Public Quality, Safety & Experience Committee

Tue 08 October 2024, 14:00 - 16:00

Virtual - MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee Meeting held on 16.07.2024

Ceri Phillips

1.4 - Unconfirmed QSE Public Minutes 16.07.2024 (1).pdf (6 pages)

1.5. Action Log – Following the meeting held on 16.07.2024

Ceri Phillips

1.5 - Public QSE Action Log for 27.08.2024 (4).pdf (1 pages)

1.6. Chairs actions taken since last meeting

Ceri Phillips

14:05 - 15:35
90 min

2. Items for Review and Assurance

2.1. PCIC Clinical Board - Assurance Report

25 mins *Anna Mogie*

2.1 PCIC Assurance Report.pdf (16 pages)

2.2. Quality Indicators Report

15 mins *Alexandra Scott*

2.2 QI paper OCT 24 QSE.pdf (3 pages)
2.2a Quality Indicators Report OCT 24 2024 (1).pdf (16 pages)

2.3. Improving Patient Experience within Emergency Unit Department following HIW Inspection

20 mins *Lisa Green*

2.4. Emergency Unit, Acute Medicine and Frailty Showcase

10 mins *Richard Lea / Richard Brian Marsh / Siobhan Lewis*

2.5. Looked After Children – Assessment Backlogs

10 mins *Jason Roberts / Andy Jones*

2.5 - QSE LAC Report Board Sept 24 final copy AJ 30 9 24.pdf (6 pages)

2.6. Royal College of Psychiatrists Review – Update

10 mins *Richard Skone*

15:35 - 15:40
5 min

3. Items for Approval / Ratification

3.1. UHB 068 – Blood Component Transfusion Policy

3.1a - Blood Component Transfusion Policy Covering Report (1).pdf (2 pages)
3.1b - EP-BLD-TxPolicy (1).pdf (21 pages)

3.2. UHB 528 - Development and Approval of UHB Local Procedure Specific Patient Information Leaflets Principles and Framework

3.1c - LPSPIL - Board & Committee Covering Report 2024-25 (1) (1).pdf (2 pages)
3.1d - LPSPIL Principles and Framework FINAL.pdf (20 pages)

15:40 - 15:40
0 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees and the Safeguarding Steering Group (SSG)

Jason Roberts

4.1.1a - CW QSPE Minutes 23.04.2024.pdf (13 pages)
4.1.1b CW QSPE Minutes 25.06.2024.pdf (9 pages)
4.1.1c CW QSPE Minutes 23.07.2024.pdf (9 pages)
4.1.1d CW QSPE Minutes 27.08.2024.pdf (10 pages)
4.1.2 CDT QSE Minutes 25.7.24.pdf (13 pages)
4.1.3 - Medicine Clinical Board Minutes 17 July 24 v2.pdf (5 pages)
4.1.4 - Medicine Clinical Board Minutes 21st August 2024.pdf (7 pages)

4.2. Ombudsman Annual Letter

Jason Roberts / Angela Hughes

4.2a - Cardiff's report to Q PS Cttee PSOW October 24.pdf (5 pages)
4.2b - PSOW Annual Letter.pdf (10 pages)
4.2c - Annual Quality Report 2023 – 2024.pdf (37 pages)

15:40 - 15:40
0 min

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

Ceri Phillips

15:40 - 15:40
0 min

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

Ceri Phillips

- *Private Minutes*
- *Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*
- *Plans/Trajectories for Overdue Follow Ups*
- *Ophthalmology WET AMD – Update*
- *Discharge Advice Letters – Update*

15:40 - 15:40
0 min

7. Any Other Business

Ceri Phillips

15:40 - 15:40
0 min

8. Review of the meeting

Ceri Phillips

15:40 - 15:40
0 min

9. Date & Time of Next Meeting:

26th November 2024 at 2pm Via MS Teams

Unconfirmed Minutes of the Public Quality, Safety & Experience Committee

Held on 16th July 2024

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Edward Chapman	EC	Head of Clinical Engineering
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Richard Skone	RS	Interim Executive Medical Director
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Francesca Thomas	FP	Head of Corporate Governance
Matt McCarthy	MM	Interim Head of Safety, Quality & Organisational Learning
Adam Christian	AC	Clinical Board Director – CD&T
Sarah Lloyd	SL	Director of Operations – CD&T
Helen Luton	HL	Director of Nursing – CD&T
Sarah Martin	SM	Research and Development Manager
Matt Wise	MW	Locum Consultant in Intensive Care
Suzanne Wood	SW	Consultant in Public Health Medicine
James Dunn	JD	Locum Consultant in Emergency Medicine
Helen Williams	HW	Interim Regional Director of Llais Cymru
Observers		
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Angela Hughes	AH	Assistant Director of Patient Experience
Matt Phillips	MP	Director of Corporate Governance
Emma Cooke	EC	Executive Director of Therapies & Health Science

QSE 24/07/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QSE 24/07/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 24/07/003	**Declarations of Interest** No declarations of interest were raised.	

QSE 24/07/004	**Minutes of the Committee meeting held on 21.05.2024** To view the minute: https://youtu.be/x_YRjpnuo4c?t=116 The minutes of the Committee meeting held on 21.05.2024 were received. **The Committee resolved that:** a) The minutes of the meeting held on 21.05.2024 were approved as a true and accurate record of the meeting.	
QSE 24/07/005	**Action Log following the Meeting held on 21.05.2024** To view the minute: https://youtu.be/x_YRjpnuo4c?t=151 The Action Log following the Meeting held on 21.05.2024 was received. QSE 23/12/007 – Royal College of Psychiatrists (RCP) Review: - the Executive Medical Director (EMD) informed the Committee that they had received the report and several Executives had met with the Mental Health team to discuss the various themes, which included: dynamic risk assessments, note-keeping, communication, and patient engagement. A plan would be developed to address staffing and improvement delivery. The Chief Operating Officer (COO) added that they would meet with the Clinical Board every four weeks. He noted that they had not received the formal RCP report yet and suggested that an update be brought back to the QSE Committee in October. QSE 24/03/009 - Consent to Examination and Treatment: - The EMD noted that this had been brought to SLB recently, and that it was agreed that it should form part of the mandatory training. The EMD had met with the Executive Director of People & Culture (EDPC) and the Medical Education team to ensure it became embedded within the induction programme for junior doctors and consultants. **The Committee resolved that:** a) The Action Log from the meeting held on 21.05.2024 was noted.	
QSE 24/07/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QSE 24/07/007	**Clinical Diagnostics and Therapeutics (CD&T) Clinical Board – Assurance Report** To view the minute: https://youtu.be/x_YRjpnuo4c?t=518 The Clinical Board Director-CD&T (CBD-CD&T) shared a Patient Story with the Committee which showed the journey of a patient through the laboratory. The COO thanked the team and suggested that the video be shared with patients. The Independent Member – Community (IM-C) noted that patients may not want to know but suggested that it may be useful for training. The CBD-CD&T responded that this was the first time they had shown the video, and that they hoped to educate staff on where they sat in the patient pathway. He noted that whilst patients may not need detailed explanations, the goal was to raise public awareness and interest in pathology.	

	The Interim Regional Director of Llais (IRDL) noted that some patients would want to understand more about the journey through the laboratory, and that it would depend on the individual. The Director of Nursing-CD&T (DON-CD&T) presented the Assurance Report which provided the Committee with a summary of the arrangements, progress, and outcomes within the CD&T Clinical Board. It outlined the achievements and innovations leading to improved quality and care for patients, and it described some key challenges, risks, and the mitigations in place to continue into 2024/25. The Committee Vice Chair (CVC) asked for more detail around the robust action plan to overcome the radiology backlog. In addition, she asked how the team captured the good sustainability work being undertaken. The Director of Operations-CD&T (DO-CD&T) responded that the action plan involved multiple strategies due to the variety of modalities and challenges. Efforts would include increasing activity through existing facilities with consultants and sonographers, and utilising independent service providers for additional capacity. In addition, there was a South-East Wales programme which looked to improve regional diagnostic access. Regarding sustainability, the DON-CD&T noted that the Clinical Board had a dedicated Green Group with members who also participated in the Health Board's Sustainability Group to provide feedback and insights. The CC noted that the diagnostic backlog was topical in conversations between Welsh Government (WG) and the Executives. **The Committee resolved that:** 1) The progress made by the Clinical Board to date was noted; and 2) The content of the report and the assurance given by the CD&T Clinical Board was noted.	
QSE 24/07/008	**Quality Indicators Report** To view the minute: https://youtu.be/x_YRjpnuo4c?t=2699 The Assistant Director of Quality and Patient Safety (ADQPS) presented the Quality Indicators Report and slides which provided assurance in relation to several quality, safety, and patient experience priorities. The Executive Director of Public Health (EDPH) asked whether equity could be incorporated into the Quality Indicators Report. The CC welcomed the EDPH's suggestion. The CC asked to what extent a thematic analysis of Health Inspectorate Wales (HIW) reports had been undertaken to address the common themes. The ADQPS explained that the Clinical Safety Group were in the early stages of implementing a thematic analysis of HIW reports. **The Committee resolved that:** 1) The assurance provided by the quality indicators was noted.	
QSE 24/07/009	**Never Events Deep Dive** To view the minute: https://youtu.be/x_YRjpnuo4c?t=3348 The ADQPS presented the Never Events – Deep Dive report to the Committee which provided an overview of the Nationally Reportable Incidents (NRI) framework, the	

	definition of Never Event categories, a thematic analysis of the NRIs reported in Cardiff and Vale UHB between 1st April 2023 and 31st May 2024, and the work undertaken to reduce further risk. The EMD noted that they had placed emphasis on the Five Steps to Safer Surgery in theatres in the University Hospital of Llandough (UHL). The CC acknowledged the slight increase in the number of Never Events in CAVUHB and stressed the need for processes to minimise human failings. The CC emphasised the need to understand the rate of Never Events in the context of the total number of procedures undertaken across the Health Board. **The QSE Committee resolved that:** a) The assurance provided by the improvements being implemented to eradicate Never Events was noted.	
QSE 24/07/010	**Update on the Hepatitis B/C Recovery Plan** To view the minute: https://youtu.be/x_YRjpnuo4c?t=3873 The EDPH informed the Committee of the three main priorities in public health (vaccination, smoking and obesity), and highlighted the ongoing Health Protection responsibility. She noted that the Hepatitis B/C Recovery Plan formed part of their proactive approach to preventing disease. The Consultant in Public Health Medicine (C-PHM) took the paper as read, and highlighted the following: - The goal set by the World Health Organisation (WHO), WG, and the local authorities was to eliminate Hepatitis B & C by 2030 - Significant effort was required to achieve this, which included adequate resources, capacity, and delivery mechanisms - The C-PHM chaired a multi-agency forum which met bi-monthly to ensure the action plan was on track - The prevention and treatment of Hepatitis B & C were highly cost-effective and offered significant savings in lives and NHS costs The CC asked for a further update to be provided to the Committee in six months. **The QSE Committee resolved that:** 1) The progress to date was noted; and 2) The content and ambition of the Hepatitis B and C Elimination Plan 2024/25 was noted.	
QSE 24/07/011	**Joint Inspection of Child Protection Arrangements (JICPA) Update** To view the minute: https://youtu.be/x_YRjpnuo4c?t=4136 The Executive Nurse Director (END) presented the JICPA report to the Committee which provided an overview of the multi-agency inspection which took place during January 2024, the findings of the review, the immediate improvement plan assigned by HIW, and the actions taken to provide assurance. The CC requested that a further update on the Improvement Plan be provided to the Committee in six months. **The QSE Committee resolved that:** 1) The safeguarding arrangements across the UHB were noted for awareness.	
	Items for Approval / Ratification	
QSE	**Policies**	

24/07/012	*No policies for approval.*	
QSE 24/07/013	**Patient Safety Notice 066 (Safer Identification of Unknown Patients)** To view the minute: https://youtu.be/x_YRjpnuo4c?t=5045 The Interim Head of Safety, Quality & Organisational Learning (IHSQOL) presented the report to the Committee which summarised the Patient Safety Notice 066 requirement for the Health Board to develop a plan for a system for safer identification of unknown patients, and outlined the update to the Emergency Unit (EU) Clinical Workstation to allow for the generation of these safer temporary identifiers when an unknown patient is admitted to the EU. The Independent Member – Trade Union (IM-TU) asked how frequently unidentified patients came into the EU. The IHSQOL responded that it was not an everyday occurrence, but that it was not unusual. The Senior Service Improvement Programme Manager (SSIPM) asked how the records of patients married up once the patient's identity had been found. The IHSQOL responded that it went back into Medical Records. **The QSE Committee resolved that:** 1) The go-live of the updated process for identification of unknown patients, in line with the requirements of Patient Safety Notice 066, was approved.	
	Items for Noting & Information	
QSE 24/07/014	**Minutes from Clinical Board QSE Sub-Committees and the Safeguarding Steering Group (SSG)** To view the minute: https://youtu.be/x_YRjpnuo4c?t=5537 **The QSE Committee resolved that:** 1) The minutes from the Clinical Board QSE Sub-Committees and the Safeguarding Steering Group (SSG) were noted.	
QSE 24/07/015	**Research and Development Update** To view the minute: https://youtu.be/x_YRjpnuo4c?t=5559 The Research and Development Manager (R&DM) presented the report and slides which provided the Committee with an overview of research activity ongoing within the Health Board. The EMD highlighted the close dialogue between the finance team and the research team and emphasised the importance of research in improving patient care and outcomes. He informed the Chair that he would bring the necessary information back to the QSE Committee for informed decision-making. The CC suggested that an update on Research and Development activity be brought back to the QSE Committee in six months. **The QSE Committee resolved that:** 1) The Research and Development Update was noted.	
	Items to bring to the attention of the Board / Committee:	

QSE 24/07/016	*No items.*	
	Agenda for Private QSE Meeting	
QSE 24/07/017	*i) Minutes and Action Logs from the Private QSE Committee on 21.05.2024* *ii) Any Urgent / Emerging Themes – Verbal Update* *iii) Ophthalmology WET AMD*	
	Any Other Business	
QSE 24/07/018	*No items.*	
	Date & Time of Next Meeting:	
QSE 24/07/019	Tuesday 27th August 2024 at 2pm via MS Teams	

Action Log

Public Quality, Safety & Experience Committee

Update for meeting 8th October 2024
(Following the meeting held on 16th July 2024)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions					
QSE 24/07/005	**Royal College of Psychiatrists Review**	For an update on work being undertaken following the Royal College of Psychiatrists Review to be presented.	**08/10/2024**	Richard Skone / Jason Roberts / Paul Bostock	**COMPLETED** *Added to the Forward Plan for October's QSE meeting.*
QSE 24/07/010	**Update on the Hepatitis B/C Recovery Plan**	For an update on the Hepatitis B/C Recovery Plan to be presented at a future Committee.	**07/01/2025**	Claire Beynon	**COMPLETED** *Added to the Forward Plan for January's QSE meeting.*
QSE 24/07/011	**JICPA Update**	For the Improvement Plan to be presented at a future Committee.	**07/01/2025**	Jason Roberts	**COMPLETED** *Added to the Forward Plan for January's QSE meeting.*
QSE 24/07/015	**Research and Development Update**	For an update on Research and Development activity to be presented at a future Committee.	**07/01/2025**	Sarah Martin / Matthew Wise	**COMPLETED** *Added to the Forward Plan for January's QSE meeting.*
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					

Report Title:	Primary, Community & Intermediate Care (PCIC) Clinical Board Assurance Report			Agenda Item no.	2.1
Meeting:	Quality, Safety & Experience Committee	Public	x	Meeting Date:	8th October 2024
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Deputy Director of Nursing, PCIC Clinical Director for Quality, Safety and Governance				

Main Report
Background and current situation:

The primary assurance bodies in PCIC are the Clinical Board, the Quality, Safety and Experience Group (QSE) and the PCIC Senior Management Team (SMT); The QSE and Clinical Board each meets in alternate months. PCIC SMT meets weekly and following a review of the meeting structures there will now be a monthly focus on Clinical Governance within the agenda.

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 inclusion of information governance on the Business Unit summary report template. Risk and QSE is also included in the bi-monthly Operational Performance Meetings with each Business Unit as well as being discussed at high level during QSE and Clinical Board meetings.

Governance/Practitioner Performance

- In relation to independent contractors, 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. The legislation is operationally supported by the *Framework for the Management of Performance Concerns for General Medical Practitioners* and *Getting the Balance Right in Wales* (for GDPs). GMC *Good Medical Practice* and GDC *Standards for the Dental Team* also support this work.
- 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, Dental or Optometry Performers List.
- Health Board employed doctors and dentists can also be managed via *Upholding Professional Standards in Wales*.
- For independent contractor practice governance (GMS, GDS, Optometry and Community Pharmacy) there are various contractual and quality assurance mechanisms are in place:
    - For GMS, the Health Board (through the PCIC Primary Care Team) is responsible for contract management. The GMS Assurance Framework is a governance process for the evaluation of assurance on services delivered through the Unified Contract, in the context of the Duty of Quality legislation. The Assurance Framework is intended to be iterative, with the information available to the Health Board and practices being both expanded and refined as data develops. The process brings together all the sources previously available to the Health Board such as Post Payment Verification reports, HIW reports, Ombudsman referrals, Clinical Governance Practice Self-Assessment Toolkit (CGPSAT) and Information Governance toolkits, clinical data, and information included in the annual contract assurance return. Following review of all data (which may also include a practice visit) practices will be assessed providing a level of

assurance ranging from substantial assurance to no assurance, and actions followed up as necessary with the contractor.
    - General Dental Services (GDS) governance is covered off by GDC regulations, NHS dental regulations, annual Quality Assurance Self-Assessment, inspections by HIW, periodic activity reports by the clinical advisor from NHS Business Services Authority, monthly UHB performance reporting and meetings, GDC investigations, local investigations, Primary Care Q&S meetings and monthly clinical case review meetings.
    - Optometrists have NWSSP practice inspections, PPV inspections, GOC standards, and a declaration between the contractor and NWSSP. A Quality in Optometry Toolkit is currently in draft format, with Implementation due in 2025/26.
    - All community pharmacy contractors are bound The National Health Service (Pharmaceutical Services Wales) Regulations 2020 specifically Schedule 5 Terms of service. These regulations are used by the PCIC community pharmacy team to assure the UHB that consistent clinical and information governance requirements are followed alongside the NHS complaints procedures (including the Duty of Candour) and incident reporting processes (via Datix). The team provide a supportive annual contract monitoring programme and each pharmacy site is visited by the team at least once every 3 years as part of this rolling programme. The contractual breach process in accordance with the regulations enables the pharmacy team on behalf of the UHB to review and ensure the contractors are performing against the expected contractual requirements and take appropriate action or sanction as necessary. In addition all contractors in Wales must submit an annual IG and CG toolkit supported by DHCW and NWSSP. As registered pharmacy sites and therefore all NHS CP contractor must ensure they adhere to General Pharmaceutical council (GPhC) regulations and standards and this is overseen by the GPhC.

- The PCIC Director of Nursing and CD for Clinical Governance meet regularly with the UHB Safeguarding Lead Nurse and Executive Deputy Director of Nursing to review and ensure practitioner professional concerns are being progressed and managed in a timely fashion
- The Clinical Director for Quality, Safety and Governance meets regularly with the Responsible Officer, the GMC Employer Liaison Advisor and NHS Resolution to discuss practitioner performance concerns.
- The QSE team are also involved in GP Appraisal and Revalidation discussions with the Responsible Officer, the Health Board Revalidation Support Unit and HEIW

Inquests

Following increase in Coroner capacity there has been an increase in the number of inquests over the last 6 months. The are currently 14 open coroners' cases with PCIC involvement. The Clinical Board has a monthly tracker meeting in conjunction with the Q&S team to ensure staff support is maintained and any necessary actions progressed in a timely fashion.

Quality and Safety

- Work is being progressed to move the PCIC Clinical Board and Business Unit Risk Registers onto share point to improve and facilitate updating and live management of risks which is due to be completed in September 2024. 6-8 weekly 'deep dives' are in place where all high-level risks are reviewed in detail by the Director of Operations, Director of Nursing, Deputy Director of Nursing and Deputy Clinical Board Director.
- Following the imposition of several new duties on all Clinical Boards, including PCIC, particularly around the Duty of Candour (DoC) aspects of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 in Spring 2023 the PCIC Quality and Safety team worked with the Patient Safety Team to implement an appropriate process for managing DoC declarations and continue to refine this whilst adhering to existing NRI and Claims processes.

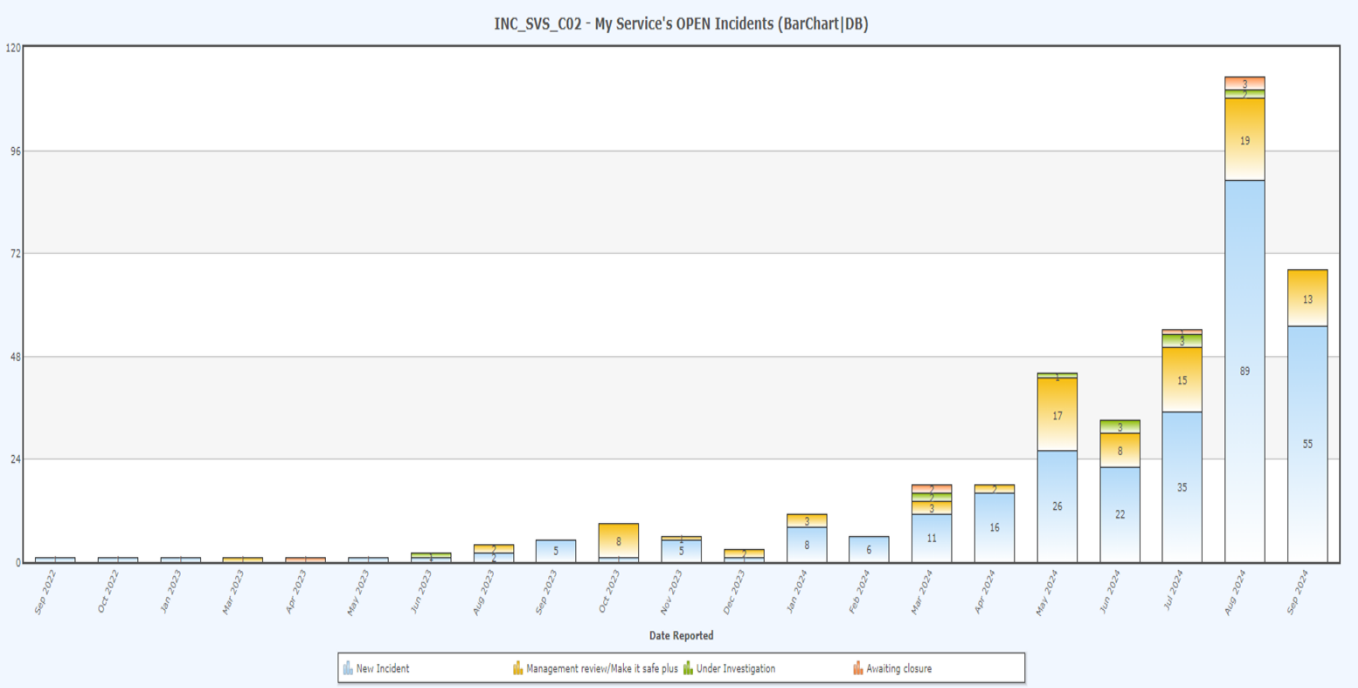
- There has been a total of 9 DoC declarations within PCIC board since April 2023. These include 8 avoidable pressure damage and 1 delayed skin cancer diagnosis relating to a GP practice. All cases have been discussed with the redress team. To date, one case has been referred for compensation under redress. There have been no new declarations in July or August 2024 within the Clinical Board.
- The Medical Examiner Service (MES) was due to be fully implemented for all non-coronial deaths (in hospital and in the community) from April 2023. However legislative process delays have resulted in the implementation within the Primary Care setting being delayed until 9 September 2024. The Quality and safety team have however supported Secondary Care mortality review cases where there is a primary/ community care element which has already started to provide some useful and pertinent themes and learning. The PCIC Director of Nursing and CD for Clinical Governance attend the regular Mortality Screening Panels and Learning from Mortality meetings which are now established across the UHB. There is currently no mortality review data to present from a PCIC only perspective but it is anticipated that once more data starts to be received on non-coronial deaths in the community from the MES this will provide additional data on key themes and learning to support improvement actions.
- Changes in the process for certifying death through the Medical Certificate of Cause of Death (MCCD) were also implemented on 9 September 2024. PCIC has supported GMS practices with this change, including regular communication to practices and signposting to training.
- The introduction of the DoC, MES and an increase in practitioner performance requirements have generated significant additional pressures for the small PCIC Quality and Safety team. additional administrative support was agreed however turnover and subsequent recruitment within the team has constituted a pressure on maintaining the workload.

Safe Care

Incidents

There is currently 1 NRI within the clinical board in relation to a delayed chest X-ray and subsequent cancer diagnosis. This is sitting with PCIC however involves Primary Care, Secondary Care and Shared Services. This was reported on 12th July 2024 and is due for submission to the NHS executive on 18th November 2024.

There are currently **397** open Datix incidents (as of 10/9/24) that are being managed by PCIC. The current position is illustrated below:



Pre-investigation harm is broken down as follows: -

None	Low	Moderate	Severe	Catastrophic	Total
93	203	83	16	2	397

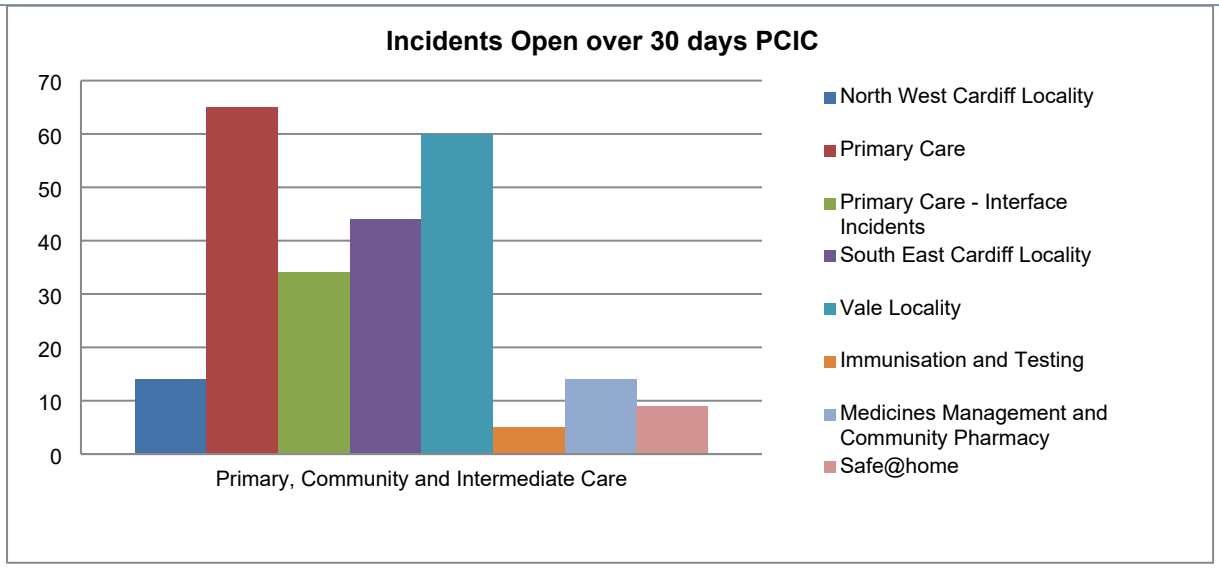
This indicates that 51% of all incidents managed by PCIC are identified as Low harm. The hot spots continue to be incidents that remain open from 2022. There are currently only 2 (previously 5) that remain open from this time period. The 2 incidents are complex and have been passed to teams from staff who have left the organisation which has impacted on the delay. Weekly scrutiny of open Datix incidents are undertaken by the Quality and safety team to support staff undertaking investigation, management and closure and to ensure correct allocation of incidents and the number of overdue open incidents has reduced significantly with support provided to the teams from the PCIC Quality and Safety and Patient Safety Team. The next workstream will support the closure of 2023 incidents, of which there are currently 26 open.

Primary Care Interface and Patient Safety Incident Reporting

The PCIC Clinical Board has a well-established process to enable General Practitioners (GP) to report incidents principally in line with Welsh Health Circular (2018) 014 Communication standards all-wales-communication-standards-between-primary-and-secondary-care.pdf (gov.wales) but also for any other patient safety incident. Datix Cymru has been offered to all General Medical Services (GMS). However, there has been reluctance to engage in the process or to fully adopt the system into GMS. There is no legislative requirement for practices to do so.

In the absence of GMS practices adopting DatixCymru and to support a streamlined single reporting system, GMS teams are now asked to submit Datix incidents to the Health Board via the DatixCymru *off line* reporting process.

Of the 397 incidents, 247 remain open over the 30-day target as indicated below. Primary care incidents are currently the highest proportion and include multiple services including, OOH's and immunisation and interface incidents reported via GP practices.

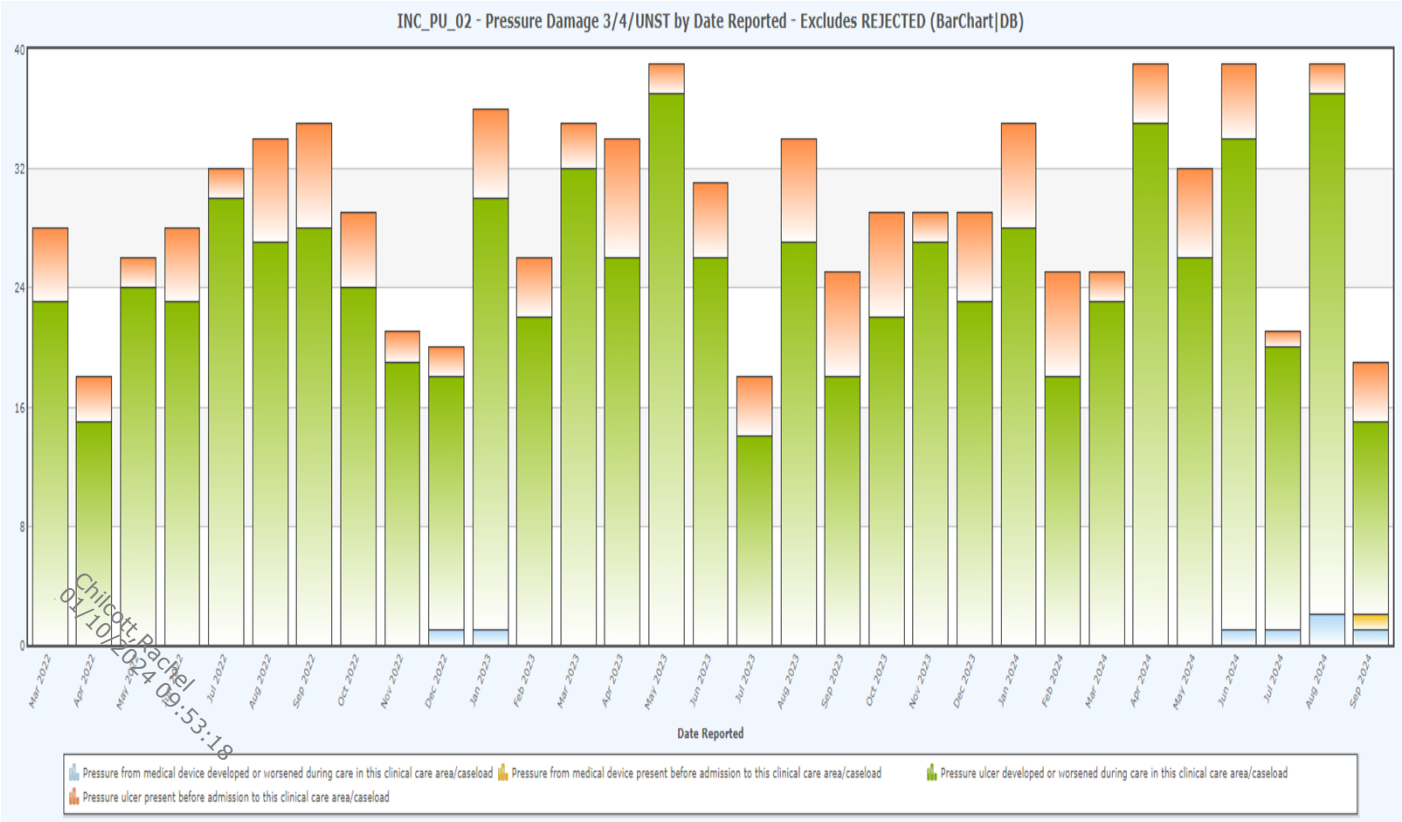


Pressure Ulcers

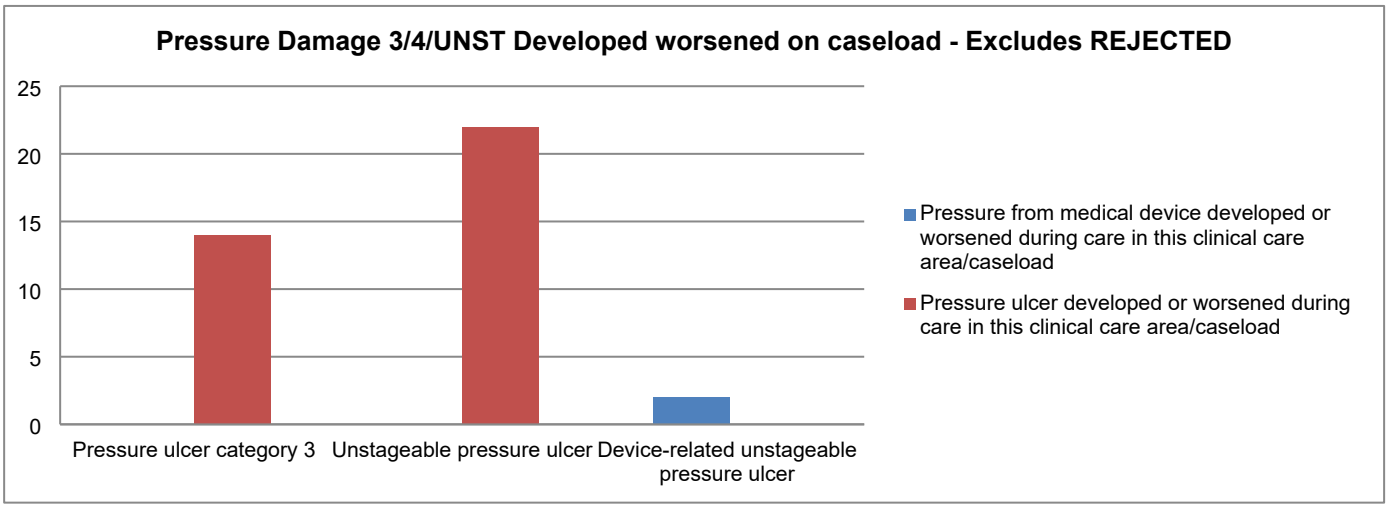
Weekly pressure ulcer scrutiny panels are fully embedded in practice within PCIC. The aim of the panels is to focus on grade 3, 4 and unstageable pressure damage prevention and management, ensuring patient safety through scrutiny, clinical supervision, education and integrity throughout and supports the All Wales Pressure Ulcer Reporting and Investigation process.

The panels provide a focused approach and early management of incidents and create a forum for peer support and wider learning. This is a multidisciplinary approach.

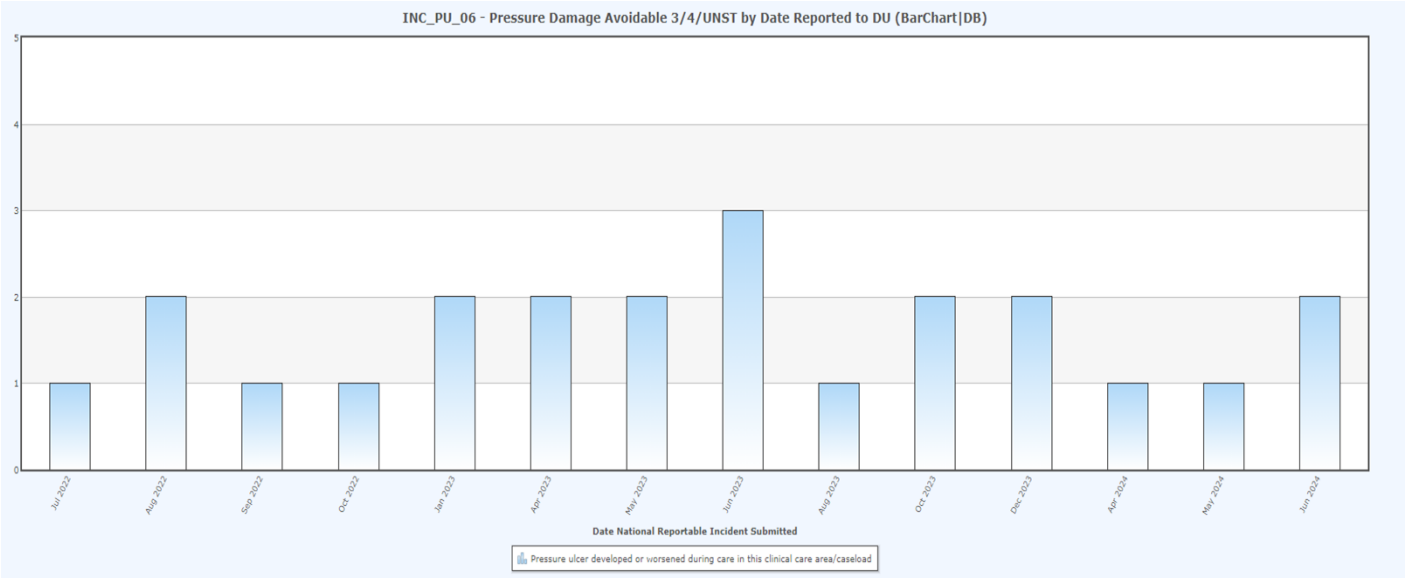
In August 2024, there were a total of **148** (excluding rejected) pressure damage incidents reported within the Clinical Board. Of those **39** incidents reported were categorised as stage 3,4 or unstageable pressure damage. The data below illustrates the rolling position across the clinical Board.



Of those **39,** 3/4/ UNST reported, **37** developed or worsened during care on the caseload. A breakdown of the category is illustrated below.



In August **0** incidents were identified as avoidable and reported as an NRI to the NHS Executive (formerly the Delivery Unit DU). The data below indicated the monthly position in relation to avoidable pressure damage. The last avoidable incident was in June 2024.



Learning from avoidable damage is shared across teams and presented at PCIC Q&S meeting for wider sharing of learning. Themes previously identified from avoidable pressure damage include delayed provision of pressure reliving equipment, completion of risk assessments and care plans. Teams are being supported by the PPDN team in relation to education and support. Education, training and team leader support has been invaluable in the reduction of avoidable pressure damage within the Clinical Board.

Infection Prevention and Control (IP&C)

There is now a dedicated part time IP&C nurse supporting PCIC. Part of their role includes supporting the Root Cause Analyses (RCA) investigation process for Clostridium difficile. The investigative requirements are shared with the relevant GP practices for action; there has been a robust engagement since the re-introduction of the requirement in February 2022.

Another part of their role is investigating the PCIC attributed Staphylococcus aureus bacteraemia source and identifying if there is any health care contact attributed to these, thus identifying areas for targeted training and support. MSSA bacteraemia are a particular area of concerns as we have seen an increase in cases across all of Wales compared to pre-pandemic cases.

PCIC CB are not currently on trajectory to meet the Tier 1 reduction expectation for five of the six organisms, which are Clostridium difficile, MRSA bacteraemia, MSSA bacteraemia, E. coli bacteraemia or Klebsiella bacteraemia, we are currently on trajectory to meet the Pseudomonas bacteraemia reduction expectation and are in fact 2 cases below the reduction expectation.

This is in line with Cardiff and Vale UHB which is in a similar situation overall, and are currently on trajectory to meet the Pseudomonas bacteraemia reduction expectation only.

IP&C training sessions have commenced across all of PCIC CB, and to date IP&C have provided 11.25 hours of face to face training with additional face to face and Teams sessions book, a total of 96 staff have attended these sessions.

From April 2023 to July 2023 Cardiff and Vale UHB exceeded our reduction expectation for Clostridium difficile with 39 cases, the reduction expectation for this period is 26 cases, 31% of these cases were attributed to PCIC (12 cases). PCIC are over the reduction expectation for this period.

From April 2023 to July 2023 Cardiff and Vale UHB exceeded their reduction expectation for MSSA bacteraemia with 54 cases, the reduction expectation for this period is 26 cases, 39% of these cases were attributed to PCIC (21 cases).

More recently PCIC have also been involved in regular HCID Preparedness discussions

General Medical Services (GMS)

GMS sustainability remains a significant risk in terms of the impact on wider service delivery, patient safety and experience. It remains a prominent feature on PCIC and UHB risk register, as well as remaining a key discussion point at national level.

The main contributing factors that affect GMS sustainability are well known;

- Workforce – recruitment and retention of clinical and non-clinical staff
- Finance – the increase in value per patient against other rising costs and how this affects business viability
- Patient demand – patient behaviours driven by expectations, perceived workload shift from secondary to primary care
- Population growth – lack of capacity to meet growing population due to workforce and physical space. Increased average age, changing demographic factors, widening health inequalities and increased complexity also impact
- Estates – ownership and/or security of tenure of GMS premises

The PCIC Primary Care Team support continue to monitor and support sustainability by:

- Reviewing and delivering a quality assurance framework and process that provides us with a clear perspective on how practices are delivering the GMS contract, how delivery may be impacted by the factors referred to above, and to support any improvement actions identified.
- Providing multi-professional team peer support and advice and assist in driving service improvement
- Monitoring GMS escalation levels to ensure that we are aware of where short-term issues for practices are reflective of more deep-rooted problems so we can offer support at the earliest stage.

Dental Services

In terms of CDS services following a significant review of the model there has been a substantive improvement in activity and work continues on changing the service to improve sustainability and efficiency. The CDS service reports into PCIC Senior Management Team on a weekly basis in terms of the capacity they have delivered. In addition to this, the performance management of the CDS service, is discussed in monthly Operational Performance Management meetings with the PCIC Senior Management Team.

Access to GDS NHS dentistry is a UK wide issue and does form a key theme in concerns which PCIC receive. C&V UHB is the only UHB which maintains a central waiting list for allocation to an NHS dentist and the primary care team undertake regular cleansing of this list to ensure patients are allocated in as timely and effective way as possible given the capacity constraints. The C&V Dental Centralised Waiting List (DCWL) currently has 27k patients waiting for access to a dentist. The average wait time for patients is 18 months. A waiting list validation is currently being undertaken by an outside agency and it is hoped the list will reduce follow this exercise. By 20th November 2024, all Health Boards DCWL will transfer to DHCW as per Ministerial direction.

Effective Care

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 new student streamlining staff due to commence in September 2024. All streamliners undertake a focused orientation education programme supported by the Professional Practice Development Nurse (PPDN) team. This provides excellent support and supports staff retention.

The six, Band 4 Assistant Practitioners continue to be a huge asset to the DN service and have worked hard to complete their competency frameworks. Continual evaluation of the role is ongoing and we are exploring opportunities to transition and build in the Nurse Associate Role into our establishments.

As part of the All Wales Community Nursing Specification, we have now completed two self-assessments and one peer review based on the requirements. The key findings from this were in relation to our ability to increase up to 80% of our weekday working over the weekend period, provide additional palliative care support and ensure robust supervision and support for all staff. Work is ongoing to progress and deliver on these areas.

Dignified Care

PCIC has achieved excellent performance with its response to complaints over the last 12 months. There are currently **4** Formal concerns managed under PTR – with only **1** response overdue and breaching the 30-day deadline.

In August 2024 there were:

4 concerns managed under PTR and x **1** closed.
5 under early resolution that were actioned and closed
21 enquires logged on Pals

NB. It is important to note that these are concerns that are submitted directly to the Health Board concerns team. We do not have sight of concerns that are submitted directly to the independent contractor services, GP, optometry and Dental.

Themes include

- Quality of care provided/daily assessments/ medication prescriptions
- Referral process
- Dental waiting list enquires
- Communication challenges
- Delivery of medical products

Complaints in relation to our independent contractor services that are submitted directly to the Health Board concerns team are forwarded to the relevant independent contractor for onward management.

It is important to note that we do not have sight of concerns that are submitted directly to the independent contractor services (GP, Optometry, pharmacy and Dental) as these are managed directly by the contractor.

Individual Care

Safeguarding

Following the Joint Interagency Review of Childrens Safeguarding Arrangements in January 2024 PCIC has strengthened the focus and oversight of safeguarding within the Clinical Board's QSE agenda

Mandatory and Statutory training across the clinical board identified within is currently **82.62 %.** This is a similar picture with the overall Health Board compliance at 81.66%. The detail below indicates individual staff group compliance and it has been noted that there is a need for focus particularly on Medical and Dental practitioner compliance.

Clinical Board	Primary, Community Intermediate Care			
Competence Name	Staff Group	Sum of Assignment Count	Sum of Achieved	% Compliance
⊟NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	Add Prof Scientific and Technic	56	53	94.64%
	Additional Clinical Services	184	160	86.96%
	Administrative and Clerical	230	204	88.70%
	Allied Health Professionals	121	116	95.87%
	Estates and Ancillary	64	58	90.63%
	Medical and Dental	77	34	44.16%
	Nursing and Midwifery Registered	430	384	89.30%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years| Total		1162	1009	86.83%
⊟NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	Add Prof Scientific and Technic	56	52	92.86%
	Additional Clinical Services	184	156	84.78%
	Administrative and Clerical	230	202	87.83%
	Allied Health Professionals	121	115	95.04%
	Estates and Ancillary	64	55	85.94%
	Medical and Dental	77	26	33.77%
	Nursing and Midwifery Registered	430	374	86.98%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years| Total		1162	980	84.34%
⊟NHS|MAND|Mental Capacity Act - 3 Years|	Additional Clinical Services	122	104	85.25%
	Administrative and Clerical	3	3	100.00%
NHS|MAND|Mental Capacity Act - 3 Years| Total		125	107	85.60%
⊟NHS|MAND|Mental Capacity Act - No Renewal|	Add Prof Scientific and Technic	6	6	100.00%
	Administrative and Clerical	16	14	87.50%
	Estates and Ancillary	50	44	88.00%
NHS|MAND|Mental Capacity Act - No Renewal| Total		72	64	88.89%
⊟NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years|	Add Prof Scientific and Technic	56	50	89.29%
	Additional Clinical Services	184	150	81.52%
	Administrative and Clerical	230	186	80.87%
	Allied Health Professionals	121	102	84.30%
	Estates and Ancillary	64	52	81.25%
	Medical and Dental	77	17	22.08%
	Nursing and Midwifery Registered	430	326	75.81%
NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years| Total		1162	883	75.99%
Grand Total		3683	3043	82.62%

Within the Clinical Board the current open safeguarding cases include: -

- Professional allegation/concern – 6
- Adult safeguarding cases - 8

In relation to open professional allegation/concerns, the following staff groups include: -

- Administrative - 2
- Medical - 2
- Nursing - 1
- Dental - 1

Professional Performance Concerns

Professional performance concerns that are managed through the PCIC governance team include both independent contractors and employed staff. Cases that are currently open include: -

- Medical Performers List (MPL) - 2
- Upholding Professional Standard in Wales (UPSW) - 2
- General Optical Council (GOC) - 1
- General Dental Council (GDC) - 7
- Professional Safeguarding Concerns cases – 3
- Service reviews - 1

Compliments

We receive many compliments from across our business units which are shared with the individuals/teams. We ask business units to log all compliments on the Patient Experience Quadrant Spreadsheet which is saved centrally.

<u>Cardinal Risk / Risk Register Score 20 and above</u>

Domiciliary medication administration/support

Risk: Sufficiency of domiciliary medication administration/support arrangements.

