted. No exceptions reported.	
CWQSE/ 2022/019	**3.9 NICE Guidance – Update on Progress** • TA779 - Dostarlimab for previously treated advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency • HST19 – Elosulfase alfa for treating mucopolysaccharidosis type 4A • NG217 – Epilepsies in children, young people and adults • HST20 – Selumetinib for treating symptomatic and inoperable plexiform neurofibromas associated with type 1 neurofibromatosis in children aged 3 and over • QS145 – Vaccine uptake in under 19s • NG218 – Vaccine uptake in the general population It was requested that all responses to be followed up for completion and the completed templates submitted to Clinical Audit to be shared with the Clinical Board to note progress and compliance. **The CWQSE resolved:** **a)** The NICE guidance was noted and shared for action.	**ALL**

CWQSE/ 2022/020	**3.10 Awareness Raising of Sharps Policy in Maternity first floor** It was agreed that awareness of the safe disposal of sharps policy would be shared as part of the safety briefing and also as part of sharing through the Directorate Q&S meeting following an incident where a housekeeper sustained a sharps injury as part of shared learning. **The CWQSE resolved:** a) The incident was noted and awareness will be raised to highlight awareness on the safe disposal of sharps policy throughout all areas.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2022/021	**4.1 Employee Wellbeing Service Workshops August – December 2022** Wellbeing Workshops - Cardiff and Vale University Health Board (nhs.wales) **The CWQSE resolved:** a) Employee Wellbeing Service Workshops were noted for information and onward dissemination across all areas.	
CWQSE/ 2022/022	**4.2 Long Covid Guidance *(also available in Welsh)*** **The CWQSE resolved:** a) Long Covid Guidance was noted for information and onward dissemination across all areas.	
CWQSE/ 2022/023	**4.3 Resuscitation Newsletter – July 2022** **The CWQSE resolved:** a) The Resuscitation Newsletter was noted for information and onward dissemination across all areas.	
CWQSE/ 2022/024	***4.4 Previously circulated Circulars:*** **Change of Supplier - Adrenaline and Amiodarone Pre-filled syringes SBARs** **The CWQSE resolved:** a) The circular was noted for information and onward dissemination across all areas.	
ANY OTHER BUSINESS		
CWQSE/ 2022/025	**5.1 WP10(HP) prescriptions** There have been incidents relating to WP10 pads going missed. It was reiterated of the need to ensure that these are being secured and only accessible to necessary practitioners. **The CWQSE resolved:** a) Directorate Teams to ensure that the message of securing the WP10 pads is actioned.	**DMT's**
CWQSE/ 2022/026	**5.2 Strike Action** It was acknowledged that there is potential strike action imminent, and all were asked to ensure that areas are "strike ready".	**DMT's**

	The CWQSE resolved: **a)** The Strike action was acknowledged and requests for preparations to begin.	
CWQSE/ 2022/027	**5.3 PH Strips – Change to Supplier** Change to the manufacturer is being progressed and changeover will take place on 3rd October. Training sessions are being developed, including online sessions. Further communication will be shared. **The CWQSE resolved:** a) The changeover of manufacturer and training sessions were noted.	
CWQSE/ 2022/028	**5.4 AMaT System** The rollout of the new Audit Management System is commencing in September 2022. Further discussions are ongoing to understand the processes for implementation and the possibility of whether this will require additional resource to facilitate this. It was agreed that further discussion would take place at the next meeting to monitor progress of the rollout. **The CWQSE resolved:** a) The rollout of the system will be added to the agenda for discussion and ongoing monitoring.	**KH**
CWQSE/ 2022/029	**5.5 Date and Time of Next Meeting** **Tuesday 27th September 2022, 8.30am, via Microsoft Teams**	

