Quality, Safety & Experience Committee

Tue 30 August 2022, 09:00 - 12:30

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 15 June 2022.

Susan Elsmore

1.4 Public QSE Minutes 15.06.22MD.pdf (13 pages)

1.5. Action Log – Following the meeting held on 15 June 2022

Susan Elsmore

1.5 Public Action LogMD2.pdf (3 pages)

1.6. Chair's Action taken since last meeting

Susan Elsmore

09:10 - 11:05
115 min

2. Items for Review & Assurance

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

Anna Mogie Helen Kemp

25 minutes

2.1 PCIC QSE Assurance Paper August 2022.pdf (6 pages)

2.2. Quality Indicators Report

Jason Roberts

10 minutes

2.2 Quality Indicators Report.pdf (14 pages)

2.3. HIW Activity Overview to include:

15 minutes

2.3.1. HIW report relating to WAST and review of patient safety, privacy, dignity and experience whilst waiting in ambulance during delayed handovers

Jason Roberts Hannah Evans

- 2.3 HIW Update Paper.pdf (7 pages)
- 2.3a HIW Appendix 1.pdf (10 pages)

2.4. Community Health Council Activity Review

Jason Roberts

10 minutes

- 2.4 Community Health Council Activity Review.pdf (3 pages)
- 2.4a APPENDIX 1 - Q2 AND Q3 SCRUTINY VISIT DATES (1).pdf (1 pages)

2.4.1. NHS Pharmacy Services in Cardiff and the Vale of Glamorgan

See supporting documents folder

2.4.2. Patient Experience Report of Cardiac Services in Cardiff and the Vale of Glamorgan

See supporting documents folder

2.4.3. NHS Dental Services Availability in Cardiff and the Vale of Glamorgan

See supporting documents folder

2.4.4. Accessing NHS Eye Care Services in Cardiff and the Vale of Glamorgan

See supporting documents folder

2.4.5. Sensory Loss Patient Experience when Accessing NHS Healthcare

See supporting documents folder

2.4.6. LGBTQ+ and access Healthcare

See supporting documents folder

2.5. Quality, Safety and Experience Implications arising from IMTP

Jason Roberts

10 minutes

- 2.5 QSE Report IMTP AUG 22 - v3.pdf (8 pages)

2.6. Update on Falls

Fiona Jenkins / Alex Scott

10 minutes

- 2.6 Update on Falls Report.pdf (9 pages)
- 2.6 Appendix 1.pdf (1 pages)

2.7. Tenables Quality Dashboard Presentation (Verbal)

Jason Roberts

15 minutes

2.8. Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response

Audit Wales

10 minutes

2.8 Review of Quality Governance Arrangements.pdf (36 pages)

2.9. Board Assurance Framework – Patient Safety

Nicola Foreman

5 minutes

2.9 BAF Patient Safety Covering report - 2022.NF.pdf (3 pages)
2.9a Patient Safety BAF Risk.pdf (3 pages)
2.9b Workforce updated.pdf (4 pages)

2.10. Annual Letter from the Ombudsman

Jason Roberts

5 minutes

2.10 Annual Letter from the Ombudsman.pdf (4 pages)
2.10a Cardiff and Vale Ombudsman Letter.pdf (8 pages)

11:05 - 11:20
15 min

3. Items for Approval / Ratification

3.1. Interventions not normally undertaken (INNU) policy and intervention list

Fiona Kinghorn

10 minutes

3.1 INNU Report for CEG & QSE Aug 2022.pdf (2 pages)
3.1a List of Interventions Not Normally Undertaken.pdf (32 pages)
3.1b INNU policy and EHIA August 2022.pdf (30 pages)

3.2. Unpaid Carers Charter

Abigail Harris

5 minutes

3.2 Unpaid Carers Charter Paper.pdf (4 pages)
3.2a CAV Unpaid Carers Charter.pdf (1 pages)
3.2b Young Carers Charter.pdf (1 pages)
3.2c Unpaid Carers Charter companion document-Final Draft 12.08.22.pdf (24 pages)

11:20 - 11:40
20 min

4. Items for Noting & Information

4.1. Exception Reports (Verbal)

Jason Roberts / Meriel Jenney

10 minutes

4.2. Minutes from Clinical Board QSE Sub Committees:

Angela Hughes

5 minutes

4.2.1. CD&T Clinical Board – 19.5.22

4.2.2 CD&T Minutes 19.5.22.pdf (10 pages)

4.2.2. Medicine Clinical Board – 19.5.22

4.2.3 Medicine Clinical Board QSE Minutes 19 May 2022.pdf (7 pages)

4.2.3. Specialist – 28.4.22 & 9.6.22

4.2.4 Speciliast Minutes 28.04.22.pdf (6 pages)
4.2.4a Specialist Minutes 09.06.22.pdf (6 pages)

4.2.4. Surgical – 17.5.22

4.2.6 SCB Minutes QS 17.05.2022.pdf (8 pages)

4.3. Corporate Risk Register

Nicola Foreman

5 minutes

4.3 Corporate Risk Register - QSE Update August 2022.pdf (4 pages)
4.3a Appendix A - QSE Committee - Corporate Risk Register Entries August 2022.pdf (4 pages)

11:40 - 11:40
0 min

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

Susan Elsmore

11:40 - 11:40
0 min

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

Susan Elsmore

i) Minutes of the Private Committee Meeting – 15.6.22

ii) Pandemic Update & Any Urgent / Emerging Themes – Verbal

iii) Maternity Case Review - Verbal

iv) Cardiac Surgery Update Report – Verbal

v) DNAR Orders at St. David's Hospital Update – Verbal

vi) HIW report relating to the Emergency Unit at UHW

11:40 - 11:40
0 min

7. Any Other Business

Susan Elsmore

11:40 - 11:40
0 min

8. Review of the Meeting

Susan Elsmore

11:40 - 11:40
0 min

9. Date & Time of Next Meeting:

Tuesday, 11 October (Special Meeting) at 9am via MS Teams

11:40 - 11:40
0 min

10. Declaration

Susan Elsmore

“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 15 June 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		
Susan Bailey	SB	Clinical Board Director CD&T
Caroline Bird	CB	Interim Chief Operation Officer
Timothy Davies	TD	Head of Corporate Business
Hayley Dixon	HD	General Manager
Marcia Donovan	MD	Head of Corporate Governance
Claire Evans	CE	Assistant Director of Primary Care
Angela Hughes	AH	Assistant Director of Patient Experience
Meriel Jenney	MJ	Executive Medical Director
Fiona Kinghorn	FK	Executive Director of Public Health
Jason Roberts	JR	Interim Executive Nurse Director
Paul Rogers	PR	Directorate Manager of the Artificial Limb and Appliance Service
Observing		
Stephen Allen	SA	Chief Officer – Community Health Council
Vanessa Davies	VD	Head of Reviews – Health Inspectorate Wales
Emily Howell	EH	Audit Wales
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Nicola Foreman	NF	Director of Corporate Governance
Akmal Hanuk	AH	Independent Member – Community
Rajesh Krishnan	RK	Associate Medical Director (Clinical Governance and Patient Safety)

QSE 22/06/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 22/06/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 22/06/003	**Declarations of Interest**	
QSE 22/06/004	**Minutes of the Committee meeting held on 12 April 2022** The minutes of the meeting held on 12 April 2022 were received. **The Committee resolved that:** a) The minutes of the meeting held on 12 April were approved as a true and accurate record of that meeting.	
QSE 22/06/005	**Action Log following the Meeting held on 12 April 2022** The Action Log was received, and all ongoing actions discussed.	

	The Committee resolved that: a) The Action Log from the meeting held on 12 April 2022 was noted	
QSE 22/06/006	**Clinical Diagnostics & Therapies (CD&T) Clinical Board Assurance Report** The CD&T Clinical Board Assurance Report was received. The Clinical Board Director of CD&T (CBDCDT) presented the Committee with the metrics of where the Clinical Board was at present. The work outlined within the report received by the Quality, Safety and Experience Committee reflected the key metrics that were taking place to improve quality, safety and patient experience within the CD&T Clinical Board in order to improve quality and care outcomes for patients. It also outlined the considerable development, improvement and innovation work which was underway within that Clinical Board. It was noted that the CD&T Clinical Board provided a wide range of diagnostic and therapeutic procedures on a local, regional and UK wide basis and collectively those services underpinned, and were core components of, almost every aspect of Clinical activity undertaken within the Health Board. It was noted that the Clinical Board consisted of 7 Directorates: • Laboratory Medicine • All Wales Therapeutics and Toxicology • Radiology, Medical Physics and Clinical Engineering • Medical Illustration • Outpatients/Patient administration • Therapies • Pharmacy and Medicines Management The CBDCDT advised the Committee that it had been calculated that CD&T had around one million contacts a year with patients. It was noted that during Covid-19 the Clinical Board had not stood down any Quality & Safety meetings and that the Clinical Board had remained very keen to keep "business as usual" The CBDCDT advised the Committee of the key risks held within the Clinical Board which included: • Point of Care Testing (POCT) - Risk rating 20 – It was noted that a Clinical Lead had been appointed to support the service but a lack of a POCT Governance committee had led to reduced corporate oversight. CD&T were working with the Medical Devices Group to seek support in establishing a Health Board wide governance process. • Backlog of diagnostics and therapies (as a consequence of Covid19) due to a reduction in capacity - Risk rating 16 – It was noted that weekly monitoring of waiting lists was undertaken and a significant improvement was noted. It was noted that the Directorate was currently undertaking a capacity and demand exercise to ensure the service was "right-sized" going forward. • IT/Digital - Risk rating 16 – It was noted that there had been impact from aging hardware, software and slow delivery of key IT systems and that there were some on-going stability issues. It was noted that the Clinical Board was	

	fully engaged with the National Programme to work towards standardisation and interoperability. • Estates and Facilities - Risk rating 16 – It was noted that the fabric of some estate was sub-optimal to the delivery of modern, safe and sustainable healthcare and failed to meet regulatory requirements. It was noted that CD&T continued to engage with schemes to update/replace aging infrastructure, e.g. Mortuary and Radiopharmacy, and that delivery of the schemes would be essential to satisfy the regulatory bodies. The CBDCDT advised the Committee that the Clinical Board had recognised the significant risks from Work Related Stress, and set Wellbeing, Resilience, and Mental Health as a key priority and that it was just as important than ever in the post-pandemic world. She added that the Clinical Board had recognised the significant impact the values and behaviours of staff had on each other and on the patients. It was noted that the Clinical Board adopted a "train the trainer" approach to delivering the Values in Action training and that managers across the Clinical Board were delivering the training to their teams to demonstrate leadership and commitment to the messages in the videos. The Committee was advised that the feedback from that work had been very positive and that the Clinical Board would be sharing the work with other parts of the Health Board. It was noted that the Clinical Board had recognised the ongoing impact upon managers and so a weekly Resilience session for managers was established. That was a safe space where managers could 'off load', receive support from peers and take a short time out. The CC noted that the service developments around Point of Care Testing (POCT) was impressive and asked when that would be in place. The CBDCDT responded that she hoped it would be in place as soon as possible because it was a risk that the Health Board was carrying and that the number of devices being used in remote locations meant that it was important to make sure everything worked as it should. The Interim Executive Nurse Director (IEND) advised the Committee that issues regarding POCT had been picked up by the Office of Professional Leadership and that he had agreed to chair the POCT group moving forward and work with the CD&T Clinical Board. The Independent Member – Trade Unions (IMTU) asked how staff morale was within the Clinical Board. The CBDCDT responded that it was still quite low but improvements had been seen. She highlighted an email she had received that had identified a member of CD&T Clinical Board staff who had gone above and beyond to help a patient who was distressed. The Independent Member – Community (IMC) asked what measures were in place in relation to the risk rating of 16 for the backlog and waiting lists. The CBDCDT responded that there were reasonable mitigation strategies in place and that she would meet the IMC offline to go through those in detail and to provide the plans and improvement trajectories in place against each of the risks. He added that the risk should start to reduce quite significantly over the coming months as the Clinical Board had made good progress.	**SB**

	The Chief Officer for the Community Health Council (COCHC) advised the Committee that taking things "offline" meant that the public would not be sighted on those discussions. The Head of Corporate Business (HCB) responded that a summary would be provided about the risk aspects that had been discussed which would reassure any members of the public and the Committee and noted that they would also be added to the Corporate Risk Register which is received by the Board at every Board meeting. The DOCDT advised the Committee that the CBDCDT would be retiring in October 2022 and thanked her for her leadership and approach to the CD&T Clinical Board and noted that it was a much safer place for Patients and Staff because of it. The CC concurred and noted that the CBDCDT was an exemplar in terms of what she had achieved on behalf of the Clinical Board. **The QSE Committee resolved that:** a) The content of the report was discussed and noted.	**TD**
QSE 22/06/007	**Quality Indicators Report: to include Pressure Damage Update** The Pressure Damage Update was received. The Director of Nursing for Surgery Clinical Board (DNS) advised the Committee that since the last QSE meeting, the data had progressed and that, as previously discussed, the goal of the Pressure Damage Collaborative was to reduce the incidence of Healthcare acquired pressure damage with the Health Board by 25% by July 2022. It was noted that the current data available to the Pressure Damage Collaborative, which could now for the first time can be presented per 1000 beds days, showed that the pressure damage per 1000 bed days had reduced from 3.51 in May 2021 to 2.61 in March 2022 for inpatient areas. That was a reduction of 24%, which at a very high simplistic level, would indicate that the reduction goal had already been met. The DNS advised the Committee that some of the data the team hoped to collect going forward as part of the quality assurance dashboard included: a) Total number of patients with pressure damage b) A breakdown of stages (moisture lesion, 1,2,3 etc) c) Pressure damage that occurred under Health Board care (Acute) d) Pressure damage that occurred under Health Board care (Community) e) Percentage of patients whose pressure damage deteriorates. f) What pressure damage was reported g) Length of time taken for pressure damage to develop h) The number of days pressure damage was free per Clinical area. The Independent Member – University (IMU) advised the Committee that the data was welcomed but noted that clarity was required regarding duplication of reporting on the same in-hospital incidents. The DNS responded that good incident reporting would be one way to stop duplication. With the new quality dashboard and by using the relevant data, patients could be tracked through the system which would show the pressure damage and where it was last recorded.	

She added that it would be trickier to add the data into the Community setting although she was confident that, moving forward, Patients could be tracked throughout all of their Healthcare experiences.

The COCHC asked if the delays in discharge would affect the pressure damage data on future reports.

The DNS responded that it could and that one of the things that was available to staff was a medically fit button on the Clinical workstation and that it was one of the areas that could be looked at now that data was available to see if the Health Board was causing any more harm to patients by keeping them longer in hospital.

The Quality Indicators Report was received.

The Assistant Director of Patient Experience (ADPE) presented the Committee with the QSE Framework structure and noted that the Patient Safety Team was currently setting up the Clinical Safety Group and the Organisational Learning Committee.

The National Reports Incidents (NRIs) were presented to the Committee where it was identified that in December 2021 there had been a spike of NRIs which was retrospective and hospital acquired pressure damage that had been reported.

She added that there had been a lot of work undertaken that had focussed on the NRIs management and noted that over half of the overdue NRIs on the system had been effectively managed.

It was noted that there were 46 NRIs open at present but all had a plan in place to be closed.

The Committee was advised that in terms of the number of concerns received, the number had increased to around 100/120 a week. That was a significant increase and represented a pressure for the Clinical Boards as well as the Central Team.

The ADPE advised the Committee that the Concerns response time remained at around 81% which was above the Welsh Government (WG) target.

The Committee was presented with a number of Quality Indicators which included:

i) Infection Control – It was noted that number of recorded infection control incidents was 76.

j) Mortality – Fracture Neck of Femur data, Cardiac data, Stroke data.

k) Patient Safety Notices – It was noted that there were 2 Patient Safety Notices that were non-compliant:

l) PSA012 – Deterioration due to rapid offload of pleural effusion fluid from chest drains

m) PSA008 – Nasogastric tube misplacement: continuing risk of death and severe harm. It was noted that the Delivery Unit had been kept informed of the Health Board's progress and that a robust solution would be in place. The Committee noted it was an all Wales issue.

n) Falls

The QSE Committee resolved that:

	a) The contents of the Pressure Damage Collaborate update report and the actions being taken forward to address areas for improvement were noted. b) The Quality Indicators report was noted.	
QSE 22/06/008	**Mortality Indicators** The Executive Medical Director (EMD) advised the Committee that the paper could be taken as read but noted the complexity of it. It was noted that there had been concerns about the Risk Adjusted Mortality Index (RAMI) being high, hence why the Medical Team wished to present a paper to the Committee. It was noted that some of the disruption in the RAMI was due to poor coding. That was partly due to Covid-19 because there had been a significant loss of staff in the coding arena. The EMD advised the Committee that not only was there a coding issue which had led to the increase in RAMI but other areas were also being investigated, such as: • Length of stay • Unscheduled care • Intensive care The EMD added that she was now chairing an internal group within Intensive Care because she was concerned about RAMI in Intensive Care and further details would be provided to the Committee in November 2022. The IMD advised the Committee that from an assurance point of view, the Medical Examiner work was now bringing in a much stronger governance structure around deaths within the Health Board, and the level one reviews were done in a much more systematic way before going back to the Medical Examiner for the second stage review. She concluded that RAMI should remain high on the QSE agenda and noted a further report could be received in November 2022. The COCHC advised the Board that it had been a complex paper to read and noted that the public could struggle to understand some of the information. The EMD responded that it was the first time the Committee had received an evidence-based paper with short, sharp data summaries and noted that it would be looked at for future meetings. The IMU agreed that the paper was quite complex and asked if there would be any value in adding a mortality review to a list for a focussed discussion/workshop. The CC responded that there were a number of items on the Action Log that required a specific Board development session and noted that mortality could be added. **The QSE Committee resolved that:** a) The contents of the paper and that henceforth, the mortality paper would be submitted in the above format with detailed narrative around the different ratios, was noted.	**MJ** **MJ** **MJ** **DCG**
QSE 22/06/009	**Maternity Services – Verbal Update**	

	The Maternity Services – Verbal Update was received. The IEND advised the Committee that there had been a strained environment regarding national Maternity Services over the past few years with issues raised in Telford, Cwm Taf and the subsequent Ockenden Report. It was noted that the Health Board had carried out its own thematic review and that Welsh Government (WG) had put an assurance template together so that there was a standard template across Wales for all Health Boards. It was noted that the Health Board had provided assurance against that template and that it had been submitted to the Chief Nursing Officer (CNO) and WG for validation. **The QSE Committee resolved that:** a) The Maternity Services – Verbal Update was noted.	
QSE 22/06/010	**HIW Activity Overview** The HIW Activity Overview was received. The IEND advised the Committee he would take the paper as read. He added that HIW had performed 2 unannounced inspections: • Cardiothoracic services – UHL – Unannounced Visit – It was noted that the inspection was carried out by HIW in Cardiothoracic services in Llandough hospital in February 2022. Provisional feedback from the inspection was overall very positive. More detail would be shared with the QSE Committee when the report had been published. • Mental Health Services – Unannounced Visit – It was noted that the inspection took place at Hafan y Coed, Llandough Hospital in February 2022. The following areas were inspected: - Cedar Ward – Adult Crisis Admission - Oak Ward – Adult Locality treatment ward - Willow Ward – Adult Locality treatment ward The inspection was based around how services met the Health and Care Standards (2015). HIW had also considered how services complied with the Mental Capacity Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. It was noted that overall, HIW had found that the service provided safe and effective care to patients. HIW had found a dedicated staff team that were committed to providing a high standard of respectful care to patients, with individualised care plans that considered the patients' views reflecting the Welsh Measures domains. The IEND advised the Committee that staff had raised concerns in relation to being overstretched due to the pressures of the COVID 19 pandemic. HIW had identified that as an area in need of improvement, to ensure that the appropriate staff numbers and skill mix were available to prevent staff fatigue and to allow management to have sufficient supernumerary time to undertake their operational duties. The IMU asked about the thematic review of the Stroke pathway and noted that the report suggested there would be a quality insight bulletin and asked when that would be received.	**JR**

	The IEND responded that as soon as it was received, he would circulate to Committee members. The Head of Reviews for HIW added that HIW would be writing to all Chief Executives across Wales and noted that an update on the site visit would be provided for the Health Board with a summary letter to be sent initially to the relevant individuals. The CC noted that the report could come back to the August Committee and asked to amend the second recommendation that stated: "*Agree that the appropriate processes were in place to address and monitor the recommendations*" to state that the Committee would *"agree that the appropriate processes were in place but the monitoring outcomes would come to a future meeting".* **The QSE Committee resolved that:** a) The level of HIW activity across a broad range of services was noted. **b)** It was agreed that the appropriate processes were in place to address the recommendations but the monitoring outcomes would be presented to a future Committee	**JR** **JR**
QSE 22/06/011	**Board Assurance Framework – Patient Safety** The Board Assurance Framework – Patient Safety was received. The Head of Corporate Business (HCB) advised the Committee that he would take the report as read. It was noted that the particular risk within the report had a very direct and more obvious impact on patient safety. It was noted that risk was deemed to be at the highest risk score to the Health Board – that was 25 out of 25. **The QSE Committee resolved that:** a) The risk in relation to Patient Safety to enable the Committee to provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety, was noted.	
QSE 22/06/012	**Dental Services Update** The Dental Services Update was received. The Interim Chief Operating Office (ICOO) advised the Committee that she would take the paper as read. The Committee was advised that the paper was being brought in light of concerns raised by Committee and Board Members regarding access to Dental Services. It was noted that like most services, Dental Services had been impacted by Covid-19. That had resulted in patient access difficulties and constraints, as well as an increase in the backlog of patients waiting to be seen. It was identified that plans had been put in place to address the position as well as the recovery and redesign around Dental Services.	

	It was noted that that WG had set out priorities up to 2026 and had made a commitment to reform Primary Care Dentistry and also to increase access to dentists. The ICOO advised the Committee that WG had issued a direction to all Health Boards in Wales to restart the Dental Contract Reform from 1st April 2022 through to 2023 using an action learning approach. She added that all General Dental Services (GDS) practices were to be given a choice, to either be part of the reform programme with a suite of delivery measures, or to return to contractual arrangements based wholly on Units of Dental Activity (UDA's). It was noted that the position for the Health Board was: c) 73% (46) would be operating under Dental Contract Reform d) 17% (17) would be operating under UDA's The Committee was advised that the Health Board was seeing an improvement trajectory. The COCHC advised the Committee that during the pandemic the Community Health Council (CHC) had performed two reviews of Dental Services and noted three concerns which included: • Patients had been told they could not be seen under the NHS but could be seen privately. • The number of people on the centralised waiting lists • The Roath estate The Assistant Director of Primary Care (ADPC) responded that there was a large centralised waiting list for access to GDS. That centralised list had been developed by the Health Board to allow a better understanding of the issue and what would be required to move forward. She added that the Health Board would see an additional 29,000 patients in year due to the contractual changes (ie the Dental Contract Reform) and so the waiting lists should decrease. The Independent Member – University (IMU) asked what support would be provided to the failing estate at the Roath surgery. The ADPC responded that the Roath site could not be used due to Infection Prevention and Control (IPC) guidance which did not allow for drilling or highspeed dentistry. She added that due to the age of the Roath estate, relevant changes could not be made to the building to accommodate the IPC changes which had reduced capacity. It was noted that it had been placed on the PCIC Risk Register and long-term solutions were being considered. That included moving to the Cardiff Royal Infirmary (CRI) site and the Park View development, although it was noted that those developments were a long way off and so that was why it was deemed a risk. It was noted that it would be taken to the Capital Planning and Estates forum to see if an interim solution could be found. The CC advised the Committee that the CHC inspection reports would be received by the Committee in August 2022.	**JR**

	The QSE Committee resolved that: a) The current position in regard to all Dental Services was noted.	
QSE 22/06/013	**Ultrasound Clinical Governance position** The Ultrasound Clinical Governance position was received. The Directorate Manager of the Artificial Limb and Appliance Service (DMALAS) advised the Committee that following an Internal Audit of Ultrasound Governance across the Health Board, several shortcomings were identified. Those had centred around a lack of assurance of appropriate governance in the correct and safe use of Ultrasound across the Health Board and insufficient communication and escalation pathways. It was noted that the Ultrasound (US) Audit Report published in August 2021 had found limited assurance for Ultrasound Governance arrangements within the Health Board and the two high priority recommendations were: • The design and implementation of Ultrasound Governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure. • Roles and responsibilities in the management of diagnostic and therapeutic ultrasound services. The Committee was advised that the following actions had been taken or were in progress to address the short fallings found in the August 2021 Ultrasound Audit: • Review of the Ultrasound Clinical Governance Group (USCGG) and new Terms of Reference (ToRs) • Membership of the USCGG was extended to include all areas of Diagnostic and Therapeutic Ultrasound across the Health Board • Suitable chair of the USCGG appointed • Clear reporting pathway for USCGG ToRs • Change of name for the Medical Ultrasound Risk Management Procedure and Policy to Ultrasound Clinical Governance Procedure and Policy • Arrange regular USCGG meetings. • Requirements to appoint Ultrasound (US) roles of Clinical Lead User, Speciality Lead User, and Educational Supervisor / Training Supervisor within relevant Clinical Boards would be actioned as part of the formation of the new USCGG • Creation and implementation of the US Safety Training would be actioned and implemented as part of the formation of the new USCGG • An annual audit template would be developed by the membership of the USCGG to include a balanced range of performance indicators on the effective management of US devices including training, competence and maintenance as part of the US governance framework.	

	The CC advised the Committee that one of the Internal Audit reports for quality had supplied a limited assurance in terms of ultrasound governance due to the lack of attendance at meetings. She asked the DMALAS if assurance could be provided moving forward that attendance would improve. The DMALAS responded that the group have been very fortunate to receive support from senior managers and noted that some of the responsibility had been put back onto the Clinical Boards to ensure that their individual Directorates and teams would attend. **The QSE Committee resolved that:** a) The actions being taken to address the recommendations made by Internal Audit in the Ultrasound Governance audit report dated August 2021 were noted.	
QSE 22/06/014	**Concerns, Redress and Claims** The Concerns, Redress and Claims information was received. The Assistant Director of Patient Experience (ADPE) advised the Committee that she would take the paper as read. The IEND thanked the ADPE and her team for the sustained over 80% response rate for Patient Concerns. The CC agreed and noted that exemplary work being undertaken under the most challenging circumstances should be celebrated and to be able to maintain over 80% was very good. **The QSE Committee resolved that:** a) The contents of the assurance report were noted. b) The mitigation being taken to ensure a person-centered approach.to improve quality, safety and experience and reduce harm was noted.	
QSE 22/06/015	**Committee Effectiveness Survey Results 2021-2022** The Committee Effectiveness Survey Results 2021-2022 were received. The Head of Corporate Governance (HCG) advised the Committee that for 2021/22 the audience of who received the survey had been widened. She added that she was pleased to report that the survey results did not identify any areas of improvement for the Committee and the results would be fed into the Annual Report. The IMU advised the Committee that the way in which the Committee self-evaluated with the current tool was not the richest or most valuable way of evaluating what was being done as a Committee because he could recall writing qualitative comments which were not captured in the graphs displayed within the result. The Vice Chair of the Health Board (VCHB) agreed and noted that there were much better methods to capture Committee effectiveness which would be looked at. The HCG advised the Committee that plans were in motion to replace the current methodology with a new and more appropriate one.	

	The QSE Committee resolved that: a) The results of the Annual Board Effectiveness Survey 2021-2022, relating to the Quality, Safety and Experience Committee were noted.	
QSE 22/06/016	**Exception Reports (Verbal)** The Exception Reports (Verbal) were received. The EMD advised the Committee that there was nothing formal to raise but noted ongoing concerns around the "front door" which was resulting in long lengths of stay for Patients. The IEND commented that there was a lot of work ongoing and advised the Committee that the Executives had done a focussed piece of work which included an action plan and that it was an ongoing piece of work. The ICOO advised the Committee that a significant amount of work was being undertaken across the whole system and alongside colleagues at the Welsh Ambulance Service Trust (WAST). **The QSE Committee resolved that:** a) The Exception Reports were noted.	
QSE 22/06/017	**WHSSC Quality Committee – Chairs Report** The WHSSC Quality Committee – Chair's Report was received. The Vice Chair of the Health Board (VCHB) advised the Committee that it was felt that whilst the Quality and Patient Safety Committee at WHSSC reported into the WHSSC Joint Committee it was not necessarily being brought to the Health Board. He added that it gave Members an opportunity to be made aware of the processes involved. The CC thanked the VCHB for the report and noted that it connected and aligned with the Quality and Safety National Framework. **The QSE Committee resolved that:** a) The WHSSC Quality Committee – Chair's Report was noted.	
QSE 22/06/018	**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 Assistant Director of Patient Experience (ADPE) advised the Committee that action logs from each sub Committee were being looked at. The COCHC advised the Committee that it was difficult to read some of the minutes as each template was different. The ADPE noted that a standard template could be provided to all sub-Committees moving forward. The Senior Corporate Governance Officer made a note to send the template out.	

	The Committee resolved that: a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	**NS**
QSE 22/06/019	**Corporate Risk Register** The Corporate Risk Register was received. The HCB advised the Committee he would take the report as read and noted that questions had been raised throughout the meeting in relation to risk management. He added that it was recognised that there was a considerable amount of training planned on the Risk Management System which had been suspended due to Covid-19 and Winter pressures but noted that momentum on the work would now continue. The COCHC noted that some of the risks were identified as “ongoing” or “in progress” and asked that clarity be given on future registers so that the general public would be able to read the register and understand that the risks were being dealt with. **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 was noted.	
QSE 22/06/020	**Items to bring to the attention of the Board / Committee**	
QSE 22/06/021	**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 22/06/022	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: Tuesday, 30 August 2022	

Action Log

Quality, Safety & Experience Committee

Update for meeting 30 August 2022
(Following the meeting held on 15 June 2022)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 22/04/007	**Quality, Safety and Experience Implications arising from IMTP**	Waiting for KPIs to be received from WG. Once received, they would be brought back to the QSE Committee along with a quarterly report on milestones.	**30.08.2022**	Jason Roberts	**COMPLETED** Scheduled for the QSE meeting in August 2022. Item 2.5
QSE 22/06/006	**Clinical Diagnostics & Therapies Clinical Board Assurance Report**	The Head of Corporate Business to provide a summary in relation to the risk items that had been discussed under this agenda item and ensure that the same are added to the Corporate Risk Register.	**28.07.2022**	Nicola Foreman/ Tim Davies	**COMPLETED** Relevant risk was placed on the July 22 Corporate Risk Register and presented to July's Board**.**
QSE 22/06/010	**HIW Activity Overview Report**	The Chair requested that this report would include monitoring outcomes as well as any recommendations made by HIW.	**30.08.2022**	Jason Roberts	**COMPLETED** On the agenda for August's Committee (see agenda item 2.3)
QSE 22/06/012	**Dental Services - CHC inspection report**	A copy of the CHC inspection report relating to Dental Services is to be presented to the Committee	**30.08.2022**	Jason Roberts	**COMPLETED** On the agenda for August's Committee (see agenda item 2.4.3).
QSE 22/06/018	**Clinical Board QSE Sub Committee minutes**	The Corporate Governance officer to circulate the standard minutes	**30.08.2022**	Nathan Saunders	**COMPLETED** Templates circulated 01.08.22

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
		and action log templates to the QSE sub committees			
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.	**29.11.22**	Meriel Jenney/Sue Bailey	**Update by 29 November 2022**
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 by 29 November 2022.**
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 by 29 November 2022.**
QSE 22/06/010	**HIW Activity Overview**	HIW Report from visit to Stroke Centre	**29.11.2022**	Jason Roberts	**Update by 29 November 2022**
QSE 22/06/010	**HIW Activity Overview**	Committee to receive copy of the HIW Report regarding Cardiothoracic services	**29.11.2022**	Jason Roberts	**Update by 29 November 2022**
Actions referred to Board / Committees					
QSE 22/06/008 **QSE 22/02/008**	Items to bring to the attention of the **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	29 November 2022	Jason Roberts/ Nicola Foreman	**Update by 29 November 2022** Original Board Development Session date of 25 August has been postponed. Committee to be updated by 29 November 2022 with a new provisional date when this item can

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
					be brought to a Board Development Session 2022/23
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	Meriel Jenney/Nicola Foreman	**Completed** On the Board Development Session arranged for 25 August 2022 (see agenda item 2)

Report Title:	Primary, Community & Intermediate Care (PCIC) Clinical Board Assurance Report			Agenda Item no.	2.1
Meeting:	Quality, Safety & Experience Committee	Public		Meeting Date:	30 August 2022
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Director of Nursing, PCIC				

Main Report
Background and current situation:

The primary assurance bodies in PCIC are the Clinical Board and the Quality, Safety and Experience Group (QSE); each meets in alternate months. QSE minutes are submitted to the Corporate QSE meeting for oversight. In turn, the PCIC QSE receives summary reports from Quality and Safety meetings which are held in each individual Business Unit, also in alternate months. Assurance on Information Governance is gained via the PCIC Information Governance Group which meets 3 times per year. Risk is also included in the Operational Performance Meetings (undertaken monthly) with each Business Unit.

In relation to independent contractors, practice and/or practitioner performance is managed against the National Health Service (Performers Lists) (Wales) Regulations 2004 (as amended), the NHS Wales Act 2006 and the Medical Profession (Responsible Officer) Regulations 2010, supported by the GMC Good Medical Practice and GDC Standards for the Dental Team. For practitioner performance, a collaborative, formative approach is the preferred option but a number of sanctions can be imposed ranging from reflections to be reported during appraisal, re-training and restrictions on practice up to and including suspension and removal from the Medical or Dental Performers List. Practice performance is also mapped against the contractual elements required for each commissioned service.

Work has been undertaken to develop one PCIC Clinical Board Risk Register (from the previously separate QSE and corporate risk registers), this was to avoid duplication and ensure greater focus on the key risks. 'Deep dives' have also been introduced (usually on a 6-8 weekly basis) where risks are reviewed in detail by the Director of Operations, Director of Nursing, Deputy Clinical Board Director/Governance Director.

Work has also recently commenced to develop a core information set and specific measures that can be reviewed within PCIC Clinical Board and also form part of the assurance assessment undertaken through the Executive Performance Reviews. Information from the following sources is likely to be included as part of this assurance:

- Patient Experience
- Education and Learning Reports
- National Reportable Incidents investigations and Action Plans
- Clinical Negligence Claims
- Information Governance Reports
- Health and Safety Reports
- Internal Audit
- External Audit and reviews

This paper has been developed around the themes in the Health and Care Standards.

Safe Care

Incidents
There are three nationally reportable incidents currently open. One relates to the prison, another to an unexpected child death and the third to a diabetic eye problem.

There are currently 291 open Datix incidents within the Clinical Board. Lead nurses continue to support their district nursing teams in ensuring DATIX incidents are reviewed within 7 days to reduce the risk of harm events not being actioned. The PCIC QSE team is undertaking monthly scrutiny of all open Datix incidents to support the timely management and appropriate allocation of incidents. Superusers for each business unit have been identified and training is being provided.

Interface Incidents

In May and June there have been 38 interface incidents submitted via the web-based form reported from Primary care GP Practices. The main themes are: -

- GPs being asked to follow up on patients after discharge from hospital.
- Secondary Care doctors asking GPs to arrange investigations following outpatient clinic appointments.
- GPs being asked to provide fit notes/med3 following secondary care treatment/investigation.

The introduction of the new Datix system in March 2022 has added additional work for our QSE team and currently there has not been the ability to properly interrogate and draw down meaningful data to identify key themes and risk areas within the new system. The QSE team has made the software easier for GPs to raise Datix incidents and there is a dedicated member of staff in the Vale who co-ordinates GP incidents, particularly ambulance delays in the community (ADC) and interface incidents. PCIC is also leading on a national piece of work regarding GP mitigations for ADC.

Pressure Ulcers

The Datix Cymru system was successfully rolled out on 1 March 2022. For May and June 2022 there have been 279 reported pressure damage incidents, of which 197 have been investigated and closed. Pressure ulcer scrutiny panels supported by Patient Safety and our Tissue Viability team continue to meet weekly to discuss category 3 and 4 pressure ulcers and to determine whether they are avoidable or unavoidable. This scrutiny process has been identified as an exemplar of good practice across the Health Board and the senior lead and wound care specialist nurse, who have led on the process, have been shortlisted for an RCN nurse of the year award.
Out of 45 incidents during May and June, 4 were deemed to have been avoidable.

Infection prevention and control

There have been 2 Root Cause Analyses (RCA) for Clostridium difficile in May and June 2022. There have been 9 cases to investigate since commencement of the process in February 2022. These have been disseminated to the GP practices for action.

Acute Response Team
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 has been taken to suspend all new anticoagulation referrals into the service from secondary care. Interim arrangements are currently in place for other Clinical Boards to retain the dosing and prescribing responsibility until the patient is stabilised and can safely be transferred over to and accepted by Primary Care.

Effective Care

To help provide further assurance regarding effective care there is ongoing work to commence clinical audits in hand hygiene, fridge temperature monitoring and resuscitation equipment. Audits will be undertaken in three areas in the next few months which will include the Department of Sexual Health, Cardiff and Vale Health Inclusion Service and HMP Cardiff.

District Nursing (DN)
All DN teams have been reporting escalation 3 level and occasionally level 4 for a number of months. Staffing has been managed across the teams depending on the level of risk. Recruitment remains challenging, however there are 11 new student streamlining staff due to commence in September. In addition to this, we have successfully recruited six band 4 Assistant practitioners with enhanced competencies to join our localities. PCIC is one of the first Clinical Boards to introduce this role, which will be a real asset to our DN teams. This new role will be evaluated over the next three years.

Dignified Care

PCIC is achieving excellent performance with the response to complaints, with the July data showing 95% of complaints were responded to within 30 days (compared to a target of 80%). Currently there are 6 active concerns within PCIC. The key themes from concerns across PCIC relate to access to NHS Dentist and waiting times and the quality of care provided to patients.

Individual Care

Safeguarding

There are currently 11 open health cases of which 6 are pressure damage. There are 5 professional concerns currently ongoing within PCIC. All senior nurses have attended health lead professional training so are able to support the lead nurses in management of safeguarding.

Compliments

Some of the recent compliments received relate to 3 compliments to the community dental service, including the Designed 2 Smile team supporting a young autistic boy and the session provided at the Huggard Centre where the team provided advice and information for homeless people.

There was also a compliment from the family of a gentleman in HMP Cardiff. The family said “HMP Cardiff Healthcare unit has been the best place that he has ever been placed. Staff have made a real difference by ensuring there is a therapeutic relationship and that they understand his needs, despite the challenging situation. Prison officers have been exceptional and wanted you to be aware of the positive impact they are having for him.”

Key Risks

The current key risks include:

Workforce
This relates to the impact of insufficient staffing across various teams to be able to manage and deliver services, mainly due to increased demand or due to staff absences/vacancies. There has been a significant increase in demand for the CAVHIS due to the Afghan and Ukrainian refugees, pressure on the community teams (CRT and VCRS) due to staffing across health and social care and the increase in the number of hospital discharges to support, there has also been an increase in demand for the CAV24/7 OOHs service (although staffing pressures for this team are not as challenging).

Action taken or planned – we have been deploying staff across teams to mitigate risk, reviewing staffing models and seeking to recruit on both permanent and time limited basis. Intermediate care services are under review and a more efficient model is planned in order to ensure a more seamless referral process, assessment and subsequent pathway for patients. This will support a reduction in duplication of calls, a more generic, skills-based approach and an efficient allocation of our workforce to maximise capacity.

GMS Sustainability
There is significant pressure on GMS and also other independent contractors. We have seen 2 contract resignations from GP practices this year which has taken significant resource to manage and ensure patients were allocated to other practices in the area. There are also a number of practices that have been regularly reporting high escalation levels for significant periods of time (this increased to just under 25% of practices reporting pressures at some points but in the main has been around 12-18% of practices).
Action taken or planned - there has been significant support from the primary care team to work with practices to actively manage the contract resignations and ensure patients were able to access services from other practices close to their home. There has also been funding to support practices to recruit additional staff and to improve buildings for more clinical space to see the patients transferred from the practice closures. We have also increased capacity within the team including clinical and administrative support to be able to actively work with practices and avoid/minimize the risk of other closures. The primary care team has undertaken visits to the 10 practices deemed to be most at risk due to sustainability issues. This risk has been escalated at a national level and the Director of Operations, PCIC (on behalf of Directors of Primary Care) has chaired a sustainability workshop with Welsh Government and other national bodies to find solutions. This national work is ongoing.

Dental services
Whilst we have not had any general dental contracts handed back (as has been the case in other Health Boards), there is growing concern in this area due to the backlog in demand (as practices were operating at 40-50% of activity during the Covid period due to the need to follow IPC guidance) and the requirements of the national dental contract. Activity has increased to 60% of pre-Covid activity (based on the July data). 73% of practices have signed up to contract reform which means there is a requirement for new patients to be taken on which should provide sufficient capacity to address the current waiting list, although uncertain over what period this will be achieved).
There is significant pressure on the community dental service due to a high number of staff vacancies (where there is a national recruitment issue) and the suitability of some of our premises. The current activity is around 33% of pre-Covid.
Action taken or planned - proactive work with general dental practices to reduce the waiting lists. Work is being undertaken to validate the central waiting list (which is currently around 13,000 although some of these will be duplicates, or will have been taken on by a practice). The risk has been issued at a national level and it is likely there will be similar national work undertaken (as is currently the case for GMS sustainability). Various recruitment exercises for community dental although these have not been successful. Estates colleagues are seeking to identify alternative premises so capacity can be increased.

Complex packages of care
There is a risk of breakdown in the sustainability of complex packages of care for people who require specialist support as there are a limited number of agencies in Cardiff and the Vale. There are also challenges in the domiciliary care sector so agencies are unable to take on packages and we have also seen packages being handed back to local authorities. This in turn is putting significant pressure on our community teams and could result in people having to be placed in residential care, being admitted or unable to be discharged from hospital.
Action taken or planned – there is regular contact with individuals and care providers to identify any risks at an early stage, to enable the identification of contingency plans in the event of a breakdown in the package of care provided. There is also proactive work to develop relationships with new providers. However, more work is needed with statutory partners to support increased resilience in

the domiciliary care market, as well as developing a better range of alternative supported housing models locally.

Estates
There are a number of specific components within this risk. One relates to the GMS risks where current practices do not own their premises and therefore their leases could be terminated (this was the case with 1 of the practice closures and there are a small number of other GP practices also in this position where the landlord is looking to sell the premises). There has also been a high-profile public case where some local residents are not supportive of plans to relocate the Pentyrch branch surgery to a new build site in Rhydlafar. This resulted in a referral by the Community Health Council to the Minister, however this referral was not supported by the Minister. There is a potential risk of judicial review. This has taken significant staff time to manage and therefore has distracted from the ability to progress support to other practices with sustainability issues.
There are risks associated with the capacity of the PCIC team to plan and ensure delivery of the Health and Wellbeing Centres and Wellbeing Hubs. There is significant pressure on the three locality teams (the SE Locality has the additional demand due to the Afghan and Ukraine refugees, the NW Cardiff and Vale Localities have the pressure of additional demand on services, to support the increased hospital discharges as well as the national work on 1,000 beds)
Action taken or planned – we have appointed to additional posts within the primary care team to provide additional capacity to manage the sustainability issues and other GMS risks. In relation to capacity for the locality teams we have tried to recruit project support but have been unsuccessful on a number of occasions. Work is ongoing to try and secure resource from some of the corporate teams with planning, programme/ project management capacity.

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

- The teams across PCIC continue to work exceptionally hard to ensure the delivery of safe, effective care. It has been particularly challenging for the community teams due to the significant pressures due to increased demand and staffing shortages. The teams have worked flexibility and have been deployed to other areas to help mitigate risks.
- There has been significant pressure on the primary care team due to the GMS sustainability issues. There are now increased risks in dental services and further action will need to be taken to secure additional staff and suitable premises.
- There have unfortunately been some deaths in HMP Cardiff. To improve integrated working across general and mental health teams working within the prison a new Head of Healthcare post has been established. All deaths within the prison are investigated under the NRI, HIW and the Public Services Ombudsman with any lessons learned being subject to action plans monitored via QS&E.
- The Covid testing and immunisation teams continue to deliver against all national requirements and more than 1,300,000 vaccines have been delivered. We will be commencing the Autumn boosters from 1 September. There has been an internal audit of the immunisation delivery and reasonable assurance was received.
- The Health and Social Care (Quality and Engagement) (Wales) Act 2020 will be required to be implemented from Spring 2023 and will 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. The Act applies to both managed and commissioned services which adds greater complexity to effective implementation within PCIC
- The Medical Examiner Service is due to be fully implemented for all non-coronial deaths (in hospital and in the community) from April 2023. Local implementation arrangements for the Mortality Review process (which is triggered when further queries are raised about a death by the Medical Examiner) are being developed in line with the Mortality Review Model Framework issued by the Delivery Unit in July 2021.

Recommendation:
The Board / Committee are requested to: Note the current position and also the actions taken since the previous report to strengthen assurance and manage risks within PCIC Clinical Board.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	X	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
Risks are highlighted in the main report.
Safety: Yes
Safety issues and action taken or planned is included in the main report.
Financial: No
This report does not have specific finance implications.
Workforce: Yes
Workforce issues and associated actions are included in the main report.
Legal: No
There are no legal implications.
Reputational: Yes
There could be reputational implications if risks are not appropriately managed but this report includes action taken or planned in order to mitigate this.
Socio Economic: Yes
The actions taken or planned referenced in this report relate to the provision of services and how they can be improved. There are a range of services provided by PCIC which aim to improve access or quality of services for more vulnerable groups e.g. prison services, community dental services .
Equality and Health: No
No requirement as a result of this report for an EHIA to be undertaken.
Decarbonisation: No
Not applicable in relation to the content of this report.

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

Report Title:	Quality Indicators – Progress Report				Agenda Item no.	2.2	
Meeting:	QSE		Public	✓	Meeting Date:	30/08/2022	
			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. To enable this, work has been undertaken with the Information Department to develop a QSE dashboard.

This paper provides an overview of current performance against those quality indicators that are available within the dashboard. We have also included some Covid related specific measurements in this report.

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 the Autumn of 2022.

Concerns

Increasing numbers per month - up to 446.

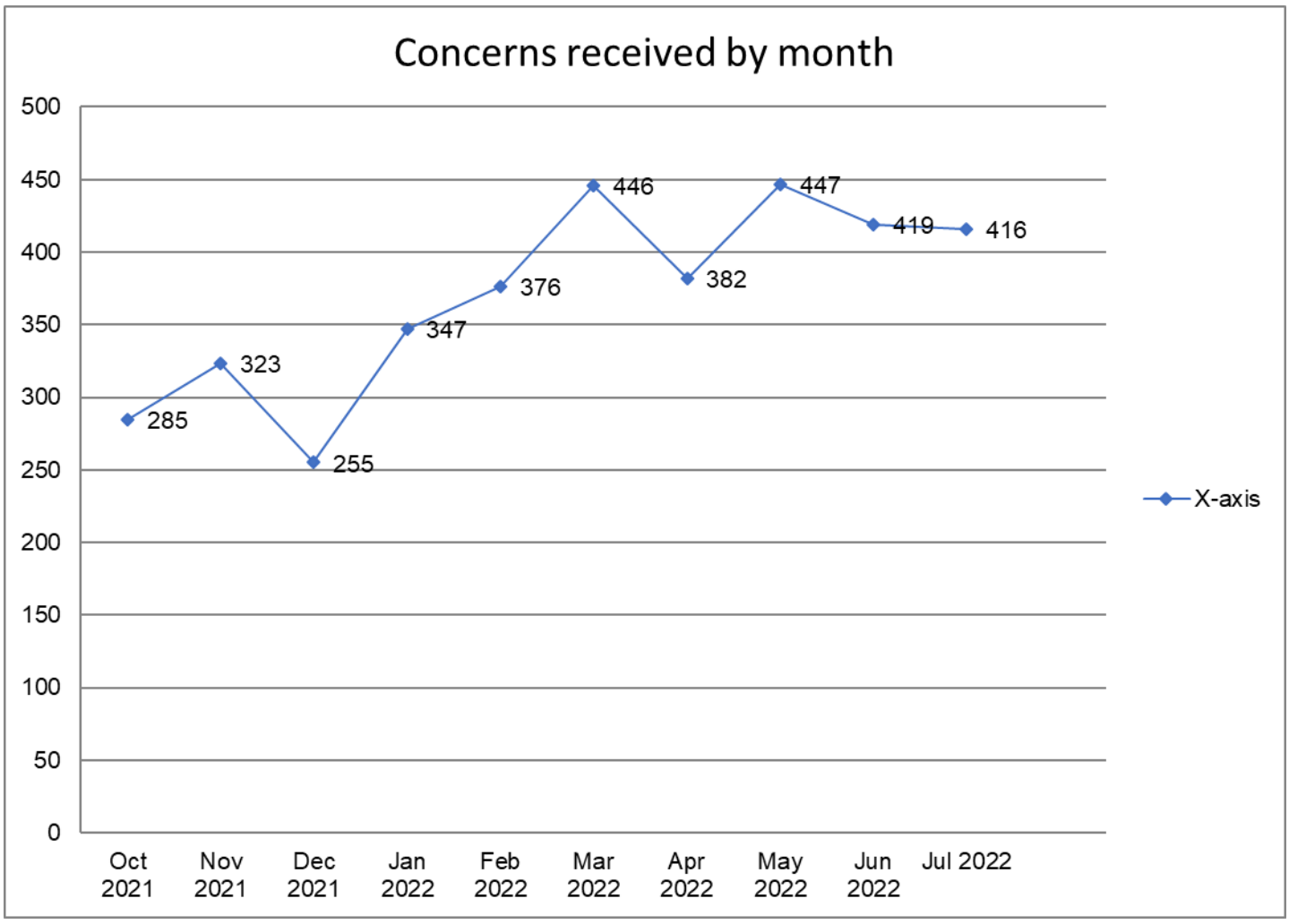
In order to support Clinical Boards, the central Concerns Team are processing as many concerns under early resolution as possible and this has maintained an overall 30 working day response time for all concerns, which remain consistent at 82%.

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

The main themes remain as waiting times, communication and concerns.

We have proactively worked with Clinical Boards to advise people on waiting lists of current waiting times and shared information on prehab to rehabilitation e.g. smoking cessation, diet control - we

provided a telephone number in the Concerns Team for people to phone us if they needed information regarding waiting lists etc.



As a quality indicator, the numbers of concerns referred to and subsequently investigated by the Ombudsman remains very low. From 1st April 2022, we have dealt with 37 Ombudsman's cases, the breakdown is as follows:

15 - Currently under investigation

11 - Decision not to investigate

5 - Voluntary settlements

6 - Information requests

The cases are spread across the Clinical Boards as follows:

5 in Mental Health Clinical Board
7 in Surgery Clinical Board
9 in Medicine Clinical Board
7 in Children and Women Clinical Board
7 in Specialist Clinical Board
2 in Primary Care and Intermediate Clinical Board

The annual letter demonstrated that our process of early engagement, listening to people who raise concerns and always offering a meeting to discuss the response and address any outstanding issues, is in line with the Ombudsman's' model for complaints handling policy and with the Putting Things Right (PTR) regulations.