Source of uncertainty/cause:

Monitored Dosage Systems (MDS) and less commonly Medicines Administration Records (MARs) are required by domiciliary care workers to administer medication to people receiving their care. Community Pharmacies are not required under their contract to supply MDS/MAR for this purpose and there are less pharmacies now willing to provide this service for individuals who do not require it as part of reasonable adjustment arrangement to support them independently managing their own medication.

Consequence:

1. Inability or significant delay in being able to discharge patients with medication support needs with increased risks associated with extended hospitalisation in terms of deconditioning and independence.
2. Impact on staffing resources across the system trying to source Community Pharmacy willing to provide MDS's or MARs for patients requiring support from care workers.
3. Increased pressure on Community Pharmacies willing to support MDS/MAR provision

4. Inequity as some patients are being charged by pharmacies for this service provision pressure on Community Pharmacies willing to support MDS provision

Assurance

A Regional LA Policy on domiciliary care workers dispensing via boxes and bottles is agreed and a business case has been developed to support the commissioning of MAR charts via community pharmacy with funding routes continuing to be explored. This has been included within the PCIC IMTP return on 5th September as an unfunded cost pressure.

HMP Staffing

Risk:

The Healthcare Dept at HMP Cardiff is facing challengesdue to a high number of vacancies in the nursing and medical team. This particularly affects the administration of medication, the assessment of new arrivals and the ongoing triage and care of unwell patients.

Controls:

- Senior management colleagues are working clinically
- Clinicians are being drawn from the in-house mental health, substance misuse and pharmacy teams to support the administration of medication
- Efforts to recruit to vacant posts are ongoing
- Agency nurses have been utilised to support rotas.
- Pharmacy Technicians have been recruited to dispense medication.
- Overtime payments are offered to staff.
- Regular support is being provided by PPDNs to train and support new staff.
- Working with the Governor and prison service to manage prison daily regime to support reduced capacity within health care
- A Health Needs Assessment is being undertaken
- Demand & Capacity Modelling is being undertaken
- Review of Operating model (based on the previous 2 bullet points)
- Review of workforce model to deliver the operating model (all disciplines)
- Review of pharmacist structure to build resilience and capacity.

Assurances:

- Staffing and escalation levels meetings are held weekly basis between the Locality Management Team and Clinical Board Senior Management Team

DOSH – Millcare system

Risk - The company supporting the Electronic Patient Record system Millcare which is used across the department of Sexual Health in Cardiff Royal Infirmary went into liquidation on Friday 13th January 2023. There is a risk that Millcare will slowly lose functionality or suddenly lose all functionality resulting in a total loss of the system. The result of any functionality of the Millcare system will severely disrupt service provision within the department, impact on continuity of care provision, potentially risk delay or unactioned positive results as Millcare provides the interface between lab authorised results and appropriate care/treatment being instigated. The risk of total loss of Millcare includes the risk of losing clinic data, information including patient data, appointments, clinical records and the interfacing between results reporting and the department.

Controls

- C&V IT team have secured Database login and password to pull essential information

- CD & SMT looking at essential data to pull off system in advance of potential loss
  SMT engaged with external companies and funded a support package as interim cover
- Support from PHW lab and Local C&V lab to instigate excel spreadsheet of authorised tests should the department experience any functionality concerns
- SOP developed for functionality loss in Millcare and return to paper recorfs in the event of total loss
- Emergency procurement steps have been instigated to move with pace onto an alternate DoSH digital solution
- Business case has been developed and approved at Capital Management Group on 16/09/24

Assurances
- Proceed with procurement of a new DOSH Electronic Patient Record

CAV 24/7 111 press 2

Risk - The 111 press 2 service was implemented within CAV 24/7 in February 2023 as part of the National initiative and development of 111. Over the last 6 months we have experienced considerable levels of sickness and staff turnover within the team who directly provide access to mental health clinicians which has caused difficulty in covering the 24-hour rota and has meant that business continuity arrangements have had to be enacted on a small number of occasions.

Controls

- Business continuity arrangements are in place
- Mental Health Clinical Board supporting remotely where possible
- Discussions are being taken forward with the Mental Health Clinical Board to align 111 press 2 with the Primary Care Liaison Service to provide a solution that ensures sustainability, resilience and supervision

Assurance

Regular escalation reporting and oversight monitoring by PCIC SMT. Directors of Operations PCIC and Mental Health Clinical Board developing the longer term plan to ensure sustainability

<u>Developments</u>

PCIC Academy

Across Wales Health Boards are required to establish a local Primary and Community Care Academy, who will work to achieve the following vision: “To facilitate the delivery of high-quality education and training for people working in primary and community care to support the delivery of excellent evidence-based person-centered care”. PCIC have successfully recruited a team of 3 Academy members to progress the work throughout the Clinical Board.

The expectation of the Academy will be to effectively consider and coordinate training and education for a broad range of professionals working within primary and community services as set out in the Primary Care Model for Wales to ensure the multi-professional workforce has access to the necessary training and education and associated support to deliver a wider range of services and interventions within these settings. The Academy will work across the breadth of Primary & Community Care services.

Enhanced Community Care

As part of the Further Faster funding, we have successfully embedded the new Safe@Home service across both Cardiff and the Vale of Glamorgan. The soft launch of the team commenced in January 2024 and is currently taking on average 24 patients per week. The multidisciplinary team aims to prevent avoidable hospital admissions by providing rapid intervention in an individual's own home. The team is working in collaboration with our Community Resource Team, Vale Community Resource Service and Acute Response Team.

We are currently in the process of developing an Enhanced Community Care (ECC) business case. Enhanced Community Care is as defined by the Strategic Programme for Primary Care as an *Integrated community-based health and social care* model. There are 4 Delivery Groups reporting into the ECC Steering Group:

- Connected Community Care – Social Prescribing and MDT Cluster Working
- Urgent Primary Care & Treatment – UPCCs to UTCs & Single Point of Access/Digital Hub
- Safe@Home phase 2
- Community Beds – rapid access to step up sub-acute beds

CAV 24/7

The CAV 24/7 service has seen positive developments including:

- UPCC - CAV 24/7 currently provide urgent care provision to the South and East Locality, situated within CRI, open 9-6pm Monday to Friday. Challenges include underutilisation of appointments.

- Emergency Dental Service (EDS) - The new dental contract came into existence April 2023. Service provision required from general dental practices was increased and this has allowed the service to increase the number of available urgent patient slots.

- EU Re-Direction of Patients - Work between PCIC and Medicine Clinical Board has been ongoing to increase the number of re-directions EU send to CAV 24/7 – where patients symptoms / conditions are more appropriate for urgent care services. Patients are now starting to be redirected to the CAV24/7 service via this process.

- HMP Cardiff - A Standard Operational Procedure (SOP) was agreed by both services in July 2023. A pilot is now ongoing where CAV24/7 clinical staff provide clinical advice to HMP health care staff supporting the medical care of prisoners. This initiative takes place during the OOH period – i.e. evenings, weekends and bank Holidays. To date there has been a positive response from both services.

- *Contact First* -Patients contacting 111 and requiring a non-urgent assessment at EU are transferred to CAV 24/7 where a clinical triage takes place – patients may receive self-care advice, referral to their own GP, referral to other community service, allocation of a time slot to attend the emergency department – either minor injuries or ambulatory care unit. Booked appointment slots are also available at Barry Minors Injuries Unit Monday to Friday 9 – 4.30pm.

ANCLE Café – District Nursing

The ANCLE café project represents a novel approach in conjunction with Cardiff Metropolitan University, School of Sport and Health Sciences and Cardiff and Vale University Health Board to undergraduate and qualified staff multidisciplinary working. The project aims to improve healing times and reduce reoccurrence of chronic venous leg ulcer (CVLU's), reduce social isolation and loneliness within this patient population, and improve independence and wellbeing. The project will also better educate the future workforce for the management of the CVLU population.

This is due to be launched in September 2024.

National QSE Workstreams

Members of the PCIC SMT team continue to collaborate with All Wales Primary Care colleagues through the following national programmes of QSE work:

- The All Wales Primary Care AMD Governance Group
- The Strategic Programme for Primary Care
- All Wales Performer Concerns Task and Finish Group – working towards a Unified Framework to manage Performance Concerns for all clinicians on a Performers List
- Clinical Governance Practice Self-Assessment Toolkit Steering Group
- EPS Steering Group
- HEIW GP Stakeholder Committee

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 continued to be challenging for the community teams due to the significant pressures arising from 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 and work associated with the Community Pharmacy contract and reform of the dental contract. This will continue with the work required to preparing for the introduction of the optometry contract
- The sustainability and delivery of health services in HMP Cardiff continues to constitute a risk for the Clinical Board which has been impacted further by the recent move on of key management and clinical staff. New and interim appointments have been progressed and the Business Unit team are working hard to support the delivery of care as work is taken forward at pace to review and agree a sustainable and effective workforce model based on a refreshed health needs assessment
- DOSH Psychosexual Therapy Service - Following a number of similar concerns being raised in relation to the service recently a Clinical Board internal risk assessment and deep dive review of the service against National Standards has been initiated

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 Paper			Agenda Item no.	2.2
Meeting:	Quality Safety and Experience Committee	Public Private	★	Meeting Date:	October 2024
Status *(please tick one only):*	Assurance	★	Approval		Information
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Assitant Director of Patient Experience				

Main Report

Background and current situation:

The Quality Indicators report offers assurance on various priorities related to quality, safety, and patient experience. It presents data up to the end of August 2024 and outlines actions being taken to achieve necessary improvements. The report also includes exception reporting to highlight emerging quality and patient safety issues or trends for the committee's attention. As the quality indicators evolve, additional metrics will be incorporated to monitor the timeliness of patient care, as well as the equality and equity of care provision and health outcomes

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

- Thirteen Nationally Reportable Incidents were reported in August 24 slightly above the national average
- C diffcile for the period between April to end of August the Health Board has had 94 cases, this is 45 more cases compared to the equivalent period in 2023.
- The UHB has achieved compliance with all issued safety solutions (alerts and notices).
- An unannounced follow up inspection of Cedar Ward Hafan y Coed occurred in July 24
  - The final report of the maternity services at UHW was published in June 24
  - The indicators show an improving picture of compliance with tendable audits
- 731 Concerns were raised between July and August 2024 78% were closed within 30 working days and 38% under Early Resolution
- Since April 23 Duty of Candour has been triggered on 198 occasions
- The UHB has 414 inquests currently being managed by Patient Experience.
- 19706 Civica survey have been sent with and 18% response rate 90% of responders stated they were satisfied with the care that they received.
- 72% of CIVICA Emergency Department responses stated that people were satisfied with the care that they received
- 76% of CIVICA mental health survey responses state that the patients were satisfied with their overall experience

Recommendation:			
The Committee is requested to: **NOTE** the assurance provided by the 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
The review of compliance with recommendations will be undertaken
Safety: Yes
The Ombudsman provides an independent scrutiny of cases
Financial: Yes
The ombudsman can offer financial redress to people raising concerns
Workforce: n/a
Legal: n/a
Reputational: Yes
There is significant reputational risk from Public interest reports
Socio Economic: n/a
Equality and Health: n/a

Decarbonisation: n/a	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Quality Indicators Report

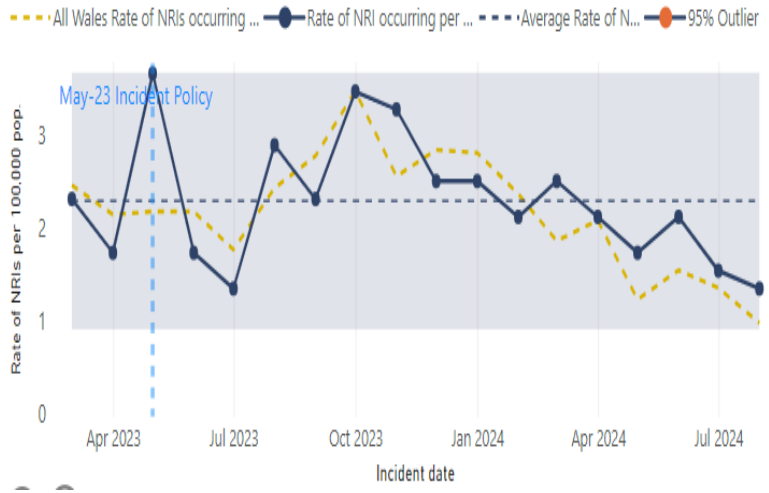
Quality Safety and Experience Committee

July 2024

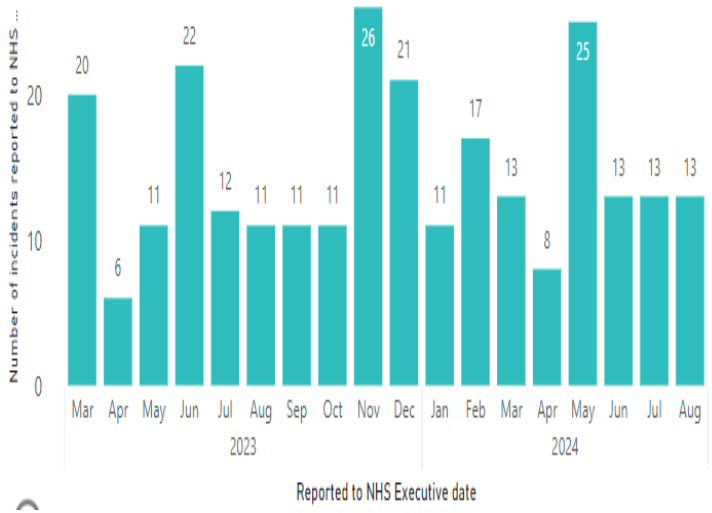
National Reportable Incidents and Never Events

Safe Care

CVU UHB rate of NRIs occuring (by incident date) per 100,000 population as of 05/09/2024



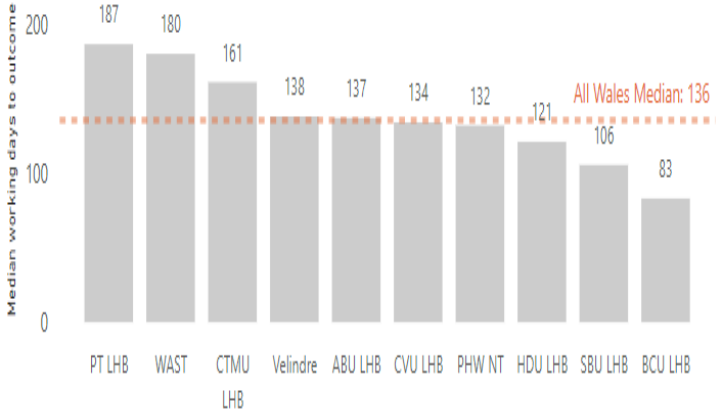
CVU UHB NRIs reported to NHS Executive as of 05/09/2024



CVU UHB top 10 NRI categories occurring by volume (incident dates between Mar-23 and Aug-24) as of 05/09/2024

NRI category	Total
Pressure ulcer developed or worsened during care in this clinical care area/caseload	40
Neonate	30
Clinical assessment, clinical diagnosis	27
Unexpected death	22
Treatment or procedure issues	18
Access to services or admission delayed	8
Maternal	8
Diagnostic testing - Pathology	6
Slip, trip or fall	6
Diagnostic testing - Radiology	5

Median working days to incident category NRIs investigation completion (includes ongoing open incidents as working days since date reported to NHS Executive) for all NRIs excluding pressure ulcers to date by organisation (as of 05/09/2024)



Thirteen NRIs were reported in August 2024. C&V are slightly above the national average, we have an open reporting culture and a low threshold for NRI reporting. Pressure ulcers are the most commonly reported by C&V followed by neonatal incidents; this reflects the change in the national requirement to NRI report all MBRRACE neonatal deaths as NRIs to enable national oversight, there were no care concerns for these incidents and would otherwise not meet NRI criteria. Due to C&V's tertiary referral status and the presence of a Fetal medicine department, Cardiff sees more complex pregnancies and neonatal deliveries. This also accounts for 29% of the unexpected death NRIs

Actions

Improving diagnosis was the topic of the annual WHO World Patient Safety Day; diagnostic incidents are the third highest reported NRI category. This event showcased some fantastic initiatives all aimed at improving diagnosis. Brainomix within Stroke Services utilises AI to improve timely diagnosis of stroke leading to improved patient outcomes.

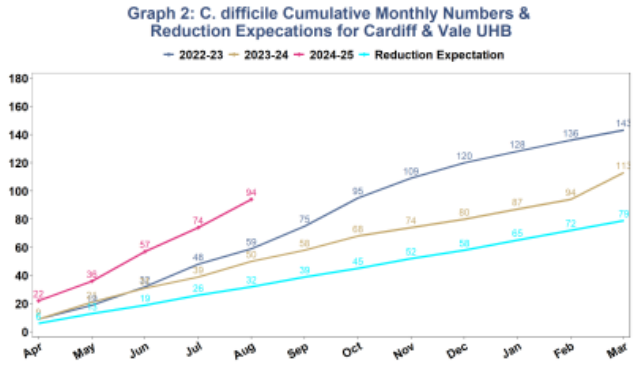
Capsule and Transnasal (TNE) endoscopy are improving access to GI diagnostics for those who are unable to undergo the more invasive endoscopies. It is hoped that this will also help in reducing waiting times as TNE becomes more embedded.

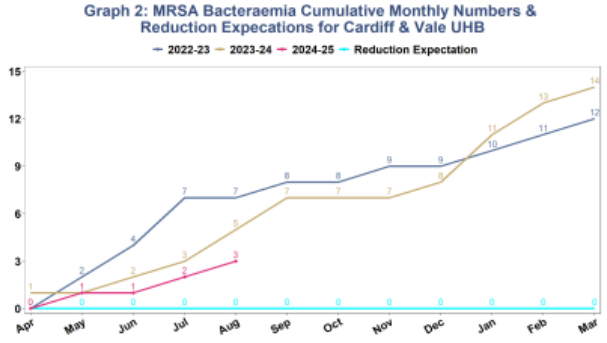
The Rapid Diagnosis Clinic aims to improve early diagnosis of cancer in patients with vague symptoms.

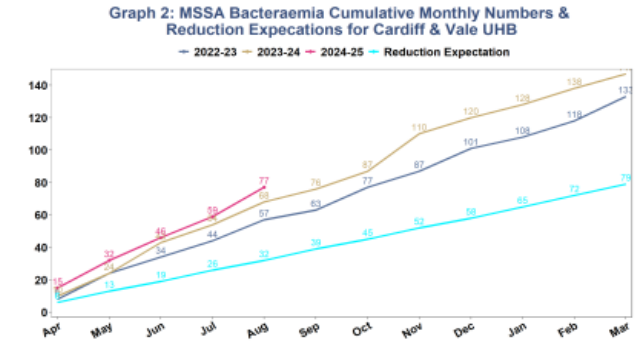
Timely investigations of all incidents, but especially NRIs, is crucial for learning and improving as well as ensuring the patient and their family get the answers that they need. Cardiff and Vale are working hard to reduce the number of overdue NRI investigations, we are just below the All-Wales median for the number of working days from reporting to closure of NRIs.

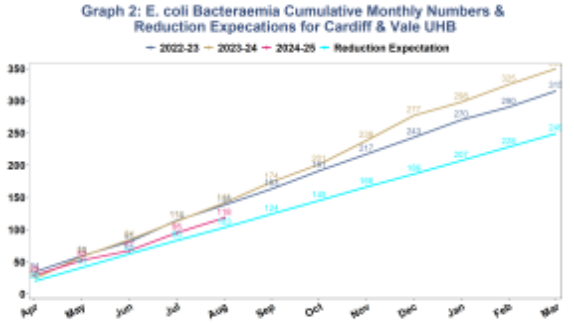
Infection Prevention and Control

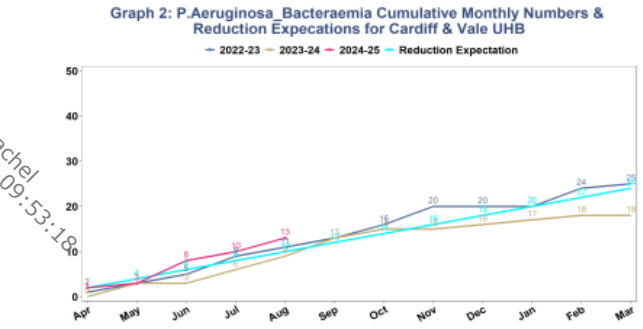
Safe Care

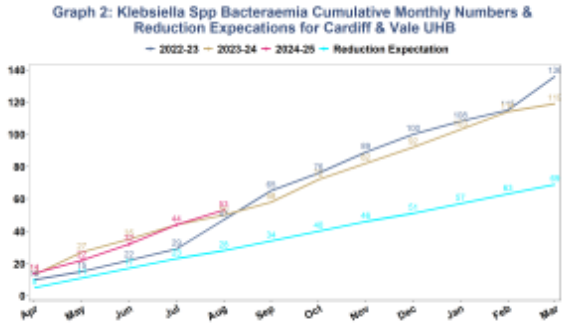












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C. Difficile

For the period between April to end of August the Health Board has had 94 cases, this is 45 more cases compared to the equivalant period in 2023. The WHC has not yet been received by the Health Board.

Klebsiella Spp Bacteraemia

The UHB has reported 2 more cases compared to the same period in 2023 with 52 cases since April 2024.

E. Coli Bacteraemia

CAV continues to reduce the number of *E.coli* bacteraemia. Cumulative cases are 8.6% below the same period last year with 118 cases since April 2024.

MRSA Bacteraemia

One MRSA case was reported during August, giving a total of 3 cases between April and August, a reduction of 2 cases (40%) for the equivalent period in 2023.

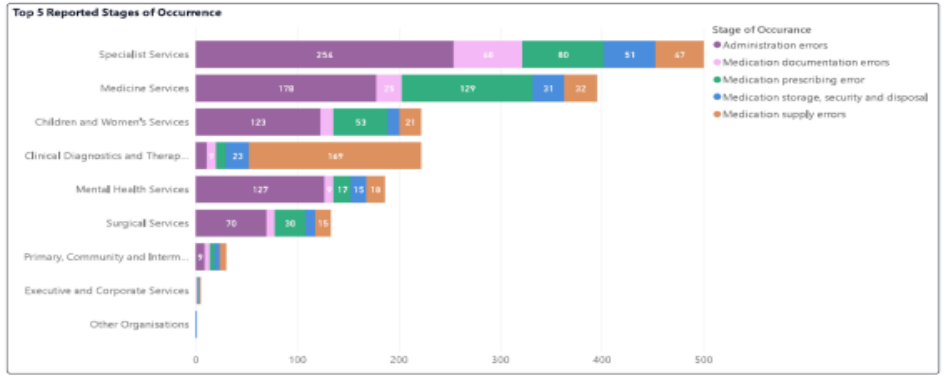
MSSA Bacteraemia

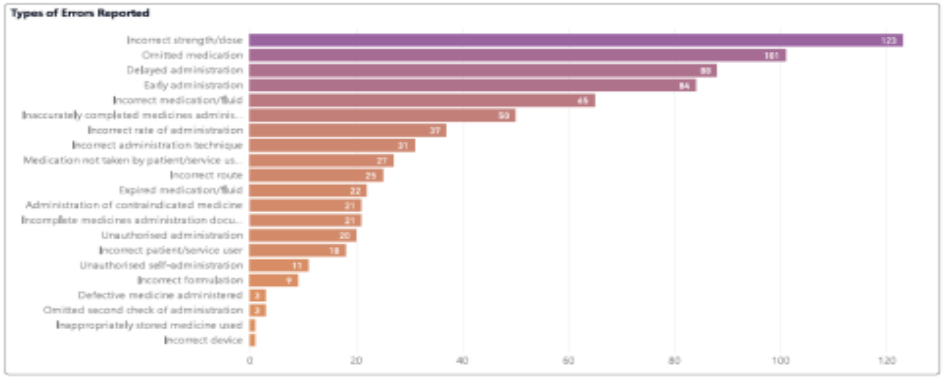
The UHB has reported 78 cases since April 2024, an increase of 13.4% with 9 more than during the same period in 2023 .

P. Aeruginosa Bacteraemia

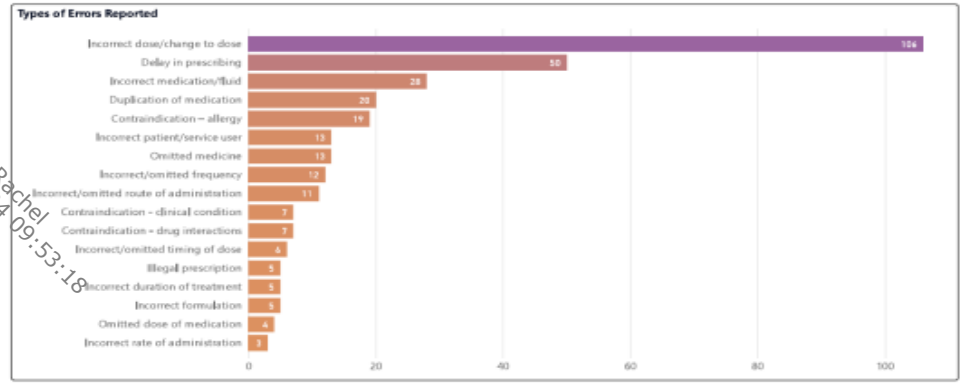
As of August 2024, the UHB has 35.7% more cases than the same period last year and 14% more than 2022 with 14 cases in total since April 2024.

Medication Incidents





☐ Medication administration incidents by type



☐ Medication prescription incidents by type

Between 1st April 2023 - 31st March 2024, 1809 medication incidents were reported via the Datix Cymru system. This represents a 38% increase against the previous year.

Of those incidents, 761 were recorded as administration errors, with the most commonly reported error being administration of an incorrect strength/dose. Omitted and delayed doses were also commonly reported.

Among the 325 prescribing errors, the most common type was incorrect dose/change to dose, followed by delay in prescribing.

Actions

A working group has been established to drive improvements with timely administration of medications, based on the agreed all-Wales list of time-critical medications which has now been agreed. This includes workstreams considering communications, education and policy.

Learning from reported medication incidents is being used to inform the design and configuration of the electronic medicines prescribing and administration system (ePMA). This will ensure that the system has the maximum positive impact on the safety of medications prescription and administration.

Patient Safety Solutions

CVU UHB Outstanding PSS (12/08/24)		
0 Alerts	0 Notices	0 Total PSS

CVU UHB current compliance of all safety solutions to date (12/08/24)	CVU UHB compliance at deadline of all safety solutions to date (12/08/24)
82 of 82 (100.0%)	55 of 82 (67.1%)

CVU UHB PSS Compliance Status timeline by outstanding references

PSS | Ref | Title

Current Compliance Status of outstanding PSS notices (12/08/24)

PSS	ABU UHB	BCU UHB	CVU UHB	CTMU UHB	HDU UHB	SBU UHB	PT HB	WAST	Velindre	PHW NT	Total
Notices	1	0	0	0	0	0	0	0	0	1	2
PSN026											1
PSN066											1
Total outstanding PSS	1	0	0	0	0	0	0	0	0	1	2

As of 18th September, the UHB has achieved compliance with all issued safety solutions (alerts and notices).

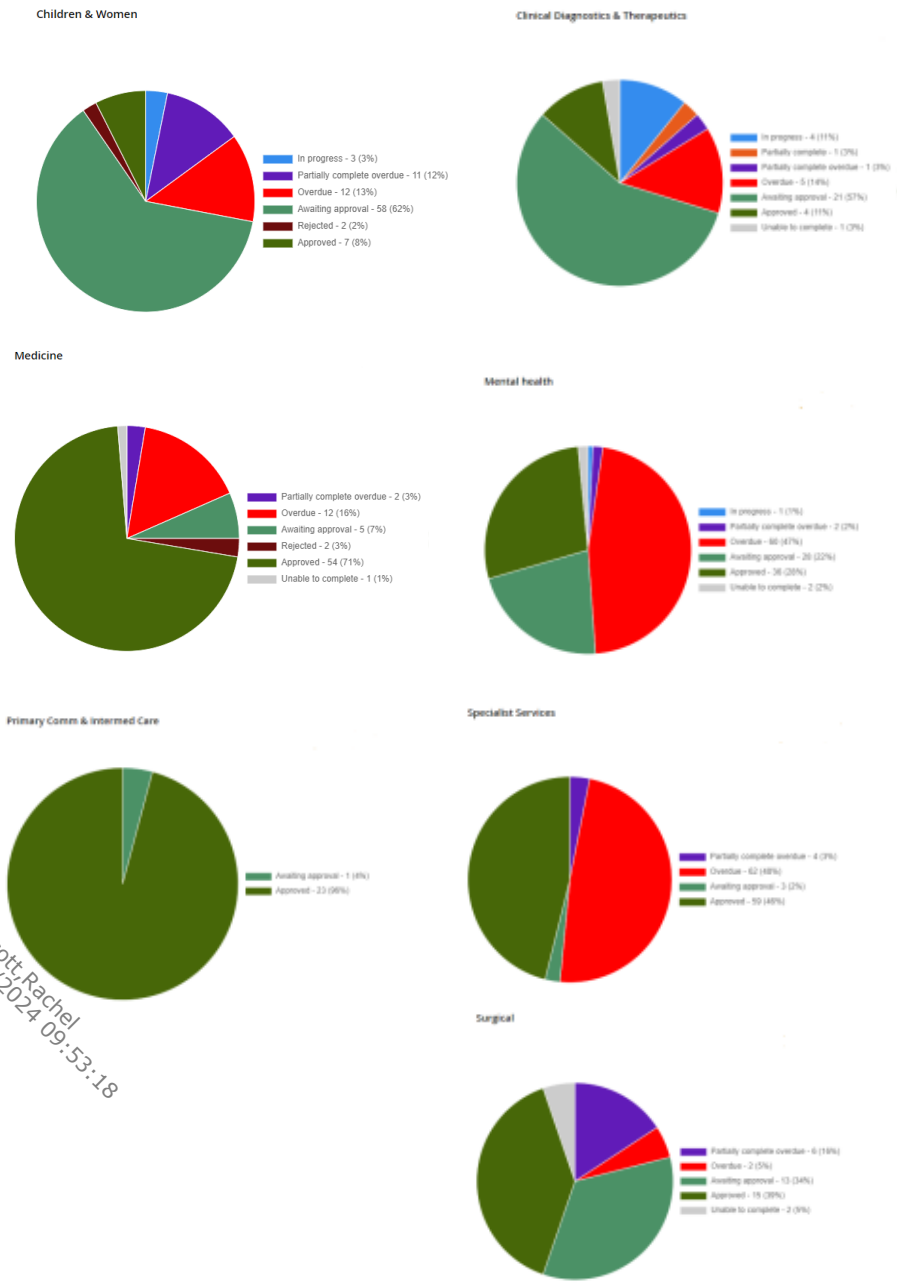
The UHB have recently responded to a CMO letter, confirming that the implementation of NRFit to reduce the risk of wrong-route injection has been completed ahead of the December 2024 deadline.

The UHB contributes to the All-Wales Patient Safety Solutions Reference Group (AWPSSRG), where progress against alerts is discussed and new potential alerts considered.

Safe Care

Safe Care

HIW



Cedar Ward – Hafan y Coed

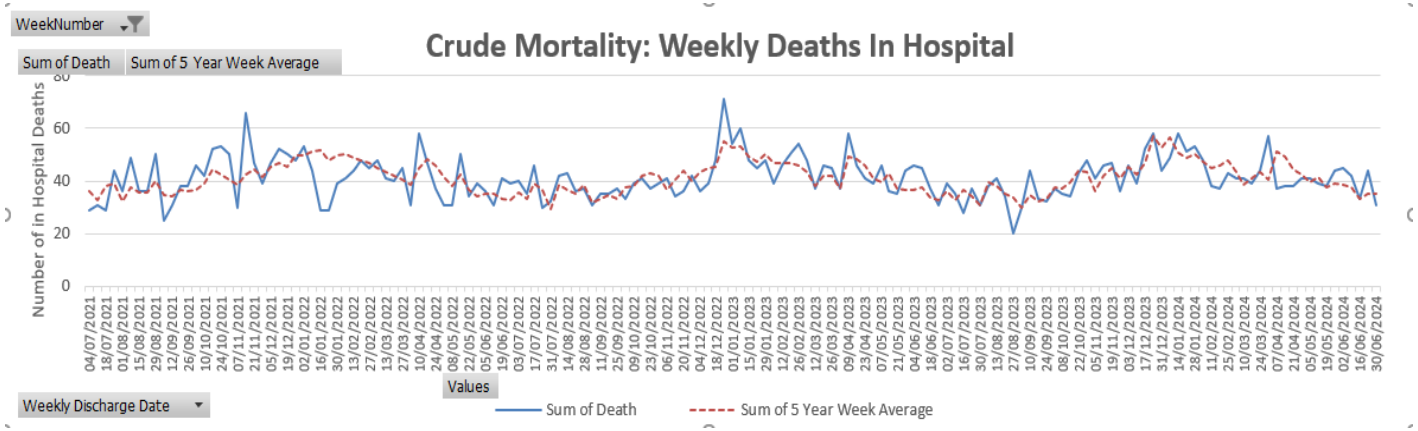
Cedar Ward was subject to an Unannounced inspection by HIW on Monday 1st July. Verbal feedback was provided following the inspection and written notification of recommendations is pending at the time of writing this report.

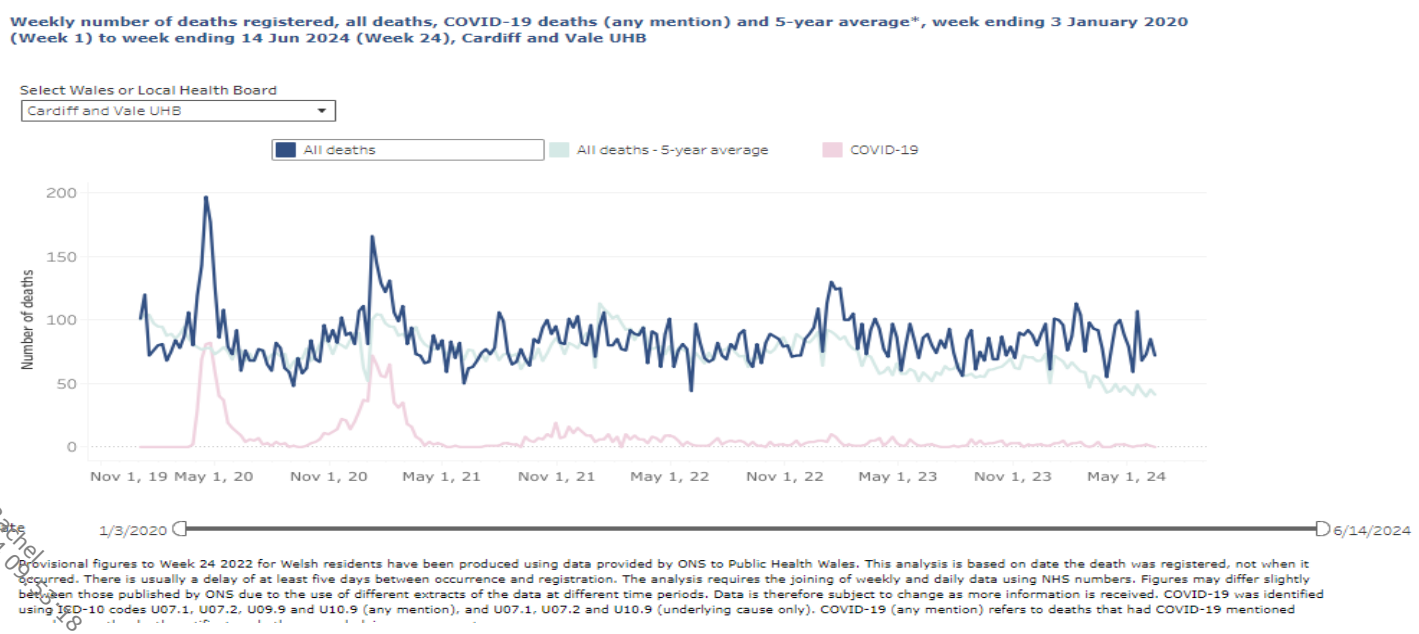
An Unannounced follow up inspection of maternity services in UHW was undertaken on 19 to 21 March 2024 and the final report was published on 21 June 2024. The inspection recognised the work undertaken by the ELAN team to address inequalities in care and to support women seeking sanctuary. They also recognised the public health work undertaken including breast feeding promotion. During the inspection concerns were raised about the availability of baby security tags which was addressed immediately. A further five immediate improvements were required that related to checks of resuscitation equipment, availability of scrubs for birth partners in theatre, locking of the clean utility room door, scheduling of abduction drills and storage of medication. In addition there were further recommendations that related to the ward environment, the management of patient safety incidents and staffing rates. The full report and improvement plan can be read at :
UHW maternity inspection report and action plan. HIW June 2024
An Update of the Improvement plans relating to an unanounced inspection on Island Ward undertaken on 27 and 28 November 2023 was provided to HIW in May 2024. The update demonstrated that all improvement actions had been complete and were subject to ongoing monitoring when appropriate.

A Diagnostic Imaging Department Inspection was undertaken by HIW on 14 and 15 November 2023 and an update of the improvement actions was completed in May 2024. All but three improvements were complete. The three remining actions were :

- **The employer is required to put in place a standard template for audits**
- A standardised audit template has been developed and approved. Currently in the process of transferring this onto the AMaT system.
- **The health board is required to inform HIW of the efforts made to provide formal paediatric on call cover**
- The establishment of a formal 24/7 on call rota is reliant on recruitment of additional Consultant Paediatric Radiologists in sufficient number to ensure robust service provision. Recruitment is ongoing and there is an anticipated start date for a Consultant Paediatric Radiologist is September 2024
- **The employer is required to review the process of the patient contacting the GP for advice on skin burns from high dose procedures.**
- A referral pathway from radiology into dermatology has been developed and was being finalised in May 2024.

Mortality





Provisional figures to Week 24 2022 for Welsh residents have been produced using data provided by ONS to Public Health Wales. This analysis is based on date the death was registered, not when it occurred. There is usually a delay of at least five days between occurrence and registration. The analysis requires the joining of weekly and daily data using NHS numbers. Figures may differ slightly between those published by ONS due to the use of different extracts of the data at different time periods. Data is therefore subject to change as more information is received. COVID-19 was identified using ICD-10 codes U07.1, U07.2, U09.9 and U10.9 (any mention), and U07.1, U07.2 and U10.9 (underlying cause only). COVID-19 (any mention) refers to deaths that had COVID-19 mentioned

Inpatient Mortality
Crude Mortality remains in line with the five year average. Work is underway nationally to agree an All Wales adjusted Mortality measure that allows national benchmarking

All Cause Mortality
Excess deaths above the five year average have been observed across the UK including Wales since late 2022. Work undertaken by Public Health Wales has explored this data by condition. In 2023 the mains causes of death in Wales were dementia and Alzheimer's disease accounting for 15% of deaths, Ischaemic heart disease 6.8%, chronic lower respiratory disease 5.7% and cerebralvascular disease 5.7%. Premature deaths from key non communicable diseases has been reducing across Wales since 2007 and this is mirrored across Cardiff and the Vale.

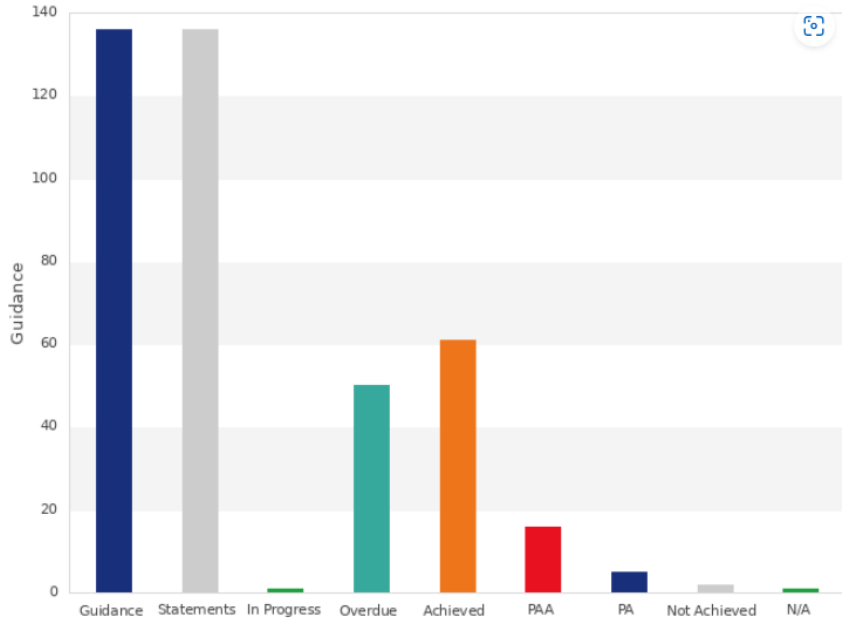
Morbidity from cancer in Wales demonstrates that in males this is most commonly prostate cancer, colorectal and then lung cancer while in women it is breast cancer, lung and then colorectal cancer but deaths from lung cancer are the most common casuse of cancer related death in both men and women.

Comparisons with the European Age Standardised Mortality Rate per 100 000 persons of all ages between 2020 and 2023 demonstrates that there has been a significant increase in diabetes and liver disease featured on deaths certificates. The current method for calculating excess deaths does not account for increasing population size and mortality rates, however from 2024 the Office of National Statistics will be changing the way this data is presented to account for these factors.

Clinical Effectiveness

Effective Care

Guidance overview



- **Guidance (136)** - total number of guidance (that may contain one or more statements)
- **Statements (136)** - total of 'In Progress', 'Achieved', 'Partially Achieved', and 'Not Achieved' bars
- **In Progress (1)** - number of the trust's Guidance Statement entries that do not currently have a status
- **Overdue (50)** - number of the trust's Guidance Statement entries that are overdue
- **Achieved (61)** - number of the trust's Guidance Statement entries that have this status value
- **PAA (16)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Acceptable' status value
- **PA (5)** - number of the trust's Guidance Statement entries that have 'Partially Achieved' status value
- **Not Achieved (2)** - number of the trust's Guidance Statement entries that have 'Not Achieved' status value
- **Not Applicable (1)** - number of the trust's Guidance Statement entries that have 'Not Applicable' value

☐ Guidance overview 2023/24

Circulated Guidance April 24 -

Title

Artificial Intelligence (AI)-derived software to help clinical decision making in stroke (January 2024) *This guidance replaces MIB262

Endometriosis: diagnosis and management

Twin and triplet pregnancy (2019) *This guideline updates and replaces CG129

Natalizumab for the treatment of adults with highly active relapsing-remitting multiple sclerosis (August 2007)

Ranibizumab and pegaptanib for the treatment of age-related macular degeneration (August 2008)

Ranibizumab for treating visual impairment caused by macular oedema secondary to retinal vein occlusion (May 2013)

Ranibizumab for treating choroidal neovascularisation associated with pathological myopia (November 2013)

Alemtuzumab for treating relapsing-remitting multiple sclerosis (May 2014)

Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma

Cladribine for treating relapsing-remitting multiple sclerosis (December 2019) *This guidance replaces TA493

Dostarlimab with platinum-baed chemotherapy for treating advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency

Cabozantinib with nivolumab for untreated advanced renal cell carcinoma

Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma in people 3 years and over * This guidance partially updates TA540

Selinexor with dexamethasone for treating relapsed or refractory multiple myelmona after 4 or more treatments *This guidance partially update TA700

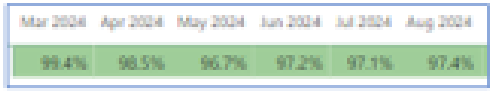
Effeithiol
Effective

Tendable Audit Programme

Nursing

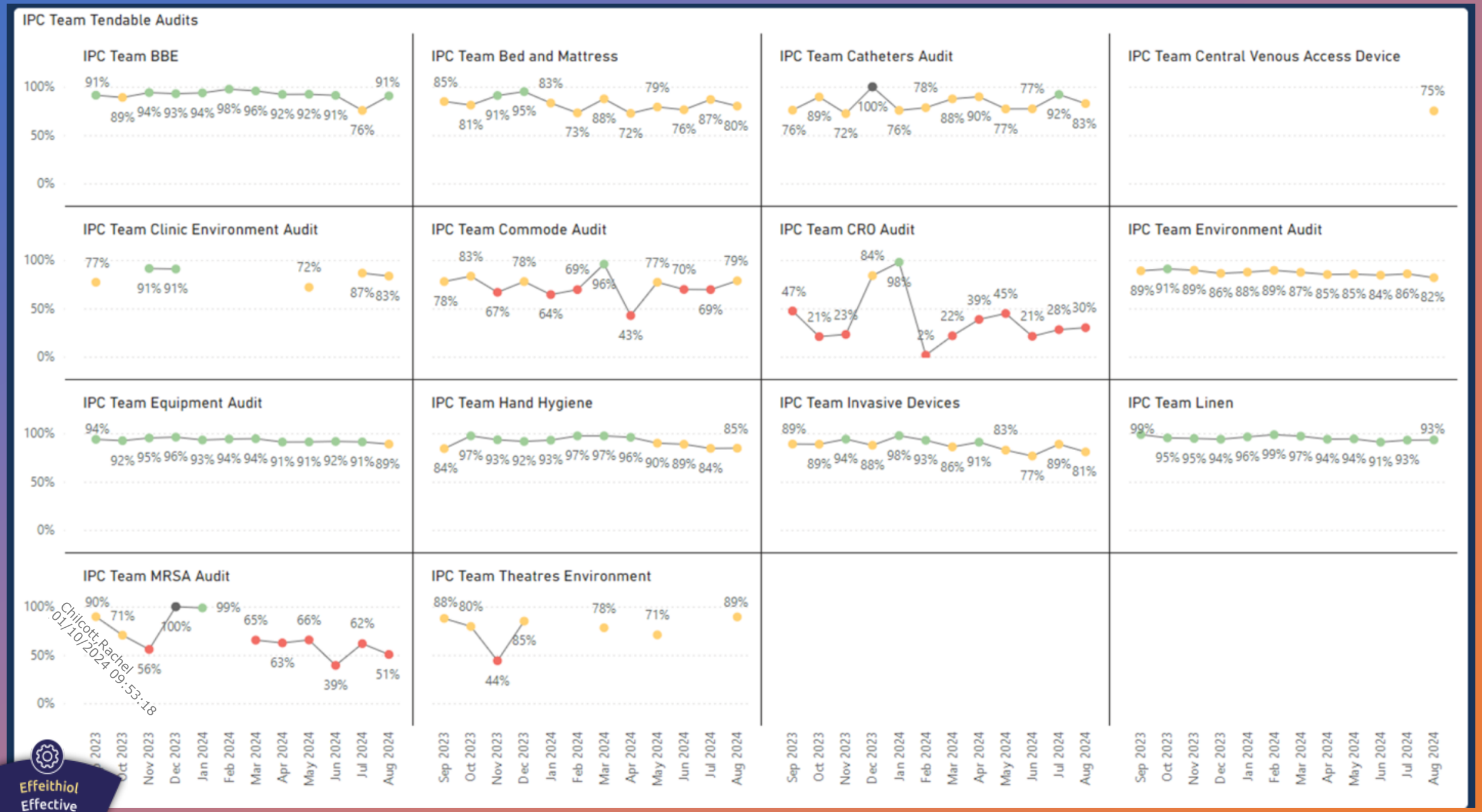
Infection Prevention and Control (March – August 2024)			
	Ward Results (6-month average)	IPC Team Results (6-month average)	Chart
Hand Hygiene	96%	89%	
Bare below the elbow	96%	87%	
Peripheral Cannula	86%	77%	

Medicines Measures		
Are any unsecured medicines visible anywhere in the ward/department area? (UHB wide)	96.4% WARD AUDIT **(6-month average)**	90.5% LEAD AND SENIOR NURSE AUDIT **(6-month average)**
Are the medication preparation and storage rooms locked when unattended? (UHB wide)	91.4% WARD AUDIT **(6-month average)**	84.1% LEAD AND SENIOR NURSE AUDIT **(6-month average)**
Controlled Drugs (Daily reconciliation checks, reviewed monthly)	85.5% LEAD AND SENIOR NURSE AUDIT	**Coming soon** Pharmacy led CD audit and Reconciliation audits set up in Tendable from September 2024

Patient Risk Assessment Measures		
	Ward Results	Summary of results
WARRN (Mental Health Risk Assessment – Mental Health Clinical Board only)	73% July 2024	**What's going well?** Does this patient have a WARRN in place? 100% **What needs improvement?** Is there evidence the WARRN includes the voice of the patient? 41% Has the WARRN been shared with the patient? 31%
Nutritional Risk Assessment (Acute adult inpatients within 24 hrs of admission)	97.7% (6-month average)	
Pressure Damage Risk Assessment (Acute adult and paediatric inpatients within 6 hrs of admission)	96.8% (6-month average)	
Falls Risk Assessment (Acute adult inpatients within 6 hrs of admission)	96.6% (6-month average)	
Escalation and response to NEWS scores of 3 and above (Adult inpatient areas)	94.1% (6-month average)	

A summary of results available from the Tendable Core audit programme accessible here:

CAV Nursing Team Dashboard - Power BI


IPC Team Tendable Audits
IPC Team BBE
91% 89% 94% 93% 94% 98% 96% 92% 92% 91% 76% 91%
IPC Team Bed and Mattress
85% 81% 91% 95% 83% 73% 88% 72% 79% 76% 87% 80%
IPC Team Catheters Audit
76% 89% 72% 100% 76% 78% 88% 90% 77% 77% 92% 83%
IPC Team Central Venous Access Device
75%
IPC Team Clinic Environment Audit
77% 91% 91% 72% 87% 83%
IPC Team Commode Audit
78% 83% 67% 78% 64% 69% 96% 43% 77% 70% 69% 79%
IPC Team CRO Audit
47% 21% 23% 84% 98% 2% 22% 39% 45% 21% 28% 30%
IPC Team Environment Audit
89% 91% 89% 86% 88% 89% 87% 85% 85% 84% 86% 82%
IPC Team Equipment Audit
94% 92% 95% 96% 93% 94% 94% 91% 91% 92% 91% 89%
IPC Team Hand Hygiene
84% 97% 93% 92% 93% 97% 97% 96% 90% 89% 84% 85%
IPC Team Invasive Devices
89% 89% 94% 88% 98% 93% 86% 91% 83% 77% 89% 81%
IPC Team Linen
99% 95% 95% 94% 96% 99% 97% 94% 94% 91% 93% 93%
IPC Team MRSA Audit
90% 71% 56% 100% 99% 65% 63% 66% 39% 62% 51%
Chilcott,Rachel
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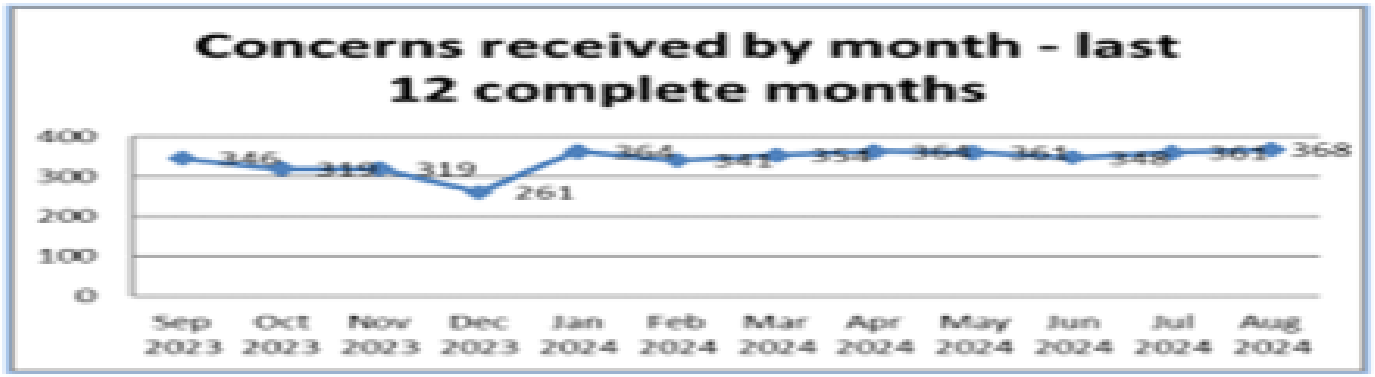
IPC Team Theatres Environment
88% 80% 44% 85% 78% 71% 89%
100%
50%
0%
Sep 2023
Oct 2023
Nov 2023
Dec 2023
Jan 2024
Feb 2024
Mar 2024
Apr 2024
May 2024
Jun 2024
Jul 2024
Aug 2024

Person Centred Care

Patient Experience

CONCERNS

As a Health Board we are committed to listening to people who use our services, resolving their concerns where possible in a proportionate and empathetic manner. We aim to provide an effective and timely process for responding to concerns, which enables the Health Board to improve services based on lessons learnt, with the aim of achieving high quality, compassionate and effective care for all service users, whether in provided or commissioned services.