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 27th September 2022 at 9am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board (Chair)
Janice Aspinall	JA	Staff Side Representative/RCN Safety Representative
Anthony Lewis	AL	Clinical Board Pharmacist
Alison Davies	AD	Senior Nurse, CYPFHS Directorate
George Chucas	GC	Quality, Safety & Patient Experience Coordinator, CYPFHS Directorate
Lois Mortimer	LM	Interim Deputy Head of Midwifery
Matthew McCarthy	MM	Patient Safety Facilitator
Abigail Holmes	AH	Head of Midwifery, Obstetrics & Gynaecology Directorate
Emma Ward	EW	Interim Clinical Risk Midwife
Martin Edwards	ME	Assistant Clinical Director, CHFW Directorate
Becci Ingram	BI	General Manager, CHFW Directorate
Ashleigh Trowill	AT	Care Group Operational Service Manager, CYPFHS Directorate
Donna James	DJ	Digital Midwife, Obstetrics & Gynaecology Directorate
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
In Attendance		
Bryany Tweedale	BT	Consultant Midwife, Cwm Taf Morgannwg UHB
Elinore Macgillivray	EM	Lead Midwife Maternity Improvement Programme, Cwm Taf Morgannwg UHB
Secretariat		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Apologies:		
Louise Waughington	LW	Associate CNS, Infection Prevention and Control
Angela Jones	AJ	Senior Nurse Resuscitation Service
Paula Davies	PD	Lead Nurse, CYPFHS Directorate
Clare Rowntree	CR	Clinical Board Director, C&W Clinical Board
Catherine Wood	CW	Director of Operations, C&W Clinical Board

Item No	Agenda Item	Action
CWQSE/ 2022/031	**1.1 Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2022/032	**1.2 Apologies for Absence** **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2022/033	**1.3 Minutes of the previous Q&S Meeting held on 30th August 2022** **The CWQSE resolved:** a) The minutes of the meeting held on 30th August 2022 were agreed to be an accurate record.	

CWQSE/ 2022/034	**1.4 To note and update the action log of the meeting of 30th August 2022** Updates were provided on the actions from the last meeting and it was noted that a number of actions have been resolved. The outstanding actions were noted as: **Business Continuity Plans** Business Continuity plan for Obstetrics & Gynaecology is awaited. It was agreed that the action would be closed by exception and the plans would be submitted within the next 7 days. **Guideline for management of constipation in this setting for readmission** The guideline is being drafted and will be shared when finalised. It was noted that this is awaiting approval through Directorate Q&S process. **Health & Safety Management System** Further meeting to be arranged to discuss Clinical Board level overview and progression to implementation. **The CWQSE resolved:** a) An update on the outstanding actions will be provided at the next meeting.	**AH/LM** **AH/LM** **KH**
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		
CWQSE/ 2022/035	**2.1 Presentation – Cwm Taf Health Board PREMS and Dashboard Data** Presentation was shared on the Quality Improvement Plans at CTM by using the implementation of the Dashboard and Maternity Patient Reported Experience Measure (PREM) and the approach being taken to drive this work forward. PREM data does not look at the outcome of care but the impact of the process of care on the women's experience. Questionnaires are sent to patients around 20weeks, 37weeks, 14 days after livebirth, 12 weeks after livebirth subject to there being no triggers built into the system to stop this happening. Responses are around 20-25% return rate. Outcomes of the feedback is then shared as part of the dashboard and will be used to track progress and highlight points that require review/resolution and focus. As part of the improvement progress further developments are ongoing including the implementation of the Birmingham Symptom Specific Obstetric Triage System (BSOTS). Thanks were expressed to both Bryany & Elinore for attending and sharing the work that is being taken forward. It was acknowledged that some of the data information presented is based on information systems already developed within C&V UHB by Donna James, Digital Midwife and it was agreed that a presentation be provided on the work that is being taken forward in house before visiting CTM Health Board. **The CWQSE resolved:** **a)** The presentation was noted and presentation of C&V Information would be shared at a future meeting.	**DJ**