Below are the details from the recent Ombudsman annual review for 2021/2022:

Appendix A - Complaints made to PSOW

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	142	0.24
Betsi Cadwaladr University Health Board	213	0.30
Cardiff and Vale University Health Board	89	0.18
Cwm Taf Morgannwg University Health Board	113	0.25
Hywel Dda University Health Board	88	0.23
Powys Teaching Health Board	10	0.08
Swansea Bay University Health Board	110	0.28
Total	765	0.24

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/ Voluntary Settlement	Discontinued	Other Reports Not Upheld	Other Reports Upheld	Public Interest Report	Total
Cardiff and Vale University Health Board	23	7	30	11	1	2	6	1	**81**
% share	28%	9%	37%	14%	1%	2%	7%	1%	

Nationally Reportable Incident (NRI) reported

NRI Improvement Trajectory

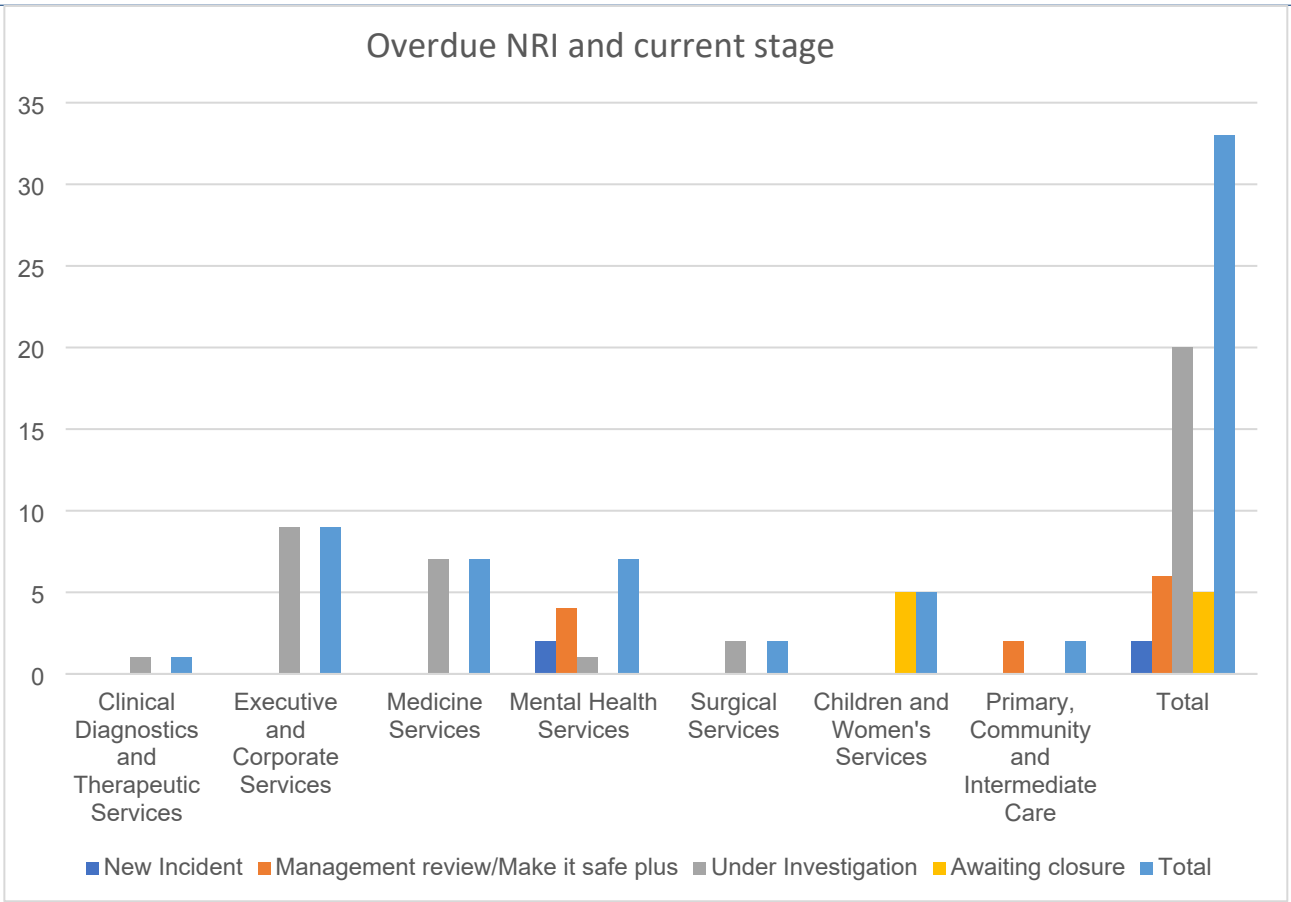
There is a backlog with NRI closure forms and we have developed an improvement trajectory to see a sustained improvement in the closure of cases whilst maintaining the quality investigations and the learning/improvement plans.

This trajectory demonstrates an improved position than we were in some months ago. We had 110 open NRIs with 79 overdue. We are working with Clinical Boards and have put in some processes, challenge and targets.

On the 9th August we had 64 open NRIs with 32 overdue and the graph demonstrates the stages where each NRI is within the closure process.

It should be noted that as an Organisation we encourage a reporting culture and due to activity, we will report higher numbers but the percentage of overdue NRI closures from activity may be a more equitable measure.

On the trajectory, we will aim to be under 10 by the end of October 2022.

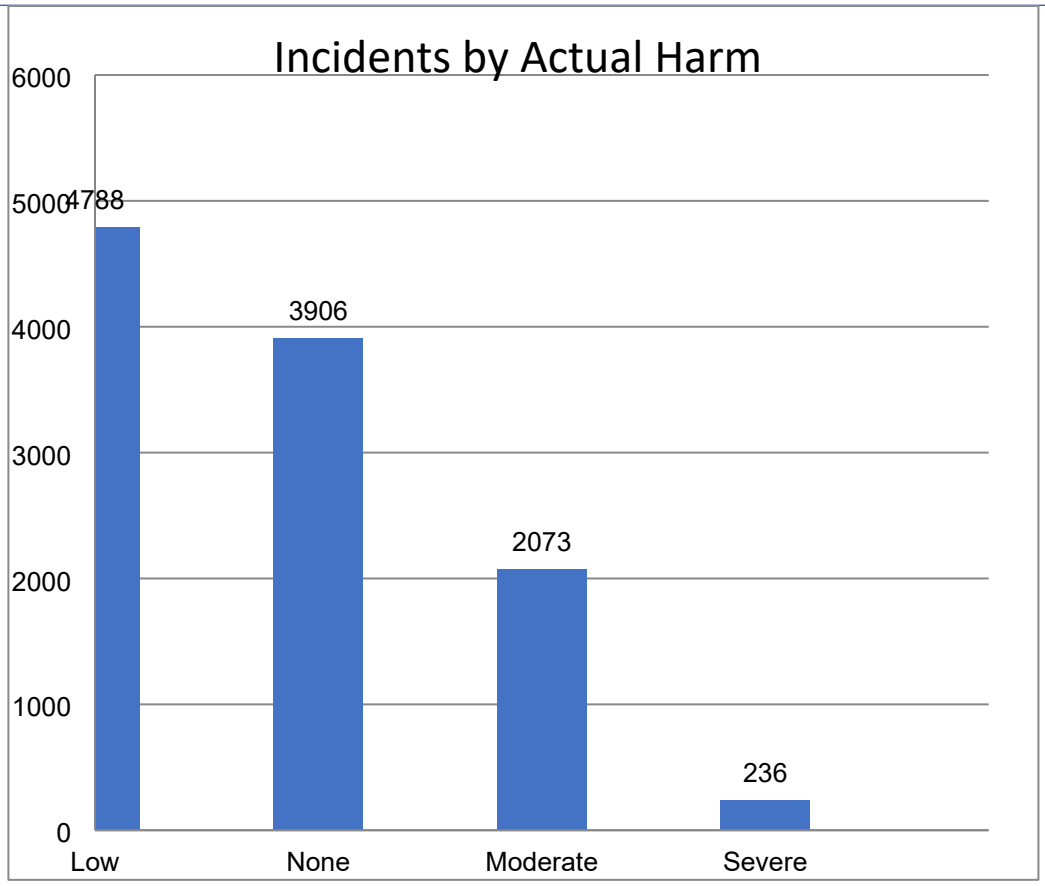


Our culture needs to be, that overdue is by exception and the not expectation. However, this is an area where we need to continue the focus and the plan is in place.

We have, with both complaints and claims, ensured we have a robust performance process in place with understanding of how we measure the quality as well as the performance – however, getting performance right enables us to have the time to focus upon the quality and learning.

On average, Cardiff and Vale report more than 26,000 patient safety incidents a year.

Based upon the current Incident system, active since March 2022 (with open cases migrated to the system), there are 2309 incidents with harm graded as moderate and 2% of the overall incidents graded as severe.



Slips, Trips and Falls continue to be the most commonly reported incident – 16% of all incidents reported since 1st March 2022. Of these, the majority have no or low harm (87% of falls). 11% were reported with moderate harm, 2% with severe harm and 0.001% with catastrophic harm.

Learning from inpatient fall investigations has identified the following factors:

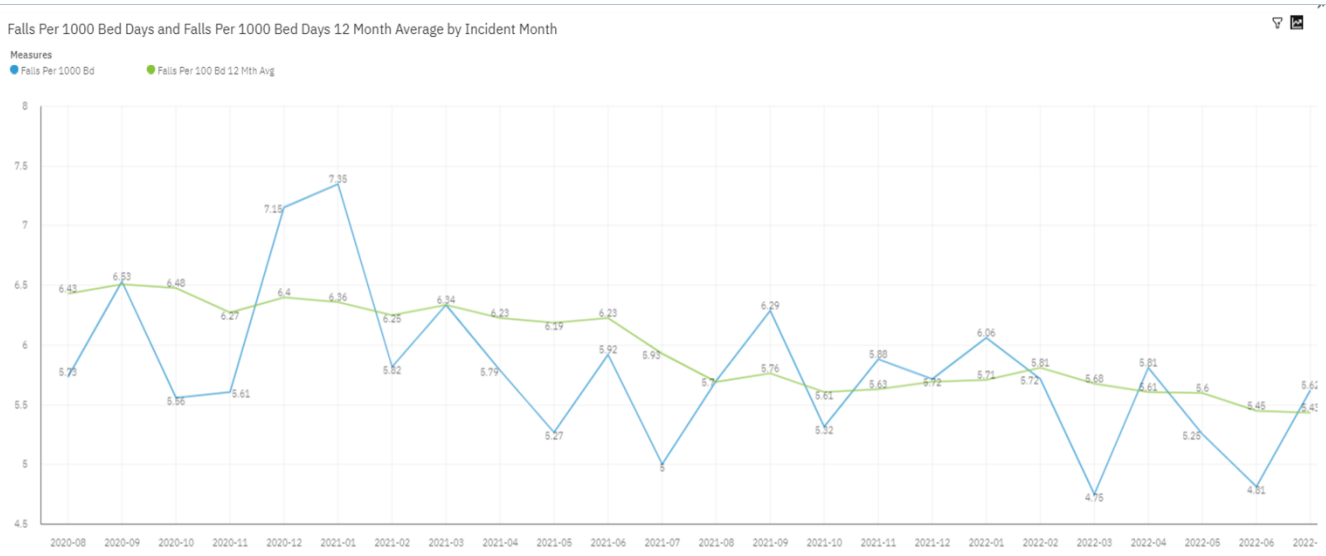
- Lack of knowledge of guidance
- Deviation from guidance
- Need for Training

Three main themes:

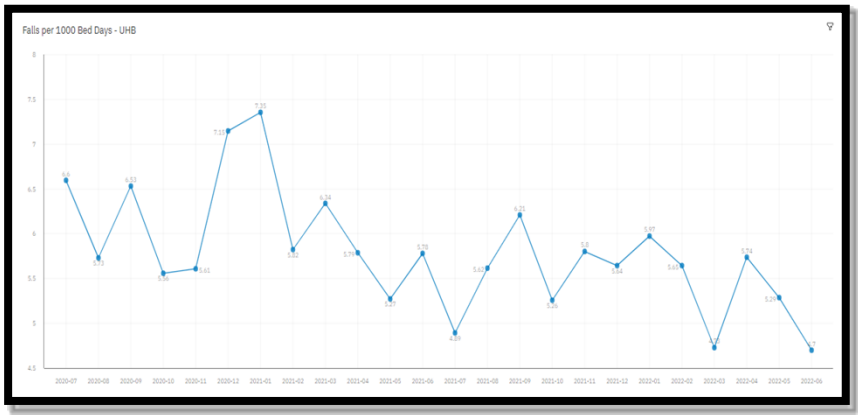
- Lack of Orthostatic Hypotension Assessment (L&S BP)
- MFRA not completed at correct times
- Lack of (evidence of) Medication Review
- Deviation from bed rails and enhanced supervision guidance

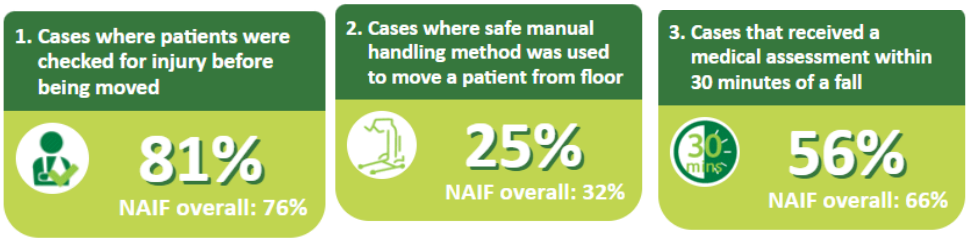
Falls group is established and working through the quality improvement around the learning. We are currently in the recruitment process for the Fall Lead for the organisation.

Fractured Neck of Femurs continue to be the most commonly reported injury post-fall.



Falls per 1000 bed days July 21-22



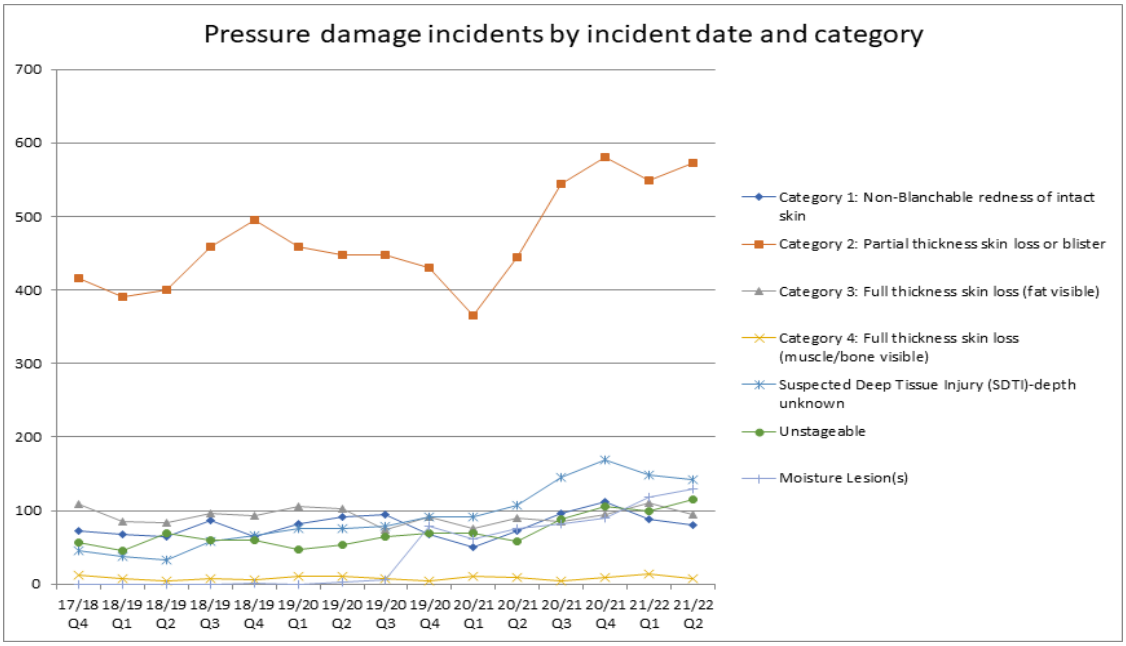


All inpatient falls resulting in a serious injury are subject to review to understand if there were any factors that could have prevented the fall.

The aim is in line with the Health Board strategy to prevent admission and keep people safe in their community, to this effect various initiatives with other providers are in progress.

- Community initiatives to provide tailored advice on how to maintain strength, balance and general health
- Research work underway to assess the efficacy of virtual clinics
- Extension of the WAST / C&V falls pick up project with an aim of avoid unnecessary admission to hospital

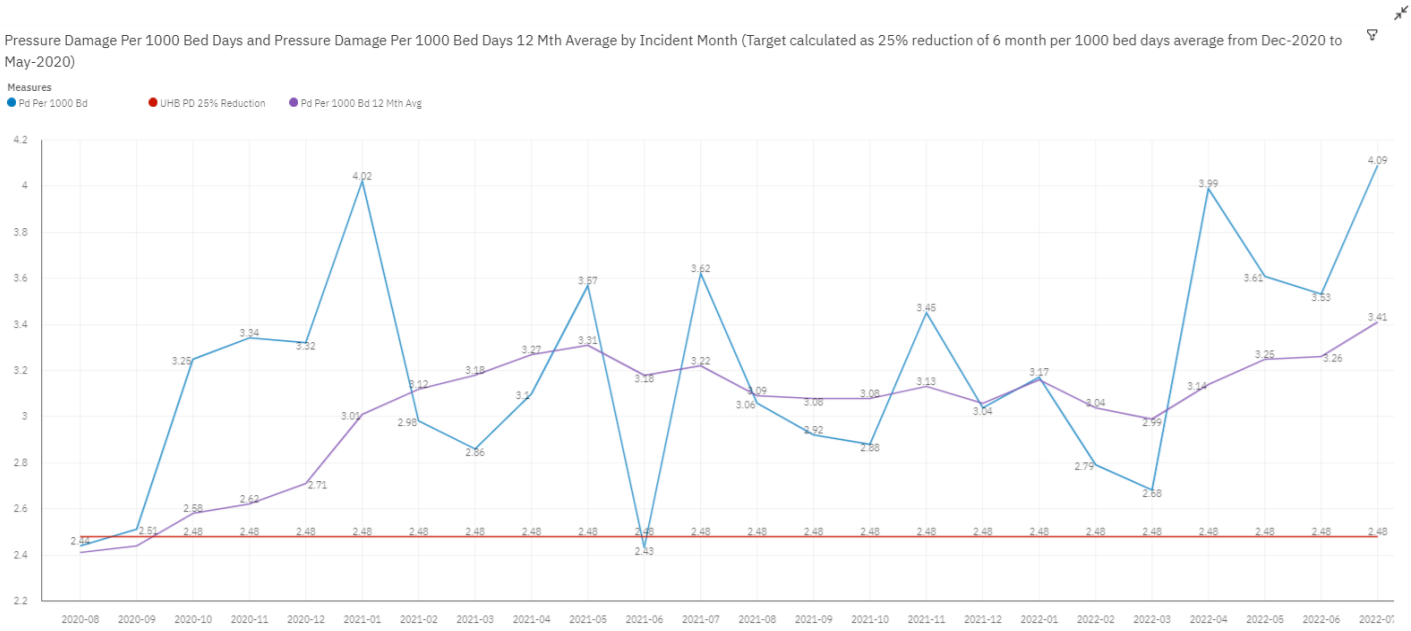
Pressure Damage

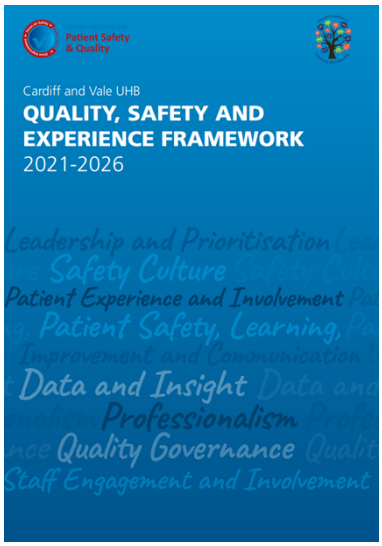


Whilst most cases of pressure ulcers remain in the lower category it is known that a grade 3 or 4 pressure ulcers increased significantly the risk of morbidity and mortality.

- The Cardiff and Vale UHB Pressure Damage group was re-established as a collaborative in 2022 to progress a number of quality improvement initiatives. The collaborative, reports directly to the QSE committee.

The aim of the collaborative, is to demonstrate a reduction in avoidable pressure ulcer cases - this will be achieved through education and training and having validated data that can drive improvement and experience.





We realised that we needed a shift in our approach. Traditionally, we have focused on things that go wrong and of course this is important and something we will always be committed to. 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.

The Quality and Safety team are now mature enough to move away from traditional 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.

We believe that in focusing on these 8 key priorities, we can aspire to provide safe, effective services that deliver excellent user experience, equal to the best healthcare organisations in the world.

These 8 key areas are:

- Safety culture
- Leadership and the prioritisation of QSE
- Patient Experience and Involvement

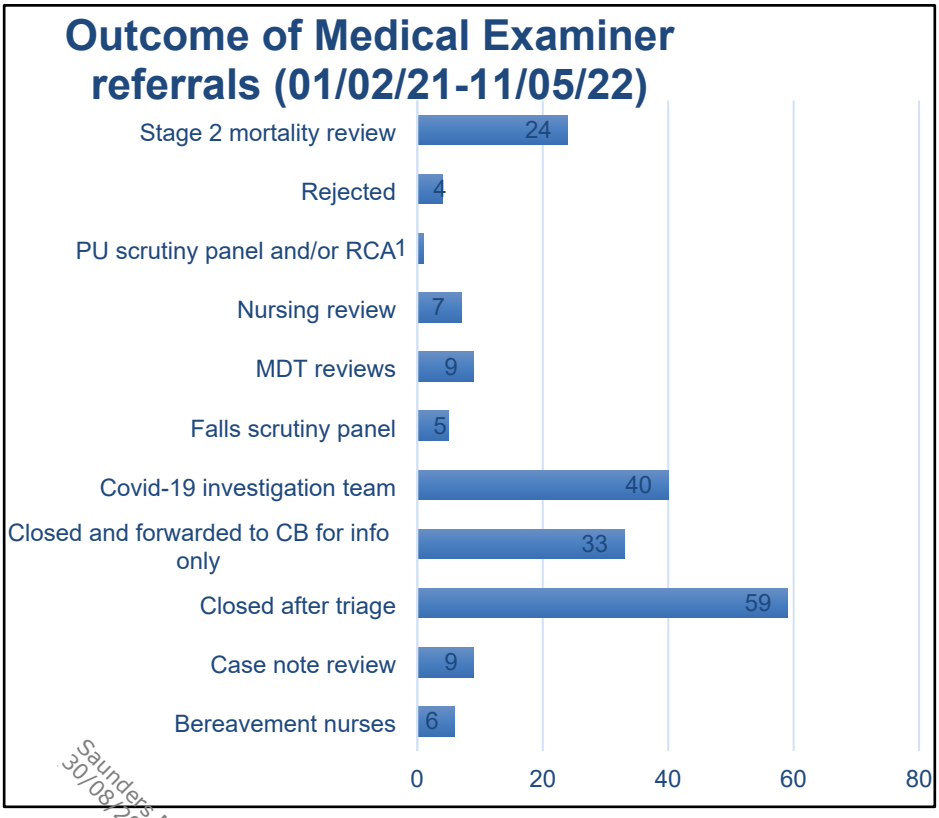
- Patient Safety Learning and Communication
- Staff Engagement and Involvement
- Data and Insight
- Professionalism of QSE
- Quality Governance arrangements

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 which will meet in quarter 3.

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.



The Medical Examiner started reviewing inpatient deaths in early 2021 and by next year will review all deaths that occur in hospital and in the community. This service provides independent scrutiny and supports the wider All Wales learning. The Associate Medical Director for Quality and Safety, leads the mortality workstream and engages closely with the Medical Examiner 's work

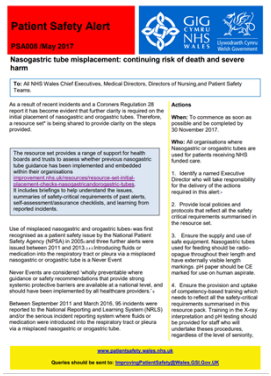
In addition, we are developing a Learning from Death Framework: that draws on information and data from multiple sources, including National Audit, Business Intelligence, the Medical Examiner Mortality and Morbidity reviews and Inquests.

The service is currently reviewing approximately 60% of inpatient deaths in Cardiff and Vale UHB. The Medical Examiner discusses the care of the deceased with the next of kin, to ensure their concerns are captured and addressed.

Where any concerns are identified, the next of kin is advised of the concerns process or with their consent the concerns are shared with the Concerns Team, to ensure that all issues are thoroughly investigated and any learning is captured.

Compliance with Patient Safety Notices - PSN

We remain in a position of non-declaration of compliance with 2 PSNs but as you can see below, both have been progressed and we should be in a position of compliance in the next few months.


Patient Safety Alert
PSA008 /May 2017
Nasogastric tube misplacement: continuing risk of death and severe harm

PSA008 Nasogastric Tube Misplacement: continuing risk of death and severe harm

- Procurement of Avanos pH strip confirmed
- Training resources including posters QR codes to videos and intranet pages under development
- All community patients identified to provide training
- 3rd October remove all old pH strip and introduce Avanos.


Patient Safety Alert
PSA012 / April 2021
Deterioration due to rapid offload of pleural effusion fluid from chest drains

PSA012 Deterioration due to rapid offload of pleural effusion fluid from chest drains

- Pleural pathway developed by the respiratory team
- C&V pleural chest drain locSSIPs under development
- Refresh of UHB NatSSIPs group
- A pleural pathway is currently being developed along with a LocSSips and this will support governance in non-specialty areas e.g. ITU theatres
- There are plans to roll out education to all general staff around the bundle
- A health board policy is under development that be clearly articulate the British Thoracic Society standards and will ensure all additional LocSSiPs are compliant

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.

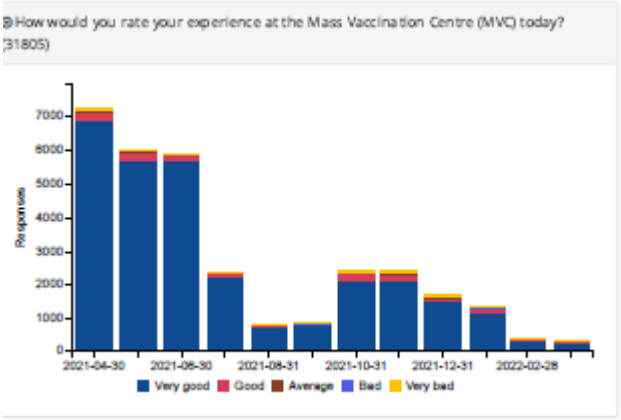
CAVUHB HCAI Reduction Expectation Position – 2022/23

1. Organism	2. Max no. to achieve the required reduction	3. No. to end of July	4. % difference to the equivalent period 2021/22	5. UHB position - FY rate (1st = lowest)
6. C difficile	7. 126	8. 47	9. ↓ 8%	10. 2nd
11. SAUR (MRSA/MSSA)	12. 100	13. 50	14. ↑19%	15. 3rd
16. E. coli bacteraemia	17. 338	18. 114	19. ↑5%	20. 2nd
21. Klebsiella sp. bacteraemia	22. 100	23. 29	24. ↓33%	25. 5th
26. P. Aeruginosa bacteraemia	27. 27	28. 9	29. ↑29%	30. 5th

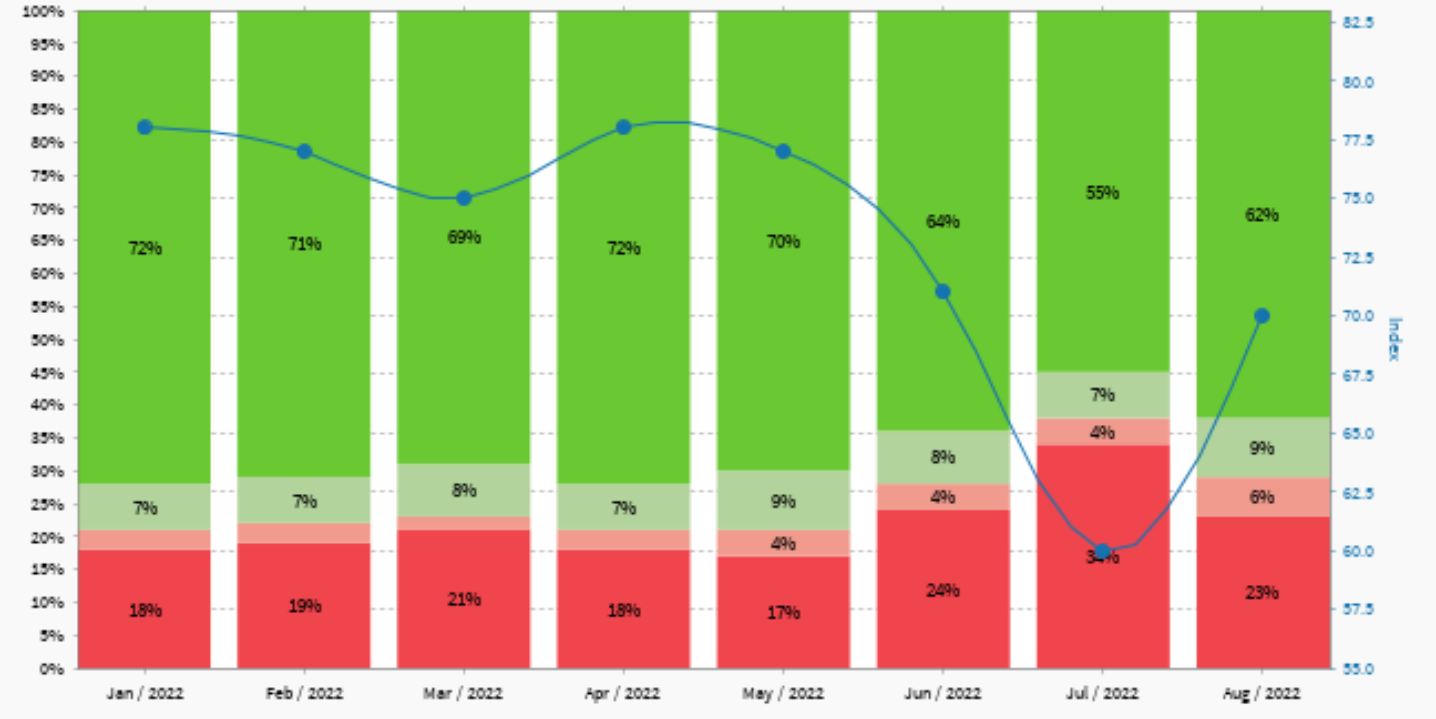
Actions to progress the improvement trajectory

- 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 standardise 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

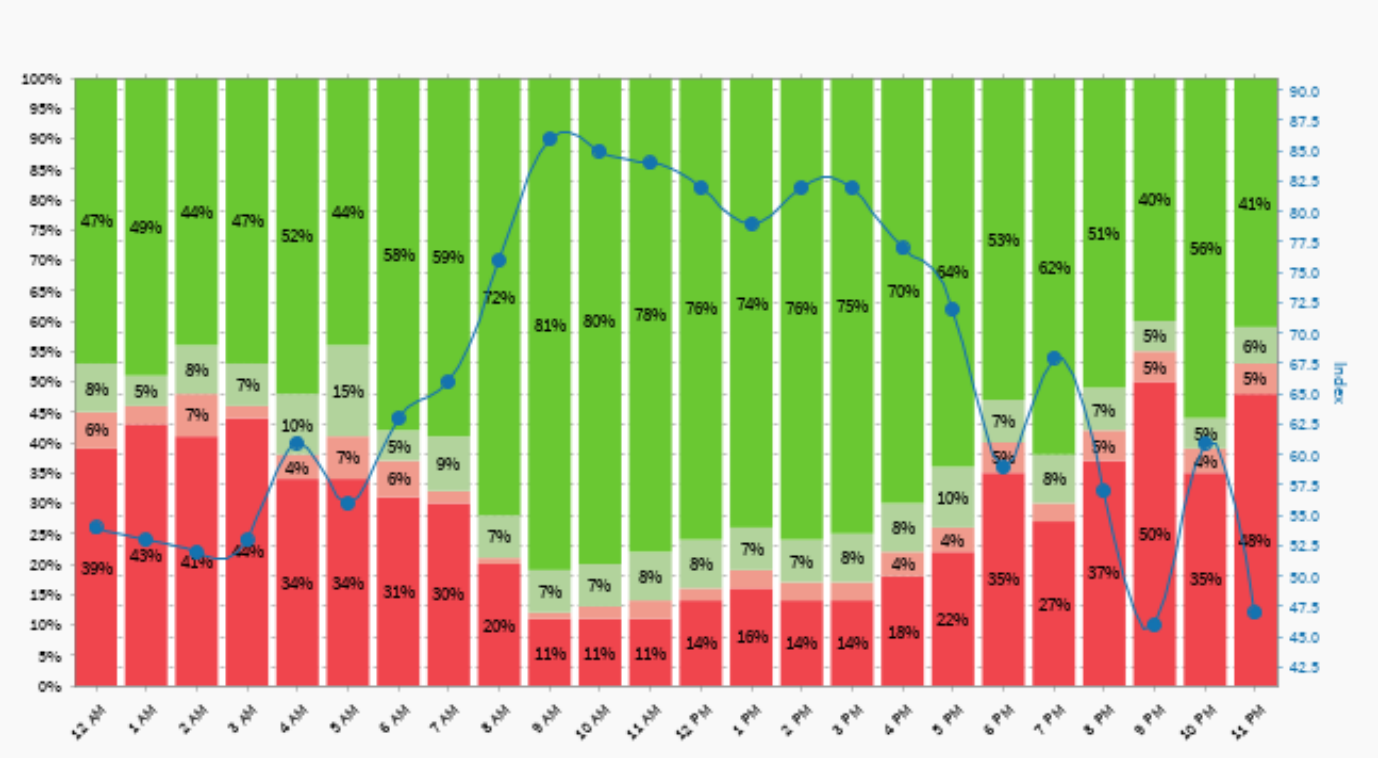
Feedback



- Over 31,000 people used our feedback machines in the Mass vaccination Centres - 98% rated their care as very good/good.
- In 2022 we have used our Happy or Not kiosks.
- We receive approximately 2,500 responses per month



It is also evident that overnight the experiences score much lower from – 10pm to 7am



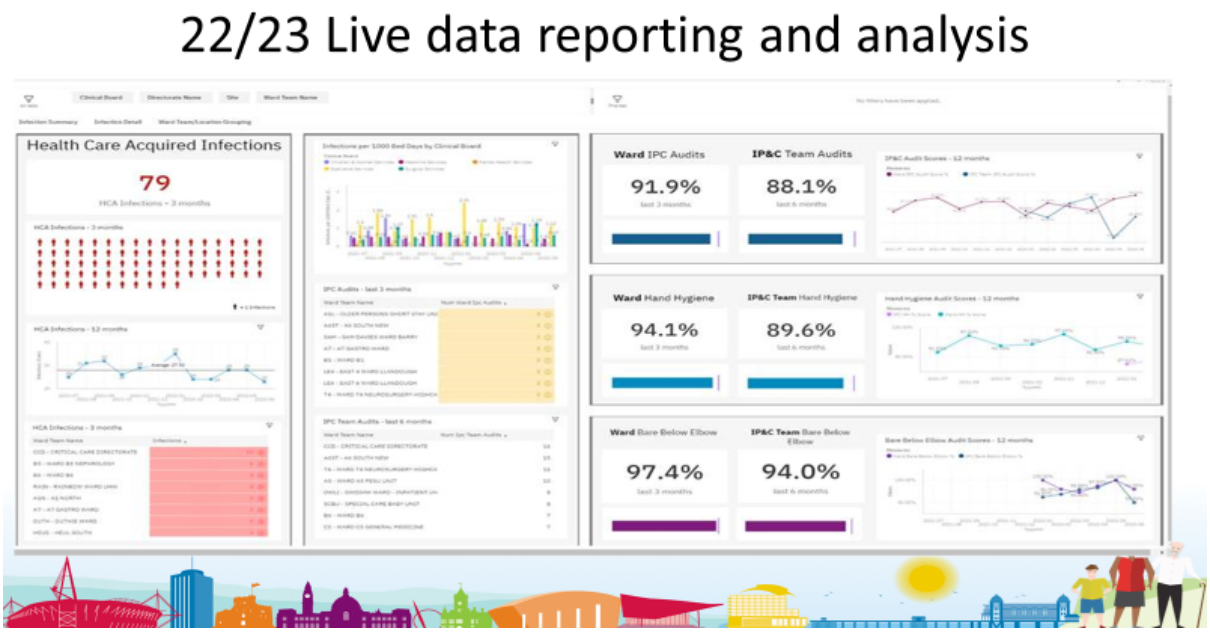
Preparation for Duty of Candour and the Duty of Quality

We are currently working on staff awareness and the organisational preparedness for implementation of Duty of Candour (DOC). We have established a steering group to commence in September, with several task and finish groups to ensure we are organisationally ready for the implementation of the DOC.

Through implementation of our framework, we wish to address 3 simple questions:

- **Are we safe?**
- **Are we delivering high quality care and excellent outcomes?**
- **Are the people who use our services getting a great experience?**

The vision will be live data reporting of the quality metrics



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
30/08/2022 11:22:01

<table>
<tr><td>Report Title:</td><td colspan="4">Healthcare Inspectorate Wales Activity</td><td>Agenda Item no.</td><td colspan="2">2.3</td></tr>
<tr><td rowspan="2">Meeting:</td><td colspan="2" rowspan="2">Quality, Safety & Experience Committee</td><td>Public</td><td></td><td rowspan="2">Meeting Date:</td><td colspan="2" rowspan="2">30 August 2022</td></tr>
<tr><td>Private</td><td></td></tr>
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(please tick one only):</td><td>Assurance</td><td>X</td><td>Approval</td><td></td><td colspan="2">Information</td><td></td></tr>
<tr><td>Lead Executive:</td><td colspan="7">Jason Roberts, Executive Nurse Director</td></tr>
<tr><td>Report Author (Title):</td><td colspan="7">Angharad Oyler, Head of Quality Assurance and Clinical Effectiveness and James Rugg Primary Care Support Manager</td></tr>
</table>

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

All General Practices and General Dental Services / Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local CHC. The HIW inspections result in an Action Plan which is assessed and followed up on by HIW. The UHB then ensures ongoing compliance with the outcomes of the inspection.

Since the start of the Covid-19 pandemic HIW visits have taken place remotely in the form of a Covid-19 "Quality Check" for both GMS and GDS. The following information was also provided:

"HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focused on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance"

Due to the de-escalation of COVID-19 measures in NHS Wales, HIW have confirmed that they intend to return to on-site inspections for GMS and GDS for 2022/23. Recently published GDS reports have been a mixture of the Covid-19 "Quality Check", and the pre-Covid "Inspection Report" format. There is yet to be a GMS visit that follow the "Inspection Report" format.

A HIW publication schedule is available on www.hiw.org.uk :

Unannounced Inspections

Cardiothoracic services – UHL – Unannounced Visit

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Cardiac Surgery Ward (West 6) at the University Hospital Llandough, on the 1 and 2 March 2022. HIW explored how the service met the Health and Care Standards (2015). No immediate concerns were identified.

Overall, HIW found evidence that the service provided safe and effective care. Staff were focused on care of the patients and patients felt well cared for and looked after. Patients shared that they held staff in very high esteem and felt supported by staff interventions. HIW observed positive interactions between staff and patients supporting patients in a dignified and respectful way.

Staff were maintaining skilled and compassionate care in challenging circumstances. Staff were cheerful and welcoming during our inspection, there appeared to be good leadership which reflected in patient care.

There were areas identified that required improvement:

- The general layout and security of the ward to improve visibility of patients and storage of equipment and items
- Ensuring the resuscitation trolley is available at all times, unobstructed and conveniently located on the ward
- Mandatory training and appraisal compliance. Ensure that there is a process in place to share and discuss errors and near misses with staff ideally in ward meetings and documented.
- Patient information boards to display audit results and information for patients regarding raising concerns. And information boards with patient identifiable information are bot accessible in patient /public areas

An improvement plan was submitted to HIW to address the issues identified and all actions are now complete with the exception of the transition of cardiac surgical services back to UHW. Work is underway with Capital Estates to support this action. The full report and action plan are available on the Health Care Inspectorate Wales website www.hiw.org.uk :

Emergency unit and Assessment Unit UHW – Unannounced visit

An unannounced visit took place in EU at UHW on the 20th, 21st and 22nd of June. The report is yet to be published.

Update on Thematic Reviews

Review of patient Safety, Privacy, Dignity and Experience Whilst Waiting in Ambulances During Delayed Handover - UPDATE

The report was published in October 2021 and found that the issue of prolonged handover delays is a regular occurrence outside Emergency Departments (ED) across Wales. The review found that overall, handover processes at EDs across Wales are broadly similar; some variations exist in processes between individual EDs within Health Board areas. Whilst WAST has developed clear systems, which identify risks, provide mitigation and escalate concerns, it was clear that the systems alone are not enough and more collaborative work between WAST and Health Boards is required to resolve the issue of prolonged handover delays.

A HIW task and finish group: Fundamentals of Care Workshop took place on the 23 of June 2022.

Progress of the HIW review action plan is included in Appendix **1**

Primary Care Contractor Reviews

The responsibility for responding to recommendations made following HIW reviews lies with the independent contractor.

The Primary Care Team undertakes a review of each practice report and any potential actions for follow-up including concerns raised or immediate assurance requirements. These are followed up to gain assurance the necessary improvement has been made and sustained.

General Dental Services:

During this reporting period there have been five HIW reports received by the Primary Care Team all of which are available on the Health Care Inspectorate wales website.

Alison Jones Practice
Report available on the Healthcare Inspectorate Wales Website www.hiw.org.uk :

HIW undertook a remote quality check of Alison Jones Dental Practice and made the following recommendations:

- Information is displayed encouraging patients to communicate and receive information through the medium of welsh
- Consider obtaining a hearing loop to support patients with hearing loss.
- To maintain an audit log of PPE stocks
- Implement regular
- Fridge temperature checks

Charles Street Dental Surgery
Report available on the Healthcare Inspectorate Wales Website www.hiw.org.uk :

HIW undertook a remote quality check of Charles Street Dental Surgery and made one recommendation:

- Nominated practice staff receive refresher training in first aid and fire safety.

St Mellons Dental Practice
Report available on the Healthcare Inspectorate Wales Website www.hiw.org.uk :

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of St Mellons Dental and made one recommendation:

- The statement of purpose and the patient information leaflet should be published on the practice website

Cyncoed Dental Practice
The report and action are not yet published on the HIW website; however, recommendations were made in relation to:

- Review of suggestion box feedback
- Radiographs are reported on and there is consistent grading of radiographs and BPEs documented in patient notes
- Review of the practice programme of audits
- Provision of brief intervention training in smoking cessation to all dentists

Tongwynlais Dental Practice
Report available on the Healthcare Inspectorate Wales Websitewww.hiw.org.uk :

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Tongwynlais Dental Practice.

- No areas for improvement were noted

Primary Care continuously monitor the implementation of the requisite improvements undertaken to address recommendations made by HIW to ensure the necessary progress.

General Medical Services:

There have been two GMS HIW report received by the Primary Care Team during this reporting period.

Llandaff and Pentyrch Surgeries
Report available on the Healthcare Inspectorate Wales Website www.hiw.org.uk :

This report is a positive one, and describes the processes that have been put in place during the Covid-19 pandemic and refers to good planning and compliance with guidance. HIW make no recommendations for improvements.

Brynderwen Surgery
Report available on the Healthcare Inspectorate Wales Website www.hiw.org.uk :

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Brynderwen Surgery as part of its programme of assurance work. Brynderwen Surgery have confirmed that they have completed the actions suggested by HIW, and await a formal response to conclude the inspection process.

The Primary Care Team have received no concerns raised, or immediate assurance requirements in relation to GMS practices since during this reporting period.

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

Monitoring of HIW Activity within Cardiff and Vale UHB

The Health Board has procured AMaT (Audit tracking and Monitoring System) which is a central web based management system for quality assurance activity. The system has a multitude of functionality and modules, one of which is an inspections module. The system has been used in England with CQC inspections and can be utilised similarly for HIW inspections.

Current processes focus on completion of immediate improvements identified but it is acknowledged that capturing the progress and completion of all action plans across the UHB is challenging. It is recognized that a more robust approach is required to fulfil quality assurance requirements.

Implementation of AMaT will support a robust process, providing oversight of all Improvement plans from HIW inspections. It is expected that this will generate increased workload for clinical boards and the corporate function, and a review of impact and required resource will need to take place in due course to ensure that achievability.

There are currently preliminary discussions occurring on an All Wales basis with AMaT users regarding the potential increased functionality and capability of AMaT to achieve direct secure communication with HIW. This would require agreement of All NHS organisations in Wales. Further information on the limitations and benefits will be shared will be shared in due course.