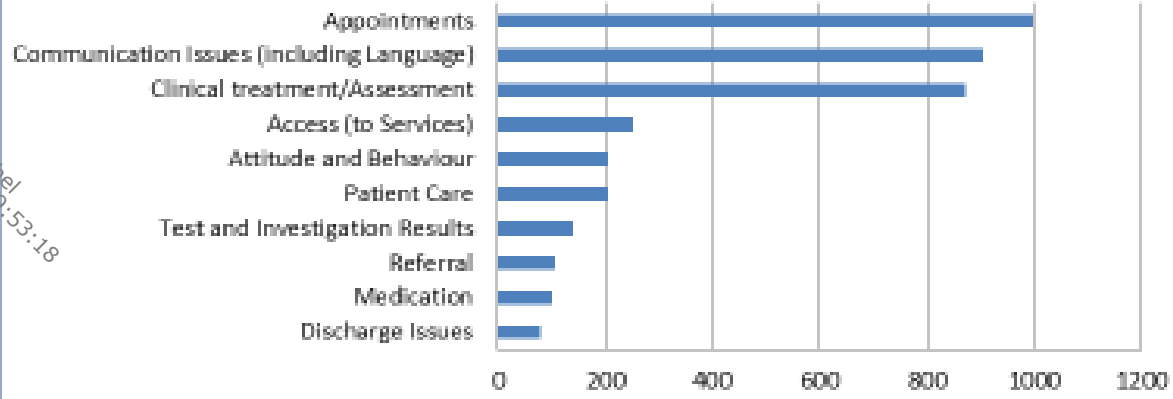
During July and August 24, the Health Board :

- Received 731 Concerns
- Closed 683 concerns
- 78% closed within 30 working days (including Early Resolution)
- 38 % closed under Early Resolution (within 2 days including day of receipt)
- Received 226 Enquiries
- Received 84 Compliments
- We currently have 291 active concerns

Top 3 themes and trends

- Concerns around appointments (waiting times/cancellations)
- Communication
- Clinical Treatment and Assessment

- Concerns Received by Top 10 Primary Subjects - last 12 rolling months



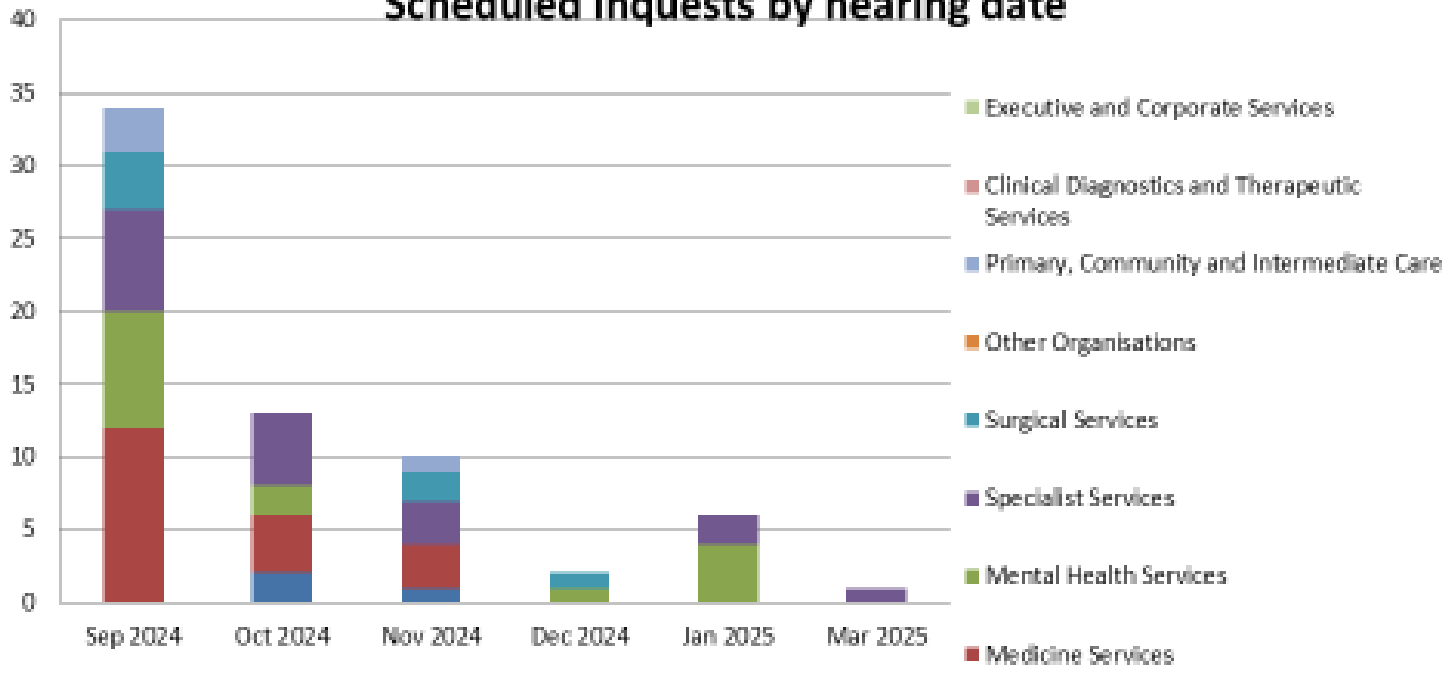
Duty of Candour

- Since April 1st, 2023, 37, 730incidents have been reported by staff across the Health Board
- Approximately 33% incidents regraded with clinical input and feedback to the reporter
- We continue to support DOC awareness sessions across Primary and Secondary care
- Since April 1st, 2023, we have triggered the DOC on 198 occasions
- We have internally audited the process and compliance

Person Centred Care

Patient Experience Inquests

Scheduled Inquests by hearing date



The numbers of inquests is increasing and the complexity is challenging

The focus is upon staff support and ensuring that wherever possible the family's questions are addressed before the inquest

A focus of the team has been on the compilation of lessons learned to reassure the families and HMC in cases where we have identified any concerns regarding our systems, processes or care delivery

We have 414 Inquests managed through Patient Experience

Focus upon

- Focus on learning –we share a lesson learned at all inquests
- Staff support pre and post inquest
- Weekly meetings with Legal and Risk
- Use of teams channels for complex inquests
- Preparation of information for the coroner in a timely manner
- Alignment to Redress where appropriate

Person Centred Care

Patient Experience - CIVICA

AW2, TT(A) Survey

SMS sent: 19706

Survey responses: 3592

Response rate: 18%

Bedside responses: 204

89% were satisfied with their overall experience.

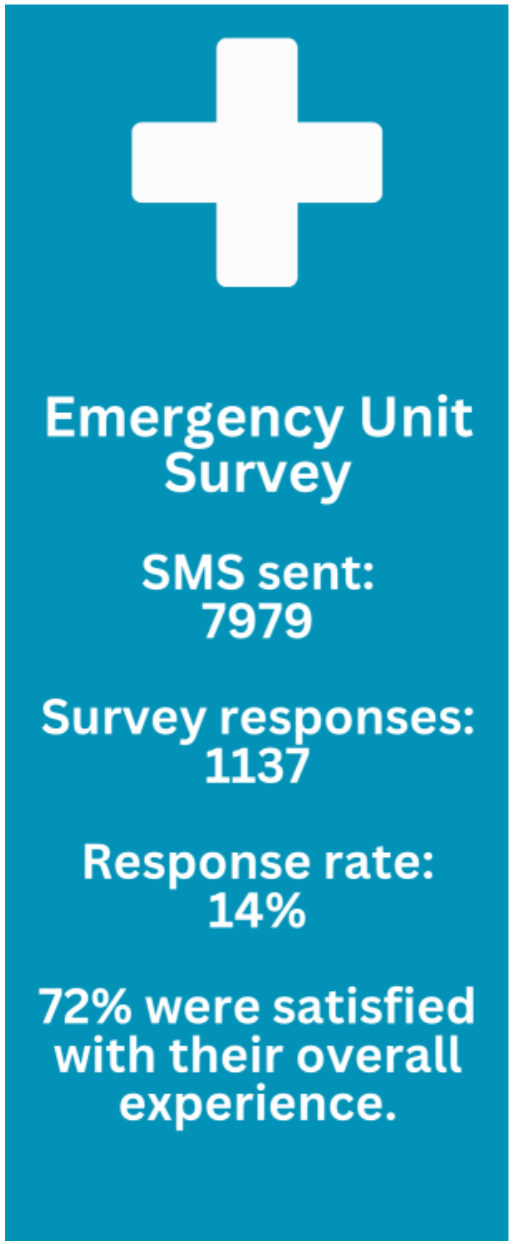
AW2 Survey results

Based on **3,592** partial/full survey completions (1st July – 31st August 2024 discharges).

- Whilst in our care did you feel safe? **86%** of respondents answered 'Always'.
- Were staff kind and caring? **84%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **76%** of respondents answered 'Always'.
- **90%** were satisfied with their overall experience.

Person Centred Care

Patient Experience - CIVICA



Emergency Unit Survey results

Based on **1,137** partial/full survey completions (1st July – 31st August 2024 discharges).

- Did you feel that you were listened to? **66%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **29%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **57%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **63%** of respondents answered 'Always'.
- Were things explained to you in a way that you could understand? **71%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **68%** of respondents answered 'Always'.
- **72%** were satisfied with their overall experience.

Person Centred Care

Patient Experience - CIVICA

Mental Health Survey results

Based on **254** partial/full survey completions (1st July – 31st August 2024 discharges).

- Did you feel that you were listened to? **61%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **25%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **58%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **58%** of respondents answered 'Always'.
- Were things explained to you in a way that you could understand? **60%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **56%** of respondents answered 'Always'.
- **76%** were satisfied with their overall experience.

Effeithlon
Efficient

Safe Care

- This infographic provides overview for all 25B wards under the Nurse Staffing Levels (Wales) Act. The dashboard can focus down into each area.

- SC compliance since June recorded for 25B wards. This continues to be monitored monthly.

- Both professional judgement and red flags are recorded, providing overview across the Health Board.

- Increasing compliance in SafeCare over the last 6 months, has increased the number of acuity scores recorded. Monitoring of trends of acuity levels using Welsh Levels of Care continues.

- Nurse staffing levels for both registered and unregistered against planned shifts is recorded in the final graph. Nurse staffing levels across 25B wards are being met during the night with an improving picture for day shifts in October and November.

Efficient Care

Report Title:	Children looked after– Assessment Backlogs			Agenda Item no.	2.5
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	08.10.2024
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	X
Lead Executive:	Executive Nurse Director				
Report Author:	General Manager, Children, Young People and Family Health Services				

Main Report
Background and current situation:

The purpose of this report is to provide Committee Members with an updated position regarding assessments for Children looked after.

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

The Children Looked After (CLA) team are an integral part of the Children, Young People and Family Health Directorate and deliver an area of work where there are statutory health requirements. It is well known that children in care have greater adverse health outcomes so the assessments are aimed at improving health outcomes and reducing health inequalities, as well as ensuring identified health needs are actioned and monitored. The service is provided by a small staffing team of Medical session, Specialist Nurses and more recently Health Visitors. The nursing team was increased in March 2023 in response to the number of children waiting for a statutory health assessment. This enables changes to be made around the service model in respect of age categories by clinical team.

In January 2024 a Joint Inspectorate of Child Protection Arrangements (JICPA) was undertaken in CAV as part of an All Wales review. The CLA service was reviewed and although it was noted that additional capacity had already been put into place to address the backlog of statutory assessments, further action was requested for CLA in line with the JICPA Assurance Improvement Plan. The action is for the Directorate to review the process in place for CLA health assessments ensuring they take place within statutory timescales, concluding with the required report. A number of actions are ongoing and being closely monitored as this paper describes below.

Performance against Statutory Regulations

The regulations stipulate that within 28 days of a child being accommodated by the local authority they should have a holistic health assessment. For children under the age of 5 years, a review health assessment should be undertaken every 6 months. For those aged 5+ years this health assessment should be completed annually. The statutory requirements to see children within 28-days of entering care for an initial health assessment, is often not achievable due to delays in notification from the local authority.

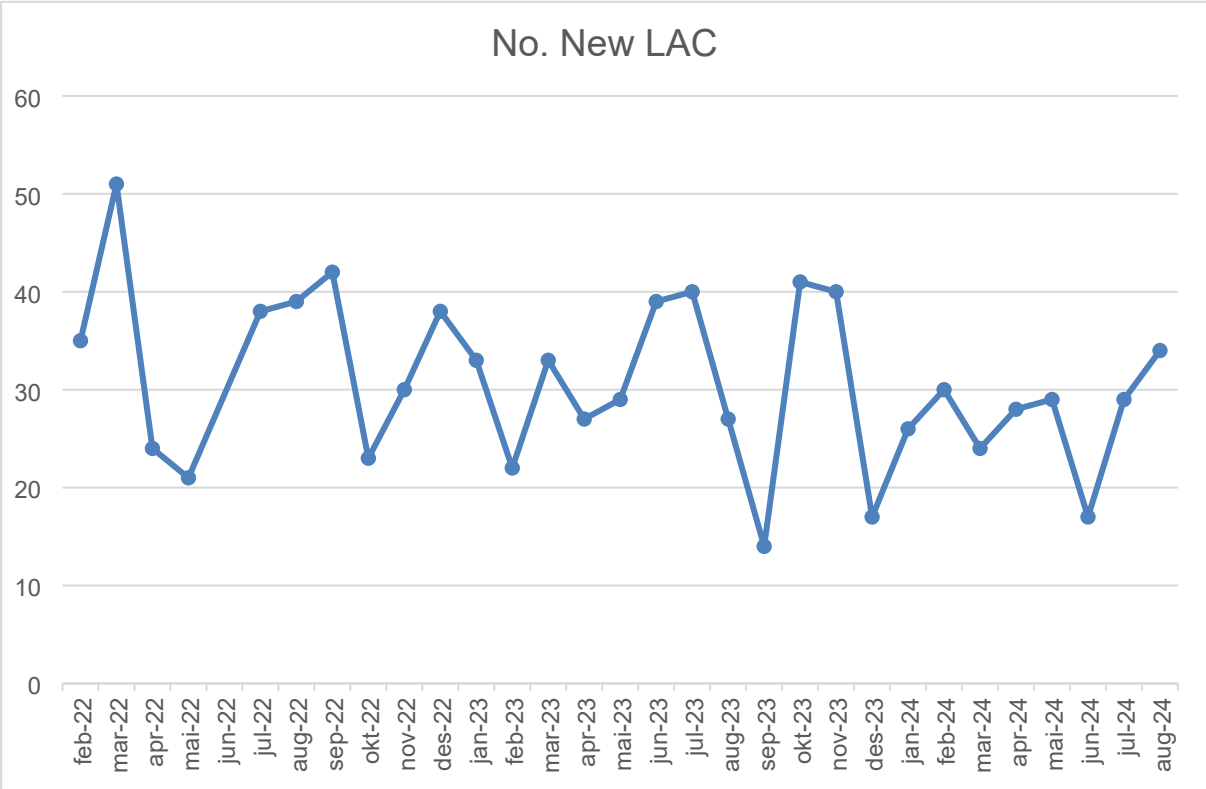
Growth

As previously reported there had been a consistent increase in children in care in Cardiff and the Vale of Glamorgan. There are currently 1,600 children on the CLA database. Included within this are 413 children from Cardiff and Vale, who are looked after out of area, and 236 children placed in Cardiff and Vale from other local authorities. This growth appears to have plateaued since January 2024.

The increase in numbers of children looked after has had a significant impact on the number of initial & review Health Assessments required each year. However, capacity had remained the same until recently, resulting in a backlog of both new and review health assessments.

The graph below shows the number of new CLA cases per month. In 2023 there were 362 new cases referred into the service, an average of 30 per month. In 2024 there have been 217, an average of 17 per month.

Graph 1 - Number of new LAC referrals



Impact of actions taken

During the last 18 months we have increased the workforce.

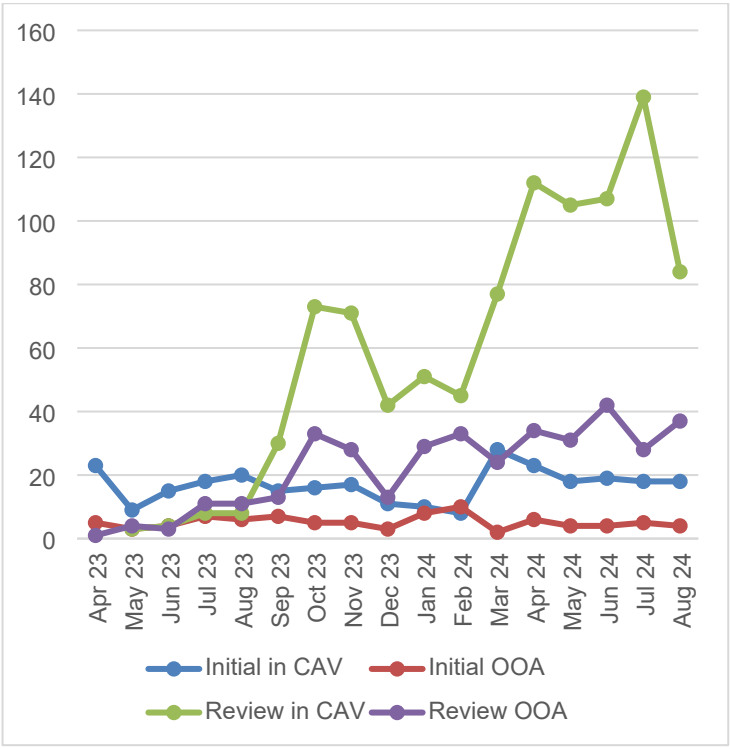
- Nurses are now undertaking all initial and review health assessments for children over 5 (excluding adoptions). Prior to March 2023 medical staff were undertaking all health assessments for children under 10.

- Health Visiting roles now contribute to review Health assessments for the under 5s (excluding adoptions). This is a pilot project with C & V UHB being the first health board in Wales to implement. This will clear the back log of the under 5s Health assessments and ensure they continue to be completed bi-annually as per statutory guidance. The pilot evaluation will be available in October 2024.

- One additional GPwSI session delivering initial Health Assessments for under 5's since April 2024.

The graphs below demonstrate the increase in Heath Assessments undertaken, both within Cardiff and Vale and for those children placed out of area.

Graph 2 – Total Health Assessments undertaken in C&V and out of area

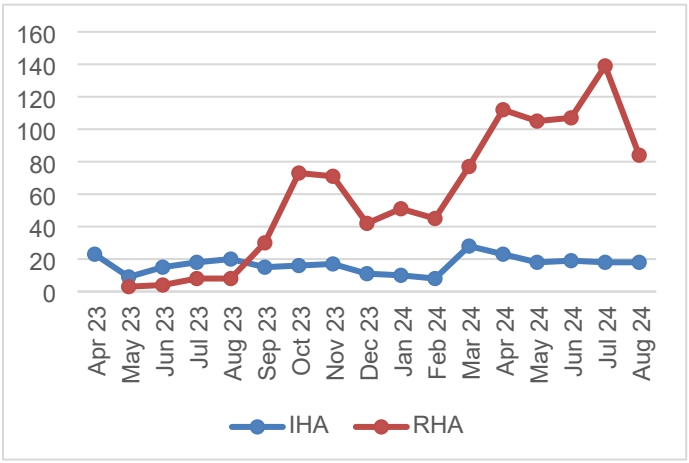


This graph demonstrates the significant increase in the number of assessments both within Cardiff and Vale, and out of area.

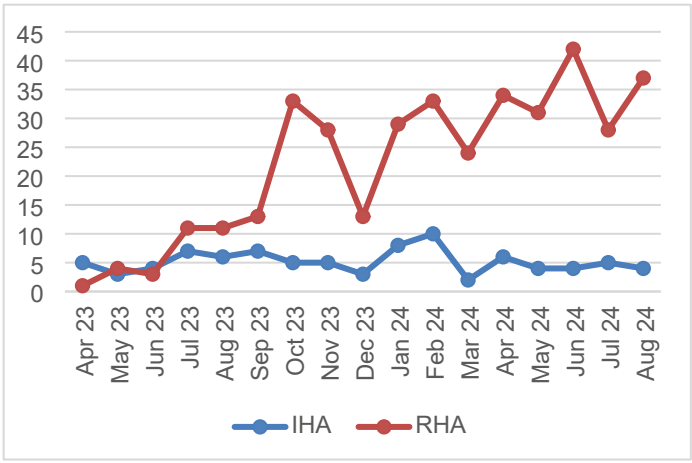
The significant increase in CV is as a result of increasing numbers of specialist nurses, the introduction of heath visitors and an additional medical session.

The increase in assessments being undertaken out of area demonstrates the efforts of the team leader engaging with health boards where children are placed, to ensure a statutory Heath Assessments is undertaken. Whilst the children are placed out of area we maintain responsibility for ensuring the completion of Health Assessments by their host Health Board / Trust.

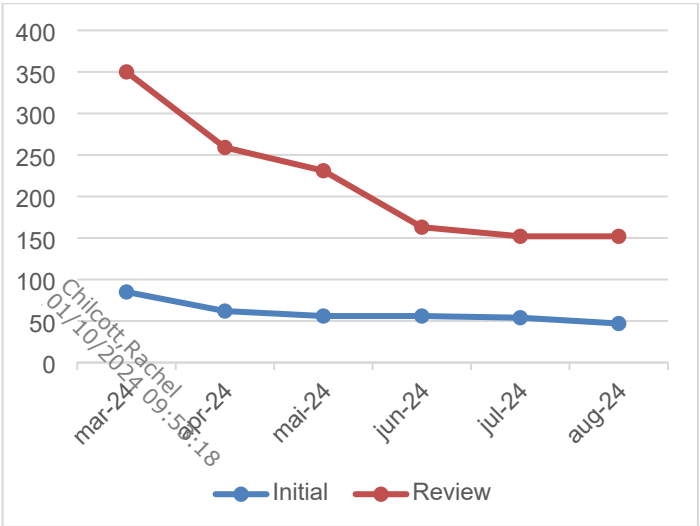
Graph 3 - Assessments undertaken in C&V



Graph 4 – Assessments undertaken out of area



Graph Number Health Assessments outstanding March 24 to August24

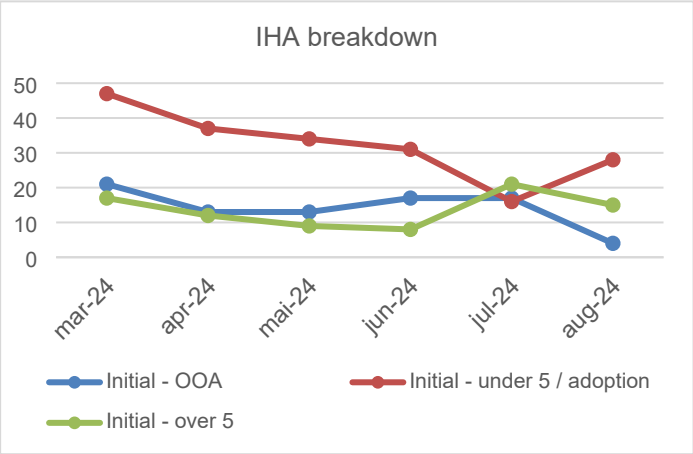


This graph demonstrates the significant improvement in the number of children looked after awaiting a health assessment.

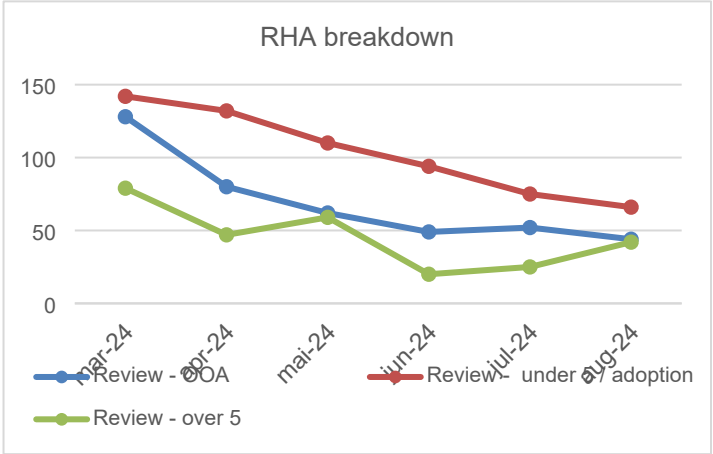
Initial – reduction from 85 in February 2024 to 47 in August 24.
Review - reduction from 350 in February 2024 to 152 in August 24.

The graphs below break this backlog down between, children placed out of area (undertaken but health board / Trust placed in), children under 5 or on adoption pathway (medical staff) and children over 5 (nursing and health visiting).

Graph 6 – Backlog of initial assessments



Graph 7 – Backlog of review assessments



Whilst there has been a significant improvement in the numbers waiting, meeting these regulations continues to be a challenge in the under 5 and adoption population due the small medical workforce.

All appropriate health assessments have been allocated nurses and health visitors in order for medical staff to focus on under 5 IHA and adoptions. There is limited capacity for medical advisors.

In addition to the demand and capacity gap the increase in the number of children looked after has resulted in nurses and health visitors carrying significant numbers of children on their caseload, in excess of the recommended 100 (nurses) and 75 (health visitors). Based on the current caseloads this require an additional 3 WTE nurses and 1.00 WTE Health Visitor.

Impact of PARIS development

A new module for CLA has been developed within PARIS. Processes have been digitised to maximise capacity of clinicians and resources and enable more effective reporting, audit and analysis across the service.

This will streamline clinicians reporting time, releasing capacity to increase face to face support and assessments.

This update has also enabled the Health Board to recover costs associated with health services for those children placed into the region from elsewhere. This is in line with other Health Boards charging C&V.

Impact on Enfys

Enfys is commissioned to provide support to those under the care of either Cardiff or Vale of Glamorgan Children's Services. Enfys is a Dyadic Developmental Psychotherapy (DDP) informed, specialist service consisting of psychology and occupational therapy. Enfys works directly and indirectly with young people and the systems around them. Enfys' dominant population group is children looked after, it also supports adoption services and families, children on the edge of care and provides consultation into health and mental health services within the NHS.

This team has a small baseline budget with expansion in recent years being funded by Cardiff and Vale Local Authority, and Regional Integration Funds (RIF) through the Regional Partnership Board (RPB).

It is widely acknowledged that children who have been in care and adopted are more likely to have experienced and continue to experience developmental trauma.

Statistics have consistently shown that there is an increasing demand for therapeutic support to the families and the system around the family (i.e., social workers, other professionals, education sector). Locally, this demand is being reflected directly in the increased request for support from Enfys and more noticeably in the rising cost of outsourced work. In addition to the increase in demand there has been a change in process for the therapeutic requests for adopted children. To note much of this work is Court directed.

The table below demonstrates the increase in costs by Local Authority. These costs reflect 50% contribution to costs.

	2021/22 £ '000	**2022/23 £ '000**	**2023/24 £ '000**
Cardiff	32	39	85
Vale	21	40	35
Total	**53**	**79**	**119**

SUMMARY OF IMPACT

- CLA specialist nurses appointed will undertake all Health Assessments for all children over 5. This has increased capacity and reduced the numbers waiting.
- Health Visitors appointed undertake review Health Assessments for all children under 5. This has increased capacity and reduced the numbers waiting.
- Additional medical capacity in April 24 has reduced backlog for under 5s. This will increase further in November 24 when medical staff returns from maternity leave.
- A new digitalised system will release capacity to increase direct work with the children and young people.

FURTHER ACTIONS TO CONSIDER / COMPLETE

- Currently reviewing role of medical advisor to increase capacity to undertake assessments for children on the adoption pathway.
- Consideration of skill mix of band 4s to support the nurses with follow ups and non Health Assessment work
- The current evaluation of the Health Visitors is indicating caseloads are high and unmanageable. Skill mix of Band 4s is also being considered to support Health Visitors in line with specialist nursing. Pilot evaluation will be completed in October.
- Assessment forms currently being reviewed on a National level. Lead Consultant for fostering adoption sits on the national group as part of the Public Health Role. These new forms are likely to improve information sharing at point of referral. The forms will also include a section on consent which will also speed up the process and remove some time delays in undertaking assessments. This National work was due for completion in January 2024, but has encountered delays. It is expected these will be available early 2025.
- Review use of outsourcing for therapeutic support in conjunction with Local Authorities to explore the opportunity to employ staff to reduce costs across the region.

Recommendation:

The Board / Committee are requested to note the content of the paper and the actions taken to mitigate the risks associated child health assessments.

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
This has been risk assessed and entered onto the Risk Register
Safety: Yes
In the main body of the report
Financial: Yes
Immediate financial risk has been mitigated by redirecting resource to CLA service due to risk being held.
Workforce: Yes
Detailed in body of the report
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation:No

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

Report Title:	Blood Component Transfusion Policy			Agenda Item no.	3.1
Meeting:	QSE	Public	X	Meeting Date:	27.08.2024
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Executive Medical Director				
Report Author (Title):	Transfusion Practitioner				

Main Report
Background and current situation:

This is an updated version of the current Transfusion Policy, with the data being reviewed and updated. The integrity and commitment of the policy remains unchanged. This document has been reviewed and approved by the Hospital Transfusion Group. This policy is also supported by the Transfusion Procedure, which is a comprehensive guide regarding how to undertake safe transfusion practice within Cardiff and Vale UHB.

Recommendation:

The Committee is requested to:

a) Review the Blood Component Transfusion Policy and ratify.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "X" in the relevant box below ***(this section must be completed)***

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	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 place an "X" in the relevant box below ***(this section must be completed)***

Prevention		Long term		Integration	X	Collaboration		Involvement	

Impact Assessment:
Please state yes or no for each category. ***If yes please provide further details. This section must be completed***

Risk: Yes/No

The risks associated with transfusions are well documented. Appropriateness of transfusion and the exploration of alternatives should be considered prior to any transfusion being authorized. Testing of blood components is carried out through the Welsh Blood Service. Both the blood Transfusion Laboratory and WBS comply with the Blood Safety and Quality Regulation (BSQR 2005).

Safety: No

Financial: No

There are no financial implications associated with this policy.	
Workforce: No	
Legal: No	
Reputational: No	
Socio Economic: Yes/No	
This policy applies irrespective of low income of any individual concerned.	
Equality and Health: Yes/No	
Addressed in the main body of the policy.	
Decarbonisation: n/a	
Approval/Scrutiny Route: ***Please insert any previous meetings where this paper has been received***	
Committee/Group/Exec	Date:

Reference Number: UHB 068 **Version Number: 4**	**Date of Next Review:** 07/03/2027 **Previous Trust/LHB Reference Number:** UHB 068

Blood Component Transfusion Policy

Policy Statement

Donated blood is an essential adjunct to health care but is also a limited resource. It is increasingly expensive, subject to public health concerns and can present a source of risk for patients (namely, the risk of 'wrong blood/component transfused' incidents, as reported to the Serious Hazards of Transfusion scheme (SHOT) as being the most commonly occurring adverse incident of blood/component transfusion).

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we are committed to the lawful, safe and appropriate administration of blood/components according to current law, national guidelines and regulatory requirements, and to the maintenance of patient information in accordance with the Data Protection Act 2018. The UHB is also committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate against individuals or groups.

The policy applies to all UHB staff and patients involved at any stage in the process of blood/component transfusion and is applicable to both children and adults. A copy of the policy will be issued by the Blood Transfusion Laboratory Manager with the Technical Service Level Agreement(s) held between the UHB and relevant third parties.

Policy Commitment

We will ensure

- The organisation supports and promotes quality within the field of transfusion both in the BTL and clinical environments. This includes the reporting of incidents, accidents and near misses in relation to transfusion, the investigation of their cause and the implementation of corrective and preventative actions.
- That the health care professionals it employs are informed of, and have access to, UHB policies on blood transfusion and have received the appropriate training and competency assessment relevant to their scope of practice.
- Prudent Health Care includes encouraging clinical staff to consider the appropriateness of transfusion and to explore alternatives while minimising avoidable risks of transfusions by providing clarity to the critical points of the process including appropriate consent Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production; Care for those with the greatest health need first, making the most effective use of all skills and resources; Do only what is needed, no more, no less; and do no harm. Reduce inappropriate variation using evidence-based practices consistently and

transparently.

- The Blood Transfusion Laboratory (BTL) has a robust Quality Management System (QMS) which complies with the Blood Safety and Quality Regulations (BSQR) (SI 2005 No. 50 as amended)

Supporting Procedures and Written Control Documents

This Policy is supported by one procedure

- UHB Transfusion Procedure

This describes the following with regard to safe and appropriate use of blood components:

- Request of Blood Components
- Blood Transfusion Samples
- Sample Acceptance
- Testing
- Component Selection
- Labelling
- Collection
- Prescription/Authorisation
- Administration

Other supporting documents include:
Provision of Intra-Operative Cell Salvage Policy (UHB030)
Blood Shortage Planning Procedure (UHB 285)
Consent to Examination or Treatment Policy (UHB 100)
Labelling of specimens submitted to Medical Laboratories Policy (UHB 017)

Scope
The policy applies to all UHB staff in all locations including those with honorary contracts involved at any stage in the process of blood/component transfusion and is applicable to both children and adults

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

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	UHB Transfusion Group
Accountable Executive or Clinical Board Director	Divisional Director Clinical Diagnostics and Therapeutics

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.

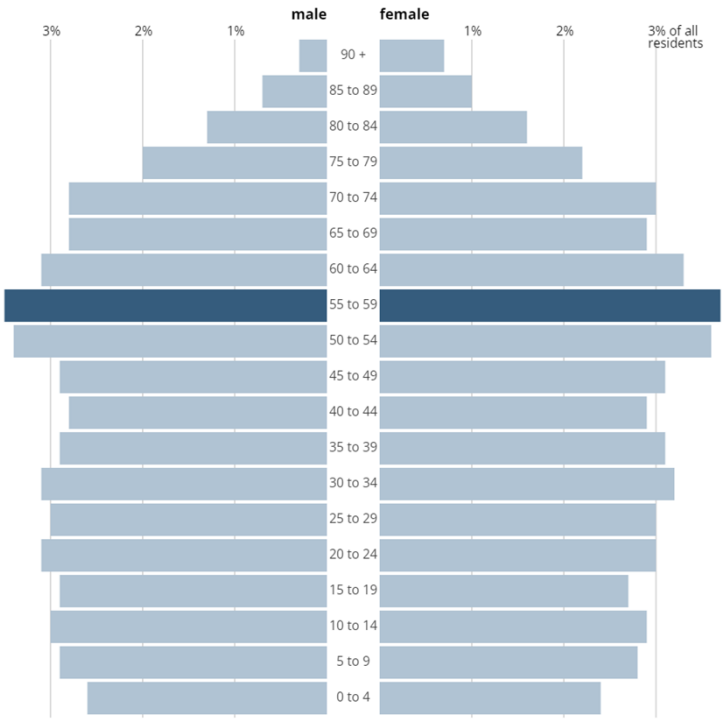
Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	20/09/2009	23/08/11	Incorporates Better Blood Transfusion Practice Blood Safety and Quality Regulations All Wales Zero Tolerance Safer Practice Notices Massive Haemorrhage
2	21/02/2017	23/02/2017	The former policy has been split into two documents: A Policy and procedure. There has been no change to the commitment of the policy
3	09/10/2020	06/04/2021	The previous document has been reviewed and updated. The integrity and commitment of the policy remains.
4	08/03/2024	TBC	The previous document has been reviewed and updated. The integrity and commitment of the policy remains.

Equality & Health Impact Assessment for

Blood Component Transfusion Policy

1	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Blood Component Transfusion Policy Reference number UHB 068
2	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Clinical Diagnostics and Therapeutic Services [Haematology] Dr Andrew Goringe Ext 42033
3	Objectives of strategy/ policy/ plan/ procedure/ service	The objectives of this policy and associated procedure are to provide a rational and practical framework on which to maximise patient safety during blood/component transfusion by: • Assisting clinical staff to minimise avoidable risks of transfusions by providing clarity to the critical points of the process, namely pre-transfusion blood sampling, removal of blood components from blood fridges including Blood Track, transfer of blood components across clinical areas (including to satellite fridges) and administration of blood components. An understanding of the policy will provide the basis of knowledge required to comply with the National Patient Safety Agency (NPSA) (2008) Safer Practice Notice (SPN) 14 Right Patient Right Blood. • Managing, investigating and reporting adverse events and reactions. • Encouraging clinical staff to consider the appropriateness of transfusion and to explore alternatives. • Promoting safer transfusion as part of clinical governance responsibilities and highlighting Good Manufacturing Practice (GMP) and the organisation's regulatory responsibilities.
4	Evidence and background information considered. For example • population data • staff and service user's data, as applicable	Cardiff and Vale University Health Board is one of the largest NHS organisations in Europe. Employing approximately 14,500 staff and spending around £1.4 billion every year on providing health and wellbeing services to a population of around 472,400 people living in Cardiff and the Vale of Glamorgan. We also serve a wider population across

	• 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	South and Mid Wales for a range of specialities. As of 2022, Cardiff is the most densely populated area of Wales. In Cardiff, the population size has increased by 4.7%, from around 346,100 in 2011 to 372,400 in 2022. Nearby areas like the Vale of Glamorgan have seen their populations increase by 4.3% to 133,492, The average age of people in both Cardiff and the Vale is increasing steadily, with a projected increase in people aged 85 and over in the Vale is 20% over the next 5 years and nearly 50% over 10 years. Cardiff has one of the most ethnically diverse populations in Wales, with one in five people from a black or minority ethnic (BME) background. 'White other' and Indian ethnicities are the second and third most common ethnic groups after White British. There are an increasing number of people in our area with diabetes, as well as more people with dementia as the population ages. The number of people with more than one long-term illness is increasing.  The graph above indicates the population of Cardiff change. Office of National statistic census 2021. Cardiff population change, Census 2021 – ONS The UHB's usual arrangement with regard to consultation

		was followed (i.e. 28 days on the intranet). As part of good practice, other policies from different organisations were considered. • Stakeholders were not engaged in the EHIA and/or policy development. • Blood Safety and Quality Regulations 2005 (SI 50) • The Blood Safety and Quality (Amendment) Regulations 2006 (S I 2013) • British Committee for Standards in Haematology [BCSH] guidelines for Transfusion • National Patient Safety Agency [NPSA] Safer Practice Notices/Rapid Response Notices • Serious Hazards of Transfusion [SHOT] the UK independent, professionally led haemovigilance scheme has been considered in this policy. • Advisory Committee on the Safety of Blood, Tissue and Organs [SaBTO] guidelines have been considered in this policy • Blood Health National Oversight Group (BHNOG)
5	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The policy applies to all UHB staff involved at any stage in the process of blood/component transfusion and is applicable to both children and adults. A copy of the policy will be issued by the Blood Transfusion Laboratory Manager with the Technical Service Level Agreement(s) held between the UHB and relevant third parties

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Refer 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	No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of age.	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	This policy applies to all employees and organisational partners (e.g. our contractors, suppliers and joint venture partners) when undertaking services for, or on behalf of CVUHB. The policy applies equally to physical and emotional wellbeing.	Copies of the policy can be made available in alternate formats (e.g. electronic or paper copies).	Specific policies and procedures exist to account for all disability groups and the necessity to make reasonable adjustments accounted for. Examples include potential protected disability characteristics through the wellbeing policy and safe access through normal and emergency situations in the fire safety policy.

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. Refer to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There appears not to be any impact on staff regarding gender. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of gender. Guidelines for The Use of Group O Rh D Negative Red Cells is followed	N/A	Policy put out for consultation within the organisation and ratified by Transfusion Group
6.4 People who are married or who have a civil partner.	This policy applies irrespective of whether individuals are married, in civil partnership or not. There appears not to be any impact. No documented evidence found from the assessment review of the information available on the date the search was performed to		Policy put out for consultation within the organisation and ratified by Transfusion Group

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. Refer to where the mitigation is included in the document, as appropriate
	suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of sexual orientation. Stonewall and Terrance Higgins Trust websites accessed and no evidence found.		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	This policy applies irrespective of whether individuals are on maternity leave or have recently had a baby. There appears not to be any impact.		This is covered in the UHB Maternity Procedure which requires managers to complete a Maternity Risk Assessment for pregnant employees.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears not to be any impact regarding race, nationality, colour, culture or ethnic origin. No documented evidence found from the assessment review of the information available	Whilst there doesn't appear to be any impact, if a member of staff was known to have difficulties with the written word, good management would dictate that alternative	All departments to be aware of their staff profiles. Policy put out for consultation within the organisation and ratified by Transfusion Group

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. Refer to where the mitigation is included in the document, as appropriate
	on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of race	arrangements be made, such as individual meetings. Members of the public would be supported by staff or family members as appropriate	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is unlikely to be any impact on staff regarding their religion. There is documented evidence in relation to religion, specifically Jehovah Witnesses which is discussed in the Blood Component Transfusion Procedure.	Staff are able to raise any issues with their line manager/Human Resources. There is documented evidence in relation to religion specifically Jehovah Witnesses which is discussed in the Blood Component Transfusion Procedure.	Policy put out for consultation within the organisation and ratified by Transfusion Group
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	This policy applies irrespective of sexual orientation. There appears not to be any impact on staff.		The UHB is committed to equal opportunities and ranked on the Stonewall Index which indicates the UHB is committed to making the workplace LGBT+ friendly in all its policies.
6.9 People who communicate using	Bilingually patient information leaflets	The policy prompts staff to	Policy put out for consultation within the

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. Refer to where the mitigation is included in the document, as appropriate
the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	are available for patients. This is in line with our current Welsh Language Scheme and the future Welsh Language Standards. The leaflets are available in one, the leaflet should be bilingual in one single document English on one side and Welsh on the other side. The aim of the 'active offer' is that staff should ask for the language choice (of either Welsh or English) of the patient. The language choice should then be integrated into the patients' treatment. In other words, the patient could request their treatment be in Welsh. If we are unable to provide a fully Welsh language service for the patient, we should then aim to maximise the coverage of treatment and care in Welsh for them using the staff and resources we	ask patients which language the patient/service users would like to communicate in, either English or Welsh, in line with the 'Active Offer' requirements of the Welsh Governments' More than Just Words Strategy.	organisation and ratified by Transfusion Group

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. Refer to where the mitigation is included in the document, as appropriate
	already have.		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	This policy applies irrespective of the income of the individual concerned. There appears not to be any impact	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact on staff, and this policy has a positive impact on people on low income as the policy is applicable to all people.	N/A	Policy put out for consultation within the organisation and ratified by Transfusion Group
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	People who speak other languages other than Welsh or English will be impacted positively as the policy refers to issues of language accessibility. There are no other groups including Carers or risk factors to consider with regard to this Policy.	There have been new statements regarding language accessibility within the policy	Policy put out for consultation within the organisation and ratified by transfusion Group

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 aim of this policy is to enable blood/components to be transfused safely, in particular to minimise the risk of giving blood/components of the wrong group to a patient in error and to avoid unnecessary transfusion in general. It is based on national multidisciplinary guidelines [(2)] and informed by local experience. Red cells are the most commonly transfused blood component; however, the principles described in the policy apply to all blood components (e.g. platelets and plasma).	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	As a policy, there will be no impact.	N/A	Other procedures exist to cover this, including stress at work and Alcohol and Substance Misuse.
7.3 People in terms of their income and employment	The Cardiff and Vale Health Board staff have a yearly Values Based	To comply with the organisation's regulatory requirements, the	

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
status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Assessment (VBA) where the opportunity to discuss good transfusion practice can be explored for evidence of competency. Assisting clinical staff to minimise avoidable risks of transfusions by providing clarity to the critical points of the process, namely pre-transfusion blood sampling, removal of blood components from blood fridges, transfer of blood components across clinical areas (including to satellite fridges) and administration of blood components. An understanding of the policy will provide the basis of knowledge required to comply with the National Patient Safety Agency (NPSA) (2008) Safer Practice Notice (SPN) 14	Blood Transfusion Laboratory (BTL) must ensure that they have a robust Quality Management System (QMS). The organisation supports and promotes quality within the field of transfusion and the principles must be adhered to both in the BTL and clinical environments. This includes the reporting of incidents, accidents and near misses in relation to transfusion, the investigation of their cause and the implementation of corrective and preventative actions.	