CWQSE/ 2022/036	**2.2 AMaT Rollout Update** Deferred **The CWQSE resolved:** **a)** The AMaT Rollout Update would be rescheduled for a future meeting.	**KH**
CWQSE/ 2022/037	**2.3 CCNS RAG Action Plan – External Review of CCNS Service Swansea Bay** Deferred **The CWQSE resolved:** **a)** The CCNS RAG Action Plan will be rescheduled for a future meeting.	**PD/KH**
CWQSE/ 2022/038	**2.4 Health & Care Standards Directorate QSE Exception Reporting** **2.4.1 CHFW Directorate Report** • Wellbeing Wednesdays are being implemented within the CHFW in partnership with Tesco as part of improvement of wellbeing and staff morale showing staff how much they are valued and appreciated. • Number of risks associated with equipment which is being worked through • Issues continue with emergency barcodes for the BM machines. This is causing significant pressures within the CHFW which requires resolution. This issue has been raised and is being followed up. • NRI's are progressing. • Several new guidelines shared through Directorate Q&S including Guidelines for Urinary Tract Infections, the use of Omalizumab for Chronic Spontaneous Urticaria & Angioedema and also and ECG Performa. • ANP have completed a significant amount of work on two new Paediatric Surgical guidelines which have now been ratified, these were a Rectal Suction Biopsy Protocol with parental advice leaflet and guidelines for Blunt Abdominal Solid Organ Trauma. • Work ongoing with regards to IP&C Audits with BBE Audits achieving 100% in recent audits. Tenable is also being rolled out across the Directorate. • COVID guidance is challenging at present with regards to surgical pre-assessment pathway. Queries were raised with regards to whether they should be cancelled if they have symptoms, even though this may be a common cold. There is no ability to get PCR Tests completed unless they are cardiovascular patients and they cannot be POC tested. Discussion ensued and it was noted that this may need further discussion with regards to Paediatric Anaesthetics. KM noted that this meeting is being arranged and further update will be provided. • No safeguarding nurse within the CHFW at present due to sickness. This concern has been flagged to the Safeguarding Team. It was suggested that Alice Fairman, Safeguarding Midwife may be able to support in the short term. • AMaT presentation has been provided within the Directorate and work is being progressed to implement for use. • ALLOCATE system is being used across all areas and changes that need to be made is delayed which impacts on the rosters.	

	• Patient Passport in Paediatric Oncology has been developed, which will be patient led and allow a smoother admission process particularly when moving across areas and when within shared care. • TCT not accepting patients, which is impacting on bed numbers and the inappropriateness of 17yr old patients being nursed with younger children • Recruitment is ongoing, 45 new nurses due to start, including overseas nurses. Q&S Lead Nurse has been appointed. A Paediatric Neurology locum is due to start shortly. • New Directorate Pharmacist has been appointed for CHFW, Clara Danielson. **The CWQSE resolved:** a) The report provided was noted for information and key highlights and actions were recorded.	
CWQSE/ 2022/039	**2.4.2 CYPFHS Directorate Report** • Concerns around access to beds for 16-18yrs olds continue. to require intensive joint working with AMH colleagues. Tier 4 gatekeeping process not meeting needs for all patients which continues to be a challenge. SIMA training is progressing to help support. • CCNS has significant capacity issues to deliver continuing care packages due to staff absences and a 34% vacancy. There is also a national shortage of Band 5 staff. Workforce planning strategy with temporary staffing solutions, overseas nurses and the development of a band 4 role within the service is being explored. • Local Directorate option for Paediatric Phlebotomy service is being explored whilst a longer-term solution is being discussed. • Contact has been made to families to advise of process for any concerns to be addressed whilst there is the inability to provide all of the areas of the HCW programme due to staff shortages and capacity issues. Risk Assessments have been completed and are part of the risk register for continued review. • X2 private births by private midwives recently and HV service were not aware. Contact has been made with the private midwives and a process is now in place to ensure that the service is notified and appropriate screening can take place. • Fluenz programme commenced on 19th September 2022. Mop up clinics also being explored during half term. • E consent app has received interest from NHS Scotland and a meeting is being arranged with Welsh Government. • Vaccine supply issues continue. It was requested that any issues are copied to AL for further escalation. • Guidance and pathways being developed for children who are at highest risk of developing pressure ulcers. • SOP for developed to support administration of medications by designated Teaching support staff for pupils with complex health needs is awaiting sign off by the Executive Nurse Director. AJONES agreed to follow up. • Sharp increase in pupils attending special schools and concerns have been raised with regards to risks of capacity to meet demand of children attending. • Consultation sessions being held for Memorandum of Understanding for CCNS Service is progressing. Parental contract for expectations from parents of the service and also for the service itself.	