HIW Strategic Plan 2022-2025

HIW have published their Strategic plan for 2022-2025. The strategy focuses on the learning that has taken place over the past 3 years, and in particular during the pandemic. Full publication available on the Health Care Inspectorate Wales Website www.hiw.org.uk :

HIW Operational Plan 2022-23

HIW launched their Operational Plan 2022-2023 in June 2022. The plan outlines the actions they aim to take to achieve their new priorities, which were set in the Cardiff and Vale UHB Strategic Plan 2022-2025. These are:

- Focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- Adapt their approach to ensure we are responsive to emerging risks to patient safety
- Work collaboratively to drive system and service improvement within healthcare
- Support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Recommendation:

The Committee is requested to:

- **NOTE** the level of HIW activity across a broad range of services.
- **Note** the assurance provided by the improvements implemented and by the processes to monitor and audit the improvements
- **AGREE** that the appropriate processes are in place to address and monitor the 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	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
30/08/2022 11:22:01

Management response action plan for Welsh Ambulance Service Trust local review: Review of Patient Experience whilst Waiting in Ambulances during Delayed Handover

Review Recommendations		
Recommendation 1		
Health boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.		
Action	**Responsible Officer**	**Timescale**
ED Initiatives • **The Onboarding Process** The flow co-ordinator and the controller of ED together will identify a patient to move to a ward where there has been a discharge confirmed for later that day. This initiative is to expedite handovers for patients who have remained on the back of an ambulance for over 2 hours. **This will be reviewed in Monthly meetings.**	**Interim Head of Operations for Patient flow**	**Complete**
• **The Full Capacity Protocol (FCP)** developed by the health board in April 2022, this process is specifically designed to create resuscitation capacity for a critically unwell patient. This may be an ASHICE from WAST or self-presenting patient to the ED. Both processes have been implemented successfully and have been enacted on a number of occasions in recent months. Following an activation of the FCP protocol a debrief is undertaken to identify challenges and further learning.	**Lead Nurse and Directorate Manager for EU**	**Complete**
• **Escalation Cards:** ED have developed escalation cards to support a standardised approach to managing risk associated with capacity and patient flow. Two hourly safety		

huddles are implemented to oversee patient flow, and the ED physician and controller attend to discuss pressures and actions to be completed in the next two hours. These actions are intended to support Ambulance offloads and patient flow.	**Lead Nurse and Directorate Manager for EU**	**Complete**
• A weekly ED board and monthly Quality and Safety meetings are implemented to monitor risk associated with the FCP and Onboarding process.		
• There is a well developed at home programme which includes the development of intermediate care services including admission avoidance as well as the development of out of hospital support and services (at home programme)	**Head of Integrated care**	**Completed**
• Creation of Intermediate care beds for step-up step-down to expedite discharges and avoid admissions (1000 beds programme)	**Head of Integrated care**	**October 2022**
• A Joint action plan has been developed in partnership with the two Local Authorities the Health Board which focuses on increasing domiciliary care capacity and also developing residential reablement capacity within the independent sector (1000 beds programme)	**Head of Integrated care**	**October 2022**
• Senior managers in community and primary care and the Head of Integrated Care meet regularly to discuss flow and capacity issues in residential homes and Primary and Community Care.	**Head of Integrated care**	**Complete**

• An audit has been undertaken by the Delivery Unit to review the discharge process in UHW and UHL and this will inform an action plan.	**Delivery Unit**	**September 2022**
Recommendation 2		
WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and emergency department staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.		
Action	**Responsible Officer**	**Timescale**
• Cardiff and vale ED have an allocated member of staff who has responsibility for inputting the Health Board component of the dual pin process. • The OPAT team have developed a business case and are reviewing existing job descriptions to support the implementation of a Hospital Ambulance Liaison Officer (HALO) whose responsibilities will include completion of the WAST component of the dual pin process.	**Interim Head of Operations for Patient flow**	**November 2022**
Recommendation 3		
Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.		
Action	**Responsible Officer**	**Timescale**
• **Dedicated reception facility for WAST** are in place to ensure minimal delay in access to booking patients into the hospital. • **Dedicated Major Assessment Nurse (MAN)** is based at the front door and is responsible for receiving handover of patients arriving via WAST. The MAN is responsible in identifying suitable patients to offload into an ambulatory care area or stream into an appropriate clinical space. The MAN is also responsible for maintaining	**Interim Head of Operations for Patient flow**	**Complete**

the Ambulance Handover Screen. The MAN works with WAST to ensure dual pin is achieved in a timely manner. • **Band 7 Senior Controller** is appointed to oversee and manage capacity and flow to ensure the Welsh Government Measures are being achieved. It is the Senior Controller's responsibility to escalate if these measures are at risk of not being met.		
Recommendation 4		
Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.		
Action	**Responsible Officer**	**Timescale**
• An Appendix B standard operating procedure has been developed to support the joint investigations of patient safety incidents between WAST and C&V UHB. The aim of the process is: a) To establish the WAST, ED and site position at the time of each incident b) To establish if the incident fit the criteria for reporting as a Nationally Reportable Incident c) To establish if there is any learning identified to be shared more widely across C&V UHB eg with Primary Care	**Assistant Director of Quality and Patient Safety**	**Complete**
The Health Board will engage in the All Wales appendix b task and finish group	**Executive Director of Nursing**	**August 2022**
Recommendation 5		
If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.		
Action	**Responsible Officer**	**Timescale**
	Directorate Manager	**complete**

• Standard Operating Procedures are shared at the fortnightly silver operations meetings and where significant amendments have been made to existing SoP's these are also reported at the WAST and CAV monthly strategic meetings.		
Recommendation 6		
WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.		
Action	**Responsible Officer**	**Timescale**
• It is the role of the Majors Assessment Nurse (MAN) to inform the patient of the anticipated wait and clinical plans and to ensure that they are kept updated. • WAST colleagues liaise with the families of patients to ensure they are updated where the patient does not have capacity to do so. • The British Red Cross and Patient Experience Team based in ED have two WiFi phones and facilitate contact between the patients and their relatives • Complaints and patient experience information is considered at monthly quality and safety meetings and weekly ED board meeting to capture emerging themes relating to patient and experience and communication.	**Lead Nurse for ED**	**Complete**
Recommendation 7		
WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.		
Action	**Responsible Officer**	**Timescale**
• ED are working closely with the Patient Experience Team. • Once admitted into the hospital patients have access to 'Happy or Not' devices across the directorate. These devices allow patients and visitors to provide a quick response or alternatively there is an option to provide written feedback.	**Lead Nurse for EU**	**Complete**

• Feedback from the 'Happy or Not' machines is provided weekly and provides real time data that evidences variation in patient experience throughout the day. This used to inform EU Improvement work. This is also discussed at the directorate's monthly performance meetings under the QSE agenda • Posters are displayed in EU to encourage patients and their families to provide feedback using a QR code. • Volunteers and Patient Experience Support Workers are based in EU to collate real time feedback. • If patients wish to raise concerns in line with the C&V UHB Concerns process, senior management will aim to resolves concerns through early resolution or where necessary provide a more in-depth response formally.		
• The implementation of CIVICA platform will allow further scrutiny of patient experience data and support analysis of any group of patients including those whose handover has been delayed	**Assistant Director of Patient Experience**	**October 2022**
• Patient experience data and information is considered at weekly ED board and Quality and Safety meetings. To explore emerging themes	**Lead Nurse for ED**	**Complete**
Recommendation 8		
WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.		
Action	**Responsible Officer**	**Timescale**
• Patients are assessed by the MAN on arrival to ED and patients who are identified as clinically high risk are admitted into the department without delay to ensure timely investigations and treatment	**Lead Nurse for EU**	**Complete**

• WAST will undertake regular observations and escalate concerns to the MAN as required. • In March 2022 an onboarding protocol was developed to support the proactive movement out of the ED department and onto wards wherever possible to support handover of patients waiting on ambulances • The Full Capacity Protocol (FCP) was developed by the Health Board in April 2022, this process is specifically designed to create resuscitation capacity for a critically unwell patient • All patient safety incidents relating to patients held for prolonged periods on the back of ambulances are reviewed and themes considered in the monthly quality and safety meetings		

Recommendation 9		
Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.		
Action	**Responsible Officer**	**Timescale**
• WAST are able to access to toilets within the Emergency and Acute Medicine footprint for those patients that are able to mobilise with assistance. • For those patients that are unable to mobilise and require assistance, the MAN will assist in toileting, ensuring that this is completed in a private and dignified manner. Personal care will be completed by the nursing staff if required.	**Lead Nurse for EU**	**Complete**

• Patient experience feedback will be monitored through the monthly the Quality and Safety meetings		
Recommendation 10		
During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.		
Action	**Responsible Officer**	**Timescale**
• The MAN will identify those patients that are at risk of pressure damage and undertake a Waterlow assessment. • Development of an SoP to establish a standardised response to bringing patients into the department in response to the Waterlow Score	**Lead Nurse for ED**	**October 2022**
Recommendation 11		
WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.		
Action	**Responsible Officer**	**Timescale**
• The Red Cross Team support with the nutrition and hydration needs of patients both on the back of ambulances and throughout the ED department. • A record of nutritional and fluid input provided to patients cared for on the back of ambulance is maintained by the Red Cross Team Patients are provided with sandwiches, hot soup and drinks during meals times and snack and water in between • Nutrition and hydration audits are performed on a regular basis and are discussed in Monthly meetings with dietetics and catering. • Dietetic Support workers were introduced into EU from April 2022 to support patients at mealtimes with a plan to roll out further.	**Lead Nurse for ED**	**Complete**
Recommendation 12		

WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.		
Action	**Responsible Officer**	**Timescale**
• The MAN will aim to provide appropriate hygiene requirements to patients that require assistance. Patients are taken to designated room on EU and hygiene care is provided by nursing staff. • A protocol for care of patients on the back of ambulances has been developed to ensure that patients arriving by ambulance receive efficient and safe care. This is a joint protocol between the Emergency Medicine Directorate (EMD) and the Welsh Ambulance Service Trust (WAST) • In the event of reduced capacity within EU, resulting in patients waiting on an ambulance the protocols outlined below are to ensure that high standards of patient care and safety are maintained.	**Lead Nurse for EU**	**Complete**
Recommendation 13		
WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.		
Action	**Responsible Officer**	**Timescale**
• As in Recommendation 13 there is a joint protocol has been developed to ensure clarity on roles and responsibilities between EU and WAST whilst the patient is cared for on the Ambulance outside EU • The role of the MAN has clear responsibilities in relation to responsibilities. • The lead Nurse for EU will undertake a review of one set of notes each week to ensure compliance with the protocol and will provide feedback to the monthly quality and safety meeting on the outcomes of that review	**Lead Nurse for EU**	**Complete**
Recommendation 13		

WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.		
Action	**Responsible Officer**	**Timescale**
• There is a health board process to assess staffing risks across the Organisation on a daily basis and to movie staff to mitigate risk as required. • Nurse staffing remains on the ED risk register, every directorate is reported into a central nurse staffing forum, Directors of Nursing risk assess the staffing levels daily at the Directors of Nurse Staffing meeting and evaluate the risks across the UHB and initiate movement of staff from lower to higher risk areas. • Shortfalls in nurse staffing are backfilled by to temporary staffing and the skill mix is considered to backfill with health care support workers where RN posts cannot be filled. • EU have recently recruited 59 staff nurses into 62 vacancies • The Emergency and Acute Medicine Department reports its workforce position on a weekly basis at the directorate's operational meeting, and then clarifies that position along with ongoing plans and recurring recruitment themes at a monthly Directorate Performance Reviews. • There are a number of initiatives to support staff recruitment and retention: - a) Rolling band five advert b) over recruitment above establishment to support sickness levels c) Recruitment events d) Wellbeing support weekly in the department	**Lead Nurse EU**	**Complete**

Report Title:	**South Glamorgan Community Health Council Activity Review**			Agenda Item no.	**2.4**
Meeting:	**Quality, Safety & Experience Committee**	Public	x	Meeting Date:	**30/08/2022**
		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 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:

- Ward B1 Cardiology, UHW - CHC Visit Final Report (**Appendix 2).**
- Lakeside Wing, UHW - CHC Final Report (**Appendix 3).**
- Stroke Rehabilitation Unit, UHL - CHC Final Report (**Appendix 4).**

The main themes highlighted by the reports include:

- 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 Lakeside Wing report also cited concerns regarding low staffing levels and potential impact to patient care and experience.

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 Q1 and Q2, the full reports are within **Appendix 5** to this report.

- NHS Pharmacy Services in Cardiff and the Vale of Glamorgan
- Patient Experience Report of Cardiac Services in Cardiff and the Vale of Glamorgan
- NHS Dental Services Availability in Cardiff and the Vale of Glamorgan
- Accessing NHS Eye Care Services in Cardiff and the Vale of Glamorgan
- Sensory Loss Patient Experience when Accessing NHS Healthcare
- LGBTQ+ and access Healthcare.

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 **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

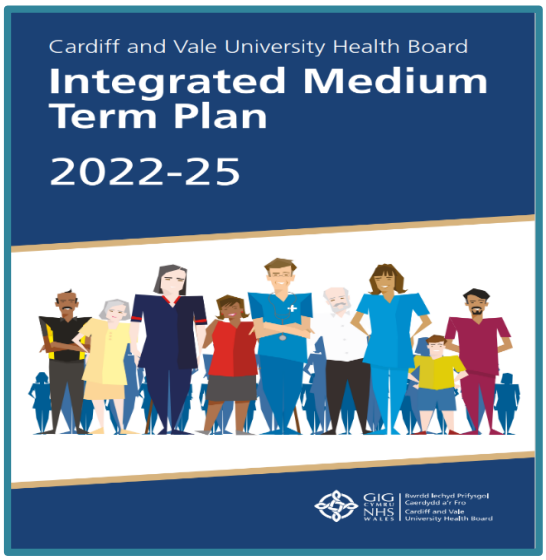
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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:	Quality, Safety and Experience Implications arising from IMTP					Agenda Item no.	2.5
Meeting:	QSE		Public	✓		Meeting Date:	30/08/2022
			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:



QSE is a golden thread throughout the IMTP

The essence of our planning is about improving the lives of the communities we serve and supporting people to have the same chance of leading a healthy life, regardless of their background or circumstances.

The ten strategic objectives of Shaping our Future Wellbeing

The IMTP continues to articulate the delivery of our long-term strategy Shaping Our Future Wellbeing (SOFW) (http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/10%20-%20UHB%20Shaping%20Our%20Future%20Wellbeing%20Strategy%20Final.pdf) and its ten strategic objectives. These objectives remain our well-being objectives, with a focus on long-term thinking, prevention, working with partner organisations and engaging with our residents and service users.

Recognition of golden threads

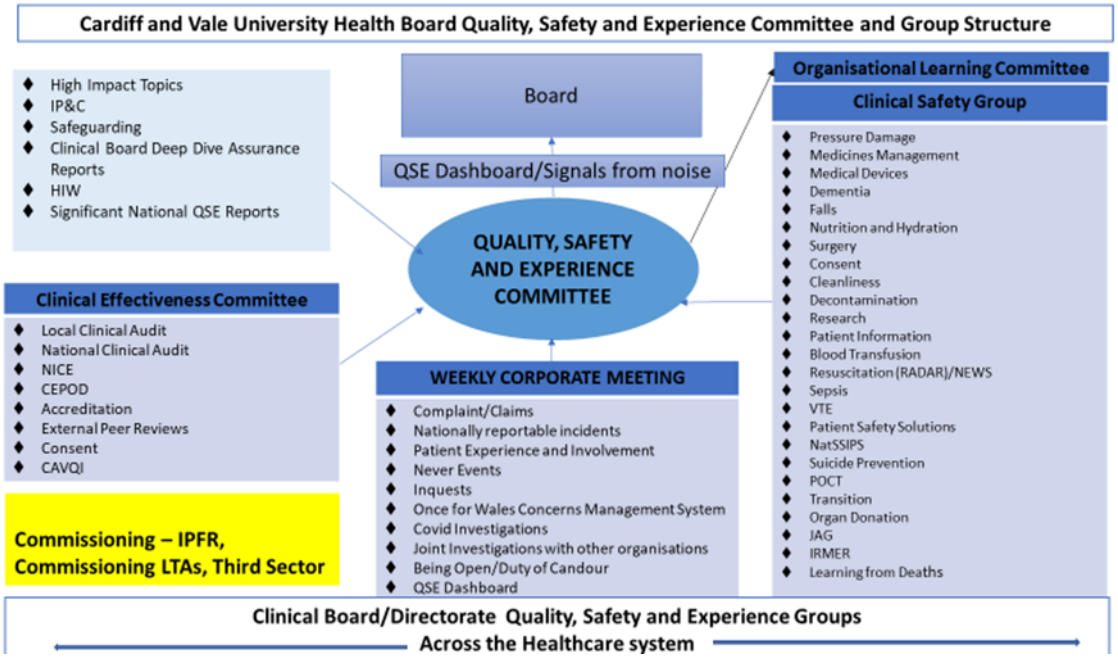
This is an integrated plan which has tried to avoid creating a silo view(s) on important legislation or policy agendas such as (for example), the Wellbeing of Future Generations Act, the Socio-Economic Duty or the Foundational Economy.

Rather, these are considered ‘golden threads’ for us and our commitment to them should be evident through the description of how we are choosing to conduct our work throughout this plan.

QUALITY, SAFETY AND PATIENT EXPERIENCE (QSE)

We have developed our five-year QSE framework with our frontline staff, patients, carers, relatives and external regulators. Our focus on quality, safety and the patient experience, extend across all settings where healthcare is provided. This includes our responsibility as a commissioner of services from a wide range of providers to have the necessary assurances in place where care is being provided by others for our population.

The chart below highlights our committee and group structures to support the delivery the framework:



As an integrated healthcare organisation, our focus on quality, safety and the patient experience must extend across all settings where healthcare is provided, as we look to be one of the safest organisations in the NHS. We will ensure there is no undue bias towards secondary care, recognising that the majority of care received by patients is provided in a primary or community care setting and that the primary and community care element of the patient's pathway is as key to delivering safe, high quality care as that part of the pathway which is provided in more acute settings.

We have eight key enablers in our revised QSE Framework for the next five years: These are:

- Safety Culture
- Leadership for QSE
- Patient Experience and Involvement
- Patient Safety learning and communication
- Staff engagement and Involvement
- Data and Insight
- Professionalism of QSE
- Quality Governance

We understand that this cannot be a framework that focuses on secondary care, but one that recognises that the majority of care received by patients is provided in a primary or community care setting and that the primary and community care element of the patients' pathway, is as key to delivering safe, high quality care as that part of the pathway which is provided in more acute settings. What really matters for our patients' carers and people in our communities, must be central to our decision making, so that we can use our time, skills and other resources more wisely. There is no simple solution to improve safety and no single intervention, implemented in isolation that can fully address the issue (Patient Safety 2030). The challenge is to commission services that improve the health of our residents in Cardiff and Vale and provide prudent, integrated health and social care for a growing local population whist providing increasingly complex emergency, elective and tertiary care to meet local and regional demand within the resources available, has never been greater.

We are always mindful that we are a statutory organisation and are also bound by primary legislation, statutory instruments and standing orders, which are the rules by which the organisation works and makes decisions.

Our public, communities, staff and partners are at the center of everything we do. There is no better and more important way of developing or improving services, than by listening to what individuals think, feel and experience throughout their journey, of using any of the NHS Wales services, programmes, functions and beyond. Whether this is in a hospital ward, outpatient appointment, any of the National Screening Programme, GP practice (primary care), engaging with health promotion practitioners or at any event delivered by an NHS Wales organisation. It is a key element of quality, alongside providing governance assurance and safer services. The way that the wider health and prevention/promotion system delivers its service and supports the wider systems – from the way the phone is answered, to the way cleaning staff speak with you, all the way to mangers engagement with the public and staff– has an impact on the experience and should be used for quality improvement and governance assurance. If clinical and general excellence is the 'what' of healthcare and health prevention, then experience is the 'how'. Starting with and listening to the needs and designing the experience, to meet these needs is achievable and results in an environment where individuals feel valued and supported.

One of the most important lessons learnt in the last few years is that organisations need to be ambitious. The experience we deliver for our service users will only ever improve when an entire organisation examines and re-creates its culture, which is more than just words, leadership, public and community engagement, staff engagement and cross-organisational measurement systems in order to improve quality and strive for excellence.

Below are the key messages we have heard:

Safety Culture

'Quality, Safety and Experience is everybody's business'

Leadership and prioritisation

Management is doing things right; leadership is doing the right things".

Patient experience and involvement

'No decision about me, without me'[1]

Staff engagement and involvement

Inspire, educate, skill and protect health workers to contribute to the design and delivery of healthcare systems'

Patient safety learning and communication

let's focus on systems and human factors; not on individuals'

Data and insight

If you don't measure, you don't know'

Professionalism

' if we always do what we've always done, we'll always get what we've always gotten'

Quality governance

The Standard you walk past is the standard you accept'

OUR PRIORITIES for 2021 -2026

- Achieve the maximum possible reduction in avoidable harm
- Embed a systems based and human factors approach to safety investigations and solutions
- Introduce Safety Culture work programme
- Agree a common language for quality, safety and experience
- Increase knowledge and awareness of Safety 1 – Safety 11
- Promote a culture of openness and transparent
- Develop a Psychological Safety Framework

The summary table below provides an overview of the headline milestones which the QSE team are focusing on through 2022-2023, in order to make tangible progress in embedding the framework and the priorities above. We have been closely involved in the development of the National NHS Quality and Safety Framework which was published in September 2021 and it aligns well with our own framework.

In summary: Our Quality, Safety and Experience

2022-2023 Qtr 2	Development of the support framework for staff involved in inquests.	Staff who are well prepared for inquests, feel supported and understand the process.	Review on going feedback to monitor staff feedback including time off work and feelings of stress.
	Implementation of the "What matters to me" conversations	A culture of listening and hopefully understanding what matters to a patient within the larger context of their life. When patients are engaged with their health care decisions, it can greatly improve their outcomes.	Through the use of PREMS, STAFF feedback and monitoring Concerns re complaints and claims where consent is a concerns and communication about treatment.
	Align some aspects of the QSE Framework all Wales experience self-assessment framework with Perfect Ward and the ward accreditation process (Gold, silver, bronze).	An ability to monitor the quality of care at ward level.	
2022-2023 Qtr 3	Agreement of a Humans Factor Framework and Implementation plan	Agree a Human Factors Framework identifying the components or major factors that need to be addressed to gain a better understanding of the nature of preventable adverse events.	Through accreditation, feedback, complaints, claims, incidents and compliments.
2022-2023 Qtr 4	Maximise the learning from near misses (to include the work currently being taken forward with Cardiff University to examine COVID related incidents)	Proactive management of near misses can reduce harm.	Identify how human factors currently impact Look for commonalities Examine outcome reliability.
	Establishment of the UHB stakeholder panel	A crucial forum for stakeholders to inform,	

	scrutinise and shape our work.	
Development of the organisational learning committee	A themed approach to UHB wide learning	Monitor reduction in harm Review impact upon health Inequities Reduction in same type incidents, complaints and claims
Implement AMAT to strengthen governance in relation to National and Local audits, NICE Guidance and Patient Safety Solutions	Able to evidence compliance with national audits and Patient safety solutions	
Work with Welsh Government to implement the requirements of the Health and Social Care (quality and Engagement) (Wales) Act 2020	Awareness of staff of: Duty of candour Duty of quality Citizens voice body	evidence of themes and you said we did from ward to UHB wide
Establish CAVQI as work stream to roll out of the current outputs from Health Foundation research project	Agreed implementation plan and timeframe	Information shared with the public, staff and stakeholder panel Undertaking PEER review with other organisations
Implement the CIVICCA - Once for Wales service user experience system	Able to demonstrate the roll out across the UHB	
Complete the implementation Once for Wales Concerns Management System	All available modules in use	
Development of a QSE accreditation/ syllabus	Agree Syllabus and timetable	

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

Work continues to embed the QSE Framework to align with the IMTP and we will update the Quality, Safety and Experience Committee.

Recommendation:

The Committee is requested to:

a) **Note** the alignment of the QSE Framework and the IMTP as set out in this report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

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

Prevention		Long term		Integration		Collaboration	✓	Involvement	✓

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

Risk: Yes

Failure to implement the QSE element of the IMTP could lead to harm for our population with a resultant financial and reputational risk.

Safety: Yes

QSE being considered throughout the IMTP will promote safety awareness and culture.

Financial: Yes

Failure to identify learning from themes will lead to increased harm and litigation.

Workforce: Yes

Opportunities to consider the workforce mix required to deliver the IMTP

Legal: Yes

We need to adhere to the relevant legislation and best practice guidance.

Reputational: Yes

There is media interest in QSE.

Socio Economic: Yes

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

The IMTP has an Equality impact assessment completed

Decarbonisation: No

Delivering safe care with a good experience close to home reduces waste and variation- could potentially reduce unnecessary travel.

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Report Title:	**Falls Prevention and Management**			Agenda Item no.	2.6
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	30 August 2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	**Executive Director for Therapies and Health Science**				
Report Author (Title):	**Patient Safety and Organisational Learning Manager**				

Main Report
Background and current situation:

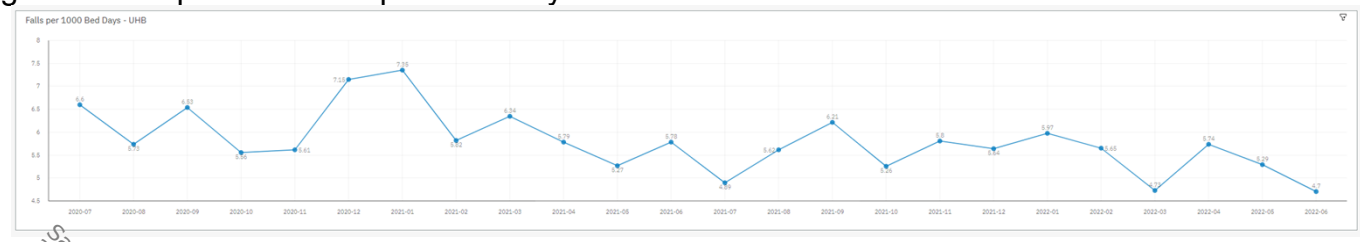
Governance, Leadership and Accountability

The Falls Delivery Group continues to meet quarterly and is attended by a wide variety of internal stakeholders, together with representatives from external partners such as WAST, South West Fire and Rescue, Cardiff Council Telecare, and Cardiff Care and Repair, thus ensuring that a more joined up approach of the whole falls pathway from community to secondary care is made. Two significant members of the group have recently retired and left the organization, namely the Consultant Nurse for Vulnerable Adults (CNVA) and the Patient Safety Organisational Learning Manager (PSOLM). The CNVA post is actively being recruited into, however it is thought that the revised role profile will have little or no input into falls. A full-time position for a band 7 falls lead who will sit within the Quality Improvement and Organisational Learning team is currently being recruited to. The departure of these key individuals is resulting in a significant gap in the ability of the Falls Delivery group to fulfil its role in monitoring performance and implementing improvement activities and standards of care.

In patient falls

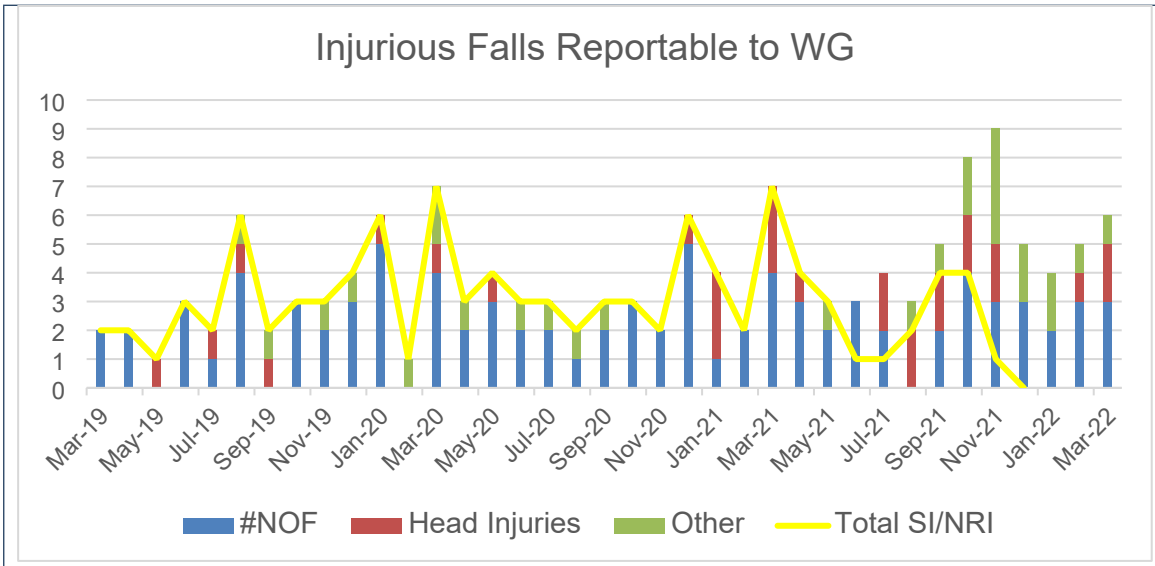
The Business Intelligence team have provided support to the Falls Delivery Group and work continues to develop a Falls Dashboard. A suite of data is presented at the Falls Delivery Group which shows themes and trends of falls within the UHB and provides a direction for focused quality improvement. Over the past 2 years there has been a gradual decrease in the number of inpatient falls per 1000 occupied bed days (Figure 1). In 2020 this was ranging between 6.6 and 7.35, whereas in the first 6 months of 2022 this has fallen to between 4.7 and 5.97. This improvement can 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 as is detailed later in this paper.

Figure 1 Falls per 1000 occupied bed days



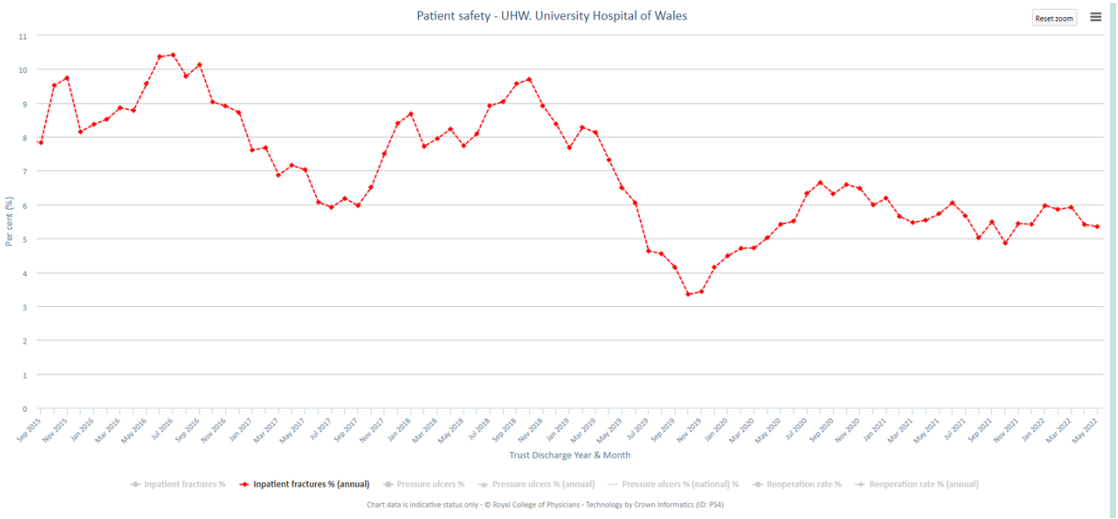
The criteria for reporting injurious falls changed in June 2021 resulting in an expected decrease in externally reportable incidents (Figure 2). An increase noted in September and October 2021 is as a result of retrospective reporting by clinical areas following rapid reviews.

Figure 2 Injurious falls reportable to WG



Hip fractures sustained as an inpatient has reduced from 10.37% of all Cardiff and Vale UHB hip fractures recorded on the National Hip Fracture Database in April 2016 to 5.41% in April 2022.

Figure 3 Hip Fractures Sustained as an Inpatient (NHFD)



Falls Review Panel

As recommended by the Royal College of Physicians the UHB continues to hold a regular Falls Review Panel in order to provide scrutiny of completed falls investigation reports. Feedback is provided directly to Clinical Boards and organisational learning from inpatient falls is shared throughout the UHB via an infographic (appendix 1). One of the limitations of reaching frontline staff with the learning is that not all staff have an email address, however it is expected that this will be resolved particularly for all nursing staff who will need to access the digital nursing record. This will support more effective and wider dissemination of learning from falls. Themes from falls incidents have been fairly consistent and include 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.

In addition, this group escalates themes and trends to the National Forum for Inpatient Falls and has been working with the Delivery Unit on their plans to change the way Health Boards report falls to Welsh Government.

Inpatient Falls Training
Falls is not currently part of the mandatory training for UHB employees. The Falls Delivery Group are driving a proposal for inclusion in this list and an e- learning module has already been prepared by the outgoing Patient Safety Organisational Learning Manager. In addition, focused teaching sessions have been conducted in MHSOP, nurse induction, and Specialist CB. In MHSOP this has resulted in excellent engagement in ensuring patients with suspected spinal injuries are moved safely following a fall and now the Hoverjack, which was previously unused in the Clinical Board, is being used to safely lift individuals. Good progress has been made with the implementation of routine lying and standing BP, especially in Mental Health, Trauma and Orthopaedics, and Medicine Clinical Boards. Further work needs to be focused on completion of multifactorial risk assessments, compliance with the bedrails and enhanced supervision guidance and medication reviews.

Simulation Training
A well evaluated programme of simulation training was devised as part of a Leading Improvement in Patient Safety (LIPS) project in 2018. Despite initial enthusiasm, attendance had been dwindling pre-pandemic due to difficulties in releasing clinical staff to attend. There are now plans to provide mobile falls simulation training which will provide training in the clinical area, involving the whole MDT.

Tendable
Collaboration with the Tendable project has resulted in the inclusion of falls audit questions being included in the first phase of roll out. The Tendable application enables the Falls Delivery Group to analyse data from the clinical areas, which will inform improvement work going forward.

Prevention of falls in the Community
One of the key aims of Shaping our Future Wellbeing (Cardiff and Vale University Health Board, 2015) is to enable people to live in their own home for as long as possible, with access to community support that is responsive to their needs and ultimately reduces the need for referral onto secondary care services. The Shaping our Future Population Health framework includes falls prevention as a key element of the 'ageing well' approach for Cardiff and Vale and key to addressing the demand on unscheduled care.

Falls impact people's lives in many ways, and can mean they cannot remain living independently; they can require increased health and social care support and suffer both physically and mentally following a fall (NICE, 2013). Falls are a major cause of hospital admissions, and emergency attendances. In Cardiff and Vale the most recent quarterly data for admissions due to falls was the highest it has been since 2016, and the impact of Covid-19 is one of the factors influencing this rise (Public Health England, 2021). One of the biggest risk factors for falling is having had one or more previous falls. If appropriate interventions are put in place the risk of having an initial or subsequent fall can be significantly reduced (Public Health England, 2021). Proactive preventative health promotion and interventions to help people to avoid falls can improve general health and wellbeing, and reduce people's risk of falls.

Falls Delivery Group
Cardiff and Vale UHB Falls Delivery Group aims to provide expertise, review and monitor practice, and promote the prevention and management of falls and fractures. The group focuses on both in-patients and community falls prevention, and brings together a range of partners internal to the UHB, and external including WAST, Care and Repair, South Wales Fire and Rescue, local authorities and third sector.

In relation to community falls prevention, the key consideration relates to early intervention, and identifying individuals at risk of falling, and then having a service in place to support these individuals to reduce their risk. This approach follows NICE guidelines for falls prevention in the community.

The Stay Steady Clinics were established through partners on the Delivery Group in 2018. Clinics are run by UHB physiotherapists, and offer a multi-factorial assessment of falls risks for individuals who have been screened as suitable for the clinic. Screening is a simple process of asking an individual if they have had a fall in the last year (injurious or not), if they are unsteady on their feet, or if they are worried about falling. They do not need to have been medically treated for a fall, and if they are triaged and not suitable for the Stay Steady clinic due to complex needs or frailty they are referred elsewhere. Stay Steady Clinics provide tailored advice to individuals on how to reduce their falls risks, and a programme of strength and balance activity. People will be signposted to suitable exercise classes such as strength and balance classes delivered by Elderfit, specialist exercise instructors who are qualified to teach older people. Elderfit deliver around 25 classes per week across Cardiff and Vale, with around 400 participants. The Stay Steady clinics offer face to face clinics in Roath and Barry Fire Stations, through a partnership with South Wales Fire and Rescue, and also virtual or telephone appointments which started during the pandemic and have continued as they enable access to a wide range of people.

In 2021/22 the clinics had 291 referrals. Most people self-refer to the clinics, whilst others are signposted by GPs, Community Resource Teams or other healthcare professionals.
In 2021, a partnership was formed with Sport Cardiff, Cardiff Metropolitan University and Elderfit to trial a FaME (Falls Exercise Management) programme in Cardiff. FaME is a programme with a strong evidence base around reducing falls risks, strengthening muscles, improving balance and teaching people how to get up if they do fall. It runs for 24 weeks, and participants are then encouraged to attend community classes afterwards to keep exercising. Participants are identified as suitable for FaME through Stay Steady clinic assessments. After a successful pilot, 2 further FaME courses are being delivered in 2022, but further funding will need to be identified beyond this year to run further courses.
Other work in the community overseen by the Delivery Group includes:

- Falls brief intervention training – delivered by the Public Health Team. This provides anyone working with older people with skills and knowledge to advise on falls risks, and to signpost to appropriate services
- Falls Awareness Week – campaign to promote awareness of falls risks and how to reduce them – planned for week of 19th September 2022

Key areas for future focus

- Further resources for Stay Steady clinics as there is a waiting list and growing demand in the community for this service
- Secure longer-term funding for FaME courses
- Establishment of a Falls Response Crisis Team – an MDT which provides fast follow up for fallers who have not been conveyed to hospital by WAST, or have been identified by Telecare. The aim is to avoid admission, and put in place actions to quickly reduce falls risks.

Welsh Ambulance Service Trust

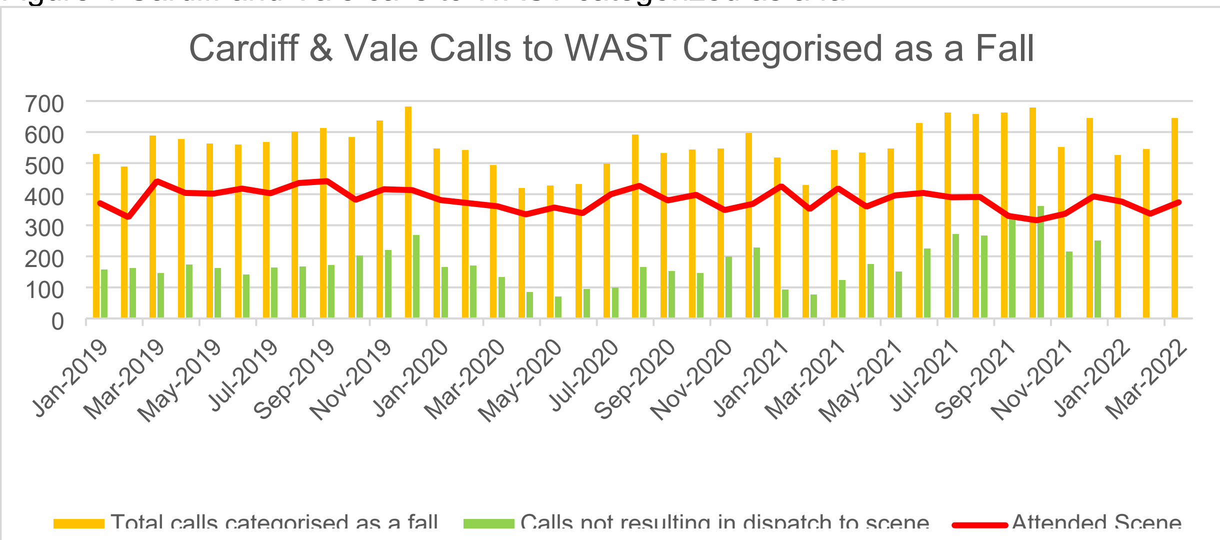
There was an increase in falls related calls in the past quarter, but it is not reaching the peak seen towards the end of Summer and Autumn 2021 (Figure 4). Although there has been an increase in March 2022, January and February showed a decrease and the figures remain fairly static.

WAST provide a Falls Assistant specifically for the UHB supporting with non-injury, lower acuity type falls in the community and supporting patients to stay at home. The conveyance rate of non-injured fallers is about 35%-40%, in comparison with the usual ambulance response without specialist services which tends to be near the 60% conveyance rate. WAST are working to improve their response to avoid conveyance to hospital.

As part of the WAST Falls and Frailty Framework, work is underway to review falls responses. More work is being done around prevention, engaging with 111 partners and responses to fallers on the floor and the advice given to them. WAST are aware that low priority calls may have a long response time and there are concerns around the harm caused as a consequence. WAST are looking to carry out a small test of change on scripted advice for people to try and get up from the floor.

The Falls and Frailty Framework shows different response models, so for the more complex patient presenting with frailty or onset or worsening frailty or a minor injury but with complexity, WAST sends a level 2 response (a paramedic and a community-based therapist) who perform a much more comprehensive function. The falls assessment establishes whether the patient is at imminent risk of another fall in the next 24 hours and what referral routes need to be accessed to enable the patient to stay safely at home.

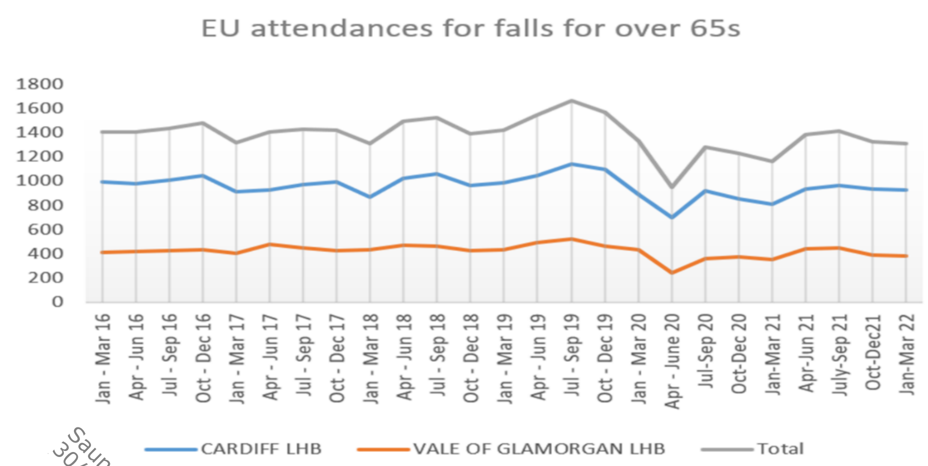
Figure 4 Cardiff and Vale calls to WAST categorized as a fall



EU attendances for falls

For the over 65s EU attendances for falls, this number is relatively static.

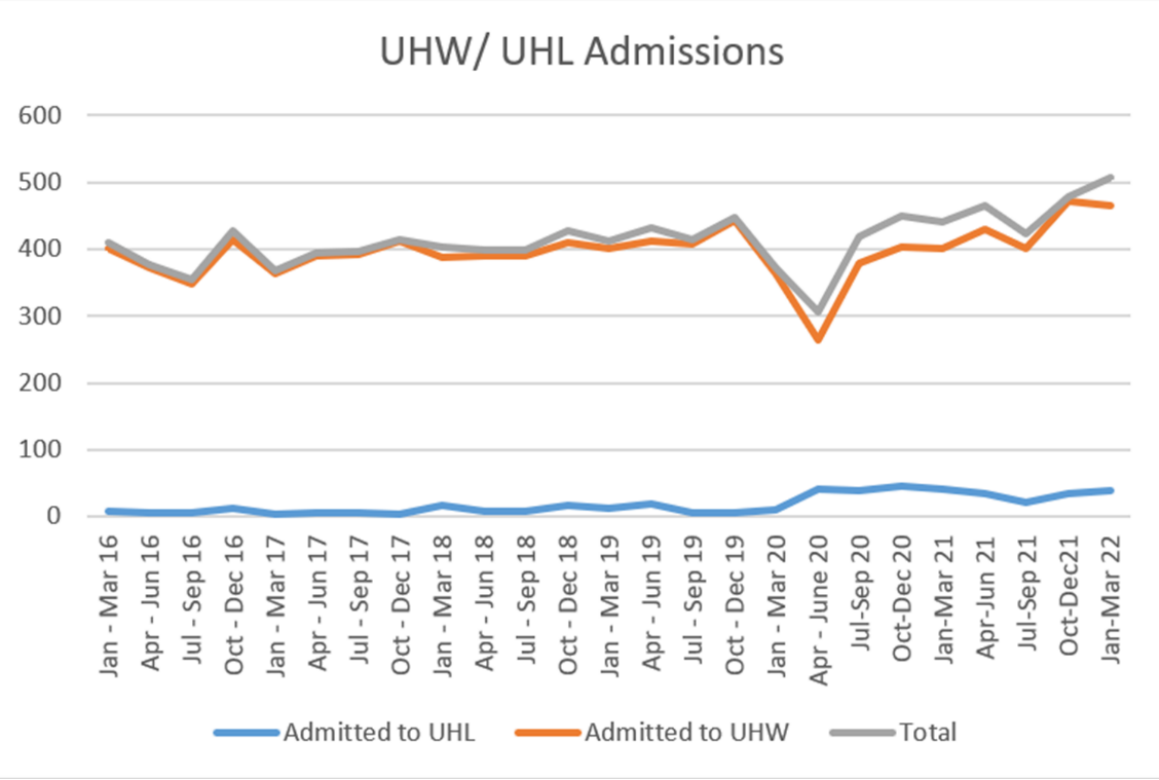
Figure 5- Eu attendances for falls for over 65's



Hospital admissions with Falls

Falls admissions are increasing to rates not seen since 2016 (Figure 6) and this concurs with the Public Health England report into COVID and frailty and deconditioning as alluded to earlier in this report. This highlights the priority required to tackle prevention and management of falls in the community.

Figure 6-UHW/UHL admissions with falls



National Audit data

Participation in the national audits continues, with latest data from the National Audit of Inpatient Falls is illustrated in Figure 7. The UHB has improved from 64% in 2021 to 81% of cases where patients were checked for injury before being moved and exceed the NAIF overall performance. However, cases where a safe manual handling method was used has dropped from 100% to 25%. Manually assisting a patient who may have fractured their femur from the floor risks the patient experiencing unnecessary pain and discomfort as well as staff injury. Training and education on the use of the Hoverjack has been undertaken in areas such as Mental Health where it has not been routinely used before, although the drop-in performance may well be as a result of the Hoverjack being out of action on the UHW site with only 1 for the whole site at present located in the Lakeside wing. Medical assessment within 30 minutes of a fall has also decreased from 71% to 56%. Mandatory in- patient falls training was one of the recommendations of the National Audit of Inpatient Falls 2020 Report[1] published in 2021, although currently the UHB do not provide this. Benchmarking against Wales and the UK as a whole, the UHB are performing well in prompt orthogeriatric review, NICE compliant surgery and bone medication (Figure 7,8,9). Performance is poor in getting patients to a specialist ward as compared with both Wales and the UK and comparative for the remaining KPI's.

Figure 7-National Audit of Inpatient Falls (NAIF)

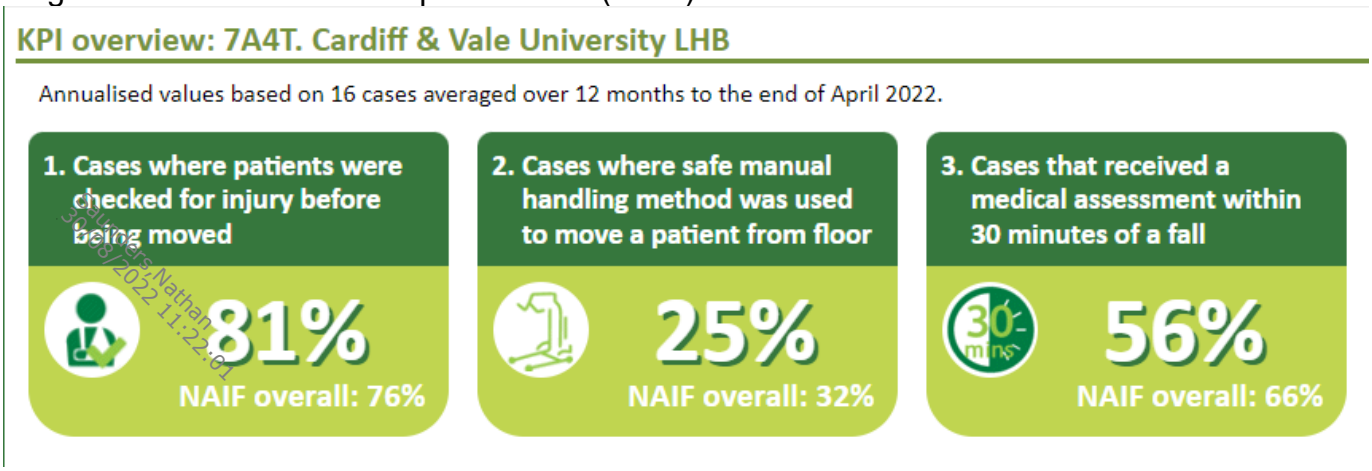


Figure 7/8/9-National Hip Fracture Database (NHFD) key performance indicators UHW/Wales/UK

KPI overview: UHW. University Hospital of Wales

Annualised values based on 485 cases averaged over 12 months to the end of June 2022.

KPI	Value	NHFD overall
0. Admitted to Specialist Ward	1%	NHFD overall: 7%
1. Prompt orthogeriatric review	84%	NHFD overall: 87%
2. Prompt surgery	54%	NHFD overall: 61%
3. NICE compliant surgery	75%	NHFD overall: 69%
4. Prompt mobilisation	72%	NHFD overall: 80%
5. Not delirious post-op	58%	NHFD overall: 63%
6. Return to original residence	68%	NHFD overall: 69%
7. Bone Medication	67%	NHFD overall: 31%

KPI overview: [Wales]

Annualised values based on 3,936 cases averaged over 12 months to the end of June 2022.

KPI	Value	NHFD overall
0. Admitted to Specialist Ward	3%	NHFD overall: 7%
1. Prompt orthogeriatric review	69%	NHFD overall: 87%
2. Prompt surgery	59%	NHFD overall: 61%
3. NICE compliant surgery	71%	NHFD overall: 69%
4. Prompt mobilisation	74%	NHFD overall: 80%
5. Not delirious post-op	64%	NHFD overall: 63%
6. Return to original residence	70%	NHFD overall: 69%
7. Bone Medication	32%	NHFD overall: 31%

KPI overview: [ALL]

Annualised values based on 64,531 cases averaged over 12 months to the end of June 2022.

KPI	Value	NHFD overall
0. Admitted to Specialist Ward	7%	NHFD overall: 7%
1. Prompt orthogeriatric review	87%	NHFD overall: 87%
2. Prompt surgery	61%	NHFD overall: 61%
3. NICE compliant surgery	69%	NHFD overall: 69%
4. Prompt mobilisation	80%	NHFD overall: 80%
5. Not delirious post-op	63%	NHFD overall: 63%
6. Return to original residence	69%	NHFD overall: 69%
7. Bone Medication	31%	NHFD overall: 31%

Future plans

- Recruitment of Falls lead into the Patient Safety and Quality Improvement team
- Work with the Business Intelligence team to improve the falls dashboard and refine the suite of information reported to the Falls Delivery Group;
- Participate in training needs analysis for falls education;
- Improve provision of preventative information in out outpatient clinics and on discharge from hospital inpatient stays;
- Tendable development.

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

The Falls Delivery Group continues to meet quarterly and is attended by a wide variety of internal stakeholders, together with representatives from external partners such as WAST, South West Fire and Rescue, Cardiff Council Telecare, and Cardiff Care and Repair, thus ensuring that a more joined up approach of the whole falls pathway from community to secondary care is made

Over the past 2 years there has been a gradual decrease in the number of inpatient falls per 1000 occupied bed days (Figure 1). In 2020 this was ranging between 6.6 and 7.35, whereas in the first 6 months of 2022 this has fallen to between 4.7 and 5.97.

Hip fractures sustained as an inpatient has reduced from 10.37% of all Cardiff and Vale UHB hip fractures recorded on the National Hip Fracture Database in April 2016 to 5.41% in April 2022

As recommended by the Royal College of Physicians the UHB continues to hold a regular Falls Review Panel in order to provide scrutiny of completed falls investigation reports. Feedback is provided directly to Clinical Boards and organisational learning from inpatient falls is shared throughout the UHB via an infographic

In 2021/22 the Stay Stedy clinics had 291 referrals. Most people self-refer to the clinics, whilst others are signposted by GPs, Community Resource Teams or other healthcare professionals.

Emergency Unit attendances for Falls in the over 65 age groups remains static.

Recommendation:

The Committee are requested to:

NOTE the assurance provided by the Process and quality data.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
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	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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: 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 (Learning from Falls)

June 2022 Falls Review Panel
Learning and Feedback

CARDIFF AND VALE UHB
Patient Safety & Quality

Language around falls – avoid saying **'high risk of falls'**, **'low risk of falls'** or **'no risk factors for falls'**. NICE guidance clearly states that all inpatients over the age of 65 have risk factors for falls. Better language would be to say **'multiple risk factors for falls'** or **'modifiable risk factor for falls'**. Please avoid using the term 'mechanical fall' which is not recognised in national guidance.

Be mindful of where staff are during handover, **do not leave ward unsupervised** whilst all staff gather at the same time to handover

If lack of staff is preventing enhanced observation, please report this via **Datix**

Be mindful of the risk of **post ICU delirium** and the risk this poses to patients when they are transferred to another area for step down care

Use of hoist rather than hoverjack. Also use of slide sheets in tight space to pull patients out so hoverjack can be used.

Positive feedback of comprehensive review tool from ward

Use **focussed review on new Datix**, rather than old template – technology making our lives easier!

Ensure all student clinicians are supervised appropriately **at all times**.

Note that antipsychotic medication can cause **postural drop in BP** or make an existing drop worse

#NOF and #Femur to be severe harm on Datix as per national guidance

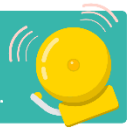
Loose catheter straps – could obtaining leg covers mitigate the risk?

Do not assist patients to put on slippers whilst they are stood up.

Standing / Lying BP should be part of the Multi Factorial Risk Assessment for Falls for all inpatients who can stand.
Use the QR codes to refresh your knowledge.

Falls Policy *How to measure BP* *Procedure reference cards*

Multifactorial risk assessment must be completed **within 6 hours of admission and transfer to another area**, as well as weekly for acute patients and monthly for long term patients.



@CV_UHBSafety

Please contact Annie Burrin for more information
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Archwilio Cymru
Audit Wales

Review of Quality Governance Arrangements – Cardiff and Vale University Health Board

Audit year: 2019

Date issued: June 2022

Document reference: 2962A2022

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Contents

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Cardiff and Vale University Health Board (the Health Board) carried out during 2021. To test the 'floor to board' perspective, we examined the arrangements for general surgical services.

Key messages

6 Overall, we found that the **Health Board has agreed quality and safety priorities at all levels of the organisation. Corporate and operational structures for quality governance are reasonably effective. However, there are opportunities to strengthen aspects of culture and quality improvement. Further investment is required to enable the Health Board to fully roll-out and embed planned quality and safety improvements.**

7 The Health Board has agreed quality and safety priorities at all levels of the organisation. There are reasonable corporate and operational arrangements in place for monitoring risk. Arrangements for monitoring mortality and morbidity are developing. The Health Board has effective arrangements to monitor and track progress with complaints, where it consistently achieves performance targets and arrangements to capture patient experience are reasonably effective. The Health Board has a well-established values and behaviour framework which is embedded in workforce processes. There is collective responsibility for quality and safety amongst Executive Leadership. Corporate and operational structures and processes for quality and safety are reasonably effective and the Health Board is taking steps to strengthen these further. Agendas for corporate and operational quality and safety meetings provide a wide coverage of quality and safety issues for discussion and there is sufficient information for scrutiny and assurance at both a corporate and clinical board levels and the Health Board's use of quality data is maturing.