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
	Right Patient Right Blood [3]. Managing, investigating and reporting adverse events and reactions. Encouraging clinical staff to consider the appropriateness of transfusion and to explore alternatives. Promoting safer transfusion as part of clinical governance responsibilities and highlighting Good Manufacturing Practice (GMP) and the organisation's regulatory responsibilities.		
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	For this policy, there will be no impact.		

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
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			
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		Evidentiary record can be seen that the Jehovah Witness committee members have close links with the Transfusion Practitioner team and support patients within the Cardiff and Vale UHB. Representatives from the JW committee frequently attend and present on Link Nurse groups.	

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 Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	This policy has a positive impact by ensuring that the same processes are followed irrespective of macro-economic, environmental or sustainability factors		

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This review of the Transfusion Policy reaffirms the commitment of the senior management team who support the update. The policy aims to ensure the Health Board has appropriate policies, procedures and other written documents to allow it to fulfil its responsibilities. There is an impact on staff whose first language is not English and those of visual impairment. This revision will be rolled out to employees to ensure they are aware of their responsibilities and duties under the policy and confirm their commitment to it. It is assessed that the impact of this policy will be overwhelmingly positive for all employees, patients, carers and service users.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Time scale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy.	Dr Andrew Goringe	1 month	Action in accordance with UHB Employment Policies and Procedures.

	Action	Lead	Time scale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very limited impact identified, unnecessary to undertake a more detailed assessment.	N/A	N/A	

	Action	Lead	Time scale	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). • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	The policy and EHIA have been discussed and agreed by the Hospital Transfusion Team, presented and ratified at Transfusion group. It has been approved by the Transfusion Group, and will continue to be reviewed every 6 months as part of the groups Terms of Reference. When this policy is reviewed, this EHIA will form part of that consultation exercise. The policy will be published on the CVUHB intranet site and made available through SharePoint. The policy and EHIA will be reviewed every three years after ratification unless changes to legislation, or best practice determine that an earlier review is warranted. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).	Dr Andrew Goringe	6 months 3 years	

Report Title:	Request for approval of the 'Development and Approval of UHB Local Procedure Specific Patient Information Leaflets Principles and Framework'			Agenda Item no.	*3.1*
Meeting:	Quality, Safety and Experience Committee	Public	X	Meeting Date:	08.10.24
		Private			
Status *(please tick one only):*	Assurance		Approval X	Information	
Lead Executive:	Executive Medical Director				
Report Author:	MCA Project Lead				

Main Report
Background and current situation:

The Welsh Risk Pool, via the All Wales Consent to Examination Treatment Group, aim to improve patient safety and ensure compliance in relation to the process for sharing information and obtaining informed consent to examination and treatment.

As part of this work, it was identified that health boards would benefit from providing staff with guidance relating to locally produced information leaflets to ensure that they are appropriate for use and meet required standards; as no such guidance currently exists.

The Welsh Risk Pool are clear that EIDO leaflets should be the first source of patient information provided. Where there is no EIDO leaflet available for a specific treatment or procedure then an alternative from a nationally recognised body may be used (e.g. Royal College of Surgeons) and only where neither of these exist should a locally produced leaflet be used; using the attached guidance.

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

The attached guidance has been developed to outline a clear framework for the development of locally produced information leaflets where there is no alternative available from EIDO or a relevant nationally recognized body.
This sets out clear standards of issues to be considered and what information should be included in such patient information leaflets.

Recommendation:

The Committee is requested to:

a) Review the contents of this guidance and consider approval for publication

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "X" in the below boxes as relevant.

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

Five Ways of Working (Sustainable Development Principles) considered *Please place an "**X**" in the below boxes as relevant*									
Prevention	X	Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	X	*Not required*

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 - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES*
Equality and Health: No - *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)*
This procedure supports the UHB's Consent to Examination and Treatment Policy, for which an EHIA has been undertaken, in terms of ensuring that the UHB provides appropriate patient information to support the consent process where there is no EIDO or nationally recognized alternative available.
Decarbonisation: No
Welsh Language: No

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

Reference Number: *TBA unless document for review* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Development and Approval of UHB Local Procedure Specific Patient Information Leaflets Principles and Framework

Introduction and Aim

This guidance aims to set out the principles and framework for the development and approval of Local Procedure Specific Patient Information Leaflets within the UHB, to ensure that they are evidenced based and up to date.

It aims to assist the UHB to comply with its external obligations to meet the standards laid down by Standard 4.2 in the Health and Care Standards for Wales which reinforces the need for people who use health care services to be given information which enables them to make appropriate choices, to make informed decisions about their health and care and which enables them to lead healthier lives.

Objectives

Local Procedure Specific Patient information leaflets where EIDO or nationally recognised alternatives are not available provide particular benefits to enhance the informed consent process and improve patient safety as well as reducing risk for both individual healthcare professionals and the UHB. The particular benefits are;

- Improved communication of the nature of the treatment or procedure as well as risks, benefits and alternatives,
- Standardisation of evidence-based information which is reviewed for readability and meets Welsh Language requirements,
- Clinical teams can agree and develop forms and implement across the Health Board, leading to standardised care delivery across the organisation,
- A standard checklist has been developed at the request of the All Wales Medical Directors Forum to support /inform a local governance framework to develop Local Procedure Specific Patient Information Leaflets for information about procedures, treatments and investigations
- Using Local Procedure Specific Patient Information Leaflets can improve the efficiency of the informed consent process in out-patient clinics or treatment areas so allowing more time for discussion and agreement with patients.

The UHB encourages clinical staff to generate Local Procedure Specific Patient Information Leaflets according to the process set out in this guidance, where this is no EIDO or compliant nationally recognised alternative.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts who are looking to develop Local Procedure Specific Patient Information Leaflets (LPSPIL)

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has not been completed, as this procedure has been developed in support of the Consent to Examination or Treatment Policy.

Reference Number: *TBA unless document for review* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Documents to read alongside this Procedure	Consent to Examination or Treatment Policy, 2023
Approved by	Consent Group

Accountable Executive or Clinical Board Director	Executive Medical Director
Author(s)	Consent Lead
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1		T	New document

Contents

1. ROLES AND RESPONSIBILITIES

Executive responsibility for this procedure lies with the Medical Director.

Clinical Board Directors are responsible for ensuring that staff are aware of this procedure, how to access it and what to do if they have queries about it.

All staff who are involved in the development of Procedure Specific Patient Information leaflets have a responsibility to familiarise themselves with, and follow the content of, this framework and to ensure that they remain up to date with regard to relevant legislation, case law and guidance regarding Consent to Examination or Treatment.

1.1 The Mental Capacity Team/Consent Lead will:

- Ensure that the LPSPIL is compliant with the requirements of this guide namely that the CAVUHB LPSPIL checklist has been adopted
- Keep a register of LPSPIL developed in accordance with this guidance
- Monitor the date that a LPSPIL is due for review
- Archive LPSPIL's that are no longer applicable / in use following a review.

1.2 Specialties

Specialties are responsible for:

- Development and seeking approval and translation of LPSPIL's in accordance with this guidance
- Initiating the review of LPSPIL's
- Conducting the review of LPSPIL' s
- Contacting Medical Illustration in order for them to produce the documentation
- Complying with the framework described in this guidance.

Specialties are responsible for appointing a lead clinician who will identify the necessity for and the development of the LPSPIL

Specialties should at all times endeavour to create a UHB wide LPSPIL in relation to the treatment / procedure. If this is not possible a clear explanation needs to be given when the LPSPIL is submitted to the specialty's relevant Quality and Safety Group for approval.

1.3 Healthcare professionals

Healthcare professionals are responsible for:

- Knowing how to access patient information from the intranet
- Ensuring that their departments keep up to date LPSPILs
- Giving patients LPSPIL's appropriate to their condition and/or treatment and ensuring that the latest version is provided

- Using LPSPIL's to support verbal information given to patients
- Identifying the need to develop LPSPIL's in line with service requirements
- Adhering to this Guidance and to the UHB's Consent to Examination or Treatment Policy.

2. SOURCE OF PATIENT INFORMATION FOR USE WITH ALL WALES CONSENT FORMS AND PROCEDURE SPECIFIC CONSENT FORMS

On 2nd July 2020 the Welsh Risk Pool (WRP) Committee issued a WRP Management Alert, number 2020/01 requiring all Welsh health bodies to use EIDO leaflets, where available, as part of the consent to treatment process. On 3rd December 2020, the Criteria for use of Procedure-specific Patient Information Leaflets following publication of RMA2020-01 was issued.

Therefore, the UHB's first option is the use of EIDO Patient Information documents, which provide detailed information to support and inform consent for specific treatments. They are available on the intranet site to download (EIDO Healthcare (eidosystems.com). These documents will then provide the patient information which is included in the PSCF.

The second option is to use existing nationally produced procedure specific leaflets such as leaflets from the Royal Colleges or Professional Associations, NICE, Cancer Research UK and MacMillan if available

The final option, if there is no EIDO or nationally produced leaflet, is to produce a UHB own patient information leaflet. Such leaflets must be developed in accordance with UHB's guidance for the development of patient information leaflets. The procedure to confirm use of nationally produced patient information leaflets or approval of UHB developed patient information leaflets to the WRP is set out on All Wales Consent to Examination and Treatment Improvement Programme SharePoint page.

3. CHECKLIST FOR WRITING INFORMATION ABOUT PROCEDURES, TREATMENTS AND INVESTIGATIONS

3.1 Local Procedure Specific Patient Information Leaflet Content

The below should be considered and incorporated when developing the local procedure specific patient information leaflet These are not an exhaustive list or designed to provide definitive procedure, and professional judgement within the general scope of this policy must be exercised at all times, as the guidelines may not be appropriate in all contexts. Whilst the procedure refers specifically to patient information leaflets it is also likely to be relevant to other forms of written patient information.

3.1a Checklist for writing information about operations.

- What is the leaflet / document etc about, and who is it for?
- What is the procedure, treatment?
- Why are they having it?
- Do they need a general anaesthetic, sedation or local anaesthetic?
- Include details about intended benefits and significant, unavoidable or frequently occurring risks: during and following the procedure / treatment - Essential
- Indicate that other important (material) risks specific to this patient during and following the procedure / treatment will be discussed with the patient (to be completed at the time that the consent is sought from the patient) - Essential
- Are there any alternatives including no treatment? - Essential
- What preparation do they need or not need?
- Will they be asked to sign a consent form?
- What happens when they arrive at the hospital or the clinic, and who will they meet?
- What does the procedure involve? How long does it last? What does it feel like?
- What happens after the procedure – pain control, nursing checks, stitches etc.
- How long will they stay in hospital?
- Do they need someone with them or any special equipment when they go home?
- What care do they need at home?
- What follow-up care is needed? Do they need to visit their doctor?
- What can go wrong, what signs to look out for and what to do if something goes wrong
- When can they start their normal activities again, for example, driving, sport, sex or work?
- Who can they contact if they have any more questions?
- Tell people where they can find more information, for example, support groups and websites.
-

3.1b Checklist for information about conditions and treatments

- What condition is being described?
- What is the leaflet about, and who is it for?
- What causes it? Or, if the cause is not known, say so.
- Does anything increase the risk, for example, age, sex, ethnic origin or a family history of the condition?
- What are the signs and symptoms?
- Are there any tests or examinations needed to confirm the diagnosis?
- What treatments are available? Give brief descriptions.
- What are the side effects and the Significant, Unavoidable or Frequently
- Occurring risks of getting treatment or not getting treatment?

- Indicate that other important (material) risks specific to this patient during and following the procedure / treatment will be discussed with the patient (to be completed at the time that consent is sought from the patient
- What are the next steps?
- What can patients do for themselves?
- Are there other implications, for example, infecting other people?
- Who can they contact if they have any more questions?
- Say where the patient can find more information, for example, support groups and websites.

Checklist for Producing Patient Information

All patient information should be checked against the following questions before it is sent to the MCA Team/Consent Lead.

Does the patient information include?

1. A title

2. Health Board Trust name and logo

3. Identify the Author

4. Date of production

5. Date for review, maximum of 3 years

6. Statement regarding availability of large print, other formats and languages

7. Contact details for further information

8. Statement that the document is also available in Welsh

Is the patient information?

1. Typed in Arial or non-serif font and 12 pitch

2. Written in plain English using everyday words including consistency of terms and tenses

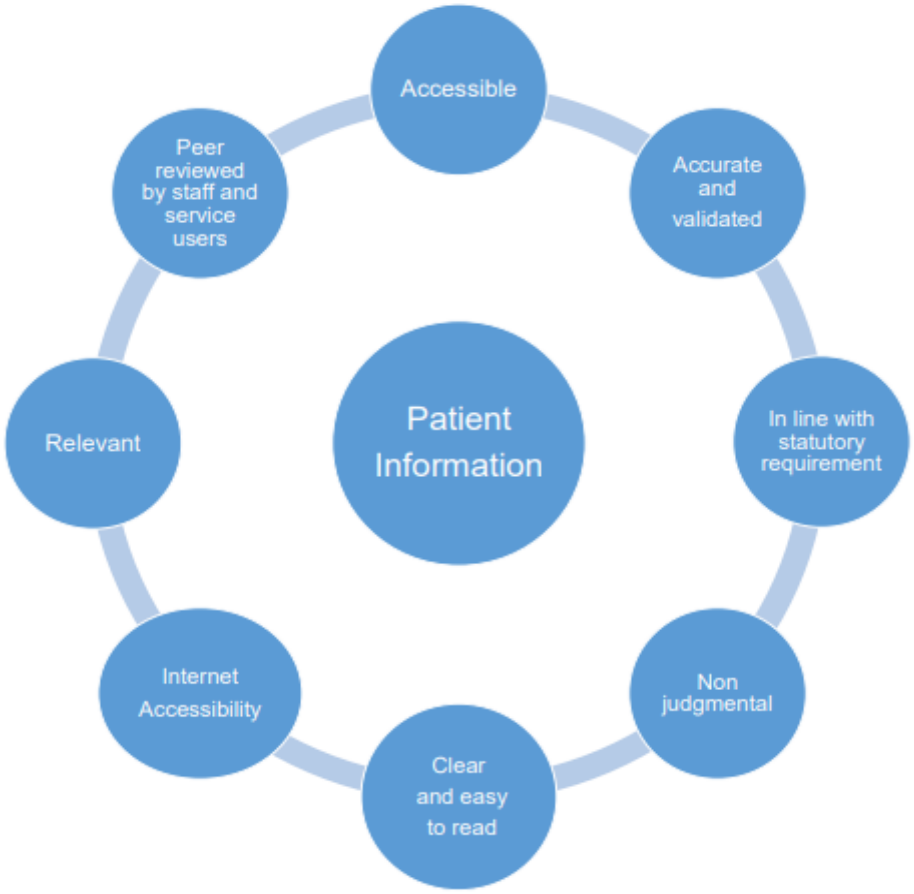
3. Easy to understand (medical terminology explained)

4. Clear - instructions or diagrams easy to understand

Has the patient information been reviewed by a lay-person?

Where possible all information produced for patients, should be shared with a member of that patient population prior to panel, and feedback sought

Figure 1 - Requirements for Service User and Carer Information



Ensure the information is:

- Accessible: The information provided must ensure that our patients, service users and carers are aware of alternative formats of information with the consideration on the Equality Act (2010), Information for People with Sensory Loss (WG, 2013), All Wales Standards for Accessible Communication and the Accessible Information Standards (2017).

- Accurate and Validated: All information must be factual and commensurate with the treatment pathway. If clinical information is included, then this must be approved prior to its inclusion on the panel. The information should provide adequate resources and include further reading in line with the NHS Wales Information Governance Policy (2018).

- Current: All information should be up to date with current policy and legislation in line with GDPR.

- Balanced and Non-judgmental: Allowing our patients, service users and carers to make effective decisions by providing them with relevant and balanced information. The provision of such enables the understanding of the options and choices associated with their treatment, including their side effects and wider implications

- Internet Accessibility: All public sector websites in the UK must comply with WCAG 2.11 AA standards. These standards recommend that all documents housed on websites meet the necessary accessibility checks before being published online. These include clear and simple instructions and the ability to link alternative pages for additional information.

- Relevant: Produce information, which targets its audience, through clear, concise and easy to read formats. Do not include any unnecessary information.

- Peer Reviewed: Relevant professionals, patients and the public representatives should review the information in order to ensure that the information is fit for the purpose which it is intended and that the views of key stakeholders underpin this process. Any BCUHB developed procedure specific patient information leaflet which involves the consent to treatment processes will be passed back to the author to establish if this material already exists on the EIDO Inform TM Download Centre or whether there is a professionally recognised patient information leaflet , which has been produced using a consistent national approach. This may therefore include procedure-specific leaflets from the Royal Colleges or Professional, Associations, NICE, Cancer Research UK and MacMillan.

3.2 The law on consent to treatment

All clinical staff should have regard to the judgement in the case of:
Montgomery –v- Lanarkshire Health Board Montgomery Update &
Supreme Court Update

Following this case, **clinical staff are reminded of their professional responsibility to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments." The test of whether a clinician acted in accordance with a responsible body of medical practitioners (The Bolam Test) should no longer be applied in relation to consent to treatment and clinical staff should move away from the percentage risk of an occurrence as set out in Chester v Afshar.**

Clinical staff must decide what counts as a "material risk" to the patient in question. The test of materiality is fact and patient sensitive. The law defines it as either a risk

to which a reasonable person in the patient's position would be likely to attach significance to or a risk that a doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and consent must be obtained before treatment.

This standard of consent is similar to that required in GMC Guidance – Decision making and Consent – 9th November 2020.

You must give patients clear, accurate and up-to-date information, based on the best available evidence, about the potential benefits and risks of harm of each option, including the option to take no action. You should tailor the discussion to each individual patient, guided by what matters to them, and share information in a way they can understand See GMC Guidelines Decision making and Consent - Consent (sharepoint.com)

Doctors must now be satisfied of all of the following:

- The patient knows about the material risks of the treatment proposed
- The patient knows about reasonable alternatives to this treatment
- He / She has taken reasonable care to ensure that the patient actually understands all this
- Whether any of the exceptions to the duty to disclose apply here

The three exceptions to the duty to disclose are.

- The patient tells the doctor that he or she prefers not to know the risks.
- The doctor reasonably considers that telling the patient something would cause serious harm to the patient's health.
- Consent is not required because the patient requires urgent treatment and is unconscious or lacks capacity.

3.3 Process for developing a new locally produced specific patient information leaflet

(please read in conjunction with Appendix 1)

a) Getting started - Authors must use the All Wales LPSPIL checklist to develop their LPSPIL (Appendix 2).
b) Review of the draft by users – by the relevant specialty's reader panel (stakeholder reference group & virtual editorial panel)
c) Specialty approval –The LPSPIL should then be ratified by the specialty's relevant clinical governance group
d) Final approval – All LPSPIL's should be sent to the Consent Lead for review and taken to the Consent Group for final ratification
e) Translation – the author or the specialty identified lead Clinician (if different) should contact CAV Welsh translation team via CAV Welsh translation page Alternatively, go to Cardiff Council - Bilingual Cardiff Translation Request
f) Leaflets should be sent to Medical Illustration for design support (this service is free of charge within the UHB)

g) Publication
- Links to both English and Welsh versions of the form should be available on the relevant specialty's SharePoint page
- If it is necessary to have hard copies, request should be made to Medical Illustration for printing to ensure quality and that the most up to date version is provided.
- There may be circumstances when it is necessary to pre-print forms, in bulk, in A4. In this situation, authors should agree this within their specialty. The specialty is responsible for all printing costs.

3.4 Archive

All forms that are out of date and which have been superseded by a newer version will be archived by the Consent Lead A copy of each form will be archived including a copy of any revised forms which may be electronic or paper copies. Copies of revised forms will be retained in line with the Health Board's Record Management Policy.

3.5 Review

The LPSPIL should be reviewed by the relevant specialty every three years following the publication date or earlier in light of new evidence / information. It is the specialty's responsibility to ensure that this is done.

Any errors in the LPSPIL should be recorded and corrected by the author before being sent for review at the specialty's relevant clinical governance group for ratification.

If significant changes are made to the content of the form, the form should be re-sent to the Consent Lead for review, prior to translation.

3.6 Audit

Audit of LPSPILs is required in order to ensure that the documents developed are appropriate and that their development is compliant with this guidance. Clinical audit of the use and completion of the LPSPIL should be undertaken by the relevant specialty.

4. EQUALITY INCLUDING WELSH LANGUAGE

An Equality Impact Assessment has not been carried out as this procedure has been developed in support of the UHB's Consent to Examination or Treatment Policy. There is no evidence that the Consent Policy adversely affects any of the equalities groups and it is neither directly nor indirectly discriminatory under the equalities legislation.

When producing a LPSPIL, authors will need to consider the needs of different groups of people. These groups will include people whose first language is not English or Welsh and people with sight or learning difficulties. People with learning difficulties may need a healthcare professional to go through the leaflet with them, especially if the leaflet has not been specifically designed for people with learning difficulties. The Mental Capacity Act 2005 requires clinicians to optimise every patient's ability to make decisions.

The UHB is committed to providing information to patients in a range of formats i.e. other languages, easy read and other formats (including audio).

The guidance advises on use of the Welsh Language where appropriate. The PSCF template has been designed to be bilingual, thus supporting the taking of consent in the Welsh language.

5. TRAINING

All Staff developing LPSPIL's and seeking consent from patients should undertake Consent training. This is available through ESR via the NHS Wales Consent to Examination and Treatment E-learning Programme and classroom sessions provided by the Mental Capacity Team/ Consent Lead.
It is recommended that relevant staff undertake Consent training once within each revalidation cycle.

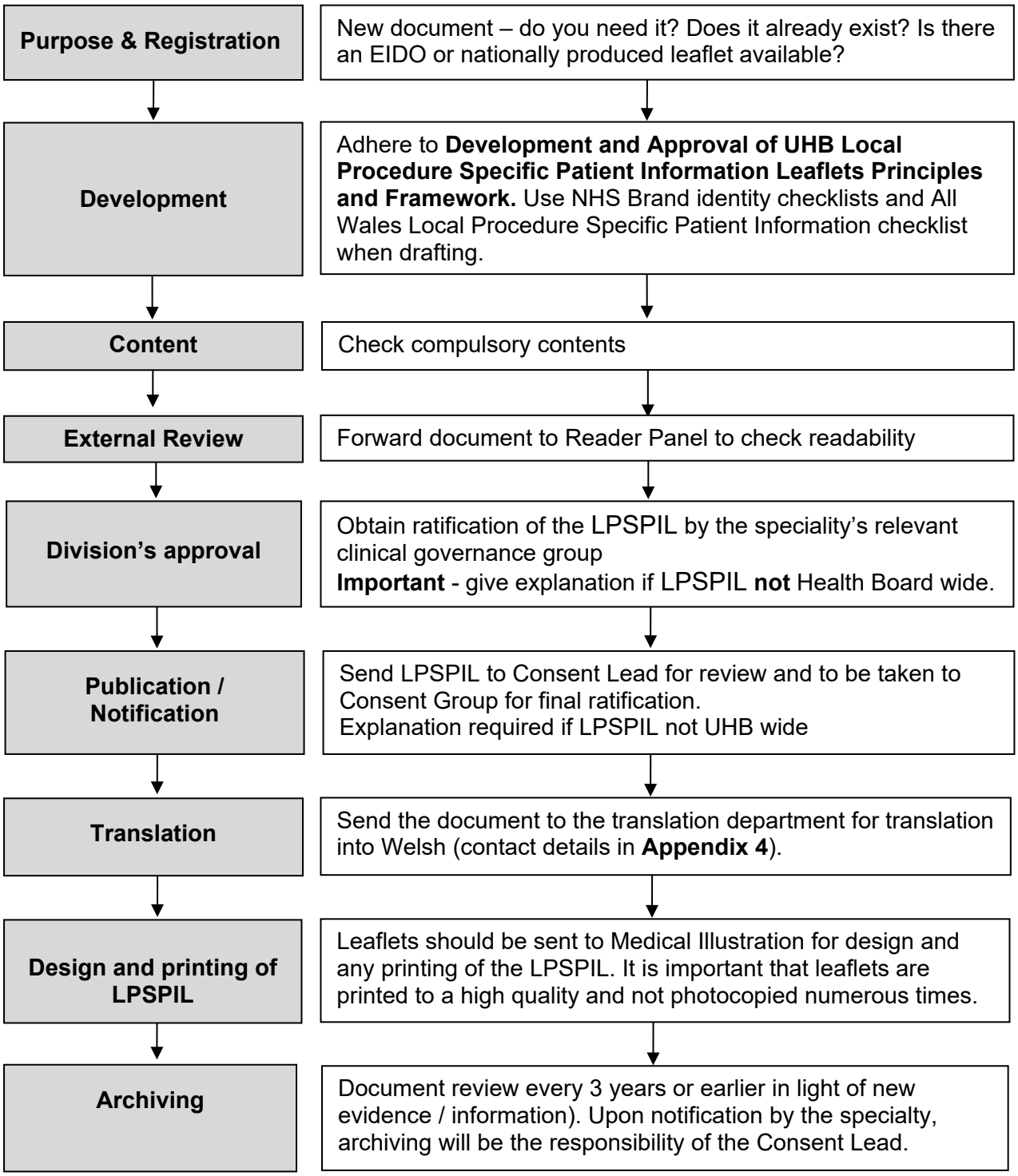
6. DISTRIBUTION

This procedure will be made available on the UHB's SharePoint site.

7. REVIEW OF THIS GUIDANCE

This procedure will be reviewed every three years or sooner if appropriate.

Example Appendix 1 – Locally produced specific patient information leaflet: Summary of Process



Appendix 2

Rhaglen Cydsynio i Driniaeth Cymru Gyfan

All Wales Consent to Treatment Programme

Example checklist - Local Procedure Specific Patient Information to be used in the consent to examination and treatment process

This checklist has been developed at the request of the All Wales Medical Directors Forum to support / inform a local governance framework to develop local procedure specific patient information where there is no appropriate EIDO leaflet or compliant nationally recognised alternative.

The following checklist provides a list of possible subheadings that you should consider when developing written patient information. This is not an exhaustive list and professional judgement within the general scope of this guidance must be exercised at all times, as the information may not be appropriate in all contexts.

Checklist for writing information about procedures, treatments and investigations

- What is the leaflet / document etc about, and who is it for?
- What is the procedure, treatment or investigation?
- Why are they having it?
- Do they need a general anaesthetic, sedation or local anaesthetic?
- Include details about intended benefits and significant, unavoidable or frequently occurring risks: during and following the procedure / treatment - **Essential**
- Indicate that other important (material) risks specific to this patient during and following the procedure / treatment will be discussed with the patient (to be completed at the time that the consent is sought from the patient) - **Essential**
- Are there any alternatives including no treatment? - **Essential**
- What preparation do they need or not need?
- Will they be asked to sign a consent form?
- What happens when they arrive at the hospital or the clinic, and who will they meet?
- What does the procedure involve? How long does it last? What does it feel like?
- What happens after the procedure – pain control, nursing checks, stitches etc.
- How long will they stay in hospital?

- Do they need someone with them or any special equipment when they go home?
- What care do they need at home?
- What follow-up care is needed? Do they need to visit their doctor?
- What can go wrong, what signs to look out for and what to do if something goes wrong.
- When can they start their normal activities again, for example, driving, sport, sex or work?
- Who can they contact if they have any more questions?
- Tell people where they can find more information, for example, support groups and websites

Appendix 3

Guidance to health professionals

(to be read in conjunction with the Consent Policy)

The form should act as an *aide-memoire* to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. **In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.**

The law on consent

See the Welsh Government's Reference *guide to consent for examination or treatment* (www.wales.nhs.uk/consent).

Provision of Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds.

The patient should be informed about important (material) risks. Materiality is whether, in the circumstances of the particular case

- **A reasonable person in the patient's position would be likely to attach significance to the risk, or**
- **The doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.**
-

Health professionals should make a record of the information given. Further advice is given in the GMC guidance on consent.

You should always answer questions honestly. If there is insufficient space on the consent form to include all the details discussed, these should be documented in full in the patient's notes.

Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. To give valid consent the patient needs to understand in broad terms the nature and purpose of the procedure. Where information is refused, you should document this on the form or in the patient's notes.

Appendix 4

Canllaw i staff proffesiynol iechyd

(i'w ddarllen ar y cyd â'r Polisi Cydsynio)

Beth yw pwrpas ffurflen gydsynio?

Mae'r ffurflen hon yn dogfennu cytundeb y claf i fynd ymlaen â'r archwiliad neu driniaeth rydych chi wedi'i gynnig/chynnig. Nid yw'n hawlildiad cyfreithiol – os na fydd cleifion, er enghraifft, yn cael digon o wybodaeth i seilio eu penderfyniad arni, mae'n bosibl na fydd y cydsyniad yn ddilys, er bod y ffurflen wedi cael ei llofnodi. Mae gan gleifion hefyd yr hawl i newid eu meddwl ar ôl llofnodi'r ffurflen (cyn belled bod yr unigolyn yn parhau i fod â'r gallu meddyliol i wneud y penderfyniad hwn). Os bydd y claf wedi colli galluedd meddyliol cyn i'r driniaeth ddechrau, dylai gweithwyr iechyd proffesiynol ystyried a yw'r driniaeth er ei fudd neu beidio.

Dylai'r ffurflen fod yn *gymorth cof* i weithwyr iechyd proffesiynol a chleifion, trwy ddarparu rhestr wirio o'r math o wybodaeth dylid ei chynnig i gleifion, a thrwy alluogi'r claf i gael cofnod ysgrifenedig o'r prif bwyntiau a drafodwyd. **Fodd bynnag, ni ddylid ystyried yr wybodaeth ysgrifenedig mewn unrhyw ffordd fel rhywbeth sy'n cymryd lle trafodaethau wyneb-yn-wyneb â'r claf.**

Dim ond dan amgylchiadau clinigol penodol ddylai staff proffesiynol iechyd dderbyn cydsyniad, yn dilyn ymgymryd â hyfforddiant ffurfiol, gan gynnwys cydsynio a gallu meddyliol a'u bod wedi'u hasesu'n alluog. Dylent gyfarwyddo eu hunain gydag unrhyw ganllaw proffesiynol priodol, polisi cydsynio'u sefydliad a chanllaw Llywodraeth Cymru ar gydsynio.

Y gyfraith ar gydsyniad

Gweler canllaw Cyfeirio *Llywodraeth Cymru at gydsyniad ar gyfer archwiliad neu driniaeth*). http://www.wales.nhs.uk/sitesplus/documents/1064/Welsh%20Government%20Guide%20to%20Consent%20for%20Examination%20or%20Treatment%20%28July%202017%29.pdf

Darparu Gwybodaeth

Mae gwybodaeth am yr hyn bydd y driniaeth yn ei chynnwys, ei buddion a'i risgiau (gan gynnwys sgîl-effeithiau a chymhlethdodau) a'r dewisiadau amgen i'r weithdrefn benodol a gynigiwyd, yn hanfodol i gleifion wrth iddyn nhw wneud penderfyniad.

Dylid hysbysu'r claf am risgiau (perthnasol) pwysig. Mae perthnasedd yn golygu, dan amgylchiadau'r achos dan sylw

- **Byddai unigolyn rhesymol yn sefyllfa'r claf yn debygol o allu cysylltu arwyddocâd i'r risg, neu**
- **Dylai/mae'r meddyg yn rhesymol ymwybodol bod y claf penodol yn debygol o allu cysylltu arwyddocâd iddo.**

Dylai staff proffesiynol gofnodi'r wybodaeth a roddwyd. Rhoddir cyngor pellach yng nghanllawiau'r GMC ar gydsyniad.

Dylech bob amser ateb cwestiynau'n onest. Os nad oes digon o le ar y ffurflen gydsynio i gynnwys yr holl fanylion a drafodwyd, dylid eu dogfennu'n llawn yn nodiadau'r claf.

Weithiau, bydd cleifion yn mynegi'n glir nad ydyn nhw eisiau cael unrhyw wybodaeth am yr opsiynau, ond eisiau i chi benderfynu ar eu rhan. Mewn achosion fel hyn, dylech wneud eich gorau i sicrhau bod y claf yn cael gwybodaeth sylfaenol iawn o leiaf am yr hyn a gynigir.

Er mwyn rhoi cydsyniad dilys, mae angen i'r claf ddeall natur a phwrpas y weithdrefn yn gyffredinol. Pan fydd claf yn gwrthod gwybodaeth, dylech ddogfennu hyn ar y ffurflen neu yn nodiadau'r claf.

Appendix 5 - Contact Details

Consent Lead, Safeguarding - Tel: 029 2183 2001

Head of Corporate Governance - Tel: 029 21836691

Appendix 6- Approval of UHB Local Procedure Specific Patient Information Leaflets (Form to be sent with final version of Local Procedure Specific Information Leaflet)

Title of Document	
Name of Lead Clinician (identified by specialty – *responsible for clinical information content*) Base: Phone Number: Email: Signature:	
Name of main author (if different to above): Base: Phone Number: Email:	
Reader Panel Approved	Date
EIDO Healthcare Patient Information Leaflet title and document reference / Nationally recognised Patient Information Leaflet document title / Health Board developed leaflet (If applicable). Please provide link / attach the relevant leaflet here:	
Does the LPSPIL apply Health Board wide? **If no, please explain why**	Yes / No
Attach minutes of the relevant Clinical Governance Group ratifying the LPSPIL here	Date of meeting:
Attach electronic version of the LPSPIL here	
Review Date:	

This form should be forwarded to the Consent Lead at: mca-lps.cav@wales.nhs.uk

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 23rd April 2024 at 8.30am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board
Catherine Wood	CW	Director of Operations, C&W Clinical Board
Abigail Holmes	AH	Director of Midwifery & Neonatal Services, C&W Clinical Board
Alison Lewis	AL	Patient Safety Facilitator
Rachael Sykes	RS	Asst Head of Health & Safety
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Lois Mortimer	LM	Head of Midwifery/Directorate Lead Nurse, O&G Directorate
Gareth Saunders	GS	Fire Safety Advisor
Laura McLaughlin	LMc	Risk Manager, O&G Directorate
Jane Jones	JJ	Clinical Director, CYPFHS Directorate
Janice Aspinall	JA	Lead Staff Side H&S Representative
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Paula Davies	PD	Lead Nurse, CYPFHS Directorate
Anthony Lewis	AL	Clinical Board Pharmacist
Samuel Barrett	SB	General Manager, CHFW Directorate
Kylie Hart	KHart	Clinical Governance & Risk Lead Nurse, Neonatal Services
Sandeep Hemmadi	SH	Clinical Board Director, C&W Clinical Board
Hannah McLoughlin	HM	Clinical Governance & Risk Lead Midwife, O&G Directorate
Siwan Jones	SJ	Clinical Nurse Specialist, Infection Prevention & Control
Debbie Jones	DJ	Deputy Head of Quality Assurance and Clinical Effectiveness Lead
Nia Evans	NE	Associate Clinical Nurse Specialist, Infection Prevention & Control
Becci Ingram	BI	General Manager, CYPFHS Directorate
In Attendance		
Kirsty Hook	KHook	Risk, Governance & Patient Experience Facilitator, C&W Clinical Board
Ian Morris	IM	Consultant Neonatologist, CHFW Directorate
Rebecca Pocket	RP	Senior Nurse, Neonatal Services, CHFW Directorate
Apologies:		

Item No	Agenda Item	Action
CWQSE/ 2024/055	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2024/056	**Apologies for Absence** No apologies have been received for this meeting.	
CWQSE/ 2024/057	**Minutes of the previous Q&S Meeting held on 27th February 2024**	

	The minutes of the meeting held on 27th February 2024 were agreed to be an accurate record. **The CWQSE resolved:** a) The minutes were noted	
CWQSE/ 2024/058	**1.4 To note and update the latest action log (from AMaT System)** The action log is now available via AMAT for live updates to be provided. Outstanding actions from the last meeting were noted. Requests were made for the action log to be updated via the AMaT system following the meeting. **Thematic Reviews of Datix Incidents – ACH** Work is ongoing with the team to commence the review. Further update will be provided once complete. **PSLR – AR – Datix** PSLR has been completed, and report can now be shared with the family. **Sodium Valproate** Meetings to take place with the consultant teams to ensure that this is completed. Further update to be provided when complete. **Safeguarding Level 3 Training** Discussions are ongoing and work is ongoing to address the compliance requirements for level 3 training. It was noted that other options are being explored in terms of medical staff compliance, as some do level 3 training external to the organisation and exploring how this can be fed through in terms of compliance and record keeping. **MHRA Bed Rails - CHFW** Meeting has taken place with Medstrom. The risk has been added to the risk register as the current rating is noted at 20. A Trial bed from Medstrom is being explored to review if this is an option going forward. Further update to be provided when available. **HSE Inspection** HSE have now closed this however work is ongoing on some of the outstanding actions identified. Risk Assessments from Paediatrics have been completed, and further work required on some other risk assessments, further discussion to take place outside of the meeting. **The CWQSE resolved:** a) Leads to update outstanding actions on AMaT system b) Further update to be provided on any outstanding actions at the next meeting.	**ALL** **ALL**
HEALTH & SAFETY		
CWQSE/ 2024/059	**Annual Health & Safety Plan & Management Review** The Clinical Board are required to develop a H&S Plan. A team's channel has been set up for the Directorates to upload their Directorate plans so that an overarching plan can then be developed. It was agreed that a meeting would be arranged outside of the meeting to go through the requirements in order to progress the development of the Clinical Board plan.	

	The CWQSE resolved: a) Update was noted. b) Meeting to be arranged	**KH**
CWQSE/ 2024/060	**Update from last UHB Operational H&S Meeting** Update was shared with the Directorates following the Operational H&S Meeting. Mandatory training compliance was noted and thanks expressed to all as support and commitment in striving to achieve targets over 80%. World Safety week is happening this week. There is a stall in concourse, which shares some of the work that is being taken forward as part of this week. H&S department will be undertaking annual management reviews which will audited against H&S plans. As this is the first year for development it will be an overview of the current position and the progress being made to develop and further the plans going forward. Tunnel clearance work continues, and all items will be available for collection. Emergency alarms were noted as part of the HSE inspection. There is a need to ensure that all areas are aware of the different alarms and what responses are required, including the need to ensure that there are clear protocols or procedures in place or that need to be developed locally. Deputy fire safety group held on 22nd March. AJONES will be representing the Clinical Board on this forum and will be sharing information as this is circulated. Occupational Health surveillance requirements are being reviewed. Hand arm vibration monitoring action plans are being revisited and any further requirements needed. The following policies and procedures are progressing for approval • IMS-06-03-CAV-PEEP Policy • PEEP procedure • Patient Hoist Sling Examination Procedure • Violent Warning Marker Procedure Discussion ensued with regards to fire safety wardens and it was noted that there is a need to ensure that there is an appropriate number of fire wardens per base, as opposed to services/teams, whilst acknowledging the importance of Fire Safety. It was noted that at a recent Senior Leadership Board there was discussion with regards to the plan for responsibility and co-ordination of requirements and paperwork for Fire Safety across 6 areas within the Health Board. Further discussion is ongoing and information will be shared when available. It was noted that the areas for C&W Clinical Board would be the Children's Hospital for Wales and Women's Unit. Queries were raised with regards to Fire Warden training and it was noted that training is available, dates of which are available on the SharePoint page. **The CWQSE resolved:** a) Update was noted.	

CWQSE/ 2024/061	**H&S Dashboard** The H&S Dashboard was shared for information. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2024/062	**C&W Clinical Board Exception Report – February 2024** The Clinical Board H&S Exception report was noted for information. This report was presented at the last Operational Health & Safety Meeting for noting. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2024/063	**H&S Training DNA Report** The H&S Training DNA report was shared for information. The report outlines a breakdown of the DNA across the Clinical Board of attendance at pre-booked Health & Safety Training. It was noted that there is a need to ensure that the correct competencies are assigned on ESR as this will affect the training compliance. The group were asked to review areas for competency levels, to ensure this is accurate and add as an ongoing action within the H&S annual plans. **The CWQSE resolved:** a) Update was noted. b) Competency levels to be reviewed to ensure accuracy of recording/reporting	**ALL**
CWQSE/ 2024/064	**COSSH Update** COSSH coordinators are in place and there was a request to ensure that areas are updating and monitoring the completion of any outstanding assessment. Discussions are ongoing with regards to the Sypol system used for the assessment and further updates will be provided as this develops. Any issues to be highlighted to the Health & Safety department. Any new substance issues can be highlighted and shared as part of the exception reports. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2024/065	**Fire Safety Update** One fire incident recently reported outside Haematology area. The fire was well managed. 55 unwanted fire signals reported across the Health Board, 19 incidents were stood down by the Fire Safety team. Compliance with risk assessments is at 99% completion. Fire Safety training is at 72.5% and requests were made to encourage attendance to improve compliance across all areas. All were encouraged to increase attendance at Fire Warden Training to help support the management of fire safety across the Clinical Board. Evac training will be run as separate courses and further update will be shared as this develops.	