	• New CD has been appointed for the Directorate and will commence in role in October. A new Senior Nurse appointed in CAMHS and will commence in October 2022. • AL confirmed that he will provide maternity cover within CYPFHS whilst the Directorate Pharmacist is on maternity leave. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2022/040	**2.4.3 O&G Directorate Report** • No report for this meeting. **The CWQSE resolved:** a) The update report would be provided for information and for key highlights to be recorded.	
CWQSE/ 2022/041	**2.5 Waiting Times Update (including Long Waiting Patients)** **CHFW Directorate** Risks remain as previous month. For Paediatric Surgery there continues to be a high number of patients waiting over 36weeks, with a number at clinical priority level 3. WAG Planned Care targets of 52 weeks for outpatient appt and 104weeks for inpatients is being managed and are on target to deliver. Within General Paeds, there are 600 patients that will require an outpatient appointment by the end of March 2023 and this is being progressed. Within Cardiology, there have been pressures to manage the waiting list due to consultant sickness, however a plan is in place to improve this position. 111 children awaiting endoscopy of which 81 have waited over 8 weeks. Work being taken forward with Swansea to look at this and look to how this can be improved. Neurology locum will commence in post in October, and advert is out for x2 permanent Paediatric Neurologists with a view to have a fully established Paediatric Neurology Team shortly. **CYPFHS Directorate** Reduction in waiting lists across PMH, CAMHS and Continence Service. At the end of August, there were 84 patients waiting for a PMH assessment with the longest wait at 9 weeks but average wait of 23 days. 170 patients waiting for a CAMHS assessment with the longest wait at 44weeks, however this is reducing quite significantly with an average wait of 16weeks. For the continence service there were 627 patients waiting with the longest patient waiting 132 weeks. Neurodevelopment WL has increased for initial assessment with the longest wait at 138weeks. Progress has been made to the Waiting List Initiative with staff having been recruited and hoped there will be an improvement across the waiting list as a result of this. Within Therapies there are 637 patients at the end of August, with the longest wait within OT with 336 patients waiting with 236 waiting 14weeks and over. Within the Looked After Children (LAC) Service there is a backlog of 84	

	initial health assessments and currently failing to meet the statutory target of all initial health assessment being undertaken within 28days. An SBAR is being completed to outline possible staffing options to look at addressing this. **The CWQSE resolved:** a) The updates were noted.	
CWQSE/ 2022/042	**2.6 New Risks to be considered for the Clinical Board Risk Register** **Waiting Times and Antenatal Clinic risks** It was noted that the O&G Directorate have recently met to review the risk register and two new risks relating to Waiting Times and Antenatal Clinic have been added. Once finalised these will be shared with the Clinical Board for noting. **SOP – Calvert Trust** The SOP was shared which has been developed for the administration of medicines through the gastrostomy by the teaching assistant. AL noted that this has been approved from a Pharmacy perspective. Training and competency frameworks have been undertaken with the teaching assistant. The SOP has been developed and sets out the minimum standards in line with the UHB medicines code. Robust care plan has been developed for the young person. It was agreed that this should be shared with Gemma Taylor who is the new Medicines Management Lead Nurse (Louise Williams replacement). **The CWQSE resolved:** a) New risks in O&G noted and final detail awaited. b) SOP was noted and will be shared with the new medicines management lead nurse for final ratification.	**AH/RJ** **AD**
SAFE CARE		
CWQSE/ 2022/043	**3.1 Update on Serious Incidents** 12 open NRI's, 4 of which are overdue. Some of the NRI's will requesting an extension due to the difficulty with appointing Investigating Officers to undertake the investigations. Updated Patient Safety Investigation Review Tool is being developed which will replace the RCA process and once this has been trialled/ratified, training will be developed and rolled out. MM agreed to circulate for comment. **The CWQSE resolved:** a) The update provided by Patient Safety Team was noted. b) Patient Safety tool to be shared for comment.	**MM**
CWQSE/ 2022/044	**3.2 SI's/RCA's/Closure Forms for noting/exception reporting** **Final RCA Report – In148337 LK** The final report was noted for information. Lady was transferred from Swansea Bay and was a known cardiac patient, with an indwelling device. Planned with elective delivery via induction of labour at 39 weeks of pregnancy. No concerns noted antenatally, with no concerns of growth of baby however it should be noted that the patient did	