8 However, we found poor alignment between corporate and operational quality and safety priorities and monitoring and reporting on their delivery needs strengthening. There is scope to ensure the corporate Quality, Safety, and Experience Committee maintains greater oversight of risks overseen by other committees where there is a clear quality and safety impact. Arrangements for clinical audit require significant improvement. The Health Board also needs to ensure that staff feel able to raise concerns. Whilst the departure of key clinical executives from the organisation potentially poses risks to rolling-out and embedding the new Quality, Safety and Patient Experience Framework; additional resources have been allocated to enable the Health Board to achieve this. There are opportunities for the agenda of corporate Quality, Safety and Experience Committee meetings to be more dynamic to reflect new and emerging quality risks and issues. Reporting on the four harms[1] associated with COVID-19 requires strengthening. Furthermore, reporting requires development at directorate level for services commissioned by the Health Board.

[1] The four harms are – (i) harm from COVID-19 itself; (ii) harm from overwhelmed NHS and social care system; (iii) harm from reduction in non-COVID-19 activity; and (iv) harm from wider societal actions / lockdown

Recommendations

9 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Quality and Safety Priorities R1 The Surgery Clinical Board and Surgical Services Directorate revised their quality priorities in response to the COVID-19 pandemic. However, there appears to be poor alignment between these operational priorities and the Health Board's key delivery actions for quality and safety as outlined in its Annual Plan for 2021-22. The Health Board, therefore, should ensure there is better alignment between operational and strategic quality and safety priorities as articulated in the Health Board's 10-year strategy and new Quality, Safety, and Patient Experience Framework.
Risk Management R2 There is scope to ensure the corporate Quality, Safety and Experience Committee maintains greater oversight of risks scrutinised by other committees where there is a clear quality and safety impact. There is scope to improve the quality of risk information recorded on operational risks registers and the escalation and de-escalation of risk to / from the Corporate Risk Register. The Health Board, therefore, should ensure: a) the corporate Quality, Safety and Experience Committee seeks assurance from other Health Board committees where their risks potentially impact on quality and safety; and b) review and improve the quality of risk information recorded on operational risks registers and introduce an appropriate process for the escalation and de-escalation of risk to / from the Corporate Risk Register.
Clinical Audit R3 The Health Board is developing a Clinical Audit Strategy and Policy, but there has been a delay in progress due to capacity and IT system challenges within the Clinical Audit Team. Internal Audit completed a review of the Health Board's clinical audit arrangements during 2021 and gave a limited assurance rating, identifying several key matters that need to be addressed. Whilst the Health Board is making some progress in this area, it should: a) complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide, and local audits

Recommendations

informed by areas of risk. This plan should be approved by the corporate Quality, Safety and Experience Committee and progress of its delivery monitored routinely; and

b) ensure that recommendations arising from the Internal Audit review of clinical audit are implemented as a priority.

Values and Behaviours

R4 The Health Board's Values and Behaviours Framework sets out its vision for a quality and patient-safety-focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses, incidents, and raising and listening to staff concerns. The Health Board, therefore, should undertake work to understand why some staff feel:

a) that their mistakes are held against them or kept in their personal file;

b) that the Health Board does not provide feedback about changes put into place following incident reports or inform staff about errors that happen in their team or department; and

c) they don't feel free to question the decision or actions of those with more authority and are afraid to ask questions when something does not seem right.

Personal Appraisal Development Reviews (PADRs)

R5 The Health Board compliance rate for appraisals is consistently below the national target of 85%. The Health Board reports that operational pressures are adversely affecting compliance and enabling work has not delivered the level of improvement anticipated over the COVID-19 pandemic period. The Health Board, therefore, should take appropriate action to improve performance in relation to PADRs at both corporate and operational levels.

Resources to support quality governance

R6 Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles. The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.

Recommendations

Monitoring and Reporting

R7 There is no evidence to indicate that the four harms associated with COVID-19 have routinely been reported to the Board either through the integrated performance report or systems resilience update. Furthermore, there was limited evidence that Clinical Boards consider the four harms associated with COVID-19 as part of the reporting to the corporate Quality, Safety, and Experience Committee. The Health Board, therefore, should ensure that the four harms associated with COVID-19 are routinely considered by Clinical Boards and reported to the corporate Quality, Safety, and Experience Committee and Board.

Detailed report

Organisational strategy for quality and patient safety

10 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

11 We found that **whilst the Health Board has agreed quality and safety priorities at all levels of the organisation, there is scope to ensure that operational priorities are better aligned to corporate priorities. Risks are managed appropriately at both a corporate and operational level, but opportunities exist to improve these arrangements further.**

Quality and patient safety priorities

12 The Health Board's 10-year strategy, 'Shaping our Future Wellbeing', sets outs its mission of "caring for people and keeping people well" and its vision that "a person's chance of leading a healthy lifestyle is the same wherever they live and whoever they are". To achieve its mission and vision, the Health Board has developed a strategy based on a "home first" approach which aims to avoid harm, waste, and variation; empower people; and deliver outcomes that matter to them. The Health Board's strategic objectives cover four key areas: population, service priorities, sustainability, and culture.

13 A key priority for the Health Board is to develop a patient safety and service quality culture to ensure quality improvement is a part of everyday practice. The 10-year strategy identifies several outcomes for the Health Board if it maintains a continued focus on patient safety, such as:

- zero tolerance of never events and hospital acquired infections;
- patient safety principles are embedded, owned, understood, and acted on by staff at all levels of the organisation; and
- recognised as a leading UK organisation for its work on patient safety initiatives and the application of improvement methodology.

14 To achieve these outcomes, the Health Board's strategy identifies several key actions which include:

- establishing governance processes that demonstrate learning from the depth and breadth of quality, safety, and patient experience sources; and
- investment in an expert specialist patient safety team who can support and work alongside teams to respond rapidly when things go wrong, supporting patient's, families, and staff and to ensure that actions are taken to prevent harm in the future.

15 The Health Board's Annual Plan 2021-22 outlines its commitment to "focus on quality, safety, and patient experience across all settings where healthcare is provided as we [the Health Board] look to be one of the safest organisations in the NHS". To achieve this, the quality, safety, and patient experience element of the plan identifies eight quality priority themes:

- Quality, Safety and Experience Framework 2021-2026 (see **paragraph 17**);
- Organisational safety culture;
- Leadership and the prioritisation of quality, safety, and experience;
- Patient experience and involvement in quality, safety, and experience;
- Patient safety learning and communication;
- Staff engagement and involvement in safety, quality, and experience,
- Patient safety, quality and experience data and insight;
- Professionalism of patient safety, quality, and experience.

16 The Health Board's headline activities and delivery timescales are designed to support the achievement of its quality priorities. However, there is no monitoring and reporting framework in place. As a result, we found limited assurance and scrutiny at the corporate Quality, Safety and Experience Committee (QSE Committee) on the key areas of delivery. This creates a risk that the Committee, and subsequently the Board, are not fully sighted on aspects where quality delivery aims are not being achieved or where there is limited progress. This was also a key finding in our 2021 Structured Assessment report[2], which resulted in a recommendation being made for the Health Board to strengthen its arrangements for monitoring and reporting on overall delivery of the 2021-22 Annual Plan and subsequent plans.

17 Our work found that the Quality, Safety, and Improvement Framework 2017-20 remained in place beyond its 2020 expiry date whilst the Health Board completed work on its new Quality, Safety, and Patient Experience Framework for the period 2021 to 2026. The framework, which was presented to the corporate QSE Committee in September 2021 for approval, focusses on eight key themes:

- Safety culture,
- Leadership and prioritisation,
- Patient experience and involvement,
- Patient safety, learning and communication,
- Staff engagement and involvement,
- Data and insight,
- Professionalism and
- Quality Governance.

18 The Health Board engaged stakeholders as part of the new framework development by seeking the views of clinical and non-clinical staff, patients and their families / carers, and other key external stakeholders and partners, such as the Community Health Council.

19 Both the Surgery Clinical Board and Surgical Services Directorate identify quality and patient safety priorities and monitor their progress. The Clinical Board and Directorate revised their priorities in response to the COVID-19 pandemic.

[2] https://www.audit.wales/sites/default/files/publications/cardiff_vale_health_board_structured_assessment_2021_phase_two_english_1.pdf

However, there appears to be poor alignment between these operational priorities and the Health Board's key delivery actions for quality and safety as outlined in its Annual Plan for 2021-22. **(Recommendation 1)**

Risk management

20 The Health Board revised its risk management strategy, approach, and Board Assurance Framework (BAF) during 2021, and established a risk appetite for the safety, quality, and accessibility of care which it defines as 'open'[3] with the intention to move to 'seek'[4].

21 One of the ten principal risks to the Health Board as set out in the BAF relates to patient safety, which has been assigned to the clinical Executive Directors as leads responsible for managing the risk and to the corporate QSE Committee to seek and provide assurance that the Health Board is managing the risk appropriately. The BAF clearly outlines the current controls and assurances alongside any gaps and actions to address them.

22 Our observation of the corporate QSE Committee in February 2022 indicated that a brief presentation, discussion, and scrutiny took place on the BAF as well as the patient safety risk assigned to the committee.

23 There is scope to ensure the corporate QSE Committee maintains greater oversight of risks assigned to other committees where there is a clear quality and safety impact. For example, workforce risks are a consistent theme in the Surgery Clinical Board assurance report, the Corporate Risk Register (CRR), and the BAF. Whilst the strategic workforce risk is appropriately assigned to Executive Director of People and Culture as lead and to the Strategy and Delivery Committee for assurance purposes, the Health Board should consider how the corporate QSE Committee oversees and gains assurance on the wider workforce risks from a quality and safety perspective. **(Recommendation 2)**

24 The Health Board's CRR provides an overview of the key operational risks from the divisions and corporate directorates. Each risk is linked to a sub-committee of the Board for assurance purposes with any risks scoring 20 and above escalated onto the BAF as a principal risk to the Health Board. The CRR identifies several risks in relation to quality and safety.

25 At an operational level, the Health Board's Surgery Clinical Board and Surgical Services Directorate maintain and actively manage risk registers. They clearly articulate quality and safety risks at this level which are scored appropriately and

[3] Definition of 'open' risk appetite - "despite short term inherent risks it recognises potential for long term gain. The Health Board often challenges current clinical practices and pursues innovative treatment and care solutions. Confident in its risk control the Health Board allows non-critical decisions to be devolved to a low operational level."

[4] Definition of 'seek' risk appetite - "despite short term inherent risks it seeks potential for long term gain. The Health Board will routinely challenge current clinical practices and pursue innovative treatment and care solutions".

have appropriate controls. However, whilst the Clinical Board risk register identifies risk owners, the Surgical Services risk register does not. Risk also features on the agenda for both the Surgery Clinical Board and Surgical Services Quality, Safety, and Experience Committee meetings. Whilst operational processes for managing risk are reasonably effective, our discussions with staff found that risk management arrangements are developing. There is scope to improve the quality of risk information recorded on operational risks registers and the process of escalation and de-escalation of risks to / from the CRR to maintain the quality of the BAF and ensure the Board is appropriately sighted of key risks facing the organisation. We understand that the Health Board is currently addressing these issues.

Organisational culture and quality improvement

26 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

27 We found that **the Health Board has a dedicated Quality Improvement Team, but the COVID-19 pandemic has impacted on the support it provides to the Health Board. Arrangements for monitoring mortality and morbidity are developing, but arrangements for clinical audit require significant improvement. There is a well-established values and behaviours framework, but more work is required to develop an open and supportive culture to enable staff to raise concerns. The Health Board has effective arrangements to monitor and track progress with complaints, and consistently achieves performance targets. There are reasonable arrangements to capture patient experience, but more work is required to improve Board and Committee oversight of patient stories.**

Quality improvement

28 The Health Board's Quality Improvement (QI) Team consists of 2.6 Whole Time Equivalent (WTE) staff (4 headcount). The capacity of the team has recently increased through the reconfiguration of a previous role and securing 12 months' non-recurring funding for 1 WTE post.

29 Prior to the COVID-19 pandemic, the QI team delivered the Leading Improvement in Patient Safety (LIPS) Programme on a bi-annual basis to both clinical and non-clinical staff. However, the pandemic is limiting usual training activity. The Health Board's intention is to reinstate and refresh the programme during April and September 2022. However, the programme is under review as part of a wider review of the quality improvement process across the Health Board. The Health

Board was also able to secure a Health Foundation research grant for its Cardiff and Vale Quality Improvement (CAVQI) programme which aims to support departments across the organisation with data analysis and improvement. The Health Board has completed an evaluation of the programme which identified several positive outcomes, including the development of a dashboard to analyse incident report data in real-time. The Health Board intends to introduce the programme across the organisation.

30 The Health Board supports the Improving Quality Together Learning Programme; however, it did not provide data to demonstrate the proportion of staff that have completed the various levels of training.

Clinical audit

31 Clinical audit is an important way of providing assurance about the quality and safety of services. At the time of our review, the Health Board was developing a Clinical Audit Strategy and Policy, but there has been a delay in progress due to staffing challenges (long-term sickness) and awaiting confirmation from the Health Board on investment plans for clinical audit.

32 The Health Board categorises clinical audits into three tiers:

- Tier 1 – Mandatory national clinical audit;
- Tier 2 – All other national audits and local clinical audits undertaken to address the patient safety and quality agenda; and
- Tier 3 – Local clinical audit for any other reason including revalidation and continual professional development (CPD) purposes.

33 The Health Board approved its clinical audit plan for 2021-22 which includes all tier 1 and anticipated tier 2 audits. Whilst it does not include tier 3 audits, there are arrangements in place to ensure all tier 3 audits are scrutinised and are beneficial to the directorate and clinical board. At the time of our review, we found limited evidence that the Health Board has approved a clinical audit plan for 2022-23.

34 Both the Surgery Clinical Board and Surgical Services Directorate have a programme for national, local, and bespoke clinical audits, but have no system to track delivery. They provide progress updates to the corporate QSE Committee through the Clinical Board Assurance Reports. There are arrangements in place to share and discuss clinical audit findings, learning, and good practice across the Health Board's governance structure and with regional networks.

35 A corporate QSE Committee update in September 2021 highlighted the activity of the Clinical Effectiveness Committee (CE Committee) since December 2020. The report outlined the progress of tier 1 audits and highlighted several key messages issues, learning, and actions arising from the reviews to discuss at the committee. We also found evidence of verbal updates provided to the corporate QSE Committee during its subsequent meetings. We comment on the purpose of the Health Board's CE Committee in **paragraph 75**.

36 The CE Committee update highlighted capacity and IT system issues within the Clinical Audit Team which are impacting on the support available for local (tier 2) clinical audit activity, the quality of assurance around the development of improvement plans, and the progress being made in addressing audit recommendations. Results from our data collection survey found that corporate resources for clinical audit have reduced over the last 3 years to enable the Health Board to achieve cost reductions. The team currently comprises 6.21 WTE (7 headcount) and, at the time of our review, there was one vacancy. The Health Board's benchmarking exercise and review of current resources and team structure has also identified that clinical audit requires investment to deliver desired improvements. In addition to increasing the team's capacity, the Health Board has also invested in the AMaT[5] audit management system to better utilise clinical audit as a source of assurance and establishing a process for monitoring and reporting local (tier 2) clinical audits.

37 Internal Audit completed a review of the Health Board's clinical audit arrangements during 2021. The review focussed on three areas: roles, responsibilities, and resources; programme planning and programme delivery; and board assurance. A limited assurance rating was given, and several key matters were identified in relation to the absence of a clinical audit strategy, policy, and procedures; inadequate resources and clinical audit IT system; absence of a clinical audit training plan; and limited oversight and scrutiny of local clinical audit activity. **(Recommendation 3)**

Morbidity and mortality

38 Mortality and morbidity review meetings provide a systematic approach for peer review of adverse events, complications, or mortality to reflect, learn from and improve patient care. We found that the processes around universal mortality reviews were recently superseded by the commencement of the Medical Examiner function.

39 The Health Board has established a bi-monthly multi-disciplinary Mortality (Learning from Deaths) Group. The Assistant Medical Director for Clinical Governance and Patient Safety chairs the group. Meetings have a balanced agenda encompassing a range of issues including: Covid-19 mortality; mortality reviews; divisional updates; and detailed reviews of mortality data. Meetings are well attended by clinical staff with good quality reports, presentations, discussion, and challenge.

40 Mortality and morbidity feature in the corporate QSE Committee's Quality Indicator report. The February 2022 update provides information on the implementation of the new process for mortality reviews and identifies emerging themes and actions within the Health Board. For example, the report identifies communication as a

[5] Audit Management and Tracking

recurring theme and, as a consequence, the Health Board is recruiting staff to ensure there is timely and regular communication with families.

41 At an operational level, mortality data analysis is a standing item on the agenda for the Surgery Clinical Board's Quality, Safety and Experience Committee. However, there is limited evidence of detailed discussion. Furthermore, results from our divisional and directorate data collection surveys suggest there were arrangements in place pre-pandemic to review mortality and morbidity through regular meetings, with learning and good practice shared outside the meetings via distribution of minutes and updates provided to the Surgery Clinical Board's Quality, Safety and Experience Committee. However, they have not been able to maintain these arrangements during the pandemic.

Values and behaviour

42 The Health Board's Values and Behaviours Framework sets out its vision for a quality and patient-safety-focussed culture. It focuses on being kind, caring and respectful, and emphasises, integrity, and personal responsibility. The Health Board has embedded values and behaviours in workforce processes, such as recruitment, appraisals, and induction. However, the quality of induction for substantive and temporary staff appear to vary in quality. Of the staff who completed the Health Board's internal patient safety survey[6], only 36% agreed or strongly agreed that induction arrangements for new and temporary staff in their work area / department support safe and effective care.

43 Results from the Health Board's internal patient safety survey also revealed a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns:

- 45% agreed or strongly agreed that when an event is reported, it felt like the person is being reported, not the problem.
- 36% agreed or strongly agreed when asked if they felt their mistakes are held against them.
- 46% agreed or strongly that they were worried that mistake's they make are kept in their personal file.
- 32% agreed or strongly agreed that staff are given feedback about changes put into place based on incident reports.
- 51% agreed or strongly agreed that staff are informed about errors that happen in their team / department.
- 57% agreed or strongly agreed that teams / department discuss ways to prevent errors from happening again.

[6] The Cardiff and Vale University Health Board's Patient Safety Staff Survey ran for a period of 4 weeks in 2021. The survey attracted responses from 988 staff. The findings are unlikely to be representative of the views of all staff across the Health Board. As a result, we have only used them to illustrate particular issues.

- 24% staff indicated a mistake is rarely or never reported if it is caught and corrected before affecting the patient.
- 21% staff indicated a mistake is rarely or never reported if it has no potential harm to the patient.
- 45% staff indicated a mistake is usually or always reported if a mistake could harm the patient. **(Recommendation 4)**

44 The most recent NHS Wales Staff Survey[7] showed a small but still significant proportion of staff expressing concerns relating to bullying, harassment, or abuse by another colleague, member of the public, or line manager over the past year (18.8%, 18.1% and 9.7% respectively). Fewer than half agreed or strongly agreed that the organisation takes effective action if staff are bullied or harassed by members of staff or a member of the public (40.3%). However, results from the Health Board's internal patient safety survey show that 67% of staff agreed or strongly agreed that people treat each other with respect in their team or department.

45 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. November 2021 figures show an overall organisational compliance of 72.26%[8]. Whilst this level slightly improved since September 2021, it is still below the target of 85%. The Health Board's internal patient safety survey found that 61.28% of staff disagreed or strongly disagreed that they have enough time at work to complete any statutory and mandatory training. The Surgery Clinical Board and Surgical Services Directorate have indicated that managers are allowing staff time to complete statutory and mandatory training, although this has been challenging over the last year due to pressures caused by the pandemic. Senior leadership and managers within the Surgery Clinical Board and Surgical Services Directorate encourage and monitor staff compliance through the appraisal process and revalidation events.

46 Personal Appraisal Development Review (now Values Based Appraisal) is a two-way discussion which helps staff understand what is expected of them in their role, become more engaged, and take responsibility for their own performance and development. Against a national target of 85%, the overall Health Board compliance rate for appraisals in November 2021 was 31.6% which has remained broadly consistent with the position reported in September 2021 of 31.9%. Compliance reported by the Surgery Clinical Board during our fieldwork was 27%. The Health Board reports that operational pressures are adversely affecting compliance. At an operational level, the Surgery Clinical Board are encouraging managers to use the Electronic Staff Record (ESR) system by enabling them to access training. However, enabling work has not delivered the level of

[7] The NHS Wales Staff Survey ran during November 2020 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 22%, compared to an all-Wales average of 19%.

[8] The Health Board is required to report compliance to the Welsh Government monthly and the target for compliance for all health boards is 85%.

improvement anticipated over the COVID-19 pandemic period. **(Recommendation 5)**

Listening and learning from feedback

Patient Experience

47 The Health Board's standalone Patient Experience Framework which expired in 2020, was replaced in 2021 by the new Quality, Safety and Patient Experience Framework for 2021 to 2026. The new framework identifies patient experience and involvement as one of its eight key themes and includes the development and implementation of a Patient Safety Partner (PSP) framework and a 'What Matters to You' campaign.

48 Our work found that Clinical Boards provide patient experience updates to the corporate QSE Committee via their Quality, Safety, and Experience Sub-group meeting minutes, Clinical Board Assurance Reports, and the quality indicators progress report. We also note a standalone patient experience update was provided to the February 2022 corporate QSE Committee. The report provides an overview of the role of the Patient Experience Team and how it operates under the recent Health and Social Care (Quality and Engagement) (Wales) Act 2020. It also highlights key achievements, and areas of risk or concern.

49 The Surgery Clinical Board and Surgical Services Directorate use short surveys, suggestion boxes, and 'Happy or Not' kiosks to capture patient experience information. There are also plans to install patient / visitor ward information boards at the entrance to all ward areas. They share the compliments or concerns raised by patients and their carers with staff to help them understand the patient's perspective of care received and any action to be taken where necessary.

50 During the pandemic, the Health Board withdrew its monthly feedback surveys and 'Happy or Not' kiosks and adapted its methods for gaining patient feedback by introducing a range of online surveys. The 'Happy or Not' kiosks have now been reintroduced to gather feedback from the Mass Vaccination Centres. The Health Board also issues surveys to patients and staff as part of bespoke studies across a range of different services.

51 The Health Board has a Complaints and Patient Advice and Liaison Service (PALS) that sits under the remit of the Executive Director of Nursing.

52 The Health Board is rolling out the Once for Wales Service User Feedback System that will introduce real-time feedback and 'ward to board' reporting functionality. This will ensure a consistent approach across the organisation and enable it to monitor actions and undertake more effective thematic analysis.

Concerns and Complaints

53 Against a national target of 75% of complaints responded to within 30-days, the Health Board achieved 77% as at January 2022 which represents a slight decrease in performance of 88% in December 2021. However, the Health Board consistently exceeds the national target through its Corporate Concerns Team, whose approach is to resolve as many concerns as possible under early resolution.

54 The Health Board uses information from concerns, complaints, serious incidents (known also as Nationally Reportable Incidents), and never events to identify themes and trends which it includes in its Quality Indicators Report. The top reported categories for serious incidents since June 2021 have been pressure ulcers, patient accidents / falls, unexpected deaths, delayed diagnostic processes / procedures, and delayed access / admission. The main themes in relation to concerns are waiting times, communication, care, and treatment.

55 The Surgery Clinical Board reported 812 concerns received between 1st September 2020 to 30th September 2021. It has embedded its arrangements for tracking concerns, with tracker meetings across all directorates aligned to an overarching Clinical Board tracker database. This enables effective monitoring of timelines in responding to concerns and supports the ability to take prompt action where there are delays. The effectiveness of these arrangements and the support received from the Corporate Concerns Team is reflected in the Surgery Clinical Board's performance, with 86% of concerns closed within the 30-day target for the period 1st September 2020 to 30th September 2021. The latest assurance report from the Surgery Clinical Board to the corporate QSE Committee in February 2022 identifies the main themes arising from concerns as: clinical treatment / assessment, appointments, communication issues, admissions, and attitude / behaviour. However, there was limited evidence within the report to demonstrate how the Clinical Board is learning and acting on the main concerns themes.

56 The Assistant Directors of Patient Experience and Patient Safety provide a report and presentation annually to the corporate QSE Committee which outlines the quality, safety, and experience themes and trends identified across the Health Board during the year. The 2020-21 report mainly focuses on the Health Board's work to adapt its reporting and working requirements across the organisation during the pandemic. However, the accompanying presentation identifies themes and trends in relation to key aspects of quality and safety, including patient safety incidents, concerns, redress, mortality reviews, COVID-19 investigations, and national clinical audit.

57 There appears to be a generally positive culture within the Health Board in relation to learning lessons and improving patient safety. Results from the Health Board's internal patient safety survey found that:

- 65% staff agreed or strongly agreed that they are actively doing things to improve patient safety.
- 58% staff agreed or strongly agreed that mistakes have led to positive change.

- 43% staff agreed or strongly agreed that after staff make changes to improve patient safety, and they evaluate their effectiveness.

Listening to staff concerns

58 The Health Board is committed to listening and learning from staff experiences and concerns. In December 2021, it reviewed and updated its Incident, Hazard, and Near Miss Reporting Procedure to reflect changes made by the NHS Wales Delivery Unit to the way NHS bodies report serious incidents. The procedure outlines a range of mechanisms for staff to raise concerns, including the 'freedom to speak up' initiative, 'safety valve' and whistleblowing policy. However, whilst the procedure references the 'safety valve' process as an option for raising concerns, the Health Board no longer uses it.

59 The Health Board's 'freedom to speak up' initiative aims to develop a culture of openness across the organisation. It supports and encourages staff to raise any concerns they may have. During June 2021, the Health Board updated its internet site and established a new communication plan to raise awareness across the organisation.

60 Whilst the Health Board regularly reports concerns to its corporate QSE Committee, it was unclear whether this includes concerns raised by staff. Subsequently, we could not assess the effectiveness of the arrangements.

61 The Health Board encourages staff to use Datix to report incidents. Whilst all staff within Corporate Services, the Surgery Clinical Board, and the Surgical Services Directorate appear to have access to the Datix system, the results from our data collection surveys suggest only some have received training or support to use the system to report concerns, near misses or run reports.

62 There is a mixed picture in relation to the culture around listening to staff concerns. Results from the Health Board's internal patient safety survey found 67% agreed or strongly agreed that staff will freely speak up if they see something that may negatively affect patient care, and 60% staff agreed or strongly agreed that their supervisor / manager seriously considers staff suggestions for improving patient safety. However, 41% agreed or strongly agreed that staff felt free to question the decision or actions of those with more authority and 27% agreed or strongly agreed that staff are afraid to ask questions when something does not seem right. **(Recommendation 4)**

Patient Stories

63 Patient stories feature on the agenda of meetings of the Board, corporate QSE Committee, other sub-committees of the Board such as the Mental Health Capacity and Legislation Committee, and the Clinical Board Quality, Safety and Experience Committees. Patient stories are regularly shared in public Board meetings using videos. The corporate QSE Committee note patient stories included in Clinical Board Assurance Reports and in the minutes of the Clinical Board Quality, Safety

and Experience Committees presented during the meeting. Learning and actions arising from patient stories are identified at Clinical Board level.

Patient Safety Walkarounds

64 Patient safety walkarounds provide Independent Members with an understanding of the reality for staff and patients, help make data more meaningful, and provide assurance from more than one source of information. The Health Board has re-commenced its programme of walkarounds having paused them during the pandemic. However, they are on a smaller scale whilst COVID-19 restrictions and considerations remain in place. Independent Members commented positively on the walkarounds. They indicated that the walkarounds help them to triangulate information, to gain a sense of staff morale, and to understand the day-to-day issues affecting staff. Reports arising from patient safety walkarounds are shared with the respective Clinical Board and reported to the corporate QSE Committee annually.

Internal / External Inspections

65 Our 2021 Structured Assessment work found that the Corporate Governance Directorate presents a legislative and regulatory tracker report to each Audit and Assurance Committee meeting. The update provides an overview of the Health Board's progress in implementing recommendations made by inspection and regulatory bodies, such as the Health and Safety Executive, Health Inspectorate Wales (HIW), and Community Health Council. The Corporate Governance Directorate has recently enhanced the content of the report to provide more robust assurance to the Audit and Assurance Committee, as well as to provide a commentary on the Health Board's management of Welsh Health Circulars, and Patient Safety Solutions. However, there are opportunities for the Audit and Assurance Committee to strengthen its role in seeking assurance from the corporate QSE Committee. Doing so might help provide a greater level of assurance to the Board that appropriate action is being taken to address and monitor external recommendations relating to quality and safety.

66 The corporate QSE Committee receives updates on HIW and CHC activity. Updates provided to the Committee meeting in February 2021, June 2021, and February 2022 provide an overview of CHC reports, and HIW local inspections and thematic and national reviews. All update reports gave sufficient information to ensure awareness amongst Committee members of all activity that could potentially impact on the Health Board.

Governance structures and processes

67 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

68 We found **strong collective responsibility for quality and safety amongst the Executive Leadership of the Health Board. However, the departure of key clinical Executives from the organisation potentially poses risks to rolling-out and embedding the new Quality, Safety and Patient Experience Framework. Corporate and operational structures and processes for quality and safety are reasonably effective and the Health Board is taking steps to strengthen these arrangements further. However, resources require further investment to enable the Health Board to fully roll-out and embed its planned quality and safety improvements.**

Organisational design to support effective governance

69 There is strong collective responsibility for quality and patient safety amongst the Executive Leadership of the Health Board, with the Executive Director of Nursing, Medical Director, and Director of Therapies and Health Sciences in particular providing visible leadership in this area. The Health Board's senior leadership is supported by a team of Assistant Directors who provide day-to-day leadership for a range of functions including quality and safety Improvement; patient safety; quality assurance; and clinical effectiveness. The Health Board's Director of Nursing is retiring in July 2022 and, therefore, the Health Board will need to recruit to this role. This potentially poses a risk to the Health Board, as both the Director of Nursing and previous Medical Director were instrumental in the development of the new Quality, Safety, and Patient Experience Framework and will have left the Health Board before it has been fully implemented and embedded across the organisation. Our review found that the Executive Management Board regularly discuss quality and safety as a standing agenda item at its twice weekly meetings.

70 Whilst there is collective responsibility and accountability for quality and safety at a corporate level, our work found that at an operational level there is evidence of 'silo' working and a lack of clarity among Clinical Directors around their responsibilities for quality and safety. We understand that the Health Board is addressing this through the job planning process.

Quality, Safety and Patient Experience Framework and Structures

71 We comment in **paragraph 17** on the Health Board's new Quality, Safety and Patient Experience Framework for 2021-26 which was approved by the corporate QSE Committee in September 2021. The framework articulates a structure which includes a range of committees and groups focussing on specific aspects of quality and safety. Each committee / group is required to provide assurance to the

corporate QSE Committee which, in turn, provides assurance to the Board via the quality, safety and experience dashboard and signals from noise data tool. It is expected that the committees / groups in the quality, safety, and experience structure will ensure an increased focus on key quality areas, reduce the workload of the corporate QSE Committee, and provide greater assurance to the Board. Key quality and safety exception reports such as, HIW reports, infection prevention and control reports and significant national quality, safety, and experience reports provide further assurance.

72 Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety, and how they align with the corporate structures to provide 'floor to board' quality and safety assurance. For example, each of the Health Board's Clinical Boards have a local Quality, Safety, and Experience Committee which are underpinned by directorate or site-based leadership Quality, Safety, and Experience groups. Clinical Boards provide assurance to the corporate QSE Committee through periodic assurance reports and the inclusion of minutes from the local meetings. The Health Board is still in the process of rolling out and embedding the new quality, safety and patient experience structure with some key committees and groups - such as the Organisational Learning Committee and Clinical Safety Group - yet to meet.

Corporate Quality, Safety, and Experience Committee

73 The corporate QSE Committee is responsible for providing assurance and advice to the Board in relation to quality and patient safety. The corporate QSE Committee considers and seeks assurance from a range of quality and safety information. As part of our work, we observed the committee on several occasions, and found them to be well-chaired with good quality discussion, scrutiny, and challenge from Independent Members. However, our recent structured assessment work highlighted some concerns expressed via the 2020-21 Board Effectiveness Survey regarding the length of the committee agendas.

74 The committee's arrangements for providing assurance on quality and safety matters has improved. The committee reviews and scrutinises a range of quality and safety indicators and provides an overview of the Health Board's performance at each Board meeting.

Clinical Effectiveness Committee

75 The monthly Clinical Effectiveness Committee (CE Committee) was established in December 2020 to provide a forum for senior clinicians to monitor the implementation of NICE[9] guidelines, to provide strategic direction for the Health Board's national and local clinical audit programme, and to receive reports from

[9] National Institute of Health and Care Excellence

sub-groups and escalate issues / provide assurance to the corporate QSE Committee and Board as appropriate. The committee has multidisciplinary membership and invites representatives from Clinical Boards to discuss items on its agenda.

Clinical Safety Group, Organisation Learning Committee, and Serious Incidents / Concerns Group

76 The Health Board intends to further strengthen its quality and safety arrangements by establishing a Clinical Safety Group and an Organisational Learning Committee.

77 The Clinical Safety Group's draft Terms of Reference indicates that its role will be to provide advice and assurance to the corporate QSE Committee by overseeing Health Board plans; considering external review / investigation reports and their implications on patient and citizen experience; considering outcomes for patient feedback; reviewing compliance with Health and Care Standards; and monitoring implementation of the Quality, Safety and Experience Framework. The committee will have multidisciplinary membership from nursing, medical, and corporate staff.

78 The Organisational Learning Committee's draft Terms of Reference indicate that its role will be to provide strategic direction and leadership to ensuring cross divisional learning from themes and trends. It will also be responsible for agreeing actions for improvement and monitoring the sharing of good practice. The committee will report to the corporate QSE Committee for assurance purposes. Whilst the proposed committee membership includes staff from a range of professional backgrounds, we do note a lack of nursing representation.

79 The role of the Serious Incident / Concerns Group is to provide oversight around the management of complaints, claims, serious incidents, patients experience, never events, inquests etc. We comment on the positive impact this group has had on the Health Board's concerns / complaints performance in **paragraph 53**. Our observations of several Serious Incident / Concerns meetings found there to be a positive culture around quality, safety, and patient experience. Meetings were well chaired with open and honest discussions amongst attendees. Clear actions were identified and agreed and assigned to responsible officers.

Clinical Board Quality, Safety and Experience Committees

80 The Quality, Safety, and Experience Committees within Clinical Boards are responsible for providing assurance and advice to the corporate QSE Committee. There are bi-monthly Surgery Clinical Board Quality, Safety, and Experience Committee meetings which are chaired by a Consultant Anaesthetist.

81 There is good multidisciplinary attendance at meetings from nursing, medical, and corporate staff. The structured meeting agenda aligns to the Health and Care Standards. There are also items relating to sharing feedback from the corporate QSE Committee and considering exception reports and escalation of key issues from Directorate Quality, Safety, and Experience Committees and specialties. This

ensures both ‘floor to board’ quality and safety assurance and enables sharing of key corporate quality and safety information down through the quality and safety structure.

Directorate Quality, Safety, and Experience Committees

82 The Directorate Quality, Safety, and Experience Committees are responsible for providing assurance and advice to the Clinical Board Quality, Safety, and Experience Committees. Monthly Surgical Services Directorate Quality, Safety and Experience committee meetings are held and chaired by the Lead Clinician responsible for quality and safety. Meetings are well chaired and have good multi-disciplinary attendance from nursing, medical, and corporate staff. There is good quality discussion among participants with sufficient time given to each item allowing everyone to contribute to the discussion.

Resources and expertise to support quality governance

83 There are several corporate teams working to support quality and safety issues across the Health Board. The Patient Experience Team and the Concerns Team report to the Executive Director of Nursing. This is in addition to the Quality Improvement, Clinical Audit, and Infection Prevention and Control Teams referred to in this report (see **paragraphs 28, 36, and 85**).

84 The Patient Experience Team (3.86 WTE, 4 headcount) provides a range of bespoke training to operational areas supporting staff, carers, and volunteers across the Health Board, alongside its more structured induction training for new staff. The Concerns Team (10.4 WTE, 14 headcount) provides training and support to operational staff in relation to early complaint resolution, breach of duty, putting things right, and other areas of bespoke training. Both the Patient Experience and Concerns Teams had no vacancies at the time of reporting. However, resources within the teams have reduced over the last three years to achieve cost reductions. Results from our data collection survey indicate that the Health Board does not have a corporate data analytics team.

85 The Health Board has a dedicated Infection Prevention and Control Team (7 WTE, 8 headcount), which provides formal and bespoke training and support to operational staff across the Health Board on matters relating to infection prevention and control. During the COVID-19 pandemic, the team worked in association with external / partner organisations and agencies such as Cardiff University, Cardiff Metropolitan University, Cardiff Council, and Vale of Glamorgan Council to provide PPE[10] and general infection prevention and control training and also ensured attendance at TTP[11] operational and board meetings. This has had a significant impact on the team’s capacity to provide both support to the immediate pandemic

[10] Personal Protective Equipment

[11] Test, Trace and Protect

response and to provide advice and training across the Health Board on its regular infection and prevention control work. The team had no vacancies at the time of reporting.

86 At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety such as: managing concerns, patient experience, infection prevention and control, quality improvement, risk management, Datix, and data analytics. However, we found that some designated leads do not have protected time to fulfil several of these roles, particularly at the directorate level.

87 Indeed, the lack of resources and capacity for quality and safety activity was a consistent theme during our interviews with Health Board staff. Furthermore, results from the Health Boards internal patient safety survey identify this as a significant issue:

- 67% of staff disagreed or strongly disagreed that there is enough staff to handle the workload.
- 43% of staff agreed or strongly agreed that staff in their team / department work longer hours than is best for patient care.

88 Corporate and operational resources for quality and safety, therefore, require further investment to enable the Health Board to fully roll-out and embed its planned quality and safety improvements. **(Recommendation 6)**

Arrangements for monitoring and reporting

89 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

90 We found that **corporate and operational agendas provide a wide coverage of quality and safety issues for discussion. There is sufficient information for scrutiny and assurance at both corporate and Clinical Board levels, and the Health Board's use of quality and safety data is maturing. However, there are opportunities for agendas to be more dynamic to reflect new and emerging quality risks and issues. Reporting on the four harms associated with COVID-19 requires strengthening. Furthermore, reporting requires further development at directorate level and around services commissioned by the Health Board.**

Information for scrutiny and assurance

91 The Board's integrated performance report and balanced scorecard provide performance information against the NHS Wales Delivery Framework measures including complaints, serious incidents, mortality, and falls. The report provides a detailed commentary on quality and safety performance and includes links to other papers that provide further information on specific aspects of quality and safety.

For example, the report provided to Board in January 2022 included a link to a separate paper on pressure damage reduction.

92 The Board introduced a 'COVID-19 Update Report' in November 2020 (which was renamed "Systems Resilience Update" in November 2021) to provide updates on key aspects of the Health Board's activities during the COVID-19 pandemic, including in relation to quality and safety. The quality and safety element of the report provides an overview of operational pressures and their impact, as well as some commentary in relation to people experience and investigations into hospital acquired COVID-19. However, there is no evidence to indicate that the four harms associated with COVID-19 have routinely been reported to the Board either through the integrated performance report or systems resilience update. The Board also receives a range of separate quality and safety related reports around topics such as stroke performance, nurse staffing levels, and the Public Services Ombudsman's Annual Report.

93 In June 2020, the corporate QSE Committee agreed a range of quality indicators to routinely monitor at each meeting through a quality, safety, and experience dashboard. Although work on the dashboard is still progressing, the committee continues to provide oversight of quality indicators through its Quality Indicators Report which includes measures on nationally reportable incidents, pressure damage, COVID-19 related incidents, never events, concerns, patient experience, and falls. Whilst the corporate QSE Committee also receives reports from all Clinical Boards which assist in providing assurance across the breadth of the Health Boards services, there are opportunities to strengthen reporting on the quality and safety of services, including services commissioned by the Health Board.

94 Clinical Boards provide regular assurance reports to the corporate QSE Committee on the quality and safety of services at an operational level. The report from the Surgery Clinical Board is aligned to the Health and Care Standards and contains performance information on a range of quality metrics, including never events, healthcare acquired infections, incidents, concerns, and patient feedback. The report also highlights key risks and mitigating actions and work completed in response to COVID-19. However, there was limited evidence that Clinical Boards consider the four harms associated with COVID-19 as part of the reporting to the corporate QSE Committee. **(Recommendation 7)**

95 At an operational level, the Surgery Clinical Board's Quality, Safety, and Experience Committee reviews various presentations, performance reports, and dashboards including data around serious incidents, Datix management, mortality reviews, pharmacy prescribing, medication, patient experience, concerns, and infection control. We found that supporting papers were not provided for some agenda items, with verbal reports and updates provided instead. Whilst verbal reports and updates are appropriate in some cases, a lack of supporting information limits opportunities for attendees to review information in advance and provide sufficient scrutiny and challenge at meetings.

Coverage of quality and patient safety matters

96 The corporate QSE Committee's remit is clear in relation to providing oversight of quality and patient safety. Agendas are structured and include several standing items, such as Clinical Board Assurance Reports, Quality Indicators Report, reports on HIW activity, Primary Care updates, and review of the relevant Board Assurance Framework risks. The committee also receives exception reports and specific updates on key aspects of quality and safety such as pressure damage, regular review and approval of quality and safety related policies, and meeting minutes from all Clinical Board Quality, Safety, and Experience Committee meetings.

97 Whilst meeting agendas are structured, there are opportunities for them to be more dynamic to reflect new and emerging quality risks and issues. Furthermore, our work identified concerns around the size of agendas, presenting a risk that there is too much information to adequately scrutinise and seek assurance. However, as stated in **paragraph 71**, the establishment of additional committees and groups in the new quality, safety and experience structure should provide focus on key quality areas to provide assurance to the Corporate QSE Committee and, therefore, help to reduce the workload of the committee.

98 Operationally, the Quality, Safety and Experience committees within the Surgery Clinical Board and Surgical Services Directorate use standardised agendas which are aligned to Health and Care standards and cover key aspects of quality and safety such as: risk, patient stories, regulatory compliance and external accreditation, patient safety incidents, patient safety alerts, complaints, and infection control. However, the agendas for these meetings are also large which can result in meetings overrunning beyond their allocated time.

99 Results from our data collection surveys indicate that the COVID-19 pandemic did not impact the way in which the Surgery Clinical Board and Surgical Services Directorate monitors and reports quality and patient safety matters. They share minutes from meetings with the directorate, divisional and executive, management teams.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
R1 Quality and Safety Priorities The Surgery Clinical Board and Surgical Services Directorate revised their quality priorities in response to the COVID-19 pandemic. However, there appears to be poor alignment between these operational priorities and the Health Board's key delivery actions for quality and safety as outlined in its Annual Plan for 2021-22. The Health Board, therefore, should ensure there is better alignment between operational and strategic quality and safety priorities as articulated in the Health Board's 10-year strategy and new Quality, Safety, and Patient Experience Framework.	To work with all Clinical Boards to agree the QSE priorities aligning to the framework and Annual Plan and to the IMTP. Develop generic and specific Quality indicators aligned to the QSE Priorities in the QSE framework for Clinical Boards which are reported through QSE structure. and QSE Committee. These will be reported by exception as required and in totality at their scheduled presentation to the Committee.	September 2022 September 2022	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality

Recommendation	Management response	Completion date	Responsible officer
R2 Risk Management There is scope to ensure the corporate Quality, Safety and Experience Committee maintains greater oversight of risks scrutinised by other committees where there is a clear quality and safety impact. There is scope to improve the quality of risk information recorded on operational risks registers and the escalation and de-escalation of risk to / from the Corporate Risk Register. The Health Board, therefore, should ensure: a) the corporate Quality, Safety and Experience Committee seeks assurance from other Health Board committees where their risks potentially impact on quality and safety; and b) review and improve the quality of risk information recorded on operational risks registers and introduce an appropriate process for the escalation and de-escalation of risk to / from the Corporate Risk Register.	a) All risks detailed within the Corporate Risk Register that might impact on quality and safety will continue to be shared at the Quality, Safety, and Experience Committee. In addition, risks detailed within the Board Assurance Framework that are shared at other committees, such as Work Force, which is discussed at the Strategy and Delivery Committee will, where the risk may have Quality and Safety implications, also be shared with the Quality, Safety and Experience Committee. b) The Health Board's Risk and Regulation Team operate a check and challenge system to manage the escalation and de-escalation of risks from the Corporate Risk Register. Training is also provided to risk leads to improve the detail recorded within risk registers. Both areas remain a work in progress and will continue to be implemented and improved.	October 2022 Underway and an ongoing requirement - March 2023	Director of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
R3 Clinical Audit The Health Board is developing a Clinical Audit Strategy and Policy, but there has been a delay in progress due to capacity and IT system challenges within the Clinical Audit Team. Internal Audit completed a review of the Health Board's clinical audit arrangements during 2021 and gave a limited assurance rating, identifying several key matters that need to be addressed. Whilst the Health Board is making some progress in this area, it should: a) complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide, and local audits informed by areas of risk. This plan should be approved by the corporate Quality, Safety and Experience Committee and progress of its delivery monitored routinely; and b) ensure that recommendations arising from the Internal Audit review of clinical audit are implemented as a priority.	The Clinical Audit Plan is to be shared at the Audit and Assurance Committee and discussed at the October QSE Committee meeting. The plan will reference all of the actions from this report. Compliance with internal audit findings will continue to be monitored via the Audit and Assurance Committee. Some investment has been provided to Clinical Audit from in year one form the internal Business case (monies to be provided over a 3 year period). Posts are being recruited into -investment was provided for a Clinical Effectiveness lead Band 8a and an Audit co-ordinator band 5. Additional resource was provided for a band 5 post to support the AMAT programme. AMAT - Audit management and tracking system has been purchased and is being rolled out through a phased implementation.	October 2022 October 2022 Recruitment completed by September 2022 Implementation completed by March 2023	Head of Quality Assurance & Clinical Effectiveness

Recommendation	Management response	Completion date	Responsible officer
R4 Values and Behaviours The Health Board's Values and Behaviours Framework sets out its vision for a quality and patient-safety-focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses, incidents, and raising and listening to staff concerns. The Health Board, therefore, should undertake work to understand why some staff feel: a) that their mistakes are held against them or kept in their personal file; b) that the Health Board does not provide feedback about changes put into place following incident reports or inform staff about errors that happen in their team or department; and c) they don't feel free to question the decision or actions of those with more authority and are afraid to ask questions when something does not seem right.	A safety culture with a focus upon psychological safety is an enabler of the QSE Framework. Members of the team are undertaking an IHI (Institute for Healthcare Improvement) Leadership course, and their focussed piece of work will address these issues. A project plan is being developed and will be part of the QSE implementation of the framework. Culture surveys and feedback will be part of the evaluation with our quality metrics and will be undertaken annually in quarter 4 to assess whether values and behaviours have improved. Work will be aligned with organisational development colleagues supported through the people and culture plan.	QSE Framework to 2026 May 2023 Project plan completion October 2022 Annual surveys to be undertaken	Head of Patient Safety and Quality reporting to Executive Nurse Director as Executive sponsor for the programme

Recommendation	Management response	Completion date	Responsible officer
R5 Personal Appraisal Development Reviews (PADRs) The Health Board compliance rate for appraisals is consistently below the national target of 85%. The Health Board reports that operational pressures are adversely affecting compliance and enabling work has not delivered the level of improvement anticipated over the COVID-19 pandemic period. The Health Board, therefore, should take appropriate action to improve performance in relation to PADRs at both corporate and operational levels.	The UHB has recognised the issue regarding VBA compliance and an improvement plan has been put in place focusing on communication and engagement, training and support and the impact on staff wellbeing and performance outcomes. This improvement plan has been developed with Trade Union Partners and will be delivered in collaboration with TU Partners. Recognising ongoing service pressures across the UHB as we manage the pandemic recovery phase and ever increasing service demands, the UHB target is to increase compliance to 50% in 2022/23, followed by a target of 85% in 2023/24. These KPIs are reflected in the People and Culture Plan and are reviewed monthly. A focus on promotion and engagement of the new VBA approach (launched in 2019), will develop manager capability and team buy-in through effective and accessible training and development, engagement, and support, including development in delivering an effective VBA, the importance of VBAs on staff wellbeing, performance, motivation, and quality. A range of bite-size learning is also in development which will also provide employees with support in preparing for their VBA.	50% compliance rate – March 2023 85% Compliance Rate – March 2024	Assistant Director of OD, Wellbeing and Culture

Recommendation	Management response	Completion date	Responsible officer
	Targeted intervention will support developments regarding pay progression.		
R6 Resources to support quality governance Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles. The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.	The increase in concerns remains significant and resource is an issue. There has been some investment through the Business case which is spans a 3-year period. Management of resources through the pandemic was challenging for the Infection Prevention & Control team. However as the pandemic reduces the focus for the IPC team is back on normal tier 1 IPC targets, we are now seeing the move back to normal business. Active recruitment also in place to recruit to outstanding vacancies. Recently surgery clinical Board have a dedicated QSE nurse who liaises with corporate teams. The corporate team will work with the clinical board to identify QSE leads and responsibilities with an exercise to identify the time required to effectively deliver these agendas.	May 2024 September 2022 Completed October 2022	Assistant Director of Patient Experience Executive Director of Nursing Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality

Recommendation	Management response	Completion date	Responsible officer
R7 Monitoring and Reporting There is no evidence to indicate that the four harms associated with COVID-19 have routinely been reported to the Board either through the integrated performance report or systems resilience update. Furthermore, there was limited evidence that Clinical Boards consider the four harms associated with COVID-19 as part of the reporting to the corporate Quality, Safety, and Experience Committee. The Health Board, therefore, should ensure that the four harms associated with COVID-19 are routinely considered by Clinical Boards and reported to the corporate Quality, Safety, and Experience Committee and Board.	The revised template for the Clinical Boards QSE meetings will incorporate the 4 harms associated with COVID-19 reporting. The notes and action logs of the clinical Boards will be shared at the QSE Committee meetings.	August 2022	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Report Title:	**Board Assurance Framework – Patient Safety & Workforce**			Agenda Item no.	2.9
Meeting:	Quality, Safety and Experience	Public	x	Meeting Date:	30th August 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 Patient Safety Risk and the Workforce Risk on the Board Assurance Framework due to the impact upon patient safety within the organisation.

There are currently nine key risks on the BAF, agreed by the Board in May 2022, which are impacting upon the Strategic Objectives of Cardiff and Vale Health Board. Patient Safety and Workforce are two of of those key risks and they specifically identify that:

Patient Safety

'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'

Workforce

'There is a risk that the organisation will not be able to attract, recruit and retain people to work in our clinical teams to deliver high quality care for the population of Cardiff and the Vale'.