	The CWQSE resolved: a) Update was noted.	
CWQSE/ 2024/066	**Feedback from H&S Staff Side** There were no specific issues to highlight for this meeting. Support is available for workplace inspections, and work is ongoing to recruit further representatives to support. **The CWQSE resolved:** a) Update was noted.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CWQSE/ 2024/067	**Presentation – Neonatal Mortality Report (2021 Data)** IM was welcomed to the group and provided an update on the 2021 MBBRACE UK Data. This is a national programme that conducts surveillance and investigation of the causes of maternal deaths, stillbirths and infant deaths. The data includes any deaths of babies born in C&V, at or above 24weeks' gestation who died within 28 days of birth. For 2021, 15 babies were included within this criteria. This date is benchmarked against UK level 3 Neonatal Units with surgical provision. It was noted that there were 14 additional deaths that occurred that did not meet criteria. It was noted that internal and other benchmarking databases suggest we are not an outlier for mortality, but consistently higher than average. All deaths undergo clinical review by a senior clinician who has had no or minimal involvement in the care of the infant, using the standardised Perinatal Mortality Review Tool (PMRT). There are four categories: A – No issues with care identified B - Care issues that would have made no difference to the outcome C - Care issues which may have made a difference to the outcome D - Care issues which were likely to have made a difference to the outcome Provisional update was provided on mortality data for 2022/23. For 2022, there were a total of 27 deaths, 15 of which were reported as MBBRACE-UK deaths. The comparison against other Health Boards shows a stabilised mortality rate. It was acknowledged that this data will not be finalised until September for publication. For 2023, acknowledging that is unverified data, 21 deaths were reported, 8 of which are MBBRACE-UK deaths. It was noted that the National Bereavement Care Pathway standards for good bereavement care, the Health Board is significantly behind the gold standard expected in England due to current resources available. It is however anticipated that there will be bereavement nurse support in the near future. An extensive action plan has been developed in conjunction with the Clinical Board and Executive Team. It was noted that there has been good performance across the 2022 National Neonatal Audit Programme (NNAP) which is hoped will have a positive impact in the future. **Key developments 2023/2024**	

	• Move to perinatal governance team, 8a risk lead, 1 session consultant time, review of perinatal meetings • AHPs – dietician (0.6), SALT (0.6), physio (0.6), OT (0.6), infant feeding lead (1.0) • Releasing time to care team – Jan 2024 (focus on infection) • Changes in ward management structure - addition of roles to support patient flow, investment in practice ed team • Periprem (Perinatal optimisation) and ATAIN (Reducing avoidable term admissions) programmes **Key needs** • Nursing workforce / training • Tier 2 and tier 3 medical rota - ? Resident consultants • SPA time – leadership roles • Clarify and implement governance structures – including review need for neonatal CD • AHP further investment • MDT mortality and morbidity processes – bereavement nurse, foetal medicine, paediatric sub-specialities • Cot configuration – greater capacity needed in CAV (ITU beds mainly) – WHSSC ongoing review • Data manager, development of Perinatal dashboard Discussion ensued with regards to the PMRT backlog and it was noted that a plan is in place to review for post 2023 onwards, however there are 45 cases that are pre-2023 which require obstetric/fetal medicine review which will require resolution. It was noted that the death will be reviewed and completed, however the PMR tool cannot be signed off or completed until all specialties have inputted into the document. It was agreed that this would be reviewed to look at a resolution for the pre-2023 cases as soon as possible. AL noted that all MBBRACE cases are now reported as NRI, and it was noted that due to the issues with regards to delays for completing the PMRT process will impact on the NRI closure. KHart noted that where there are cases that are reported to the coroner, until the outcome is complete, the PMRT cannot be completed and closed. Further discussion to take place as to the most appropriate way forward for closure of the NRI element of the process. It was acknowledged that the pressures have been raised on an all Wales basis. Discussion ensued and it was noted that there is duplication and additional pressures in the work that is needing to take place and it was agreed that the process should be looked at to review the best way forward to avoid unnecessary duplication between the PMRT process and NRI process for the same reported cases that meet MBBRACE criteria. DJ noted the C&W National Audit programmes are shared at the Clinical Effectiveness Group also. **The CWQSE resolved:** a) Update was noted. b) Presentation to be shared for information c) Further options to be explored for a plan to address the pre-2023 backlog	**KH** **AH/SH**
CWQSE 2024/068	**Health & Care Standards Directorate QSE Exception Reporting** The detailed report was shared for information and an update was provided on the key highlights from the report. AMAT now being used to provide the Directorate Assurance Reports. Summary	

	report will be provided at the next meeting. Directorates were asked to highlight any high-level risks/issues to the meeting. **CYPFHS Directorate Report** • Identification of reduction in referrals into the Crisis Team since the development of the IHTT team implementation which has had a positive effect • Work has been taking place with Cardiff City Football Club for health promotion specifically with regards to HPV campaign, with information being displayed via social media and at football matches in the anticipation of improving uptake. • Safeguarding Medical incident within St David's Children's Centre. No harm caused, however meeting has been set up with Carl Ball to look at the appropriateness of the area and health and safety requirements. • Digital and electronic record keeping risks with regards to contract being reissued. There is also a longer-term risk associated with Paris 2028 – 2031 and the change to the WIKIS 2 system. It was also noted that the loss of Attend Anywhere will have a significant impact as circa 50% of assessments are undertaken through this platform. Work is ongoing in relation to further options that are being considered, however this is a significant risk for the service. It was agreed that this would be highlighted at the next Clinical Board Executive Performance Review. • Incidents review process is being undertaken and a focus on additional training. • Working in conjunction with Adult Mental Health with regards to an NRI which is now being referred for a Child Practice Review. Learning identified across partnerships. • Significant work undertaken with regards to concerns. The main theme relates to Neurodevelopment Service and work continues to manage the waiting list and review. • Concerns highlighted regarding the transcribing process as this is no longer being supported by GP's in the community. • JICPA Review - Pilot of a local assessment form has been implemented in order to fully understand the challenges within the School Nursing service and assessment of child health needs. This has been shared with Safeguarding and also with local authorities and head teachers. This will be evaluated carefully to fully understand all challenges. • Initial Health Assessments and out of area children backlog work is ongoing. • Standard Operating procedure has been developed for Clinical Records process and comprehensive process in place which has been in partnership with Information Governance for legal requests for records and redaction. • Clinical Lead appointed for Neurodevelopment and a detailed action plan is in place to manage performance. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2024/069	**CHFW Directorate Report** • Paediatric Beds non-compliance against the MHRA requirements. This has been risk assessed and added to the Directorate Risk register. Each patient will receive a bed risk assessment completed whilst bed replacement work continues. • X3 Pressure damage incidents reported. X1 was category 2, x1 category	

	and x1 category 1 device related. All have been appropriately reviewed and none require further investigation. • Overall tendable score 93.1% for March 2024 • Measles outbreak alert has been shared. • Medicines Management - X10 closed Datix, x9 of which were low harm and x9 currently under review. Deep dive has been undertaken to identify any themes. Work being explored with regards to prescription errors and what measures can be implemented to improve. • Safeguarding – work continues with regards to level 3 safeguarding training, noting capacity restraints. • X2 RIDDORS reported over the last month, and meetings have taken place to review and explore any actions. Both incident investigations have been fully investigated and closed. • Work in progress in relation to EIDO leaflets for NG and NJ tubes following a recent incident as part of improvement plan actions. • X9 open formal concerns. Work is progressing • Recruitment is ongoing across a number of areas. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b)	
CWQSE/ 2024/070	**O&G Directorate Report** • Post-natal contraception bridging contraception methods continue provided • 8 open NRI's within Obstetrics, 9 MBBRACE cases and 11 LRI's in progress. X1 PSLR with CTM Health Board, which feedback is awaited on actions.. X3 open NRI's for Gynaecology, x4 LRI's in progress. • Weekly Datix tracker implemented to try to address the backlog for open Datix incidents. • Euroking data overlay remains a significant risk which has impacted on information data. IT team have been supporting whilst the transition to the Badgernet system is complete. • X3 pressure damage incidents for February, and x1 reported in March • X5 medicines management incidents reported. No consistent themes have been identified. • Safeguarding issues in the PAS Service at CRI highlighted on the risk register with regards to requirement for increased security. Discussions are ongoing with regards to V&A training in this area also. • Equality and Diversity work continues to support patient's who's first language is not English. Audit of requirement for interpreter services at booking is progressing, and utilisation of interpretation services during the antenatal period. • VBA rate is currently at 87.81%, sickness at 6.5%. • Mandatory training compliance currently at 85.87% • Recruitment is ongoing across a number of areas within the Directorate. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2024/071	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Risk Assessment - PARIS contract extension 2024-2028 – currently not included within the Directorate Risk Register as this is likely to be a corporately held risk	

	for the Health Board. Risk Assessment – Paediatric Beds, CHFW – noted for information. Actions have been implemented to mitigate the risks. **The CWQSE resolved:** a) Directorate Risk Registers to be submitted to the Clinical Board for review	**ALL**
SAFE CARE		
CWQSE/ 2024/072	**Patient Safety Update** Next PSLR Training date is on 21st May 2024. NRI Toolkit has been developed to support the process and outline the roles and responsibilities for the reviews. New appointment made to the Patient Safety Team, James Pullen who will cover the secondment for Suzie Cheeseman. Thanks, were expressed to Suzie for her help and support to the Clinical Board. ***Postscript*** *It was noted that work is ongoing across Obstetrics and Neonatal Services to develop a perinatal process for governance that will help the perinatal team work together more effectively.* **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2024/036	**NRI/PSLR/Closure Forms for discussion** Both cases have been discussed in detail as part of the NRI/LRI Governance Sub Group. Any comments to be shared outside of the meeting. If no comments received, the cases can be progressed for closure. **SBAR, PSLR and Improvement Plan – RB (Datix Ref 42775)** Case involved a patient who suffered a 3B tear. The background to the case was provided. Full detail of which was included within the supporting SBAR and PSLR shared as part of the meeting. As part of the investigation the main issue identified related to the patient not being referred for an obstetric review following ultrasound scan. It was acknowledged that whilst this is unlikely to have made a difference to the outcome, there would have been an obstetric discussion regarding the increased risk of shoulder dystocia, post-partum haemorrhage and tears but given the estimated fetal weight, caesarean section would not have been recommended/offered. There were also x2 incidental learning findings in relation to: *Incidental learning 1 – lack of discussion around risks and benefits of starting Syntocinon. There should be more detail documented around the discussion and decision making for Syntocinon.* *Incidental learning 2 – a hand written consent form was used to consent for theatre. Routine practice would be to use a pre-printed consent form to aid the consent discussion.* Recommendations were noted as:	

	1. When women have an ultrasound scan requested from the MLU there needs to be an obstetric review of any results outside of the normal range to ensure appropriate counselling occurs. 2. There needs to be a standardised template to complete when discussing risks and benefits of syntocinon augmentation and alternatives 3. The pre-printed consent forms should be used when consenting for trial +/- C/S. 4. Review the large for dates guidance with our local and evidence-based data. **SBAR, PSLR and Improvement Plan – CL (Datix Ref 32255)** Case involved a patient who suffered a 3B tear. The background to the case was provided. Full detail of which was included within the supporting SBAR and PSLR shared as part of the meeting. There were no specific exceptions to note from the cases and detailed discussion has taken place as part of the NRI/RCA Governance Sub Group Meeting. **The CWQSE resolved:** a) Update was noted. b) Cases to progress for closure subject to no further comments being received.	**HM**
CWQSE/ 2024/037	**3.5. Infection Prevention Control Update Report** The report was shared for information. There are no significant IP&C concerns to note for this meeting. For April there has been x2 C Diff from Rainbow Ward and Gwdihw Ward, x1 MSSA bacteraemia from PICU and x1 E Coli bacteraemia from First Floor Maternity. Reduction goals for 2024/25 are awaited from Welsh Government, however it was noted that there is expected to be a 10% reduction from the goals set for the last financial year. It was noted that a thematic analysis is being undertaken with regards to C Diff to ascertain if there are any specific themes to understand the reason for such an increase of 400% more than the equivalent period from last financial year. For MRSA, the goal was zero and there was one case reported, but it was acknowledged that whilst the goal was not achieved, there was a 67% reduction compared to the equivalent period. For MSSA, the goal was not achieved, however there was a 14% reduction in cases compared to last year. It was noted that 33% of the cases reported were line related, with source of infection being a PVC or CVC. Ask was that all staff undertaking septic procedures to ensure ANTT compliance (ESR E Learning and Face to Face assessment). For Pseudomonas Bacteraemia, there were two cases, both of which were line related. For Klebsiella Bacteraemia, the goal was not achieved, however there was a 14% reduction compared to the last financial year. Audits are ongoing and there has been very clear improvements made from the previous audits. For the coming financial year, there is work ongoing to ensure	

	that there is a designated IP&C session as part of induction training and also working with the Practice Development Nurses from Acute Child Health and O&G Directorates to progress induction training with the newly qualified midwives and nurses. IP&C Back to Basics sessions recently completed and any further sessions required, please contact the team. Discussion ensued with regards to the recent measles outbreak and it was confirmed that FFP3 mask will be needed for all care associated with any suspected measles cases. Staff were reminded that any contact with a positive case will require exclusion from work for up to 21days for those staff who have not received both MMR's. Staff should be reimmunised if there is any doubt with regards to immunisation status. All were asked to cascade information to all staff. Increase in pertussis and whopping cough across Wales. Staff to be alert to cases and quickly identifying and isolating cases. Staff with close patient contact will need to be risk assessed for prophylaxis etc. It was requested that all areas ensure staff are fit tested and records are up to date. Information to be shared on the requirements for fit testing and how to access testing. **The CWQSE resolved:** a) Update noted. b) Ensure all staff are fit tested and records are updated.	**ALL**
CWQSE/ 2024/038	**Safeguarding/Mental Capacity Act (MCA)** The following documents have been shared for information and onward sharing. Fiona Bullock, new deputy safeguarding lead appointed. • #NotTheOne Letter • Concise Child Practice Review Report CYSUR 3/2021 • Wales Safeguarding Procedures • Safeguarding Newsletter **The CWQSE resolved:** a) Documents noted.	
CWQSE/ 2024/039	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Safety Memo - Hyperkalaemia guidelines • Vaccination of Staff to Protect Against Measles - follow up to WHC(2023)043 • PHW Notice – Measles Outbreak The alerts were noted and have been disseminated widely across the Clinical Board. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/040	**NICE Guidance – Update on Progress** Report shared for information. All guidance is disseminated through AMAT. Any support required, contact the Clinical Audit team. **The CWQSE resolved:** a) Update noted.	

CWQSE/ 2024/041	**Medicines Safety Executive Update** It was noted that the Datix report and MSE minutes would be shared with the group for information following the meeting. **Postscript:** • *Datix reports increasing across UHB. Mainly due to increase reporting by some areas + pharmacy. C&W have good reporting rates. Clara working with the CH directorate to investigate spike in medication errors on NNU & PCCU (prescribing and admin)* • *One 'severe' incident discussed - medicine keys lost on maternity. Andy knows detail and actions taken were appropriate.* • *Majority of updates will be circulated separately via Microguide / Safety alerts e.g. fluoroquinolone update & Look-alike amps* • *EPMA update - system being built and configured. Roll out team recruitment underway. We have recruited a pharmacist specifically for C&W input to project*. **The CWQSE resolved:** a) Update noted	
TIMELY CARE		
CWQSE/ 2024/073	**Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:** b) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2024/074	**Draft SOP for Requests for Access to Clinical Records** Shared for information. **The CWQSE resolved:** a) Document noted and shared	
CWQSE/ 2024/075	**SOP for Health Assessment for Initial Child Protection Conferences** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/076	**Standard Operating Procedure: Transcribing of Medication by Community Based Nurses** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/077	**Protocol for the Transportation of Clients and Colleagues by Staff using their own vehicle** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	

CWQSE/ 2024/078	**SOP's for Concerns, Redress and Early Resolutions** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/079	**Concerns & Redress Newsletter** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
ANY OTHER BUSINESS		
CWQSE/ 2024/080	**C&W Clinical Board NRI LRI Reporting Sign Off Process** Deferred to the next meeting. **The CWQSE resolved:** **a)** Item to be added to the next agenda	**KH**
CWQSE/ 2024/081	**EDELife Study** Deferred to the next meeting. **The CWQSE resolved:** a) Item to be added to the next agenda.	**KH**
CWQSE/ 2024/082	**Date and Time of Next Meeting** Tuesday 28th May 2024, 8.30am, Microsoft Teams	**ALL to note**

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 25th June 2024 at 8.30am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board
Anthony Lewis	AL	Clinical Board Pharmacist
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Abigail Holmes	AH	Director of Midwifery & Neonatal Services, C&W Clinical Board
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Samuel Barrett	SB	Deputy Director of Operations, C&W Clinical Board
Becci Ingram	BI	General Manager, CYPFHS Directorate
Louise Platt	LP	General Manager, CHFW Directorate
Hannah McLoughlin	HM	Clinical Governance & Risk Lead Midwife, O&G Directorate
Lois Mortimer	LM	Head of Midwifery & Directorate Lead Nurse, O&G Directorate
Alison Lewis	AL	Patient Safety Facilitator
Jane Jones	JJ	Clinical Director, CYPFHS Directorate
Paula Davies	PD	Lead Nurse, CYPFHS Directorate
Genevieve Thueux	GT	Asst Clinical Director, CHFW Directorate
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer
Kylie Hart	KHart	Clinical Governance & Risk Lead Nurse, Neonatal Services, CHFW Directorate
Siwan Jones	SJ	Clinical Nurse Specialist, Infection Prevention & Control
In Attendance		
Kirsty Hook	KHook	Risk, Governance & Patient Experience Facilitator, C&W Clinical Board
Jane Morris	JM	Senior Nurse, Patient at Risk Team
Tina Freeman	TF	Senior Nurse, CHFW Directorate
Apologies:		
Chloe Laws	CL	Safeguarding Midwife, C&V Safeguarding
Diana Wakefield	DW	Safeguarding Nurse Advisor, C&V Safeguarding
Sandeep Hemmadi	SH	Clinical Board Director, C&W Clinical Board

Item No	Agenda Item	Action
CWQSE/ 2024/083	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2024/084	**Apologies for Absence** **The CWQSE resolved:** a) The apologies were noted	
CWQSE/ 2024/085	**Minutes of the previous Q&S Meeting held on 23rd April 2024** The minutes of the meeting held on 23rd April 2024 were agreed to be an accurate record. **The CWQSE resolved:** a) The minutes were noted	

CWQSE/ 2024/086	**1.4 To note and update the latest action log (from AMaT System)** The action log is now available via AMAT for live updates to be provided. Outstanding actions from the last meeting were noted. Requests were made for the action log to be updated via the AMaT system following the meeting. **CWQSE/2024/011** Letter has been sent to serve notice with regards to withdrawal of the service. Further information has been requested regarding the level of activity, which has been provided to Cwm Taf Health Board. **CWQSE/2024/015** Thematic Review for Neonatal Incidents for 2022 work is ongoing and a number of incidents have now been closed. Theme of remaining open cases identified relate to ATAIN cases, with closure anticipated. **CWQSE/2024/022** Resource required to support the clinical teams. Model is being reviewed. This is currently a risk and there is an established Health Board group to review this. This is a risk which is held on the Health Board risk register. AL agreed to review and advise of any specific ask required from the Clinical Board for support. **CWQSE/2024/031** Safeguarding bespoke sessions are being considered for level 3 training, and discussions are ongoing. It was agreed that information would be shared across Directorates when available. **CWQSE/2024/032** Trial beds have been received. Further beds will be implemented for trial on the wards with the patients. Further update will be shared when available. **CWQSE/2024/033** To be reviewed to ensure all outstanding HSE inspection actions are complete for Maternity Services. LM to review. **CWQSE/2024/052** AJ noted that the issue with the gases has been resolved, further update is awaited. Paediatric Resus Practitioner remains a current risk and work is ongoing in relation to this. **CWQSE/2024/067** Work ongoing with the teams to resolve the backlog. **CWQSE/2024/037** Work ongoing regarding compliance with Fit Testing. **The CWQSE resolved:** a) Action Leads to update outstanding actions directly on AMaT system b) Further update to be provided on any outstanding actions at the next meeting.	**AL** **PD** **EB** **LM** **AJONES/AJ** **ALL** **ALL**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CWQSE/ 2024/087	**Call 4 Concern Launch** Jane Morris was welcomed to the group and provided an update on the Call 4 Concern initiative to provide a clear pathway for patients and their families to highlight/escalate a second opinion for any concerns they have.	

	Call 4 Concern is aligned to Martha's Rule and is a patient safety initiative which will inform the patients and their families of the process to raising concerns for a second opinion. The information will be provided to the patient's on admission. A Paediatric response has been developed which will launch on the same day. The patient flow team member will be the initial contact. Discussions are ongoing within Maternity services, as to the most appropriate process to follow for maternity concerns. JM agreed to forward links to AH following the meeting for contacts within other Health Boards as part of benchmarking information/data. Any trends and concerns identified through data collection will be shared with the Directorates/Clinical Boards for review and action as necessary. The SOP will be shared for information. The roll out is due to commence on 1st July 2024 **The CWQSE resolved:** a) Update was noted b) Discussions ongoing within Maternity Services to work towards most appropriate pathway for maternity concerns.	**JM**
CWQSE/ 2024/088	**EDElife Study** RT-T provided an update on the EDElife Study which commences in Fetal Medicine with follow up within Paediatrics. The study is across Fetal Medicine and Child Health and relates to a rare condition as to whether or not tooth buds or sweat glands will form due to a missing protein. The drug has shown promising signs that if given in utero, then it can support the replacement of the protein therefore allowing the tooth buds and sweat glands to develop. This can be a life limiting condition due to overheating etc. The first patient will be attending from Texas, USA. Full screening will commence in Fetal Medicine, and first treatment will commence on 10th July. An amniocentesis will be undertaken to insert the drug into the amniotic fluid, and this will be a 3-treatment process. There are 7 members on the study (across 3 sites – UK, Germany and Spain), x2 of which have gone into pre-term labour, therefore the patient arriving from the USA will be staying in the UK until she gives birth. Arrangements have been made with regards to private medical insurance. Further updates will be provided as the study progresses. **The CWQSE resolved:** a) Update was noted	
CWQSE/ 2024/089	**Health & Care Standards Directorate QSE Exception Reporting** The Directorate Report submissions have been received through the AMAT System, information has been shared with a focus on the moderate/high risks, this was noted for information. It was noted that the principle of the AMAT report submissions is an aim to streamline the updates being provided to ensure that there is appropriate focus on the moderate and higher risks that may require support and action. The Directorates were asked to provide updates on specific areas of escalation and noting. **CYPFHS Directorate Report** • Work ongoing for a workforce plan to manage and support the Fluenz Programme, as there remains a deficit in staffing. Recruitment is ongoing,	

	and assurance has been received that there will be x4 nurses per sessions, however this will still leave a shortfall which will continue to be monitored. • Healthy Child Wales (HCW) compliance has improved, however there are ongoing concerns relating to the large caseloads. Work is ongoing with local authorities regarding different models and an integrated pilot is being considered for one area. • No open NRI's within CYPFHS at present. Support is being provided to an AMH NRI report which has been completed and the family have requested a meeting to discuss the report, with joint representation between AMH and Emotional Wellbeing Service. It was agreed that the final report would be shared for information. Learning has been identified across services. • High volume of informal concerns relating the waiting list for the ND service which is currently sitting at 33-36month wait and validation work continues. • RIDDOR relating to a staff member who was injured during an immunisation session. SOP has been updated to include further advice, specifically for special schools. This RIDDOR has now been closed by Health & Safety Team. • X3 new risk assessments for inclusion onto the Directorate Risk Register o Virtual Consultation discontinuation of contract. It was noted that the contract has now been extended to the end of the financial year, however this is a significant risk with regards to the need for a like for like VC option as the service is the biggest user (along with Adult Mental Health) with circa 450 individual appointments per month, and 150 group of patients per month on the system. Current risk rating 16. This has been escalated through the Clinical Board to the Director of Digital Transformation. o Admin Capacity is a significant issue across the Directorate which relates to short term and long-term sickness, increased service demand and delays to recruitment. This has impacted on Clinical staff now needing to undertake admin tasks which is resulting in loss of clinical activity. Time critical activities are being reviewed and prioritised. Current risk rating 16. o Medical Staff undertaking Child Protection medicals. Following a recent V&A incident, work is ongoing with UHB security and H&S to look at the environment and what safety measures can be implemented. Current risk rating 12. • SBAR has been developed for School Nursing highlighting the deficits within the service and the impact this is having on the workforce. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2024/090	**CHFW Directorate Report** • Measles videos being completed to support the uptake of MMR vaccinations • X5 open NRI's, with one anticipated for closure in month. • No new risks added to the risk register in month. The biggest risk relates to the new MHRA bed compliance. Demonstration on the beds was received this week. Further update will be provided as this progresses. • Pressure damage reported on PICU (initially reported as unstageable, improved quickly and was graded as a Grade 2). Scrutiny panel was completed and the findings were noted that the pressure damage was unavoidable and all appropriate management actions were undertaken. It was highlighted that with the increased use of NIV, with the masks that are being used there is an increased risk to a cohort of patients, specifically PICU patients.	

	• Tendable audits continue to be positive, and action plans are in place where any necessary improvements are required. • Shortage of levobupivacaine and fentanyl epidural bags, therefore there will be a change back to bupivacaine and fentanyl at short notice. The pain team are working on this and distribution of comms is taking place. • Call 4 Concern has been shared and will be rolled out on 1st July across Paediatrics in line with the UHB roll out. • Patient Safety Alert Bivona Tracheostomies. All necessary actions were undertaken within the CHFW, and all new stock now available. PD provided assurance that all families within the community have also been managed appropriately. • Research department producing a quarterly newsletter as part of communication on all studies being undertaken. • Information Governance Breach investigation being undertaken. Breach happened in the patient's local health board however support was provided from CHFW • X5 formal concerns open, with no specific themes to note. • Paeds General Surgery no longer in formal level 3 escalation. Predicting no children waiting over 52 weeks for surgery by the end of this quarter, with plans in place for the next quarter. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2024/091	**O&G Directorate Report** • Smoking cessation funding has been lost due to recruitment issues, therefore currently there is no support for the service. Public Health Wales have allocated funding for a Band 5 support worker. • All pregnant women will be offered a RSV Vaccination at 28 weeks gestation and work is ongoing with the Mass Vaccination service to look at how best this change in practice can be implemented. • 163 new incidents reported in May, with 154 closed in month. Weekly Datix, Clinical Risk and ATAIN meetings continue to support management of the incidents and for necessary actions to be undertaken. • x5 NRI's and 11 MBBRACE reported cases within Maternity. X3 NRI's within Gynaecology. • 8 risks on the Directorate Risk Register. New risk added in relation to WiFi capacity – Risk Rating 12. • Euroking continues to be a significant issue. Documentation is being completed and movement to Badgernet system is anticipated for January 2025. • Gynae referrals system has been developed and roll out is awaited. • Checking dashboard rolled out across all areas following the recent HIW inspection. Fridge temperature will also be included within this checking dashboard, in line with recommendations from the recent HIW inspection. • Medicines Management – x5 incidents reported. All incidents were reviewed with no/low harm reported. All appropriate actions were undertaken. • Blood Transfusion compliance is currently at 13% and it was agreed that this would be reviewed to ensure appropriate plans are in place to improve compliance. • Bi monthly ATAIN meetings have been implemented which is having positive impact. • Consultation for Hospital on Call Escalation Rota and engagement meeting has been held, and individual meetings available where necessary. • X9 new concerns for Maternity open at the end of May, x28 open for	

	Gynaecology. Work is ongoing. • Recruitment update provided and work ongoing across all areas. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Review of plans to increase blood transfusion compliance to take place	
CWQSE/ 2024/092	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Detail noted as part of the Directorate report updates. New risks added to the Risk register relate to: • Virtual Consultation (CYPFHS). Risk Rating 16 • Admin Capacity (CYPFHS). Risk Rating 16 **The CWQSE resolved:** a) New risks noted as part of Directorate Report Updates.	
SAFE CARE		
CWQSE/ 2024/093	**Patient Safety Update** Toolkit is now available on the Patient Safety SharePoint pages for more information. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/094	**NRI/PSLR/Closure Forms for noting/exception reporting** All cases have been discussed in detail as part of the NRI/LRI Governance Sub Group. Any comments to be shared outside of the meeting. If no comments received, the cases can be progressed for closure. SBAR, PSLR and Improvement Plan – MT SBAR, PSLR and Improvement Plan – JK SBAR, Birth Injury Tool and Improvement Plan – TK SBAR, Birth Injury Tool and Improvement Plan – CR SBAR, PSLR and Improvement Plan – EBM SBAR, PSLR and Improvement Plan – RC SBAR, PSLR and Improvement Plan – MD SBAR, PSLR and Improvement Plan – AB **SBAR, PSLR and Improvement Plan – SW** Comments are awaited on factual accuracy at present. It was agreed that the case will be deferred to a following meeting whilst factual accuracy is awaited. **The CWQSE resolved:** a) Update was noted. b) Case of SW will be deferred to the next meeting c) Cases to progress for closure subject to no further comments being received.	**HM** **HM/EB**
CWQSE/ 2024/095	**3.5. Infection Prevention Control Update Report** The report was shared for information. For June, x3 C Diff infections reported, x1 Pseudomonas Bacteraemia reported.	

	Concerns were noted with regards to C Diff, with x6 cases reported since April 2024 (x2 cases were recurrent cases). Actions were implemented and audit had improved. X3 recent cases have been sent for typing which is awaited. Work is ongoing with the ward staff and letter is being shared with the parents/families with regards to the importance of IP&C, hand washing etc. All patients have been isolated and are in cubicles whilst typing is awaited. It was noted that current data highlights an increased trend within the health board. HPV compliance is significantly low within CHFW and work is ongoing to improve compliance. Information has been circulated highlighting the importance of HPV cleaning following confirmation of any C Diff cases. Compliance will be monitored and any necessary interventions will be implemented. Prompts will be added to the cubicle's doors also. X2 lines related positive blood cultures reported since April 2024. Both were CVC lines and further information is awaited from the RCA investigations. It was noted that there were no issues found in the care of the lines. Joint audits are ongoing and positive feedback has been received. Bed cleaning information has been disseminated across the clinical board. MRSA screening on NICU have seen an increase of positive screens. No transmission has been identified to date, although concerns noted that the cases are hospital acquired. Work ongoing to provide assurance with regards to appropriate cleaning of environment and bed spaces. RSV Vaccination Programme requires x4 champions to be identified. Champions will be required for x3 days per week for the first 3 weeks of the programme. The Directorates were asked to identify x1 champion per Directorate. Nominations required by the end of the week. **The CWQSE resolved:** a) Update noted. b) Each Directorate to identify vaccination champion in readiness for the upcoming RSV Vaccination Programme	
CWQSE/ 2024/096	**Safeguarding/Mental Capacity Act (MCA)** The following documents have been shared for information and onward sharing. • Tarian Region County Lines Newsletter • Cardiff Children's Services Referral Guidance • NCA Alert: Financially motivated sexual extortion - https://scanmail.trustwave.com/?c=261&d=8fy55utruuWKuQEYge9HK_1Y84oOk7lKg5JRA79KBg&u=https%3a%2f%2fhwb%2egov%2ewales%2fkeeping-safe-online%2ffinancially-motivated-sexual-extortion • SUSR 7 Minute Briefing | Briffiad 7 Munud ADUS • RSB Learning and Improvement Framework 2024 • #NoGreyArea - Welsh Womens Aid - https://scanmail.trustwave.com/?c=261&d=lpXs5gKSahwbq6q0S3wVXsqesA3FKhE3UNxjmWm8UQ&u=https%3a%2f%2fwww%2esurveymonkey%2ecom%2fr%2fFR95B2V • Vale of Glamorgan Children's Services **The CWQSE resolved:** a) Documents noted.	

CWQSE/ 2024/097	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Safety Memo - Fiasp FlexTouch shortage • ISN 2024 001 - Blood transfusions • RSV Vaccination Programme • Outbreak of A(H5N1) Avian Influenza in cattle in the USA, with two associated human cases in the USA The alerts were noted and have been disseminated widely across the Clinical Board. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/098	**NICE Guidance – Update on Progress** Report shared for information. All guidance is disseminated through AMAT. Any support required, contact the Clinical Audit team. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/099	**Medicines Safety Executive Update** Ongoing issues in relation to medicines shortages including ADHD and Bupivacaine Fentynyl. Concerns have been highlighted as part of a national meeting with regards shortage of ADHD medication and the impact of this adversely affecting children and their development. Cerys Bicknell will support the EPMA project team to ensure that there are robust processes in place across all areas. Kids Meds Cymru won a Sustainability Award in NHS Wales Awards which has been a significant achievement across CHFW and wider. Data from the project will be shared when available for information. **The CWQSE resolved:** a) Update noted.	
TIMELY CARE		
CWQSE/ 2024/100	**Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:** a) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2024/101	**Learning from Events – CN/UHW/DCIQ1418 - RE** Shared for information and noting of lessons learnt. **The CWQSE resolved:** a) Document noted and shared	
CWQSE/ 2024/102	**Traceability Non-Compliance – April 2024** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	

ANY OTHER BUSINESS		
CWQSE/ 2024/103	**Paediatric Emergency Assessment and Communication Handover (PEACH) Courses** Funding made available for training for HCSWs for PEACH Courses. Places can be booked through the online booking system, with manager approval required. All were asked to highlight the available training amongst staff. **The CWQSE resolved:** **a)** Update noted. **b)** Training to be highlighted amongst staff.	**ALL**
CWQSE/ 2024/104	**Date and Time of Next Meeting** Tuesday 23rd July (H&S Focus Meeting) 2024, 8.30am, Microsoft Teams	**ALL to note**

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 23rd July 2024 at 8.30am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, Children & Women's Clinical Board
Abigail Holmes	AH	Director of Midwifery & Neonatal Services, Children & Women's Clinical Board
Louise Platt	LP	General Manager, CHFW Directorate
Rachael Sykes	RS	Assistant Head of Health & Safety
Jane Jones	JJ	Clinical Director, CYPFHS Directorate
Siwan Jones	SJ	Clinical Nurse Specialist, Infection Prevention & Control
Samuel Barrett	SB	Deputy Director of Operations, Children & Women's Clinical Board
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Lois Mortimer	LM	Head of Midwifery/Lead Nurse, O&G Directorate
Becci Ingram	BI	General Manager, CYPFHS Directorate
Paula Davies	PD	Lead Nurse, CYPFHS Directorate
In Attendance		
Sam Skelton	SS	Manual Handling Advisor
Connor Sedgmore	CS	Fire Safety Advisor (on behalf of Ryan Paxford)
Nia Evans	NE	Infection Control Nurse
Apologies:		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Alison Lewis	AL	Patient Safety Facilitator
Sandeep Hemmadi	SH	Clinical Board Director, C&W Clinical Board
Anthony Lewis	AL	Clinical Board Pharmacist
Chloe Laws	CL	Safeguarding Midwife
Ryan Paxford	RP	Senior Fire Safety Advisor

Item No	Agenda Item	Action
CWQSE/ 2024/105	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2024/106	**Apologies for Absence** **The CWQSE resolved:** a) The apologies were noted	
CWQSE/ 2024/107	**Minutes of the previous Q&S Meeting held on 25th June 2024** The minutes of the meeting held on 25th June 2024 were agreed to be an accurate record. **The CWQSE resolved:** a) The minutes were noted	

CWQSE/ 2024/108	**1.4 To note and update the latest action log (from AMaT System)** The action log is now available via AMAT for live updates to be provided. Outstanding actions from the last meeting were noted. Requests were made for the action log to be updated via the AMaT system following the meeting. **CWQSE/2024/011** Letter has been sent to serve notice with regards to withdrawal of the service. Further information has been requested regarding the level of activity, which has been provided to Cwm Taf Health Board, no further update has been received. BI agreed to follow up for further update. **CWQSE/2024/031** Safeguarding bespoke sessions are being considered for level 3 training, and discussions are ongoing. It was agreed that information would be shared across Directorates when available. **CWQSE/2024/033** All actions have been completed. Action to be updated on the AMAT system for completeness. **The CWQSE resolved:** a) Action Leads to update outstanding actions directly on AMaT system b) Further update to be provided on any outstanding actions at the next meeting.	**ALL** **ALL**
HEALTH & SAFETY		
CWQSE/ 2024/109	**Annual Health & Safety Plan & Management Review Feedback** The feedback was shared for information. The following actions were highlighted: ***Action IMS-04:*** *Assurance should be sought from the directorates that a process is in place to ensure all in scope equipment is maintained and serviced as per UHB requirements.* ***Action IMS-11:*** *Risk assess the requirement for lone worker devices within maternity and where deemed necessary ensure devices are available and used. Usage will then be tracked by H&S* It was noted that the lone worker devices are in place within Maternity Services, however it was noted that uptake and use of the devices is poor. It was noted that work is ongoing with the community staff to improve uptake and use. RS suggested that Emma Foley is contacted to provide support. RS noted that a new contract has been signed and work is underway to swap the devices over to the new contract and getting the right escalations recorded. PD noted that the school nursing service have started visiting at home, and there have been some safety concerns noted. Work is ongoing to ensure that staff have access to devices as appropriate for the service. The devices are widely used across other community services. ***Action IMS-14:*** *Reaffirm the requirement of contractor management at directorate level meetings and minute accordingly. This can be achieved by taking the salient points from the Control of Contractors Policy, IMS-14-01-CAV. Whilst many of the responsibilities in section 5.3 sit with clinical board managers, in practice, the actioner will come from the H&S team.*	

	5.3 *Service / Clinical Board Managers are responsible for ensuring arrangements are in place to implement this policy including:* • *Appointing a contractor Supervising Officer and ensure they are competent before fulfilling their duties.* • *Ensuring that there is suitable induction material and information available for contractors covering the key points for the site they are operating on.* • *Carrying out contractor induction, and maintaining suitable records.* • *Managing their own contractors and associated procurement requirements* **Control of Contractors Quick Guidance** With regards to Action IMS-14 noted above, the control of contractor's quick guidance document was shared for information to ensure that all staff are familiar with the process. Any contractors brought in outside of Capital Estates and Facilities have a job registration form completed, along with ensure that there is a supervising officer who has been allocated and that risk assessments and method statements have been completed and reviewed before the work commences. The group were asked to ensure that all areas are aware of the guidance and required actions are followed. **The CWQSE resolved:** a) Update was noted b) Request made to ensure that the actions highlighted as part of the management review are actioned accordingly.	**ALL**
CWQSE/ 2024/110	**H&S Dashboard** The latest H&S dashboard was shared for information. **The CWQSE resolved:** a) Dashboard noted.	
CWQSE/ 2024/111	**C&W Clinical Board Exception Report – May 2024** The latest H&S exception report was shared for information. **The CWQSE resolved:** a) Exception report noted	
CWQSE/ 2024/112	**H&S Training DNA Report** The latest H&S training DNA report was shared for information. It was acknowledged that release of staff within the Clinical Board can be challenging. It was noted that if staff are unable to attend the training, cancellation of the slot can be done up until the end of the day of training in order to ensure there are no charges incurred. The group were asked to reiterate the need for cancellation notice if unable to attend, and where possible notice to be given so that the slot can be available for reallocation. **The CWQSE resolved:** a) Report and update noted.	

CWQSE/ 2024/113	**COSSH Update** The latest COSSH assessment update was shared for information. The COSSH assessments request forms are available on the H&S SharePoint pages and RS agreed to share the link with the group for information. Any changes to COSSH assessors to be shared for update. **The CWQSE resolved:** a) Update noted b) COSSH assessment request form link to be shared	**RS**
CWQSE/ 2024/114	**Fire Safety Update** Training for the Clinical Board was noted at 72% and requests were made to increase compliance to target of 85%. Evac Chair Inferno Training is available and areas were asked to make contact for additional sessions to be booked. Fire Warden training available for booking through ESR. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/115	**Feedback from H&S Staff Side** No update available.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CWQSE/ 2024/116	**Health & Care Standards Directorate QSE Exception Reporting** The Directorates were asked to provide updates on specific areas of escalation and noting. **CYPFHS Directorate Report** • Presentation on Perinatal Mental Health as part of the Pathfinders Program which has had a positive impact on upskilling of workforce and work is now ongoing to review actions to sustain this going forward • Evaluation of the school nursing health assessment pilot within Cardiff East has been undertaken and the feedback has been positive. This will leave a challenge with regards to capacity in the service and meetings are taking place to discuss this impact going forward. • Work ongoing in relation the Directorate H&S Plan and actions have been identified in relation to the need for a baseline assessment for all bases, specifically with regards to fire and COSSH assessments and responsibilities. • Actions are progressing following the V&A incidents in St David's Hospital for safeguarding medicals. Assurance has been received from UHB security to provide support when required, and how this can be communicated and risks articulated. Further actions are ongoing in relation to arrangements of site visits so that the V&A issues can be fully assessed, and training is being rolled out to support staff. • Concerns received following changes to breastfeeding support groups which has not been well received. It is felt that the changes made are appropriate however there has been acknowledgement that consultation and communication of these changes could have been improved. • High level of concerns being received in relation to the waiting times for the ND Service. The pathway is being reviewed and significant changes made. • Youth Worker grant request being submitted for support to the Youth Board for consideration	

	• Supported an NRI led by Adult Mental Health involving a young person. The report is almost complete and will be shared through Q&S for learning and recommendations. • Incidents workshop being arranged with care groups to review and improve compliance. • Top risks include ND Waiting List and CCNS in terms of capacity to meet statutory obligations and continuing care. A summit has been held and work is ongoing for further actions. Pressures within the CLA Team for capacity to undertake initial health assessments for looked after children. The review health assessments compliance has significantly improved as a result of health visitors undertaking some of the reviews for under 5yr olds. Backlog continues with out of county children, specifically within CTM Health Board and regular contact continues for this backlog to be reviewed. Admin capacity remains a pressure, some posts have now been released for recruitment however capacity issues continue within the team as a result of sickness absence and resignations. Immunisation plan for fluenz and school nursing issues regarding capacity. Work is ongoing with Primary Care in relation to workforce. There will be some support from the Mass Vaccination Centre for fluenz, however there will still be a gap going into the winter programme which will need to be completed by December 2024. • Park View Redevelopment Hub plans are not conducive to the clinical teams that will be based there, due to the open plan working which will be difficult for staff with safeguarding on the caseloads. These concerns have been escalated via Primary Care however feedback has been received that the plans are not due to change. • Healthy Child Wales programme compliance is reporting a significantly improved position across all key contacts and further work is ongoing to further improve the 3.5yr contacts. **Timely Access** • There has been improved performance and compliance within Health Visiting and Children Looked After, however it was noted that there is further work ongoing in relation to medical capacity specifically for Children Looked After due to the increased demand and complexity. • ND demand continues to outstrip capacity with circa 3.5k children on the waiting list with waits of approximately 3 years. • Part 1a compliance continues to be maintained, however it was noted that some pressures are anticipated for September/October due to impending vacancies. Demand and capacity review is being undertaken to further understand the likely impact of this. Part 1b continues to report non-compliance however there is a trajectory for improvement from September a stepped reduction is being seen with the number of patients waiting, however until the backlog is clear, improved compliance will not be seen. This continues to be monitored. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2024/117	**CHFW Directorate Report** • X4 open NRI's and x4 Patient Safety Learning Reviews on Neonatal Unit. • X2 category 2, and x1 category 1 pressure damage reported in month • X11 formal concerns in progress, no specific themes to note. • NICU and PICU remain the greatest risk area.	

	• MHRA guidance – x2 trial beds received and feedback provided on both companies. No beds are currently in production. A further trail bed is awaited, which is the bed that has been selected by Great Ormond Street for consideration. All feedback will be shared with procurement services to feedback into the contract. A further bed stock take has been undertaken and there are appropriate amounts of beds available, and risk assessments have been updated. This process will continue until the new beds are implemented. • Miscommunication in handover has been a theme identified from a medicine's management incident reporting. Pharmacy will now be carrying vocera devices which will enhance availability and communication. • X1 RIDDOR reported in month. Investigation completed and the staff member has now returned to work. • Cystic Fibrosis Cav Trio Study now cascaded down to 12-24months • More requests being seen through Information Governance for data held on patients. A reminder has been sent to all staff. • Concern received in relation to effective suctioning practices. Discussions have taken place, and senior staff will join the physiotherapy ward rounds for the opportunity for suction supervision in order to provide more confidence for staff undertaking suction on the wards. Care plans are being developed, informed by the guidance recently produced by the Chartered Association of Paediatric Physiotherapists. • Recruitment continues across a number of areas within the CHFW **Timely Access Update** • Reduction in figures in July from June data. Currently there are no patients waiting over 52 weeks for a new outpatient's appointment for paediatric surgery and the longest wait is at 35weeks. For General Paediatrics and sub specialties, there are 91 patients waiting between 36-52 weeks which is a reduction from last month. • Work continues with the Phlebotomy Service for GP's and this has seen a reduction in waiting times from 17 weeks to 2 weeks, which is a very positive improvement. • Longest wait for Paediatric Cardiology is 34weeks, but a date is set for September • 48 patients waiting for Paediatric Endoscopy, with the longest wait at 50weeks. Work is ongoing and the endoscopy user group is being reinstated to support the endoscopy program within the service. **The CWQSE resolved:** a) The update was noted for information and key highlights recorded.	
CWQSE/ 2024/118	**O&G Directorate Report** • Risk due to no designated support in Maternity for smoking cessation, following loss of funding for the Band 5 smoking cessation advisor. Currently all referrals are being sent externally and the band 5 post is being advertised via the local public health team. • 177 new incidents reported in June, with 194 closed and 3 rejected. The cumulative total currently sits at 720 for obstetrics and 510 for Gynae • 6 open NRI for Maternity and 3 for Gynaecology. • T2 infrastructure has been added to the directorate risk register and a meeting is being scheduled to discuss mitigation of the risk. • X1 pressure damage incident reported in month • X5 falls reported in month all of which were low/no harm • Positive IP&C audit from Delivery Led Unit and next joint audit with estates and housekeeping is planned	

	• X4 Medicines Management incidents reported in month all of which were recorded as no harm. • Start of refurbishment of Lift 9 will commence on 16th September, which will take approximately 10 weeks to complete, with refurbishment of lift 8 anticipated for the new year. Once the scheme progresses, Estates will hold a monthly progress meeting with the contractor to review progress. • Ongoing issues with regards to blocked pipes resulting in leaks, which have been escalated for resolution. • Urgent Field Safety Notice received for Fetal Medicine in relation to the wired Avalon Ultrasound Transducers. All monitors have been reviewed by clinical engineering and no issues have been identified. • Issues for Euroking continue regarding access and negotiations are ongoing with regards to an interim contract until Badgernet is installed with go live planned for January 2025. • PROMPT Compliance 87.8%, Fetal Surveillance 90.9% • Some themes highlighted for Maternity concerns noted as antenatal care scanning booking and antenatal follow ups, emotional support provision. Themes for Gynaecology include C1 care/environment, miscarriage care, waiting list cancellations, follow ups, chasing results/treatment plans. • 24 compliments received in month. • VBA 88.5%, mandatory training 83.41%, sickness 6.77%. • Recruitment ongoing across a number of areas. Discussion ensued in relation to the 100-day concern responses and all were asked to try to prioritise responses for completion. **The CWQSE resolved:** a) The update was noted for information and key highlights recorded.	
CWQSE/ 2024/119	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Detail noted as part of the Directorate report updates. No new risks for the Clinical Board Risk Register **The CWQSE resolved:** a) Update noted.	
SAFE CARE		
CWQSE/ 2024/120	**Patient Safety Update** Toolkit is now available on the Patient Safety SharePoint pages for more information. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/121	**NRI/PSLR/Closure Forms for noting/exception reporting** No cases for noting/discussion at the meeting.	
CWQSE/ 2024/122	**3.5. Infection Prevention Control Update Report** The report was shared for information. Tier 1 targets reported as nil for July. For June x3 C Diff cases and x1 Pseudomonas case reported. Reduction expectation for 2024/25 for C Diff is 6	

	cases, and current number of cases reported is at 6 cases. All Clinical Boards have seen an increase in C Diff cases, which has also been seen across Wales. The reasons for this are being reviewed. With regards to x2 recent cases of C Diff, this related to loose stools. Both cases were asymptomatic with no active C Diff infection, however both cases were still reportable. Reminders to all staff to note that there should be x2 or more episodes of loose stools before a sample is taken. This information will also be shared as part of walkarounds. NICU has seen an increase in positive MRSA screening. X8 babies in total reported since April 2024, all of which were negative on admission. A formal PII will be arranged for August however it was noted that audits carried out on the unit have been positive, and daily IP&C walkabouts are being undertaken. Typing have been received – x8 positive screens. X4 typing results have been received, x4 are single cases and x3 awaiting typing, however it was noted that x1 case has typed the same as the strain of emergency seen last year. Further update will be provided following receipt of the typing of the final cases. There are x5 outstanding RCA Investigations. Audits are ongoing and positive scores being seen. The group were asked to confirm back the IP&C links for all wards to be shared with the team. There should be a minimum of x1 link per ward. **The CWQSE resolved:** a) Update noted. b) IP&C links to be shared with IP&C team for all ward areas.	**ALL**
CWQSE/ 2024/123	**Safeguarding/Mental Capacity Act (MCA)** The following documents have been shared for information and onward sharing. • Imminent Changes to Front Door Services in Cardiff Children's Services Joint inspection undertaken into Child Protection arrangements has been undertaken and work is ongoing in relation to this. **The CWQSE resolved:** a) Document and Update noted.	
CWQSE/ 2024/124	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** No new alerts to note for this meeting.	
CWQSE/ 2024/125	**NICE Guidance – Update on Progress** Report shared for information. All guidance is disseminated through AMAT. Any support required, contact the Clinical Audit team. All were asked to review and ensure that statement of compliance is completed/updated on the AMAT system **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/126	**Medicines Safety Executive Update** No update to note for this meeting.	
TIMELY CARE		

CWQSE/ 2024/127	**Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:** a) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2024/128	No items for noting	
ANY OTHER BUSINESS		
CWQSE/ 2024/129	**Date and Time of Next Meeting** Tuesday 27th August 2024, 8.30am, Microsoft Teams	**ALL to note**

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 27th August 2024 at 8.30am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, Children & Women's Clinical Board (Chair)
Abigail Holmes	AH	Director of Midwifery & Neonatal Services, Children & Women's Clinical Board
Lois Mortimer	LM	Head of Midwifery/Lead Nurse, Obstetrics & Gynaecology Directorate
Genevieve Thueux	GT	Assistant Clinical Director, CHFW Directorate
Becci Ingram	BI	General Manager, CYPFHS Directorate
Louise Platt	LP	General Manager, CHFW Directorate
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Rachael Sykes	RS	Assistant Head of Health & Safety
Samuel Barrett	SB	Deputy Director of Operations, C&W Clinical Board
Paula Davies	PD	Lead Nurse, CYPFHS Directorate
Lindsay Hilldrup	LH	Midwife, Obstetrics & Gynaecology Directorate
Kylie Hart	KH	Clinical Governance & Risk Lead Nurse, Neonatal Services
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer (DECLO)
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Nia Evans	NE	Associate Clinical Nurse Specialist Infection, Prevention & Control
Siwan Jones	SJ	Clinical Nurse Specialist, Infection Prevention & Control
In Attendance		
Kirsty Hook	KHOOK	Risk, Governance & Patient Experience Facilitator, C&W Clinical Board
Apologies		
Jane Jones	JJ	Clinical Director, CYPFHS Directorate
Anthony Lewis	AL	Clinical Board Pharmacist
Alison Lewis	ALEWIS	Patient Safety Advisor
Hannah McLoughlin	HM	Clinical Governance & Risk Lead Midwife, Obstetrics & Gynaecology Directorate

Item No	Agenda Item	Action
CWQSE/ 2024/130	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2024/131	**Apologies for Absence** **The CWQSE resolved:** a) The apologies were noted	
CWQSE/ 2024/132	**Minutes of the previous Q&S Meeting held on 23rd July 2024** The minutes of the meeting held on 23rd July 2024 were agreed to be an accurate record. **The CWQSE resolved:** a) The minutes were noted	

CWQSE/ 2024/133	**1.4 To note and update the latest action log (from AMaT System)** The action log is now available via AMAT for live updates to be provided. Outstanding actions from the last meeting were noted. Requests were made for the action log to be updated via the AMaT system following the meeting. **IP&C Links** Information has been shared with the IP&C Team. Action Closed. **COSSH Assessment Form** Link for the COSSH assessment form has been circulated. This will replace the previous paper-based form. Action Closed. **The CWQSE resolved:** a) Action Leads to update outstanding actions directly on AMaT system b) Further update to be provided on any outstanding actions at the next meeting.	**ALL**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CWQSE/ 2024/134	**Health & Care Standards Directorate QSE Exception Reporting** The Directorates were asked to provide updates on specific areas of escalation and noting. **CYPFHS Directorate Report** • Delivery of Fluenz remains a risk. X2 Band 5 posts appointed. Shortfall of nurses per session has been escalated and to highlight that bank and overtime will be required to further support this. • School Nursing demand and capacity is being reviewed. Pilot has commenced within the east of the city, with a view to rollout across the service from September. This has been discussed with the Youth Board and feedback is being considered. • Number of historical Datix incidents which are being reviewed. Vacancy remains within quality & safety and a post is being progressed to support the Directorate going forward. • Adult Mental Health NRI is being progressed for approval and will be shared as part of lessons learnt when complete. One issue relates to the progression of a safe space for children and young people who require a period of further assessment and planning. • X2 V&A incidents reported in month. Patient Safety Walkabout has been completed and necessary actions have been implemented, including training for staff. • Another area of high risk is CCNS service and the Directorate are working through an improvement plan and there is a further executive summit planned for October 2024. • Safeguarding capacity within the School Nursing Service which is being worked through. • Recruitment is ongoing across areas within the Directorate. Admin capacity remains a significant risk, further advert is being placed for Band 4 and Band 3. There have been some team building sessions, to support improvement of teamwork, moral and support within the team and a walkabout has been undertaken with the trade unions. Apprentice posts are being considered as part of recruitment/succession planning • Themes for concerns relates to communication with the informal concerns being received at present. This is being reviewed.	