	have a BMI of 52 and scanning images of a patient with a high BMI such as this can sometimes be difficult. Induction progress was commenced and there was a delay in care of 18hrs to transfer to delivery suite and was born by caesarean section. Baby was initially transferred to NNU and unfortunately baby passed away at 48hrs old. It was acknowledged that this was the second version of the report as there was a request that a draft version was received and in hindsight this may not have been appropriate due to the number of factual inaccuracies concerns raised by the family which needed to be further reviewed and addressed which then impacted on a further delay in the family receiving the final report. Meeting has taken place with the family and the final version has been shared and whilst not happy with the care received, they are happy with the quality of the report and this is now closed. This has also been referred as a Coroners case and anticipated that there is likely to be a delay in this case being heard. Action plan is ongoing, a number of the actions have been resolved. **The CWQSE resolved:** a) The final report was noted.	
CWQSE/ 2022/045	**3.3 To note the DRAFT minutes from the NRI/RCA Governance Sub Group held on 11.08.2022** The minutes of the meeting were shared for information. There were no specific exceptions to report for this meeting. **The CWQSE resolved:** a) The minutes were noted.	
CWQSE/ 2022/046	**3.4 Learning from Events (LFE) Claims for noting/discussion** **CN/UHW/3656 – Patient KO** The case related to an alleged delay in diagnosing and removing retained products. The case was settled without liability and for financial risk only. **CN/UHW/3787 – Patient VO-A** The case involved a joint health board and Swansea Bay patient that alleged failure to manage the patient's anxieties with regards to mode of delivery and alleged refusal to support maternal request for elective section. The claim was settled without liability and for financial risk only **CN/UHW/3501 – Patient AE** The case related to the alleged substandard skilled treatment provided when undergoing ERPOC and the patient suffering a uterine perforation by an ST3. The incident was investigated and found to have been managed appropriately as this is a recognised risk. The claim was therefore settled without liability and for financial risk only. **The CWQSE resolved:** a) The cases were noted for information.	
CWQSE/ 2022/047	**3.5 Infection Prevention Control Update Report** Noted for information. There were no specific issues to raise for the meeting.	