It is good practice for Committees of the Board to review risks on the BAF which relate to them. The role of the Committee in relation to the risk is to review it, check that the controls are in place and working and agree any further actions required in order to mitigate the risk. The Committee can then provide further assurance to the Board that the risk is being managed or mitigated as much as possible at the current time. The Executive Director Leads for the Patient Safety Risk are the Executive Medical Director, the Executive Nurse Director and the Executive Director of Therapies and Health Sciences and for the Workforce Risk it is the Executive Director of People and Culture.

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 risk and Workforce Risk (last considered by the Board in July 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 and Workforce.

Recommendation:

The Quality, Safety and Experience Committee are requested to:

Review the attached 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.

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	28th July 2022

1. **Patient Safety – Interim Medical Director /Interim Executive Nurse Director- (Meriel Jenney/ Jason Roberts)**

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 during COVID 19 creating both longer and ageing 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, higher death rate. 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		

	• Implementation of Organisation and Transformation Centres (OPAT) to focus upon operational deliver across acute sites. • New Quality and Safety and Experience Framework approved by QSE Committee 14/07/21 • Wales wide Risk Summit in March 2022 with a refresh of health and social care actions to assist the current risk in the system with work continuing to be embedded and implemented • Resilience report being reviewed at ME on a weekly basis and reported to WG		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (2) • CAHMS position reviewed at Strategy and Delivery Committee (2) • Mental Health Committee aware of more people requiring support(2) • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives (1) • Update of situation in EU shared in private session of QSE Committee in Feb 22. (1) (2) • 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. Difference in interpretation of IPC guidance reduces timeliness of discharge to care settings.		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions	Lead	By when	Update since May 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	30.09.22	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	Jason Roberts/	30.09.22	Choice framework continues to be utilised

	Caroline Bird		
3. Board to Ward and Immediate Release Protocols currently been developed via Clinical Board for dealing with pressures in EU with oversight from OPAT	Jason Roberts	30.06.22	Complete – Immediate Release Protocol agreed and in place. Board to Ward undergoing final review of document
4. Programme of work in place and being led by the Chief Operating Officer, supported by Operational Teams to address the backlog	Caroline Bird	31.03.22 Review October 22	New Action
Impact Score: 5 **Likelihood Score: 2**	**Target Risk Score:**		**10 (High)**

1. **Workforce – Executive Director of People and Culture (Rachel Gidman)**

Across the UK and in Wales there are increasing workforce challenges for healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services due to the pandemic, mass immunisation programme and urgent service recovery plans has led for an increasing need in clinical staff. There is now a sense that our workforce capacity is being stretched thinly in an attempt to cover the number of competing and simultaneous operational requirements that could be with us for some years to come.

The size and complexity of the workforce challenge is such that addressing it will require holistic and sustained action across the system on leadership, culture, workforce planning, pay, education, well-being, retention and transforming ways of working (hybrid and flexible working). (See linkage to BAF: Leading Sustainable Culture Change and Employee Well-being).

Risk **Date added: 6.5.2021**	There is a risk that the organisation will not be able to attract, recruit and retain people to work in our clinical teams to deliver high quality care for the population of Cardiff and the Vale.
Cause	• The pandemic, Winter and the Recovery Plan has placed significant pressure on our workforce. Demand for staff has been significantly higher than the supply which has meant that our existing teams have been placed under extreme pressure since March 2020. • The increased demand across the NHS has left a shortage of people with the right skills, abilities and experience in many professions/roles which has created a more competitive market. • National shortages in some professions has made it difficult to attract people with the right skills/experience and in the numbers required, for example: - Registered Nurses. - Medical staff in certain specialties (e.g., Adult Psychiatry, General & Acute Medicine, Histopathology, Radiology, GP). • Turnover across the UHB has stopped rising but is still at 13%, over 3% higher than the pre-pandemic rate. • Sickness absence remains high at just over 7% which is 2% higher than pre-pandemic. The rate is stabilising but is still very challenging. Significant operational pressures across the whole system since March 2020 has impacted negatively on the health and wellbeing of our staff. • The development of our existing workforce has reduced as a direct result of the pandemic and the significant operational pressures, which is impacting negatively on retention.
Impact	• Negative impact on our people and our teams, as a result we are experiencing: - High levels of sickness absence; - High levels of turnover; - Low morale and poor staff engagement; - Increased reliance on temporary workforce e.g. bank, agency, locums, etc; - Poor compliance with statutory and mandatory training; - Reduced capacity to undertake appraisals, identify development needs, and focus on talent management and succession planning. - Lack of capacity to upskill and develop our current workforce.

	• Negative impact on quality of care provided to the population. Inability to meet on-going demands of both pandemic, Winter and the Recovery plan.		
Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• People and Culture Plan with robust processes to monitor progress against the key deliverables. • A Workforce Resourcing Team, supported by the well-established Nurse Resourcing Team is now well established. Focusing on improving attraction, recruitment and retention. • Retention Plan developed. • The People Services Team have changed its operating model to provide specialist advice and support aligned to the organisation's priorities, e.g. reducing sickness absence, reducing formal ER cases, effective change management, etc. • All Wales International Nurse Recruitment Campaign. • Welsh Government Campaign *Train, Work, Live* to attract for Wales – GP, Doctors, Nursing and Therapies. • Medical International recruitment strategies reinforced with BAPIO OSLER and Gateway Europe. • Medical Training Initiative (MTI) 2-year placement scheme via Royal Colleges. • Medical Workforce Advisory Group (MWAG) progress and monitor employment matters that directly affect our Medical & Dental staff. • Central managed Medical and Dental Staff Bank in place to increase the supply of doctors, maintain quality and reduce costs. Fill rate is over 90%. • E-Job Planning system in place to ensure Consultants and SAS Doctors have their job plans reviewed and approved annually, compliance currently above 80%. • E-Rostering Programme Board meet monthly to ensure the roll out of the new e-rostering system is progressing as outlined in the plan. • Health & Wellbeing strategy monitored through the strategic Health & Wellbeing Group. • Monthly Executive Performance Reviews with a focus on improving our workforce position commenced in July.		
Current Assurances	• Robust monitoring of People and Culture Plan KPI's at Strategy and Delivery Committee and Board. (1) (2) • Qtrly IMTP Updates. • Effective partnership working with Trade Union colleagues (WPG, LPF). (1) (2)		
Impact Score: 5	Likelihood Score: 4	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	Ability to on-board International nurses at pace due to Visa processing. Workforce supply affected by National Shortages.		
Gap in Assurances			

Actions	Lead	By when	Update since March 2022
1. Approval to engage in the All Wales International Nurse Recruitment Campaign (cohort 2 – end of 2022/early 2023)	Rachel Gidman	Oct 22	Paper being developed for consideration by ME in Aug/Sept. Last of cohort 1 arriving in Oct 22.

2. Approval needed to extend the current Medacs contract beyond 07/08/22 – continue with the Managed Medical & Dental Staff Bank			Aug 22	Paper being presented to ME on 18/07/22, if approved it will need to be considered by Board.
Impact Score: 5	Likelihood Score:2	**Target Risk Score:**		**10 (High)**

Report Title:	Annual Letter from the Ombudsman			Agenda Item no.	2.10
Meeting:	**Quality, Safety & Experience Committee**	Public	✓	Meeting Date:	30/08/22
		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:

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

Annual Letters (www.ombudsman.wales/?s=Annual+letters) section on website the current letters are not yet published.

A report will be provided to the October Board meeting.

It is pleasing to note that the Health Board was below the average for complaints received and investigated with Health Board average adjusted for population distribution.

Appendix A - Complaints made to PSOW

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	142	0.24
Betsi Cadwaladr University Health Board	213	0.30
Cardiff and Vale University Health Board	89	0.18
Cwm Taf Morgannwg University Health Board	113	0.25
Hywel Dda University Health Board	88	0.23
Powys Teaching Health Board	10	0.08
Swansea Bay University Health Board	110	0.28
Total	765	0.24

For context, across the UHB in 2021/22 we received over 3200 concerns

Therefore, these figures demonstrate that less than 0.3 % of people who raised concerns with the UHB in 2019/20 approached the Ombudsman because they were dissatisfied with the Health Board response.

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/ Voluntary Settlement	Discontinued	Other Reports Not Upheld	Other Reports Upheld	Public Interest Report	Total
Cardiff and Vale University Health Board	23	7	30	11	1	2	6	1	**81**
% share	28%	9%	37%	14%	1%	2%	7%	1%	

From the 89 concerns received by the Ombudsman following initial review of our responses a full investigation was undertaken into only some 9 Cases and there were voluntary settlements agreed in 11 cases and 1 Public interest report

In response to the annual letter the Health Board has been asked to take the following actions by the Public service Ombudsman for Wales

- Present my Annual Letter to the Board and share any feedback from the with my office.
    - Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
    - Inform me of the outcome of the Board's considerations and proposed actions on the above matters by 30 September.
-

We have met with the Ombudsman lead for the Complaints Standard Authority which is intended to help support complaint handling staff in delivering excellent outcomes for service users. As part of their work the Ombudsman's office are providing Training Sessions e tailored to fit organisation's needs and provided without charge. Core modules focus on the complaints process, investigations, and communicating with complainants.

Soft skills modules explore additional sets of skills used in effective complaint handling and can provide an ideal refresher session for experienced staff.

We will ensure that the central concerns team will attend the modules when there is availability and we have been discussing a communications virtual module being developed for our UHB staff. This will be considered in the context of development of the Patient Experience framework

Assurance

The previous Internal audit review provided substantial assurance regarding the process within the Health Board for managing Ombudsman cases. All cases are managed via the corporate concerns team who support the Clinical Boards to respond to queries from the Ombudsman; cases are escalated to the Executive team as required. All recommendations are monitored to completion and closure by the Ombudsman's office.

Further development of the Once for Wales Concerns system and the service user experience system will enable more effective thematic and sentiment analysis to identify areas for improvement. There should also be an increased ability to benchmark comparable data across Wales to promote national learning and sharing of good practice and areas for improvement.

The Health Board has a robust process in place to manage Concerns from the Ombudsman's office

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

The reducing number of concerns reported to the Ombudsman despite the increasing numbers of concerns being received

Recommendation:

The Board / Committee are requested to: Note the Annual letter

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The Ombudsman reviews provide an independent level of scrutiny
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: Yes
Through the Ombudsman reports we monitor any workforce issues
Legal: Yes
We need to adhere to the relevant legislation
Reputational: Yes/No
There is media interest in PSOW reports
Socio Economic: Yes
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
When reviewed in detail it should be considered if any reports demonstrate equality and health inequities
Decarbonisation: Yes/No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

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PUBLIC SERVICES OMBUDSMAN FOR WALES

Ask for: Communications

01656 641150

communications@ombudsman.wales

Date: August 2022

Charles Janczewski
Cardiff and Vale University Health Board

By Email only: charles.janczewski@wales.nhs.uk

Annual Letter 2021/22

Dear Charles

I am pleased to provide you with the Annual letter (2021/22) for Cardiff and Vale University Health Board which deals with complaints relating to maladministration and service failure and the actions being taken to improve public services

This is my first annual letter since taking up the role of Public Services Ombudsman in April 2022, and I appreciate that the effects of the pandemic are still being felt by all public bodies in Wales. Our office has not been immune from this, with records numbers of cases being referred to us over the last two years. The strong working relationships between my Office and Health Boards continues to deliver improvements in how we are dealing with complaints and ensuring that, when things go wrong, we are learning from that and building stronger public services.

Complaints relating to Maladministration & Service Failure

Last year the number of complaints referred to us regarding health boards increased by 30% (compared to 20/21 figures) and are now well above pre-pandemic levels. It is likely that complaints to my office, and public services in general, were suppressed during the pandemic, and we are now starting to see the expected ‘rebound’ effect.

During this period, we intervened in (upheld, settled or resolved at an early stage) a similar proportion of complaints about public bodies, 18%, when compared with recent years. Intervention rates (where we have investigated complaints) for health boards also remained at a similar level – 30% compared to 33% in recent years.

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We will be liaising closely with Health Boards, Welsh Government and the Community Health Councils to monitor likely caseloads over the coming year, including in relation to any cases of Nosocomial transmission of Covid which may reach my office after the Board's local investigations under the national framework have been completed.

Supporting improvement of public services

Improvement Work

The Public Services Ombudsman (Wales) Act 2019 formalised our work with public bodies to improve complaints handling and learning from complaints. This work has now been consolidated within our Improvement Team who are engaging with a wide range of organisations to support better complaints handling in public bodies.

Proactive Powers

In addition to managing record levels of complaints, we also continued our work using our proactive powers in the Public Services Ombudsman (Wales) Act 2019. Specifically undertaking our first Own Initiative Investigation and continuing our work on the Complaints Standards Authority.

October 2021 saw the publication of the first own initiative investigation in Wales: Homelessness Reviewed. The investigation featured three Local Authorities and sought to scrutinise the way Homelessness assessments were conducted. The report made specific recommendations to the investigated authorities, as well as suggestions to all other Local Authorities in Wales and Welsh Government. Some of these recommendations will bring about immediate change – updating factsheets and letter and assessment templates to ensure that key equality and human rights considerations are routinely embedded into processes for example – all the recommendations were designed to bring about tangible change to people using homelessness services in Wales.

The Complaints Standards Authority (CSA) continued its work with public bodies in Wales last year. The model complaints policy has already been adopted by local authorities and health boards in Wales, we have now extended this to an initial tranche of Housing Associations and Natural Resources Wales. The aim being to implement this work across the Welsh public sector.

In addition to this, the CSA published information on complaints handled by local authorities for the first time – a key achievement for this work. The CSA receives similar data from Health Boards on a quarterly basis in line with Welsh Government reporting responsibilities, and will look to publish this data for the first time later in 2022.

The CSA has now implemented a model complaints policy with nearly 50 public bodies, and delivered 140 training sessions, completely free of charge, during the

last financial year. The feedback has been excellent, and the training has been very popular - so I would encourage Cardiff and Vale University Health Board to engage as fully as possible.

Complaints made to the Ombudsman

A summary of the complaints of maladministration/service failure received relating to your Health Board is attached.

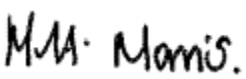
Finally, can I thank you and your officials for the positive way that health boards have engaged with my Office to enable us to deliver these achievements during what has been a challenging year for everyone. I very much look forward to continuing this work and collaboration to ensure we further improve public services across Wales.

Further to this letter can I ask that your Health Board takes the following actions:

- Present my Annual Letter to the Board and share any feedback from the with my office.
- Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
- Inform me of the outcome of the Board's considerations and proposed actions on the above matters by 30 September.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely,



Michelle Morris
Public Services Ombudsman

Cc. Suzanne Rankin, Chief Executive, Cardiff and Vale University Health Board
By Email only: suzanne.rankin@wales.nhs.uk

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Factsheet

Appendix A - Complaints made to PSOW

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	142	0.24
Betsi Cadwaladr University Health Board	213	0.30
Cardiff and Vale University Health Board	89	0.18
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Hywel Dda University Health Board	88	0.23
Powys Teaching Health Board	10	0.08
Swansea Bay University Health Board	110	0.28
Total	765	0.24

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Appendix B – Complaints made to PSOW by subject

Cardiff and Vale University Health Board	Complaints Received	% share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	3	3%
Clinical treatment in hospital	48	54%
Clinical treatment outside hospital	2	2%
Complaints Handling	12	13%
Confidentiality	0	0%
Continuing care	1	1%
COVID19	5	6%
De-registration	0	0%
Disclosure of personal information / data loss	0	0%
Funding	1	1%
Medical records/standards of record-keeping	0	0%
Medication> Prescription dispensing	2	2%
Mental Health	2	2%
NHS Independent Provider	0	0%
Non-medical services	0	0%
Other	9	10%
Out Of Hours	0	0%
Parking (including enforcement and bailiffs)	1	1%
Patient list issues	2	2%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Referral to Treatment Time	0	0%
Rudeness/inconsiderate behaviour/staff attitude	1	1%
	89	

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Appendix C – Complaints closed by PSOW - Outcomes
(* denotes intervention)

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/voluntary settlement*	Discontinued	Other Reports- Not Upheld	Other Reports - Upheld*	Public Interest Report*	Total
Cardiff and Vale University Health Board	23	7	30	11	1	2	6	1	81
% share	28%	9%	37%	14%	1%	2%	7%	1%	

Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	42	125	34%
Betsi Cadwaladr University Health Board	61	193	32%
Cardiff and Vale University Health Board	18	81	22%
Cwm Taf Morgannwg University Health Board	30	99	30%
Hywel Dda University Health Board	23	82	28%
Powys Teaching Health Board	3	6	50%
Swansea Bay University Health Board	29	105	28%
Total	**206**	**691**	30%

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Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2021/2022. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2021/2022. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Health Boards in 2021/2022. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

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Report Title:	Refresh of the Interventions Not Normally Undertaken (INNU) Policy and List			Agenda Item no.	3.1
Meeting:	Quality Safety & Experience	Public	✓	Meeting Date:	30 August 2022
		Private			
Status *(please tick one only):*	Assurance		Approval ✓	Information	
Lead Executive:	Executive Director of Public Health				
Report Author (Title):	Deputy Director of Public Health				

Main Report
Background and current situation:

Background

Continuing advances in technology and medicines, changing demographics, better information and increasing public and professional expectations all mean that it is essential to agree how best to provide high quality healthcare equitably, with the resources available, in order to meet population health need and to deliver the best health outcomes for the population we serve. Equally important is for the NHS to be clear on what it does not provide, and why.

Each Health Board has both a policy, and a list around 'Interventions Not Normally Undertaken' (INNUs). These are not available for a number of reasons including:

- There is currently insufficient evidence of clinical and/or cost effectiveness, or evidence applies to certain circumstances
- The intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE) or similar and/or
- The intervention is considered to be of low priority for NHS resources

INNUs are therefore interventions where the evidence of clinical benefit in relation to harm and/or cost effectiveness is limited to such a degree that undertaking them may be unjustifiable. They are either not normally available on the NHS, or are available when specific criteria are met.

This paper introduces a refreshed INNU policy and list together with an accompanying Equality Impact Assessment.

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

The INNU list is a 'live' document and can be updated regularly or when required. The policy is required to be updated every three years. Both documents were last updated in 2018, with a refresh anticipated in 2021, however due to the COVID-19 pandemic this was delayed due to staff capacity being focused on the COVID-19 response and recovery. The policy refresh will now move back to the three year cycle for review.

There is currently an expectation that work will be led by Welsh Government with Health Boards to generate a National INNU policy and list in the next few years, therefore this refresh has been 'light touch' in nature. The refresh of the policy has included updating out of date information and links. The policy and list were also compared to other Health Boards' lists across Wales and other organisations in the United Kingdom to consider similarities and differences.

Furthermore, all internal Clinical Boards were asked to comment on the INNU policy and list and make suggestions for revisions: these have all been incorporated. For example, the Obstetrics and Gynaecology team put forward a revision to the Caesarean Section criteria in line with new guidelines published by NICE.

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 might impact on different groups of people.

Recommendation:

The Committee is requested to:

Adopt the refreshed INNU policy and INNU list.

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

The INNU policy and list primarily focuses upon interventions that the Health Board does not provide, or provides within specific criteria, so should not generate additional costs

Workforce: No

No major changes

Legal: No

No major changes

Reputational: No

No major changes

Socio Economic: No

This was considered as part of the EQIA attached

Equality and Health: No

This was considered as part of the EQIA attached

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:
Clinical Effectiveness Committee	16 August 2022
Full EQIA undertaken	26 August 2022
Quality, Safety and Experience Committee	30 August 2022

LIST OF INTERVENTIONS NOT NORMALLY UNDERTAKEN BY CARDIFF AND VALE UNIVERSITY HEALTH BOARD

Executive Lead:	Executive Director of Public Health, Cardiff and Vale University Health Board
Approval Route:	Cardiff and Vale UHB Board 11 May 2010 (v01) Clinical Effectiveness Group (18th January 2016) Quality, Safety and Experience Committee (18th September 2018) Quality Safety and Experience Committee (30 August 2022)
Date Published:	12 May 2010 (v01) 2 June 2016 (v02) + minor amendment 24 October 2016 18 September 2018 (v03) 2 September 2022 (v04)
Area for Circulation:	Public Document
Linked Documents:	**Please note -** Embedded documents are available on request

Please read the following documents alongside this list:

- *Cardiff and Vale UHB Policy on Interventions not Normally Undertaken*
- *NHS Wales Policy on Making Decisions on Individual Patient Funding Requests*
- *NHS Wales Patient Guide to Individual Patient Funding Requests (IPFR)*

Version control	Review date	Reviewed by	Completed action	Ratified by	Date ratified	New review date
v02	October 2015 19/09/12 & July & Nov 2015 24/02/12 & July 2015	PCIC and CD & T Clinical Boards Clinical Effectiveness Group & Surgery Clinical Board review National Orthopaedic Innovation & Delivery Board & Surgery Clinical Board review	New policy statements prepared on: • Open MRI scans • Spinal injections for spinal surgery • Spinal injections for pain medicine • Hallux valgus	Clinical Effectiveness Group	18/01/16	List of Interventions Not Normally Undertaken is subject to continuous review.
V02 + minor amendments		Request from Dental Clinical Board for slight amendment to criteria & inclusion of updated evidence.	Slight change to wording of criteria for Dental implants.	Chair's action (Dr Sharon Hopkins).	24/10/16	
V03	August 2018	Consultant in Public Health and Clinical boards	Review of OCPS codes, intervention statements and updating of evidence for of all interventions in the INNU list			

			Addition of nasal surgery for snoring intervention.			
V04	August 2022	Consultant in Public Health and all Clinical Boards review	Rapid review of intervention statements considering additions, removals and changes needed due to revised evidence. Revision of Caesarean Section in line with NICE guidance	Quality Safety and Experience Committee	30 August 2022	This is a live list. Return to formal review of INNU list every three years with updates as needed in between as clinical policies are updated.

Clinical Board	Office of Population Censuses & Surveys (OPCS) code	Intervention	Criteria for Use without an Individual Patient Funding Request	Links to Further Information or Clinical Evidence Base
Children and Women Obstetrics and Gynaecology	R17.1 R17.2 R17.8 R17.9	Elective Caesarean Section (CS)	Can be undertaken when patients meet one or more of the following: • HIV (only if recommended by a HIV consultant) • Both HIV and Hepatitis C (as above, there is no evidence that CS should be performed for Hepatitis C alone) • Primary genital herpes in the third trimester (active genital herpes at the onset of labour) • Grade 3 and 4 placenta previa • Previous upper segment caesarean section / type unknown • Previous significant uterine perforation/surgery breaching cavity • A term singleton breech (if external cephalic version is contraindicated, failed or declined) • A twin pregnancy regardless of chorionicity with breech or smaller first twin • A monochorionic twin pregnancy after appropriate discussion about the risks of acute TTTS • A previous caesarean section if VBAC (Vaginal Birth after Caesarean) has been declined or is felt to be inappropriate • A previous traumatic vaginal delivery if VBAC has been fully explored but declined • A fetus at high risk of fetal distress in labour e.g. known severe placental insufficiency • A woman with tocophobia who has requested caesarean section, providing that her concerns have been fully	NICE Clinical Guideline 192 Caesarean Section (2021) https://www.nice.org.uk/guidance/ng192

			explored and documented AND support and counselling has been made available AND the patient has attended the Birth Choices Clinic (she should have been offered a referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her fears in a supportive manner. If, after providing such support, a vaginal birth is still not an acceptable option, an elective c-section can be supported). Patient request Where vaginal birth is still not an acceptable option after discussion of the benefits and risks with a senior midwife or obstetrician and offer of support, then a planned Caesarean section should be offered." An IPFR is required for all other circumstances.	
Children and Women Obstetrics and Gynaecology Saunders.Nathan 30/08/2022 11:22:01	Q37.- Q29.- N18.1	Sterilisation – Reversal of (male and female)	Can be used: If death of an existing child has occurred • If remarried after death of spouse • If loss of unborn child when vasectomy has taken place during the pregnancy. Request for exemption required in all other cases.	Royal College of obstetricians and Gynaecologists. FRSH Clinical Guidance Male and female sterilisation. September2014: https://www.fsrh.org/documents/ cec-ceu-guidance-sterilisation- cpd-sep-2014/ The evidence suggests that reversal of sterilisation for both females and males appear to be effective methods of restoring fertility. Those seeking sterilisation should be fully advised and counselled in accordance with Royal College of Obstetricians and Gynaecologists guidelines that the procedure is intended to be permanent.

Children and Women Obstetrics and Gynaecology	Q10.3 Q18.-	Heavy Menstrual Bleeding - Dilation and curettage (D&C)/ Hysteroscopy	D&C should NOT be used as a therapeutic treatment or as a diagnostic tool for heavy menstrual bleeding so will not receive prior approval for these conditions. Hysteroscopy can be used when it is carried out: • As an investigation for structural and histological abnormalities where ultrasound has been used as the first line diagnostic tool and where the outcomes are inconclusive • When undertaking endometrial ablation Request for exemption required in all other cases.	NICE Guideline 88 Heavy menstrual bleeding: Assessment and management: https://www.nice.org.uk/guidanc e/ng88
Children and Women Obstetrics and Gynaecology	Q07.- Q08.-	Heavy Menstrual Bleeding - Hysterectomy	Can be used when other treatment options have failed, are contraindicated or are declined by the woman Request for exemption required in all other cases.	NICE Guideline 88 Heavy menstrual bleeding: Assessment and management: https://www.nice.org.uk/guidanc e/ng88

Clinical Diagnostic and Therapeutics Radiology	No code	Open MRI scans	Conventional MRI scanning is provided locally by Cardiff and Vale UHB. It is expected that all patients requiring an MRI scan would use this service. Open MRI scanning will usually only be used when patients meet one of the criteria: **Category 1 – Claustrophobia** In the first instance, the Radiology department can meet with a patient that has concerns regarding claustrophobia and MRI scanning - a member of staff can describe the process to the patient and show them the scanner. If these fears cannot be alleviated by the Radiology Department, there is an option for sedation. *If suitable,* the patient will be referred to their General Practitioner for a prescription of a sedative which can be used during the scan. In most cases this is sufficient to enable an MRI scan to be performed. The patient must have had a failed attempt at conventional (closed) MRI with oral sedation, where appropriate, prior to acceptance for Open MRI. If the conventional option is not suitable (after review) and the referring clinician still feels that an Open MRI scan is needed, then the patient could be considered for an Open MRI scan. **Category 2 - Patient Size** The size of a patient and the restriction of the MRI scanner tunnel will vary depending on the patients and the circumstances. Some patients may be large but would still be suitable for a conventional closed MRI. In the first instance, the patient should be invited to attend the radiology department and be formally assessed by MRI radiographer for suitability. The patient can be talked through the procedure, and shown the scanner. The Radiographer will examine the evidence presented, and make judgement on whether to proceed with the MRI scan. If the closed MRI is not suitable (after review) and the referring clinician still feels that an MRI scan is needed, then the patient could be considered for an Open MRI. It should be noted that MRI may not be the imaging modality of choice for patients in this category and referral to a Specialist may be preferable. Request for exemption required in all other cases	A process is in place both for primary and secondary care referrals for open MRI.

Clinical Diagnostic and Therapeutics Therapies	X61.-	Complementary Therapies	Can be used as treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team) and as such will be used as part of an existing contract. The UHB will not support referral outside of the NHS for these services. Request for exemption required in all other cases.	The evidence suggests that there are large numbers of complementary and alternative therapies that have not been subject to the trials used to establish the effectiveness of conventional clinical treatments. The evidence base is developing and up to date evidence on complementary therapies and alternative treatments can be obtained from the Cochrane library and specialist evidence of NHS Library.

Dental	F11.5 F11.6	Dental Implants	Can be used for patients who need post cancer reconstruction, hypodontia, major trauma with bone loss, or on the advice of NHS specialists as outlined in the Dental Hospital Referral Criteria for Restorative Dentistry: Dental hospital referral guidelines.PDF . Request for exemption required in all other cases.	Royal College of Surgeons Guidelines for selecting appropriate patients to receive treatment with dental implants: Priorities for the NHS (2012): https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/implant-guidelines-20121009_final.pdf?la=en Updated 2019 guidance https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/implant-guidelines.pdf The evidence suggests that dental implants have been shown to be a successful treatment. However, dental implant treatment should only be provided by appropriately trained dentists in accordance with General Dental guidance

Dental	F12.1	Apicectomy	Can be used for: • Presence of periradicular disease, with or without symptoms in a root filled tooth, where non surgical root canal re-treatment cannot be undertaken or has failed, or where conventional re-treatment may be detrimental to the retention of the tooth • Presence of periradicular disease in a tooth where iatrogenic or developmental anomalies prevent non surgical root canal treatment being undertaken • Where biopsy of periradicular tissue is needed • Where visualisation of the periradicular tissues and tooth root is required when perforation, root crack or fracture is suspected • Where procedures are required that need either tooth sectioning or root amputation • Where it may not be expedient to undertake prolonged non-surgical root canal re-treatment because of patient considerations. Request for exemption required in all other case	Royal College of Surgeons of England. Guidelines for surgical endodontics 2012: https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/surgical_endodontics_2012.pdf? la=en The evidence suggests that the success rate of apical surgery on molar teeth is low.
Dental	F14.- F15.-	Orthodontic treatments of essentially cosmetic nature	Priority will be based on those with high Index of Orthodontic Treatment Need Scores - 5, 4 and 3 where a significant aesthetic component can be demonstrated and those with other major conditions e.g. cancers, craniofacial deformity. Request for exemption required in all other cases.	Evidence based on expert opinion suggests that orthodontic treatment should be directed at those individuals in which the greatest benefit can be achieved.
Dental	F09.3	Wisdom teeth - removal of asymptomatic	Can be used in cases where there is evidence of pathology. Request for exemption required in all other cases	NICE Technology Appraisal 1 Guidance on the extraction of wisdom teeth: http://guidance.nice.org.uk/TA1 Impacted wisdom teeth free from disease should not be operated on.

Surgery Ophthalmology	C44.8 C46.4 C46.8 + Y02.1	Corneal implants for the correction of refractive error in the absence of other ocular pathology e.g.keratoconus.	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 225 Corneal implants for the correction of refractive error: http://guidance.nice.org.uk/IPG225/guidance/pdf/English NICE Do not do recommendation Current evidence on the efficacy of corneal implants for the correction of refractive error shows limited and unpredictable benefit. In addition, there are concerns about the safety of the procedure for patients with refractive error that can be corrected by other means, such as spectacles, contact lenses, or laser refractive surgery.

Surgery Ophthalmology	C55.4	Scleral expansion surgery for presbyopia	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 70 Scleral expansion surgery for presbyopia: http://guidance.nice.org.uk/IPG70 NICE Do not do recommendation Current evidence on the safety and efficacy of scleral expansion surgery for presbyopia is very limited. There is no evidence of efficacy in the majority of patients. There are also concerns about potential risks of the procedure.
Surgery Ophthalmology	C44 + C45	Laser therapy for short sight	Can be used if the patient has a biometry error following cataract surgery. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 164 Photorefractive (laser) surgery for the correction of refractive errors: https://www.nice.org.uk/guidance/ ipg164 Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious for use in appropriately selected patients. However, the safety and effectiveness of this procedure should be considered against the alternative methods of correction: spectacles and contact lenses.

Surgery Ophthalmology	C88.2	Photodynamic Therapy (PDT) for late Age-related Macular Degeneration (AMD) (wet active)	Only to be offered as an adjunct to anti-VEGF as second- line treatment for late AMD (wet active) in the context of a randomised controlled trial. Request for exemption required in all other cases.	NICE Guideline 82 Age-related macular degeneration: https://www.nice.org.uk/guidance/ng82/resources/agerelated- macular-degeneration-pdf- 1837691334853 NICE Do not do recommendations: Do not offer photodynamic therapy alone for late AMD (wet active). Do not offer photodynamic therapy as an adjunct to anti- VEGF as first-line treatment for late AMD (wet active).

Surgery Cardiac/vascular	K23.4 + Y08.5	Percutaneous laser revascularisation for refractory angina pectoris	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 302 Percutaneous laser revascularisation for refractory angina pectoris : http://www.nice.org.uk/nicemedia/pdf/IPG302Guidance.pdf NICE Do not do recommendation Current evidence on percutaneous laser revascularisation (PLR) for refractory angina pectoris shows no efficacy and suggests that the procedure may pose unacceptable safety risks.
Surgery Cardiac	K23.4 + Y08.5	Transmyocardial laser revascularisation (TMLR) for refractory angina pectoris	No routine exemption criteria. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 301 Transmyocardial laser revascularisation for refractory angina pectoris: http://www.nice.org.uk/nicemedia/pdf/IPG301FullGuidance.pdf NICE Do not do recommendation Current evidence on TMLR for refractory angina pectoris shows no efficacy, based on objective measurements of myocardial function and survival. Current

				evidence on safety suggests that the procedure may pose unacceptable risks.
Surgery Orthopaedics	U13.2 + Z84.3 + Z84.6	Therapeutic use of ultrasound in hip and knee osteoarthritis	No routine exemption criteria. Request for exemption required in all cases.	
Surgery **Orthopaedics**	T59.- T60.-	Ganglia – Surgical Removal	Can be used if the ganglion is very painful and restricts work and hobbies (subject to specialist surgical assessment and advice). Request for exemption required in all other cases.	The evidence suggests that there is a high rate of spontaneous resolution for ganglia and that reassurance should be the first therapeutic intervention for most patients and all children

Surgery Orthopaedics	W71.4 W85.3	Autologous Chondrocyte implantation for knee/ ankle problems caused by damaged articular cartilage	Can be used in line with NICE guidance. As of 2 August 2022 NICE guidance states: Autologous chondrocyte implantation (ACI) is recommended as an option for treating symptomatic articular cartilage defects of the knee, only if: • the person has not had previous surgery to repair articular cartilage defects • there is minimal osteoarthritic damage to the knee (as assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis) • the defect is over 2 cm^2 and • the procedure is done at a tertiary referral centre. Request for exemption required in all other cases.	NICE Technology Appraisal 477: Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee: https://www.nice.org.uk/guidance/ ta477
Surgery Orthopaedics	NO CODE	Electrical & electromagnetic field treatments bone non-union	No routine exemption criteria. Request for exemption required in all cases.	
Surgery Orthopaedics	NO CODE	Abrasion arthroplasty	No routine exemption criteria. Request for exemption required in all cases.	

Surgery Orthopaedics **Clinical Diagnostic and Therapeutics** Radiology	U21.1 + Z66.5	Low Back Pain (Non-specific) – Plain X-rays of lumbar spine & MRI scans	MRI scans can be used in the context of a referral for an opinion on spinal fusion or if one of the following diagnoses are suspected: • Spinal malignancy • Infection • Fracture • Cauda Equina Syndrome • Ankylosing Spondylitis or another Inflammatory Disorder. Request for exemption required in all other cases.	NICE Guideline 59 Low back pain and sciatica in over 16s: assessment and management: https://www.nice.org.uk/guidance/ NG59
Surgery Orthopaedics / anaesthetics **Clinical Diagnostic and Therapeutics** Therapies	M45.59 (ICD10 code)	Low Back Pain (Non-specific) - Management	Do not offer the following for the management of low back pain with or without sciatica: • Belts or corsets • Foot orthotics • Rocker sole shoes • Traction • Acupuncture • Ultrasound • Percutaneous electrical nerve stimulation (PENS) • Transcutaneous electrical nerve stimulation(TENS) • Interferential therapy The following referrals should NOT be offered for the early management of persistent non-specific low back pain: • Radiofrequency facet joint denervation • Percutaneous electrothermal treatment of the intervertebral disc annulus • Percutaneous intradiscal radiofrequency treatment (PIRFT)	NICE Guideline 59 Low back pain and sciatica in over 16s: assessment and management: https://www.nice.org.uk/guidance/ NG59 NICE IPG 544 Percutaneous electrothermal treatment of the intervertebral disc annulus for low back pain and sciatica https://www.nice.org.uk/guidance/ ipg544 NICE IPG 545 Percutaneous intradiscal radiofrequency treatment of the intervertebral disc nucleus for low back pain https://www.nice.org.uk/guidance/ ipg545

Surgery Orthopaedics **Specialist Services** Neurosurgery	A52.1 A52.2 A52.8 A52.9 A54.9 A57.7 V54.4	Spinal Injections for Spinal Surgery	Before the use of spinal injections is considered, all patients must have been treated using conservative management techniques, as described in the UHB back pain pathway, and failed to achieve sufficient pain control. Spinal injections serve both a therapeutic and diagnostic role. The specific indications for which each of the three types of spinal injection may routinely be used are: 1. Lumbar and sacral epidural injections (A52.1, A52.2, A52.8) should only be used for therapeutic reasons where the diagnosis of spinal stenosis has been made and for post spinal stabilisation radicular pain where a nerve block might be difficult due to anatomical reasons. 2. Facet joint and sacro-iliac injections (V54.4) should be used for diagnostic purposes only. This may need to be repeated to ascertain consistency. 3. Spinal Nerve root blocks (A577) may be used for radicular pain. Injections should not be used more than twice in the same individual for the same episode of pain. If pain persists beyond this and no significant surgical target has been identified, the patient may require referral to the Pain Team to be assessed for management of chronic pain. Request for exemption required for the use of spinal injections in all other circumstances.	

Surgery Anaesthetics: Pain Medicine	A52.1 A52.2 A52.8 A52.9 A54.9 A57.7 V54.4 W90.3	Spinal Injections for Pain Medicine	Before the use of spinal injections is considered, all patients must have been treated using appropriate conservative management techniques, as described in the UHB back pain pathway, and failed to achieve sufficient pain control. The specific indications for which each of the three types of spinal injection may routinely be used are: 1. Lumbar and sacral epidural injections (A52.1. A52.2, A52.8) may be used for the following therapeutic reasons: a. Where the diagnosis of spinal stenosis has been made. b. For post spinal stabilisation radicular pain, where a nerve block might be difficult due to anatomical reasons. c. In patients with leg pain, either before or after back surgery, presenting with stenotic or radicular leg pain. 2. Facet joint and sacro-iliac injections (V54.4, W90.3) may be used for diagnostic and therapeutic purposes in patients suffering from chronic low back pain for greater than one year, as detailed below. a. Diagnostic facet joint injections may be used in order to identify patients that benefit from therapeutic Radiofrequency ablation of nerve to the facet joint in specific facet joint related back pain identified as such. b. Therapeutic facet and sacroiliac injections may be used in patients with specific facet or sacroiliac related back pain and/or referred leg pain Spinal Nerve root blocks (A57.7) may be used for radicular pain. Repeat spinal nerve root block may be required if pain persists and no significant surgical target has been identified. 3. Repeated therapeutic injections may be required in patients unable to tolerate oral medications, the independent elderly intolerant of analgesics, patients with drug dependence issues, young patients trying to avoid medication related side effects in order to retain their job, care for a family or continue study, and patients with concomitant worsening mental illness due to chronic pain uncontrolled despite optimal medical management. Spinal injections should not be used more than twice in the same individual for the same episode of pain. Such repeated injections should only be carried out if the patient reports ongoing pain relief (measured at first follow up) of greater than 50%, with improved physical functioning as demonstrated utilising suitable standardised outcome measures, 3 months or more post procedure. Request for exemption is required for the use of spinal injections in all other circumstances.	In the pain clinic, spinal injections serve both a therapeutic and diagnostic role. All spinal injections will be performed following a thorough bio psychosocial assessment and discussion with a consultant in pain medicine. They will always be performed as a part of a comprehensive pain management plan with the intention of improving patients' physical functioning and enabling participation in rehabilitative physiotherapy and/ or psychotherapy as appropriate within individualised pain management plans. The goal of spinal injections will be facilitation of pain management via reduction of the intensity of physical symptoms in order to promote patient engagement with self-management strategies in the long term.

Surgery Orthopaedics	W15.1 W15.2 W15.3 W15.6 W15.8 W16.4 W57.1 W59.3 W71.2 W79.1 W79.2	Hallux valgus (bunion): Surgical correction	Only patients identified with the following criteria should be listed for treatment: • Osteoarthritis affecting the 1st metatarsal phalangeal joint • Impending or actual skin compromise • Evidence of transfer metatarsalgia with mechanical changes requiring intervention e.g. claw toe	
Surgery Orthopaedics	W58.1 + Z84.3	Hip Resurfacing Techniques apart from in-line with published NICE guidance	Can be used in line with NICE guidance. As of 2 August 2022 NICE guidance states: Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years. Request for exemption required in all other cases.	NICE Technology Appraisal 304 Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip: https://www.nice.org.uk/guidance/ ta304
Surgery Orthopaedics	V25.- + Y08.- Y76.3	Endoscopic Lumbar Decompression and Laser Disc Decompression	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica: https://www.nice.org.uk/guidance/ ipg570
Surgery Orthopaedics	V33.7 + Y08.-	Laser Lumbar Micro-Discectomy	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica: https://www.nice.org.uk/guidance/ ipg570

Surgery Orthopaedics	W86.8	Hip Arthroscopy & Debridement	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 408 Arthroscopic femoro–acetabular surgery for hip impingement syndrome: https://www.nice.org.uk/guidance/ ipg408
Surgery Orthopaedics	W37.- W38.- W39.- W93.- W94.- W95.-	Hip Prostheses	Can be used in line with NICE guidance. As of 2 August 2022 NICE guidance states: Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years. Request for exemption required in all other cases.	NICE Technology Appraisal 304 Total hip replacement and resurfacing arthroplasty for end- stage arthritis of the hip: https://www.nice.org.uk/guidance/ ta304
Surgery ENT	F34.-	Tonsillectomy – children & adults	Can be used if patients meet ALL of the following criteria prior to referral: • Sore throat is due to tonsillitis • Five or more episodes of sore throat per year • Symptoms for at least one year • Episodes of sore throat are disabling and prevent normal function Request for exemption required in all other cases.	A six-month period of watchful waiting is recommended prior to tonsillectomy to establish firmly the patterns of symptoms and allow the patient to consider fully the implications of the operation. Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur.

Surgery ENT	F32.8	Soft-palate implants for obstructive sleep apnoea	No routine exemption criteria. As of 2 August 2022 NICE Guidance states: Current evidence on soft-palate implants for obstructive sleep apnoea raises no major safety concerns, but there is inadequate evidence that the procedure is efficacious in the treatment of this potentially serious condition for which other treatments exist. Therefore, soft-palate implants should not be used in the treatment of this condition. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 241 Soft-palate implants for obstructive sleep apnoea: http://www.nice.org.uk/nicemedia/pdf/IPG241Guidance.pdf NICE Do not do recommendation
Surgery ENT		Nasal surgery for snoring	No routine exemption criteria. Request for exemption required in all cases.	Included on National Do Not Do list
Surgery ENT	D15.1	Grommets - Drainage of middle ear in otitis media with effusion (OME)	Can be used where there has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist or GP with special interest in ENT AND the child is placed on a waiting list for the procedure at the end of this period; AND otitis media with effusion persists after three months AND the child (who must be over three years of age) suffers from at least one of the following: • At least 3-5 recurrences of acute otitis media in a year • Evidence of delay in speech development • Educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss) • A significant second disability such as Down's syndrome. Request for exemption required in all other cases.	NICE Clinical Guideline 60 Otitis media with effusion in under 12s surgery: http://www.nice.org.uk/nicemedia/pdf/CG60fullguideline.pdf

Surgery Vascular	L84.- L85.- L86.- L87.- L88.-	Varicose Veins – asymptomatic & mild/moderate cases	Can be used in the following circumstances: • ulcers/history of ulcers secondary to superficial venous disease • liposclerosis • varicose eczema • history of phlebitis. Request for exemption required in all other cases.	NICE Guidance CG168 Varicose veins: diagnosis and management (nice.org.uk) In some people varicose veins are asymptomatic or cause only mild symptoms, but in others they cause pain, aching or itching and can have a significant effect on their quality of life. This policy relates to asymptomatic and mild/ moderate cases. Most varicose veins require no treatment. The most common complaint about varicose veins is their appearance. When bleeding or ulceration occurs referral may be appropriate and of that number some may benefit from surgical intervention.
Surgery Gynaecology Saunders,Nathan 30/08/2022 11:22:01	A79.8 + Y08.-	Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain	No routine exemption criteria. As of 2 August 2022 the NICE guidance states: The evidence on laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain suggests that it is not efficacious and therefore should not be used. Request for exemption required in all cases.	NICE Interventional Procedures Guidance 234 Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain: http://guidance.nice.org.uk/IPG2 34

Surgery Gastroenterology	G80.2	Capsule Endoscopy/ Pillcam	Can be used for disease of the small bowel for: • Overt or transfusion dependant bleeding from GI tract, when source not identified on OGD/ Colonoscopy • Crohns Disease in whom strictures are not suspected • Hereditary GI polyposis syndromes Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 101: Wireless capsule endoscopy for investigation of the small bowel: http://guidance.nice.org.uk/IPG101
Surgery Gastroenterology	J18.1 J18.2 J18.3 J18.4 J18.5 J18.8 J18.9	Cholecystectomy (for asymptomatic gall stones)	Can be used in patients who are at increased risk of developing gallbladder carcinoma or gallstone complications. Request for exemption required in all other cases.	There is insufficient evidence of clinical effectiveness of cholecystectomy (for asymptomatic gallstones). Gallstone disease: diagnosis and management (nice.org.uk)
Surgery Gastroenterology	H51.-	Haemorrhoidectomy	Can be used in cases of: • Recurrent haemorrhoids • Persistent bleeding • Failed conservative treatment Request for exemption required in all other cases.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/rectal-bleeding--commissioning-guide.pdf The evidence suggests that first and second degree haemorrhoids are classically treated with some form of non-surgical ablative/ fixative intervention, third degree treated with rubber band ligation or haemorrhoidectomy, and fourth degree with haemorrhoidectomy.
Surgery Neurosurgery	No code	Subthalamic nucleotomy for Parkinson's disease	Can be used in line with NICE guidance. As of 2 August 2022 the NICE guidance states: Current evidence on the safety and efficacy of subthalamotomy for Parkinson's disease does not appear adequate to support the use of this procedure without special arrangements for consent and for audit or research. Request for exemption required in all other cases.	NICE Interventional Procedures Guidance 65 Subthalamotomy for Parkinson's disease: https://www.nice.org.uk/guidance/ipg65

Surgery Urology	N29.1	Treatment for Erectile Dysfunction (ED)	Can be used in accordance with the agreed service specification of: a. Assessment by specialist ED providers for patients with ED referred by GPs. b. Treatment (drug or mechanical device) for ED in line with WHC (1999) 06 i.e. for patients suffering from ED who fall into the eligible groups for NHS prescriptions from GPs. c. Treatment (drug or mechanical device) by specialist ED providers for patients categorised as suffering with ED and severe distress who do not fall into 1(b). Request for exemption required in all other cases.	Cardiff and Vale Formulary and Erectile Dysfunction Care Pathway http://cardiffandvaleuhb.inform.wales.nhs.uk/favicon.ico
Medicine Gastroenterology	No code	pH/Manometry Impedance Studies	No routine exemption criteria for adults. Request for exemption required in all adult cases.	
Medicine Rheumatology	M79.09 (ICD10 code)	Fibromyalgia in adults: In patient pain management/ specialised fibromyalgia programmes	There is no cure for fibromyalgia syndrome and treatment is aimed at alleviation of symptoms. There are no agreed criteria for referral to inpatient pain management or specialised fibromyalgia programmes without an Individual Patient Funding Request (IPFR).	
Medicine Respiratory **Children & Women** CAMHS	No code	Melatonin for delayed sleep phase disorder	No routine exemption criteria for use in adults. Request for exemption required in all adult cases. Use in children and adolescents should be specialist initiated and in line with Shared Care Protocol CV54 **Please refer to Cardiff and Vale formulary http://cardiffandvaleuhb.inform.wales.nhs.uk/favicon.ic o**	Shared care protocol CV54: Melatonin for children and adolescents (up to and including 18 years) with significant sleep onset difficulties https://www.wmic.wales.nhs.uk/ cv54-melatonin/

Medicine Stroke services **Clinical Diagnostic and Therapeutics** General rehabilitation	No code	Slings and Pulleys	No routine exemption criteria. Request for exemption required in all cases.	National Clinical Guidelines for Stroke 2016 https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx
Mental health	X66.-	Computer Based Cognitive Behavioural Therapy	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Clinical Guideline Depression in adults: treatment and management https://www.nice.org.uk/guidance/ng222 NICE Clinical Guideline 91 Depression in adults with a chronic physical health problem: recognition and management: www.nice.org.uk/guidance/cg91 NICE Clinical Guideline 159 Social anxiety disorder: recognition, assessment and treatment www.nice.org.uk/guidance/cg15 9

Mental health	A83.8 A83.9	Electroconvulsive Therapy (ECT)	Can be used in line with NICE guidance. Request for exemption required in all other cases.	NICE Technology Appraisal 59 Guidance on the use of electroconvulsive therapy: www.nice.org.uk/Guidance/TA5 9 NICE Clinical Guideline 222 Depression in adults: recognition and management: https://www.nice.org.uk/guidance/ng222

Please refer to the Cardiff and Vale Prescribing Formulary for a list of medicines and their indications approved for use within Cardiff and Vale UHB. The formulary can be found at: http://cardiffandvaleuhb.inform.wales.nhs.uk

Technology appraisal decisions produced by the National Institute of Health and Care Excellence (NICE) and medicines appraisal decisions from All Wales Medicines Strategy Group can be found at: https://www.nice.org.uk/guidance/published?type=ta
http://www.awmsg.org/awmsgonline/app/report;jsessionid=4f4bcc7791af5daa9bfd99212284?execution=e1s1

PART 2: SERVICES COMMISSIONED BY WELSH HEALTH SPECIALISED SERVICES (WHSSC)

LIST OF SPECIALISED SERVICES COMMISSIONING POLICIES AND SERVICE SPECIFICATIONS

The policies and commissioned services are available to view on the WHSSC website[1] All Policy Documents - Welsh Health Specialised Services Committee (nhs.wales)

As of 2 August 2022 the list is as follows, but since this is subject to change please see the website for the latest version:

- Abdominoplasty/Apronectomy following Significant Weight Loss, Policy Position Statement (PP45), July 2013 (*PDF, 578Kb*)
- Adult Congenital Heart Disease Services (Levels 1 and 2) for people aged 16 and over, Service Specification (CP214). June 2022 (*PDF, 423Kb*)
- All Wales Posture and Mobility, Service Specification (CP59). April 2017 (*PDF, 1.5Mb*)
- Allogeneic Haematopoietic Stem Cell Transplant (HSCT) for people of all ages with Sickle Cell Disease (SCD), Commissioning Policy (CP224). November 2021 (*PDF, 443Kb*)
- Alternative and Augmentative Communication (AAC), Commissioning Policy (CP93a), May 2019 (*PDF, 570Kb*)
- Asfotase Alfa for Treating Paediatric Onset Hypophosphatasia (PP156).pdf (*PDF, 284Kb*)
- Ataluren for Treating Duchenne Muscular Dystrophy with a Nonsense Mutation in the Dystrophin Gene (CP118) (*PDF, 247Kb*)
- Balloon Pulmonary Angioplasty (PP162).pdf (*PDF, 207Kb*)
- Bariatric Surgery Commissioning Policy (CP29a).pdf (*PDF, 337Kb*)
- Bariatric Surgery Service Specification (CP29b). (*PDF, 444Kb*)
- Bleeding Disorders (All Ages), Service Specification (CP77), June 2022 (*PDF, 343Kb*)
- Body Contouring, Commissioning Policy (CP44). July 2013 (*PDF, 691Kb*)
- Brachytherapy in the Treatment of Localised Prostate Cancer, Commissioning Policy (CP01). October 2021 (*PDF, 388Kb*)
- Breast Surgery Procedures, Commissioning Policy (CP69). March 2013 (*PDF, 342Kb*)
- Burosumab for Treating X-linked Hypophosphataemia in Children and Young People, Policy Position (PP177), May 2019.pdf (*PDF, 557Kb*)
- Canakinumab for treating periodic fever syndromes: TRAPS, HIDS/MKD and FMF (ages 2 and older), Policy Position Statement, (PP228). January 2022. (*PDF, 324Kb*)
- Cannabidiol with clobazam for treating seizures associated with Dravet syndrome or Lennox–Gastaut syndrome in people aged 2 years and older (PP203), February 2021 (*PDF, 545Kb*)
- Chimeric Antigen Receptor T Cell (CAR T) Therapy, Gilead Axicabtagene Ciloleucel (Yescarta®) Service Specification (CP175). March 2019 (*PDF, 433Kb*)
- Chimeric Antigen Receptor T Cell (CAR T) Therapy, Novartis Tisagenlecleucel (Kymriah ®) Service Specification. (CP176). March 2019 (*PDF, 463Kb*)
- Chimeric Antigen Receptor T Cell (CAR T) Therapy, Policy Position Statement, (PP185). October 2021 (*PDF, 369Kb*)
- Circumcision for Children, Commissioning Policy (CP34). March 2019 (*PDF, 632Kb*)
- Cleft Lip and or Palate including Non-Cleft Velopharyngeal Dysfunction All Ages (CP186) (*PDF, 680Kb*)
- Clinical Trials (CP164) (*PDF, 194Kb*)
- Cochlear implant for children and adults with severe to profound deafness (CP35) (*PDF, 259Kb*)
- Complex Devices Implantable Cardioverter Defibrillators and Cardiac Resynchronisation Therapy for arrhythmias and heart failure (PP151).pdf (*PDF, 240Kb*)
- Cystic Fibrosis Modulator therapies Policy Position Statement, (PP198). March 2022

(*PDF, 354Kb*)

Cystic Fibrosis: Adults and Young People (CP193), Service Specification. Jan 2021 (*PDF, 658Kb*)

Cytoreductive Surgery with Hyperthermic Intraperitoneal Chemotherapy for Peritoneal Carcinomatosis and Pseudomyxoma Peritonei, Policy Position Statement, (PP90). September 2015 (*PDF, 591Kb*)

Deep Brain Stimulation (CP28) (*PDF, 421Kb*)

Eating Disorder Specialised Services Tier 4, Commissioning Policy (CP20). November 2011 (*PDF, 762Kb*)

Eculizimab for Atypical Haemolytic Uraemic Syndrome (aHUS) (CP98) (*PDF, 319Kb*)

Eculizumab in the treatment of Paroxysmal Nocturnal Hemoglobinuria (PNH), Commissioning Policy (CP152). February 2019 (*PDF, 404Kb*)

Electrophysiology and Ablation Services (16 years and older), Commissioning policy (CP197a). January 2021 (*PDF, 713Kb*)

Electrophysiology and Ablation Services (16 years and older), Service Specification (CP197b) January 2021 (*PDF, 619Kb*)

Emicizumab as prophylaxis in people with congenital haemophilia A with Factor VIII inhibitors (all ages), Policy Position Statement (PP167). November 2018 (*PDF, 316Kb*)

Emicizumab as prophylaxis in people with severe congenital haemophilia A without factor VIII inhibitors, Policy Position Statement, (PP189). August 2019 (*PDF, 311Kb*)

Enhanced Image Guided Brachytherapy (IGBT) Service for the Treatment of Gynaecological Malignancies, Commissioning Policy (CP75). May 2017 (*PDF, 723Kb*)

Extra corporeal membrane oxygenation (ECMO) service for adults with cardiac failure, Policy Position Statement, (PP102). July 2019 (*PDF, 116Kb*)

Extracorporeal Photophoresis (ECP)for treatment of Chronic Graft Versus Host Disease GVHD in Adults Commissioning Policy, (CP91). November 2015 (*PDF, 321Kb*)

Extracorporeal Photophoresis (ECP) for T Cell lymphoma, Commissioning Policy (CP92). November 2015 (*PDF, 281Kb*)

Facial Surgery procedures, Commissioning Policy (CP43). July 2013 (*PDF, 329Kb*)

Facial Surgery procedures: Referral proforma Blepharoplasty (CP43) (*Word, 92Kb*)

Facial Surgery procedures: Referral proforma Face lift/brow lift (CP43) (*Word, 92Kb*)

Facial Surgery procedures: Referral proforma Miscellaneous (CP43) (*Word, 91Kb*)

Facial Surgery procedures: Referral proforma Pinnaplasty (CP43) (*Word, 91Kb*)

Facial Surgery procedures: Referral proforma Rhinoplasty (CP43) (*Word, 92Kb*)

Gatekeeping, Placement and Case Management for Specialised Mental Health Services, CP232, June 2022 (*PDF, 399Kb*)

Gender Identity Service for Adults (non surgical) Commissioning Policy (CP182a) (*PDF, 437Kb*)

Gender Identity Service for Adults (non surgical) Service Specification (CP182b) (*PDF, 468Kb*)

Genomics Service Specification (CP99). June 2022 (*PDF, 572Kb*)

Genomic Testing, Policy Position Statement, (PP184). June 2020 (*PDF, 239Kb*)

Haematopoietic stem cell transplantation for adults, Service Specification (CP79). January 2020 (*PDF, 216Kb*)

Haematopoietic stem cell transplantation, Policy Position Statement, (PP142). January 2020 (*PDF, 397Kb*)

Hepatobiliary Surgery, Service Specification (CP73). November 2021 (*PDF, 344Kb*)

Home administered Parenteral Nutrition (HPN), Commissioning Policy (CP24). August 2014 (*PDF, 732Kb*)

Hyperbaric Oxygen Therapy Policy, Commissioning Policy (CP07). June 2021 (*PDF, 387Kb*)

Hyperthermic Intraperitoneal Chemotherapy (HIPEC) and Cytoreductive Surgery for treatment of Pseudomyxoma Peritonei, Commissioning Policy (CP02). September 2015 (*PDF, 301Kb*)

- In-patient Child and Adolescent Mental Health Services (CAMHS): General Adolescent Unit (GAU) and High-Dependency Unit (HDU), Service Specification CP150. July 2021 (*PDF, 557Kb*)
- Live Donor Expenses (CP30) (*PDF, 293Kb*)
- Lutetium (177Lu) oxodotreotide for people with neuroendocrine tumours (NETs), Policy Position Statement, (PP195). September 2020 (*PDF, 367Kb*)
- Lymphovenous Anastamosis (LVA) microsurgery for Primary and Secondary Lymphoedema, Commissioning Policy (CP87b). August 2015 (*PDF, 908Kb*)
- Lymphovenous Anastamosis (LVA) microsurgery for Primary and Secondary Lymphoedema, Service Specification (CP87a). August 2015 (*PDF, 814Kb*)
- Major Trauma Centre, Service Specification (CP188), February 2021 (*PDF, 665Kb*)
- Mechanical Thrombectomy for the treatment of acute Ischaemic Stroke, Commissioning Policy (CP168). March 2022 (*PDF, 816Kb*)
- Microprocessor controlled prosthetic knees, Commissioning Policy (CP218). December 2021 (*PDF, 388Kb*)
- National Acute Porphyria, Service Specification (CP166). February 2019 (*PDF, 305Kb*)
- National Alternative and Augmentative Communication (AAC) Specialised Aids (CP93), May 2019 (*PDF, 264Kb*)
- Neuropsychiatric Rehabilitation (Specialised), (CP128).pdf (*PDF, 428Kb*)
- New Treatment Fund (CP159) (*PDF, 367Kb*)
- Nusinersen for treating spinal muscular atrophy, Policy Position Statement, (PP191). January 2022 (*PDF, 399Kb*)
- Paediatric Endocrinology (CP163) (*PDF, 221Kb*)
- Paediatric Nephrology Service Specification, CP169 (March 2021) (*PDF, 443Kb*)
- Paediatric Neurological Rehabilitation (Specialised) (CP160) (*PDF, 469Kb*)
- Peptide Receptor Radionuclide Therapy (PRRT) for the treatment opf Neuroendocrine Tumours (NETs) (CP67) (*PDF, 267Kb*)
- Percutaneous Mitral Valve Leaflet repair for primary degenerative mitral regurgitation in adults, Policy Position Statement (PP206). June 2021 (*PDF, 476Kb*)
- Personalised External Aortic Root Support (PEARS) for surgical management of enlarged aortic root (adults), Policy Position Statement, (PP104). March 2019 (*PDF, 252Kb*)
- Pipeline Embolisation Devices used for the treatment of Intracranial Aneurysms (Complex Giant or Large Intracranial Aneurysms), Commissioning Policy (CP101). July 2015 (*PDF, 619Kb*)
- Plerixafor Stem Cell Mobilisation, Policy Position Statement (PP154). July 2019 (*PDF, 167Kb*)
- Positron Emission Tomography (PET) Commissioning Policy (CP50a), July 2022 (*PDF, 353Kb*)
- Positron Emission Tomography (PET), Service Specification (CP50b). September 2020 (*PDF, 514Kb*)
- PP103 Everolimus for the prevention of organ rejection following heart transplantation.pdf (*PDF, 119Kb*)
- PP155 Pasireotide for Cushing's Disease.pdf (*PDF, 199Kb*)
- PP187 Treatment Options for Transthyretin Amyloidosis in Adults.pdf (*PDF, 389Kb*)
- PP196 Voretigene Neparvovec for Treating Inherited Retinal Dystrophies Caused by RPE65 Gene Mutations.pdf (*PDF, 448Kb*)
- Preimplantation Genetic Diagnosis (PGD), Commissioning Policy (CP37). August 2014 (*PDF, 796Kb*)
- Prosthetic Provision, Service Specification (CP89). March 2022 (*PDF, 465Kb*)
- Proton Beam Therapy for adults with cancer, Commissioning Policy (CP147). January 2018 (*PDF, 321Kb*)
- Proton Beam Therapy for children, teenagers and young adults (TYA) with cancer, Commissioning Policy (CP148). January 2018 (*PDF, 303Kb*)

- Proton Beam Therapy, Service Specification (CP146). January 2018 (*PDF, 360Kb*)
- Radiofrequency Ablation (RFA) for the Management of Barrett's Oesophagus, Commissioning Policy (CP183a). May 2020 (*PDF, 369Kb*)
- Radiofrequency Ablation (RFA) for the Management of Barrett's Oesophagus, Service Specification (CP183b). May 2020 (*PDF, 399Kb*)
- Recreational and Sport Prosthetics for a Child or Young Adult up to the age of 25, Commissioning Policy (CP221). November 2021 (*PDF, 402Kb*)
- Salvage Cryotherapy for Prostate Cancer, Policy Position Statement, (PP173). June 2020 (*PDF, 178Kb*)
- Selective internal radiation therapies (SIRT) for treating adults with hepatocellular carcinoma, Policy Position Statement, (PP227). November 2021 (*PDF, 303Kb*)
- Selexipag for the Treatment of Pulmonary Arterial Hypertension (Adults), Policy Position (PP105), March 2019.pdf (*PDF, 366Kb*)
- Services for Children with Cancer (CP86) (*PDF, 585Kb*)
- Sickle Cell Disorders, Thalassaemia Disorders and other Rare Hereditary Anaemias, Service Specification (CP179). December 2020 (*PDF, 530Kb*)
- Soft Tissue Sarcoma, Service Specification (CP149). June 2020 (*PDF, 446Kb*)
- Specialised Immunology, Service Specification (CP78). April 2014 (*PDF, 1.2Mb*)
- Specialised Paediatric Rheumatology Service Specification (CP172). November 2021 (*PDF, 475Kb*)
- Specialist Fertility Services, Commissioning Policy (CP37). July 2018 (*PDF, 382Kb*)
- Specialist Perinatal Mental Health Inpatient Service (Mother and Baby Unit) CP201, Service Specification. April 2021 (*PDF, 474Kb*)
- Specialist Spinal Cord Injury Rehabilitation, Commissioning Policy (CP141). March 2018 (*PDF, 406Kb*)
- Specialist Neurological Rehabilitation, Commissioning Policy (CP140). March 2018 (*PDF, 473Kb*)
- Spinal Services Operational Delivery Network (CP241) June 2022 (*PDF, 381Kb*)
- Stereotactic Ablative Body Radiotherapy (SABR) for the management of surgically inoperable Non-Small Cell Lung Cancer in Adults, Commissioning Policy (CP76). May 2014 (*PDF, 312Kb*)
- Stereotactic Ablative Body Radiotherapy (SABR) Service Specification (CP219) June 2021 (*PDF, 356Kb*)
- Stereotactic ablative radiotherapy (SABR) for patients with hepatocellular carcinoma (HCC) (Adults), Commissioning Policy (CP124), December 2021 (*PDF, 398Kb*)
- Stereotactic Ablative Radiotherapy (SABR) in the treatment of Oligometastatic disease, Commissioning Policy (CP121). October 2021 (*PDF, 387Kb*)
- Stereotactic Radiosurgery for Adults, Teenagers and Young Adults (TYA) (CP22) (*PDF, 389Kb*)
- Temporary Dialysis Away From Base (DAFB) Holiday Dialysis (CP33).pdf (*PDF, 272Kb*)
- Thoracic Surgery, Service Specification (CP144). September 2020 (*PDF, 448Kb*)
- Trans-catheter Aortic Valve Implantation (TAVI) for Severe Symptomatic Aortic Stenosis (SSAS) (CP58) (*PDF, 360Kb*)
- Trauma Operational Delivery Network, Service Specification (CP199). February 2021 (*PDF, 663Kb*)
- Treatment of Benign Skin Conditions, Referral Proforma Resurfacing (CP42) (*Word, 91Kb*)
- Vagal Nerve Stimulation, Commissioning Policy (CP23). August 2014 (*PDF, 683Kb*)
- Volanesorsen for treating familial chylomicronaemia syndrome, Policy Position Statement, (PP217). October 2021 (*PDF, 285Kb*)
- Vonicog alfa for the treatment and prevention of bleeding in adults with von Willebrand disease, Policy Position Statement (PP215), May 2021 (*PDF, 329Kb*)
- War Veterans - Enhanced Prosthetic Provision, Commissioning Policy (CP49). October 2020 (*PDF, 415Kb*)

Reference Number: UHB 009 **Version Number:** 4	**Date of Next Review:** Oct 2025 **LHB Reference Number:** UHB 009

Interventions Not Normally Undertaken Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will identify, monitor and review a list of health service interventions which are not normally undertaken by the UHB.

Interventions Not Normally Undertaken (INNUs) are not routinely available because:

- There is currently insufficient evidence of clinical and /or cost effectiveness *or*
- The intervention is considered to be of relatively low priority for NHS resources

They are either not normally available on the NHS in Wales, or are available only within specified criteria. The list of INNUs can be found in the supporting document *List of Interventions Not Normally Undertaken by Cardiff and Vale University Health Board.*

The Individual Patient Funding Request (IPFR) process can be used to apply for an intervention included in the INNU list in clinically exceptional circumstances.

Pharmaceutical treatments are generally excluded from the list, as there is a process for looking at these through the Cardiff and Vale UHB Corporate Medicines Management Group. Details of medicines that can be routinely prescribed along with the associated indications and criteria are detailed in the Cardiff and Vale Formulary.

Policy Commitment

- The list of Interventions Not Normally Undertaken by the UHB is a live document which will be updated as new evidence becomes available or as prioritisation decisions are made within the UHB.
- The UHB lead or designated lead in conjunction with the appropriate Clinical Board(s) and the Deputy Director of Commissioning, will agree whether an addition/deletion/amendment to the INNU list is required.
- Proposed changes will be taken to Clinical Effectiveness Committee (CEC) for approval prior to updating the INNU list.
- The INNU list part 2, for services commissioned by the Welsh Health Specialised Services Committee (WHSSC), will be updated by WHSSC.
- The current INNU list will be published on the Cardiff and Vale UHB IPFR internet page.
- The UHB Business Intelligence Team will provide a monthly INNU monitoring report on a core set of INNU interventions to Deputy Director of Public Health, Head of Outcomes Commissioning, IPFR co-ordinator, the Director of Operations, and all Clinical Boards.

Supporting Procedures and Written Control Documents

This Policy is to be used in conjunction with the supporting documents listed below:

- List of Interventions Not Normally Undertaken by Cardiff and Vale University Health Board
- NHS Wales Policy: Making Decisions on Individual Patient Funding Requests Policy
- Welsh Health Specialised Services Committee (WHSSC) Specialised services commissioning policies and service specifications
- Cardiff and Vale UHB Formulary
- Documents are publicly available as follows:

The INNU list and IPFR policy (when approved):
Individual Patient Funding Requests - Cardiff and Vale University Health Board (nhs.wales)

WHSSC Specialised services commissioning policies and service specifications:
www.whssc.wales.nhs.uk/policies-and-procedures-1

Cardiff and Vale UHB Formulary:
http://cardiffandvaleuhb.inform.wales.nhs.uk/

Scope

This policy applies to all of our staff in all locations including those with honorary contracts, and to those that deliver care to Cardiff and Vale UHB patients.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) been completed. The results highlight that whilst certain interventions relate in particular to certain protected characteristics (age, disability, pregnancy, race, sex) due to higher prevalence of related conditions or illness in particular sub groups of the population, no negative impact on protected characteristics was identified and in some aspects the impact on protected characteristics was positive. Key actions have been identified and incorporated within supporting procedures.

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Clinical Effectiveness Committee (CEC)
Accountable Executive or Clinical Board Director	Executive Director of Public Health

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	Cardiff and Vale Board	May 2010	Not applicable
2	Quality, Safety and Experience Committee 3/9/2014	Sept 2014	Additional information provided to strengthen Equality Impact Assessment
3	Quality, Safety and Experience Committee 8/09/18	20/09/18	Updated and reformatted UHB009v02 in line with the revised policy template. Changes to the interventions included in the INNU list are documented alongside the INNU list.
4	Quality, Safety and Experience Committee 30/8/22	Sept 2022	Refresh of this policy included removal of out of date documents; addition of sharing data with all Clinical Boards and update to the EHIA.

Equality and Health Impact Assessment for Interventions Not Normally Undertaken Policy

Note- Embedded documents are available on request

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Not applicable
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Public Health Executive Director: Fiona Kinghorn Fiona.kinghorn@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The purpose of the INNU policy is to outline the UHB process for identifying, monitoring and reviewing a list of health service interventions which are not normally undertaken by the UHB, or are only undertaken within specified criteria. An intervention is placed on the INNU list if the clinical and/or cost effectiveness evidence for the intervention is weak, or as a result of service prioritisation. The INNU policy is in line with the UHB's Principles for Change described in *Shaping Our Future Wellbeing Strategy 2015-2025,* in particular avoiding harm, waste and variation by: • Adopting evidence based practice, standardising as appropriate • Fully using the limited resources available, living within the total • Minimising avoidable harm • Achieving outcomes through minimum appropriate intervention

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	In 2021 there were 362,400 people living in Cardiff, and 131,800 living in the Vale of Glamorgan (Census, 2021). There are several universities in Cardiff boosting the student population. From the previous 2011 Census we know that there are an estimated 15,000 people living with some degree of sight loss, and 33,000 people have moderate or severe hearing impairment in Cardiff and the Vale of Glamorgan. There are 2000 people registered with learning disability in Cardiff and the Vale of Glamorgan and over 30,000 classified themselves in 'bad' or 'very bad' health. Population data from the *Census 2011* https://www.nomisweb.co.uk/ Cardiff and Vale identified: • Marital status: Single (incl. divorced and widowed) 56%, Married 40%, Civil partnership 0.2%, Separated 3.5% • Religion: Christian 53%, Muslim 5.2%, Hindu 1.1%, Buddhist 0.4%, Sikh 0.3%, Jewish 0.2%, other religion 0.4%; Non-religion 32% • Ethnicity: White 88%, Asian 6.8%, Mixed 2.5%, Black/African/Caribbean/British Black 1.7%, Arab 1.0%,Other ethnic group 0.5% • 50,580 carers were recorded in Cardiff and Vale of Glamorgan

		• There are 36,735 fluent Welsh speakers in Cardiff and 13,189 in the Vale of Glamorgan, equating to approximately 10% of the population *Data on disability and marital status were collected from the Household reference person. Data on sexual orientation and gender reassignment was not collected in the Census 2011. A survey undertaken for the Cardiff and Vale Population needs assessment reported 86.7% respondents specified their sexual orientation as heterosexual, 3% gay man, 2.6% bisexual, 1.7% gay woman/lesbian, 0.6% other. There are no official estimates however UK research carried out in 2009 estimated 0.6%-1.0% of the population over 15 year old identify as transgender, which would equate to between 2,300 and 3,900 in Cardiff and Vale of Glamorgan. The Cardiff and the Vale of Glamorgan Population needs assessment https://cvihsc.co.uk/about/what-we-do/population-needs-assessment/ was prepared following the introduction of the Social Services and Well-being (Wales) Act 2014. The Act placed a duty on Local Authorities and Local Health Boards to prepare and publish an assessment of the care and support needs of the population, including carers who need support. This has recently been refreshed. Information for the assessment was drawn from a number of sources including public surveys tailored to the audience; focus group interviews with local residents; a survey of local professionals and organisations providing care or support, including the third sector; and service and population data.

		The assessment report presented findings for the following population themes: • Children and young people • Health and physical disabilities • Learning disability and autism • Adult mental health and cognitive impairment • Adult carers • Sensory loss and impairment • Violence against women, domestic abuse and sexual violence • Asylum seekers and refugees • Offenders • Veterans • Substance misuse Suggested areas for action from the Population Needs Assessment that are pertinent to the INNU policy and EHIA include: Recognising the diversity within age groups (e.g. children and young people, older people) and tailoring services to meet individual needs; increasing engagement with people in decisions about them; increased clarity on referral pathways and criteria and support for professionals in decision making; recognising people with complex needs and requiring additional support. Recommendations from the Cardiff and Vale Dementia Health Needs Assessment (2017) identified the importance of treating people with kindness and compassion and the importance of avoiding unwarranted inequalities in access to services. http://www.cvihsc.co.uk/wp-content/uploads/2017/02/DHNA-Cardiff-and-Vale-Final.pdf

		An assessment of the future health and social care needs of older people in Cardiff and Vale of Glamorgan (2011) recognised the following as having increasing impact on people's health as they got older; reduced mobility, visual impairment, increased risk of falls, urinary incontinence, diabetes, stroke, mental health problems and dementia. https://cvihsc.co.uk/wp-content/uploads/2022/04/PNA-English-v2.pdf *Health inequalities impact on people and communities* Health inequalities are differences in life expectancy and healthy life expectancy between people or groups due to social, geographical, biological or other factors. Some differences, such as ethnicity, may be fixed. Others are caused by social or geographical factors. The association between social inequalities and health inequity is well documented, the latter being defined as "an unnecessary, avoidable, unfair and unjust difference between the health or healthcare of one person and that of another. The Socio-economic Duty came into force in Wales on the 31 March 2021. It will encourage better decision making and ultimately deliver better outcomes for those who are socio-economically disadvantaged. There is an enduring association between socioeconomic position and health, both over time and across major causes of death. The difference in healthy life expectancy between those living in the most and least deprived communities in Cardiff and Vale is 14.4 years for men and 18 years for women.

		To further explore the potential impact of this policy EHIA has been undertaken focusing on each of the interventions in the INNU list. A number of interventions in the INNU list are permitted only in accordance with NICE guidance. Processes within NICE require equality issues to be considered in the scoping and production phases and NICE publishes an equality impact assessment alongside its guidance. A national list of elective activity by INNU by area of residence for 2015/16 captured by Health Board was produced in September 2017 by the Financial Information Strategy team in the Welsh Health Collaborative. Activity data is not provided by protected characteristic. The following sources provided evidence for the interventions included in the INNU list: Relevant technology appraisals and clinical guidelines published by Royal Colleges and the National Institute for Health and Care Excellence www.nice.org.uk/
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Patients, staff and stakeholders will have clear and transparent information about those health service interventions not normally undertaken by the UHB or undertaken only within specified criteria. The population served by Cardiff and Vale UHB will benefit through the efficient use of limited healthcare resources and minimising of avoidable harm.

6. EHIA / 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	Certain of the interventions in the INNU list are applicable in particular to younger or older people because of the higher prevalence of a related condition or illness in that age group. Where this is the case it is clearly stated in the EHIA undertaken on the INNU list. For each intervention it is stated whether there is: • No provision because the intervention is not clinically and cost	Patients are assessed individually based on their clinical need and potential to benefit from treatment. The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases. When the IPFR panel next recruits lay members consideration should be given to diversity of the representatives.	The IPFR route is highlighted throughout the INNU list.

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
	Effective • Provision only within certain criteria		
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	Some of the interventions in the INNU list are particularly pertinent to people with disabilities an example of where this has been considered specifically was for Grommets where it highlighted a significant second disability as an additional criterion.	Patients are assessed individually based on their clinical need and potential to benefit from treatment. The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases.	The IPFR route is highlighted throughout the INNU list.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment and people who are non-binary **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change their gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	Some interventions in the INNU list may be particularly applicable to different sexes due to anatomical differences (e.g. hysterectomy; management of erectile dysfunction) or variation in prevalence of some conditions by gender (e.g. hallux valgus). Gender reassignment interventions are commissioned by Welsh Health Specialised Services Committee and the INNU list includes a hyperlink to the WHSSC policy webpage.	Patients are assessed individually based on their clinical need and potential to benefit from treatment. The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases.	The IPFR route is highlighted throughout the INNU list.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	The INNU policy states that some interventions are not available due to lack of clinical and/or cost effectiveness; or as a result of service prioritisation. No evidence was identified to suggest that people would be disproportionately affected by the INNU policy on the basis of gender or gender reassignment.		

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
6.4 People who are married or who have a civil partner.	The general health needs of married people or people in a civil partnership are the same as others within the population. The policy does not have a direct impact on people because of their being married or in a civil partnership.	None identified	N/A
6.5 Pregnant people, or people who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after	The INNU list includes one intervention that specifically relates to pregnancy- elective caesarean section. Criteria for when the procedure may	Patients are assessed individually based on their clinical need and potential to benefit from treatment.	The IPFR route is highlighted throughout the INNU list.

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
having a baby whether or not they are on maternity leave.	be undertaken were developed by NICE. The INNU policy states that some interventions are not available due to lack of clinical and/or cost effectiveness; or as a result of service prioritisation. No information was identified to suggest that pregnant people, those who had recently given birth or are breast feeding would be negatively impacted by the INNU policy.	The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases.	

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
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	At the time of the 2011 Census 15% of people living in Cardiff and 6% in the Vale were non-UK born. Cardiff has the highest ethnic minority population of the local authorities in Wales and Asian is the most represented ethnic minority group. The INNU policy states that some interventions are not available due to lack of clinical and/or cost effectiveness; or because of service prioritisation. Certain of the interventions in the INNU list may be particularly applicable to ethnic minority groups due to	Patients are assessed individually based on their clinical need and potential to benefit from treatment. The Individual Patient Funding Request (IPFR) route is available to clinically exceptional cases. When the IPFR panel next recruits lay members consideration should be given to diversity of the representatives. Data on ethnicity is not routinely and systematically collected across the UHB. This should be implemented as standard to understand	The IPFR route is highlighted throughout the INNU list.

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
	higher prevalence of related conditions or illnesses in particular populations (e.g. cholecystectomy). Where this is the case it is stated in the EHIA accompanying the INNU list. The INNU policy supports the efficient use of limited resources by not routinely making treatments which are considered to have low clinical and/ cost effectiveness or are considered low priority. No evidence of negative impact has been identified because of a person's race.	health inequalities in our community.	

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
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No evidence has been found of specific impacts from the INNU policy on people because of their religion, belief or non-belief.	Data are not routinely collected, this should be implemented as standard.	N/A
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	No evidence has been found of specific impacts from the INNU policy on people based on whether they are heterosexual, lesbian or gay, or bisexual.	Data are not routinely collected, this should be implemented as standard.	N/A
6.9 People who communicate using the Welsh language in terms of correspondence,	No evidence has been found of specific impacts from the INNU policy on people who	The INNU policy states that some interventions are not available due to lack of	The IPFR route is highlighted throughout the INNU list.

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
information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	wish to communicate using the Welsh language. Under the Welsh Language Standards, patients and service users whose first language is Welsh should be given the choice to receive a Welsh language service. This may include discussing treatment options, gaining consent and providing patient information.	clinical and/or cost effectiveness; or as a result of service prioritisation. The Individual Patient Funding Request (IPFR) route is available for clinically exceptional cases. Patient Information Leaflets for IPFR are available in Welsh and English. e-learning Welsh Language Awareness training for all NHS Wales staff is being developed.	IPFR patient information leaflets in Welsh and English are available on the Cardiff and Vale internet site or available as a hard copy.

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
6.10 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	No evidence was found of specific impacts from the INNU policy on people because of their income. However, we noted that specific groups such people who are homeless may experience difficulties accessing services generally. The INNU policy advocates clinical and cost effectiveness, taking into consideration prioritisation decisions, to determine those interventions not normally undertaken.	Data analysis by Welsh Index of Multiple Deprivation should be undertaken to understand the health inequalities in our community.	Services for health excluded groups are available to improve access to services.

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	No evidence has been found of specific impacts from the INNU policy on people because of where they live. The INNU policy applies to the resident population of Cardiff and Vale UHB.	Data analysis by Welsh Index of Multiple Deprivation should be undertaken to understand the health inequalities in our community.	Services for health excluded groups are available to improve access to services.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	The needs of other groups including carers, prisoners, refugees/asylum seekers, and people who are homeless were considered.	Promotion of services which are accessible to those who are health excluded. Working in partnership with the third sector to promote services which are accessible to those who are health excluded. Ensuring the 'digital divide' does not exacerbate existing health inequalities. Using simple language in all communications.	Services for health excluded groups are available to improve access to services. In person and digital services offered as appropriate, based on patient's need and preference. Offering communication through the preferred method, as needed e.g. through Braille, BSL, using interpretation services etc.

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 INNU policy is explicit about those interventions that should not be undertaken routinely or only under certain circumstances. This supports consistency in the management of patients between clinicians, in relation to the interventions included on the INNU list.	Data analysis by Welsh Index of Multiple Deprivation should be undertaken to understand the health inequalities in our community.	Partnership working with other agencies to make onward referrals as needed. Offering patient transport services to those who need support.
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	No specific impacts from the INNU policy on people's ability to improve / maintain healthy lifestyles have been identified. The interventions included in the INNU list are treatment		The introduction of *Making Every Contact Count (MECC)* by Cardiff and Vale UHB has supported health and social care staff to maximise their interactions and when appropriate to offer healthy lifestyle advice and signposting

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
caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (e.g. 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	rather than preventative interventions.		to support services. The *Optimising Outcomes Policy (OOP),* offers patients who require surgery additional support to lose weight or quit smoking which will improve their chances of successful surgery. A proportionate universalism approach to the delivery of preventative services is supported by the Public Health team as part of a strategy to reduce health inequalities.
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,	One policy (Spinal injections for pain medicine) negatively impacted those who are not currently employed.	One policy (Spinal injections for pain medicine) mentions treatment in order to avoid medication related side effects in order to retain their job. This could be expanded to include those not in employment currently in order to ensure equality.	

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
job security, working conditions Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No specific impacts from the INNU policy on people's use of the physical environment have been identified.	None	

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
7.5 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	No specific impacts from the INNU policy on people in terms of social and community influences on health have been identified.	None	
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	No specific impacts from the INNU policy on macro-economic, environmental and sustainability factors have been identified.	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A 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	The INNU policy outlines the UHB process for identifying, monitoring and reviewing a list of health service interventions which are not normally undertaken by the UHB, or are only undertaken within specified criteria. The INNU list makes explicit the interventions not normally undertaken, and for those interventions where the intervention may be offered to patients meeting certain criteria, what the criteria are. The policy supports the *Shaping Our Future Wellbeing Strategy 2015-2025*. Interventions are placed on the INNU list if the clinical and/or cost effectiveness evidence for the intervention is weak, or as a result of service prioritisation. The policy supports the avoidance of harm, waste and variation within the UHB and making best use of the limited resources available. The Individual Patient Funding Request (IPFR) route is available in clinically exceptional cases.

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?	The main action for the organisation is improving the systematic collection of data on the factors that may impact health inequalities. When the IPFR panel next recruits lay members consideration should be given to diversity of the representatives.	TBC ZC	TBC Next recruitment Feb 2025	
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?	No.			

	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	To seek approval for the INNU Policy, INNU List and the associated EHIA to the Quality, Safety and Experience Committee on 30 August 2022. Policy, list and EHIA to be published on Cardiff and Vale UHB internet and intranet sites Adherence to the policy will be monitored via monthly Business Intelligence Support (BIS) reports and clinical board audit processes. The EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.	CB ZC Clin. Boards Exec DPH	Aug 2022 Sept 2022 Monthly Sep 2025	Clinical Boards have responsibility for activity undertaken within their Clinical Board.

Report Title:	Unpaid Carers Charter			Agenda Item no.	3.2
Meeting:	QSE Committee	Public	X	Meeting Date:	30.08.22
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Abi Harris, Executive Director of Strategic Planning				
Report Author (Title):	Chris Ball, Ageing Well Programme Manager, Regional Partnership Board				

Main Report
Background and current situation:

Unpaid carers are critical to the care and support of citizens across Cardiff and Vale and supporting them is a priority for the Regional Partnership Board. This paper briefs the QSE Committee on the Unpaid Carers' Charter, which has been developed through engagement by the Cardiff and Vale Unpaid Carers Board. The RPB would like to ensure that its constituent orgnisations endorse the Charter. The Charter will then be presented to the RPB for approval prior to its launch in November 2022.

Included along with this cover paper are the:

1. *Unpaid Carers Charter**
2. *Young Carers Charter**
3. *Unpaid Carers Charter companion document**

**to note that design/look of these documents is to be developed but the content is final.*

Background:

Cardiff and the Vale of Glamorgan has approximately 50,580 unpaid carers of all ages (Population Needs Assessment, 2022).

Pre-pandemic, there was a *Regional Carers Workstream* 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 was developed. However, due to the pandemic the board was paused, and the carers strategy was never finally published.

Since January 2022, the group has reconvened as the Unpaid Carers Board, acting as a programme board for the RPB work around unpaid carers and to develop the strategy into what has become the Unpaid Carers Charter.

The Charter:

The aim of the Unpaid Carers Charter is to:

1) help to identify unpaid carers in the region; particularly those who might not currently see themselves as a carer or be accessing support which is available to them
2) help unpaid carers to feel supported and recognised through a set of commitments by the Health Board and local authorities
3) support the development of services for unpaid carers in the region

The Charter is accompanied by a companion document which goes into more detail around:

- Each of the commitments
- The national priorities and regional context (reflected in the Charter)

- What we are going to work on
- What good will look like

We plan to launch the Charter in November 2022, once ratified through partner's governance and the Regional Partnership Board, with a range of events throughout the following year along with resources to promote the Charter to key stakeholders to ensure it has the desired impact. This will include accessible versions in various languages and formats.

Delivery, impact and development of services through the Charter will be monitored and supported by the Regional Unpaid Carers Board and reported to the RPB.

Engagement/Assurance:
The Charter has been developed for and by Unpaid Carers, through the Unpaid Carers Board which has representatives from across the NHS, local authorities and third sector. Citizen engagement has also been utilized throughout the process to ensure the Charter is relevant and meaningful.

In developing the Charter there have been a number of engagement exercises undertaken, including from 2019 when the original strategy was developed:

- July 2022 – engagement on the Unpaid Carers Charter with responses from 94 individuals across ages, minority ethnic communities and unpaid carers.
- August 2019 – engagement on the regional priorities (now our 'commitments') with 61 people and facilitated by Tempo.
- August 2019 – engagement with adult carers(49), young carers (37), and our joint workforce (46) and the vision for unpaid carers and the regional priorities (now our 'commitments').

The Charter has also been reviewed by the Strategic Leadership Group within the RPB and will be going to Senior Leadership Board, Health Board and Local Authorities' scrutiny and Cabinets for agreement and ratification.

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

Recommendation:

The Committee is requested to:

a) **ENDORSE the RPB Unpaid Carers Charter.**

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

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

4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
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 – risks noted and monitored by the Unpaid Carers Board

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: Yes – as highlighted in the Unpaid Carers Charter companion document (attached)

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: Yes – as highlighted in the Unpaid Carers Charter companion document (attached)

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: Yes – as highlighted in the Unpaid Carers Charter companion document (attached)

The Socio Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES
(If this has been addressed in the main body of the report, please confirm)

Equality and Health: Yes – EHIA completed and considered in the development of the Charter

Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.
Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)
(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: N/A

If appropriate, has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made.

(If this has been addressed in the main body of the report, please confirm)	
Approval/Scrutiny Route:	
CVUHB QSE Committee	30th August
Senior Leadership Board	22nd September
Health Board	29th September
Local Authority Cabinets	3rd October (Vale or Glamorgan Council), 20th October (Cardiff Council)
Regional Partnership Board	Date: 25th October

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

BYW'N DDA LIVING WELL

Cardiff and Vale
Unpaid Carers Charter

Approximately 1 in 10 of us who live in Cardiff and the Vale of Glamorgan provide unpaid care to a family member or friend. This Charter pledges commitment of partners across the region including; NHS, local authorities, voluntary and 3rd sector organisations and outlines how we will support you if you care for someone.

Are you an unpaid carer?

Many people do not think of themselves as an unpaid carer. In Wales, we recognise unpaid carers as someone who provides unpaid care to an adult or disabled child. The cared for person may be a family member or a friend, who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Examples of support you might give to someone if you are an unpaid carer include:

- Helping someone wash and dress themselves and with other personal care
- Housework, food shopping and picking up and administering medication
- Taking someone to hospital and GP appointments
- Providing company and emotional support

Our commitments to you:

- We will ensure unpaid carers are identified and recognised in our communities to be able to provide the information, advice and support needed as soon as possible
- We will ensure the right information and advice is given to unpaid carers at the right time to empower choice and understanding
- We will work to improve the quality of support provided to unpaid carers
- We will develop and improve the skills of our workforce to help unpaid carers achieve what matters to them
- We will make best use of the resources available to contribute to caring for people in our communities and make sure unpaid carers have time to do the things that they enjoy
- We will work together to ensure unpaid carers are supported in education and in work

We want unpaid carers to help us improve services, so we will ensure:

- We will ask you to tell us what you think
- We will listen to the voice of unpaid carers to inform the development of services and support

We as partners across the NHS, local authorities, voluntary and 3rd sector organisations recognise our responsibility in supporting unpaid carers in our community. Therefore, we want to identify and recognise unpaid carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring.

Contact us for more information:
Carers Gateway
Tel:
Website:

Signatures
Chair of Cardiff and Vale Health Board

Signatures
Councillor Cardiff

Signatures
Councillor Vale

Cardiff Third Sector Council Cyngor Trydydd Sector Caerdydd
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board
Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

CARDIFF AND VALE
UNPAID CARERS CHARTER

Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself.

AM I A YOUNG CARER?

You're a young carer if you're under 18 and help to look after a relative with a disability, illness, mental health condition, or drug or alcohol problem.

If you're a young carer, you probably look after one of your parents or care for a brother or sister. You may do extra jobs in and around the home, such as cooking, cleaning or helping someone get dressed and move around. You may also give a lot of physical help to a parent, brother or sister who's disabled or ill.

Along with doing things to help your brother or sister, you may be giving them and your parents emotional support, too.

We realise that this can feel like a lot of responsibility, and we want to make sure you are supported and able to still have as normal a life as possible, that's why we have created a list of commitments or promises to you.

OUR COMMITMENTS TO YOU:

- We will ensure you as a young carer are recognised from as early as possible, so that we can help you
- We will help you understand what it means to be an unpaid carer and how we can support you
- We will work hard to make sure we do our very best to help you
- We will make sure that adults who might support you, such as teachers, can do the best job they can
- We will help you to still do the things you want to do, this might mean seeing friends, or doing activities
- We will work together to help you in school so that you can still learn and reach your full potential

WE THINK YOU ARE BEST PLACED TO TELL US HOW TO MAKE THINGS BETTER, SO WE WILL ALSO:

- We will ask you to tell us what you think about the support we give you
- We will listen and work hard to improve what we do based on what you say

Contact us for more information

Tel:

Email:

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

BYW'N DDA LIVING WELL

Cardiff Council, Vale of Glamorgan Council
and Cardiff and Vale University Health Board

DRAFT

Cardiff and Vale Unpaid Carers Charter Companion Document

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

BYW'N DDA LIVING WELL

Our vision
"To identify and recognise unpaid carers for the vital contribution they make to the community and the people they care for, and in doing so enable unpaid carers to have a life alongside caring."

Our vision for Young Unpaid carers
"Young unpaid carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself"

Status (Draft/Final)	Final Draft
Description	Cardiff and Vale Unpaid Carers Charter companion document
Date	May 2022
Author & Contact Details	Unpaid Carers Board Cardiff and Vale of Glamorgan Contact: Chris Ball, Programme Manager Tel: 07754829432 Email: christopher.ball@wales.nhs.uk

Acknowledgement

We would like to thank all the unpaid carers, including young unpaid carers, third sector organisations, our partners in health and social care and many others for their input to the development of this strategy. In particular, their ongoing commitment and support which has made a positive difference in developing this strategy.

Thank you also to Glamorgan Voluntary Service, Cardiff Third Sector Council, Cardiff and the Vale University Health Board, Cardiff County Council, the Vale of Glamorgan County Council the Cardiff and Vale Regional Partnership Board and the Regional Unpaid Carers Board.

Contents

Foreword

We are pleased to introduce Cardiff Council, the Vale of Glamorgan Council and, Cardiff and Vale University Health Board's Unpaid Carers Charter.

We recognise the vital contribution that unpaid carers make to our communities and the people they care for. We are committed to ensuring that unpaid carers are recognised and that every step is taken to ensure the region is an environment that supports the highest quality of life possible for unpaid carers and the people they care for.

We firmly believe that a regional approach to unpaid carers is a positive step for the area. By working together with a wide range of organisations who come into contact with unpaid carers, we can support the region to become a supportive and beneficial environment within which unpaid carers, and those who benefit from their support, can thrive.

This Charter demonstrates our commitment to deliver the best outcomes for unpaid carers and the people they care for and will give us a clear strategic direction for the next five years. The Charter will introduce eight clear commitments, which we have developed from national strategy and what unpaid carers have told us matters most to them.

The Charter further shows our dedication to work together, in partnership, to develop and deliver the best support available to unpaid carers, and make the best use of shared resources. We would like to thank everyone who has given their time to attend consultation events and for giving us their expert opinions and commitment to improving the lives of unpaid carers' in Cardiff and the Vale of Glamorgan

"To identify and recognise unpaid carers, including young carers for the vital contribution they make to community and the people they care for'

"Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself"

To be signed off by Councillor Cardiff, Councillor Vale and Chair UHB

Introduction

Cardiff Council, the Vale of Glamorgan Council, Cardiff and Vale University Health Board work together jointly to oversee the development and delivery of integrated health and social care services in Cardiff and the Vale of Glamorgan, to ensure they support local people and their needs.

Our regional partnership has worked with unpaid carers and the people they care for, to understand their experiences and what matters to them. We have taken into account what unpaid carers have told us, legislation, and local context and looked at our resources. Together we have produced a set of commitments that sets out clear direction for the planning and development of support to all unpaid carers across the region over the next five years.

The Unpaid Carers Charter outlines our vision and eight commitments which we believe are fundamental to supporting unpaid carers now and, in the future, and gives direction for the development of support to unpaid carers across Cardiff and the Vale of Glamorgan.

What is an Unpaid Carer?

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support

Across Wales there are an estimated 370,000 carers and approximately 50,580 in Cardiff and the Vale of Glamorgan. The economic value of the contribution made by unpaid carer in Wales is estimated at £8.1 billion a year (census 2011).

Carers make a huge contribution to the local and national health and social care economy through the provision of care and support to relatives, families and friends. Providing this care improves the quality of life of the people they care for and can often go unrecognised, even by carers themselves who may not recognise or see themselves as "a carer". Looking after carers' well-being is vital to delivering sustainable social services to the people in our communities.

Purpose – why have an Unpaid Carers Charter?

The purpose of our Charter is to improve outcomes for unpaid carers across the region. This Charter and companion document will outline and support our ambition to make the region a supportive and beneficial environment for unpaid carers, and those who benefit from their work, can thrive.

Our vision

"To identify and recognise unpaid carers for the vital contribution they make to the community and the people they care for, and in doing so enable carers to have a life alongside caring."

"Young carers are really important to us, to the communities where they live and to the people they care for. We want to know if you care for someone, so that we can help you and the person you care for, and make sure you have time to do things for yourself"

Aim

The Charter will enable us to:

- improve support for unpaid carers
- explore and identify new ways of working
- increase accessibility to information, advice, and assistance for unpaid carers

National Context

National Priorities

The Welsh Government Strategy for Unpaid Carers has four National Priorities.

Our regional commitments have taken account the National Strategy for Unpaid Carers and provide the framework for improving the delivery of carer support services across our region. The National Priorities state:

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 need whilst caring and when the caring role comes to an end.

Priority two
Providing information, advice and assistance – it is vital all unpaid carers have 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 Law

The two main pieces of legislation reflected in our commitments are the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.

The Social Services and Well-being (Wales) Act 2014

The Act represents a unifying set of legislation across all of health and social care in Wales. It has imposed duties on local authorities, health boards and the Welsh Assembly to work to promote the well-being of those who need care and support and unpaid carers who need support. The principles of the Act:

People are at the heart of the new system by giving them an equal say in the support they receive

Services will promote the prevention of escalating need and the right help is available at the right time

Partnership and co-operation drives service delivery

The Act outlines key duties, to ensure:

- People have control over what support they need, making decisions about their care and support as an equal partner
- New proportionate assessment focuses on the individual
- Unpaid carers have an equal right to assessment for support to those who they care for
- Easy access to information and advice is available to all
- Powers to safeguard people are stronger
- A preventative approach to meeting care and support needs is practised
- Local authorities and health boards come together in new statutory partnerships to drive integration, innovation and service change

For the first time, the Act gives carers the same rights as those they care for and brought in a broader definition of a carer:

"A person who provides or intends to provide care for an adult or disabled child"

Stronger duties are placed on local authorities to identify, assess and support carers.

- More carers are entitled to a carers' assessment and support plans
- Local authorities must offer assessments where they believe a carer has a need for support
- Staff must promote the well-being of carers who need support
- Local authorities and partners must assess the needs of carers in their area and submit a plan to Ministers on how they will meet these needs
- If a local authority determine that a carer's needs meet the edibility criteria then they must consider what can be done to meet those needs
- There is a greater focus on the role of third sector organisations in providing services and support

The Well-being of Future Generations (Wales) Act 2015

The Act places a duty on Public bodies (including health and social services) to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future. The Act requires them to: • work together better • involve people reflecting the diversity of our communities • look to the long term as well as focusing on now • take action to try and stop problems getting worse or even stop them happening in the first place.

How have we developed our commitments?

To understand the most detailed possible picture of the situation for unpaid carers in the region, we collected information from the following sources:

- Consultation across Cardiff and the Vale of Glamorgan
- Online survey for adult carers, young carers and professionals
- Outreach through social media and the third sector
- Engagement events and workshops for adult, young carers and professionals
- Research and analysis from key institutions such as the Care Inspectorate Wales and Social Care Wales
- Existing public consultation activity for example. Cardiff Debate, UK Census, Population Needs Assessment
- Local authority and health board practitioners, performance teams and analysts
- Third sector organisations
- Local, national and international examples of best practice
- Additional local, regional and national strategies and policies
- Disability Futures – Parental Engagement Sessions
- Supporting Carers - UHB Staff Survey (Carers Wales/Pollen Shop)
- Cardiff & The Vale Carer Engagement Project (The Care Collective)
- Parliamentary Review of Health and Social Care in Wales (January 2018)

A number of consultations and reviews have taken place working with and targeted at the health and social care sector. The results have helped to inform the direction of our Charter:

- A State of Caring in Wales (Carers UK, 2021)
- Preventative Support for Adult Carers in Wales: Rapid Review (Social Care Wales, 2018)
- Let's Talk (Cardiff and the Vale of Glamorgan Population Needs Assessment 2022)
- Young Carers Speak Out (Cardiff University, 2016)
- Track the Act Briefing 4 (Carers Wales, 2019)
- Provision for young carers in secondary schools, further education colleges and pupil referral units across Wales (Estyn, May 2019)
- The 'Front Door' to Adult Social Care (Wales Audit Office, 2019)

The findings of the consultation events and online surveys provided us with positive feedback on the priorities identified. Based on this information and what unpaid carers had already told us about what would help them, we finalised these as the eight commitments that our Charter should focus on.

Our commitments

Our regional commitments which set out our priority areas of work for the next five years are based on what unpaid carers have told us matter to them.

We will ensure unpaid carers are identified and recognised in our communities

What we know about unpaid carers:

- Not all unpaid carers identify themselves as being a carer, often they do not recognise their caring role and see themselves as a relative or a friend.
- Young people may be reluctant to identify as a young unpaid carers for a number of reasons, including fear of being stigmatised or bullied, a sense of loyalty to their family, or simply not recognising their caring role.
- Unpaid carers from black, Asian and ethnic minority groups can face additional challenges in recognising themselves as a carer and can struggle with language barriers, stereotypes and accessing culturally appropriate services.
- Unpaid carers can struggle with demands on their time, they may be unable to recognise their own needs and seek support.

These are some of the things we are going to do:

- Work with our partners in health, social care, housing, education, and the third sector (for example. charities and voluntary groups) to promote awareness of early identification of unpaid carers through information and training.
- Work with schools to help make the identification and support for young unpaid carers in primary and secondary schools as easy as possible.
- Work with GP practices to support the identification and recognition of all unpaid carers.

What does good look like?

  - Unpaid carers will be recognised, and able to identify themselves as an unpaid carer.
  - People will understand what being an unpaid carer means.
  - Those working with children are able to identify young carers.
  - Specific needs and issues will be identified for different carer populations, and support will be culturally and socially appropriate and accessible.

Dan's story

Dan is 15 years old and cares for his younger sibling who has epilepsy and also for his mum, who isn't very well. He is in Year 10 at school and his school life is really busy as he starts to prepare for his GCSEs.