	Timely Access • ND service continues to be a high-risk area within the Directorate. The waiting list is between 33 -36 months. There has been lots of proactive work undertaken and the current pathway is being revised. There is a focus on the transitional cases. There are some pressures within the service in relation to sickness in the team and this is impacting on clinical time due to issues with regards to ADHD medication. • Continence Service wait is currently at 77 weeks. SBAR being completed for additional required support to further improve. • Eating Disorders new risk being added to the risk register in relation to patients not being seen within recommended waiting times. Urgent cases should be seen within a week and non-urgent within 28 days. All cases are triaged, and additional sessions are being ringfenced with the clinical leads within ED for the high-risk referrals, and daily acute ED liaison meetings are being held. High risks remain, particularly in relation to the 16-18yr old group as there is no adult link into the meetings and it is difficult to establish where this should be. Ongoing clinical management and adult medical wards is still an area of concern. • EWMH trajectory to meet Part 1B interventions compliance. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2024/135	**CHFW Directorate Report** • X2 open NRI's ongoing and x4 LRI's ongoing within NICU • X11 open formal concerns. Concerns around care and access to services have been the main theme within month. • PICU and NICU remain the highest areas of risk within the Directorate. • Regular audits are being undertaken on the beds on the wards and work is progressing with the new MHRA guidance and compliance,. • Increased acuity within Island Ward with long term specialty patients stepping down from NICU and PICU. Due to a number of the patients not having parents who stay with them, there has been a requirement for an increased number of HCSW's to provide supervision • POMS related Datix incidents reported on Island Ward. Work has been undertaken to devise a POM's booklet, which is due to be shared as part of the Directorate Q&S process. • X1 open RIDDOR - staff member now back in work • Pressure damage, Category 1 reported in month. • Recent norovirus outbreak on Pelican Ward which was closed to new admissions. This has now been resolved, and the ward has reopened. • MRSA outbreak on NICU. This is being managed by the team with support from IP&C and Public Health. • Recruitment is ongoing across areas within the Directorate **Timely Access Update** • Paediatric Surgery – no children waiting over 52 weeks for new outpatients appt. Longest wait is currently at 34weeks and an appointment has been booked. • General Paediatrics – continue to work closely with the team to ensure no children waiting over 52 weeks for a new outpatient appointment. • Paediatric Cardiology – longest wait is 39 weeks, but appointment has been booked • Paediatric Endoscopy – 48 children on the waiting list, with 35 over the 8week target. X6 children cancelled at short notice due to an equipment	

	failure which has now been resolved. Endoscopy working group has been re-established. **The CWQSE resolved:** a) The update was noted for information and key highlights recorded.	
CWQSE/ 2024/136	**O&G Directorate Report** • 203 new incidents reported and 212 incidents closed in month. Work continues to reduce the historic data from 2022/2023 whilst continuing to focus on current incidents. • X4 open NRI's, x13 MBRRACE Cases, x14 LRI's and x5 Birth Injury Tools. For Gynaecology x4 NRI's and x7 LRI's. • X1 fall in Gynaecology, all actions completed. • Number of incidents reported for Medicines Management all of which are being investigated and closed as appropriate. • Number of ongoing estates issues with regards to the power closure. Work in the MLU being completed this week in relation to the anticipated women and staff expected from Swansea Bay. • X18 infants admitted to the Neonatal unit who met criteria for ATAIN in July. For 2024, there were x66 unavoidable admissions, x27 with learning points, x13 potentially avoidable and x5 to be concluded. Bi monthly perinatal meetings held to review all the term admissions, all learning is shared across all teams, through safety briefings etc as part of the Directorate governance processes. Work is ongoing with regards information sharing for patients in relation to choices made for the caesarean sections completed under 39 weeks that are not indicated for medical reason. • X30 staff voices received in July, main theme relating to the on-call escalation policy. These will be reviewed and feedback provided to staff. • Concerns – 15 informal concerns received for Maternity, 25 reported for Gynaecology. A number of themes identified within Gynaecology specifically in relation to endometriosis, delay in appointments, waiting times for gynaecology outpatients, timely follow up. • Recruitment is ongoing across areas within the Directorate • NICU Storage build has commenced to support the additional cots from Cwm Taf Health Board. NICU cots are anticipated by 9th September 2024. **Timely Access** No update available. **The CWQSE resolved:** a) The update was noted for information and key highlights recorded.	
CWQSE/ 2024/137	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Detail noted as part of the Directorate report updates. No new risks for the Clinical Board Risk Register **The CWQSE resolved:** a) Update noted.	
SAFE CARE		
CWQSE/ 2024/138	**NRI/PSLR/Closure Forms for discussion/exception reporting** **SBAR, PSLR and Improvement Plan ZG (Datix 56444)**	

	Case relates to a baby born by emergency caesarean due to an abnormal CTG, thick meconium and subsequent neonatal admission with meconium aspirate syndrome. There were x3 issues identified from the review and x2 incidental findings. These were noted as (Taken directly from SBAR): ***Incidental Issue 1: Assessment of fetal growth not organised for 39 weeks' gestation*** *ZG had received serial ultrasound scans through Fetal Medicine Unit (FMU) and should have subsequently been referred for a scan at 39 weeks gestation following discharge from FMU. This is in accordance with current fetal growth assessment guidance. This did not contribute to the overall outcome and was acknowledged as an incidental finding. If a scan had been organised for 39 weeks gestation, Baby G would have already been born and no opportunity for a repeat scan.* ***Incidental Issue 2: FMU biometry ultrasound images not stored*** *There was found to be no stored images of Baby G's biometry measurements meaning a review for assurance purposes can be performed. The stored images of the USS's performed in FMU are in relation to renal anomalies only. This did not contribute to the outcome.* ***Issue 3: The CTG remained abnormal*** ***Issue 4: Patient left theatre without clear ongoing care plan*** ***Issue 5: No escalation to the On-Call Consultant Obstetrician and/or Consultant Gynaecologist.*** *Although the CTG features improved slightly, it remained abnormal. A CS should have been performed given the combined presence of thick meconium. The improvements were likely a result of the administered terbutaline and the subsequent reduced frequency of contractions. Where thick meconium is present and CTG features indicate hypoxic stress an earlier birth is indicated. However, it is impossible to say whether than earlier birth would have avoided the meconium aspirate syndrome as the CTG cannot predict if/ when a fetus will gasp in-utero. It is however more likely to occur with repetitive decelerations.* *During observation of the CTG the Senior Obstetric Registrar exited theatre following a request to attend a Gynaecology related emergency. The Junior Obstetric Registrar who initially attended the emergency reattended theatre and the Senior Registrar exited. It was noted that there was no clear plan regarding ZG's ongoing care made by the Senior prior to their exit. The Obstetric and Gynaecology Consultants were also unaware of the competing emergency cases. The midwife escalated concerns regarding the CTG and meconium liquor, at this time ZG was re-examined and a decision for CS was made. The Gynaecology Consultant should have been made aware of the Category 1 situation to potentially allow for further arrangements to be made to allow the Senior Obstetric Registrar to remain in theatre. The Obstetric Consultant could also have been notified allowing for their attendance prior to the exit of the Senior Obstetric Registrar. It does not appear to have contributed to the outcome in this case and there was appropriate escalation by the midwife.*	

It was felt by the Senior Obstetric Registrar that the experienced Junior Obstetric Registrar could manage ZG's case and did not feel Consultant escalation was required. Despite this, ZG's case meets criterion set out in The Royal College of Obstetricians and Gynaecologists (2022) list of examples where the On-Call Consultant must attend. The criterion met being "high levels of activity e.g. a second theatre being opened". It is possible the birth may have been expedited had Consultant staff been contacted, however it is unlikely that the outcome of meconium aspiration would have changed.

The recommendations from the investigation included:

- When discharged from FMU or Consultant Led Care, there should be a clear plan for ongoing fetal growth monitoring in accordance with the Fetal Growth Assessment (GAP Protocol and GROW charts) (2022) guideline.
- All ultrasound images relating to the measurements obtained must be safely and securely stored. They must be linked to the relevant record and securely retained in traceable archives.
- A lower threshold for expediting birth should be considered in the presence of meconium stained liquor and signs of evolving hypoxia.
- Escalation to Consultant staff should be performed in the event of competing emergency case.
- There should be a low-threshold for escalation to the On-Call Consultants in the event of competing clinical demands and raised clinical activity.

An improvement plan has been developed and actions are being progressed. This will be monitored through to completion via AMAT.

It was agreed that this report could be progressed through executive sign off and closure.

SBAR, PSLR and Improvement Plan KL (Datix 52310)

Case relates to a baby born before arrival at term with low neonatal oxygen saturations. The patient experienced an unexpected birth in temporary hotel accommodation. Paramedic crews were in attendance and saturations noted to be low. Decision was made to await the arrival of the community midwife as baby remained visually well. Upon arrival it was decided that mum and baby would be transferred to UHW for ongoing observations in view of the continued low oxygen saturations.

On arrival, respiratory support was commenced and baby was admitted to the neonatal unit, where a diagnosis of Persistent Pulmonary Hypertension of the Newborn (PPHN) was noted and treatment required. Baby was transferred to Leicester for ECMO.

There were x5 issues identified from the investigation and x1 incidental issue:

Incidental issue 1: The Maternity Early Warning Score chart was not used regularly during the antenatal period

KL's BP remained normal throughout the pregnancy so did not contribute to the case's outcome. However, all readings taken during the antenatal period should be plotted on the MEWS charts to enable the monitoring of a trend and appropriate escalation of concerns.

Issue 1: Skin to skin was not initiated following the birth of Baby L

Issue 2: Low oxygen saturations following birth

	Issue 3: Unable to reach Community Midwife to attend ***Issue 4: Delayed ambulance transfer to UHW*** ***Issue 5: Neonatal team not aware of Baby L's transfer into UHW*** ***Issue 6: Delivery Suite Team and Midwifery Unit Manager not aware of Baby L's transfer to UHW's Midwifery Led Unit (MLU)*** The recommendations were noted as: 1. The MEWS chart should be used to plot all observations obtained during the antenatal period to support identification and escalation where required. 2. In the event of BBA's, effort should be made to obtain adequate neonatal thermoregulation. 3. Respiratory support should be commenced in the presence of low oxygen saturations, even in the absence of visual indications of respiratory distress. 4. The live daily planning list should be utilized via SharePoint by receptionists. 5. In the presence of clinical concerns, ambulance transfer should be initiated prior to the attendance of the Community Midwife. 6. In the event of an ambulance transfer to UHW from the community due to neonatal concerns, the Neonatal Team should be made aware of the transfer via a pre-alert to the Delivery Suite. Discussion ensued with regards to the Antenatal MEWS charts, and it was noted that a piece of work is required to understand why that has not happening as this was a ruling 28 in a different case, and was understood to be an embedded practice. Red phone has been implemented on Delivery Suite for pre-alerts from WAST. Further discussions needed as to whether Neonatal calls will also come through this line. It was agreed that an SOP should be considered for appropriate actions required for alerts received through the red phone line in Delivery Suite. Concerns were raised with regards to the ongoing discussions with WAST in regards to admission to ED and not MLU as is the preferred choice from maternity/neonatal services from a safety perspective. Some queries had been raised from patient safety with regards to the use of interpreter services. It was agreed that these would be reviewed outside of the meeting. Subject to no further changes to the report, it was agreed that this report could be progressed through executive sign off and closure. **The CWQSE resolved:** a) Cases noted. b) Both cases have been approved through the Directorate governance processes and are approved by the Clinical Board for progressing to executive sign off and closure	**LM/KH/AL**
CWQSE/ 2024/139	**3.5. Infection Prevention Control Update Report** The report was shared for information. For August there were x2 EColi positive blood cultures reported. C Diff cases the target is 6, and there have already been x6 cases reported to date, however noting that the last case reported was in June 2024. There has been increase in HPV cleaning currently at 85% which is an improvement on the previous financial year. It was agreed there was a need to further improve and ensure that HPV cleaning is completed for all cases.	

For MRSA, target is zero. There has been x1 MRSA allocated to NICU however noted that the blood culture was taken in a different health board. Datix has been submitted and the RCA investigation is awaited.

For MSSA cases, target 4 with number of cases reported x1 in April 2024.
E Coli, target is 8, with x5 cases reported to date. There have been no common themes identified and are also different at source.

Pseudomonas, target is zero, with x2 cases reported to date. Both cases relate to the same patient, with x2 positive cultures.

Klebsiella, target 4, current position is zero.

MRSA outbreak within the Neonatal Unit, with x12 positive cases since April 2024. x4 are independent cases, x2 are linked to each other and x2 are linked to previous cluster of cases from 2023. Further update is awaited on screening for x4 patients. Initial outbreak meeting held and an action plan has been implemented. Further meeting arranged for 10th September 2024.

Hand Hygiene audits have been very positive, however noted that the last audit was at 80%. Queries were raised as to whether additional actions are required due to the further cases reported since the last outbreak meeting. It was agreed that once the typing results are received, it can be considered as to whether additional actions are needed. SJ noted that the typing usually take up to two weeks to come back, however agreed to see if this could be expedited.

MPOX has been declared as a global health emergency. Requirement for a HCID plan to be in place within Acute Child Health and Maternity (Delivery Suite, PICU and Seahorse Ward identified as the main areas). Fit testing records have been requested, as an FFP3 mask will be required. Fit tester assessors required in all areas.

Need to ensure that adequate stock is in place for PPE, information has been shared from Infection Control highlighting the required kit that needs to be ordered. There should be enough PPE for up to 72hours of care.

Date is being arranged for Donning and Doffing sessions and this will be shared when set. Queries were raised as to whether cascade training can be considered to ensure that staff can be released for training appropriately.

KM noted that the Pathway from Paediatric SDEC through to PICU being completed. With regards to NICU, this will also be reviewed as part of this review and necessary requirements.

Concern was raised with regards to the MRSA outbreak and any further actions required specifically relating to the impending activity anticipated from POW, and it was noted that information has been shared in relation to the current outbreak.

Queries were raised with regards to advice for community staff and it was agreed that the HCID guidance would be shared which does include some information for community settings. Questions are being finalised at present and it was agreed that this would be shared.

RS noted that Fit Testing training sessions can be accessed through the H&S Dept. For staff who have failed the qualitative fit testing additional sessions x1 per month is available to undertaken quantitative method fit testing, which can

	also be booked via the H&S training mailbox. **The CWQSE resolved:** a) Update noted. b) Donning and Doffing session dates to be circulated.	**SJ**
CWQSE/ 2024/140	**Safeguarding/Mental Capacity Act (MCA)** The following documents have been shared for information and onward sharing. • 7-minute briefing • Safeguarding Newsletter Request has been made to meet with the safeguarding team in relation to required supervision support and the need to ensure that staff have appropriate access to supervision. Concern was raised in relation to Safeguarding Training requirements and the impact this is having on the compliance given the limited staff headroom of 4% on rosters, and is impacting on other mandatory training compliance. It was noted that these concerns have been highlighted in relation to additional mandatory training requirements, acknowledging that there is a need to ensure that professional training is prioritised where possible. AJONES agreed to highlight as part of the next executive DON's/DOM's Meeting. **The CWQSE resolved:** a) Documents noted. b) Safeguarding training concerns to be highlighted at next DON/DOM's meeting.	**AJONES**
CWQSE/ 2024/141	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • ISN 2024 002 – FreeGo Feeding Pumps • Safety Memo – Pancreatic Enzyme Replacement Therapies (PERT) • Safety Memo – Registration of Unknown Patients in EU • Safety Memo – Intermittent Supply Issues with Kay-Cee-L Syrup • Public Health Briefing – Outbreak of Clade I Mpox in the African Region All alerts have been circulated for onward sharing and action as necessary. There were no specific exceptions to note. **The CWQSE resolved:** a) Alerts noted.	
CWQSE/ 2024/142	**NICE Guidance – Update on Progress** Report shared for information. All guidance is disseminated through AMAT. Any support required, contact the Clinical Audit team. All were asked to review and ensure that statement of compliance is completed/updated on the AMAT system **The CWQSE resolved:** a) Update noted.	
TIMELY CARE		
CWQSE/ 2024/143	**Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:**	

	a) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2024/144	AWTTC Newsletter https://awttc.nhs.wales/pages/sign-up-for-the-awttc-newsletter/ The newsletter was shared for information. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/145	**CSSI Annual Report 2022** The annual report was shared for information. **The CWQSE resolved:** a) Update noted.	
ANY OTHER BUSINESS		
CWQSE/ 2024/146	**Date and Time of Next Meeting** Tuesday 24th September 2024, Microsoft Teams	**ALL to note**

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

Held on 25th July 2024 at 2pm

Present:		
Helen Luton (Chair)	HL	Director of Nursing/Multi Professional Teams
Sarah Lloyd	SL	Director of Operations
Becca Jos	BJ	Deputy Director of Operations
Robert Bracchi	RB	Medical Advisor to AWTTC
Melissa Melling	MM	Head of Medical Illustration
Seetal Sall	SS	Point of Care Testing Manager
Susan Beer	SB	Public Health Wales Representative
Mathew King	MK	Head of Service, Podiatry
Samantha Davies	SD	Radiographer, Radiology
Jo Fleming	JF	Quality Lead, Radiology
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer/Assistant Director of Therapies and Health Sciences
Sian Jones	SJ	Directorate Manager, Laboratory Services
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Jamie Williams	JW	Senior Nurse, Radiology
Jonathan Davies	JD	Health and Safety Adviser
Rhys Morris	RM	CD&T R&D Lead
Elaine Lewis	EL	General Manager, Pharmacy
In attendance:		
Harpria Bhogal	HP	Pharmacist
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Adam Christian	AdC	Clinical Board Director
Alison Lewis	AL	Patient Safety Coordinator
Paul Williams	PW	Clinical Scientist, Medical Physics
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Suzie Cheesman	SC	Nurse Advisor, Medicines Management
Alana Adams	AA	Principal Pharmacist Medicines Information and Advice
Sue Lawless	SL	Laboratory Service Manager, Haematology
Debra Woolf	DW	Sister, Outpatients
Sandra Watts	SW	Senior Nurse, EPMA
Timothy Banner	TB	Clinical Director, Pharmacy
Yvonne Hyde	YH	IP&C Team Representative
Suzanne Rees	SR	Lead Nurse for CD&T
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Tracy Wooster	TW	Sister, Outpatients
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 24/235	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 24/236	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 24/237	**Minutes of the previous meeting** The minutes of the previous meeting were received. **The Group resolved that:** a) The minutes of the previous meeting held on 25th June 2024 were accepted as an accurate record.	
CDTQSE 24/238	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 24/062 R&D Lead Laboratory Medicine* No nominations have been received and SJ will therefore attend the R&D Group on behalf of Laboratory Medicine. *CDTQSE 24/114 Radiology Chaperoning SOP* JF to present the SOP to the meeting in October. *CDTQSE 24/164 NRI* JF to present the NRI on the timely removal of stents to the October meeting. *CDTQSE 24/180 Information Asset Owners* Directorates to send Helen Jenkins the names of their Information Asset Owners in the next few weeks. **The Group resolved that:** a) The update on the actions outstanding from the previous meeting were noted.	**JF** **JF** **Dirs**
6 DOMAINS OF QUALITY		
SAFE		

CDTQSE 24/239	**Concerns and Compliments Report** In June 2024, the Clinical Board reported 25 concerns; 5 formal and 20 early resolution concerns. There were 0 breaches in response times and 5 compliments were received. The top reasons for concerns in June relate to: • Difficulties cancelling and arranging appointments • Waiting times for test result/scan report • Issues with clinical treatment The Group resolved that: a) The concerns report also provides a breakdown of the data to directorate level.	
CDTQSE 24/240	**National Reportable Incidents** Incident Number 64589 was reported by Radiology but sits with Medicine Clinical Board. Incident Number 44284 relates to an NRI that has since been downgraded to an LRI as the incident resulted in no harm. **The Group resolved that:** a) When the reviews are completed, the details of the incidents will be discussed at this group for shared learning.	
CDTQSE 24/241	**Duty of Candour Cases** **The Group resolved that:** a) There were no new duty of candour cases to report that are not within an NRI process.	
CDTQSE 24/242	**Risk Register Updates** JF reported that the temperature in the ultrasound rooms is hot and uncomfortable for staff to work in. As they are clinical rooms, the use of fans is inappropriate. A risk assessment is being completed and will be escalated to Estates. BJ asked if the MRI equipment downtime issues linked to humidity are being logged. It was noted that the risk assessment has been reviewed and the manufacturers are in the process of reviewing the humidity levels. **The Group resolved that:** a) It was requested that if there are any updates to the directorates' risk registers to submit them to HJ.	

CDTQSE 24/243	**Patient Safety Alerts** **The Group resolved that:** a) There were no patient safety alerts to report.	
CDTQSE 24/244	**Medical Device/Equipment Risks** EC reported that a Coroner's Section 78 Report is being circulated relating to how crash CD cylinders are to be operated. This follows an incident related to a user who do not realise that they needed to turn on both the cylinder and the flow. This was discussed at the UHB Medical Gases Group. There is an ESR training package available for medical gases but this is not a mandatory training module so it is important that staff need to be aware of how this equipment operates. A potential issue for examination images to be stored under the incorrect patient on certain ultrasound products was identified linked to how patients are selected on the worklist. A dialogue box will appear to advise there is an inconsistency with patient being scanned and the worklist and staff need to ensure they pay attention to this warning. Phillips have changed their NIBP hoses on their monitoring to meet a new standard for connections which will result in different hoses being in circulation. Clinical Engineering will try to manage this so there is a not a mix of hoses moving across departments. It was noted that Interventional Radiology will be receiving the new hoses and have a plan for when these are delivered. Certain MR systems conditional implants can overheat if certain conditions are met. There is a low SAR mode for certain MR systems. This is a technical issue around ensuring that values do not exceed the value on the scanned prescription user interface. GE will be undertaking corrective action. EC asked to be informed when they have visited. JF noted that adjustments have been made in the Radiology department and she will check whether GE have attended on site to undertake the software update. HL noted that the first meeting of the Total Bed Management Contract Project Group was held this week and there were a number of issues where it was suggested that Clinical Engineering could offer support. HL will discuss with EC outside of the meeting. EC stated his involvement in this group is not required until a later stage. **The Group resolved that:** a) The medical device/equipment risks were noted.	**JF**

CDTQSE 24/245	**Point of Care Testing** SS stated that the team are currently involved in multiple evaluations including diabetes systems used in the diagnosis and monitoring of diabetes from adults and paediatrics and community. Also undertaking work with haematologists that will start with an evaluation process to look at standardising activated clotting timing across the Health Board, as there is disparity and changes in practice across services. The work with Palliative Care Services discussed at the last meeting is progressing and is in early discussions. **The Group resolved that:** a) SS will update on the Palliative Care work at a future meeting.	
CDTQSE 24/246	**IP&C/ Decontamination Issues** Suzanne Rees and Yvonne Hyde were not present. **The Group resolved that:** a) There were no issues to raise.	
CDTQSE 24/247	**Safeguarding Update** At the next meeting, all departments are tasked to feedback on their safeguarding training compliance. **The Group resolved that:** a) Achieving the training compliance for all staff Band 6 and above and doctors of grade F1 and above remains a challenge.	**Dirs**
CDTQSE 24/248	**Health and Safety Issues** JD reported that the Health and Safety Team have received the indicative risk assessment forms for hand/arm vibration monitoring and the team have commenced monitoring. The UHB health and safety risk assessment template has been reviewed and a new form is to be used going forward for new risks. JD will send to HJ and she will circulate to this group and to the Clinical Board Health and Safety Group. MK asked if the UHB has identified a system of choice for audits as there are a number of systems available. I-Auditor is the preferred system for Health and Safety but this may transfer to the Tendable system.	**JD** **HJ**

	It was noted that the TDSI system in CRI is still not working and doors need to be propped open to allow staff to move through the site. The main concern is the risk of unauthorised individuals entering departments. JD received a response from the security team as to why there are delays, however the response did not include a timeframe for the repair. **The Group resolved that:** a) Podiatry will use their preferred system for recording audits and transfer across if needed. b) JD to send the response received from security re the TDSI doors to HL.	
CDTQSE 24/249	**Regulatory Compliance** The MHRA have closed their inspection in Blood Bank as they were pleased with the progress that the department made in the first quarter. BSI have informed the UHB that they will be undertaking at least one extra sampling visit per year to Clinical Engineering. Previously 2 visits were held per year. This will increase costs but may improve the quality management system. JF asked if there is any update on the procurement of Q-Pulse for multiple services. BJ noted that current agreements have been extended to December to allow time to understand the implications of the cloud-based versions and whether there are any benefits relating to merging licences across the UHB. **The Group resolved that:** a) The updates relating to regulatory compliance were noted.	
TIMELY		
CDTQSE 24/250	**Initiatives to Improve Access to Services** HL reported that there are plans to streamline the process in how death certificates are issued in the UHB. HL will ask SO for a member of the bereavement team to attend the next meeting and provide an update. SL requested for Radiology to provide an update on the implementation of the BMSU Guidelines in Ultrasound to the meeting in September. JF to request for a member of the team to present. **The Group resolved that:** a) These items will be discussed in more detail at the next meeting.	**HL** **JF**

CDTQSE 24/251	**Waiting Times Performance** BJ noted that the Radiology position is now over 10,000 for patients waiting 8 weeks or over. The majority sit in ultrasound where there is insufficient capacity due to a national shortage of sonographers. In terms of patients waiting 14 weeks or over for Therapies, the main issues are in dietetic paediatrics, where there is a plan for recruitment to provide support, acknowledging that this will not have an immediate impact. Paeds OT are reporting 146 breaches in month but have a plan to reduce this. Physiotherapy Pelvic Health has a lack of capacity to meet the high level of demand and the waiting list is rapidly increasing. Adult SLT breach numbers are reducing and plans are in place for this to continue to steadily reduce. Weight Management figures are being monitored internally as these are not nationally reportable. Demand is greater than capacity. A plan is in place to support Level 2. A business case is progressing for Level 3 which is impacted upon by the licencing of the Wegovy drug. Whilst not reportable, the waiting times for Pathology reports is an issue and this is reflected in the number of patient concerns being received. Capacity is an issue and the department is experiencing significant increases in demand. **The Group resolved that:** a) The teams involved are working hard to address their waiting times and are prioritising the most clinically urgent cases.	
EFFECTIVE		
CDTQSE 24/252	**Clinical Board Annual Report to UHB QSE Committee** The report was circulated for information. A video was produced to demonstrate the processes involved within Cellular Pathology and this was generally well-received. Further editing is needed to the video and it will be shared with this group at the September meeting. Within the paper the extensive list of inspections undertaken by regulatory bodies highlighted the significant work that has been undertaken in departments in readiness for inspections. SL shared the video with the Cancer Delivery Group and this was well received. A lot of questions were raised which	**HL**

	highlighted the need for a laboratory expert to facilitate the discussions. **The group resolved that:** a) The video will be shared at the meeting in September.	
CDTQSE 24/253	**NICE Guidance** **The Group resolved that:** a) There was no new guidance to share.	
CDTQSE 24/254	**Research and Development** RM reported that the Joint Research Governance Group was held last week and incident was raised relating to a PHD student from the School of Engineering, who did not realise that a trial needed to be reactivated following Covid despite having ethics approval and proceeded to recruit patients. A decision will need to be taken whether to allow retrospective approval for the trial. It was noted that there was no harm to any patients. The Clinical Board is required to produce an annual R&D report and a request was made for contributions. Industry has committed to a £400m investment fund to support clinical trials and health technology assessments and there will be some funding coming into R&D to support capacity and capability for clinical trials. Radiology and Pharmacy are key areas where they would be looking for ideas where specific investment could improve capacity, whether this is staffing or equipment. IRMER approvals for trials are currently being sent to North Wales, however there are delays in the process and discussions are being held around bringing this back in-house. **The Group resolved that:** a) The update from the R&D Lead was noted.	
CDTQSE 24/255	**Service Improvement Initiatives** HP was welcomed to the meeting to present the QI Project she had undertaken during her Pharmacy placement at Hafan-Y-Coed. The project focused on post rapid tranquilisation physical health monitoring on the Adult Psychiatric Intensive Care Unit. Rapid tranquilisation refers to the use of usually IM medicines to treat patients who are acutely agitated. Some of the risks associated with rapid tranquilisation include excess sedation, low blood pressure and in the worst cases it can lead to neurolactic malignant syndrome or death. The guidelines from the British Association for Psychopharmacology	

	and the National Association for Psychiatric Intensive Care Units recommend that the respiratory rate, blood pressure, heart rate and temperature is monitored for each patient for the first 15 minutes for the first 60 minutes after rapid tranquilisation and where a patient refuses, this should be documented. The aim of the project was to increase the proportion of rapid tranquilisation doses that were followed by a complete set of observations to 20% by April 2024 in the unit. Data was collected over 5 weeks to establish the baseline. It was identified that none of the doses were followed by a complete set of observations and national audit data for the UK in 2018 highlighted that only 2% of episodes nationally were followed by a complete set of observations. For the first intervention, guidelines made across Trusts and Health Boards were reviewed and the NEWS chart used on mental health units was modified for this project. The data was collected and results showed that improvements in complete sets of observations being undertaken were variable. Intervention 2 was undertaken where the modified NEWS charts were placed alongside each patient's medication chart. The results following this intervention, identified a shift in the data with doses followed by no observations reduced to 7% and 100% completion increased from 0 to 21% and the median increased from 0 to 63%. The outcome of the project identified: Most rapid tranquilisation doses still fall short of national standards, despite there being an improvement. The need for further form filling contributed to the variable results in the first cycle. There are constraints as patients on the wards are extremely unwell and require high levels of care. There is a high turnover of staff and it needs to be ensured that all staff are aware of the standards and further education and training is needed. Feedback from the project was that placing the charts alongside the medication charts has been helpful. The project will continue with other pharmacists and be expanded out to other wards. **The Group resolved that:** a) There is potential for the project to be rolled out to other non-mental health settings, particularly the EU department. It was noted that it would be worthwhile sharing the guidelines to other wards for awareness.	

CDTQSE 24/256	**Information Governance/Data Quality** **The Group resolved that:** a) There were no IG or data quality issues to report.	
CDTQSE 24/257	**HIW/LAITH Reports and Improvement Plans** Following the HIW inspection in EU, a dashboard in Power BI is being developed by Clinical Engineering to flag when PPMs are overdue. **The Group resolved that:** a) There have been no other inspections held that have impacted on this Clinical Board.	
CDTQSE 24/258	**Policies and Procedures** The Therapies QSE Group ratified its new study leave policy which is in line with the UHB policy, to ensure there is consistency across all the therapy departments. It was noted that the policy has been agreed with Trade Union representatives **The Group resolved that:** a) There are no relevant UHB policies or procedures out to consultation and no Clinical Board policies or procedures to be received.	
EFFICIENT		
CDTQSE 24/259	**Exception Reports from Directorates** Therapies Exception Report from its QSE Group has been received. **The Group resolved that:** a) There were no other issues raised from directorates.	
CDTQSE 24/260	**Clinical/Internal Audits** **The Group resolved that:** a) There were no updates relating to audits to report.	
CDTQSE 24/261	**Waste and Sustainability** The UHB is rolling out the new recycling bins across the Health Board in line with the new recycling legislation for workplaces. **The Group resolved that:**	

	a) The next Clinical Board Waste and Sustainability Group will be held in September.	
EQUITABLE		
CDTQSE 24/262	**Feedback from Clinical Board Inclusion Ambassadors Group** The Clinical Board Inclusion Ambassadors Group has not met since the last meeting. **The Group resolved that:** a) The Group needs to be reinvigorated and aligned to the staff survey results.	
CDTQSE 24/263	**Equality and Diversity Issues** **The Group resolved that:** a) There were no updates to report.	
PERSON CENTRED		
CDTQSE 24/264	**Patient Story** MM presented the patient story from Medical Illustration. A Senior Clinical Photographer was recently called to a ward to take pictures of a patient's sacral pressure ulcer. The photographer attended the bedside to explain to the patient that she had arrived to undertake the photograph and the patient was visibly mortified at the thought of having an image taking of this intimate area. The photographer knew that the patient would not consent to this and therefore explained to them why the images were needed. Seeing that the patient was overwhelmed she allowed the patient to have time to consider this and discuss it with their family and offered to return in a few days to see if they had changed their mind. The photographers experience this frequently and realise that patients are more confident when they have time to consider and discuss this with their families. After two days the photographer returned to the patient and the patient agreed to have the image taken, on the basis that it was this particular photographer who would take the photograph. This was a grade 3 pressure ulcer and having the image taken meant that the most appropriate treatment could be used for the patient's ongoing care. The patient's family emailed the department to thank the photographer for their professionalism and for showing great respect to their relative. This helped their relative reach the right decision, and they also had the image taken by someone they felt comfortable with. **The Group resolved that:**	

	a) HL reflected that perhaps Ward staff fail to explain to patients the need for photography, to prepare them in advance of having the images taken. HL will highlight this issue to nursing colleagues.	**HL**
24/265	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** A designated rest area is being put in place for Podiatry staff based at St Davids. **The Group resolved that:** a) Directorates to consider how they can support the health and wellbeing of their staff and their patients**.**	
CDTQSE 24/266	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no other initiatives to report.	
CDTQSE 24/267	**National User Experience Framework/Feedback from Patient and Service User Surveys** HL will liaise with the Patient Experience Team to see if more meaningful data for this Clinical Board can be extracted from the Civica reports. MM reported that their patients often request directions to the UHW site. To help patients, Medical Illustration now provide information on the Park and Ride Scheme on their letters. JF noted that a kiosk has been allocated to Radiology to obtain patient feedback. It is likely that this will be placed in UHL. JF is liaising with the volunteer service to see if they can provide any support. SJ advised that there have been requests whether the frequency of the Park and Ride Service could be increased. HL will feed this back. **The Group resolved that:** a) HL will circulate the Civica reports as and when they are received.	**HL**
CDTQSE 24/268	**Staff Awards and Recognition** The category for the Clinical Board Staff Recognition Scheme in July is the Living Our Vales Award. The category for August is the Team Award.	

	The Group resolved that: a) Nominations are encouraged from all staff in the Clinical Board.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 24/269	CD&T Health and Safety Group Minutes 17.6.24	
ANY OTHER BUSINESS		
CDTQSE 24/270	JD asked if the leaks in Radiology have now been resolved. HL believes the work is completed but will check this is the case. Maintenance work is now required to address the flooring. SL advised that a Generator Test was undertaken on Tower Block 2 last week. Minor issues were raised but generally the test was successful. There are no plans to re-test this area.	
CDTQSE 24/271	**Date & time of next Meeting** It was agreed to stand down the meeting due to be held on 23rd August 2024. The next meeting will be held on 19th September 2024 at 2pm via Teams.	

Minutes of the Medicine Clinical Board
Quality, Safety & Experience Committee Meeting
Held on 17 July 2024 14:30 – 16:00, Via MS Teams

Present:	
Ceri Richards-Taylor	Interim Deputy Director of Nursing (Joint Chair)
Katja Empson	Consultant/ interim Clinical Board Director (Joint Chair)
Aneurin Buttress	Consultant, Integrated Medicine
Sian Rowlands	Head of Quality and Clinical Governance
Catherine Evans	Interim Deputy Head of Patient Safety, Patient Safety Team
Jason Roome	General Manager, Integrated Medicine
Liz Vaughan	Professional & Practice Development Nurse
Nicholas Denny	Organisational Learning Facilitator - Mortality Lead
Wayne Parsons	Lead Nurse, Integrated Medicine
Dave Mcrae	Lead Pharmacist, Medicine
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Angela Jones	Senior Nurse, Resuscitation Service
Lowri Warren	Senior Nurse for Professional Development, A&E
Sue Eshel	Senior Nurse, Integrated Medicine
Andrew Brown	Interim Senior Nurse, Specialised Medicine
Marianne Jenkins	Consultant Nurse Practitioner, Emergency Department
Joanne Roche	Ward Manager, B2 Link, Integrated Medicine
Derek King	Clinical Nurse Specialist, Infection, Prevention and Control
Niki Turner	Service Manager, Stroke, Integrated Medicine
Molly Baker	Service Improvement Manager, Innovation & Improvement
Nathan Williams	Service Manager, Endoscopy, Specialised Medicine
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Claire Main	Interim Director of Operations for MCB/ Acute and out of hospital care
Barbara Davies	Interim Director of Nursing (Chair)
Richard Marsh	Consultant, Internal Medicine, Integrated Medicine
Mike Bond	Director of Workforce and Financial Improvement
Hannah Mastafa	Deputy Director of Operations
Alexandra Scott	Assistant Director of Quality Safety
Lyndsey MacDonald	Clinical Director, Emergency Medicine
Siobhan Lewis	Consultant, Internal Medicine, Integrated Medicine
Kath Prosser	Quality & Governance Lead, Medicine
Dave Pitchforth	Lead Nurse, Specialised Medicine
Ceri Martin	Lead Nurse, Acute and Emergency Medicine
Natasha Whysall	Interim Lead Nurse, Integrated Medicine
Rachel Maiden	Senior Nurse, Integrated Medicine
Cath Morris	Senior Nurse, Acute & Emergency Medicine
Beth Jones	Senior Nurse, Specialised Medicine
Sian Brookes	Senior Nurse, Integrated Medicine
Lisa Green	Senior Nurse, Acute & Emergency Medicine
Katie Innes	General Manager, Specialised Medicine
Sarah Wright	Clinical Nurse Specialist, Infection Prevention & Control
Sam Hughes	Professional & Practice Development Nurse
Craig Davies	Service Manager, Acute Medicine
Dharmaraj Durai	Consultant, Specialised Medicine
Brijesh Srivastava	Consultant Hepatologist, Gastroenterology, Specialised Medicine

Sharon Jones	Consultant, Specialised Medicine
Samantha Hughes	Professional & Practice Development Nurse
Harriet Foley	Senior Nurse, Integrated Medicine

Item No	1. Standing Items	Action
MCBQSE/ 2024/0096	**Welcome & Introductions** – were undertaken. **Declarations of interest** – none raised.	
MCBQSE/ 2024/0097	**To receive the minutes of the previous meeting held on 19/6/24** – the group were asked to read the minutes and advise CR-T if any amendments are required. The group resolved: if no amendments are required, the minutes will be accepted.	
MCBQSE/ 2024/0098	**Action Log** – the group were asked to provide Sian Rowlands with any updates on actions on the Action Log, so that the log can be updated prior to the next meeting.	All
MCBQSE/ 2024/0099	**Declarations of Interest** – none.	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2024/0100	**Patient Story** – delivered by Jo Roche Ward Sister B2 Link, Integrated Medicine The patient story relates to a 75-year-old lady who had been on the ward for a while. The patient had a background history of Alzheimer's and had been living at home with her husband with no package of care. On admission to A&E, the was deemed not to have capacity, had behavioural issues and was given PRN medication. A Read About Me was completed with the family. The patient settled when her family were present and 24 hour enhanced care was put in place following the completion of behaviour charts in line with Enhanced Supervision practice. A social work referral was made. Consultant Nurse for older people (RC) was contacted for advice. With the agreement of the family, the administration of covert medication was commenced; enhanced care was reduced and checks were put in place. The patient improved with a plan put in place to discharge her home with a package of care and respite care to support the patient's husband. Court of Protection paperwork is in place in case the patient needs to move into a care facility at a future date. The group resolved: RC is doing a lot of work around enhanced supervision. Involving RC was a turning point in this case regarding managing the risks differently. **Actions from discussion**: none.	
MCBQSE/ 2024/0101	**Concerns, Claims, Compliments** **Compliments** - were shared in relation to C7; Endoscopy and East 2. **Concerns** – for all of MCB there are 78 active concerns including early resolution. The group resolved: to keep sharing feedback. **Actions from discussion**: to keep sharing feedback.	
MCBQSE/ 2024/0102	**Family Feedback ME Reports** - Civica reports now capture family feedback. - Positive family feedback themes were added as a visual display/ word cloud. Feedback is often that the care is good, however, staffing was low. - Negative feedback themes were added as a visual display/ word cloud. The group resolved: to note the above. **Actions from discussion:** SR/CR-T to share this visual feedback with teams.	Sian Rowlands/ Ceri Richards-Taylor
MCBQSE/ 2024/0103	**Infection Prevention and Control (IP&C) update:** 185 days since last MRSA bacteraemia 21 days since last MSSA bacteraemia 6 days since last *C difficile* 48 days since last E. *Coli* bacteraemia 26 days since the last *Pseudomonas* 5 days since last Klebsiella bacteraemia • There are 4 wards in outbreak at UHL, affecting 12 patients, 5 staff members, resulting in 8 bed days lost. • DMT scores –all wards within MCB remain compliant for the last 4-week period.	

	• HCAI reduction goals – no new cases of MRSA or *E. coli.* in May 24.
	• MCB position based on same period last year:
	  ○ 62% increase with *C. difficile.*
	  ○ 71% reduction with *E. coli.*
	  ○ 66% increase with *Pseudomonas.*
	  ○ 33% reduction with SAUR Bacteraemias.
	  ○ 50% reduction *with Klebsiella*
	• Audit results are improving.
	• A Back to Basics teaching session was run in June 24, no staff attended. Another session will run in July 24. Training to take place at UHL.
	• MCB IP&C meeting was stood down in June 24.
	• HPV cleaning – showed an improvement in compliance.
	
	The group resolved: to note the above.
	Actions from discussion: A Datix should be submitted for any case of hospital acquired *C. difficile* or healthcare associated infection. When information is received from the Medical Examiner regarding a deceased patient, there is rarely an incident report logged. Lead and Senior Nurses to drive compliance with this.
		Lead & Senior Nurses

MCBQSE/ 2024/0104	**Peer Review Report of Dermatology Cancer Services** - A draft report has been issued. The peer review was largely positive. A deadline to respond has been given and an action plan will be formulated. **The group resolved**: to note the above. **Actions from discussion:** none.	
MCBQSE/ 2024/0105	**Overdue NICE Guidance Responses** An exercise has been undertaken where the Patient Safety Team generated the approach to various areas for different items of NICE guidance to return evidence of compliance with guidance. Justification is required if non- compliant. Outstanding elements of NICE Guidance apply to many areas, some of which are outside of Medicine. Information is being stored on AMAT. **The group resolved**: to note the above. **Actions from discussion:** Tim Ayres is leading on the Hospital Health Pathways work for the Emergency Department. The staff working on the Hospital Health Pathways are linking in with specialist areas and looking at current guidelines in place. Align both pieces of work. Sian Rowlands will liaise with Tim Ayres and link in with Alex Scott to ensure all is connected.	Sian Rowlands
3	**ITEMS FOR APPROVAL/ RATIFICATION**	
MCBQSE/ 2024/0106	**National Reportable Incidents (NRIs)** MCB NRI Position – there are 16 open NRIs and 2 IRMERS. 2 open in Integrated Medicine. 9 open in Specialised Medicine, 5 of which have breached the closure date. Acute & Emergency Medicine 5, 4 of which have breached the closure date. A Never Event has been reported recently regarding a retained guide wire. A meeting to discuss this historic incident has been planned. **NRIs for closure:** **Emergency & Acute Medicine**: **ID47081** An individual attended A&E in February 2023 following sudden onset of abdominal pain. The patient was diagnosed with constipation and discharged with laxative medication and safety netting advise. The patient represented two days later and was diagnosed with a ruptured spleen. Despite treatment, the patient's condition worsened and on 18/2/23 the patient died. **Findings/learning** RCEM guidance advises all patients over the age of 70 with abdominal pain require senior review prior to discharge. A senior review should have taken place which may have led to performing a CT scan earlier on admission which may have identified the ruptured spleen.	

	- If medication usually taken is stopped, it should be appropriately documented within the In patient Medicines Chart. - Findings of the review to be shared with relevant colleagues. **The group resolved**: to note the above. **Actions from discussion:** none.	
MCBQSE/ 2024/0107	**LFE CN/UHW/DCIQ1035** – the claim relates to follow-up of results. The patient was an 87-year-old female admitted via A&E on 20/5/22 following a referral by her GP for high blood pressure and palpitations. **Conclusion**: there was a delay in review of the investigation results and as a consequence in diagnosing Atrial Fibrillation and initiating anticoagulation therapy which on balance, would have resulted in the patient avoiding the stroke. **Learning**: - There was a delay in reviewing the investigation results and as a consequence in diagnosing Atrial Fibrillation and initiating anticoagulation therapy. - Outpatient clinic has a manual system to track test results for follow-up and flag for review and action once received. - This is supported by a twice weekly review between responsible clinician and secretary of any outstanding results. - There are arrangements in place to provide cover in the event of staff absence due to sickness or holiday. **LFE RED7A4-0245/AD** – the claim relates to delayed diagnosis. The patient was a 48-year-old female who attended A&E on 12/7/19. **Conclusion**: (based on expert report). Care provided up until 16.07 reasonable. However, once the CRP had risen on 16.07, and in the face of an intermittent pyrexia, further assessment should have been undertaken to ascertain a different, or deeper-seated infection by way of more robust examination and CT scanning. Decision to defer CT scanning due to the decline in renal function and risk of contrast nephropathy was incorrect as risk of failing to identify a further infective source was greater. Causation denied. **Learning**: Timeliness of CT scanning and discussion of risks around contrast nephropathy, steps to minimise, informed consent so that scanning not inappropriate delayed. **The group resolved**: Learning from Events Report will be provided to Welsh Risk Pool. **Actions from discussion:** SR will share the update on both of these LFER's for further learning. Radiologists need to be involved and this to be shared with CD&T.	Sian Rowlands
4	**ITEMS FOR NOTING AND INFORMATION**	
MCBQSE/ 2024/0108	**Patient Safety Alerts/MDAs/ISNs:** Public Health Wales Briefing: Changes to Clinical and Public Health Management of Confirmed and Suspected Pertussis Cases June 2024 **The group resolved**: share for information. **Action from discussion**: share for information.	
MCBQSE/ 2024/0109	**Medicines Management** **Managing Unavailable Medicines (non-CDs) in Community Hospitals Flowchart -** A member of the Pharmacy Team put the flow diagram together to request medicine to be transferred to community hospitals from acute sites. **The group resolved**: this updated document is to be noted. **Action from discussion:** SG will re-share this flowchart with Ward based teams.	
MCBQSE/	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions**	

2024/0110	- Rheumatology QSE meeting 18th June 2024 - Acute & Emergency Medicine (meeting 9th July await minutes from meeting 11th June 2024) - Integrated Medicine, UHL/UHW (await minutes from meeting held June 2024) - Integrated Medicine UHL/UHW next QSE meetings September 2024 - EUG next meeting 18th July 2024 **The group resolved**: for noting. **Action from discussion:** directorate minutes are required to be shared at MCB QSE. Work to be done to track all directorate QSE meetings and ensure minutes are followed up.	Ceri Richards-Taylor/ Sian Rowlands
MCBQSE/ 2024/0111	**Minutes from QSE Sub Groups:** - IP&C meeting in June 2024 - meeting cancelled. - H&S meeting await minutes last meeting 26/06/2024 - Medicines Access and Governance Group await minutes last meeting 21/06/2024. **The group resolved**: to note the above. **Action from discussion:** none.	
MCBQSE/ 2024/0112	**Feedback from UHB QSE Committee** – no update. **The group resolved**: no update. **Action from discussion:** no update.	
5. ANY OTHER BUSINESS		
MCBQSE/ 2024/0113	**Any Other Business** **Field Safety Notice Philips Respironics BiPAP Machines** – these are used within the community for patients requiring life support. There is an issue with the alarm which could cause the device to stop working. A risk assessment has been drawn up, and a plan to replace the machines is in place. The risk is low; however, it is potentially serious. 21 machines need to be replaced and there is a cost implication. The immediate risk regarding these machines is being addressed. **The group resolved:** discussed here for information. **Action from discussion**: none.	
6. DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2024/0114	21 August 2024 at 14:30-16:00 via MS Teams	

Minutes of the Medicine Clinical Board
Quality, Safety & Experience Committee Meeting
Held on 21st August 2024 14:30 – 16:00, Via MS Teams

Present:	
Barbara Davies	Interim Director of Nursing Chair
Dr Katja Empson	Consultant/ interim Clinical Board Director
Katherine Prosser	Quality and Governance Lead
Sian Rowlands	Head of Quality and Clinical Governance
Derek King	Clinical Nurse Specialist, Infection, Prevention and Control
Chisom Uwaezuoke	Clinical Nurse Specialist, Infection Prevention and Control
Angela Jones	Senior Nurse Resuscitation Service
Sarah Wright	Clinical Nurse Specialist, Infection Prevention and Control
Natasha Whysall	Lead Nurse Integrated Medicine
Marianne Jenkins	Consultant Nurse Emergency Medicine
Claire O'Keeffe	Senior Nurse Integrated Medicine
Beth Jones	Senior Nurse Specialised Medicine
Andrew Brown	Senior Nurse Specialised Medicine
Rachel Maiden	Senior Nurse Integrated Medicine
Hibaq Musa	Clinical Nurse Specialist, Infection Prevention and Control
Dr Lindsay George	Consultant Diabetes
Emma Keen	Deputy General Manager Integrated Medicine
Catherine Evans	Interim Deputy Head of Patient Safety
Secretariat	
Apologies:	
Claire Main	Interim Director of Operations for MCB/ Acute and out of hospital care
David Pitchforth	Lead Nurse Specialised Medicine
Lisa Green	Lead Nurse Emergency and Acute Medicine
Wayne Parsons	Lead Nurse Integrated Medicine
Ceri Richards-Taylor	Interim Deputy Director of Nursing

Item No	1. Standing Items	Action
MCBQSE/ 2024/0115	**Welcome and Introductions** – were undertaken.	
MCBQSE/ 2024/0116	**To receive the minutes of the previous meeting held on 17/7/24** – the group were asked to read the minutes and advise if any amendments are required. The group resolved: if no amendments are required, the minutes will be accepted.	
MCBQSE/ 2024/0117	**Action Log** – The action log needs to be reviewed to remove longstanding actions.	All
MCBQSE/ 2024/0118	**Declarations of Interest** – none.	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2024/0119	**Patient Story – Acute and Emergency Medicine were unable to present a patient story secondary to staffing levels and operational pressures.**	
MCBQSE/ 2024/0120	**Concerns, Claims, Compliments** **Compliments** - were shared in relation to OPSU, C7 and SRC **Concerns** – Highlighted continued themes centring around communication, access to services, attitudes and behaviours. Requirement to maintain traction on 30 day response rates, improvement noted across Directorates. The group resolved: to keep sharing feedback. **Actions from discussion**: to keep sharing feedback.	

MCBQSE/ 2024/0121	**Family Feedback ME Reports** - Civica reports now capture family feedback. - Positive family feedback themes were added as a visual display/ word cloud. Feedback often is that care is wonderful and staff are compassionate. - Negative feedback themes mainly focused on clinical areas being busy, delays in issuing medical cause of death for bereaved families and poor communication. The group resolved: to note the above. **Actions from discussion:** To continue to share these across Directorates along with other Mortality information. **Care After Death Phase 1 –** Referral to the Medical Examiner, Coroner and completion of the Medical Cause of Death. Important to ensure we improve the time to complete the Medical Cause of Death in a timely manner. This new process has been shared widely across Directorates and with Clinicians. Noted it can be challenging when trying to identify the correct clinician. The group resolved to note the above. **Actions from discussion:** To invite Nick Denney to the next QSE meeting to share how this new process is progressing. **Mortality Case Review template –** A Mortality Level 2 review template was shared to support clinicians in providing a structured M&M review. The template is going to be tested in areas to review cases referred for further consideration by the Health Board's Mortality Screening Panel. **Actions from discussion:** Any comments to be shared with SR so a final template can be agreed and used appropriately.	ALL KP ALL
MCBQSE/ 2024/0122	**Infection Prevention and Control (IP&C) update:** 7 days since last MRSA bacteraemia 18 days since last MSSA bacteraemia 11 days since last *C difficile* 6 days since last *E. Coli* bacteraemia 43 days since last *Pseudomonas* bacteraemia 29 days since last *Klebsiella* bacteraemia 3 outbreaks within the MCB, affecting 31 patients, 1 staff member, resulting in 18 bed days lost. DMT scores – All wards within MCB remain compliant for the last 4-week period, except for one area, score 94%. HCAI reduction goals – There were new cases of all reduction goal organisms in July, Except MRSA. The MCB did not achieve any of the 6 reduction goals during the period 2023-2024. MCB position based on same period 2023-2024: ○ 300% increase with *Pseudomonas.* ○ 55% increase with *C. difficile.* ○ 63% reduction with *E. coli.* ○ 38% reduction with SAUR Bacteraemia's. ○ 33% reduction has been seen *with Klebsiella* There are 9 outstanding RCAs overdue. Audit results are showing an improvement. Back to basics teaching being held September 19th –. Winter planning teaching planned for the end of September. HCID training planned. Concerns noted in the increase of C. *difficile* which is reflected across other Clinical Boards, and across Wales as a whole. Ongoing planning within Emergency Medicine and Infectious Disease around M-pox. The group resolved: to note the above. **Actions from discussion**: Reiterated the importance of submitting a Datix for all healthcare associated infections. For those patients who have died as a result of a healthcare associated infection the Infection Prevention and Control RCA is subject to scrutiny for potential NRI reporting if there was any act or omission which contributed.	Lead & Senior Nurses

	Resus Medical Clinical Board Report – shared for information. The information is taken from BIS for all areas where a 2222 call has been placed for either a cardiac arrest call or escalation of a high NEWS score. This can include themes around education, training and staffing to support Clinical Boards identifying where further actions are required. The group resolved: to note the above. **Actions from discussion**: A reminder to all staff the Resuscitation audit is currently being undertaken and for all areas to complete. **HEIW Visit to GIM at UHL and UHW 24.07.2024** For information the revisit has been conducted, the risk rating remains the same. Action plan required by 6th September 2024 with some recurring themes noted around induction and awareness of the Stroke Pathway. The group resolved to note the above. **Actions from discussion**: Formal report and Improvement Plan to be brought back to the next QSE meeting in September. **Llais visit to SRC 15.08.2024 –** Verbal feedback from Llais was extremely positive. Formal report pending. The group resolved to note the above. **Actions from discussion**: Formal report if received to be shared at the next QSE meeting in September.	ALL SR SR
3	**ITEMS FOR APPROVAL/ RATIFICATION**	
MCBQSE/ 2024/0123	**National Reportable Incidents (NRIs)** MCB NRI Position – currently 19 open NRIs across the Clinical Board. Integrated Medicine 2 Specialised Medicine 13 (5 breached closure date) Acute & Emergency Medicine 4 (3 breached closure date) **NRIs for closure:** **Emergency & Acute Medicine**: ID45504 delay in treatment and diagnosis resulting in a perforated Duodenal Ulcer – Issues identified: 1. The timing of a clinical abdominal examination 2. The timeliness of a surgical review 3. The timeliness of CT imaging 4. Access to theatres Recommendations noted as: 1. An acute abdominal pathway should be prioritised during development of Hospital Health Pathways. 2. Learning from the case should be presented at Medicine Clinical Board (including emergency department) and Surgical Clinical Board QSE meetings to include: a. Need for clear documentation b. Importance of abdominal examination in assessment of unwell patients c. Importance of collateral history taking in patients unable to provide a clear clinical history d. Increase awareness of the availability of the Ambulance Summary sheet in Welsh Clinical Portal e. Informing consultant in charge of a patients care if there is a significant change in their clinical condition 3. An audit to ensure that a baseline EWS (Early Warning Score) is recorded for all patients admitted to the emergency department resuscitation (resus) area. 4. There is verbal referral to specialty teams for patients with a National Early Warning System (NEWS) score of 6 or above, alongside digital referral on the Whiteboard IT system. 5. The ED/Medical admissions proforma document should be updated to include separate examination sections for cardiovascular, respiratory, abdominal, neurology and other, as a prompt to clinicians completing the booklet. 6. Radiology department to undertake an audit of the demand for inpatient CT	

scans performed in the emergency department in hours and out of hours for each of the referral priorities, compared to the available scanner and staff capacity during these periods. Data should be used to review the need for any changes to the existing CT radiology model.
7. An audit template or dashboard should be developed to allow radiology departmental and QSE leads to undertake regular audits to assess referral demand and capacity on a recurrent basis.
8. Formal senior cross cover should be provided for the CEPOD/inpatient surgical registrar referral bleep and to undertake referrals during periods they are unavailable in the operating theatre.

ID48819 failure to undertake appropriate monitoring for an Insulin/Dextrose infusion to treat a high Potassium – Issues identified:

1. The patient had a history of Chronic Kidney Disease and frailty, caution should have been given when considering treatment to reverse the high Potassium.
2. Blood glucose levels were not monitored in line with The Emergency Management guide for the treatment of Hyperkalaemia in Adults.

Recommendations noted as:
1. The Emergency Management Guide for the treatment of Hyperkalaemia in Adults pathway should highlight the need for consideration of other co-morbidities that can impact patients' blood glucose levels prior to prescribing insulin/dextrose infusion.
2. The Emergency Management Guide for the treatment of Hyperkalaemia in Adults pathway Clinical guidance to be stored in a centralised place for all staff to easily access Safety notice- The Emergency Management Guide for the treatment of Hyperkalaemia in Adults pathway to be widely shared.
3. Create a document similar to the Acute NIV pathway booklet where the monitoring of blood glucose and the pathway are combined together within one document and all patients receiving this treatment would have the document within their notes as a reference for staff and would keep the information together.

ID50503 Injurious injury: Unwitnessed fall resulting in a fracture to the right shaft of femur. The falls focused review identified there was potentially a missed opportunity to have noted the patient had become more confused several hours prior to the fall which would have prompted the staff to review PART B of the admissions booklet, including falls risk assessment which would have supported escalating for closer observation.
A Tendable Core Standard audit undertaken noted 100% satisfaction with the quality of falls documentation and identification of risks to mitigate falls and 100% compliance with the completion of the Part B assessment with relevant actions and interventions that tell staff how to care sensitively for patients in the care environment. These audits have senior and lead nurse oversight to ensure standards are maintained.

ID64874 Injurious injury: Unwitnessed fall resulting in a fractured neck of femur. The falls focus review identified Secondary to the patient only being within the clinical area for 12 hours and not very well known to staff an enhanced supervision assessment was not undertaken. The patient was also noted to have increased urinary frequency prior to the fall. Lying and standing blood pressure was not undertaken on admission to identify any potential postural drop in line with best practice. In addition, common practice on the ward during the night is to have one member of staff at the entrance of each bay so they can visualise the patients. At the time of the patients fall staff had left to obtain pain relief for another patient whilst another member of staff was assisting another patient. The staff should have requested for another member of staff to observe the area if the patients were known to have a high falls risk.
A Tendable Core standard audit completed 22nd July 2024 noted 100% compliance with MFA being completed within 6 hours of admission and 100% compliance with the completion of lying and standing blood pressure. In addition, a Care Specific audit noted 100% compliance with patient's mobility being assessed and pre-

	admission falls history information recorded with interventions noted as part of the mandatory actions. Raised over a week's period at safety briefings to re-iterate the importance of the required level of observation/staff whilst 'tag' baying areas where patients are deemed a risk of falls **The group resolved**: to note the above. **Actions from discussion:** none.	
MCBQSE/ 2024/0124	**LFE RED195 AS** - concern The patient was a 79 year old male brought by ambulance to UHW on 06.04.2023 following a fall outside his home. He had known heart failure and was for admission under a medical referral that day but fell before being brought in. CT head identified a left sided subarachnoid haemorrhage and subdural haematoma necessitating urgent neurosurgical advice. Risk assessment was completed on admission, a high risk of falling identified and acknowledgement that a visible space was needed and staff support during any mobilisation. **Conclusion**: In-patient falls did not lead to the patient's death with the significant intracranial injury occurring prior to admission and no significant changes whilst an inpatient however there was learning. **Learning**: - Escalation process for staff shortfalls via the nurse in charge, raising of red flag via Safe Care system, Lead and Senior Nurses and Director of Nursing. In the event of no mitigation, documentation of risk and support provided to manage risk, workload and staff allocation; - Reminders sent to staff to keep beds at lowest point when patients are not receiving personal care or interventions; - Ward Education Board in place to highlight key messages; - Safety briefings at each shift handover so that each individual patient's needs / requirements are communicated to all staff. **LFE CN/UHW/3219 AC** – claim Patient was a 36 year old male who attended A&E on 02.08.14, longstanding history of alcohol dependency and had collapsed in the street following an epileptic seizure. He had experienced two previous fitting episodes the same day. He was able to transfer independently from stretcher to trolley and no concerns regarding capacity, initial impression was that he was withdrawing from alcohol. On asking for the location of a toilet and declining the use of a urinal, a nurse noted that he was alert and steady on his feet and so directed him to the toilet however the Claimant returned with a HCSW who thought he was slightly unsteady. He then asked to use the telephone, he was advised that someone could make the call for him but he became agitated and he was therefore directed to the nurse's station and the phone placed in front of him, it was at this point he fell hitting his head on the floor and was noted as having a seizure. Underwent CT and transferred to neurosurgery for evacuation of subdural haematoma, discharged on 02.09.14. **Learning**: - Importance of completing falls risk assessment as soon as possible following admission which is included in induction process; - Use of Tendable audits to ensure documentation completed and spot checks of this by the nurse in charge to support with any outstanding assessments, and to identify themes; - Escalation to the nurse in charge of those with falls risk to support with mitigation; - Pre and post falls management education for new starters and refresher training for established staff; - Education and information boards visible for staff and patients. **The group resolved**: Learning from Events Report will be provided to Welsh Risk Pool.	

	Actions from discussion: Discussion around how the learning can be shared from the outcome of LFEs. To bring back to QSE to share how this process works including potential values based on the outcome.	KP/SR
4	**ITEMS FOR NOTING AND INFORMATION**	
MCBQSE/ 2024/0125	**Patient Safety Alerts/MDAs/ISNs:** Memo for clinical teams Fragmin and Arixtra pre-filled syringes – Do not use in patients with latex allergy Medicines Management Memo: Intermittent supply issues with Kay-Cee-L Syrup Medicines Management Memo for Healthcare Professionals: Supply Issues with Pancreatic Enzyme Replacement Therapies (PERT) Safety Memo: Registration of unknown patients in the Emergency Department ISN 2024 002 – FreeGo feeding pumps **The group resolved**: for noting **Action from discussion**: shared for information.	
MCBQSE/ 2024/0126	**Medicines Management** **Medicines Safety Briefing for Healthcare staff** Shared for information **The group resolved**: for noting **Action from discussion:** Shared for information	
MCBQSE/ 2024/0127	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions** - Acute & Emergency Medicine minutes from meeting 11th June 2024 - Integrated Medicine UHL/UHW next QSE meetings September 2024 - EUG minutes 18th July 2024 **The group resolved**: for noting. **Action from discussion: D**irectorate minutes are required to be shared at MCB QSE. Work to be done to track all Directorate QSE meetings and ensure minutes are followed up.	
MCBQSE/ 2024/0128	**Minutes from QSE Sub Groups:** - IPC meeting 5th July 2024 cancelled. Meeting held 2nd August 2024 await minutes - H&S minutes last meeting 26/06/2024 - Medicines Access and Governance Group await minutes 21st June & 19th July 2024 **The group resolved**: to note the above. **Action from discussion:** none.	
MCBQSE/ 2024/0129	**Feedback from UHB QSE Committee** – consent will form part of mandatory training. UHB Clinical Safety Group completing a thematic review of HIW reports. A deep dive into the number of Never Events was also provided. **The group resolved**: no update. **Action from discussion:** no update.	
5. ANY OTHER BUSINESS		
MCBQSE/ 2024/0130	**Any Other Business** **Datix queues –** concerns raised regarding the number of Datix sitting open within the Clinical Board, particularly the number of Datix not initially reviewed within the first 7 days which could result in the level of harm/incident being missed. Raised the management of Datix is predominately seen as nursing led with more engagement required from medical colleagues.	

	Action from discussion: Clinical Board Director to discuss with relevant Directorate CDs to encourage clinical colleagues to complete the relevant Datix training. **C&V UHB Tuberculosis procedure** – any comments to be sent to Infection, Prevention and Control **IRMER Incidents – Radiology Annual Summary** – useful Radiology communication around IRMER investigations and the learning **Field Safety Notice Philips Respironics BiPAP Machines** **The group resolved:** assurance provided that this had been resolved with the support of clinical engineering. **Action from discussion**: none. **World Patient Safety Day 17th September**. On 13th September displays will be visible both at UHW and UHL. Brainomix is being shared as part of the theme around 'early diagnosis' set by World Health Organisation.	KE/KP (completed)
6. DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2024/0131	18th September 2024 at 14:30-16:00 via MS Teams	

Report Title:	To discuss the actions from the Ombudsman's annual letter			Agenda Item no.	4.2
Meeting:	Quality Safety and Experience Committee	Public ★ / Private		Meeting Date:	October 2024
Status *(please tick one only):*	Assurance		Approval		Information ★
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Assitant Director of Patient Experience				

Main Report

Background and current situation:

The Public Services Ombudsman for Wales (Ombudsman) writes annually to each Health Board in Wales, providing an overview of trends, performance, and key insights from the Ombudsman's office over the past year. These letters are publicly available on the Ombudsman's website.

A copy of the letter can be found in the Annual Letters section of the PSOW website.Annual Letters

The Annual Letter will be presented to the Board in November 2024, and this paper outlines the actions in response.

For context, the data from the Annual Letter indicated that the Health Board was at the average level for complaints received and investigated, measured per 1,000 residents for each health board area.

Health Board	Complaints Received	Received per 1,000 residents
Aneurin Bevan University Health Board	175	0.30
Betsi Cadwaladr University Health Board	214	0.31
Cardiff and Vale University Health Board	150	0.30
Cwm Taf Morgannwg University Health Board	109	0.25
Hywel Dda University Health Board	138	0.36
Powys Teaching Health Board	21	0.16
Swansea Bay University Health Board	132	0.35
Total	939	0.30

The subject and themes resonate with those reported in our regular quality indicators reports to QSE –

Cardiff and Vale University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	3	2%
Adult Mental Health	10	6%
Ambulance Services	0	0%
Appointment procedures (including outpatients)	4	2%
Child and Adolescent Mental Health	1	1%
Clinical treatment in hospital	84	56%
Clinical treatment outside hospital*	6	4%
Complaints Handling	13	9%
Covid-19	3	2%
Continuing care	1	1%
De-Registration	1	1%
Disclosure of personal information / data loss	2	1%
Funding	3	2%
Independent Health Care providers	0	0%
Medical records/standards of record-keeping	2	1%
Medication > Prescription dispensing	0	0%
Non-medical services	2	1%
Nosocomial*	0	0%
Other*	3	2%
Out of Hours GP care	0	0%
Parking (including enforcement and bailiffs)	1	1%
Patient list issues	5	3%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Recruitment and appointment procedures	0	0%
Referral to Treatment Times	4	3%
Regulation and Inspection (including private sector provision)	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Services for people with a disability inc DFGs	0	0%
Service for vulnerable Adults (eg with learning difficulties or mental health issues)	0	0%
Total	150	

Clinical treatment in hospitals has been the most significant concern raised with the Ombudsman regarding Cardiff and Vale University Health Board.

The outcomes of the Ombudsman's investigations are outlined below.

Appendix C - Complaint Outcomes
(* denotes intervention)

Cardiff and Vale University Health Board		% Share
Out of Jurisdiction	37	23%
Premature	19	12%
Other cases closed after initial consideration	57	36%
Early Resolution/ voluntary settlement*	23	15%
Discontinued	2	1%
Other Reports - Not Upheld	9	6%
Other Reports Upheld*	11	7%
Public Interest Reports*	0	0%
Special Interest Reports*	0	0%
Total	**158**	

Appendix E – Compliance performance comparison

Health Board	Number of recommendations made in 2023-24	Number of Recommendations falling due in 2023-24	% of recommendations, complied with on time
Aneurin Bevan University Health Board	209	208	75%
Cardiff and Vale University Health Board	104	95	81%
Cwm Taf Morgannwg University Health Board	123	121	60%
Swansea Bay University Health Board	119	127	62%
Hywel Dda University Health Board	160	151	81%
Betsi Cadwaladr University Health Board	253	246	58%
Powys Teaching Health Board	10	12	67%

When a report is upheld, the Ombudsman's recommendations aim to prevent or reduce the risk of recurrence by implementing robust actions to address the identified failings. While the Health Board currently demonstrates a compliance rate of 81% within the requested time frame, we recognise this as an area for improvement. The Patient Experience Team is utilising AMAT, an audit management and clinical tracking system, to monitor compliance with recommendations and escalate any issues to the weekly Executive meetings. We are optimistic that this will lead to an improvement in compliance rates.

Annual Letter actions

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

• *Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.* -***November Board Meeting on 28th November 2024***

• *Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.* -***to be discussed at the QSE-Quality. Safety and Experience Committee October 7th 2024***

• *Provide my office with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality. -We provide a regular Quality Indicators report to the* ***QSE-Quality. Safety and Experience Committee in line with always on reporting. Some examples are linked below.***

Quality Indictors to QSE August 23

Quality Indicators to QSE October 23

Quality Indicators to QSE March 24

The recent AGM-Annual General ,meeting held on 11 September 2024 presented the Annual report 23/24 and the Annual Quality Report 23/24

As a Health Board we welcome the independent scrutiny of your office and the publications provided which help us to review our services. I

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

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

The Annual letter will be discussed at the Board Meeting in November 2024

Recommendation:

The committee is requested to: **Note** the contents of the report.

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The review of compliance with recommendations will be undertaken
Safety: Yes
The Ombudsman provides an independent scrutiny of cases
Financial: Yes
The ombudsman can offer financial redress to people raising concerns
Workforce: n/a
Legal: n/a
Reputational: Yes
There is significant reputational risk from Public interest reports
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a

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

Ombwdsmon
Ombudsman
Cymru • Wales

Ask for: Communications
01656 641150
Caseinfo@ombudsman.wales

Date: 9 September 2024

Charles Janczewski
Cardiff and Vale University Health Board

By email only
charles.janczewski@wales.nhs.uk
suzanne.rankin@wales.nhs.uk

Annual Letter 2023/24

Dear Charles

Role of PSOW

As you know, the role of the Public Services Ombudsman for Wales is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. I also undertake investigations into public services on my own initiative.

Purpose of letter

This letter is intended to provide an update on the work of my office, to share key issues for health boards in Wales and to highlight any particular issues for your organisation, together with actions I would like your organisation to take.

Overview of 2023/24

This letter, as always, coincides with my Annual Report – "A New Chapter Unfolds" – and comes at a time when public services continue to be in the spotlight, and under considerable pressures. My office has seen another increase in the number of people asking for our help – a 17% increase in overall contacts compared to the previous year, with nearly 10,000 enquiries and complaints received. Our caseload has increased substantially - by 37% - since 2019.

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

During 2023/24 we considered and closed more enquiries and complaints than we ever have done before, and we reduced the average cost for each case and investigation. We started the year with a focus on reducing our aging cases, those over 12 months old, by 50% by the end of the year. These cases are often the most complex and distressing for the people making the complaint. I am extremely pleased to say we exceeded this target, reducing our aged investigations by over 70%. We are now well on track to meeting our objective to complete investigation of complaints within 12 months.

Public Service Complaints and compliance with recommendations

We received 939 complaints about health boards last year – roughly the same number as the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 31% of health board complaints - a similar proportion to previous years.

Last year, we received 150 complaints about Cardiff and Vale University Health Board, we closed 158 (some complaints were carried over from the previous year) and intervened in 22% of cases. Further information on the complaints we dealt with last year can be found in the appendices.

In total, we made 104 recommendations to your health board during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2023/24, 95 recommendations were due and 81% were complied with in the timescale agreed. The remainder were complied with, but outside the timescales agreed, or remained outstanding as at 9 April 2024.

Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Further to the report my office issued in June 2023, Groundhog Day 2: An opportunity for cultural change in complaint handling? I wish to thank the Health Board for its consideration of the report and recommendations. I trust that it has ensured that lessons learned from the PSOW's findings and recommendations on cases we considered last year are included in your Health Board's Annual Report on the Duty of Candour and Quality.

Supporting improvement of public services

We continued our work on supporting improvement in public services last year and worked on our second wider Own Initiative investigation. The investigation considers carers' needs assessments undertaken by local authorities in Wales. My report on this work will be finalised and published in the near future.

We have continued our work on complaints handling standards for public bodies in Wales and now have 56 public bodies following our model complaints handling policy. These public bodies account for around 85% of the complaints we receive.

We continued our work to publish complaints statistics into a third year with data, gathered from public bodies, now published twice a year. This data allows us to see information with greater context – for example, last year 4% of complaints made to Cardiff and Vale University Health Board's complaints went on to be referred to PSOW. I would encourage all health boards to use this data to better understand their performance on complaints and ensure that all complaints are appropriately logged.

Colleagues from my Improvement Team continue to meet regularly with Cardiff and Vale University Health Board to discuss compliance with our recommendations and our complaints standards work. We have seen real benefit come from these conversations, as well as improved working relationships, and we would like to pass on our thanks to Vicky Stuart and their team for their work with our officers.

Action we would like your organisation to take

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

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.

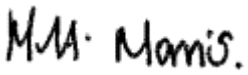
- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.

- Provide my office with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality.

- Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

Finally, I would like to thank you, and your teams, for your work with my officers in the last year. Their work is important in ensuring that patients and families receive timely and thorough responses to complaints, and in improving outcomes for all service users – not just those who complain.

Yours sincerely,



Michelle Morris
Public Services Ombudsman

Cc. Suzanne Rankin, Chief Executive, Cardiff and Vale University Health Board.

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Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1,000 residents
Aneurin Bevan University Health Board	175	0.30
Betsi Cadwaladr University Health Board	214	0.31
Cardiff and Vale University Health Board	150	0.30
Cwm Taf Morgannwg University Health Board	109	0.25
Hywel Dda University Health Board	138	0.36
Powys Teaching Health Board	21	0.16
Swansea Bay University Health Board	132	0.35
Total	939	0.30

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Appendix B - Received by Subject

Cardiff and Vale University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	3	2%
Adult Mental Health	10	6%
Ambulance Services	0	0%
Appointment procedures (including outpatients)	4	2%
Child and Adolescent Mental Health	1	1%
Clinical treatment in hospital	84	56%
Clinical treatment outside hospital*	6	4%
Complaints Handling	13	9%
Covid-19	3	2%
Continuing care	1	1%
De-Registration	1	1%
Disclosure of personal information / data loss	2	1%
Funding	3	2%
Independent Health Care providers	0	0%
Medical records/standards of record-keeping	2	1%
Medication > Prescription dispensing	0	0%
Non-medical services	2	1%
Nosocomial*	0	0%
Other*	3	2%
Out of Hours GP care	0	0%
Parking (including enforcement and bailiffs)	1	1%
Patient list issues	5	3%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Recruitment and appointment procedures	0	0%
Referral to Treatment Times	4	3%
Regulation and Inspection (including private sector provision)	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Services for people with a disability inc DFGs	0	0%
Service for vulnerable Adults (eg with learning difficulties or mental health issues)	0	0%
Total	**150**	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Cardiff and Vale University Health Board		% Share
Out of Jurisdiction	37	23%
Premature	19	12%
Other cases closed after initial consideration	57	36%
Early Resolution/ voluntary settlement*	23	15%
Discontinued	2	1%
Other Reports - Not Upheld	9	6%
Other Reports Upheld*	11	7%
Public Interest Reports*	0	0%
Special Interest Reports*	0	0%
Total	**158**	

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Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% of Interventions
Aneurin Bevan University Health Board	73	195	37%
Betsi Cadwaladr University Health Board	81	256	32%
Cardiff and Vale University Health Board	34	158	22%
Cwm Taf Morgannwg University Health Board	39	129	30%
Hywel Dda University Health Board	55	154	36%
Powys Teaching Health Board	3	21	14%
Swansea Bay University Health Board	41	141	29%
Total	**326**	**1054**	**31%**

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Appendix E – Compliance performance comparison

Health Board	Number of recommendations made in 2023-24	Number of Recommendations falling due in 2023-24	% of recommendations, complied with on time
Aneurin Bevan University Health Board	209	208	75%
Cardiff and Vale University Health Board	104	95	81%
Cwm Taf Morgannwg University Health Board	123	121	60%
Swansea Bay University Health Board	119	127	62%
Hywel Dda University Health Board	160	151	81%
Betsi Cadwaladr University Health Board	253	246	58%
Powys Teaching Health Board	10	12	67%

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Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2023/24. 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 2023/24. 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 2023/24. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix E shows compliance performance for all Health Boards.

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

Cardiff and Vale UHB

Annual Quality Report

2023 – 2024

Contents

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Foreword from Chair and CEO

We are pleased to present our Annual Quality Report for 2023- 2024. This report provides a comprehensive overview of our ongoing commitment to delivering the highest quality standards of care and services to our patients, their families and the wider community.

At the heart of our mission lies an unwavering duty of quality. This duty compels us to continuously evaluate and enhance the care that we provide, ensuring it is safe, effective, timely, equitable and patient-centred.

In this report you will find detailed accounts of our achievement, challenges and the strategies that we have implemented to overcome them. We have focused on the critical areas including patient safety, clinical effectiveness, operational delivery and patient experience, guided by the principles of transparency, accountability and continuous improvement.

Our commitment to quality is reflected in the collaborative efforts of our dedicated staff, who work tirelessly to uphold the values of the organisations and to care for our population. Their professionalism, compassion and resilience has been instrumental in navigating the complexities and challenges that we have faced in the past year. We acknowledge that the care we have provided sometimes falls short of the standard that the population should expect, and that the legacy of the pandemic means that people continue to wait far too long for treatment. We remain steadfast in our dedication to foster a culture of excellence, where quality improvement is integral to everything we do

In September 2023, following a period of co-production and consultation with our colleagues and stakeholders, our refreshed Strategy, Shaping Our Future Wellbeing, was approved by the Board. The refreshed strategic objectives are:

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

The Strategy aims to bolster our unwavering commitment to rectifying disparities in access and health outcomes. It encompasses the implementation of robust care models, a focus on quality, adoption of innovative healthcare technologies, digitisation research and development, modern infrastructure, and adherence to best practice. These multifaceted endeavours are essential to realising our ambitions and effectively serving the needs of our communities The Strategy is underpinned by a number of programmes that are designed to deliver the improvements in health care provision and outcomes set out in the Duty of Quality and using the six enablers in the Health and Care Quality Standards to support this.

We extend our heartfelt thanks to our colleagues and partners in health and to the people who have used our services and who have provided us with feedback and information that allows us to shape our services. Together we will continue to strive for improvements in the care that we provide.

Introduction from the Medical Director, Nurse Director and the Executive Director of Allied Health Therapies and Health Sciences and Community Development.

The Duty of Quality was implemented from 1st April 2023 with the aim to improve the quality of health services and improve the outcomes of the people in Wales. The Duty places a statutory requirement on us to actively monitor progress on the improvement of quality services and outcomes and routinely share this information with our population.

This report enables us to be held to account by the public for the care we provide considering quality in its broadest sense. The Health and Care Quality Standards are a set of standards developed to ensure good quality care and services provided by the NHS in Wales. They include six domains of quality and six quality enablers, which together provide a high-level framework for planning, decision-making, delivery, and monitoring of health services. We have used these domains to structure this report. While it is impossible to for us to include information about every service we provide, it is our hope that that the report provides a transparent account of our commitments to deliver safe, timely, effective, efficient, equitable and patient-centred care. This report references documents and information that are in the public domain, including reports to Health Board committees and reports from external organisations. We are reviewing how we make these resources easier for the public to access in the near future, but for the purpose of the 2023/24 Annual Quality Report, we have included links to more detailed reports and documents throughout.

A Whole System View of Quality

Our Quality, Safety and Experience Committee provides assurance to the Board on the setting of local organisational quality and safety standards and advice to assist it in meeting its responsibilities with regards to the quality and safety of health services. Our Clinical Governance structures have evolved to support the principles of the Duty of Quality to provide a continuous focus on the quality-of-care provision and an ongoing focus on driving improvements in care and outcomes. The scale and diversity of the services provided by the organisation requires a transformative approach to improving quality.

To support us in implementing a whole systems approach to quality we have developed two key multi-professional forums:

The Clinical Effectiveness Committee ensures that we are delivering effective evidence-based care, that we can demonstrate the quality of this care and that we can target improvements where the care we are providing does not meet the standard that our population should expect. The Clinical Effectiveness Committee oversees the outcomes of the National Clinical Audit and Outcome Review Programme, that in 2023/24, comprised forty-one audits incorporating long term conditions, surgical specialities, cancer, paediatrics and maternity and measures the quality of care in both hospital and community settings comparing ourselves with other health organisations nationally. The Committee also oversees the implementation of evidence-based guidance from both National Institute of Clinical Excellence (NICE) and Health Technology Wales (HTW).

The Clinical Safety Group was implemented to triangulate emerging themes and risks in each of our Clinical Boards with the individual clinical advisory groups that function in the Health Board, and which deliver strategy and develop policy to ensure quality in their field. These groups include:

- Blood Transfusion
- Decontamination Group
- Consent Group
- Dementia Group
- End of Life Care
- IRMER (Ionising Radiation (Medical Exposure) Radiations)
- Medicines Safety Executive
- Medical Devices Group
- Falls Delivery Group
- Learning from Mortality Group
- NatSSIPs Two (National Safety Standards for Invasive Procedures) (being reconvened in 2024)
- Nutrition and Hydration Group
- Pressure Damage Group
- Research Governance
- Resuscitation (RADAR)
- Sepsis (being reconvened in 2024)
- Transition Group (convened in 2024)
- Health Care Associated Thrombosis Group

The Clinical Safety Group is supporting Health Board-wide learning from events, inspections and peer reviews, ensuring that recommendations and risks identified in individual clinical areas are shared across the entire Health Board and are used to inform the work of the clinical advisory groups.

Leadership, Workforce and Culture

The People and Culture Plan was launched in January 2022. It sets out the actions we will take over three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement of our workforce. As a Health Board we are committed to being a 'great place to train, work and live'. We need to attract, train, deploy and develop people to maximise their potential and meet the health and care needs of our population. The Plan supports and focuses on three of the enabling Quality Standards, leadership, culture and workforce:

Shaping Our Future
Workforce

Strong leadership is a pre-requisite for the development and sustainability of a strong patient safety culture. The Health Board People and Culture Plan identifies the need to have leaders in the health care system who embody inclusive, collective and compassionate leadership and identifies a range of accessible opportunities that will be developed for leaders and managers at all levels to enhance their skills.

The Plan aims to have a workforce that feels valued and supported wherever they work.

To ensure we can deliver high quality, compassionate care, and have an inclusive culture where the diversity of our people is representative of our local population, we need to continue to think differently about how we attract and recruit our current and future workforce. Maximising opportunities to attract candidates with the right values and behaviours through a widening access framework, a new careers website and increasing the range of apprenticeship opportunities available and ensuring we are an inclusive employer to create diversity within our workforce. We will support multi-professional and multi-agency working through integration of Health and Social Care Services and the development of alternative workforce models to deliver a seamless, co-ordinated approach with partners based on outcomes that matter to the person and recruit and retain the right people with the right skills. We will invest in education and learning to deliver the skills and capabilities needed to meet the future needs of the people we care for and support our people to progress their careers. We are working to ensure we have a sustainable workforce in sufficient numbers to meet the health and social care needs of our population

Learning, Innovation, Improvement and Research Shaping Change

We recognise the fact that making significant changes to improve and extend the overall quality of the broad range of services and support offered to citizens and colleagues will necessitate 'change' in different areas and at different levels. This ranges from the well-established and recognised 'improvement' activity, that helps drive efficiency and effectiveness through service and operational

optimisation, to the development and adoption of 'step-change' innovative solutions, as well as the roll-out of strategic organisational programmes. Acknowledging the critical and linked role of learning, education, innovation and improvement, underpinned by robust research and development, as an enabler for quality across our system.

Information

We have developed a Digital Strategy to support a five-year roadmap for how digital technology will enable the transformation of clinical services as set out in our Strategy Shaping Our Future Wellbeing. The Strategy recognises that by collecting timely and accurate data we will understand how our system works. We will be able to follow patients through their care pathways, learning how we can make them more efficient and ensuring their journeys are safe. The ability to collect and record patient outcomes means that we can compare ourselves to other organisations nationally to ensure that we are providing quality outcomes.

Commissioned Services

Until 2024 the Welsh Health Specialised Services Committee (WHSSC) was responsible for the joint planning of specialised and tertiary services on behalf of Local Health Boards in Wales, until it was superseded by the Joint Commissioning Committe. (JCC). We provide a number of these commissioned services for the population of Cardiff and Vale, and the wider region and work closely with WHSSC to ensure the quality of these services.

The Children's Hospital for Wales incorporates a number of services including the paediatric intensive care unit, neonatal unit and paediatric surgery. In 2023 –2024 each of these services has been subject to additional monitoring by WHSSC, because of capacity pressures that have impacted on the quality of care that we are able to provide. The availability of both paediatric intensive care beds and neonatal cots and challenges around the retention and recruitment of the workforce, in particular registered nurses have meant there are occasions when we have been unable to provide the care in the Childrens Hospital for Wales. Significant work was undertaken over the financial year to improve the recruitment position, which included the appointment of internationally educated Registered nurses.

External Inspection

Healthcare Inspectorate Wales inspects NHS services in Wales and regulates independent health care providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. The health and care quality standards are embedded and form a framework for the inspections, reports and recommendations reports.

In 2023 /2024 inspections have been undertaken across a diverse range of services provided by the Health Board including, the University Dental Hospital, ward A7 gastroenterology, the Emergency Unit and Maternity Services at UHW. In addition, inspections were undertaken in Hafan y Coed mental health unit and a diagnostic imaging review. In 2023, we introduced a digital quality assurance tool which supported greater transparency and oversight of improvement plans developed to meet the recommendations. We also developed several bespoke digital audit tools to support internal inspection to assure the sustainability of the improvements put in place to address HIW recommendations.

Our Clinical Safety Group is used to provide oversight of cross cutting themes that emerge from HIW inspections and ensure health board wide learning and improvement rather than pockets of good practice.

Safe Care

Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.

Nationally Reportable Incidents

We are proud of our transparent and open approach to report, review and learn from patient safety incidents. Incidents that are deemed to have caused the most significant harm to patients are reported externally to the Wales NHS Executive, allowing additional scrutiny. External reporting also supports national learning from these events through robust and transparent reviews of the care provided to help us to identify the factors that contributed

Between 1st April 2023 and 31st March 2024, we reported 134 Nationally Reportable Incidents (NRIs). Despite the criteria for NRIs to be related to severe or catastrophic harm, the majority are subsequently re-categorised following a full investigation.

Inpatient Suicides - WARRN

Following several suicides of individuals who were cared for in the inpatient mental health setting, a review of the risk assessment process was undertaken, and a new formulation-based risk assessment process implemented. The Wales Applied Risk Research Network (WARRN) risk assessment is a formulation-based technique for the assessment and management of serious risk (e.g. violence to others, suicide, etc.) for users of mental health Services.

The WARRN risk assessment has been gradually adopted as the risk evaluation and safety-planning technique for all seven Health Boards in Wales. It was implemented in parallel with an education package and nationally clinicians have reported increased skills in the domains of clinical risk formulation, safety-planning and communication. The associated use of a "common-language" created by having all NHS Health Boards in Wales using the same risk assessment process has been reported as facilitating the communication of safety-planning.

Fetal Monitoring within the Midwifery Led Unit (MLU)

Changes to the Health Board's approach to Cardiotocography (CTG) monitoring have been implemented in response to learning from patient safety incidents. The changes brought our practice in line with guidance from both NICE and Welsh Risk Pool. From 1st February 2024, CTG monitoring for intrapartum fetal heart concerns is no longer undertaken within the Midwifery Led Unit. All women requiring CTG monitoring are instead transferred to the Consultant Led Unit to expedite any necessary additional care in a responsive clinical environment.

Pressure Damage

Pressure damage is the most frequently reported patient safety incident across the Health Board. A thorough review of all cases ensures that we consider if there were any opportunities missed that would have prevented the pressure damage occurring or would have reduced the severity. We have implemented scrutiny panels in all our Clinical Boards to ensure that we capture all potential learning. The scrutiny panels have identified delays in risk assessment and re-assessment as a theme. We use a digital clinical audit and inspection tool in the Health Board called Tendable and pressure damage risk assessment compliance audits have been included in the suit of tools available on this system to allow clinical areas to audit and review their compliance.

An Annual Nationally Reportable Incident Report for 2023/24 was reported to the Quality and Patient Safety Committee in May 2024 and can be read at:

NRI Report 2023/24- Quality Safety and Experience Committee May 2024

Never Events

Never Events are significant and largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. All Never Events are reported externally to NHS Executive due to their significance. We reported six Never Events during 2023/24. Thorough reviews of each of these incidents are informing national work to reduce Never Events and has also led to Health Board improvements.

The current perioperative pathway is reliant on multiple patients' systems including more than one digital system and paper records, the transfer of information between each system increases the potential for error. The Surgery Clinical Board are currently working towards implementing a revised surgical database that will incorporate all parts of the patient pathway thereby reducing the need to transcribe information between systems and thereby reduce the risk of transcription errors. In the interim a protocol is being developed to standardise the approach to communicate amendments and cancellations to planned interventional procedures.

Never Events that relate to malfunctioning medical devices are reported through Wales Surgical Materials Testing Laboratory to undertake testing and analysis of products. In addition, any faulty product will be reported through the Medical and Healthcare products Regulatory Agency (MHRA) to inform national themes and support product recall where required.

Procurement of equipment has an important role in the eradication of Never Events, ensuring equipment that supports standardised check lists and clinical investigation.

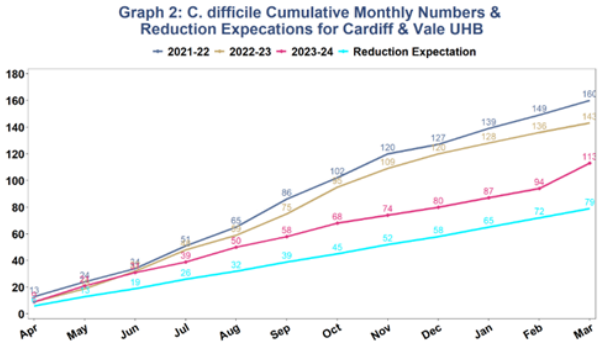
Procurement of radio-opaque neurology swabs has been implemented to ensure that these products can be identified on radiological examination. A revised protocol was implemented to safeguard against the potential for retained non-radio opaque swabs while an alternative product was being sourced. A procurement exercise within dental services has standardised the procurement of dental swabs.

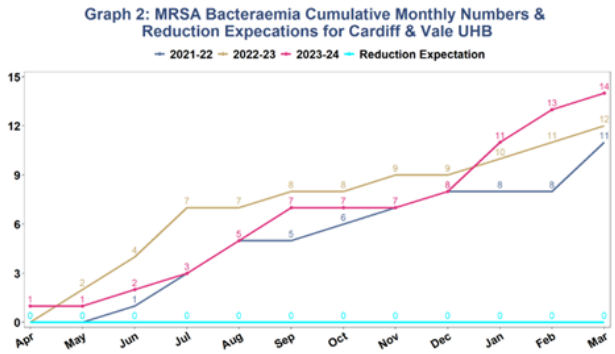
In 2023 the National Safety Standards for Invasive Procedures (NatSSIPs 2) was published, building on previous standards published in 2015 and intended to enable safe, reliable and efficient care to every patient who has an invasive procedure. We are refreshing our previous NatSSIPs Group and bringing together colleagues from workforce development and digital teams along with clinical colleagues from specialties that undertake invasive procedures to build on exisiting work to ensure the safe delivery of invasive procedures.

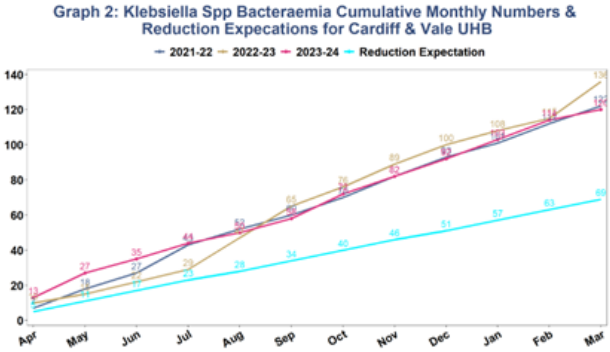
The Never Event position was reported to the Quality, Safety and Experience Committee in July 2024 and can be read at: Never Event Report 2023/24- Quality Safety and Experience Committee July 2024

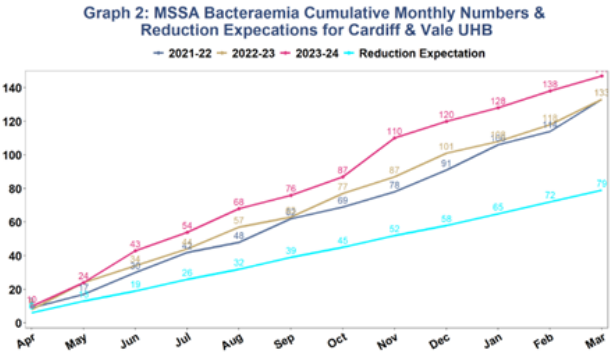
Infection Prevention and Control

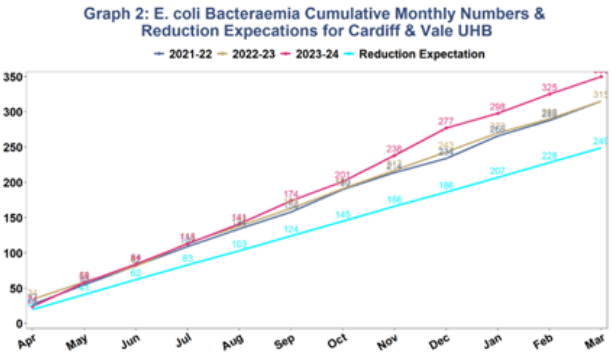
Infection Prevention and Control is a practical, evidence-based approach to preventing both patients and health care staff from being harmed by avoidable infections. It affects all elements of healthcare including hand hygiene, surgical site infections, injections safety and anti-microbial resistance. Welsh Government publish reduction targets each year to support a sustained reduction in the incidence of these bacteraemia. Every case is reviewed to understand if the care that we have provided has contributed to these infections.

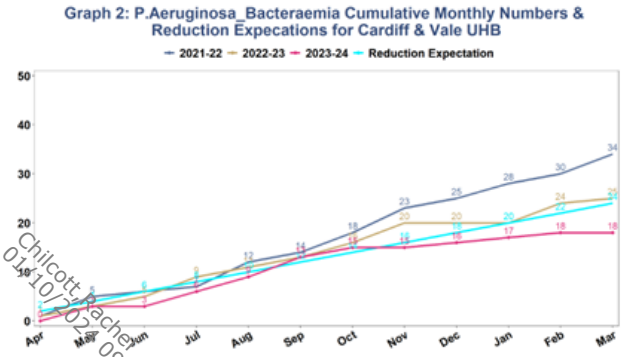












A significant amount of work was undertaken across the Health Board to support the necessary reduction in Clostridium difficile (C.difficile) cases. Every case in 2023/24 was reviewed by a multi-disciplinary team including an Infection Prevention and Control Nurse, a Public Health Wales or an Anaerobic Reference Unit Specialist Scientist, a Microbiology Consultant and a Pharmacist to identify learning. The Executive Medical Director and Executive Nurse Director chaired reviews with the clinical teams to identify areas of good practice and areas of improvement. This work results in a significant improvement and the Health Board exceeding the reduction expectation and we reported the lowest rate in Wales.

We have seen an increase in Methicillin-Susceptible Staphylococcus Aureus (MSSA) cases with 159 cases reported during the year, which equates to a rate of 31.45 per 100,000 population, exceeding the target of 20 per 100,000 by 57%. The approach taken to reducing C.difficile cases is now being replicated for each case of MSSA. There has been

increased auditing of both peripheral and central venous cannula insertion and maintenance by the Infection Prevention and Control Team and Aseptic Non-Touch Technique (ANTT) continues to be rolled out across the Health Board.