	Work is ongoing with regards to the MRSA involving Maternity and Neonates. Work has commenced on the two obstetric areas and it was agreed that the timescales for completion will be followed up. It was noted that there have been no further cases reported. It was agreed that a final meeting would be scheduled to close down given that there have been no further cases reported and work is progressing. AJONES agreed to follow up. **The CWQSE resolved:** a) The report provided was noted. b) AJONES agreed to follow up timescales with Estates and also the meeting with IP&C for closure of the outbreak.	**AJONES**
CWQSE/ 2022/048	**3.6 Safeguarding** No issues to note for this meeting. Update will be provided following the Safeguarding Steering Group. **The CWQSE resolved:** a) Update is awaited.	
CWQSE/ 2022/049	**3.7 Patient Safety Alerts (internal/external)/Welsh Health Circulars** **WHC 011/2022 - Patient Testing Framework - Updated Guidance** Alert has been disseminated widely across all areas. There were no specific exceptions to note. PH Test Strips change has been implemented across the health board and the detail has been shared. If there is an area that has regular use, these can be ordered through the usual oracle process. **The CWQSE resolved:** a) The alert was noted.	
CWQSE/ 2022/050	**3.8 NICE Guidance – Update on Progress** No new guidance to note. It was agreed that an update request would be shared following the meeting for an update on progress of any outstanding NICE Guidance. **The CWQSE resolved:** **a)** Progress update to be requested outside of the meeting.	
CWQSE/ 2022/051	**3.9 Notification of negative outlier status for NNAP 2021 measures** Data is being reviewed and how the data can be collected in a timely manner. Work continues to review how this can be improved. It was noted that concerns have been raised in relation to the questions that have been requested for a response are not fit for purpose, and some changes have been made and timeline has been increased for submission. A copy of the submission from the Neonatal Network has been requested for information and understanding of what is being submitted on behalf of the Health Board. CW agreed to discuss further outside of the meeting. This is a similar theme for Maternity with regards to the information requested for submission. **The CWQSE resolved:**	**CW/KM/BI**

	a) Update was noted and submission is awaited.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2022/052	**4.1 Duty of Candour Consultation** Shared for information/action and onward dissemination/action as appropriate. **The CWQSE resolved:** a) The consultation was noted.	
CWQSE/ 2022/053	**4.2 ABO incompatible comms - information from Dr Edwin Massey** Shared for information and onward dissemination/action as appropriate. **The CWQSE resolved:** **a)** The ABO incompatible comms was noted.	
CWQSE/ 2022/054	**4.3 Updated COVID-19 Testing Guidance for Patient Facing Healthcare Workers** Shared for information and onward dissemination/action as appropriate. **The CWQSE resolved:** **a)** The updated COVID guidance was noted.	
ANY OTHER BUSINESS		
CWQSE/ 2022/055	**5.1 All Wales WAST Meeting – Ambulance Capacity** Update was provided following the All Wales WAST Meeting with regards to ambulance capacity and the impact on services. Considerable concern regarding capacity and how they will facilitate. It was noted that discussions had taken place with regards to the appointment of an "in house" team for in utero service transport team. Further discussions will be needed to consider this given the pressures they highlighted. Work is ongoing and the aim is to reinstate homebirth services in November 2022. Work continues as to how this can be implemented and a planning day has been arranged to discuss further. AH agreed to forward a trajectory to the Clinical Board outlining the intention and how this will be progressed. Discussion ensued with regards to the possibility of a rolling recruitment advert being progressed so that this can avoid some of the potential delays being experienced within the recruitment process. Agreed that this could be explored for rotational posts. AJONES agreed to explore further with HR. **The CWQSE resolved:** a) The update was noted. b) AH to forward trajectory for homebirth services plan to Clinical Board c) AJONES to explore rolling recruitment advert for Rotational Posts.	**AH** **AJONES**
CWQSE/ 2022/056	**5.2 Off Ward Nurses Training - CHFW**	

	Concerns were raised with regards to the potential movement from the CHFW into Adult Services. This will be a significant risk to the CHFW and the patients. It was acknowledged that there is already fragility within the workforce and these concerns have been escalated to the Executive Team. The preparedness process is causing further apprehension and anxiety on the workforce. This was acknowledged and noted that this process is intending to help prepare for what may be required based on risk. With regards to the training, this should be completed by the non-patient facing staff predominantly, acknowledging that this is undertaken as much as is practically possible, aside current commitments and pressures. Reassurance to be provided to staff that the Clinical Board are very much in support of the workforce and continue to advocate for all, and the preparedness is important as a way in which to support all staff should this be required. The existing pressures were shared across all Directorates. AD noted that some of non-clinical nurses may need more than just ward based training and would require shadow shifts etc. **The CWQSE resolved:** a) The update was noted.	
CWQSE/ 2022/059	**5.5 Date and Time of Next Meeting** **Tuesday 25th October 2022 (Health & Safety Focus), 8.30am, via Microsoft Teams**	