He didn't like speaking about being a young carer because he felt different from his friends, so he just kept it to himself. He was very proud to be helping his mum and brother, but sometimes wished he could do some things on his own or with his friends and not have to worry about his family.

Dan didn't realise that school could help him. He spoke to his form teacher and said that he thinks he is a young carer. The school told Dan about a young unpaid carers youth club, which he now attends, when he can, and because his teachers are aware of his situation, he feels he can ask them for help with planning his school work.

We will ensure the right information and advice is given to unpaid carers at the right time

What we know about unpaid carers:

- Easy to access, reliable and consistent information are key to unpaid carers knowing where to go to access appropriate support services.
- Unpaid carers want to be able to access information and advice in a variety of ways. For example. young unpaid carers may prefer to use social media or the internet to access the information they need.
- Unpaid carers are more likely to access support if it is local and provided in their communities.
- Early intervention is crucial to helping unpaid carers maintain their health and well-being. Lack of local, support services can potentially contribute to a rise in A&E visits and hospital admissions as families say they often have nowhere else to turn.

These are some of the things we are going to do:

- Promote early intervention and preventative services to help unpaid carers and the person they care for.
- Make information available to unpaid carers in the most appropriate format (easy-read/braille/ in different languages).
- Use social media and the internet to make it easier for unpaid carers to find the right information when they need it.
- Inform unpaid carers of their right to support and that their rights are equal to those they care for.

What does good look like?

- Unpaid carers will know where to go to find information and advice to help them when they need it.
- Making unpaid carers aware of their rights will enable them to make informed decisions and have choice and control.
- Through early intervention unpaid carers will know where to go for help and support, before things reach crisis.
- Young carers will know who they can ask for help and will be included in age appropriate conversations about their caring role.

Isobel's story

Around twelve years ago Isobel's mum's suffered quite a major stroke. Unfortunately this left her with long term health problems and mobility issues which began to impact on her day to day life. Her mum could no longer live on her own and went to live with Isobel and her two sons.
Initially Isobel received a lot of support from hospital staff. She appreciated having somebody to talk to who was aware of her situation. However, over time, Isobel began to feel she was her own; that life was passing her by.
She didn't know where to turn to, so she eventually contacted a local charity who were able to put her in touch with a carers support group in the community. She now attends, every fortnight, and takes her mum, which they both enjoy. She has made a few friends and they are able to support each other

We will work to improve the quality of support provided to unpaid carers

What we know about unpaid carers:

- Unpaid carers would prefer to provide complex and detailed information about them, once and not have to repeat themselves.
- Unpaid carers acknowledge the sharing of information between organisations and may seek different kinds of support from different people or organisations.
- Young unpaid carers often face individual challenges which may not be linked to their caring role. These challenges need to be considered when undertaking assessments or planning support for them.
- Useful information to help unpaid carers with practical things, such as where to go to for legal help, how technology can help them to become more efficient and take some of the worry out of caring.

These are some of the things we are going to do:

- Facilitate and promote carer support networks to provide an opportunity for unpaid carers to share experiences and learning from each other.
- Develop training for young unpaid carers to recognise their skills and experience and help young unpaid carers to look after themselves.
- Continue to work with schools so they understand and are able to support young unpaid carers.
- Ensure the needs of unpaid carers are identified and they receive the appropriate support whether through a carer's assessment or in other ways.

What does good look like?

- Unpaid carers will get the support and help they need to do the things that are important to them.
- Access to learn new skills and to help unpaid carers feel confident in their caring role to help build resilience.
- Unpaid carers will receive appropriate support, whether through a carer's assessment or other ways.
- Young unpaid carers will get the support and help they need to do the things that are important to them.

Mahalia's Story

Mahalia has been caring for her neighbour for five years. Mr Wilson is 90 years old, and although he has family, they live abroad and are not able to visit often. Mahalia says she became a carer quite by accident.

At first Mahalia didn't think she was a carer, it was just something that she did. When she saw a carer's information board at her local GP surgery, she began to think maybe she was a carer. Mahalia contacted the council and explained her situation. They offered her a carer's assessment. As part of the assessment the Carer's Officer was able to give her important advice and guidance on how to manage her caring role. It was a chance for Mahalia to talk about her needs with somebody who understood. In recognising herself as a carer, she now feels she has someone to turn to and feels supported to continue her caring role.

We will develop and improve the skills of our workforce to help carers achieve what matters to them

What we know about unpaid carers:

- Often unpaid carers are too busy caring to be able to ask for help and sometimes need a person to be there to recognise this.
- Unpaid carers want people working with them to hear what they say and to show they understand. Working in partnership with unpaid carers is fundamental to achieving this.
- Making unpaid carers aware of their rights can empower them to have a voice in the support they receive.
- Unpaid carers want contact with professionals more regularly rather than just to offer an assessment.

These are some of the things we are going to do:

- Make links with our partners to identify and promote training and development opportunities for unpaid carers, and identify any training and development needs that are not currently being met.
- Train people who work with young unpaid carers, to make sure they find out about what is important to young unpaid carers and their families to find out how they can help.
- Where appropriate, share information with partner organisations involved in supporting unpaid carers.
- Work in a person-centred approach focussing on individual need to ensure unpaid carers' health and well-being outcomes are co-produced by individuals and members of the workforce.

What does good look like?

- Organisations will work in partnership and will talk to each other to share information to make things as good as they can be for unpaid carers.'
- The people who work for us will be able to help unpaid carers in the best way and they will understand what it is really like to be a carer.
- Unpaid carers and the people who work with them will understand how modern technology solutions will help manage their caring role and can take some of the worry out of caring.

Arthurs' Story

Arthur is 77 years old and has been caring for his wife Mary who has dementia. Mary also has an underlying health condition which requires a daily visit from a District Nurse.
In recent months Mary has not wanted to go out and gets very agitated when people visit the family home. Arthur and his wife used to have a very active social life.
The District Nurse suggested that Arthur should think about having some support for himself and said that she would speak to Mary's social worker about it. A visit was arranged and following a carers assessment it was agreed that a local volunteer befriending service might be able to help. The social worker got in touch with the local group for Arthur and together with the District Nurse they arranged for the visits to take place at the same time until Mary got used to the volunteer.
Arthur has re-joined his local bowls club and says that it has made him feel so much better. He now has some time to enjoy himself without worrying about leaving Mary.

We will make best use of the resources available to contribute to caring for people in our communities and make sure unpaid carers have time to do the things they enjoy

What we know about unpaid carers:

- Unpaid carers understand that resources are limited and it is essential they are used in the most efficient and effective way.
- Each carer has different, individual needs, wishes and outcomes. Support needs to be wide ranging and meet the needs of different groups of unpaid carers, including young, older and parent unpaid carers and inclusive of LGBTQ+, minority ethnic and disabled carers.
- Unpaid carers appreciate honestly about what resources are available to them.
- Unpaid carers want to be involved in the developing and creating new and flexible opportunities for support.

These are some of the things we are going to do:

- Recognise whilst there are many things unpaid carers have in common, the support available to unpaid carers need to be individual and consider the unique nature of their caring role.
- When support is provided, unpaid carers will be asked what difference it has made, to make sure we are supporting them in the best and most cost-effective way.
- Set up carer support groups at community location for example. GP surgeries, libraries, with information about keeping healthy and connected.
- Develop support for unpaid carers using digital solutions for example. use online carer forums and social media to help access information and support.

What does good look like?

- Money and resources will be spent in the best way to help unpaid carers.
- People who can support unpaid carers will understand how to do things differently to make things better for unpaid carers.
- The money we have will be spent in the best way to help unpaid carers
- Working in partnership with people who provide support to ensure carer's preferences, needs and values guide decisions and are respectful and responsive to unpaid carers.

Anna's story (Parent Carer)

Anna became a carer on the day her daughter was born. Her daughter Sophie has cerebral palsy and requires constant care and support. Anna didn't recognise herself as a carer, she just saw herself as a mum and thought that giving up her job to look after her was something that any mum would do. Anna had become increasingly isolated since her daughter was born and sometimes felt lonely when her husband was at work.

As part of their outreach program, the local council had a carers information stand in the local garden centre. Anna had a chat with a carers' officer who told her about some local community support groups that she could get in touch with and suggested that having a carers assessment might help.

We will work together to ensure unpaid carers are supported in education and work

What we know about unpaid carers:

- There is a growing need for employers to support people who juggle work and their caring responsibilities. Supporting working unpaid carers can help to reduce stress, improve morale and reduce absences.
- Often unpaid carers are too busy caring to be able to ask for help and sometimes need a person to be there to recognise this.
- Unpaid carers will face a unique set of challenges based on their circumstances, whether in education, unemployed, employed, self-employed or retired; therefore, services and information should be sensitive to this.

These are some of the things we are going to do:

- Support unpaid carers to return or remain within the workforce, either alongside or instead of the caring role if they want to.
- Work with schools to help make the identification and support for young unpaid carers in primary and secondary schools as easy as possible.
- Working with employers and their representative bodies to promote unpaid carer friendly workplaces.

What good looks like:

- Unpaid carers will be supported to achieve their personal outcomes, including continuing to work where possible.
- Young carers will know who they can ask for help and will be included in age appropriate conversations about their caring role.
- The people who work for us will be able to help unpaid carers in the best way and they will understand what it is really like to be a carer.
- Unpaid carers not in employment, education or training should be able to access the right information, advice and support to develop the skills to gain suitable employment, whether re-entering the workforce, or getting a job for the first time.

Case study

Melanie is a full-time mum who cares for her son who has autism; but she was struggling to find a job which worked alongside her busy home life. She was referred to the Carer's Gateway through their Social Worker to have a discussion about some of the wider support available in the region. Through having a 'What Matters?' conversation the Carer's Gateway found out she had an interest in floristry and so were able to support Melanie to apply for a grant to undertake an online floristry course to receive an accredited qualification.

Melanie is now able to run her own business from home, which provides additional income, whilst still being able to fulfil her caring role.

We will ask you to tell us what you think

What we know about unpaid carers:

- Unpaid carers want to be given the opportunity to tell organisations what they think about the services and support they use.
- Engagement should be pro-active and inclusive, taking into account specific, targeted engagement with diverse carer groups.
- Consistent and meaningful carer engagement should be at the heart of all good health and social care policies and planning.
- Unpaid carers by nature have limited time. Ways in which people are asked to contribute need to consider timeframes and allow for planning and timely responses.

These are some of the things we are going to do:

- Make sure consultation and engagement activities are accessible and unpaid carers are supported to be able to contribute their views and opinions effectively.
- Evaluate and review the current ways we engage with unpaid carers and how effectively different carer groups are represented and develop ways to reach any groups which may be under represented.
- Provide different opportunities for unpaid carers to have their say and ask unpaid carers to tell us the best way to involve them, for example. via social media, on their own or with a group of unpaid carers.
- Engage with young unpaid carers in evaluating support and work with them in designing support options that best suit their individual caring situations.

What does good look like?

- Feedback on what unpaid carers have told us will be used and shared more effectively in the planning of and delivery of support to unpaid carers.
- Unpaid carers will feel their voice is heard and build better relationships between unpaid carers and people who work with unpaid carers.
- Open and honest engagement with unpaid carers to evaluate the support available to them and what is working well and not so well.
- Working in partnership with unpaid carers and people who work with unpaid carers to improve the support available in the region.

Bob's story

Bob's wife Martha was diagnosed with a brain tumour shortly after they were married. Due to the location of the tumour, surgery was difficult and Martha was left with behavioural problems ever since. It changed both of their lives.

Through a local charity he found some training courses which helped him to develop his skills in caring for his wife. Most beneficial was the contact with other carers.

Through his contact with the local charity they asked Bob if he would like to be part of a panel of carers who meet to discuss the support available to them, in their local area. The carers' panel is a group of volunteers who work with local organisations to help develop, evaluate and review services for carers.

We will listen to the voice of unpaid carers to inform the development of services and support

What we know about unpaid carers:

- Unpaid carers want people to understand their role, who listen to them and are not judgemental.
- Young unpaid carers want to be heard and recognised and be included in decisions that affect their lives.
- When the cared for person is in hospital, unpaid carers want to be informed of important decisions which may impact on their role as a carer.
- Unpaid carers want to be involved in the decisions that impact on them and value honest and open dialogue with professionals.

These are some of the things we are going to do:

- Ensure unpaid carers have a choice over how to conduct an assessment that best supports their lifestyle.
- Include unpaid carers when a decision is made about them, and if it is required, ask someone to help decide what is best.
- If the person being cared for is admitted into hospital, let unpaid carers know what is happening and include them in the discussions when they are able to come home.
- Continue to engage with young unpaid carers through the Young Carers Forum and use it to create support better for young carers.

What does good look like?

- Unpaid carers will be given the opportunity to be listened to and involved in the decisions about the support they receive and the care of their family.
- Unpaid carers will be included within the hospital admission and discharge planning process.
- Young unpaid carers will be given the opportunity to be involved in the decisions about the support they receive.
- Advocacy will be proactively offered, explained and independent form the advocacy for the person they care for.

Aazad's Story

Aazad's parents came to Wales in the late 1950s. They had no older relatives in the country, they had no experience of the issues people may face as they get older.

Around seven years ago, Aazad's mum, Hayat's health started to deteriorate. Her husband didn't realise the seriousness of her condition and found it difficult to express himself to health professionals so Aazad stepped in to help his mum and dad. Shortly after, Hayat was diagnosed with vascular dementia.

Aazad said that at the time he felt stuck and very alone. He was unsure about any rights he had to be involved in the decisions around his mum's care.

How will we deliver on our commitments?

Implementation and next steps

To achieve our shared vision and deliver our eight commitments we will work together with all of our stakeholders to jointly develop and implement detailed action plans.

We will involve the right people at the right time and utilise the Unpaid Carers Board as an expert reference group to develop and implement the plans. We will work closely with unpaid carers and staff in Cardiff and Vale of Glamorgan Councils, the Cardiff and Vale University Health Board and third sector organisations to make sure we support unpaid carers the best way we can. We will continue to recognise the invaluable difference unpaid carers make to the lives of those who they care for and the vital contribution they make to our communities.

Our next steps

Our next task is to produce detailed action plans for the future. This will be based on the areas highlighted for development within this document which have been brought together in Appendix A. Our action plans will include what we are going to do to and how we will support unpaid carers in their caring role and enable them have a life alongside caring. We will make sure our plans are:

- kept within the parameters of the priorities and consistent with our vision for unpaid carers
- monitored regularly through the Unpaid Carers Board
- regularly reviewed and where necessary adjustments made to account for any changes that impact the ability to achieve the actions

How will we know when we have achieved our priorities?

We will regularly report the activity of the action plans to the Unpaid Carers Board so they can monitor and evaluate progress. We will continue to speak with unpaid carers and ask them if we have achieved our aims; this feedback will ultimately tell us if we have improved unpaid carers' well-being and the quality of support they receive.

Quality and Performance Monitoring

It is important we strive to provide high quality and sustainable support for unpaid carers. Over the next five years, we will work with unpaid carers and our partners to determine how and what support would be most beneficial to enable unpaid carers to maintain and improve their well-being whilst continuing to meet the demands of their caring role.

The Welsh Government code of practice in relation to the performance and improvement of social services in Wales requires us to report specific metrics to help understand how our work facilitates improvement in social care, specifically when contributing to the well-being outcomes of unpaid carers who need support.

Quality assurance measures will be put in place in line with Social Service and Well-being (Wales) Act 2014 and link to each of the priorities to help us evaluate their effectiveness in supporting unpaid carers to achieve their outcomes.

Needs and Demand

We have collected a wide range of information from and about unpaid carers, including local and national information. This has helped us to understand what is like to be a carer in Cardiff and the Vale or Glamorgan and what we can do to make things better.

This analysis gave us useful insight and understanding of some of the key areas we need consider when both developing our strategy and during its implementation.

Cardiff and Vale Population Needs Assessment[1]

The Population Needs Assessment for Cardiff and the Vale of Glamorgan undertaken in 2021/22 gave valuable information about the main areas of concern for unpaid carers.

Cardiff and the Vale of Glamorgan has approximately 50,580 unpaid carers of all ages, based on the 2011 Census. The figures for unpaid carers (below) are likely to be an underestimate of the true number, as data collection was over 10 years ago, and the overall population has grown in numbers since then. Additionally, Carers Wales have reported that in the first few weeks of the pandemic, in Wales alone, around 196,000 people became unpaid carers. Tables below show that the proportion of the population who are unpaid carers in the Vale of Glamorgan is the same as the national average (12%); however, in Cardiff it is less at 10%.

The number of carers in Cardiff and the Vale of Glamorgan (census 2001, 2011)

Increase in number of unpaid carers across the region as reported in the 2011 census compared to the previous census in 2001.

Cardiff & Vale of Glamorgan	**2001**	**2011**
Provides 1 to 19 hours unpaid care a week	29,527	31,610
Provides 20 to 49 hours unpaid care a week	5,066	6,779
Provides 50 or more hours unpaid care a week	10,428	12,191
Total	**45,021**	**50,580**

Current number of carers by age range in Cardiff and the Vale of Glamorgan (census)

	Cardiff & the Vale of Glamorgan
Age 0 to 15	996
Age 16 to 24	3,454
Age 25 to 34	4,928
Age 35 to 49	12,888
Age 50 to 64	17,746
Age 65 and over	10,568
Total	**50,580**

[1] https://cvihsc.co.uk/about/what-we-do/population-needs-assessment/

State of Caring 2021[2]

Each year, Carers UK carries out a survey of carers to understand the current state of caring in the UK. This report contains a snapshot of what caring in Wales is like in 2021, capturing the impact that caring has on carers' lives and evidencing the policy recommendations that would improve this.

Financial:

Caring often brings with it additional costs, from equipment and care costs to increased expenditure on fuel and transportation. When asked to describe their current financial situation, 36% of carers in Wales said they were struggling to make ends meet. A further 23% are or have been in debt as a result of caring and 8% cannot afford utility bills such as electricity, gas, water or telephone bills. When asked about how their financial situation had changed since the start of the COVID-19 pandemic, 36% of carers said that their financial situation had got worse since the start of the pandemic. Caring can be expensive and 65% of carers are spending their own money on care, support services or products for the person they care for. The average monthly spend for carers in Wales is £109.75 and with high rates of inflation and a rising cost of living, this extra spend is likely to further disadvantage carers financially.

Support and Services:

Carers often need practical and emotional support to enable them to care safely for people with complex needs, and too often they struggle to get the support they need. When asked about barriers to accessing support, the largest issue for Welsh carers was that they did not know what services were available in their area with 40% of carers reporting this as a barrier. In addition, 30% of carers were concerned about the risk of catching COVID-19 and 32% say that the care and support services did not meet their needs. Considering the future of services, 51% of carers were uncertain about what practical support they may be able to access in the next twelve months and 66% were worried that services will be reduced.

Health:

Caring can have a detrimental impact on someone's physical and mental health. 26% of carers described their physical health as bad or very bad. 34% of carers rated their mental health as bad or very bad. Looking at wider indicators of wellbeing, 36% of carers reported that they are often or always lonely, otherwise known as being 'chronically lonely'. Carers also rated their overall satisfaction with life at an average of 4 out of 10 and their level of anxiety at 6 out of 10.

Carer's Assessments:

The Social Services and Well-being (Wales) Act 2014 gives Welsh carers the right to a carer's needs assessment. Despite carers' rights to assessments only 21% of Welsh carers reported having an assessment in the last 12 months. Of those, 28% waited more than six months for their assessment. Of those who hadn't requested a carer's assessment, 37% stated that this was because they didn't

[2] https://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-2021-report

know what it was and 20% stated it was because they didn't think it would be beneficial. 10% of carers said their assessment had been postponed or they were still waiting.

Technology:

When asked about their current use of digital technology, remote healthcare such as online GP appointments was the most popular technology listed with 37% of carers stating that this made their caring role easier. Looking to the future, 31% of Welsh carers would like to continue accessing support services digitally in the future and 44% stating they would like to continue accessing health and social care services digitally.

Work

Working carers represent a significant proportion of the working population and 196 respondents were in paid work. The pandemic is continuing to have an impact on working experiences, with 51% of working carers are working from home part or full time. The limited return of services continues to have an impact. 30% of working carers in Wales stated that if care services did not return, they would either need to reduce their working hours or give up work entirely.

Finance & Resources

We will make sure that all funding streams identified for carers are co-ordinated and support in the way they need it most and when they need it most. We will consider all resources to help deliver against our seven priorities; this includes making best use of the following funding streams:

As the populations in our communities change we need to change how we provide care and support. We will see an increasingly older population who need support to manage as well as seeing increases in the number of people with complex needs and people who look to us to help them. We need to acknowledge the budget pressures we are likely to face in the future.

We will continue to work together with our partners in new and innovative ways to deliver the most efficient, effective and sustainable support to unpaid carers. Through greater collaboration and integration of services we will maximise the use of all available resources to help deliver support to all unpaid carers in Cardiff and the Vale of Glamorgan.

Appendix A

The below table, pulls out all of the key actions within the commitment document, these will be taken forward and monitored by the regional Unpaid Carers Board:

Commitment	What will we do?
We will ensure unpaid carers are identified and recognised in our communities	Work with our partners in health, social care, housing, education, and the third sector (for example. charities and voluntary groups) to promote awareness of early identification of unpaid carers through information and training.
	Work with schools to help make the identification and support for young unpaid carers in primary and secondary schools as easy as possible.
	Work with GP practices to support the identification and recognition of all unpaid carers.
We will ensure the right information and advice is given to unpaid carers at the right time	Promote early intervention and preventative services to help unpaid carers and the person they care for.
	Make information available to unpaid carers in the most appropriate format (easy-read/braille/ in different languages).
	Use social media and the internet to make it easier for unpaid carers to find the right information when they need it.
	Inform unpaid carers of their right to support and that their rights are equal to those they care for.
We will work to improve the quality of support provided to unpaid carers	Facilitate and promote carer support networks to provide an opportunity for unpaid carers to share experiences and learning from each other.
	Develop training for young unpaid carers to recognise their skills and experience and help young unpaid carers to look after themselves.
	Continue to work with schools so they understand and are able to support young unpaid carers.
	Ensure the needs of unpaid carers are identified and they receive the appropriate support whether through a carer's assessment or in other ways.
We will develop and improve the skills of our workforce to help carers achieve what matters to them	Make links with our partners to identify and promote training and development opportunities for unpaid carers, and identify any training and development needs that are not currently being met.
	Train people who work with young unpaid carers, to make sure they find out about what is important to young unpaid carers and their families to find out how they can help.
	Where appropriate, share information with partner organisations involved in supporting unpaid carers.
	Work in a person-centred approach focussing on individual need to ensure unpaid carers' health and well-being outcomes are co-produced by individuals and members of the workforce.
We will make best use of the resources available to contribute to caring for people in our communities and make sure unpaid carers have time to do the things they enjoy	Recognise whilst there are many things unpaid carers have in common, the support available to unpaid carers need to be individual and consider the unique nature of their caring role.
	When support is provided, unpaid carers will be asked what difference it has made, to make sure we are supporting them in the best and most cost-effective way.

	Set up carer support groups at community location for example. GP surgeries, libraries, with information about keeping healthy and connected.
	Develop support for unpaid carers using digital solutions for example. use online carer forums and social media to help access information and support.
We will work together to ensure unpaid carers are supported in education and work	Support unpaid carers to return or remain within the workforce, either alongside or instead of the caring role if they want to.
	Work with schools to help make the identification and support for young unpaid carers in primary and secondary schools as easy as possible.
	Working with employers and their representative bodies to promote unpaid carer friendly workplaces.
We will ask you to tell us what you think	Make sure consultation and engagement activities are accessible and unpaid carers are supported to be able to contribute their views and opinions effectively.
	Evaluate and review the current ways we engage with unpaid carers and how effectively different carer groups are represented and develop ways to reach any groups which may be under represented.
	Provide different opportunities for unpaid carers to have their say and ask unpaid carers to tell us the best way to involve them, for example. via social media, on their own or with a group of unpaid carers.
	Engage with young unpaid carers in evaluating support and work with them in designing support options that best suit their individual caring situations.
We will listen to the voice of unpaid carers to inform the development of services and support	Ensure unpaid carers have a choice over how to conduct an assessment that best supports their lifestyle.
	Include unpaid carers when a decision is made about them, and if it is required, ask someone to help decide what is best.
	If the person being cared for is admitted into hospital, let unpaid carers know what is happening and include them in the discussions when they are able to come home.
	Continue to engage with young unpaid carers through the Young Carers Forum and use it to create support better for young carers.

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

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD
QUALITY SAFETY AND EXPERIENCE SUB-COMMITTEE

MINUTES OF THE MEETING HELD ON 19TH MAY 2022

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Nigel Roberts	Laboratory Service Manager, Biochemistry
Bolette Jones	Head of Medical Illustration
Jamie Williams	Senior Nurse, Radiology
Lesley Harris	Professional Head of Radiography UHL
Robert Bracchi	Medical Advisor to AWTTC
Sian Jones	Operational Service Manager
Cath Marshall	Physiotherapy (attending for Jacqueline Sharp)
Nia Came	Head of Adult Speech and Language Therapy
Chris Cheetham	Occupational Therapy (attending for Kim Atkinson)
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Tracy Wooster	Sister, Outpatients
Rhys Morris	CD&T R&D Lead
Seetal Sall	Point of Care Testing Manager
Catherine Evans	Patient Safety Coordinator
Jenna Walker	Pharmacist, Pharmacy
Kim Atkinson	Acting Head of Occupational Therapy
Jonathan Davies	Health and Safety Adviser
Matthew Howells	(Observing) Deputy Directorate Manager, AWMGS

Apologies:

Sandeep Hemmadi	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Becca Jos	Deputy Director of Operations
Suzanne Rees	Clinical Board Lead Nurse
Judyth Jenkins	Head of Dietetics
Timothy Banner	Head of Patient Services
Alicia Christopher	General Manager, Radiology and Medical Physics/ Clinical Engineering
Alun Roderick	Laboratory Service Manager, Haematology
Scott Gable	Laboratory Service Manager, Cellular Pathology
Louise Long	Public Health Wales Microbiology
Jacqueline Sharp	Acting Head of Physiotherapy
Paul Williams	Clinical Scientist, Medical Physics
Emma Cooke	Clinical Director of AHPs
Mathew King	Assistant Director of Therapies/Head of Podiatry

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 22/137 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 22/138 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 22/139 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 21st April 2022 were **APPROVED.**

CDTQSE 22/140 Matters Arising/Action log

The action log was **RECEIVED** and it was noted that a number of actions had been completed. The outstanding actions were updated as follows:

CDTQSE 22/040 Patient Stories

Sue Bailey will produce a new schedule commencing in August for directorates to present their patient stories.

Action: Sue Bailey

CDTQSE 22/054 Toxicology Lift at UHL

Jonathan Davies raised the issue with the lift engineer and his advice was to produce a risk assessment in order to escalate the issue as a priority. Nigel Roberts advised that risk assessments have been completed and he will forward them to Jonathan Davies who will then escalate to Estates.

Action: Nigel Roberts/Jonathan Davies

CDTQSE 22/085 Decontamination Procedure for POCT Equipment for Covid

The procedure has been rolled out to wards and staff have been trained. The monthly environmental swabs to be taken as a background check has not yet been implemented due to capacity issues. The aim is for the POCT team to do this initially and put in a procedure so that wards could undertake this going forward.

CDTQSE 22/087 Security Issues at Field Way

The company utilised by estates have taken measurements for security fencing and will provide a quote.

No progress has been made for CCTV and lights to be installed. Ed Chapman will undertake a risk assessment and escalate to Estates.

Action: Ed Chapman

CDTQSE 22/107 Offsite Storage Facility

Ed Chapman reported that equipment records need to be retained for 10 years from when equipment is disposed of. He has a plan for the records that could also help with the space issues at Field Way and he will discuss with Sion O'Keefe outside of the meeting.

Action: Ed Chapman

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 22/141 Patient Story

There was no presentation at today's meeting. Next month the Group will receive a presentation relating to sustainability.

CDTQSE 22/142 Feedback from UHB QSE Committee 12th April 2022

The minutes of the UHB QSE Committee held on 12th April 2022 are not yet available.

CDTQSE 22/143 Health and Care Standards

No update to report.

CDTQSE 22/144 Risk Register – Review and Revision

There were no new risks or revisions to current risks to report.

CDTQSE 22/145 Exception Reports

Cath Marshall reported that the breakdown of the lifts in Lakeside Wing is impacting on patients who require access to the Physiotherapy department on the first floor.

She also reported on an incident that occurred in Physiotherapy in the Rehab Centre at UHL. The new doors are heavy and do not open and close automatically and a patient fell out of their wheelchair whilst opening the door.

There are concerns relating to the Lymphoedema Service where no physiotherapy staff will be left in the team at the end of June. Physiotherapy is currently looking at mitigation that can be put in place. Sue Bailey will raise this issue with the Clinical Board.

Action: Sue Bailey

Seetal Sall reported that a new risk assessment needs to be submitted with regards to the use of lateral flow kits for patients that are being discharged to care homes which has been implemented in line with Welsh Government guidance. This falls under the remit of POCT and normally POCT would take a kit that could be in a pathway and evaluate it. As this is a national directive, the POCT team have not

been able to evaluate this and have raised concerns that they are not held accountable for this and end users should be held accountable. The team have agreed to support with training but raised the concern that they need to have a list of named operators that are trained and the wards that are involved in this pathway. Sue Bailey suggested the team undertake a risk assessment and escalate to the Medical Equipment Group.

Action: Seetal Sall

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 22/146 Initiatives to Promote Health and Wellbeing of Patients and Staff

Sian Jones reported that Mental Health First Aid Training sessions are being provided to Clinical Board staff throughout the summer. The Clinical Board are particularly keen for male members of staff sign up for the training.

The final figures for uptake of the flu vaccination have been released. This Clinical Board reported the highest uptake by frontline staff again this year, however the uptake figures were not as high as in previous years. Thoughts around promoting the vaccine for next year's flu campaign are being considered.

SAFE CARE

CDT QSE 22/147 Concerns and Compliments Report

In April 2022 the Clinical Board reported an Amber status. 21 concerns were received and there were 4 breaches in response times. 55% were resolved through early resolution and 8 compliments were received.

Physiotherapy reported a Red status. It received 3 concerns and reported 1 breach in response times, however it received 3 compliments.

Radiology reported an Amber status. It received 8 concerns and reported 3 breaches in response times. Of the 8 concerns, it resolved 75% within early resolution timeframes and received 1 compliment.

The following departments reported a Green status: Outpatients, Podiatry, Speech and Language Therapy, Dietetics and Medical Illustration.

Difficulties arranging and cancelling appointments continue to be the main theme of the concerns received. Some actions will be taken to try to address this issue going forward; the concerns team will be issued with information to ensure that patients have the right contact numbers.

CDTQSE 22/148 Patient Safety Incidents

The Incident Report was **RECEIVED.** The report contains NRIs, IRMER and SABRE incidents.

It was noted that the patient safety team have the functionality to produce reports specifically for NRIs and will provide these for future meetings.

Action: Catherine Evans

It was agreed that both reports would be useful for this meeting.

CDTQSE 22/149 New NRIs (National Reportable Incidents)

The Clinical Board currently has the following open NRIs:

Th incident relating to an Ultrasound trainee and concerns around competence. There has been a delay in completing the report but this is now being finalised.

An incident was reported in Fetal pathology involving pregnancy remains that entered the sensitive disposal pathway before the post mortem took place. A meeting was held with the family and they are being supported locally within their Health Board. The investigation has highlighted improvements that can be made to processes and the learning and RCA will be shared at this meeting when completed.

An incident has been reported that a patient was cancelled in a Urology clinic due to a consultant taking annual leave and the appointment was not re-booked. The patient has since presented with metastatic prostate cancer and the inference is that this could have been avoided if the patient had been rebooked and seen. Checks are being undertaken to determine if any other patients have not been re-booked and a factfinding meeting will be arranged next week. The clinic coordinators are currently based in the Medical Records department but at the time of the incident they were based in Urology in the Surgery Clinical Board but have since transferred across to this Clinical Board.

A No Surprises incident has been reported around fully covered metal stents that are inserted during an ERCP procedure. ERCP is an endoscopic procedure and some stents are designed to remain in place and others are meant to remain in place for a short period of time. A list of patients that have had stents placed since 2019 and that could be affected are being reviewed

Cath Marshall reported an incident that is currently at investigation stage involving a bariatric patient who fell as they could not sustain a standing position and endured a fracture. There have been difficulties obtaining the patient notes as currently the patient is an inpatient and the full investigation is very in depth. The incident occurred on a medical ward and the Investigating Officer is working closely with Medicine Clinical Board. Feedback will be presented to a future meeting.

Catherine Evans noted that any feedback on the new Datix Cymru system would be welcomed. Guidance will be issued to incident managers on how to transfer

incidents that are not NRIs across from the old system. It was requested that as many incidents as possible that are currently on the old system are closed off where possible.

CDTQSE 22/150 Patient Safety Alerts

Field Notice PICO50 Arterial Blood Sampler Notice

The Field Notice was **RECEIVED.** Nigel Roberts noted that an evaluation on an alternative syringe product has been signed off and approved for use and a request has been made to Procurement to obtain a price and add this to the catalogue on Oracle.

Jamie Williams enquired if PICO70 (without needles) are still available on the Oracle system. It was confirmed this is the case but Seetal Sall will also send Jamie Williams the product code for the alternative product.

Action: Seetal Sall

CDTQSE 22/151 Medical Device Risks/Equipment and Diagnostic Systems

A risk has been reported that Phillips Non-Evasive Ventilators V60 could suddenly stop working and have to be taken out of use. A patient safety alert is being produced.

Issues raised with UVC air scrubbers utilised in Endoscopy have been resolved and they are being put back in use.

CDTQSE 22/152 IPC/Decontamination Issues

Sian Jones circulated an email relating to an increase in count for legionella at UHL. The flushing regime for sinks and taps needs to be increased and undertaken daily. Areas that have taps and sinks not currently in use to inform Estates so that they can undertake this process. Also, if areas have any taps and sinks that are redundant to arrange to have them removed.

CDTQSE 22/153 Point of Care Testing Issues

Seetal Sall reported that the Point of Care Testing team are awaiting a refresh on pregnancy testing devices.

CDTQSE 22/154 Safeguarding Update

Nothing to report.

CDTQSE 22/155 Health and Safety Issues

Nigel Roberts raised an issue relating to the doors to the laboratories on the upper ground floor UHW. During the power outage, the laboratory doors locked and staff were unable to enter or leave the area. Security have been notified but no

response has been received. It was suggested that Nigel Roberts escalates the issue to Damian Winstone.

Action: Nigel Roberts

Jonathan Davies stated that this is a fire risk and he will escalate to the Fire Officer.

Action: Jonathan Davies

CDTQSE 22/156 Regulatory Compliance and Accreditation

The Clinical Board is reporting a good position in terms of regulatory compliance.

UKAS inspections have been undertaken in the laboratories and good feedback was received.

An IRMER inspection is being undertaken in PETIC in July. This service is managed by Cardiff University.

A Section 10 Audit has been undertaken in SMPU and a number of areas were highlighted that require action.

CDTQSE 22/157 Policies and Procedures

The Medical Device Policy has been published.

EFFECTIVE CARE

CDTQSE 22/158 NICE Guidance

NICE guidance relating to rehab following a traumatic injury was received and it was noted that this has not been implemented. In line with UHB processes, a discussion on the guidance will need to be led by Sandeep Hemmadi at the next meeting. Sue Bailey will discuss this further with Sandeep Hemmadi outside of the meeting.

Action: Sue Bailey

Welsh Risk Pool – Consent to Treatment EIDO Patient Information Leaflets

The UHB has access to the library of leaflets that should be provided to patients having treatment and a link has been circulated. Where there are claims relating to consent, Welsh Risk Pool are unlikely to reimburse the Health Board if there are any EIDO leaflets available that have not been used.

CDTQSE 22/159 Research and Development

The next Clinical Board R&D Meeting is being held next week.

Pharmacy has held a meeting with the Joint Research Office to discuss capacity to undertake R&D.

Therapies were successful in securing funding for a research project and have appointed a Band 6 0.6 wte for 12 months to a funded research post.

CDTQSE 22/160 Service Improvement Initiatives

Nothing to report.

CDTQSE 22/161 Information Governance/Data Quality

Nothing to report.

CDTQSE 22/162 Waste and Sustainability

Dr Stacey Harris is hosting a Cardiff and Vale Green Group and Sian Jones will be setting up a Clinical Board Green Group.

Interesting discussions are being held with laboratories on a sustainability project. Discussions are also being held around electric vehicles. The plan is to build these into case studies.

An update will be provided from Elaine Lewis and Charlotte Olivier at next month's Quality and Safety meeting relating to changes to medical gases.

Ed Chapman noted that Clinical Engineering have been unable to procure electric cars due to current chip shortages. Kim Atkinson noted that OT are experiencing the same issue.

DIGNIFIED CARE

CDTQSE 22/163 HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans

Nothing to report.

CDTQSE 22/164 Initiatives Related to the Promotion of Dignity

Nothing to report.

CDTQSE 22/165 Equality and Diversity

NHS Wales Equality Week is underway this week. Online seminars that are being held will be recorded and made available. Sue Bailey attended a seminar on staff experiences of working in the NHS with sensory loss.

TIMELY CARE

CDTQSE 22/166 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 22/167 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Sion O'Keefe was not present.

INDIVIDUAL CARE

CDTQSE 22/168 National User Experience Framework

Patient questionnaires are not currently being issued.

STAFF AND RESOURCES

CDTQSE 22/169 Staff Awards and Recognition

A Physiotherapy Staff Celebration Event was held this month.

Mark Groves, working in waiting list management in Radiology was awarded winner of the Clinical Board Staff Recognition Scheme for April in the category of an Individual Making an Outstanding Contribution.

CDTQSE 22/170 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting 80% compliance against the mandatory training target.

Compliance against Values Based Appraisals is poor and directorates are being tasked to produce plans to increase their compliance within specific timeframes. This will be monitored in the Directorate Performance Reviews.

RECEIVED AND NOTED ITEMS

Image Optimisation Group Minutes 1.2.22

Previously Circulated:

MHRA Class 4 Medicines Defect Information: Pfizer Limited, Depo-Medrone with Lidocaine 40 mg/ml (1ml and 2ml vials – single vial preparations)

MHRA Class 2 Medicines Recall – Fresenius Kabi Ltd

WG Medicines Shortage Advisory Group – Hormone Replacement Therapies Shortage

Welsh Government COVID-19 Therapeutic Alert Baricitinib for Patients Hospitalised Due to COVID-19 - Adults and Children Aged 2 Years and Over

ANY OTHER BUSINESS

Jamie Williams presented an SBAR relating to a longstanding issue around the practice of rectal medications. The radiology nurses need to give rectal suppositories in ERCP procedures which is not covered by the new edition of medicines code. Currently there is no governance to give this medication route unless there has been attendance on D.R.E (digital rectal examination course) that actually does not cover rectal medication administration and the course is not currently available.

As there is a time sensitive element to the administration of the drug: this leads to patients being placed at risk of receiving pancreatitis. The patient group at the highest risk is female patients aged 16-30. There are nurses in the team who are qualified to teach and assess (END 998) the actual risk of insertion of a suppository is minor, the risk always related to the drug given.

The proposal put forward is to offer inhouse training for rectal suppository insertion by qualified educators with a full complement of training documents, learning outcomes and assessment criteria.

An SOP will be created and logged on the Q-Pulse system. An assessment document will be created and added to existing interventional nurses' competences. All members of the nursing team with prior experience of administration will be assessed and training provided to nurses without experience who will then be assessed when trained.

The proposal was **APPROVED.**

It was noted that there are currently 56 open incidents in this Clinical Board on the old Datix system. Sue Bailey has a report that she will filter and issue to departments.

Action: Sue Bailey

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 17th June 2022 at 9am via Teams

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

Minutes
Medicine Clinical Board (MCB)
Quality, Safety & Experience Committee
19 May 2022 14:30 – 16:00, via MS Teams

Attendees:
Aled Roberts, Clinical Board Director, MCB (Chair)
Iain Hardcastle, Director of Operations
Diane Walker, Deputy Director of Nursing, MCB
Lyndsey MacDonald, Consultant, Acute & Emergency Medicine
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team
Sam Barratt, General Manager, Integrated Medicine
Catherine Bingham, Service Manager, Integrated medicine
Emma Keen, Deputy General Manager, Integrated Medicine
Angela Jones, Senior Nurse
Derek King, Clinical Nurse Specialist, Infection Prevention & Control
Gemma Taylor, Practice Development Nurse, Integrated Medicine
Sam Hughes, Practice Development Nurse, Integrated Medicine
Barbara Davies, Lead Nurse, Specialised Medicine
Ceri Richards-Taylor, Lead Nurse, Integrated Medicine
David Pitchforth, Lead Nurse, Integrated Medicine
Marianne Jenkins, Consultant Nurse Practitioner, Emergency Unit
Jacqui Westmoreland, Senior Nurse, Covid Investigations
Jenna McLaren, Senior Nurse, Acute & Emergency Medicine
Ruth Cann, Senior Nurse, Integrated Medicine
Carly Simpson, Senior Nurse, Integrated Medicine
Natasha Whysall, Senior Nurse, Integrated Medicine
Elinor Gerrard, Senior Nurse, Integrated Medicine
Beth Jones, Senior Nurse, Specialised Medicine
Philip Harborne, Consultant Gastroenterologist, UHL
Craig Davies, Service Manager, Acute Medicine
Molly Baker, Academia Wales Graduate, Acute & Emergency Medicine
Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Jane Murphy, Director of Nursing, MCB Kath Prosser, Quality & Governance Lead, Medicine Sharon Jones, Consultant, Specialised Medicine	
Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	**Minutes of the previous meeting** – received and accepted.	
1.2	**Maters arising** **Tendable**: BD is MCB lead for Tenable. Main focus going forward is that the data, when ready, will be fed into this meeting so that there is a report. Tendable was originally called Perfect Ward and is an audit tool to be used on wards. IP&C audits are all fed in via Tendable.	

	Concerns: JM ensuring that themes from Coroners inquests are discussed and the loop is closed on discussing and dealing with these. Corporately it should be ensured that our teams are supported when going to inquest. **Action: DW will liaise with Tracey Skerm, who is heading up the Inquest Team, to ensure staff are supported when going to an inquest.** **Psychology support for staff** – the Psychologist is based in C6 office. Positive feedback has been received.	DW
1.3	**Patient Story** – delivered by Barbara Davies, Specialised Medicine. The patient (X) needed an endoscopic procedure under general anaesthetic (GA). X contacted the Concerns Team in Spring 2021. X's procedure was delayed because of Covid and also the loss of capacity in the general anaesthetic list. X felt discriminated against because of her mental health disorder and her PTSD situation following extensive abuse sustained in her past. The procedure was arranged under propofol, which is a method of deep sedation, the person is not conscious during the procedure and will recover quicker. X felt unable to proceed with this as it was not a general anaesthetic, and went back on the waiting list. In December 2021 X was invited to pre-assessment. In January 2022 further concerns were raised stating failure to comply with urgent suspected cancer pathways and timeframes. X was referred with Urgent Suspected Cancer (USC), vetted and downgraded to urgent. Timescale for these are 2 weeks for USC and 4 weeks for urgent, however, it was running at 9 weeks secondary to waiting lists. Conversations with X led to staff quickly prioritising her following the concerns relating to events sustained in her earlier life. Staff sourced a way to alleviate X's anxiety and completed her colonoscopy under general anaesthetic and biopsy results are awaited. X's Mum thanked staff advising her daughter felt treated holistically as an individual. **Learning** – administrative staff are excellent at booking patients in for procedures, however, staff were trying to accommodate the procedure swiftly, but not totally understanding the patients concerns. The procedure was successfully carried out in the patient's best interests with a reasonable outcome. BD will link in with the Frequent Attenders Team to discuss this patient.	
1.4	**Feedback from UHB QSE Committee 12/4/22** A Health and Social Care Wales Act will be implemented in April 2023 regarding Duty of Candour. The Health Board (HB) is committed to ensuring there is a training package regarding understanding of Duty of Candour and its full implementation. Present back finding of an audit carried out at St David's Hospital regarding blanket DNA CPR's decisions. **Action: AR will liaise with CR-T regarding this.**	AR
1.5	**Directorate QSE minutes – exception reporting** Endoscopy User Group meetings minutes will be sent to this group in future.	
1.6	**RCN Wales Nurse of the Year, 9/11/22**. Nominations to be submitted by 30/6/22.	
1.7	**C&VUHB Endoscopy Operational Policy,** presented by Dr Phil Harborne. This policy has been ratified by the Endoscopy User Group (EUG) and now seeking ratification from the MCB QSE group. The original policy has been updated to prepare for Joint Advisory Group (JAG) accreditation. JAG is a national body that credits endoscopists /units to enable them to carry out endoscopies, not many HB's in Wales have accreditation. Part of getting	

	accreditation requires the operational policy to be brought in line with JAG requirements. The updated operational policy is now an instruction manual and there is separate clinical guidance for endoscopy. The adverse incident form has space for further information to be added and some things do not need to be reported on datix, however, may be useful for wider learning and discussion at EUG. **Action: prior to ratifying this policy a discussion will take place with Phil Harborne, DW, SC to discuss further the adverse incident form and datix and the capturing of information on both systems.** **Action: SG to ask KP to add this item to next month's agenda.**	DW/SC SG
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**Virtual Ward (VW) Standard Operating Procedure (SOP) for Ratification** VW has had a successful first 5 months. Figures for last month are 157 referrals, 121 of which would have been in-patients, 36 would have been day returners, estimated saved medical bed days is 214, with 5 new admissions onto the ward daily. The average length of stay for a patient is 8 days. The SOP will be an ongoing development as the service grows. **Decision:** SOP was ratified by the group.	
2.2	**Healthcare acquired Covid investigations update, as of 30/4/22** There are 3,249 patients to be investigated. 668 of those are deaths, significant rise for wave 4 patients, whereas there are over 1000 patients of which there were 65 deaths. Internal communications will be given to staff prior to contacting patients and families. Two more investigators are joining the team. All patients were entered on one datix per outbreak, however, an individual datix is now required per person so that harm can be categorized.	
2.3	**Learning and Education Plan (LEP)** The LEP has been shared with lead nurses for sharing with senior nurses. The LEP will reflect the priorities as they arise in MCB. Learning from NRI's, concerns, falls and lying and standing blood pressure will be added to the plan. A Pressure Ulcer Scrutiny and Learning Panel has commenced and needs to get to a point of reviewing live, not retrospective. **New datix system** - there is a section on the new datix system on investigations, pressure damage and falls, no paper or electronic tool is required, just complete within the datix. If staff need to save a datix before it is completed they should move it on to 'management review/make safe' the mandatory fields disappear and the datix will be saved for later completion. **Action: CR-T to update ward managers. SC will liaise with ward managers if /as required.**	CR-T
2.4	**Clinical Audit Plan** **Action: AR and DW will work together to prepare a plan by the next meeting.**	AR/DW
2.5	**NCEPOD, Community Acquired Pneumonia Case Study Reviewers needed** **Action: all to circulate around nursing and medical teams.**	ALL
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	**Nationally Reported Incidents (NRI) update, 14 open NRI's** **NRI for closure: ID2512** Pressure ulcer developed by an elderly, frail patient on E4, UHL who died five days after being admitted. The category 1 ulcer evolved into a category 2 ulcer and then further deteriorated. This was investigated and led staff to look at skin changes at life end, discussions are ongoing.	

Learning: this was avoidable. Issues were documented around categorisation of pressure damage and there were gaps in intentional rounding. This has been discussed at the Pressure Ulcer Scrutiny and Learning Panel, themes have been extracted and a training package has been prepared for E4 staff and will be rolled out to other wards.

3.2

Infection Prevention and Control update

55 days since last MRSA bacteraemia (UHW AU)
11 days since last MSSA bacteraemia (UHL E4)
31 days since last *C difficile (UHW A7)*
24 days since last E. *Coli* bacteraemia (UHW SRC)
23 days since last Pseudomonas bacteraemia (UHW LSGF2)
38 days since last Klebsiella bacteraemia (UHW A7)

News/Issues/Concerns

- There are no incidents or outbreaks.
- DMT scores – All wards within MCB are compliant for the 4-week period. All areas achieved > 97%.
- Awaiting reduction goals for 2022-2023.
- MCB position based on the same period 2020-2021: *C. difficile* 40% reduction, *Klebsiella* 66% reduction. 72% increase with *E. coli*, +2 increase with SAUR and +1 increase with *Pseudomonas*.
- 21 RCA's remain outstanding.
- Visor compliance is very poor across the MCB with mask wearing compliance decreasing (across MDT).
- MCB wide MRSA audit within the next 2 weeks.
- Community case rate for COVID-19 continues to fall – 20.2 (Cardiff) / 21.0 (Vale), (18.3 Wales). Down from 50's.
- Legal requirement for mask wearing for review at the end of May.
- Influenza rates in the community remain below baseline activity, with a very slight increase compared to last week.
-

Action: All to encourage compliance with mask wearing.

ALL

DMT scores are high, DW and Ceri R-T had a walkaround where some areas failed, a deep clean was then done. A further walkaround took place and areas failed again. All to challenge the scores if they appear incorrect and, if required, contact DK and team to carry out a further audit.