Work previously undertaken in Primary Care to support effective urine sampling and prescribing for urinary tract infections had resulted in a significant reduction in Escherichia coli (E. coli), however in 2023/24 we reported 345 cases which equates to 68.24 cases per 100,000 population above the target of 67 per 100,000. The appointment of a Primary Community and Intermediate Care Infection Prevention and Control Nure will further support this work.

The Infection Prevention and Control Team have also worked across the Health Board to agree the cleaning products used in clinical areas, to ensure the effective decontamination of medical devices including ultrasound probes and sourcing alternative pre-operative skin cleansing products due to a national shortage of products.

A report into infection prevention and control was reported to the Quality Safety and Experience Committee in September 2023 and can be read at:

Infection Prevention and Control -Quality Safety and Experience Committee September 2023

Reports to Prevent Future Deaths

A Prevention of Future Deaths Report is made by HM Coroner to relevant authorities to attempt to prevent future deaths from causes identified during an inquest. The report identifies areas where action is needed to protect lives. Forty-one Prevention of Future Deaths Reports were issued to health organisations across Wales in 2023/24 and two reports were issued to Cardiff and Vale UHB.

In response to the reports issued directly to the Health Board, we have worked with clinical teams to put in place improvements.

Prison health care:

A review of health care workforce at HM Prison Cardiff was undertaken in response to a Prevention of Future Deaths Report and has resulted in the appointment of a Head of Healthcare to provide senior leadership to the healthcare team. There has been the development of standardised processes to support effective and safe communication between agencies and organisations relating to individuals with complex mental and physical health care needs. A Food and Fluid Policy was developed between the Health Board and HMP Cardiff to develop explicit responsibilities for staff in the management of prisoners who are suspected of, or who are refusing food and fluids.

Safe sleeping Arrangements for infants:

The Health Board Community Maternity and Health Visiting services have built in a number of formal opportunities to discuss safe sleeping arrangements, risk reduction and Infant death risk reduction with new parents between twenty-eight weeks of pregnancy and up to sixteen weeks after the baby is born.

The reports and the Health Board response can be accessed in the links below:

Prevention of future deaths report - Courts and Tribunals Judiciary November 2023

Prevention of future deaths report - Courts and Tribunals Judiciary March 2024

Patient Safety Solutions

Where potential safety issues are identified nationally, organisations such as NHS Wales, NHS England or the Medicines and Healthcare Products Regulatory Agency (MHRA), will issue Patient Safety Alerts to healthcare organisations to allow them to put in place appropriate actions and mitigation to eradicate or reduce the risk to patients. We receive and respond to these alerts to ensure that any identified patient safety risks are reduced.

Emergency Steroid Therapy:

Adrenal insufficiency is a rare disorder which can lead to adrenal crisis, particularly when critical time medication is delayed or omitted. A Patient Safety Notice was issued in 2021 which required organisations to ensure patients with adrenal insufficiency are identified and that the signs and symptoms of adrenal insufficiency and crisis are recognised. In 2023 we recognised that we needed to strengthen the measures that had been put in place across the Health Board. A multi-professional group was convened to oversee further actions. The recently compiled All Wales list of time-critical medications has been used as a basis for a relevant 'Inform, Ask & Act' campaign to ensure colleagues across the Health Board are aware of the necessity of these medicines, including patients on steroids. Various resources have been produced, including posters for cascade across the Health Board. There have been several education and training events undertaken and planned. An adrenal insufficiency training day for both doctors and nurses planned for September 2024 and the topic is being incorporated into the routine training for junior doctors in the Health Board.

Alerts relating to critical time medications are being developed and built into the Electronic Prescribing and Medication Administration (EPMA) system that will be implemented in the Health Board later this year and the All Wales Medicines Safety Group have produced a policy which will support the empowerment of patients who are able to take their own steroids to do so when in hospital and we are seeking to introduce this into the Health Board.

NRFit®

Following a Safety Notice from NHS Wales, we implemented the NRFit® connection system for spinal and epidural injections.

There is a risk of serious harm or death when medications are given via the incorrect route. While the risk of these errors can be reduced through measures such as checklists, training, and labelling of syringes and despite the efforts of all staff, errors can still occur. Both intravenous (directly into the bloodstream) and neuraxial (spinal and epidural) medication is given using syringes and other equipment which uses the Luer connector. Therefore, a medication intended to be administered directly into a vein could potentially be given in error via a spinal route, if there is no physical barrier preventing inadvertent wrong-route administration. To address this issue, healthcare and industry has developed a neuraxial-specific connector known as 'NRFit®. NRFit syringes are easily identifiable and other products will not connect to a standard intravenous device therefore reducing the risk of accidental wrong route administration.

Falls

Falls remain a patient safety priority, and inpatient falls are one of the more frequently reported patient safety incidents.

Falls occur more frequently as we age but are not inevitable. There are many things that can be done to reduce the risk of falls, both at home and when in hospital. Falls can not only cause physical injury, but also affect an individual's confidence and independence.

We are working to enhance the falls prevention programmes available in the community, developing it in collaboration with citizens, community groups, local authorities and third sector organisations. The programme is designed to support people to 'age well', encouraging physical activity, social connection and reducing the risk of falls and ensures equitable access to these services for all communities across Cardiff and the Vale of Glamorgan.

We know that falls can also occur when patients are in hospital and we are working to reduce avoidable inpatient falls, as well as improving the management of falls which do occur. We participate in the National Audit of Inpatient Falls each year, submitting data relating to the care of patients who sustained a hip fracture as a result of a fall while an inpatient. We have piloted a training programme for staff which includes education on assessing a patient's risk of falls, supporting staff to identify ways of reducing recognised risks safely assessing and caring for patients who have fallen. This training has received excellent feedback, and we are aiming to roll out this training more widely. Sometimes when a person falls, we need to use special equipment to lift them from the floor safely. We are reviewing this equipment to make sure that it can be quickly transported to a fallen patient when needed.

Timely

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

The Legacy of Covid-19 has profoundly impacted our ability to deliver care in a timely manner. We have had to reevaluate the way we provide have delivered a number of services and the flow of patients through our care. We have made some very significant improvements in several clinical pathways including stroke, emergency and unscheduled care and hip fracture, but we recognise that our population continue to wat too long for planned and diagnostic procedures.

Stroke Care

Stroke is a life changing event and the fourth highest cause of death in Wales, as well as being the leading cause of disability. Getting emergency stroke care right is crucial in reducing the disabling impact of stroke. Stroke clinical standards include timely scanning (within one hour of arrival), specialist assessment and timely treatment with thrombolysis (clot-busting treatment) or thrombectomy (clot removal), where appropriate, as well as admission to a Stroke Unit within four hours. Patients treated with thrombolysis and thrombectomy are likely to recover better with less lasting effects affects following the stroke as well as having improved survival rates.

The ability of the Stroke Service to meet these clinical standards at University Hospital of Wales (UHW) was significantly affected by the Covid-19 pandemic. Necessary reorganisation of the Emergency Department footprint and admission processes led to a deterioration in performance against key indicators in the emergency assessment pathway for stroke, with significant variation. At UHW in December 2022, 44.8% of patients were scanned within one hour of arrival, 50% had their swallow function assessed within four hours and only 6.2% of patients were directly admitted to the Stroke Unit within four hours. Thrombolysis rates were variable and at their lowest in March 2023, 3.6%.

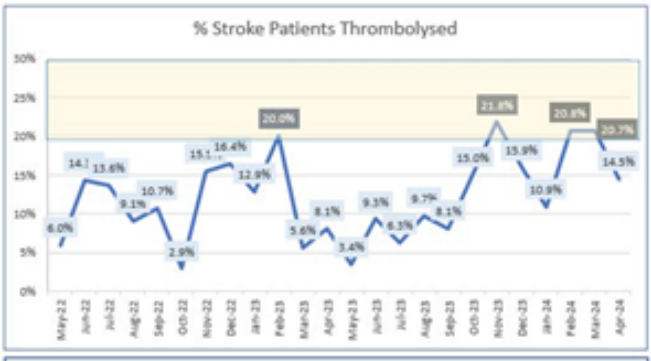
To improve performance, the Stroke Team identified several areas for improvement. From February 2023, the 18 beds in the Acute Stroke Unit were protected to ensure that they were kept for stroke patients. Senior clinical decision makers were redirected, when possible, to provide oversight and support to patients presenting to the Emergency Department with signs of stroke. Emergency Department staff were trained on swallow screen assessment to ensure this was completed according to the clinical standards.

In late 2023, Brainomix eStroke, an artificial intelligence supported image interpretation software, was implemented allowing immediate virtual review of scans

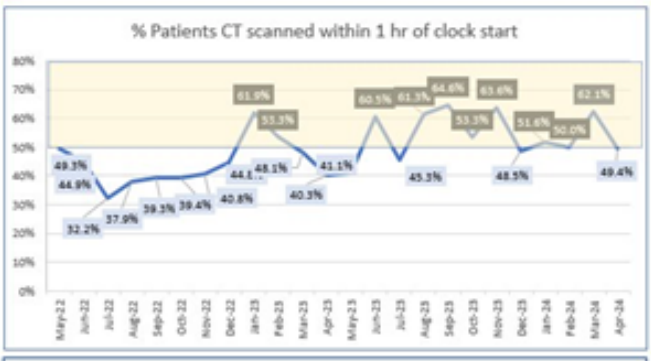
which supports timely treatment decisions. The optimal stroke imaging pathway was implemented to standardise the approach to radiology imaging to support treatment decisions. Adoption of the extended thrombolysis treatment window was introduced increasing the number of patients eligible for this treatment.

Performance against key indicators of the optimal stroke pathway is measured via the Sentinel Stroke National Audit Programme (SSNAP) and monitored by the NHS Wales Executive Performance and Assurance (P&A) Team and the Health Board's Operations and Performance Team. Key partners in this improvement work included the stroke multidisciplinary team, emergency and acute medicine and radiology colleagues and patient flow and site services.

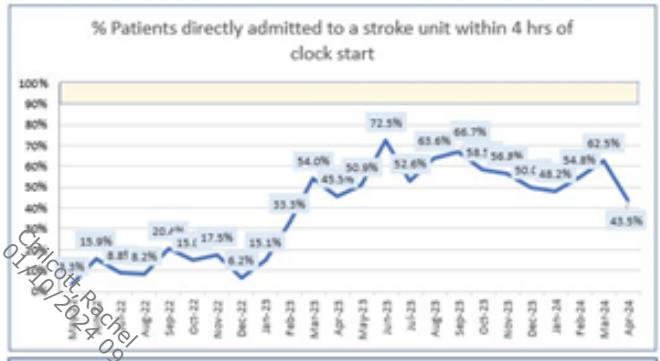
The Stroke Team also worked with Welsh Ambulance Service Trust (WAST) to pilot a pre-hospital video triage in stroke. The initial symptoms of stroke can sometimes mimic other conditions, and at other time the symptoms can be subtle. Timely diagnosis and treatment is invaluable in minimising the long-term effects of stroke and ensuring a good recovery. We worked with colleagues in WAST to start the stroke pathway in the patient's home. Paramedics were able to contact a stroke consultant on a secure video call to support in the assessment of the patient. This allowed quick decisions to be made about the most appropriate place for patients to be treated. Some patients were then conveyed directly to the Regional Stroke Centre bypassing their local Emergency Department.



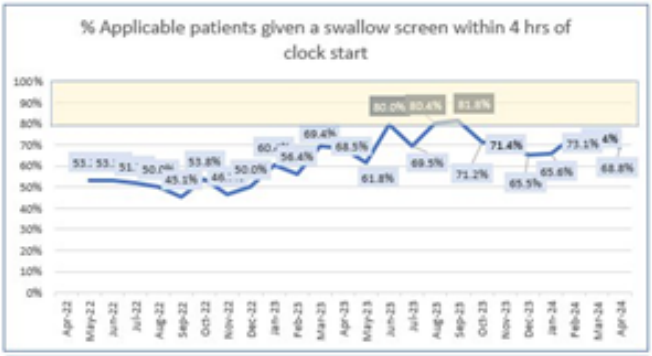
SSNAP A grade: consistent 20% thrombolysis rate, 90% of eligible patients thrombolysed. 45 minute QIM (DU) 1 hour standard (SSNAP)



SSNAP A grade: consistent 50% scanned within 1 hour, 95% within 12 hours with a median time of <1hr



SSNAP A grade: consistent 90% admitted within 4 hours with a median time of <2hr. 90% of patients to spend 90% of their UHW stay on the stroke unit

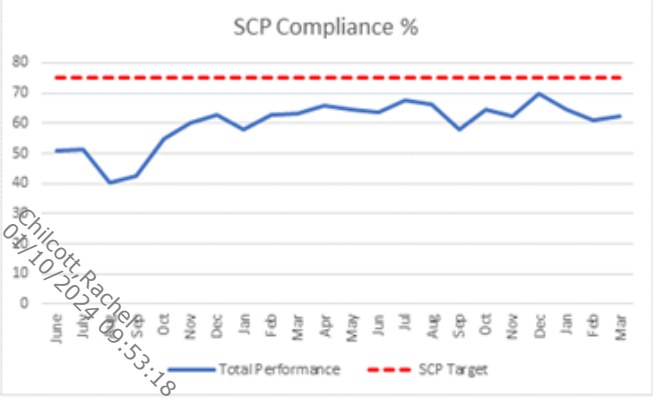


SSNAP A grade: consistent 80% screened within 4 hours, 80% formal assessment within 72 hours

Cancer Care

Providing timely diagnosis and treatments to people with cancer is of paramount importance to ensure the best outcomes for these individuals. The Suspected Cancer Pathway (SCP) was introduced in Wales in 2019 and sets a standard that Health Boards should ensure that the majority of their patients receive their diagnosis in a timely manner and commence their treatment within 62 days from the first point that cancer is clinically suspected. Equally, meeting this standard means that patients who commence on this pathway, but whose investigations demonstrate that they do not have cancer, will be reassured promptly. We have continued to improve performance in relation to the 62-day standard and by the end of March 2024, 62.3% of patients referred with symptoms suspicious received their care in line within the 62-day standard.

Ensuring parity of care for patients who have an incidental finding of cancer as those referred to the Health Board under the SCP is important. This year, Cancer Services introduced safeguards to ensure that anyone with a radiological investigation, or a pathology test that is suspicious of cancer, will be identified without delay by the Cancer Team. These patients are referred to the most appropriate clinical team and are tracked through their diagnostic journey until they are either discharged or commence treatment.



Cellular Pathology

Cellular Pathology is the examination of cells and tissue taken from the body during surgical procedures in theatres, out-patient clinics, General Practitioner (GP) clinics or at post-mortem examination. These tests are undertaken to diagnose cancer and other conditions.

Cellular pathology reporting times remain longer than they should be, and this means that patients are waiting too long for diagnosis which can in some cases lead to delays in starting treatment. Work has been undertaken in the past two years to address delays in the cellular pathology process. The service has moved from a five to a seven-day service and procured additional immuno-histopathology platforms to increase the capacity of the service. Some histopathology work has been outsourced to external companies or other NHS organisations to help to manage the volume of tests and to support the timely reporting of results.

Delays in microtomy, the action of processing tissues and creating slides, continues to require further improvement. The pathology department are currently recruiting to specialist microtomy posts

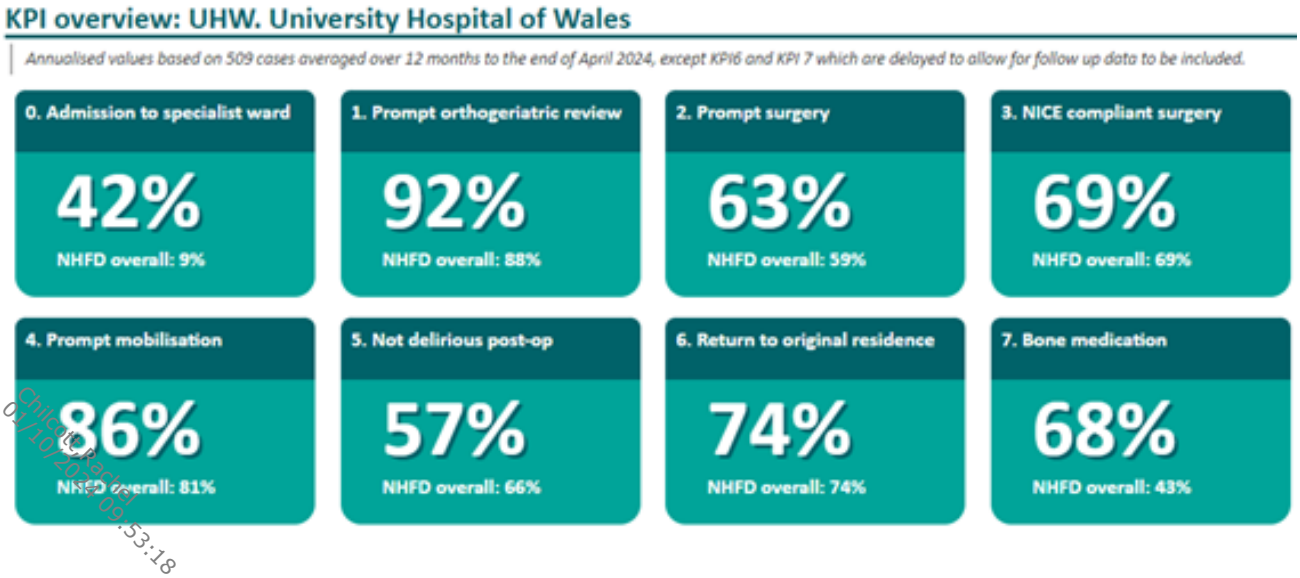
and are exploring technological options to automate some of the microtomy process. The team are visiting Toyota in 2024 to learn from their methods and practices to support the most efficient and productive ways of working and to then translate this learning into practice in the Health Board. There is continuing scrutiny and oversight of performance to ensure that performance improves and patients receive the outcome of investigations without delay.

Hip Fracture

Hip fracture is the most common reason for an older person to require admission to hospital for emergency surgery. Improvements in hip fracture care nationally, means that the number of patients who died in the month following a hip fracture has halved since 2007. The National Hip Fracture Database is a national audit programme that measures the care provided to patients with hip fractures against a number of evidence-based standards. Adherence to these standards is improving the clinical outcomes, reducing the length of stay in hospital and increasing the number of people returning to their homes following a hip fracture.

The prompt admission to a specialist ward is vital so that patients can reach the care of a specialist multidisciplinary team who will progress their assessment and perioperative care. In 2022 only 3% of patients were admitted to a ward within 4 hours, but the redesign of the hip fracture pathway now means that 42% of patients are admitted within this time scale. The number of patients who had prompt surgery increased from 59% in 2022 to 63% in 2023.

There is a continuous focus on performance against the hip fracture pathway at all levels of the organsiation and we recognise that there is a requirement for us to further improve our compliance against the standards to ensure that the care of patients is optimised.



Planned Care and Diagnostics

We have worked hard to reduce our waiting lists across planned care. Improvements have been made despite the challenging operational pressures across the Health Service and the unprecedented breadth of industrial action. Our delivery of service change has been led through our planned care programme and this includes close regional working across Southeast Wales in specialities such as Ophthalmology, Orthopaedics and Endoscopy. The total number of patients waiting for treatment on a Referral to Treatment (RTT) waiting list has increased to 147,620 in March 2024. One of the key ministerial priorities was the reduction in the number of patients waiting over two years for treatment. The Health Board was able to meet the standard of having less than 3% of the waiting list waiting over two years in December. We made further progress over winter, reducing this to less than 2% in March. This meant we had 2,681 patients waiting on RTT waiting lists more than two years; we were pleased to reduce the number of specialities reporting these long waits from 14 to 7 over the year. We know patients are still waiting too long and we continue to make this a priority for the coming year.

Despite our reductions in extremely long waiting patients (over two years), the number of patients waiting over 52 weeks for treatment has increased to 31,124. Within our outpatient clinics we have been concerned at the high number of patients who are awaiting a follow-up appointment. We know that there is potential clinical risk within this cohort of patients and have been working hard to improve the position. Each follow-up has a target date; in April 2024 over 54,000 patients had waited over twice as long as their target date. This number has reduced to 28,000 in March 2024. Whilst still far too high, there is a concerted effort to reduce all follow-up delays during 2024/25.

Cardiff and Vale Health Board are developing the Surgical Hub at Llandough Hospital. The plan is to be live from September 2024 and the Health Board will have dedicated and ring-fenced theatre time and a day-case ward to focus on sustainably increasing our capacity. The unit will be for day-case procedures predominantly and as such will be a unit which will be able to accommodate high volumes of patients. As this develops, we are expecting to treat up to 5,000 patients per year through this unit. This will enable us to increase our capacity supporting managing the long waiting times that our patients are currently experiencing.

Effective

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

National Clinical Audit

Welsh Government have mandated a series of national clinical audits which are used to measure and drive improvements in health care services in Wales and across the UK, by measuring and benchmarking against national standards. The audit programme includes conditions such as cancer, long-term conditions, including diabetes and respiratory disease, maternity and paediatric, surgical specialities and specialties including kidney disease and intensive care.

The Health Board Clinical Effectiveness Committee oversees the outcomes and improvements associated with the audits and these reports can be accessed here:

Bi Annual National Clinical Audit Report- Quality Safety and Experience Committee September 2023

Clinical Effectiveness Committee Report May 2024 Quality, Safety and Experience Committee

In 2023 we published the UHB clinical audit strategy which set out a commitment to use clinical audit to support a quality management system, to provide assurance about the services we provide and informing quality improvement. The Health Board audit process operates on a tiered system:

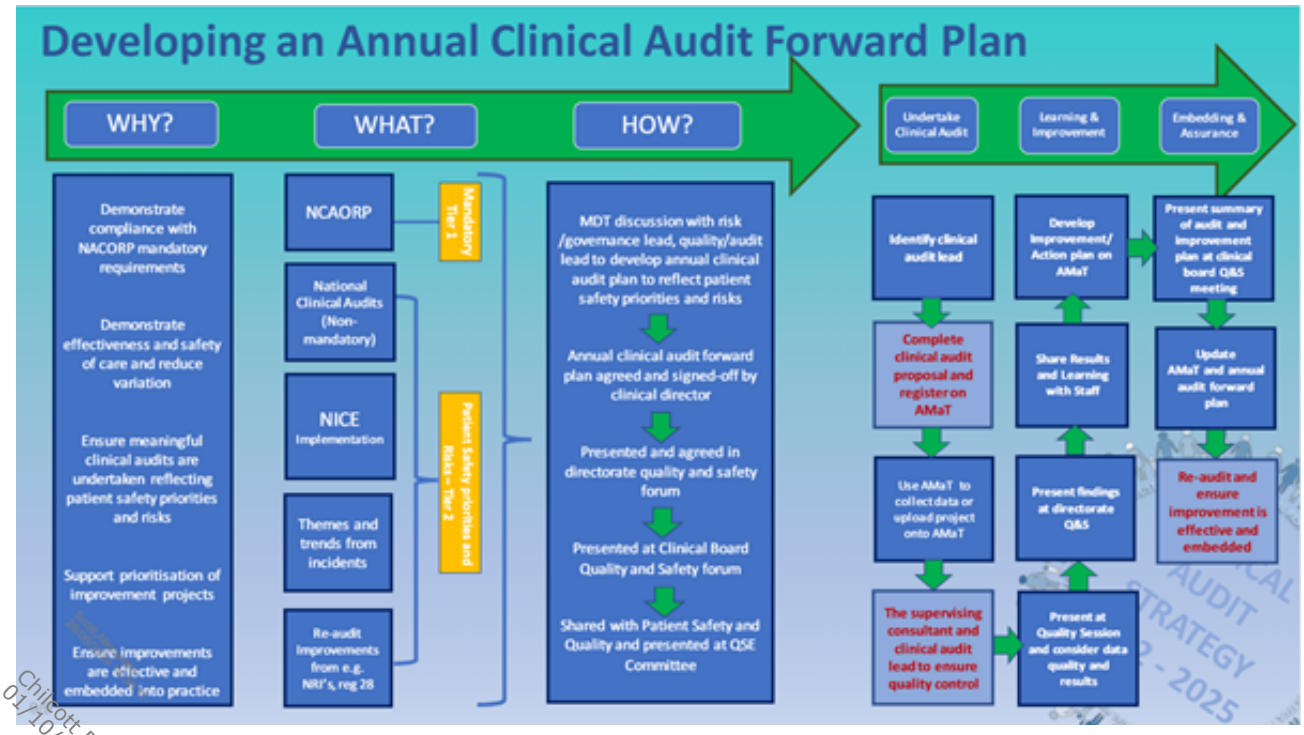
Tier 1 - Mandated national clinical audit set out in the National Clinical Audit and Outcome review Programme;

Tier 2 - All other national and local clinical audits undertaken to address patient safety and quality priorities;

Tier 3 - Local clinical audit undertaken for other reasons such a revalidation and professional development purposes.

We implemented a digital clinical audit and assurance platform in late 2022 and in 2023/24 worked with colleagues across the Health Board to train and support them in using the platform. Standardising the approach to audit and providing the right digital tools has enabled staff to develop and implement audit programmes aligned to their quality priorities. In November 2023 there were 175 audits scheduled across the organisation to provide assurance about the quality of care we provide.

[Clinical Audit Forward Plans- Audit Committee November 2023]



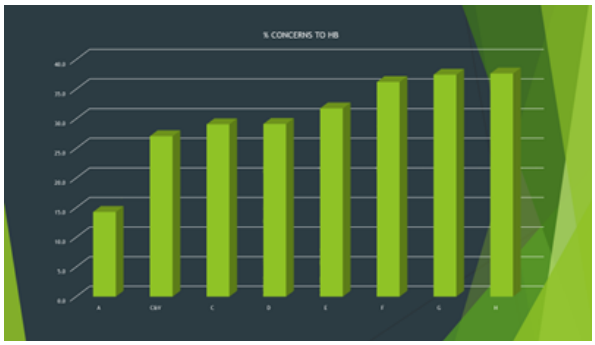
Medical Examiner

The Medical Examiner Service, which is independent of Health Boards in Wales, currently provides scrutiny of all in-patient deaths that are not investigated by HM Coroner. Scrutiny is undertaken by a Medical Examiner (ME) who is an experienced doctor with additional training in death certification.

The ME will notify the Health Board in relation to cases where they believe there should be further consideration or where the family have raised concerns about the care their relatives have received. A multi-professional mortality screening panel has been established to consider the ME notifications and to agree the terms of further investigation or review.

Themes and trends from ME notifications are fed into the various clinical advisory groups in the Health Board to allow them to develop strategy and policy that will deliver the necessary improvements and service development. Feedback from relatives is fed into the Civica patient experience platform so that it is accessible to clinical areas to ensure learning.

The ME shares data with health organisations on a quarterly basis and demonstrates that 27.1% of cases receiving independent scrutiny result in a notification back to the Health Board.



Tendable

The Tendable ward audit system was introduced in 2020 and was pre-dominantly used by our nursing colleagues to audit and inspect the care that they provided on wards and in other clinical environments. The tool is now used more widely by the multi-disciplinary team. The digital platform allows health care colleagues to measure the care that they provide against a set of standards. These standards include completion of patient documentation and risk assessments, infection prevention and control, management of peripheral and central venous lines and nutrition and hydration.

429
Total no. of locations set up in Tendable, with significant number not used.

1179 Live Registered Users

232
No. of areas set up in our core audit programme

~36
On average 36 Executive Walkaround audits are completed each year, covering core audit areas and more.

Welsh Nursing Care Record

The Welsh Nursing Care Record is a digital system that is transforming the way that nurses store and access patient information. The benefit of a digital record is that nurses can easily access historical records and share information across the clinical teams within the Health Board. The system has been piloted in several clinical areas and has shown benefit and will be rolling it out to all in-patient areas in 2024/25.

Access to digital risk assessments means that there is a wealth of patient information available to inform quality improvement and strategy. This can include analysing information in risk assessment of individuals who sustain a fall as an in-patient to understand common themes including prescribing of specific medications or conditions or poor eyesight. This allows us to further understand these risks and to change the way we provide care to mitigate these risks.

Quality Driven Decision Making

Making decisions about how the services we provide are delivered, how services should evolve and how resources should be allocated should always be done through a quality lens. This process should consider the health and care quality standards assessing the effect of strategic decisions on the quality and safety of the health care systems.

We are currently developing a quality driven decision-making policy to support a standardised approach to the application of this process, endorsing a formal quality impact assessment for all strategic decisions made across the Health Board.

Maternity Services

Maternity services across the UK and locally have been under significant scrutiny over the past twenty-four months. In March 2022, the second and final report by Donna Ockenden into the Maternity Services at Shrewsbury and Telford NHS Trust was published and outlined 89 recommendations that all Trusts and Health Boards in the UK should adhere to. In July 2023, the Wales Maternity and Neonatal Safety Support Programme (MatNeoSSP) Wales published its first report; Improving Together for Wales, into Maternity and Neonatal Services across Wales. The report outlined 16 priority areas with 110 recommendations.

In November 2022 Health Inspectorate Wales (HIW) attended the Maternity Unit at the University Hospital Wales for an unannounced inspection and undertook a further unannounced review in March 2023. HIW identified a number of areas where improvements were required as well as recognising areas of good practice. A combined inspection report was published in June 2023 that made a number of recommendations to the Health Board.

As well as developing an improvement plan to address the local HIW findings, a review of the recommendations of the two national reports was undertaken to identify required improvements or development and the UHB committed significant additional investments into maternity and neonatal services to support these improvements.

The full report can be read at: University Hospital of Wales | Healthcare Inspectorate Wales (hiw.org.uk)

The additional investment has been used to increase midwifery establishments and to fill all existing vacancies. The recruitment of specialist neonatal nurses to support the Transitional Care Unit and support the care of babies in the most appropriate setting ensuring that families are not separated.

The development of the maternity dashboard and further work to extend the dashboard to neonatal services supports a data informed approach that provides real time information on the quality and safety of service provision in perinatal services.

The reconfiguration of the maternity department ensures improved experience for women with increased single rooms available to ensure improved privacy and dignity. The appointment of a Preceptorship Lead Midwife and the redesign of the induction programme now means that newly qualified midwives have additional support for the first year of training.

A full report of progress against Ockenden, MatNeo SSP and the HIW recommendations was reported to the October 2023 Quality Safety and Experience Committee. You can read the full report at Maternity Update Quality Safety and Experience Committee October 2023

Person-centred

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

Patient Experience

We are committed to providing quality services in line with our strategic objectives and committed to improving patient experience. Whilst every effort is made to do what is right for our patients, there have been times when we have got it wrong, and it is essential that we learn from their experience. 'Patient experience' encapsulates all aspects of our clinical and non-clinical care including the care environment, staff attitude and communication, team working, access issues, involvement in decisions about treatment choices and our ability to be responsive and resolve problems quickly. It is also about treating patients with honesty, dignity, and respect. It applies across all services provided to patients in the Health Board.
We currently send up to 1,000 texts each day which includes contacting 600 patients randomly selected from general hospital activity, 200 people who have attended our Emergency Department and 200 patients who have accessed Mental Health Services. This Information helps us to understand the experience of the people who use our services allows us to put in place improvements.

In response to feedback, we have introduced contact cards for each consultant to hand to patients to make navigating our health systems and contacting their health care team easier and we have introduced a digital system to keep patients attending the Ophthalmology Departments updated to appointment waiting times.

Many people who have been cared for as inpatients have told us that they felt bored and isolated during their stay. In response we have developed digital library trolleys which were initially being used on five wards and are now being spread to other areas. These trolleys are being supported by volunteers and include radios, books and portable DVD players and discs as well as a number of spiritual resources including an audio Quran, audio Bible, large print Bibles, Buddhism mindfulness cards and prayer mats.

Safe at Home

Safe@Home is a multi-agency, multi-professional urgent response service designed to provide an immediate and safe alternative to ambulance conveyance and avoidable hospital admissions. The service which started in January 2024 enables individuals to remain at home and receive the care that they require there. The service is focussed on supporting frail elderly individuals who present with infections, or those that have had a fall but have not sustained a serious injury. This group of patients are at risk of long hospital admissions which can present additional risks.

SIRAN (Safety Incident Response Accreditation Network)

The Mental Health Clinical Board were proud to achieve their SIRAN accreditation in March of this year after a year-long process. SIRAN is a quality improvement and accreditation network for mental health organisation's patient safety incident review process. The Network endorses a set of standards in particular increasing the involvement of patients and their families, allowing them to add their reflections to review reports and to pose specific questions and influence the terms of reference of each review

Daring to Dream

Nearly half of all adults in Wales are estimated to be living with at least one longstanding illness. Of those, the lives of more than half are either somewhat or severely limited by their illness.

Daring to Dream, a charity that focuses on emotional support for adult patients, has helped transform spaces within the University Hospital Wales for the emotional wellbeing of those in our care. Quiet Rooms in hospitals are very important spaces. They are the rooms used for difficult conversations with patients and their families and it is vital that they are comforting for those in need. To support the emotional health of patients, there are now multiple re-furbished quiet rooms within the hospital in General Surgery, Critical Care, Nephrology, and Cardiology. The newest quiet room within the hospital can be found in the Department of Integrated Medicine.

Often drab and uncomfortable, Daring to Dream helps turn quiet rooms into spaces where patients, families, and colleagues can feel at ease after receiving distressing news. Spaces where people can feel and express their emotions openly benefit the mental health of anyone that needs its calming presence.

Efficient Care

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

See on Symptoms and Patient Initiated Follow up (SOS and PIFU)

To help us provide high-quality, patient-centred outpatient care, we have adopted two new approaches in some of our clinics – See on Symptoms (SOS) and Patient-Initiated Follow-Up (PIFU):

See on Symptoms: SOS is designed for patients with short-term, stable conditions who are expected to improve over time. Patients on this pathway are instructed to contact us if they experience worsening symptoms or have any concerns.

Patient-Initiated Follow-Up: The PIFU pathway is designed for patients with chronic or long-term conditions who require ongoing monitoring. Instead of having follow-up appointments scheduled at fixed intervals by the healthcare team, patients on the PIFU pathways are given flexibility to schedule appointments when they need them, based on their circumstances and symptom progression.

SOS and PIFU have significant benefits for patients, giving autonomy to manage appointments and seek care when needed, without the burden of unnecessary appointments. This, in turn, allows the clinical team to allocate their time more effectively, reducing waiting times and ensuring patients can be seen promptly when needed.

With an unnecessary out-patient appointment costing the Health Board around £160, avoiding unnecessary appointments allows us to use this money elsewhere to improve our services. There is also an environmental benefit to the wider population through reduced unnecessary travel to appointments with the associated carbon emissions. SOS and PIFU are better for patients, better for clinical teams and better for the planet.

Safe Care

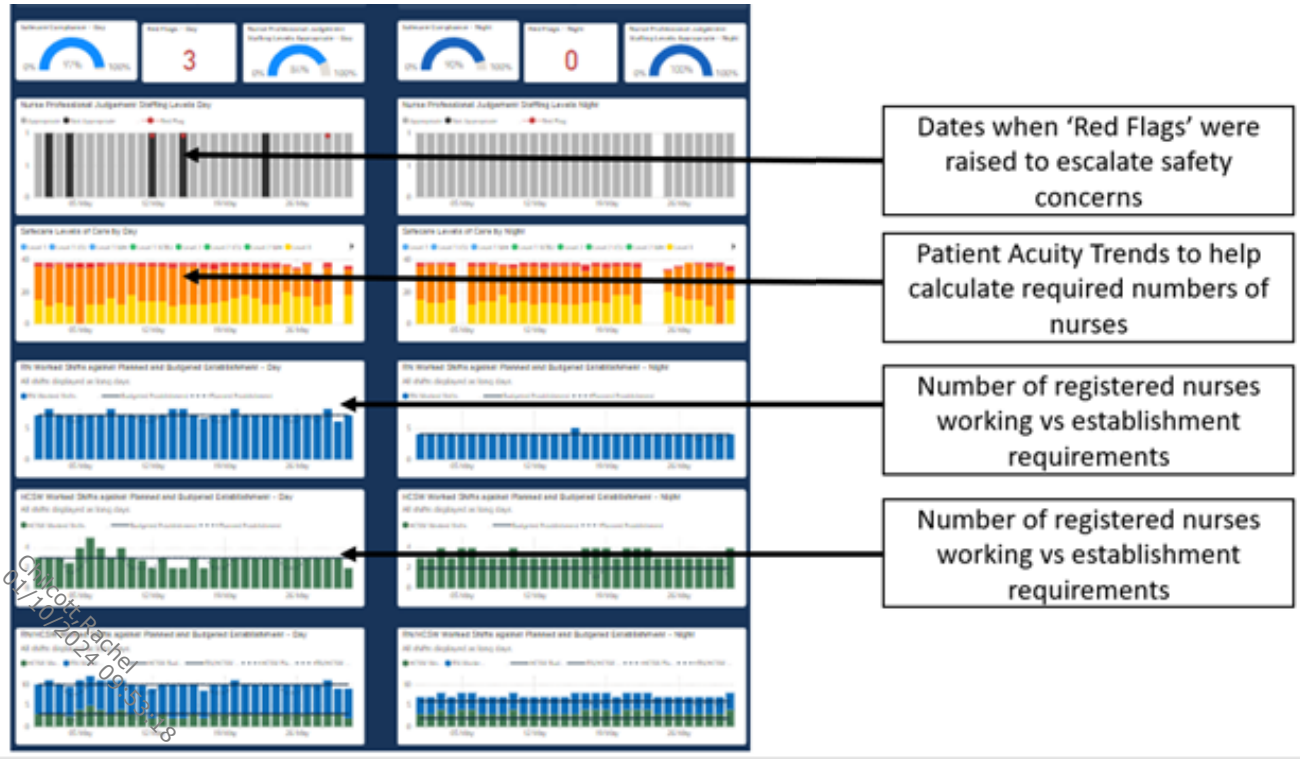
The Nurse Staffing Levels (Wales) Act became law in 2016 and requires health organisations in Wales to ensure appropriate and safe nurse staffing levels. The Act requires us to be able to triangulate nurse staffing levels in Acute Medicine and Surgical in-patient areas considering the acuity of the patients being cared for.

We use a digital platform called Safe Care to help us to monitor staffing levels and to escalate risks in areas where staffing falls below the required level. Safe Care is now used on all relevant wards and has demonstrated 90% compliance with the Act's requirements. The platform has allowed much greater scrutiny of rostering practice and identified variation in study leave and annual leave provision. Having access to this information supports much more efficient rostering.

Health Pathways

Community health pathways and hospital pathways are designed to standardise care across a condition specific pathway of care including assessment, management and referrals between the community and the hospital setting. Pathways ensure that care is provided in line with evidence based guidance including NICE and ensures an efficient use of resource by supporting the provision of care in the right place, at the right time and by the right people.

These pathways are used across the Health Board to ensure equitable access to evidence-based care.



Equitable

Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system.

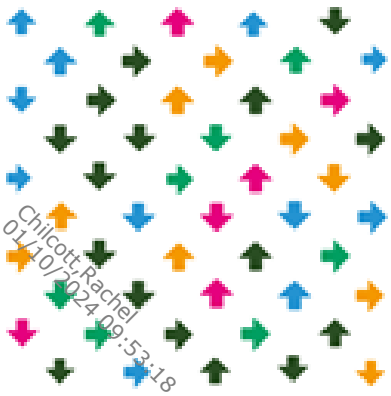
Equity, Equality, Experience and Patient Safety Framework

The Equity, Equality, Experience and Patient Safety Framework was published in 2023 setting out an ambition to deliver equitable and excellent preventative clinical service. We will achieve this by reducing variation in health outcomes, access to services and the quality of services that people receive and to ensure that we have a workforce that is representative of the population.

A support pack was published alongside the framework, which is designed to help our colleagues think through how they can make a difference in reducing variation in the care that we provide to different populations.

Initial areas of Focus for Cardiff and the Vale University Health Board

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



We will achieve this by:

- **Identify** - recognising that individual services might not meet the needs of all people;
- **Intelligence for Action** - by using the data and information available to us to start to measure these disparities;
- **Interventions Tailored to Need** – putting in place services that meet the need of the local people.

Cardiff and Vale Health Inclusion Service (CAVHIS)

Health inclusion is an approach aimed at readdressing extreme health and social inequities among the most vulnerable and marginalised in a community. The concept of health inclusion typically encompasses people experiencing homelessness, vulnerable migrants, sex workers, Gypsies, Roma Travellers (GRT) and those in contact with the Criminal Justice System. These marginalised populations share common overlapping risk factors for poor health that include poverty, adverse life experiences, discrimination, violence, and complex trauma. These risk factors, accompanied with multiple barriers and negative experiences when attempting to access health and care services, result in significantly poorer health outcomes, putting those affected beyond the extreme end of the gradient of health inequalities.

CAVHIS is a Health Board service for groups that face significant challenges when attempting to access health and social care services. Support includes Public Health screening for asylum seekers and refugees, including GP registration and access to medical care for up to 3-4 months, whilst individuals are supported in transitioning into traditional primary care.

The Homelessness Team was established in 2019 to provide therapeutic intervention, support, and treatment to people with complex support needs within homelessness services. The team is made up of clinicians and practitioners

Average age of death for homeless **men is 45 and 43 for women** (ONS, 2021).

In 2021, across England and Wales, there were an estimated **741 deaths** of people experiencing homelessness. The estimated number of deaths among homeless people has **increased by 54%** since records began in 2013 (ONS, 2021).

Study revealed that **68% of street-based sex workers** interviewed meet the criteria for post-traumatic stress disorder – this is in the same range as victims of torture and combat veterans undergoing treatment (Litchfield et al., 2010).

Annual number of people dying whilst under probation services in Wales **increased exponentially by 194%** between 2018/19 and 2020/21 (PHW 2023). Accidental drug deaths were the leading cause of death.

Gypsy, Roma and Traveller people face life expectancies **between 10 and 25 years shorter** than the general population (Friends, Families, Travellers 2021).

An international systematic review found that among adult asylum seekers and refugees, the prevalence of **PTSD was 31.46%** and **depression was 31.5%**, compared to the general population which is 3.9% for PTSD and 12% for depression (Blackmore et al., 2020).

from several different organisations that include Cardiff and Vale Drug and Alcohol Service (CAVDAS), Dyfodol, South Wales Police, Probation, Cardiff Council (Housing and Adult Social Care) and the Department of Work and Pensions. The Team focusses on delivering in-depth assessments leading to person-centred co-ordinated support and treatment plans.

A Young Person Team was set up in 2021 to focus on the 16–24-year-old age group, presenting to the homeless service with significant complex needs. The service provides a transition social worker, mental health and substance use professionals, case co-ordinators and offers therapeutic interventions, including counselling and substance use support. The Team is based with the Area Planning Board funded Cardiff and Vale Drug and Alcohol Service.

ELAN

The ELAN team was initially developed in 2003 to provide specialist maternity support within Ely and Llanederyn where there were higher levels of deprivation. Within a year the services had been expanded to meet the need of all overlooked groups in Cardiff and the Vale and provide support relating to substance abuse, teenage pregnancies severe mental health issues, homelessness and learning disabilities.

The team provides an enhanced service seven days a week providing all antenatal and postnatal care by named midwives to a caseload of around 35 women. The support includes individualised parent education provided in the home.

Vaccinations Information

Vaccines are the most effective way of preventing many infectious diseases and they prevent millions of deaths worldwide each year. We see variation in uptake of vaccinations, including childhood vaccination across Cardiff and Vale, with lower uptake often associated with areas of greater deprivation

In 2023 increased rates of Measels were noted across the UK. Work undertaken by the Health Board Public Health Team included working in partnership with schools where MMR vaccine uptake was below 90% to improve uptake and to provide factually accurate information about vaccinations.

NHS Staff Survey

The NHS Wales Staff Survey 2023 saw a response rate of 21.4% from staff across the Health Board. Although this is disappointing in terms of levels of participation, the feedback received from 3,662 colleagues will be important in helping the UHB understand the current experiences of those working within the organisation.

In the week following the release of the over-arching organisational results in February 2024, the Chief Executive Officer worked with the Communications Team to share, in full, what had been received. This aligned with the messaging leading up to the staff survey, promising that the UHB would be open and transparent in sharing results, and work with colleagues to understand and act upon feedback received.

The UHB is keen to work in a collaborative and inclusive way, and colleagues have been asked to become part of a 'Staff Survey Task Group' where results can be shared, discussed and ideas for improvement can be generated and acted upon. The first meeting of the Group will take place in June 2024.

Next steps with the survey results will be to assess the level of analysis that can be extrapolated from the data in the format provided, which will be shared with Clinical Boards and Directorates. The People and Culture Team are working with Clinical Boards to support understanding or, further engagement in, and actions required following results. The UHB are conscious that the long timescales currently seen could impact on trust in the Staff Survey process, and future engagement in the NHS Wales Staff Survey, therefore communication and engagement will continue throughout 2024.

The UHB have also introduced a consistent approach to cultural assessments, using the Culture and Leadership Programme created by NHSEI, The King's Fund and The Centre for Creative Leadership. This approach is being adopted in a prioritised and targeted way, owned at a local level and supported by organisational expertise. The results of the cultural assessments are being collated to support a wider organisational understanding, and to inform actions required to make improvements or amplify successes.

Welsh Language

We have published a Welsh Language for In-patients Policy this year to ensure that we consistently meet our statutory requirements to provide patients with an active choice on whether they wish to communicate in Welsh or English.

To be able to meet this commitment, we will record Welsh language skills for every member of staff and clinical areas will be able to utilise the Welsh Language skills of their staff to provide the best level of service for patients who prefer to speak Welsh. Staff will be encouraged to wear the "*Iaith Gwaith*" to identify themselves as Welsh speakers. All patients will be

asked their preferred language which will then be recorded on the Patient Management System.

HIW undertook an unannounced inspection on the Renal Wards, B5 and T5, in March 2023 and recommended that further work was required to ensure that an active offer of provision of health care in both Welsh and English was made. In response Welsh language greeting cards were placed by all telephones to support staff to be able to answer the phone and greet callers in Welsh. The wards have reviewed all patient information leaflets to ensure provision in Welsh and English and undertook a review of all signage to ensure that it was bilingual.

You can read the full report and improvement plan at: 20230706UHWNephrologyEN.pdf (hiw.org.uk)

Tobacco

Smoking is highly damaging to health and is the cause of death for around half of long-term smokers. It remains the single largest cause of preventable ill health and 13% of the population in Wales and 12% in Cardiff and Vale are smokers. There is significant variation in smoking rates across different populations in Wales with 22.4% of adults from the most deprived groups of Wales smoking compared to 6.6% in the least deprived, and the proportion of individuals with long-term mental health conditions who smoke is 31%.

Smoking Cessation support is available to everyone in Cardiff and Vale; Help Me Quit community services are available to deliver smoking cessation support, providing behavioural support and nicotine replacement therapy on a one-to-one basis and through group support. Pharmacies across Cardiff and Vale, but particularly in areas of deprivation, are delivering smoking cessation support to the communities for whom smoking is having the most impact. Public Health practitioners are providing support to schools and education settings and youth services in the most deprived areas to deliver smoking prevention education.

Help Me Quit - Denise's Story (youtube.com)

Looking Forward 2024 /2025

The Health Board is committed to delivering the highest quality care, treatment and intervention and addressing unfair differences in access and outcome. We recognise that currently we are not providing the quality of services we could or should, so patients and staff do not have the best experience or outcomes.

We have launched Shaping Our Future Wellbeing, the Cardiff and Vale University Health Board's 2023-2025 strategy: In our strategy we commit to providing outstanding services which are equitable, timely and safe and where people are treated with kindness and are supported to achieve the outcomes that matter to them.

We will seek to eradicate avoidable harm in each of the four strategic objectives, Putting People First, Providing Outstanding Quality, Delivering in the Right Places and Acting for the Future

In 2024 we will launch the Quality Excellence programme to deliver an effective quality management system through the building of capacity and capability across the domains of quality planning, quality control and assurance and quality improvement activities underpinned by leadership practices that foster a culture of learning. The programme will provide a particular focus on several areas that we have determined are our clinical priorities.

Shaping Our Future
Quality Excellence