C. *diff* (<2 month)	MRSA	MSSA (<1 month)	E.*coli* (>4 month)	Pseudo-monas	Klebsiella (<1 month)
3 new cases: UHW MDU, B7, A7	0 new cases: EU/AU	2 new cases: UHW MDU, UHL SRC	7 new cases: UHW C5, C7, A7, LSGF2, UHL Rhydlafar, SRC x 2,	1 new case: LSGF2	1 new case: UHW A7
Total = 3 (Goal < ? cases)	Total = 0 (Goal 0 cases)	Total =2 (Goal < ? cases)	Total =7 (Goal < ? cases)	Total =1 (Goal 0 cases)	Total =1 (Goal < ? cases)

	<table><tr><th></th><th>C. *difficile*</th><th>SAUR</th><th>E. coli</th><th>P. *aeruginosa*</th><th>Klebsiella spp</th></tr><tr><td>Medicine Total to end April 2021</td><td>5</td><td>0</td><td>2</td><td>0</td><td>3</td></tr><tr><td>Medicine Total to end April 2022</td><td>3</td><td>2</td><td>7</td><td>1</td><td>1</td></tr><tr><td>Variance</td><td>-2</td><td>+2</td><td>+5</td><td>+1</td><td>-2</td></tr><tr><td>Percentage change</td><td>-40</td><td></td><td>+72</td><td></td><td>-66</td></tr></table> Key: (Not currently on target) (Currently on target)	
3.3	**Point of Care Testing** – no actions required.	
3.4	**Medical devices/equipment issues** – no issues raised.	
3.5	**Patient Safety Alerts/MDA's/ISN** – these have been circulated. All to note and share with teams. • MHRA Medicines recall: Olopatadine USV 1mg/mL eye drops, solution • Medicines Shortage Advisory Group Wales Medicine Shortage: Fesoterodine • Medicines Shortage Advisory Group Wales Medicine Shortage: • Hormone Replacement • Medicines Shortage Advisory Group Wales Medicine Shortage: There is a national shortage of adrenaline and lidocaine. A risk assessment has been carried out in Dermatology. There is only one box left to last the week with no assurance of a supply. Looking at alternatives with Pharmacy. Blood gas syringes were and remain an issue in EU. **Action: if a more permanent outcome is not in place soon, Jenna McLaren to advise AR.** There is a shortage of Cardiac Arrest boxes. There is not enough supply to replace the expired boxes.	ALL Jenna McLaren
3.6	**Falls** **Regulation 28 AB Health Board** A regulation 28 is a report to prevent further deaths. A patient in another health board died as a result of a fall and falls training is being arranged. A mortality review has been undertaken regarding a patient who died on a ward at UHL. The Medical Examiner (ME) asked for a further investigation to take place. This had been investigated and it was found that the falls this patient had did not lead to his death however the ME advised the patient had 3 falls, had been identified as having a high risk of falls and was still falling. The ME is happy that no further investigation takes place and that falls training is on the Learning and Education Plan. SH has requested to become part of the full steering group looking at falls starting in July.	
3.7	**LP proforma** – this will be used in MEACU for returners for LP's and helps with taking consent. This has been brought here for comment before going	

	into clinical use. A SOP will be developed along with the pro-forma. MJ will bring the SOP back to a future MCB QSE meeting. **Action: approval was given from the MCB QSE meeting. AR will take this back to the team to ensure all are comfortable to use the form.**	AR
DIGNIFIED CARE		
4.1	**Patients Safety/Quality Care** There is significant concern regarding staffing levels and the impact on staff to deliver safe quality care. This is formally noted on the minutes. Reporting of Emergency Medicine incidents– there has not been a reduction in incidents recorded and it was confirmed incidents are being reported, although noted that on occasion some may not be reported. In other directorates it was felt there may be under reporting of incidents, staff are finding the new datix system difficult to use. **Action: SC will look how figures from January to April compare. The new system went live in March.** Everyone is task focused reflecting the high workloads.	SC
4.2	**Learning from Events 25288** Presented by David Pitchforth regarding a medical negligence/concern from 2019 relating to an 83 year-old lady admitted to C6 for monitoring after being unwell. She was diabetic and had frequent hypo glycaemic episodes. Later that evening she fell and fractured her left femur whilst being assisted to the toilet which required surgical intervention. Before the fall her blood sugar level was 4.4mmols, after the fall it was 1.1mmols. The patient sustained a hypo glycaemic event. The family raised concern through putting things right, and it was found that the patient's blood sugar level should have been taken more frequently and if this was done the hypo glycaemic event may have been avoided. **Learning**: monitor blood sugar levels and ensure staff are competent to undertake blood sugar levels and record them. During the pandemic, blood glucose level training has not been fully available, however, this is now on the Learning Education Plan. There is currently no audit in place for blood sugar charts. GT and SH will be undertaking an annual training schedule and diabetes will be part of this. Ward managers will then be able to plot new starters onto the relevant training. **Action: DP will look at auditing and how this is done and come back to this group.** **Action: DP will link in with BD regarding the 'Think Glucose' and with CR-T regarding diabetes team viewpoint**	
4.3	**Consent to Treatment EIDO Patient Information Leaflets** **Action: carry over to next meeting. SG to ask KP to add to next month's agenda.**	SG
TIMELY CARE		
5.1	**Datix update** - there are 73 open datix which need to be closed by mid-day on 23/5/22, after that the datix which are on the old system cannot be updated. NRI's cannot be closed, however, if the closure form has been sent, the NRI can be closed by Patient Safety Team.	
INDIVIDUAL CARE		
6.1	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans	
6.2	**DTOCs** – no update.	

6.3	**Safeguarding** – no update.	
6.4	**Concerns update** –	
6.5	**Compliments** **Specialised Medicine** – received as below: I express my sincere gratitude for the excellent care I received from Ward A7 staff at UHW. I was an inpatient on A7 for two admissions last year, requiring Naso-Jejunal feeding for protracted vomiting and subsequent weight loss. Being unwell enough to require inpatient care is physically and emotionally tough for anyone. My experience was made as positive as possible due to the very special staff on A7. Throughout both admissions, I was amazed by the quality of care I received. Each member of the team (nurses, student nurses, healthcare assistants, ward clerks, catering team, domestic staff) was nothing short of fantastic at every interaction, nothing was ever too much trouble, even in such a busy environment. Aside from their excellent medical care, I was always treated with compassion and all staff made a huge effort to chat with patients, meaning that someone made me laugh each day. I cannot find enough words of praise for this wonderful team! I am also hugely grateful to the Gastroenterology Team, particularly Dr Durai, Dr Hewett and Charlotte Dowd from Dietetics for their involvement in my care. My continued recovery would not be possible without their contributions. Dr Hewett led my care from the medical perspective but also miraculously managed to arrange my prompt admissions (despite the significant bed crisis) which was greatly appreciated by my family and me. **Integrated Medicine** – received as below: Thank you to all the wonderful Lakeside staff for your help and wonderful care given to our Mother. We are so grateful for everything. Thank you for being such a lovely, supportive and welcoming team. You are all amazing people, who the patients, families and visiting nurses are lucky to have. Keep doing what you are doing, you are amazing! Katie SAU Nurse.	
Staff and Resources		
7.0	**Any update to share** – no update.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	**Date and time of next meeting** – 16/6/22 at 2.30pm	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 9:30, Thursday 28 April 2022
Teams Meeting
MINUTES

In Attendance: Claire Main (CMain), Interim Director of Nursing, Specialist Services Board (CHAIR)
Colin Gibson, (CG), Consultant Clinical Scientist, ALAS
Angela Jones, (AJ), Senior Nurse, Resuscitation
Cath Evans (CE), Patient Safety Facilitator
Jo Clements (JC), Lead Nurse, Critical Care
Guy Blackshaw, (GB), Clinical Board Director, Specialist Services Board
Lisa Simm, (LS), Service Manager, Neurosciences
Sharon Daniels, (SD), Directorate Support Manager Nephrology & Transplant
Kevin Nicholls, (KN), Service Manager, Cardiac Services
Gareth Jenkins, (GJ), Service Manager, Haematology, Immunology & Metabolic Medicine
Clare Smerden, (CS), Senior Nurse, Neurosciences
Sarah Lloyd, (SL), Interim Director of Operations, Specialist Services
Lisa Higginson, Interim Lead Nurse, Nephrology & Transplant
Jane Morris, (JM), Senior Nurse, PaRT
Nick Gidman, (NG), Directorate Manager, Cardiac Services
Claire Mahoney, (CM),
Mathew Price, (MP, Directorate Manager, Neurosciences
Rachel Barry, (RB), Lead Nurse, Neurosciences
Lorraine Donovan, (LD), Senior Nurse, Neurosciences
Sian Williams, (SW), Cardiac Services
Helen Thomas, (HT), Lead Pharmacist for Specialist Services Clinical Board
Keith Wilson, (KW), Consultant Haematologist
Professor William Gray, Consultant Neurosurgeon
Helen Hughes,

Present: Mandy McGee, PA Specialist Services

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions C Main welcomed all to the meeting and asked for feedback and comments on the new structure and timings of the meeting.	
1.2	Apologies for absence Received from Richard Parry, Bev Oughton, Caroline Burford, Ravi Nannapaneni, Ceri Phillips, Jonathan Davies, Rachel Long	
1.3 Saunders.Nathan 30/08/2022 11:22:01 ACTION	To review the Minutes of the previous meeting 4 April 2022 The minutes of the meeting held 4 April 2022 were agreed as an accurate record. Matters Arising Heparin Protocol Work to be undertaken on how this can be adapted for our Specialist Services, CMain to meet with Helen Thomas to take this forward.	CMain

	Medical Equipment – Incident Reporting CE confirmed that this topic has been added to the Agenda for future NRI meetings.	
1.4	<u>HD Gene TRX2 Trial- Professor Liam Gray</u> Prof Liam Gray gave a presentation on the UniQure Trial. CMain thanked Prof Gray for his presentation. GB thanked Prof Gray and asked if there are any longer-term outcomes and results available to date, Prof Gray replied that this work is part of the first safety and efficacy trial, which has been running for approximately 9 months, 8 cases have been undertaken in the USA so far, there have been no problems so far, assessing outcomes will take a number of years. GB asked if the trial will be taking place using a dedicated research scanner, Prof Gray replied that there is no dedicated research scanner available but the company would be reimbursing the NHS for the use of scanner and staff time. ACTION Helen Hughes asked if there could be a formal response from the Group, CMain confirmed that she would arrange this as Chair of the Group. ACTION Resend the SBAR to the Group.	CMain PA
1.5	<u>P@RT CXR Requesting – Jane Morris</u> JM presented to the group on the proposal to have the additional element of requesting chest X-rays included to the scope of practice of PaRT practitioners.	
PART 2: SAFE CARE		**Action**
2.1	<u>Open Nationally Reportable Incidents</u> CE provided an update to the group, 6 NRI's were closed last month. there are currently 3 open NRI's • IN146473 Patient SB sustained a fall while an in-patient on B4 Haem, the Lead Nurse is finalising the report on this case. • IN152962 Patient MC known to ALAS who sustained a fall from his wheelchair. The RCA has been completed and the Directorate are finalising an Improvement Plan. • IN161318 Patient EM, a case of mistaken identity on the IT system which led to the wrong size valve being inserted in a patient, the patient has recovered and the correct valve subsequently inserted. The RCA and Improvement Plan have been completed. CMain thanked all for the progress made on these cases.	
2.2	<u>Closure Forms</u> NG reported on 3 Cardiac cases • Patient diagnosed with severe aortic stenosis, 68 yr old gentlemen, accepted for surgery in August 2019, sadly passed away in December 2019. When the patient was referred over from ABUHB	

	there were 40 weeks of the patients' cardiology pathway missing, from a management perspective, the patient was seen to be waiting under 36 weeks when in fact the patient had been waiting closer to 70 weeks. • Patient referred in March 2020, accepted for surgery in May 2020, sadly passed away in February 2021. The main issue was the Covid pandemic, from April 2020 cardiac surgery, other than emergency cases, was stopped until September 2021 resulting in increased waiting times for all patients. Actions Plans are in place for both of these incidents, the key action is the introduction of an aortic stenosis pathway, which will reduce the referral to treatment time significantly. • Female patient diagnosed with acute aortic stenosis who underwent an aortic valve implant (TAVI procedure) in the Cardiac Catheter Lab, the implant was placed on 20 Jan 2022 with a good initial clinical outcome. After discharge the patient presented in ABUHB A&E with shortness of breath and after consultation with the TAVI Team was transferred to UHW. Tests revealed that the implanted valve had moved within the aorta and a decision made to undertake a valve in valve procedure. Subsequent findings were that initially incorrect images had been uploaded for the patient resulting in the incorrect size valve being placed. The patient and her family have been kept informed, interim actions have put in place to mitigate further risk of this re-occurring. The main action is for the UHB to acquire the software to allow the team to size the valves in-house to allow a more robust checking process within Cardiology to ensure that this error does not happen again. CMain thanked the NG and Cardiac Team for all their work with these challenging cases. Closure Forms to be sent out to group CE reminded all of the closure of Datix from 13 May, and asked all to close any incidents that have been completed, any incidents that need to remain open should be transferred over to Datix Cymru. CMain will send out a report with details of any out-standing incidents to the relevant Directorates. CE asked anyone needing any help to close incidents down to contact the Patient Safety Team. Datix Cymru will be releasing an on-line training package next week.	ACTION PA ACTION CMAIN
2.3	<u>Alerts/Patient Safety Notices</u> The following notices have been disseminated to the Group for information and action as appropriate. • CEM//CPhA/2022/18 -USV UK Limited - Olopatadine USV 1mg_ml Eye Drops, Solution, EL(22)A • CPhO//MedsLet/2022/12 - Clomifene 50mg tablets (002)	

	• CPhO MedsLet 2022 11 - Fesoterodine (Toviaz) 4mg and 8 mg modified release tablets • UFSN - Vygon Blunt Needle • CPhO/MedsLet/2022/13 - Sarilumab (Kevzara) 200mg per 1.14ml solution for injection pre-filled pens and syringes	
2.4	<u>Healthcare Associated Infections</u> • Specialist IP&C Report April 2022 completed 27 April 2022 CM referred to the attached report which gives details of the current situation. CM highlighted the end of year infection reduction expectation, comparison showed that there had been a good reduction in E.coli bacteraemia and Pseudomonas, with work needed on infections caused by other organisms which had increased. The Welsh Health Circular has been issued giving details of this years' expectation, these will be circulated in due course. KW asked if there had been any progress in producing denominator data. CMain replied that this work will be undertaken within Specialist Services by the new IP&C lead when appointed.	
2.5	<u>Health Care Standard 2.9 Medical Devices</u> Prior to the meeting CG had sent the following report Please see attached BD FSN - BD Plastipak™ 50mL Syringe with Luer-Lok™ Tip (25 March 2022) which is being distributed for information in which it states: 'BD is conducting an Advisory Field Safety Corrective Action to advise customers of a potential for air ingress into the BD Plastipak™ 50mL syringe when the syringe barrel is damaged and the syringe is used in an infusion pump. This Advisory Notice affects all BD Plastipak™ 50mL syringes, Product Code (REF) 300865. No other product codes are impacted at this time. BD has received several customer complaints from hospitals in France involving an observation of air in a damaged syringe while being used in a pump. A damaged syringe barrel … could result in a loss of contact between the stopper and the barrel wall, thereby creating a leak path. It is believed that this air ingress, if injected into the patient, could result in a gas embolism. BD has confirmed a complaint rate of less than 1 complaint per million devices sold. It should be noted that this complaint rate is for damage to the syringe barrel and not specifically for this adverse event… The intention of this advisory notice is to emphasise good clinical practice to visually inspect the syringe for any damage prior to use.'	 BD FSN - BD Plastipak™ 50mL Syr
2.6	<u>Vaccination Update</u>	

Action	RB confirmed that there was nothing to report. It was agreed to remove this item from the agenda for the time being.	PA
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1	Feedback from UHB QSE Committee CE informed that the minutes from the February meeting are now available on the Intranet site.	
3.2	Mortality Review CB on leave	
3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups Haematology GJ reported that there are on-going issues with nurse vacancies on the Haematology ward and the resulting risk to patient safety, the lead nurses are currently working on a recruitment and retention plan but there is a short-term risk involved with the number of vacancies, the Risk Register will be updated to reflect this. KW informed the group that there will be a new consultant member of staff joining the Haematology Team in May and highlighted that due to the on-going issues with the office accommodation there is no suitable base available for that person. Cardiac Services KN reported that there is a delay in the Cath Lab refurbishment, the lab was due to re-open this week but this was stopped as further air quality testing is required in the venting of the Cath Lab, resulting in a delay of approximately a week and leading to cancelation of patient appointments. Nephrology & Transplant Nothing to report. Neurosciences Nothing to report PaRT Nothing to report ALAS Nothing to report	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	Heath Technology Wales Annual Report 2021 For information only.	
4.2	NCEPOD CAP Study – Case Reviewers For information only	
PART 5: ANY URGENT BUSINESS		

5.1	Any Urgent Business	
PART 6: DATE OF NEXT MEETING		
6.1	Next Meeting Thursday 9 June 2022 9:30am via Teams	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 9:30, Thursday 9 June 2022
Teams Meeting
MINUTES

In Attendance: Claire Main (CMain), Interim Director of Nursing, Specialist Services Board (CHAIR)
Colin Gibson, (CG), Consultant Clinical Scientist, ALAS
Angela Jones, (AJ), Senior Nurse, Resuscitation
Cath Evans (CE), Patient Safety Facilitator
Lisa Simm, (LS), Service Manager, Neurosciences
Sharon Daniels, (SD), Directorate Support Manager Nephrology & Transplant
Kevin Nicholls, (KN), Service Manager, Cardiac Services
Gareth Jenkins, (GJ), Service Manager, Haematology, Immunology & Metabolic Medicine
Clare Smerden, (CS), Senior Nurse, Neurosciences
Sarah Lloyd, (SL), Interim Director of Operations, Specialist Services
Lisa Higginson (LH), Interim Lead Nurse, Nephrology & Transplant
Jane Morris, (JM), Senior Nurse, PaRT
Nick Gidman, (NG), Directorate Manager, Cardiac Services
Claire Mahoney, (CM), CNS Infection Prevention & Control
Rachel Barry, (RB), Lead Nurse, Neurosciences
Sian Williams, (SW), Cardiac Services
Helen Thomas, (HT), Lead Pharmacist for Specialist Services Clinical Board
Jonathan Davies (JD), Health & Safety Adviser
Richard Parry (RP), Q&S Facilitator
Dan Jones (DJ), Assistant General Manager, for Critical Care and MTC
Beverley Oughton (BO), Senior Nurse, Cardiac Services
Alannah Foote (AF), Directorate Support Manager for Nephrology and Transplant
Khalid Hamandi (KH), Clinical Director for Neurology
Emma Swales (ES), Senior Nurse, Nephrology & Transplant

Present: Mandy McGee, PA Specialist Services

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions C Main welcomed all to the meeting.	
1.2	Apologies for absence Received from Guy Blackshaw, Keith Wilson, Bethan Ingram	
1.3	To review the Minutes of the previous meeting 28 April 2022 The minutes of the meeting held 28 April 2022 were agreed as an accurate record. Matters Arising 2.2 Closure Forms Closure Forms relating to the Cardiac cases to be sent out to the Group for review.	CMain

PART 2: SAFE CARE		Action
2.1	Open Nationally Reportable Incidents RP provided an update to the group, there are currently 2 open NRI's both approaching the final stages and closure submissions. • IN152962 Patient MC known to ALAS who sustained a fall from his wheelchair. A Learning from Events form has been produced, currently preparing and gathering information to present at the Redress Panel • IN146473 Patient SB sustained a fall while an in-patient on B4 Haem, RP in the process of completing the closure form. The investigation found no breaches, expected to present the case at a forthcoming QSE. RP reported that there are a large number of potential NRI's all currently at the fact-finding stage, none have met the NRI reporting criteria to date. CE reminded all that any incidents that need to remain open should be transferred over to Datix Cymru by 23 June 2022. RP added that there are a number of incidents to be migrated over, one of the major problems is that there are a number of managers still to register on the new system, therefore there is no-one to allocate the incidents to, one solution may be to allocate a number of these incidents to a designated person. RP asked that all register with Datix Cymru as soon as possible and to check if they have any outstanding incidents via the migration dashboard on the old Datix system and work on these accordingly. CE said that if there are incidents on the old system where no harm was reported and based on the information provided, appropriate action was taken at the time, the incident could be closed down rather than migrated over. CMain thanked RP and CE and asked that all on the call ensure that they have access to both systems and review the Datix sat within the Directorates as a team, if there are particular areas which are not manageable, we can look at how support can be provided. CE informed that there is a new link on CAVWeb to the updated training, https://nhswales365.sharepoint.com/sites/CAV_E-Datix%20incident%20reporting/SitePages/DatixCymru-incident-manager-training.aspx RP said that any technical issues should be reported to the Datix helpdesk.	
ACTION		Directorates
2.2	Closure Forms Nothing to Report	
2.3	Alerts/Patient Safety Notices The following notices have been disseminated to the Group for	

information and action as appropriate.

- CEM//CPhA/2022/19 -Pfizer Limited – Medrone with Lodocaine 40mg/ml (1ml and 2ml vials – single preparations)
- Consent to Treatment EIDO Patient Information Leaflets
- Rapid Policy Statement Interim Clinical Commissioning Policy: Baricitinib for patients hospitalised due to COVID-19 (adults and children aged 2 years and over)
- CEM/CMO/2022/15 COVID-19 Therapeutic Alert - Baricitinib for Patients Hospitalised Due to COVID-19 (Adults and Children Aged 2 Years and Over)
- Clinical Guide – Patients hospitalised due to COVID-19
- CEMCPhA 2022 21 – Class 2 Medicines Recall – Fresenius Kabi Ltd Sodium Bicarbonate 1.26% Solution
- CPhO Medslet 2022 14 – Hormone Replacement Therapies Shortage
- CEMCPhA2022 22 – Class 2 Medicines recall – Pfizer Ltd, Accupro film coated tablets – 5mg,10mg20mg,40mg
- CEMCPhA 2022 23 – GlaxoSmithKline UK Ltd, Zovirax I.V. 500mg EL (22)A-22
- CPhO Medslet 2022 15 – Droperidol 2.5mg / 1ml solution for injection ampoules
- CPhO MedsLet 2022 16 – Glycerol 1g & 5g suppositories
- Substitution of Zerobase 11% cream for Diprobase (discontinued) memo
- CEMCPhA 2022 24 – TRAMS update
- CEMCPhA 2022 25 – Class 2 Medicines Recall- Quadrant Pharmaceuticals Ltd, Mefenamic Acid 500mg film coated tablets
- CPhO MedsLet 2022 17 – insulin isophane (Insuman Basal SoloStar) 100IU/ml suspension for injection in pre-filled pen
- CEMCPhA 2022 28 – Orifarm UK Ltd Loprazolam 1mg Tablets EL (22) A-25

HT reported that the recent large number of reports had been raised at Corporate Medicine Management Group and it was agreed that some filtering is required. It has been proposed that the Clinical Board Pharmacist is sent all of the medicines related notices and will filter through and share what is relevant.

Of the alerts received HT drew attention to the supply problem with IV Aciclovir, as a precaution this has been removed from areas which do not

	use this frequently and it will be supplied to these areas on a named patient basis to try and maintain stocks. There is a meeting planned to decide how information about drug shortages is communicated efficiently.	
2.4 Action	Healthcare Associated Infections • Specialist IP&C Report May 2022 completed 1 June 2022 CM referred to the attached report which gives details of the current situation. Included in the report are the excellent results from a recent Catheter Care Audit undertaken within Specialist Services. There have been a series of PVC and VIP audits to try and determine the problems with S Aureus bacteraemia, there have been 15 cases in the CB this year. The results were generally good but there are areas which need improvement as detailed in the report. There have been 15 cases of C.Difficile this year, CM is looking at these cases to establish causes. CMain asked if there was anything regarding C. Diff that all should be aware of, CM replied that there is a rise in cases nationally and work is underway to try and establish why. LH informed that the next IP&C meeting for N&T will be dedicated to understanding the causes for the rise in bacteraemia cases in Renal and devise and action plan to deal with the situation. C Main asked that this is brought back to LH QSE.	C Main
2.5	Health Care Standard 2.9 Medical Devices Prior to the meeting CG had sent the following Please see attached *Device Safety Information Date 05/05/2022 DSI/2022/003(Wales) Paclitaxel drug-coated balloons (DCBs) or drug-eluting stents (DESs): Updated position on use in patients with critical limb ischaemia and intermittent claudication* (that links to Paclitaxel drug-coated balloons (DCBs) or drug-eluting stents (DESs): Updated position on use in patients with critical limb ischaemia and intermittent claudication DSI/2022/003 - GOV.UK (www.gov.uk)) which was shared by the UHB MDSO Group at its last meeting (albeit this may have already been shared via other routes given that the information relates to both medicines and their means of delivery via medical devices.	DSI-2022-003 (Wales).pdf
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1	Feedback from UHB QSE Committee Nothing to report	
3.2	Mortality Review Nothing to report	

3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups Cardiac Services Nothing to report Nephrology & Transplant Nothing to report. Critical Care Nothing to report. MTC DJ reported that the MTC have taken on the TARN Team with effect from 1 April, this has come with some challenges which are currently being worked through locally. CMain suggested that it would be helpful to provide an overview of the work of TARN once everything has had an opportunity to embed into the Team. Haematology GJ reported other than the continuing workforce challenges on the ward there are no further issues to report. Neurosciences KH reported that it seems that nothing has moved forward with regard to the issues raised a few months ago about the footprint, Covid Recovery, the Neurology Ward, the Epilepsy Telemetry, the Out-patient and the Day Unit space, all are on-going daily challenges being faced with no sign of being resolved.	
ACTION	CMain replied that there is a lot of work happening “behind the scenes” in terms of trying to de-escalate areas and that it would be useful to meet outside of this meeting to discuss further. Meeting to be arranged between Clinical Board Team and directorate. ALAS Nothing to report Health & Safety JD reported that the following points were discussed at a recent Operational Safety Group • all Clinical Boards should talk through any RIDDOR reportable staff incidents and suggested that going forward it would be useful to discuss these incidents in more detail prior to the Operational Safety Group meetings. • The organisation of H&S folders on the S drive, it would be helpful to discuss the anticipated format of the folders with regard to Safety.	CMain
ACTION	JD added that classroom training is now available and work is required to gain compliance in H&S Training within the CB	CMain
	PaRT JM reported that Cardiac Arrest figures are quite high in the morning so	

	the PaRT Team are looking to have 24/7 cover in the future for patient safety at night <u>Pharmacy</u> HT informed that a decision from the Resource Committee is awaited on the approach going forward to emergency boxes for the crash trolleys. AJ replied that a way forward has been agreed, currently waiting for information from Pharmacy before disseminating to all areas. The change will start in UHL, as the smaller site, before moving across the UHB. This will be communicated at the next RADAR meeting later this month.	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	Do you know the drill – EZIO poster For information only.	
4.2	• Doctrina Newsletter – Edition 6	
PART 5: ANY URGENT BUSINESS		
5.1	<u>Any Urgent Business</u> CE informed that there are some training sessions for Mental Capacity, these will be sent out later today	
PART 6: DATE OF NEXT MEETING		
6.1	<u>Next Meeting</u> Monday 27 June 2022 9:30am via Teams	

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 17th May 2022, 08:00-10:00 hours
MS Teams

MINUTES

Present:

Richard Hughes	Consultant Anaesthetist (Chair)
Clare Wade	Director of Nursing
Adrian Turk	Pharmacy
Angela Jones	Senior Nurse RESUS
Arul Kandan	Deputy General Manager T&O
Barbara Jones	Educational Lead
Catherine Twamley	Interim Lead Nurse Surgery, Urol, Ophth & ENT
Carolyn Alport	SCB QSE Lead
Carly Podger	Finance
Donna Davies	Head of People and Culture
Debbie Jones	Patient Safety
Emma Wilkins	Directorate Manager – General Surgery
Jan Collins	Theatre Manager
Julie Cornish	Consultant
Laura Hodges	Lead Nurse T&O
Vince Saunders	IP&C
Yvonne Hyde	IP&C

In attendance:

Zoe Sweetman	Surgery Clinical Board Secretary

PRELIMINARIES *(Chair)*		
SCB/QS:22/36	**Welcome and Introductions** Members were welcomed to the meeting and introductions were made.	
SCB/QS:22/37	**Apologies for Absence** Ceri Chinn Debra Preece Denis Williams Jayne Thain Michelle Able Naomi Goodwin Rachael Barlow Rafal Baraz Rowena Griffiths Siene Ng Terry Stephens Yvonne Hyde	
SCB/QS:22/38	**Minutes of meeting held March 2022** The Group approved the minutes of the previous meeting.	

SCB/QS:22/39	**Action Log** Please see Action Log for update	
SCB/QS:22/40	**Terms of Reference** The reviewed TOR were approved by the Group. Next review March 2023.	
PART 1: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
SCB/QS:22/41	**Patient Story – Ombudsman Report Baby M – Perioperative Care** JC – Paeds Theatre Manager presented on the RCA and Ombudsman Report relating to a complaint received in August 2020 by a parent (Ms L), who stated that the Health Board failed to take appropriate safety measures in applying chlorhexidine whilst cannulating her baby daughter (Baby M) in preparation for Surgery back in April 2016. Equally, the compliant suggested that the staff failed to change the continence sheet despite M's groin being sprayed with chlorhexidine on multiple occasions. JC gave an overview of Baby M's conditions, highlighting complex needs and the likelihood that cannulation would be difficult. It was noted that following the operation, in the recovery room burns to Baby M's skin was detected as a result of sequestering fluid underneath the child. Subsequently, burn was dressed and advise given, follow up appointment was made and incident form completed. The Group were informed that following the complaint, the Health Board was asked whether any similar incidents involving chlorhexidine had occurred; in which an RCA was provided for a similar incident in 2013 involving a 6-week-old baby who had developed red marks and blistering following application of three sprays. It was highlighted that the Health Board's records identified that the 2013 investigation report was discussed by its Surgical Support Services Quality and Safety Group, but there was no record of the action points having been completed. It was noted that the investigation concluded that the Health Board failed to take appropriate safety measures when applying alcoholic chlorhexidine to M's skin in preparation for surgery, and that it should have changed the continence sheet; these serious failings led to M suffering burns and blistering to her skin. JC reported that the outcome of this resulted in compensation to Ms L for both pain and suffering and the Health Board poor response to Ms L's complaint. Equally, it was reported that the Health Board had made a number of recommendations and an Action Plan was established. The Chair thanked JC for presenting this to the Group.	
SCB/QS: 22/42	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** Apologies sent by DW – General Manager, Performance Information Innovation. No update provided.	
SCB/QS: 22/43	**SBAR Breast Investigation** Report received and noted by the Group. CA – SCB QSE Lead reported that concerns were raised in November 2021 by the Radiology Team at UHL involving the discovery of reporting errors on images undertaken by an experienced agency Radiologist in October 2021. As a result, a full investigation was	

	undertaken and a review of 467 patients. It was noted that of the 467 reviews, 21 patients were recalled, due to concerns found in the images. Equally: - • 39 administrative errors were noted which included, inaccurate wording which did not make sense, reference to right side when it was left, poor use of language with unclear report. • 4 patients required surgery after further imaging, 1 was benign and 3 showed cancer. CA reported that the swift and thorough review carried out by the team; even though there was a recognised delay in 4 patients' diagnoses, assurance was given that no harm was caused to these patients as their surgery was within an acceptable timeframe for a suspected cancer diagnosis. It was noted that a number of recommendations was generated and appreciation was given to the Breast team for actions taken to address these concerns. CW- Director of Nursing praised the Breast Centre Staff for all their hard work; pulling these reviews together and actioning in a timely manner. It was highlighted that this was a great example of putting things right. CW advised that this was being addressed with the Agency involved.	
SCB/QS:22/44	**New MCA and Consent Lead** CE- Project Lead Liberty Protection Safeguards reported that she had intended on attending this meeting to discuss MCA and Consent Lead role, however had recently been given a new role as the Lead for Liberty Protection Safeguards. It was noted that this role had been established to help implement the new legislation for Deprivation of liberty. CE highlighted that Mental Health Capacity Act training was continuing to be rolled out to support the requirements of the legislation. CE added that the Health Board had also secured an external training provider; posters were being circulated to raise awareness. A long discussion took place around staff group suitability; CE confirmed that this was relevant to all staff groups and highlighted the benefits of them attending training. It was noted that discussions were taking place around resource for MCA and Consent Lead, to ensure this is also being supported.	
SCB/QS:22/45	**Feedback from UHB QSE Committee:** Clare Wade – Director of Nursing reported that the new Assistant Director of Quality and Safety had been appointed and would report back on these meetings, once in post.	
SCB/QS:22/46	**Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities** Directorates Exception reports were received and noted by the Group	
46.01	BJ gave an overview of the report, highlighting the following key items for **Peri-Operative** Directorate: - <u>Main Theatre</u>.	

	Incident involving Anaesthetic awareness during surgery. Facts finding revealed the reason for awareness was due cannula extravasation during total intravenous anaesthesia. Action plan being written with regard to safety of anaesthetic lines and visibility during surgery. Safety notice shared through directorate at time of incident. Incident involving arterial line damage during removal. RCA complete. Safety notice shared through directorate. Report shared with patient and staff involved. Theatre 7, Main theatres in undergoing refurbishment- awaiting completion. <u>CHfW</u> Historic incident involving BP recordings on neonate during surgery. RCA completed by women and child health. Clinical engineering reported no issue with equipment involved. Improvement plan has been written and meeting being arranged with Anaesthetic leads, incident investigator and parents in order to discuss report and feedback learning. Historic incident involving use of Chlorhexidine solution when inserting central line. RCA completed at the time, improvement plan submitted. We have received further correspondence and action plan from Ombudsman that is being worked on, awaiting responses from relevant specialities and services in order to implement changes. <u>UHL</u> In149722. An incident was reported in which a patient sustained a burn due to the use of hydrogen peroxide solution. RCA complete, action plan being written and implemented. Incident involving a cut to a patient's thumb following removal of temporary cast. Incident discussed with staff and encouraged to reflect on their practice. Safety notice shared at time of incident. Redress had been completed. Never event involving incorrect knee implant. RCA complete. Action/improvement plan being drafted and discussed with Surgeons and theatre manager. The Chair raised concern in relation to access to PESU, where the barriers outside EU had been lowered to prevent traffic. It was noted that this was impacting on patients; in particular those with mobility issues, where they are having to walk a distance to access the department. Equally, issues were raised around the lack of visible signage to PESU. CW- Director of Nursing advised that the Department link in with Estates to review access for patients. **Action**: BJ agreed to link in with Paul Warman – Theatre Manager, to action.	
46.02	**Anaesthetic** report available for information.	
46.03	**General Surgery** Report shared with the Group: no verbal update provided.	
46.04	LH gave an overview of the report for **T&O.** The following was discussed: - • Change to VTE prophylaxis for lower limb trauma • Looking at a QI project for the assessment of post-operative haemoglobin for NOF fractures. • Incident in theatres (In 160082) 15.02.22. wrong side implant inserted during total knee replacement. RCA in progress • Inquest date set for case COB on 24.5.22 • New inquest opened May 22, review underway • 2 category 3 pressure sores within the month of April. RCA underway for both	

	• No HAI reported in the month of April • Datix queues reduced to maximum of 3 on old system; 22 open concerns. 10 being about elective surgery dates • Incident involving a leaking shower in Cavoc affecting radiology. Estates aware • Elective activity ceasing in April saw surgeries cancelled which will have impacted on patient's health outcomes. • CHC visit on west 1 on the 17th May • Patient safety walk about 27th May Cavoc outpatient's department. • New spinal needles introduced • The month of April saw Breast relocate to Gilbert bay when elective activity stood down. • looking at succession planning for NP post	
46.05 46.06	**Dental** report received and noted by the Group. No verbal update provided. AT - **Pharmacy** agreed to share Medicine Safety briefings with this Group, for information and noting.	
PART 2: HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
SCB/QS: 22/47	**Initiatives to promote health and wellbeing of Patients and Staff:** **SCB H&S/IP&C Meeting –** It was noted that the next meeting was scheduled for the 6th June 2022. CA to feedback at the next meeting. **Decontamination Group update -** No update **Water Safety Group Update –** No update	
PART 3: SAFE CARE		
SCB/QS: 22/48	**Patient Safety Incidents** The following reports were received and accepted by the Group. • Overall Trends • SI's • RCA/Improvement plans • WG closure form status • WG closure forms – sign off • Regulation 28 reports (of relevance) DJ gave an overview of the data provided within the reports; although highlighted that not all data was available due to the changeover of systems. The following DATIX incidents were highlighted: - • In111997 • In140601 • In142704 • In149690 • In160082 • In1888 • In121312 • In156353 • In152383 • In132551	

	• In144182 • IN151604	
SCB/QS: 22/49	**Patient Safety Alerts (internal/external)** The following items were discussed and assurance given that action had been taken by the Directorates. • ISN 2022 Mar 002 Skin Warming • Welsh Risk Pool Safety Briefing Shortening of Penrose Drains • NATPSA - Philips Health SystemsV60, V60 Plus and V680 ventilators – potential unexpected shutdown leading to complete loss of ventilation • Action: Message from Welsh Government - CEM//CPhA/2022/19 - Class 4 Medicines Defect - Pfizer Limited, Depo-Medrone with Lidocaine 40 mg per mL - 1 mL and 2 mL vials - single vial preparations) EL • Message from Welsh Government - CEM/CMO/2022/15 - COVID-19 Therapeutic Alert - Baricitinib for Patients Hospitalised Due to COVID-19 - Adults and Children Aged 2 Years and Over • Radiometer Arterial Blood Sampler ICN 1616 NHSSC 2 • Welsh Government - CPhO/MedsLet/2022/15 - Droperidol 2.5mg per 1ml solution for injection ampoules CW -Director of Nursing reported that the process and management for distributing these notices needed reviewing, due to the number of avenues they are received into the Clinical Board. It was suggested that this be picked up with the new Assistant Director of Quality and Safety, once they are in post. **Action**: DJ/CW	
SCB/QS: 22/52 SCB/QS: 22/53	**Health Care Associated Infections** Report received and noted by the Group. The Group discussed the HCAI data for April 2022 • 0 C-Difficile • 0 MRSA • 0 MSSA • 3 E. Coli • 0 Klebsiella • 0 Pseudomonas aeruginosa YH- CNS IP&C informed the Group that the 22/23 targets had been received by the Health Board, slightly earlier than anticipated. It was noted that the Team were working through the data and would update the Clinical Board on its target shortly. YH advised that there was a new process in place for the review of MRSA. It was highlighted that fortunately there were not many cases, however they needed to be reviewed in more detail. It was also noted that the collection of data around Surgical Site Infection was being progress through the ICNET system and would include a number of procedures. **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 March 2022.	

	Any key patient safety risks:	
SCB/QS: 22/54	**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. It was noted that no incidents reported during the period.	
SCB/QS: 22/55	**Medicines Management & Corporate Meds Management Minutes** AT – Pharmacy reported that both the April and May CMMG minutes was available for information and highlighted key items within these documents: - • Safe medication practice – Bottle Adapters Compatible with EnFit Syringes; approved for use. • Safe use of Valproate • Andexanet for reversal of apixaban or rivaroxaban - This specifically used for patients with Gastric bleeds. • Rivaroxaban off label use – thromboprophylaxis temporary lower limb immobilisation.	
SCB/QS: 22/56	**Medical devices/equipment issues** The Chair highlighted the success of the recent bids within Surgery and asked the Group to prepare for future requests.	
SCB/QS: 22/57	**Blood management –** Representative to be identified.	
SCB/QS: 22/58	**Q&S Workplan 2022 -2023** Report received and noted by the Group. It was noted that T&O were due to present on Patient story at the next Meeting in July.	
SCB/QS: 22/59	**Mortality data analysis -** No Update	
PART 4: EFFECTIVE CARE		
SCB/QS: 22/60	**Monitoring of CB Clinical Audit Plan** CW- Director of Nursing advised that the Clinical Board had been asked to update the Audit Plan for 2022/23 and as a result each of the Audit Leads had been contacted to discuss further. Issues were raised around the lack of a robust system for capturing information across the Board. It was reported that a meeting had been scheduled with the Audit Team to look at a new system, where all data will be stored.	
SCB/QS: 22/61	**Research and Development** JC- Lead for R&D Surgical Board presented to the Group on research and development and highlighted the key items below: - • Deputy Lead for R&D post had been filled – Danielle Hackle • It was noted that the Trail Manager had been in post for a year; this had proven very successful.	

	• Band 5 R&D Nurse post had been filled, however recruitment of these nurses continues to be problematic. A drive to push for interest was being initiated; with suggestions of taster sessions. • Grant agreed for POLARIS • Funding agreed for Patient Journey App • Reported on recent NELA study and highlighted the findings. It was reported that as a result of the findings a Business Case had been developed asking the SCB to support funding for a NELA Nurse.	
PART 5: DIGNIFIED CARE		
SCB/QS: 22/62	**Initiatives to improve services for people with:** **Dementia** **Sensory loss** **Learning Disabilities** The Group were informed that standard template will be circulate going forward, asking the Leads to provide updates for these Sub Groups.	
PART 6: TIMELY CARE		
	No Update	
PART 7: INDIVIDUAL CARE		
	No Update	
PART 8: Staff and Resources		
SCB/QS: 22/65	**Staff awards and recognition** No Update	
SCB/QS: 22/66	**Safer Staffing levels** It was highlighted that the Surgical Clinical Board were due to meet with the Executive Team for the sign off of the safer staffing levels. CW- Director of Nursing agreed to bring these backs to the next meeting for information. **Action**: CW	
DATES OF NEXT MEETING 17th July 2022 – 8-10PM – Ms Teams		

Report Title:	**Corporate Risk Register**			Agenda Item no.	4.3
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	30/08/2022
		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 August 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 September 2022 Board meeting.

At the Health Board's July 2022 Board meeting a total of 15 (from a total of 20 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	1	
Medicine	3	
PCIC		
Specialist Services	4	
Surgery		
Digital Health		
Estates		
Children and Women	2	
Mental Health		
Capital Estates and Facilities	**5**	
Workforce and OD		
Total:	**15**	**-**

Of those risks recorded the following should be noted:

- the Estates risks shared by the Capital Estates and Facilities team continue to demonstrate ineffectual controls. This is in part due to a re-organisation within the team that has led to a delay in the appointment of a new risk lead but also due to issues in allocating resource to fully mitigate or close the risks. The Head of Risk and Regulation intends to meet with the new Capital Estates and Facilities Risk Lead prior to the September Board meeting to review and update these risks.
- It is hoped that risk 11 will be sufficiently mitigated of closed prior to the September Board Meeting following the discharge of a number of patients from the Children's Hospital for Wales into the community.
- A discussion has taken place with the Specialist Services Clinical Board regarding the Extreme Risks that they are holding, specifically aged risks 15 and 17. Given the nature and age of these risks the Clinical Board and directorates have been asked to reconsider the risks presented in advance of the September Board meeting so that an updated position is provided. In particular a request has been made for consideration to be given to whether the risks, as they are currently reported, reflect issues that the Clinical Board are managing with associated new and previously undefined risks.

An updated Register will be shared with the Board at its September 2022 meeting.

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 JULY 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 Estates and Facilities	1	Mar-21	**Risk/Issue**: UHW Cardiac Theatre GF AGSS Pump is faulty **Impact**: Failure of scavenging system in Theatre GF would lead to increased medical gas saturation with an impact on staff and patient safety and failure to comply with HTM and H&S regulations/legislation.	5	4	20	Regular inspection and maintenance.	5	4	20	Renew AGSSS Pump and Enclosure	5	1	5	Aug-22	Strategy and Delivery Committee Quality and Safety Committee	Patient Safety
	2	Mar-21	**Obsolete Medical Gas Delivery Equipment** **Risk/Issue**: Medical Gas (Oxygen) Manifold is obsolete in Barry. Medical Gas (Nitrous Oxide) manifolds are obsolete in UHW Maternity (manifolds 1&7), UHW A&E, UHW Dental (manifolds 4&10). In addition the UHW Medical Gas Pressure reducing set is obsolete. **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	Aug-22	Quality, Safety & Experience Committee	Patient Safety
	3	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**	Aug-22	Quality, Safety & Experience Committee	Patient Safety Capital Estates

	4	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	Aug-22	Quality, Safety & Experience Committee	Planned Care Capacity Capital Estates
	5	Jun-21	**Risk/Issue:** Ventilation verification of critical systems has identified UHW CHFW 1st Floor Rainbow ward Day Case Theatre and recovery, 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	Aug-22	Quality, Safety & Experience Committee	Workforce Capital Estates Staff Wellbeing
Medicine Clinical Board	7	01/03/2019	Patients are 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	**20**	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 patient's condition, the WAST crew will immediately inform the MAN. All non paramedic crews are assesseed by the Triage Nurse/Majors Assessment Nurse to ensure a patient clinical assessment is conducted.Concern by either party about the length of any delay or the volume of crews being held will be escalated by the Senior Controller/EU NIC to the Patient Access for usual UHB escalation procedures, or by WAST to their 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. For patients arriving in UHW and UHL assessments units, the NIC will assess these patients and escalate in line with policy. Standard Operating Procedure in place within the Emergency Department to support any 'Immediate Releases' requested by WAST. Update December 21: Joint CB/ WAST partnership meetings in place to focus on improvements. The Clinical Board is engaged with the NRI process for reporting incidents where WAST delays have resulted in major patient harm. Update Transformational work being undertaken across Acute and Emergency Medicine to support flow, including RATZ, virtual ward.	5	4	**20**	Daily review and risks noted within Safety Huddles and EU Controller reports. Escalated to MCB Hub and Patient Access Services. Evaluation of Standard Operating Procedure to reflect any changes required. WAST Immediate Release Standard Operating Procedure in use to support 'Red' calls in the community. Update December 2021: OPAT accross both UHW and UHL to support WAST and patient flow.	5	2	**10**	Aug-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety
	8	01/01/2021	The ability to safely provide medical cover across all Specialities and disciplines across the Clinical Board secondary to ongoing Covid pressures and overall recruitment is 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 LCC meetings with ongoing planning to ensure safe staffing.	5	2	**10**	Aug-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patienty Safety and Workforce
	9	01/12/2021	There is a risk of overcrowding with 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. Implementation of Internal Professional Standards to deliver prompt specialist review within agreed timeframe	5	4	**20**	Appropriate escalation and discussion with MCB HUB, Patient Access Services and OPAT regarding safe and timely patient flow.	5	3	**15**	Aug-22	Quality, Safety & Experience Committee	Patient Safety

Children and Women	11	16.08.21	There is a risk of patient and staff harm due to an inability to discharge or place medically fit children and young people with severe behavioural problems who are inpatients in acute paediatric settings.	5	5	**25**	1. Daily huddles and deployment of nursing resources based on risk and using bank and agency staff where possible 2. Regular discharge planning meetings 3. Regular communication with Local Authority and enhanced staffing from LA sources 4. Daily medical ward round, and review by junior doctors throughout the day as required 5. Use of physical and chemical restraint to manage violent behaviour 6. Relocation of children as necessary across wards to maintain safety 7. Signposting to Healthboard wellbeing services for staff	5	4	**20**	1. Arrange 'safe holding' training for staff who care for these patients 2. Increased numbers of suitably trained staff on wards, in collaboration with community teams. 3. Provision of appropriate Local authority accommodation for these C&YP 4. Earlier provision of psychological and other (eg educational and social) intervention whilst admitted 5. Proper engagement and timely input from the Local Authority 6. Increase targeted support for staff (physical and emotional wellbeing) 7. Assurances from the medical director and executive board regarding risk management and governance of these patients	5	2	**10**	Aug-22	Quality, Safety and Experience Committee Strategy and Delivery Committee Mental Health, Capacity and Legistaltion Committee	Patient Safety
	12	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**	Aug-22	Quality, Safety and Experience Committee	Patient Safety
CD&T	13	05.05.2021	Point of care Testing (POCT) Developments in technology and improved manufacturing processes are producing POCT devices which are more robust and less prone to error than previous generations. However, the successful implementation of POCT is still dependent on the effective organisation and management of staff. MHRA guidance (Management and use of IVD point of care test devices, January 2021) identifies key issues for POCT as - A clinical need must be identified before the implementation of a POCT service. - Consider involving the local hospital laboratory in the management of POCT services. - Lines of accountability for POCT management must be clear. - Managers of POCT services must be aware of their responsibilities under clinical governance. - Arrangements for training, management, quality assurance (QA) and quality control (QC), health and safety policy and the use of standard operating procedures (SOPs) must be made and reviewed at frequent specified intervals. - Assessment of the service by an external accreditation body is recommended. - You should consider the available evidence for the performance of the test. - Adverse incidents must be reported to the MHRA. - Clear, comprehensive record keeping and documentation is vital. - Everyone involved in POCT should know what to do in the event of any abnormal result or unsatisfactory QC result. Failure to adhere to the guidance above could lead to error and incorrect testing results leading to patient harm	5	5	**25**	POCT manager in place Clinical Lead identifed to support Central register of POCT devices Standard operating procedures (SOPs) which must include the manufacturer's instructions for use, are developed. This include instances where staff should be particularly aware of situations when the device should not be used Record keeping is essential and must include patient results, test strip lot number and operator identity Maintaining devices according to the manufacturer's guidance is essential, to ensure that they continue to perform accurately	5	4	**20**	1.Clinical Lead role in place, Clinical Scientist role to be put in place 2.Re-establishment of POCT committee - meeting held with AMD & interim EDoN June 2022 to progress. Revised TOR developed 3.Review implementation of POCT procedure within Clinical Boards 4.Review of current POCT stock and seek assurance on training, competence assessment, SOPs, main	5	2	**10**	Aug-22	Quality, Safety and Experience Committee	Patient Safety
	14	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**	Aug-22	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety

Specialist Services Clinical Board	15	Jan-16	**Critical Care - Bed Capacity** Due to an inadequate bed capacity there is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner. Where demand exceeds capacity patients are cared for in inappropriate settings such as Recovery Area, Emergency Department and ward areas and patients may be discharged at risk to generate capacity. This risk of dealyed admission to Critical Care Dept or care in inappropriate settings could lead to increased morbidity and mortality, increased re-admisison rates, longer hospital length of stay and a failure to adhere to national standards and guidelines. A resumption of pre-pandemic service levels and a restoration of previous clinical area configurations will lead the risk level to increase to its previously elevated level.	5	5	**25**	Highlight patients to Patient Access for discharge to ward areas Additional footprint identified for more Critical Care capacity Funding has been granted by the Executive Team for 6 additional Level 3 equivalent beds in CC and these have been commissioned recently. The unprecedented demand during the current Covid19 Pandemic has resulted in a temporary increase in the unit footprint and capacity which has ameliorated this issue whilst at the same time exacerbating the Crtitical Care workforce risks detailed elsewhere.	5	4	**20**	Continue to work with Patient Access and Health Board to have more effective discharge processes in place. Not all of the recommended staff are being supported at this time. Increase Patient Flow role to 7 days per week	5	2	**10**	Aug-22	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety
	16	Jul-20	**Critical Care - Clinical Environment** There is a risk that patients admitted to the Critical Care Department will not receive care in an environment that is suitable for purpose due to a number of facility shortcomings resulting in patient safety risks including serious harm and death. The normal capacity is 35 beds with a single isolation cubicle. Analysis shows that the stated normal capacity is inadequate for the population served and needs to increase to 50 beds. The number of isolation cubicles is significantly below national guidelines and presents serious Infection Control & Prevention risks. The Covid19 crisis has led to a temporary increase in capacity to 44 beds however the isolation cubicle capacity remains at 1. There is no air handling available on the unit which results in there being no means to manage airborne infection risk or manage ambient temperatures. This exacerbates the IP&C risks and also compromises the care of patients where temperatiure is a critical concern. The well being of staff working in the environment is also compromised leading to issues of heat exhaustion and collapse secondary to dedydration. The inadequate size of the facility footprint leads to there being inadequate space for all non-clinical areas including office space, consumable storage, clean utility area, dirty utility areas, equipment storage, phamaceutical storage, device storage and management hubs areas.	5	5	**25**	The clinical area is divided into zones to where patients are grouped according to IP&C risk to reduce the risk of cross-infection. Staff entering the clinical area are required to wear full PPE to reduce the risk of cross-infection.	5	4	**20**	There is an urgent need for a capital investment program and business case developed to address this need.	5	2	**10**	Aug-22	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety Capital Assets
	17	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.	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**	Aug-22	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety