Public Quality, Safety and Experience Committee

Tue 21 May 2024, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:10
10 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 Meeting held on the 26.03.2024

Ceri Phillips

00 - QSE Public Minutes 26.03.2024.pdf (7 pages)

1.5. Actions from the QSE Meeting held on the 26.03.2024

Ceri Phillips

- Royal College of Psychiatrists Feedback

Public QSE Action Log following 26.03.2024.pdf (2 pages)

1.6. Chair's Actions taken since the last meeting

Ceri Phillips

14:10 - 15:25
75 min

2. Items for Review & Assurance

2.1. Children & Women Clinical Board - Assurance Report

30 mins *Sandeep Hemmadi / Andy Jones / Catherine Wood*

2.1 - CW Clinical Board Assurance Report (Final) - April 2024.pdf (24 pages)

2.2. Deep Dive - Nationally Reportable Incidents (NRIs)

20 mins *Alexandra Scott*

2.2 - NRI paper QSE May 2024 v2.pdf (10 pages)

2.3. Prison Inquest Update

10 mins *Jason Roberts*

2.3 - QSE Inquest Paper.pdf (5 pages)

2.4. Clinical Effectiveness Committee

15 mins *Alexandra Scott / Aled Roberts*

2.4 - CEC assurance report Sep-Jan 24.pdf (19 pages)

15:25 - 15:30
5 min

3. Items for Approval / Ratification

3.1. Equity, Equality, Experience and Patient Safety Action Plan

5 mins *Claire Beynon / Oliver Williams*

3.2a - Equity Equality Experience and Patient Safety action plan. 21.05.24.pdf (2 pages)
3.2b - EQUITY_EQUALITY_EXPERIENCE_AND_PATIENT_SAFETY_ACTION_PLAN_V3.pdf (15 pages)
3.2c - Equity, Equality, Experience and Patient Safety Action Plan. QSE slides May 2024.pdf (6 pages)

15:30 - 15:45
15 min

4. Items for Noting & Information

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

Jason Roberts

4.1a - CD&T CB Minutes 15.3.24.pdf (11 pages)
4.1b - Medicine Clinical Board Minutes 20 Mar 24.pdf (6 pages)
4.1c - PCIC QSE minutes 12March24.pdf (6 pages)

4.2. Minutes from the WHSSC Quality Patient Safety Committee (QPSC)

Ceri Phillips

4.2 - Quality Patient Safety Committee Chairs Report.pdf (16 pages)

4.3. Chair's Report Radiation Protection Group

Ceri Phillips

4.3 - Radiation Protection Group Chairs Report 23.4.24.pdf (2 pages)

4.4. COVID Investigation Programme

10 mins *Angela Hughes / Alexandra Scott*

4.4 - Covid-19 End of Programme Update 2024.pdf (3 pages)

15:45 - 15:45
0 min

5. Items to bring to the attention of the Committee

Ceri Phillips

15:45 - 15:45
0 min

6. Agenda for the Private Quality, Safety and Experience Committee

Ceri Phillips

i) Private Minutes

ii) Any Urgent / Emerging Themes - Verbal (Confidential Discussion)

15:45 - 15:50
5 min

7. Any Other Business

Ceri Phillips

15:50 - 15:50
0 min

8. Review of the Meeting

Ceri Phillips

15:50 - 15:50
0 min

9. Date and Time of the next meeting

Ceri Phillips

16th July 2024 at 2pm

Via: MS Teams

15:50 - 15:50
0 min

10. Declaration

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

Unconfirmed Minutes of the Quality, Safety & Experience Committee

Held on 26th March 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		
Melanie Bostock	MB	MCA Consent Lead Manager
Emma Cooke	EC	Deputy Director of Therapies & Health Science
Mat Davies	MD	Consultant – Nephrology & Transplant
Thomas Holmes	TH	Clinical Board Director – Clinical Diagnostics & Therapeutics
Bethan Ingram	BI	Interim Lead Nurse – Teenage Cancer Trust Unit & Haematology Directorate
Meriel Jenney	MJ	Executive Medical Director
Andy Jones	AJ	Director of Nursing / Midwifery – Children & Women's Clinical Board
Matt Phillips	MP	Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Aled Roberts	AR	Clinical Board Director - Medicine
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Richard Skone	RS	Deputy Executive Medical Director
Michael Stephens	MS	Clinical Board Director – Clinical Diagnostics & Therapeutics
Catherine Twamley	CT	Interim Director of Nursing – Specialist Services Clinical Board
Tracey Vine	TV	Qualified Nurse - Patient Safety & Quality Team
Observers		
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Jessica Castle	JC	Director of Operations – Specialist Services
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies & Health Science

QSE 24/03/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QSE 24/03/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 24/03/003	**Declarations of Interest**	

	No declarations of interest were raised.	
QSE 24/03/004	**Minutes of the Committee meeting held on 13.02.2024** To view the minute: https://youtu.be/MTfd1JeHBGU?t=102&feature=shared The minutes of the Committee meeting held on 13.02.2024 were received, subject to minor wording amendments. Following on from the Surgical Clinical Board – Assurance Report in the previous meeting, the END noted that a piece of work had been undertaken to improve their Risk Registers. **The Committee resolved that:** a) The minutes of the meeting held on 13.02.2024 were approved as a true and accurate record of the meeting.	
QSE 24/03/005	**Action Log following the Meeting held on 13.02.2024** To view the minute: https://youtu.be/MTfd1JeHBGU?t=206&feature=shared The Action Log following the Meeting held on 13.02.2024 was received. QSE 23/12/007 – Royal College of Psychiatrists (RCP) Review – the EMD informed the Committee that they still had not received a response from the RCP. QSE 24/02/012 – Policies – The DCG shared the procedure with the Committee Members (https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/uhb-242-written-control-documents-development-and-approval-procedurepdf/) which set out where policies needed to be seen before they appeared at QSE, and noted that this procedure was under review. **The Committee resolved that:** a) The Action Log from the meeting held on 13.02.2024 was noted.	
QSE 24/03/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QSE 24/03/007	**Specialist Services Clinical Board – Assurance Report** To view the minute: https://youtu.be/MTfd1JeHBGU?t=410&feature=shared The Patient Story from the Teenage Cancer Trust (TCT) was presented to the Committee about the journey of a 17-year old patient from Newport who was diagnosed with a rare type of bone cancer in February 2023. The EMD acknowledged the need for further improvement in adult patient care, and suggested that the Teenage Cancer Trust (TCT) offered valuable insights for the enhancement of adult cancer services. The CEO asked how to keep the Emergency Unit (EU) effectively informed around the hospital's activities and improve the management of neutropenia and sepsis at the front end of the patient care pathway. The ILM-TCTUHD responded that there was ongoing work to refine these pathways, and that they had implemented a direct admission policy for young patients with haematology or paediatric diagnoses, which allowed for the administration of first-line antibiotics as they arrived directly onto the ward.	

The END suggested revisiting the joint guidelines which had been developed with Velindre for oncology patients in the EU (which included a hotline and protocols for immediate sepsis treatment).

To view the minute: https://youtu.be/MTfd1JeHBGU?t=1513&feature=shared

The IDN-SSCB presented the Assurance Report which provided the Committee with a summary of the achievements, innovation, and transformational work undertaken to date, and described key residual risks and their mitigating actions that carry forward into 2024/25.

The IM-TU commended the initiative to increase the number of registered nurses within neurosciences, and asked whether the individuals highlighted in the report had been existing healthcare support workers or had been recruited from elsewhere.

The IDN-SSCB responded that the majority of the Band 4 Assistant Practitioners in the Spinal Rehabilitation Setting were overseas nurses who were on the path to become Band 5s in the University Hospital of Llandough (UHL). She added that the model had been successful, and was being considered for implementation in other areas.

Regarding the Major Trauma Centre (MTC), the CVC asked how the patient numbers compared to the initial expectations, and for more detail around what had impacted the significant decline in adherence to the network repatriation policy.

The CBD-CDT (TH) and END responded that:

- The MTC was opened during the pandemic, which had made the initial modelling for patient numbers unpredictable. There were some challenges with certain pathways (e.g. chest trauma and traumatic brain injuries), but performance was considered good under the circumstances.
- The MTC relied heavily on flow and the repatriation of patients to satellite trauma units.
- There was some variance of success between Health Boards, and Cardiff and Vale UHB (CAVUHB) faced difficulty discharging patients back to secondary care.
- The initial vision for patient repatriation after a certain number of days was not realised due to capacity and flow issues in neighbouring organisations
- There was a reluctance to transfer patients back to secondary care in ambulances when there was no guarantee of immediate care upon arrival – this practice had not been exercised across the organisation, despite being a part of the plan
- The issue of repatriation was not unique to major trauma as it affected other services like cardiology and orthopaedics

The END stated that the Nationally Reportable Incidents (NRIs) were all managed and overseen via the Clinical Board Executive Reviews. In addition, the aspirational date for implementation of the Call for Concern initiative had been set for 1st July 2024.

The EMD commended the Specialist Services Clinical Board's model for how mortality should be benchmarked and reported disease-specifically, and noted that cardiac services were an area of concern.

The CEO asked whether the figures were indicative of a gradual increase in the number of incidents.

The IDN-SSCB responded that the increase in the number of NRIs aligned with the employment of a Quality & Safety Facilitator to monitor the data.

Regarding mortality, the CEO asked for more assurance on the variation in the observed mortality rates.

	CBD-CDT (TH) responded that the absolute mortality rate in the Critical Care Unit was higher compared to other units, due to the cohort of patients within Critical Care. However, the standardised mortality measure which accounted for the severity of patient conditions upon admission, was within safe margins. He suggested that the observed discrepancy was not a reflection of care quality, but rather access and capacity constraints. **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 Specialist Clinical Board was noted.	
QSE 24/03/008	**Quality Indicators Report** To view the minute: https://youtu.be/MTfd1JeHBGU?t=3447&feature=shared The ADWPS presented the Quality Indicators Report and slides which provided assurance in relation to a number of quality, safety, and patient experience priorities. Action: 1. For a paper around Never Events to be brought to a future QSE Committee. The CEO asked if their mortality data was benchmarked against themselves. The EMD confirmed that their current mortality data was a performance measure against their own standards, and that efforts were ongoing to extract similar data for wider benchmarking. **The QSE Committee resolved that:** a) The assurance provided by the report was noted.	
QSE 24/03/009	**Consent to Examination and Treatment** To view the minute: https://youtu.be/MTfd1JeHBGU?t=5022&feature=shared The MCACLM presented the Consent to Examination and Treatment report and SBAR which provided a summary of the ongoing work around the action plan for consent training. The EMD explained that a nuanced approach was required to train the remaining individuals in a manner acceptable to the Welsh Risk Pool (WRP), and that the goal was for everyone to understand what consent entailed and to ensure that the process was fit for purpose. The CEO asked whether there was a digital consent platform implemented to record consent within the organisation. The MCACLM responded that they used paper consent forms, but that the WRP were looking for a digital way to manage consent records. The END highlighted the following: - There were financial and reputational risks involved for the organisation. - If the Health Board failed to improve its stance on training staff for consent, it could result in increased premiums and reduced financial coverage for substantial costs - Consent training was important, as the lack of evidence for staff training could lead to the WRP withdrawing financial support. Action:	

	1. For the EMD, END, and the MCA Consent Lead Manager to discuss how to support the programme of mandating consent training across the organisation. **The QSE Committee resolved that:** 1) The assurance provided by the report was noted.	
QSE 24/03/010	**Patient Safety Solutions – Valproate** To view the minute: https://youtu.be/MTfd1JeHBGU?t=5767&feature=shared The CBD-M introduced the report and summarised the following: - New MHRA alerts aimed at reducing congenital malformations caused by Valproate, and the new requirement was for dual sign-off by independent clinicians for new Valproate prescriptions, as well as an annual review of the prescriptions with continued dual-sign off and further annual reviews - A group had been formed which included representatives from paediatrics, adult neurology, learning difficulties, and other areas where Valproate may be prescribed. The purpose of the group was to integrate these changes into the existing prescribing processes for Valproate. - The plan developed by the group was included in the report, and a key action was to identify where Valproate was being prescribed outside of known prescribers to include them in the plans. - They were optimistic about achieving the desired outcomes. **The QSE Committee resolved that:** 1) The assurance provided by the actions undertaken to date and the ongoing programme of work was noted.	
QSE 24/03/011	**Looked After Children – Assessment Backlogs** To view the minute: https://youtu.be/MTfd1JeHBGU?t=5948&feature=shared The DON-CW summarised the report which provided the Committee with an updated position regarding assessments for Looked After Children (LAC). The END acknowledged the increase in the number of LAC within Cardiff and noted that whilst there had been improvements made in the assessments for children aged 1-5 years and those aged 5+, the END asked about their plans to ensure that the crucial assessments within the first 28 days was not overlooked. The DON-CW responded that despite increased work capacity, the unpredictable number of children entering care and the timing of notifications from Local Authority colleagues remained a challenge to meet the 28-day compliance. Discussions were being had with Local Authorities to improve notification timeliness, and specific assessment sessions were being earmarked for new cases. The CVC asked about the LAC who were CAVUHB's responsibility but were placed in a different Health Board, and whether they had any assurance around the timeliness that those children were being assessed. The DON-CW responded that there was not immediate data available regarding other Health Board's performance in assessments, but that there was a commitment to gather this information and share with colleagues. Action: 1. For an update on Looked After Children – Assessment Backlogs to be brought back to the Committee in 6 months. The END added the following:	

	- There would be oversight on the improvement trajectory of timely assessments for LAC within the monthly Executive reviews - Discussions were ongoing around concerns related to patients with mental health and learning disabilities whose care was commissioned outside of the organisation, as their care was CAVUHB's responsibility. **The QSE Committee resolved that:** 1) The contents of the paper and the actions taken to mitigate the risks associated with child health assessments were noted.	
QSE 24/03/012	**MBRRACE-UK Neonatal Report 2021 and National Neonatal Audit Programme** To view the minutes: https://youtu.be/MTfd1JeHBGU?t=6938&feature=shared The EMD took the report as read and provided the following summary: - There had been a shift in neonatal mortality rates which had not significantly deviated from national trends, but still deviated in an unfavourable direction by over 5% (which was the threshold for concern) - An action plan with executive oversight had been implemented which addressed issues such as infection rates in the neonatal unit, environmental factors, IP&C practices, and workforce challenges. - The majority of the actions had been completed, which had led to a decrease in infection rates and some improvements in care. - Workforce concerns in the neonatal unit formed part of a broader discussion across Wales regarding the configuration of units and sharing of the limited neonatal workforce. - It was important to note the significant executive oversight and the ongoing work to optimise nursing resources and improve care delivery within the neonatal unit. Action: 1. For an update to be brought back to the Committee in 3 months. **The QSE Committee resolved that:** 1) The results of both the MBRRACE and NAP audits and the improvement work underway to address the requisite improvements were noted, and they were asked to: a. Support ongoing work around medical and nursing workforce recruitment strategies b. Support existing executive oversight of the infection action plan c. Support any recommendations and actions that arise from the RTTC team collaboration d. Support national cot reconfiguration programme in increasing capacity, with appropriate funding of additional resources that will be required in collaboration with WHSSC	
	Items for Approval / Ratification	
QSE 24/03/013	**Policies** To view the minutes: https://youtu.be/MTfd1JeHBGU?t=7317&feature=shared The following policies were approved by the Committee: - Optimising Outcomes Policy & Procedure (UHB 224) **The QSE Committee resolved that:** 1) The policies were noted and approved.	
	Items for Noting & Information	
QSE 24/03/014	**Minutes from Clinical Board QSE Sub-Committees and the Safeguarding Steering Group (SSG)**	

	To view the minutes: https://youtu.be/MTfd1JeHBGU?t=7346&feature=shared The Minutes from the Clinical Board QSE Sub-Committees and Safeguarding Steering Group (SSG) were noted. **The QSE Committee resolved that:** 1) The minutes from the Clinical Board QSE Sub-Committees and the Safeguarding Steering Group were noted.	
QSE 24/03/015	**Annual Report for Quality, Safety and Experience Committee 2023-24** To view the minutes: https://youtu.be/MTfd1JeHBGU?t=7360&feature=shared The Annual Report for Quality, Safety and Experience Committee 2023-24 was noted. **The QSE Committee resolved that:** 1) The Annual Report was noted.	
	Items to bring to the attention of the Board / Committee:	
QSE 24/03/016	To view the minutes (internal members): Public QSE 26.03.2024.mp4 The END noted that following a review from Joint Inspection of Child Protection Arrangements (JICPA), it was agreed that the Safeguarding Steering Group's (SSG) minutes would form part of the Committee papers for noting.	
	Agenda for Private QSE Meeting	
QSE 24/03/017	*i) Minutes and Action Logs from the Private QSE Committee on 13.02.2024* *ii) Any Urgent / Emerging Themes – Verbal Update* *iii) Chair's Report RADAN Application* *iv) Ophthalmology WET AMD Update*	
	Any Other Business	
QSE 24/03/018	To view the minutes: https://youtu.be/MTfd1JeHBGU?t=7426&feature=shared The CC noted that it was the EMD's final QSE Committee meeting before retirement, and thanked her for her dedicated commitment and support.	
	Date & Time of Next Meeting:	
QSE 24/03/019	Tuesday 21st May 2024 at 2pm via MS Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 21st May 2024
(Following the meeting held on 26th March 2024)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions					
QSE 23/12/005	**Action Log**	For the Committee Chair and the Director of Corporate Governance to review the items that are too far in the future and consider placing them on the annual work plan.	**21.05.2024**	Ceri Phillips Matt Phillips	*Update to be provided at the 25th May 2024 QSE during the 'Action Log' section*
QSE 23/12/007	**Mental Health Clinical Board – Assurance Report**	Report back on the feedback from the Royal College of Psychiatrists review.	**21.05.2024**	Richard Skone / Jason Roberts	**Completed** *Item added to the Forward Plan for May 2024 QSE*
QSE 24/03/008	**Quality Indicators Report**	For a paper to be brought to the Committee around Never Events.	**16.07.2024**	Alex Scott	**Completed** *Item added to the Forward Plan for 16.07.2024*
QSE 24/03/009	**Consent to Examination and Treatment**	For the EMD, END, and the MCA Consent Lead Manager to discuss how to support the programme of mandating consent training across the organisation.	**21.05.2024**	Melanie Bostock Richard Skone Jason Roberts	*Update to be provided at the 25th May 2024 QSE during the 'Action Log' section*
QSE 24/03/011	**Looked After Children – Assessment Backlogs**	For an update to be brought back to the Committee in 6 months.	**08.10.2024**	Andy Jones	**Completed** *Item added to the Forward Plan for 08.10.2024*
QSE 24/03/012	**National Neonatal Audit**	For an update to be brought back to the Committee in 3 months.	**16.07.2024**	Richard Skone	**Completed** *Item added to the Forward Plan for 16.07.2024*
Actions referred to Board / Committees					

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions referred FROM Board / Committees					

Report Title:	Children & Women's Clinical Board Assurance Report			Agenda Item no.	2.1
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	21st May 2024
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Jason Roberts, Executive Nurse Director				
Report Author (Title):	Andy Jones, Director of Nursing				

Main Report
Background and current situation:

This report provides details of the arrangements, progress and outcomes within the Children and Women Services Clinical Board in relation to the Quality, Safety and Patient Experience agenda over the last 12 months. It highlights the achievements, innovation and transformational work undertaken to date, and describes key residual risks and their mitigating actions that carry forward into 2024/25.

Quality and Safety and patient experience is at the core of all that we do within Children and Women's Clinical Board, and our operating framework is described below. Governance structures continue to develop in alignment with the 6 domains of quality as defined by the Duty of Quality Statutory Guidance 2023.

As a Clinical Board we have endeavoured to embed the culture we have built over the last couple of years to be more open to risk, innovation and transformation where clear links to improving patient quality, safety and experience can be evidenced. The value that underpins all that we do is that great teamwork greats create care.

The Clinical Board comprises three clinical Directorates with associated clinical services and sub-specialties. The Clinical Board delivers a number of highly specialised services serving the South East

region, South and Mid-Wales region and wider all Wales population, as well as providing secondary care services to the local Cardiff and Vale population.

The Clinical Board has a budget of £132,405,880 and an establishment of 2037.98 WTE staff.

Services are structured through the Directorates below:

- Acute Child Health
- Children Young People and Family Services
- Obstetrics and Gynaecology

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

- The Welsh Government Quality Delivery Plan for the NHS in Wales
- The Clinical Board's Operational Plan and IMTP
- Quality & Safety agenda
- Infection, Prevention and Control Annual work programme
- 6 Domains of Quality
- Patient Experience
- Financial and Information Governance
- Organisational Development and Workforce Planning
- National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)

Overview Quality, Safety and Patient Experience Practices and Improvements.

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

Assurance is received via the robust mechanisms which are in place such as the UHB's Internal Audit processes and strong adoption of AMaT within the Board and through the Clinical Board's QSPE group and formal business meetings all of which have strong multidisciplinary representation and are fully minuted. Introducing AMaT allows all of the learnings from investigations and clinical audits will be stored securely in one place and can be accessed to give assurances and demonstrate service improvement.

Children & Women's Clinical Board Quality, Safety and Patient Experience (QSPE)

The Clinical Board has a well-established formal Quality, Safety and Patient Experience Committee (QSPE) that meets every 4 weeks which is co-chaired by the Director of Nursing, Director of Midwifery & Neonatal Services and the Clinical Board Director. There is good engagement from core functions spanning the directorates such as IPC, pharmacy, safeguarding, H&S and patient safety who are regular contributors to the agenda.

These meetings have been reviewed and several changes have been implemented and will continue to be developed throughout the year.

The main QSPE meeting agenda has been refocussed to allow each directorate to share their escalations, quality improvements and wellbeing initiatives alongside items for discussion and escalation at a UHB level. The aim of the focused agendas is to allow directorates the space to align their risk register with escalations and initiatives that bring together a rounded view of each directorate rather than just discussing the immediate priority of the day which has been the focus historically. Once a quarter the QSPE meeting has a Health & Safety focus to ensure specific H&S issues are addressed in line with the redefined agendas and structures of the UHB group. This approach allows close links with the UHB Operational Health and Safety Group and any issues.

This structure is replicated in each of the Clinical Directorates. The QSPE group has a key sub-group that reports to it; C&W CB NRI/RCA Governance Sub-Group (Previously called Extra Ordinary Q&S).

The C&W CB NRI/RCA Governance Sub-Group meets monthly and provides a forum for robust discussion of NRI's, RCA's and incidents as well as reviewing action plans and learning from events to ensure safety and quality is embedded.

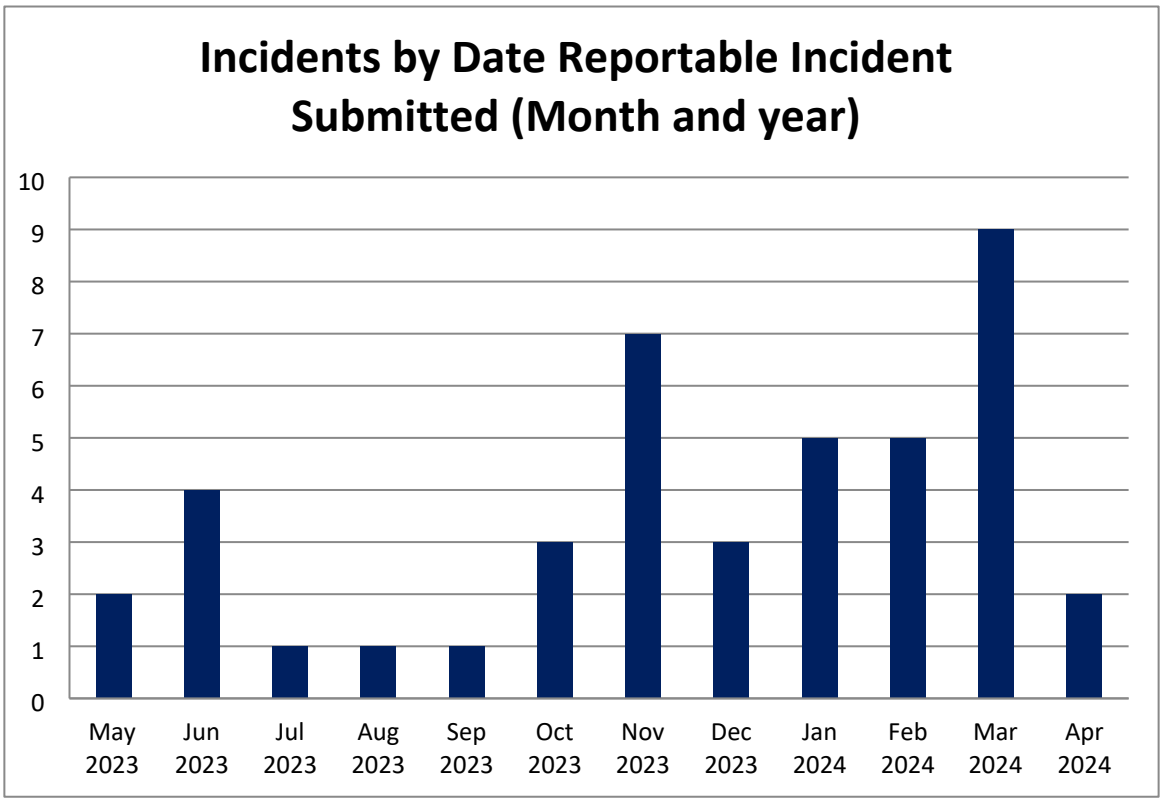
Through this agenda the aim is to draw themes and learning opportunities together so the Clinical Board can share actions, learning and service developments collaboratively.

The Clinical Board is currently in the process of reviewing its Governance arrangements to ensure reporting arrangements are robust and the structure in place supports the provision of assurance and any necessary escalation. The use of the AMaT System is a key tool for supporting a measurable audit and monitoring structure which will feed into the key priorities of the Clinical Board through the 6 domains of quality.

As part of the review of learning from incidents that are now reported in a timely manner we focussed on one of our higher risk areas, Obstetrics/Maternity and Neonatology, that historically both had a significant number of Datix reports that were left open or not reviewed for long periods of time. To focus on these two areas as a priority and develop a safe culture it was agreed to schedule regular meetings for Ockenden oversight, MatNeo safety as well as a Maternity / Neonatal oversight group chaired by the Executive Nurse Director.

NRI (National Reportable Incident) Management

The graphs below depict the numbers of Nationally Reportable Incidents (NRI's) reported to the NHS Executive within the Children & Women's Clinical Board during May 2023 – April 2024.



At the time of writing this report, the Clinical Board has 30 open NRI's, 6 of which are overdue. Also included within this number are the cases that are reported as per the MBBRACE reporting criteria (16), and no initial care concerns have been identified.

The Clinical Board has a robust review of all NRI's through initial fact-finding meetings, with subsequent progress meetings, followed by a closure and action planning meeting. The Clinical Board is in the process of establishing post closure meetings at regular intervals to ensure actions are completed and also embedded in clinical practice to provide further reassurance. Each report is also presented through Clinical Board QSPE meetings and shared more widely as appropriate.

Current position from AMaT (at time of writing the report)

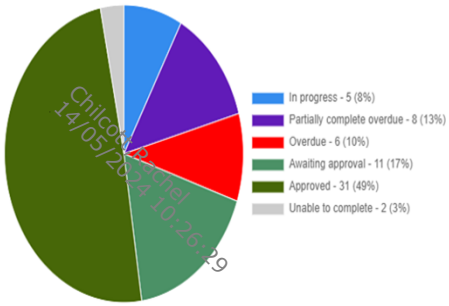
NRI Actions

By division	In progress	Partially complete	Partially complete overdue	Overdue	Total	Awaiting approval	Rejected	Approved	Unable to complete	Total
Children & Women	5	0	8	6	19	11	0	31	2	63

PIE CHART(S) BAR CHART(S)

Children & Women

DOWNLOAD



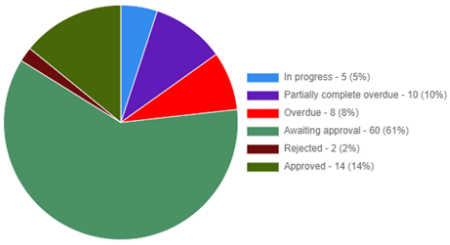
HIW Actions

By division	In progress	Partially complete	Partially complete overdue	Overdue	Total	Awaiting approval	Rejected	Approved	Unable to complete	Total
Children & Women	5	0	10	8	23	60	2	14	0	99

PIE CHART(S) BAR CHART(S)

Children & Women

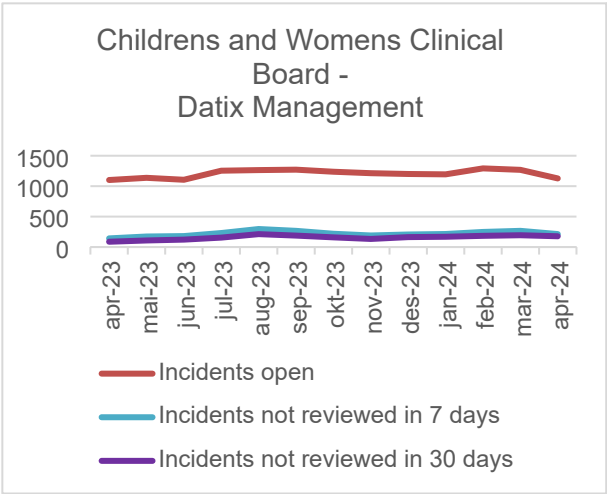
DOWNLOAD

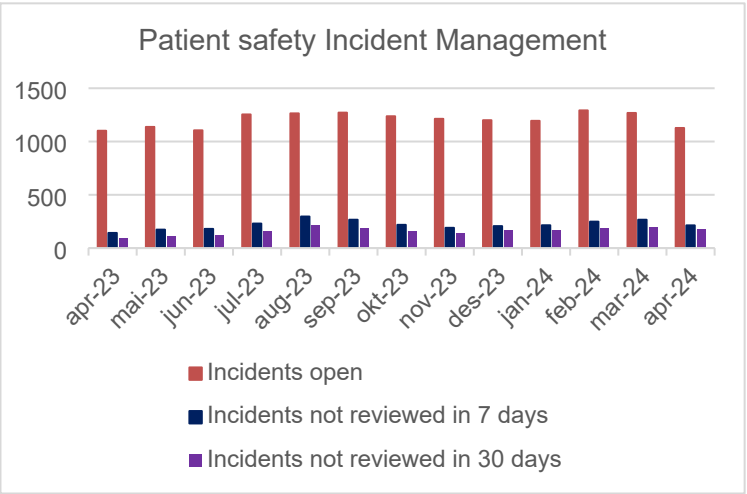


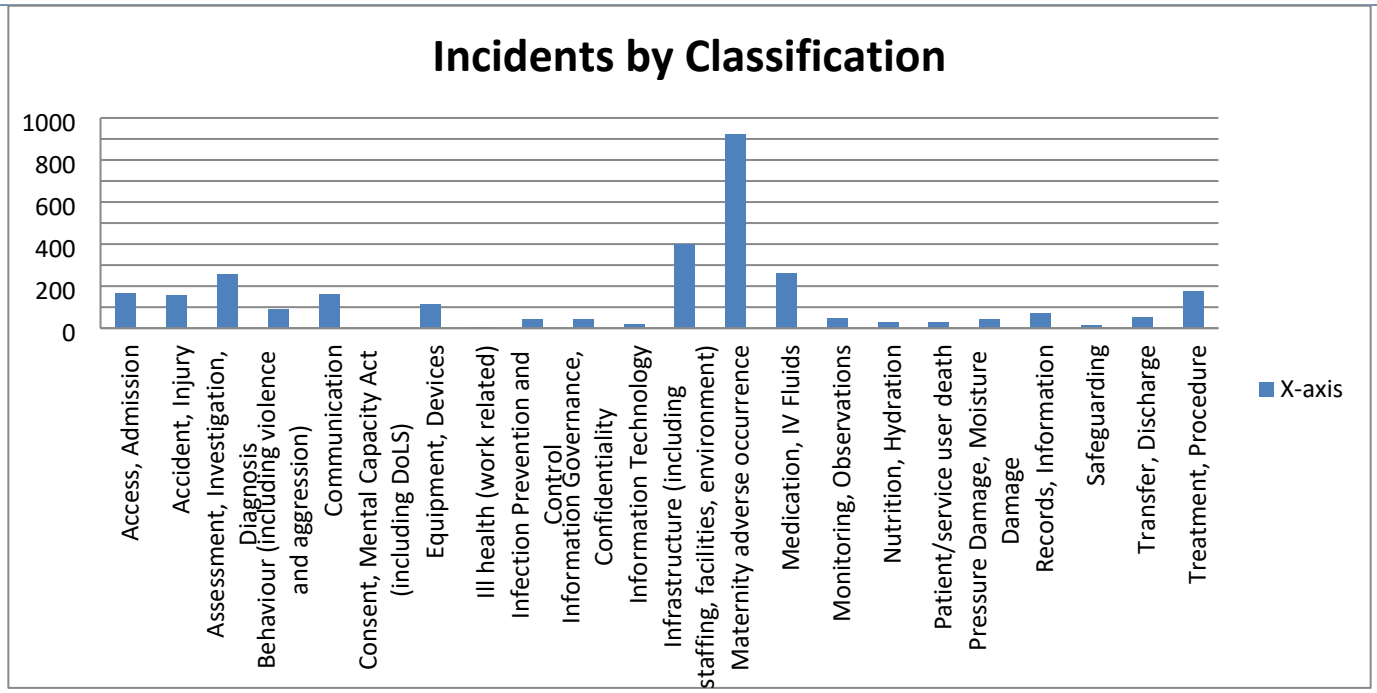
Datix/Patient Safety Incident Management

It is pleasing to see the significant incident reporting within the Clinical Board demonstrating our commitment to a culture, that is open, transparent and psychologically safe – the optimal conditions within which to deliver safe, high quality care and patient experience.

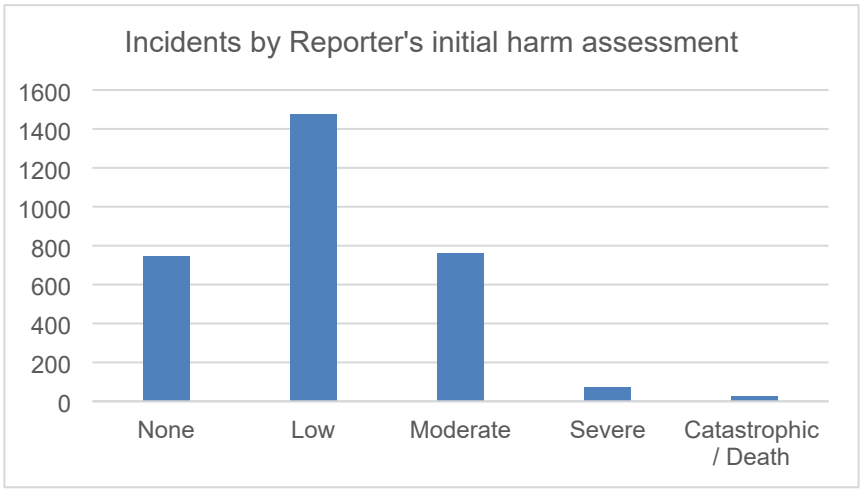
The Charts below show: The total number of open incidents at the end of each month in the 2023-24 financial year for the Children and Women's Services Clinical board. In addition, the charts show the numbers of incidents that were not reviewed in 7 days and not reviewed in 30 days in each month of the 2023-24 financial year.





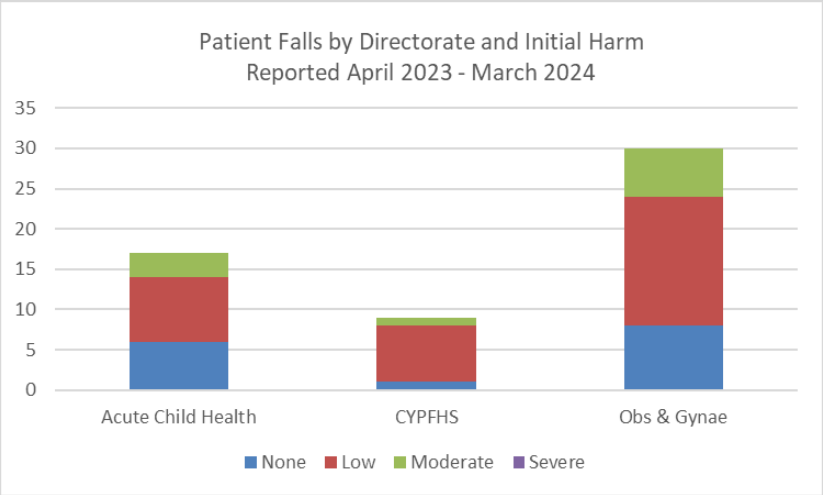


The chart below shows the number of open incidents by the level of harm as reported by the incident reporter at the time of writing this report.

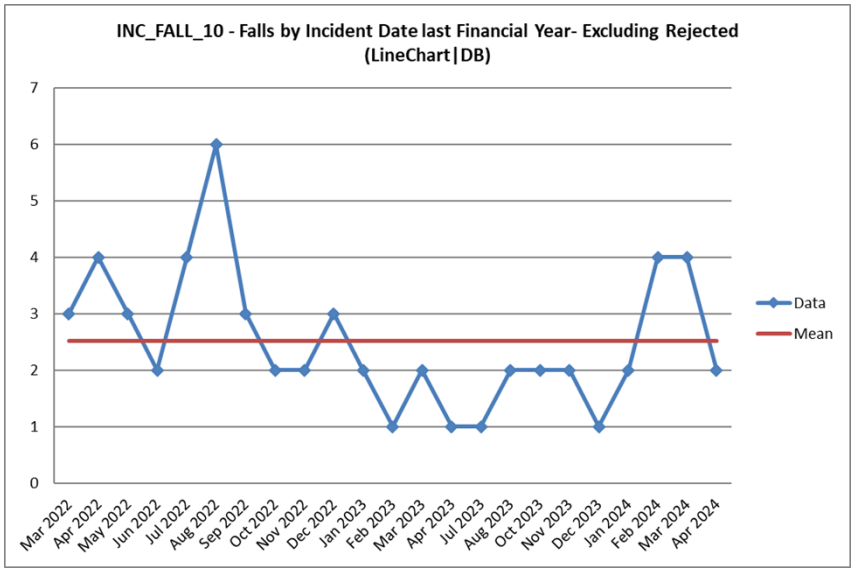


Falls

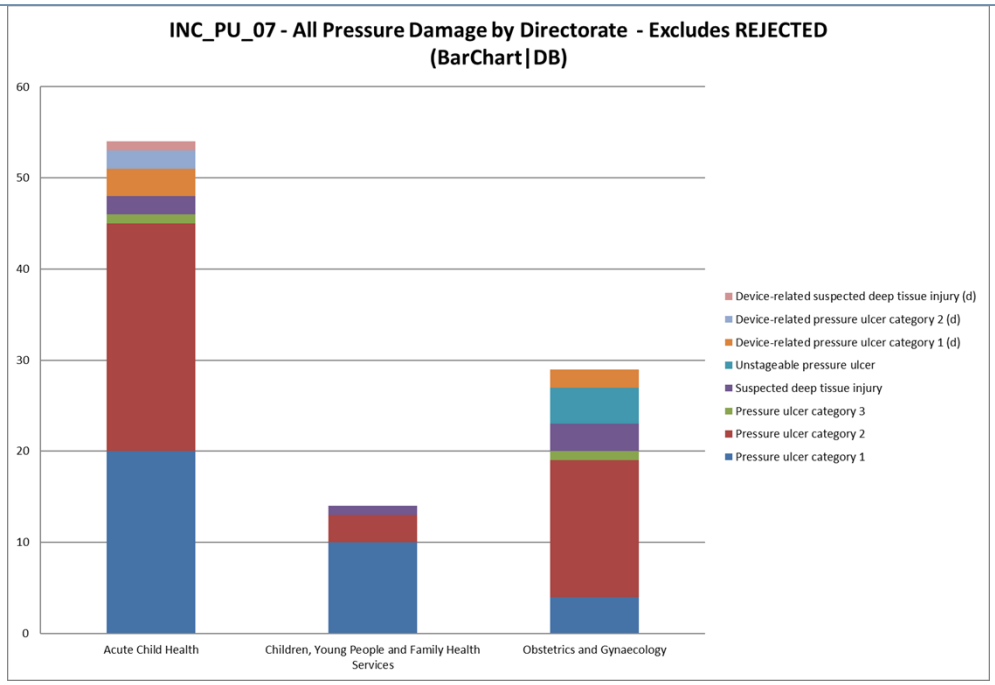
The graph below demonstrates the number of falls reported by Directorate for the period April 2023 – March 2024. There have been no incidents deemed to have caused severe harm and no falls reported have been NRI reportable during this period.



You will see from the graph below the numbers of falls incidents reported within the Clinical Board are not significant and has remained reasonably static throughout the last financial year.



Pressure and Tissue Damage, Reduction and Prevention



	Pressure u	Pressure u	Pressure u	Suspected	Unstageat	Device-re	Device-re	Device-re	Total
Acute Child Health	20	25	1	2	0	3	2	1	54
Children, Young People and Family Health Services	10	3	0	1	0	0	0	0	14
Obstetrics and Gynaecology	4	15	1	3	4	2	0	0	29
Total	34	43	2	6	4	5	2	1	97

Research and Development

Research and development are at the heart of driving the quality agenda through evidence-based care within the clinical board and we have active and well-regarded research programmes throughout the clinical board.

Below are the current open studies within the Children's Hospital for Wales.

Study Title	Speciality
UMBRELLA	Oncology
EsPhALL2017	Oncology
Characterisation of Paediatric Myelodysplasic (MDS) Syndromes	Oncology
ICONIC	Oncology
FaR-RMS	Oncology
SIOP Ependymoma II	Oncology
rEECur	Oncology
Clinical & biological factors associated with relapsed neuroblastoma	Oncology
NCCPG TDM 2018	Oncology
SKIPPER	Oncology

DOLFIN	NICU
PRIOR	NICU
neoGASTRIC	NICU
FORTIS (ST10305)	General
O-FAB	Endocrine
Contract -2	Surgery
International Congenital Lung Malformations Registry	Surgery
cCMVnet	ID
RSVoyage	Vaccine study
CMvibe	Vaccine study
Paediatric FH Register Study	Gastro
Fitness, physical activity, and lung function in CF youth	Respiratory
CF STORM Trial	Respiratory
CF-HomeSpIT	Respiratory
EDELife	Rare Diseases
Vertex x3 studies	Respiratory
Dova	Haematology
Lenny	T1 Diabetes
ELSA	T1 Diabetes
Innodia	T1 Diabetes
Noema	Neurology
Nsep	NICU
Psep	PICU
ENHANCE	Respiratory
SWISH	Respiratory
EASY	A&E/PSDEC

The Children's Hospital for Wales has become a member of the Paediatric ECMC Network for the first time. Membership of the network opens up opportunities for Welsh Paediatric patients to participate in Early Phase Paediatric oncology trials in Wales. Prior to this patients had to leave Wales to participate in the studies.

EDElife study
We are the only UK site for this study and we have the UK chief investigator.

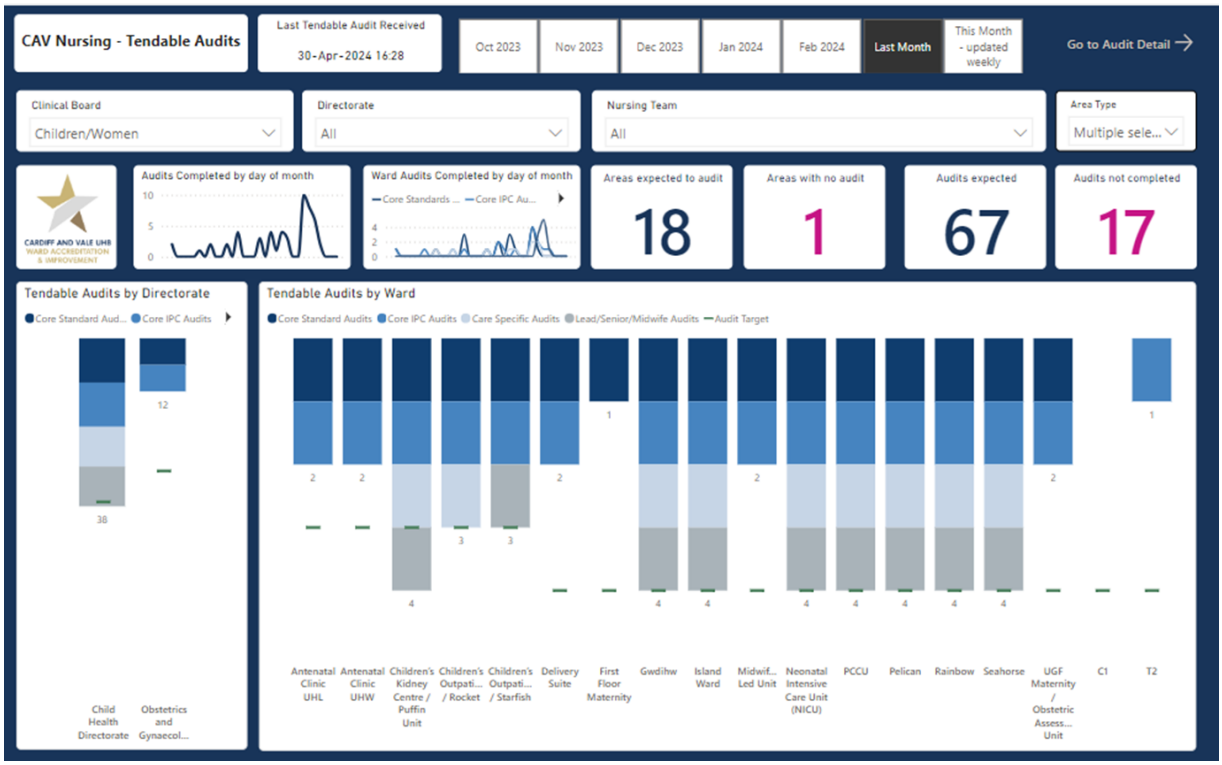
The study concerns a rare condition called XLHED. There are issues with the protein that supports the development of certain structures, including tooth buds and sweat glands. This drug was previously trialed in children after birth but was not effective. Further research has suggested that in utero administration could be more effective as it supports the protein development during fetal growth. This condition primarily impacts boys and can lead to death because of disease complications. There is currently no cure and children are offered symptom management only.

Quality Audits and Performance.

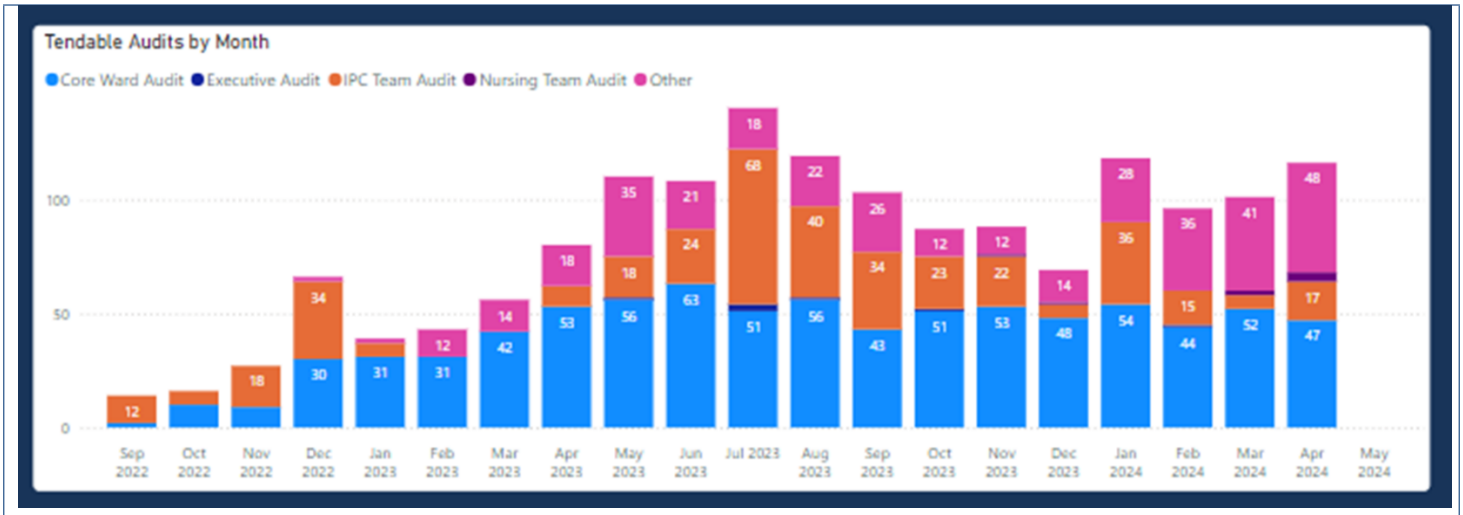
Tendable, the quality improvement and auditing app, is used across Children's and Women's Services to capture live data about quality standards, patient and staff experience and the care environment. To date, all 13 inpatient areas, 5 outpatient areas and 3 delivery theatres have been set up on the system and use it for monthly reporting and or ad hoc reporting, to meet the needs of the area. The content of the audit programme continues to evolve recognising the individual needs and wishes of service users, its partners, such as Health Inspectorate Wales (HIW) and the wealth of knowledge contributed by specialist practitioners within the services. In addition to the UHB structured audit programme, the Clinical Board has also developed additional audits to demonstrate continuous quality improvement through use of their results.

There are over 48 members of staff across the 21 clinical areas, auditing and many more registered who contribute to action planning and issue resolution. The ease of reporting via the app and through the dashboards (pictured) has contributed to the high compliance across the Clinical Board.

Tendable Compliance across C&W Clinical Board



Audit Activity



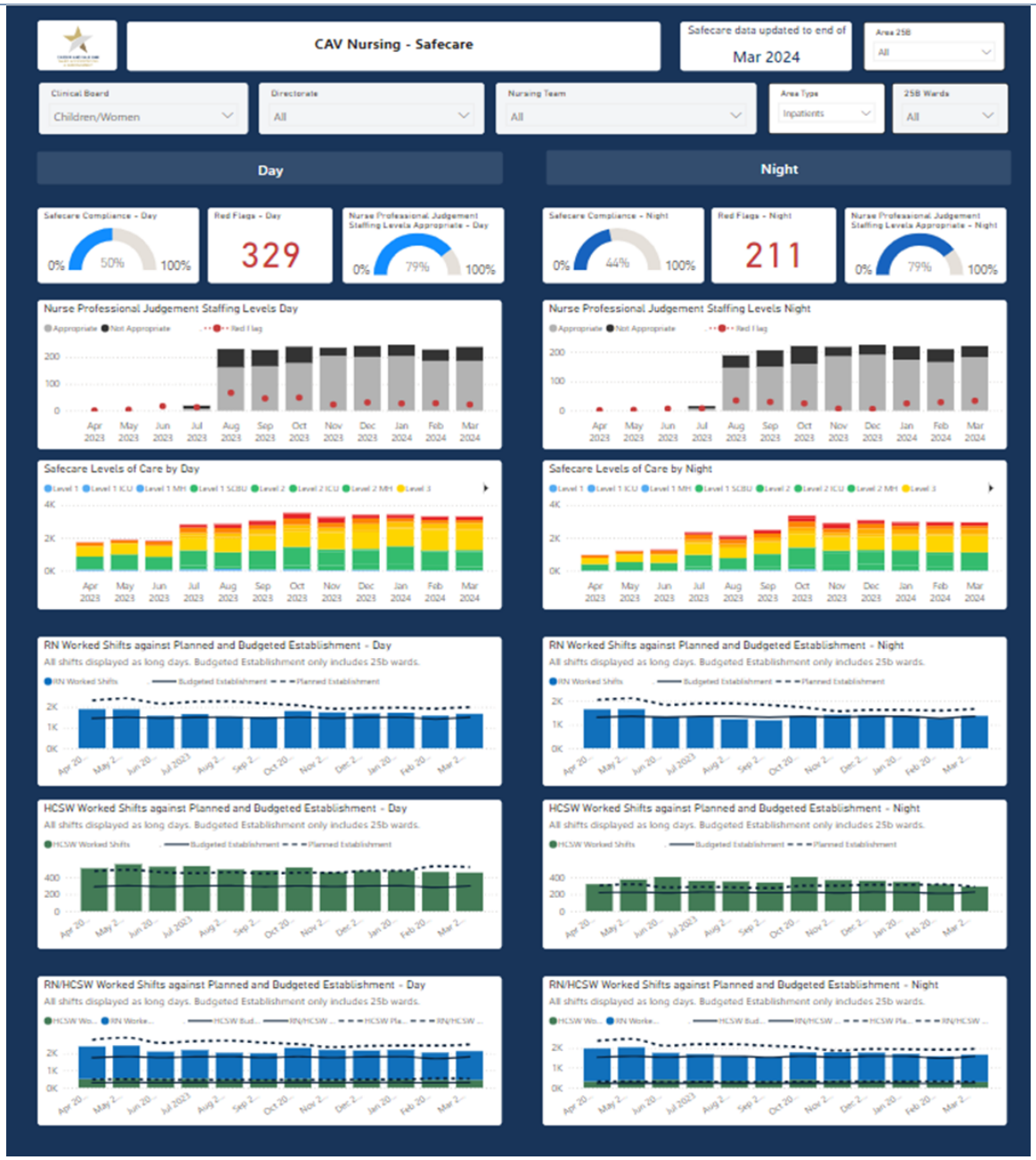
The Clinical Board monitor compliance with the ward audit programme monthly. Teams are expected to complete a:
Core Standards audit
Core Standards Infection Prevention and Control audit,
Care Specifics – monthly topic audit
Lead and Senior Nurse review.

In addition to this, the Acute Child Health areas complete monthly child and parent satisfaction services. This has supported the resolution of queries and concerns on the spot. There is also an assurance audit for Children's and Women's services.

Accreditation

The Acute Child Health Directorate is in the process of developing a Ward Accreditation programme in order to measure the quality of the services they provide, highlight their strengths and to drive continuous improvement. In order to do this a process of benchmarking has begun with the UHB Adult inpatient model and a number of NHS England Paediatric exemplar frameworks. It is hoped that a consultation with partners such as the Youth Board will commence during the Summer 2024.

Safe Care Dashboard



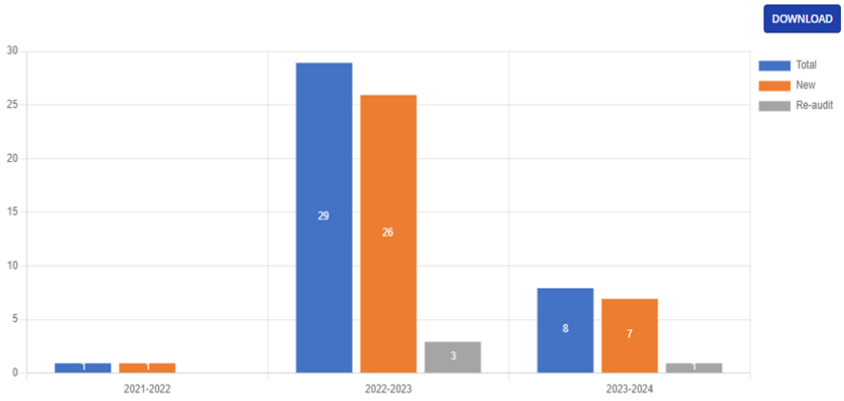
National Audit

Tier 2 Clinical Audits Registered on AMaT by Year

Number of new and re-audits by year

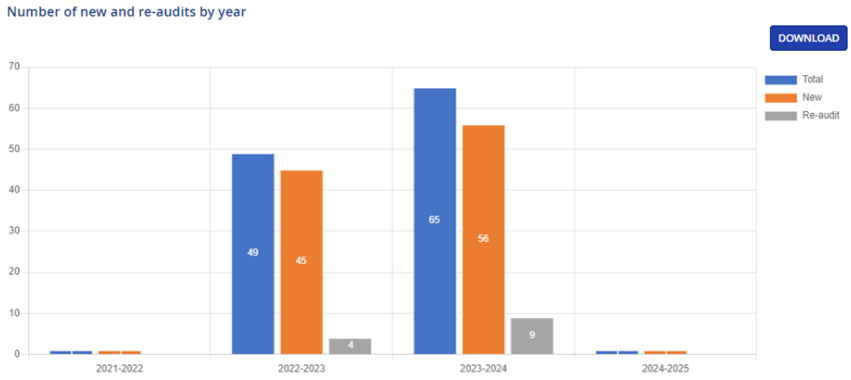
Year	Business unit	Total	New	Re-audit	Re-audit %
2021-2022					
	All	1	1	0	0.0%
	Acute Child Health	1	1	0	0.0%
2022-2023					
	All	29	26	3	10.3%
	Acute Child Health	9	9	0	0.0%
	Community Child Health	1	1	0	0.0%
	Womens	19	16	3	15.8%
2023-2024					
	All	8	7	1	12.5%
	Acute Child Health	1	1	0	0.0%
	Womens	7	6	1	14.3%

Number of new and re-audits by year



All Audits registered on AMaT by Year

2022-2023					
	All	49	45	4	8.2%
	Acute Child Health	23	23	0	0.0%
	Community Child Health	3	3	0	0.0%
	Womens	23	19	4	17.4%
2023-2024					
	All	65	56	9	13.8%
	Acute Child Health	30	28	2	6.7%
	Community Child Health	4	4	0	0.0%
	Womens	31	24	7	22.6%
2024-2025					
	All	1	1	0	0.0%
	Womens	1	1	0	0.0%

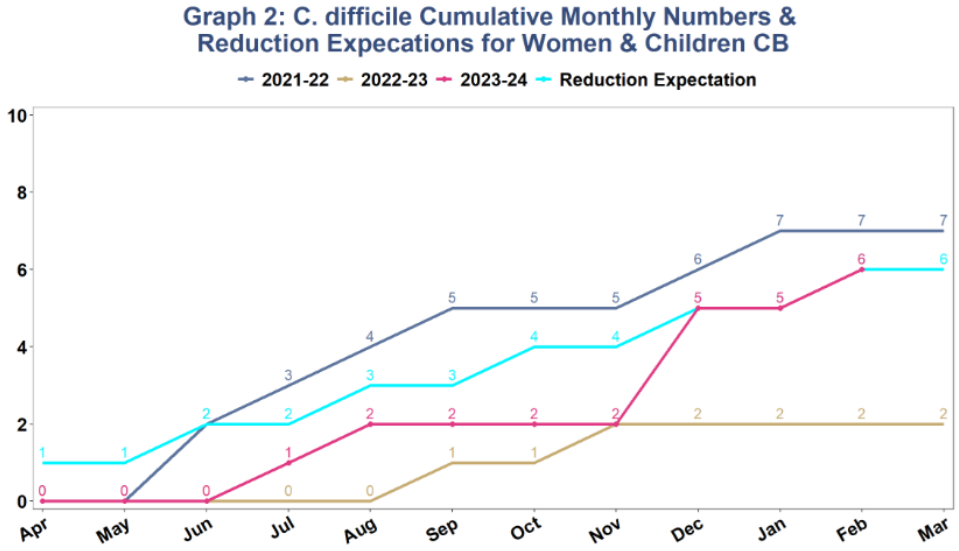


Infection Prevention and Control

C. difficile

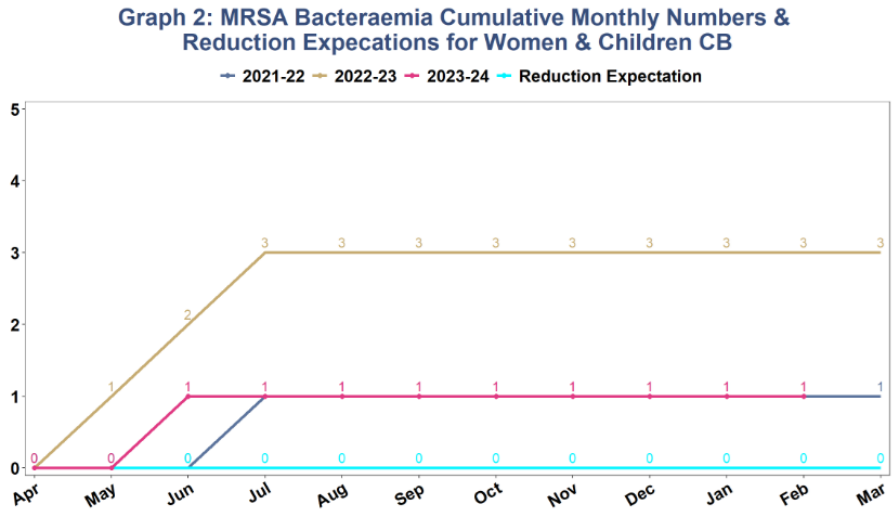
The reduction expectation for 2023/24 was 6 cases. The clinical board had 10 cases therefore the reduction expectation was not met. This equates to 400% more than the equivalent period in 2022/23. Acute Child Health had 9 cases and Obstetrics and Gynaecology had 1 case.

From the 9 cases in Acute Child Health, 4 of those cases were allocated to Rainbow ward.



MRSA bacteraemia

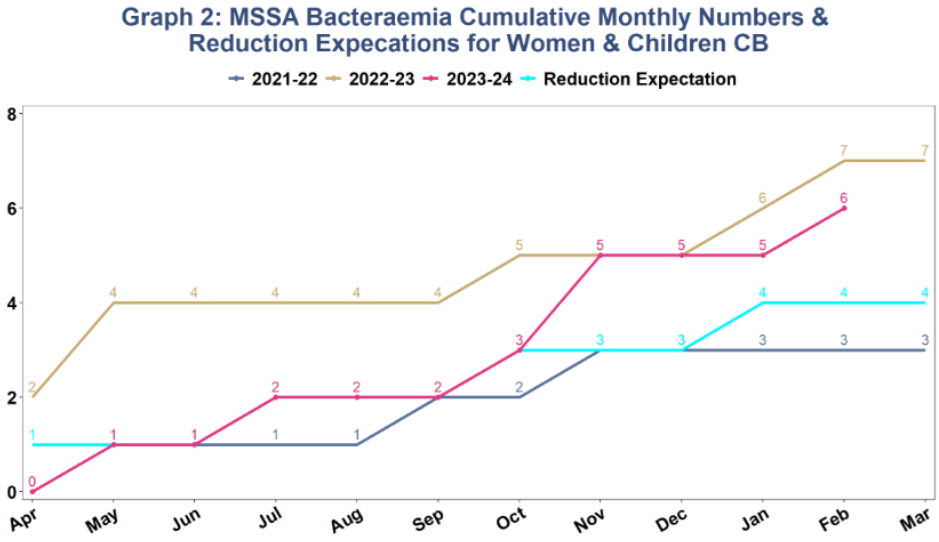
The reduction expectation for 2023/24 was 0 cases. The clinical board had 1 case therefore the reduction expectation was not met. Although the reduction expectation was not met, there was a 67% reduction compared to the equivalent period in 2022/23.



MSSA bacteraemia

The reduction expectation for 2023/24 was 4 cases. The clinical board had 6 cases therefore the reduction expectation was not met. Although the reduction expectation was not met, there was a 14% reduction compared to the equivalent period in 2022/23. Acute Child Health had 4 cases and Obstetrics and Gynaecology had 2 cases.

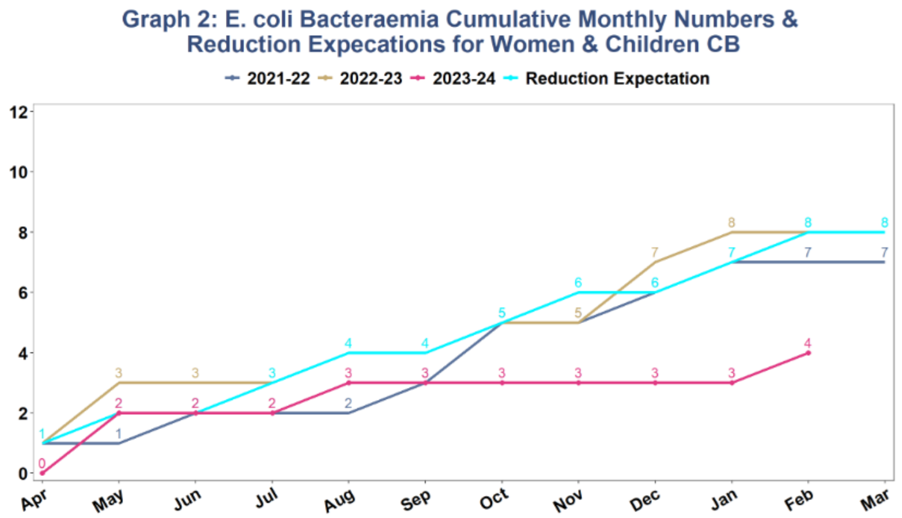
From the 4 cases in Acute Child Health, 2 of those cases were allocated to NICU.



E-coli bacteraemia

The reduction expectation for 2023/24 was 8 cases. The clinical board had 4 cases therefore the reduction expectation was met. This equates to 50% less than the equivalent period in 2022/23.

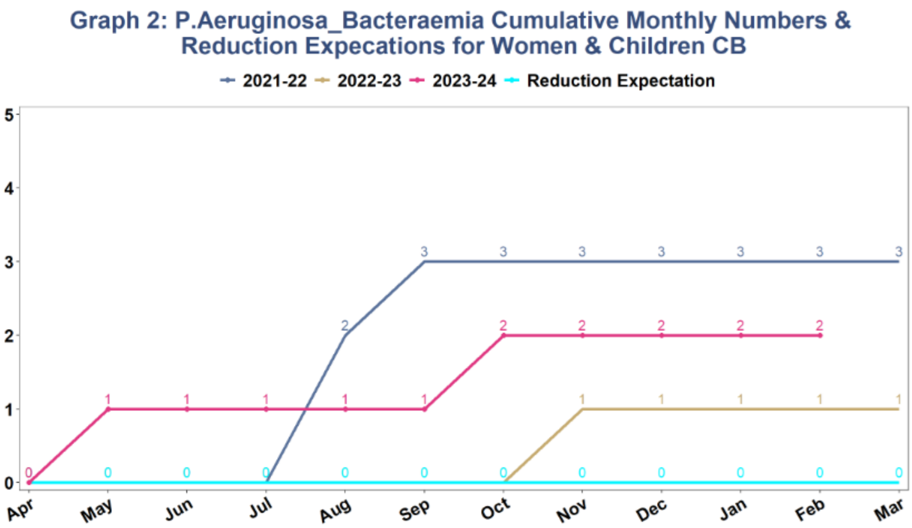
There were less cases in Child Health (-1) & Obstetrics & Gynaecology (-3) when compared to the equivalent period in 2022/23.



<u>Pseudomonas a. bacteraemia</u>

The reduction expectation for 2023/24 was 0 cases. The clinical board had 2 cases therefore the reduction expectation was not met. This equates to 100% more than the equivalent period in 2022/23.

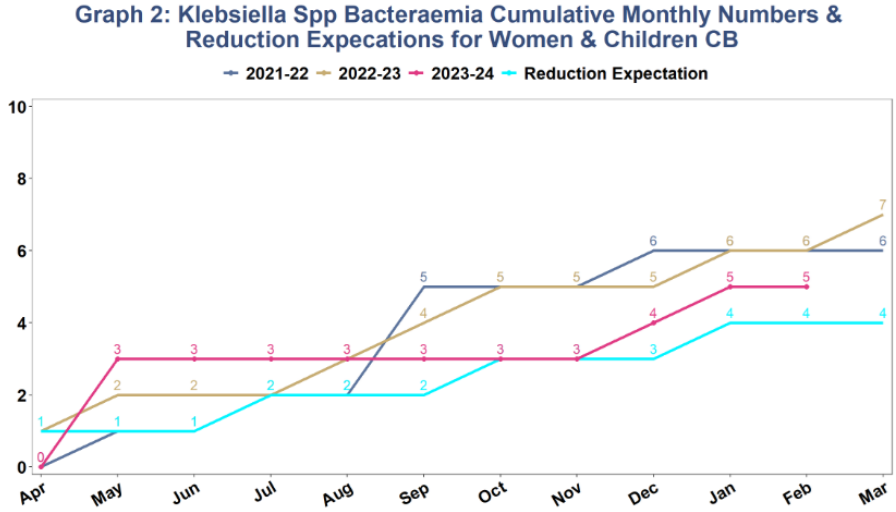
Both cases were from Acute Child Health and both bacteraemia's were line related.



<u>Klebsiella sp bacteraemia</u>

The reduction expectation for 2023/24 was 4 cases. The clinical board had 6 cases therefore the reduction expectation was not met. Although the reduction expectation was not met, there was a 14% reduction for the equivalent period in 2022/23.

Acute Child Health had 5 cases and Obstetrics and Gynaecology had 1 case but there were more cases in Obstetrics & Gynaecology (+1) when compared to the equivalent period in 2022/23. There were less cases in Child Health (-2) when compared to the equivalent period in 2022/23.



Reduction Expectation Summary

	C diff	MSSA	MRSA	E coli	Pseudomonas	Klebsiella
2023/24 total	10	6	1	4	2	6
2022/23 total	2	7	3	8	1	7
2021/22 total	7	3	1	7	3	6
Reduction Exp	6	4	0	8	0	4

The Clinical Board achieved the E-coli reduction expectation goal only. The highest increase has been seen in C.diff cases. A Period of Increased Incidence of C.diff was seen on Rainbow. 4 cases were identified between December and January. Cases were not linked through Whole Genome Sequencing. A PII meeting highlighted issues with housekeeping and no HPV clean undertaken. Lessons learnt included that a HPV clean must be undertaken on discharge/transfer of patients who have *C.diff* or are confirmed CRO.

Despite a reduction in MSSA and MRSA cases compared to 2022/23, 33% of all MSSA bacteraemia's were line related.

Safeguarding

Due to the nature of some of our areas, we see many safeguarding referrals and queries. Investigations are led by Health Lead Professionals, with appropriate actions taken and shared more widely if required. The teams have good links with the safeguarding team and psychology support for both staff and patients involved.

The Clinical Board currently has 9 open professional cases relating to nursing and midwifery staff.

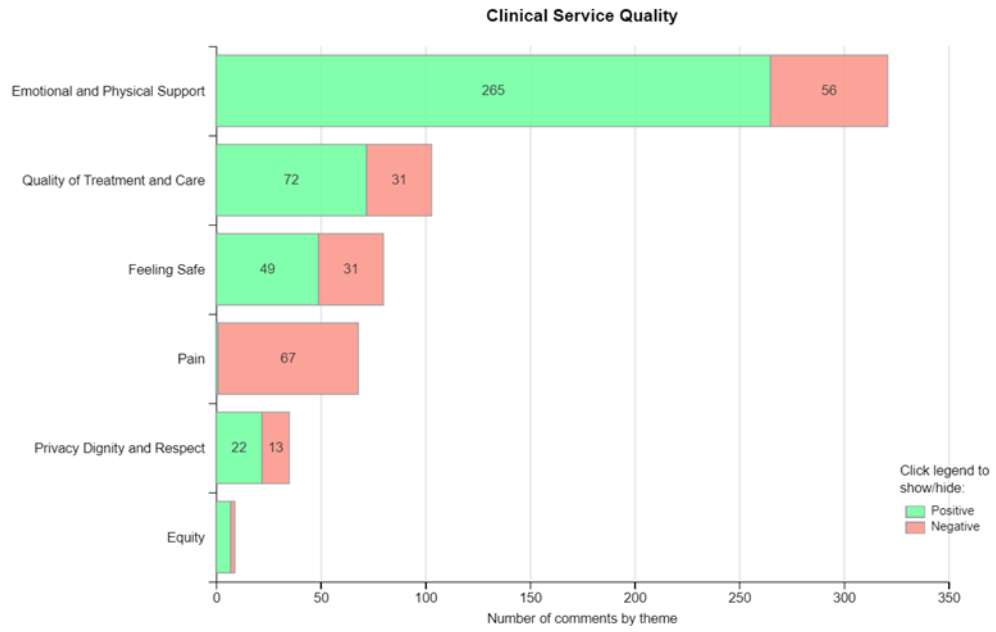
There has recently been the launch of the level 3 mandatory training for all staff Band 6 and above, F1 and above. Work is ongoing throughout the Directorates to ensure compliance against this competency. Access to training dates is difficult, however work is ongoing with the Safeguarding team with regards to additional dates and other means of training delivery for later this year. All staff are

being encouraged to have the Wales Safeguarding Procedures app on their phone and that it is available on desktops in each clinical area.

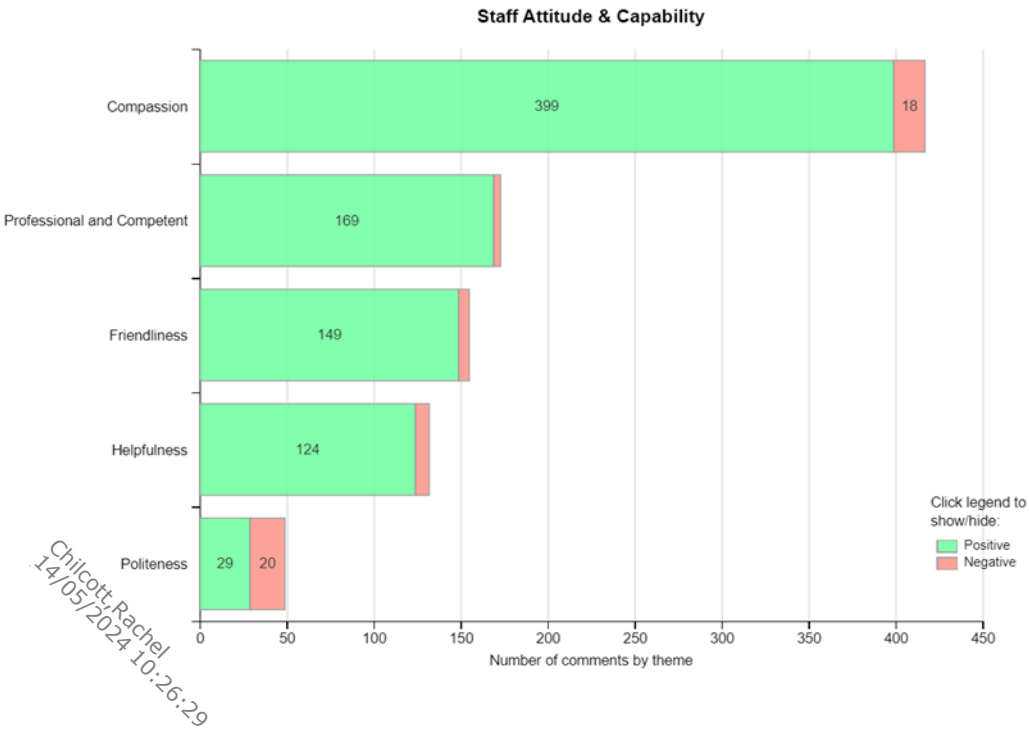
Patient Experience

The graphs below demonstrate patient feedback from the CIVICA Once for Wales Patient Experience Platform with a focus on the themes of clinical service quality and staff attitude and capability. Further work is being taken forward with the Patient Experience Team to look at further options for gathering patient feedback within paediatrics through CIVICA.

Clinical Service Quality Themes

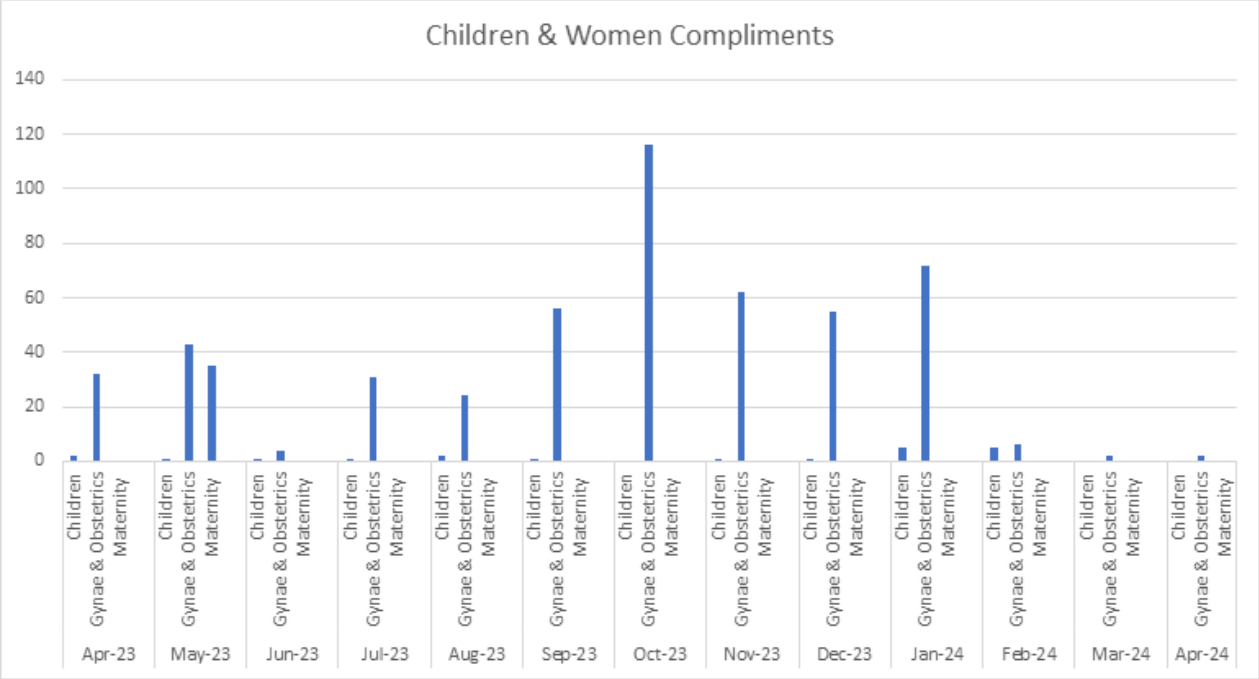


Staff Attitude & Capability Themes

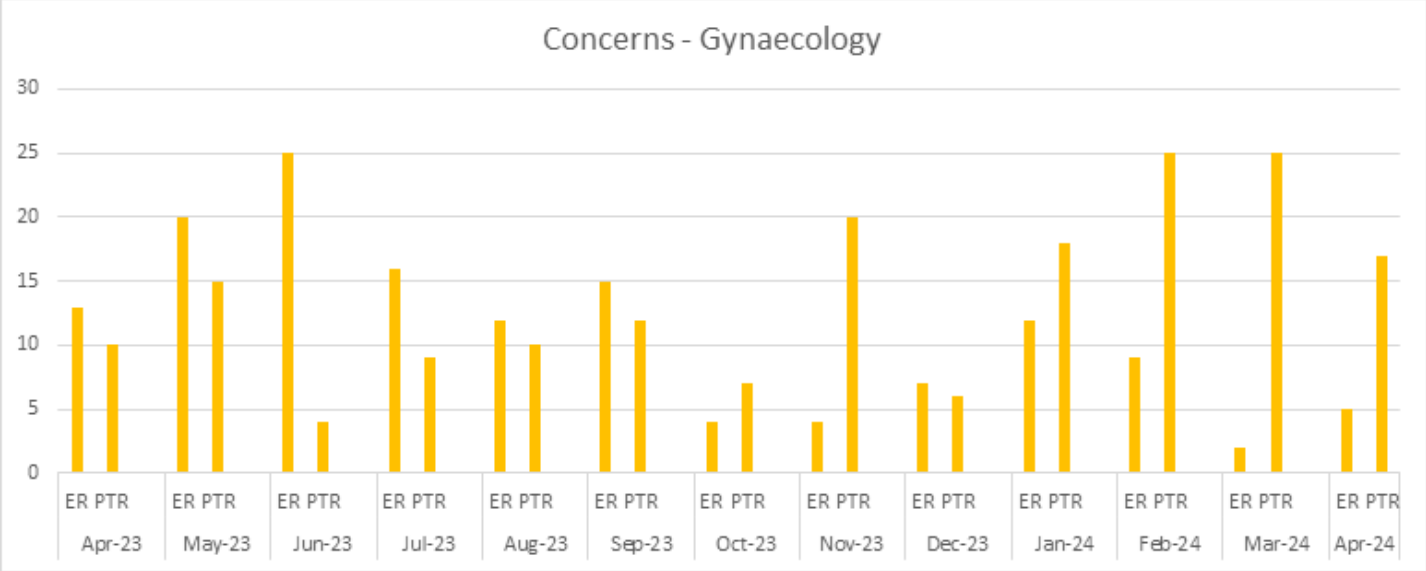


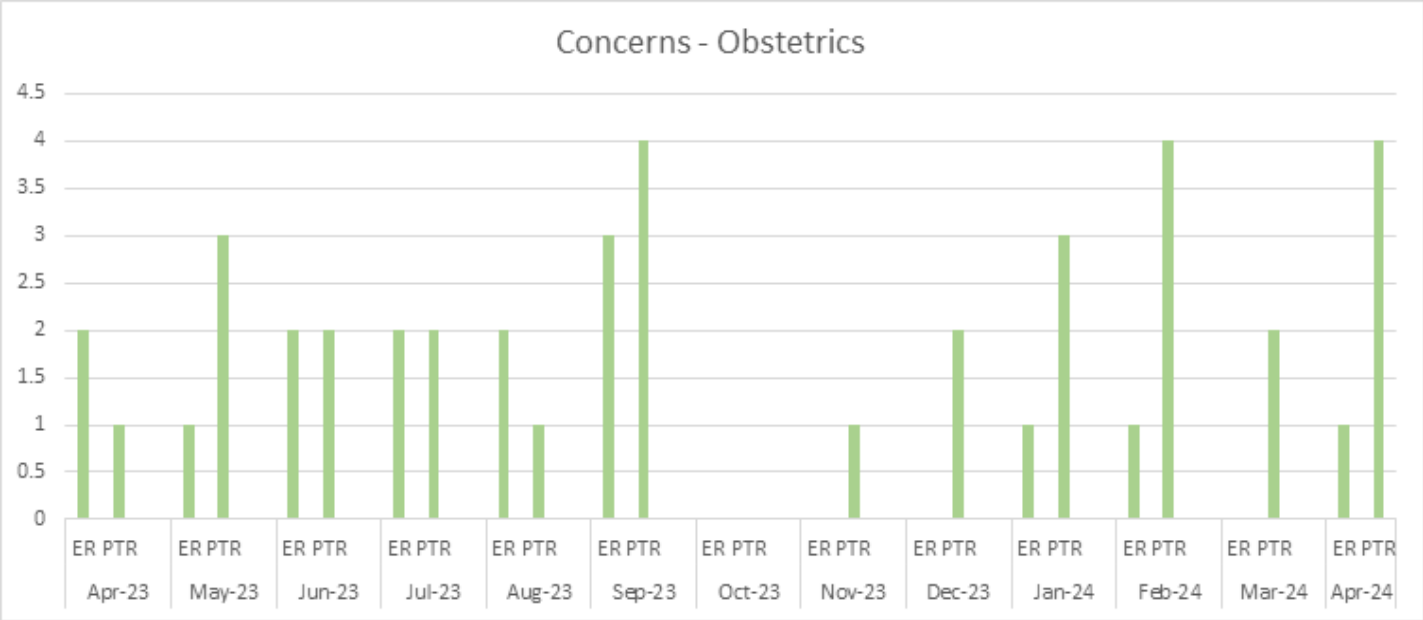
Compliments

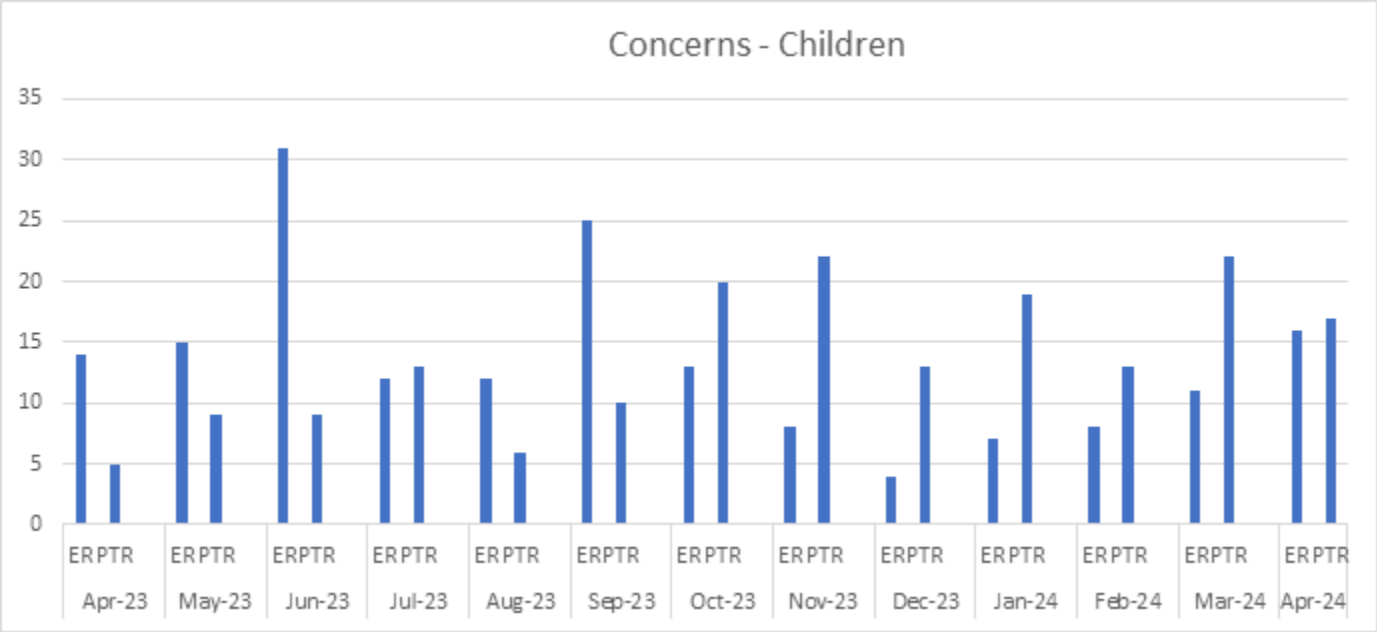
C&W CB have received 525 formal compliments from 1st April 2023 until 1st May 2024



Concerns

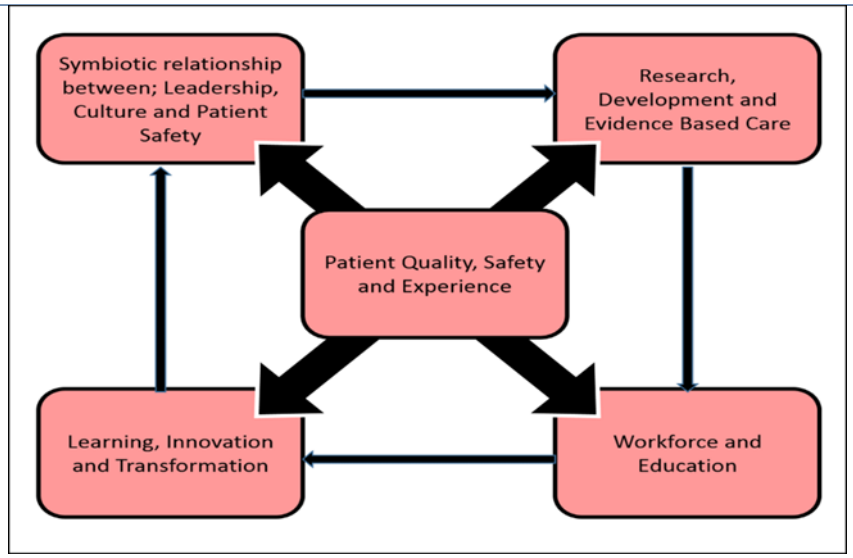






Engaged, Healthy and Motivated Workforce

Whilst the links between Quality, Safety & Experience, and the four quadrants below are often assumed, there has been a significant amount of work undertaken to change the culture across the Clinical Board to make these links explicit. Below is some of the work that has been undertaken and remains ongoing:



Engagement:
- Staff Newsletters/VLOG
- Establish Managers daily intentional check in rounds
- Staff Refreshments
- Inclusion Ambassadors for all 10 protected characteristics
- Workforce and Staff side walkarounds
- Established Internationally Educated Nurses forum
- Introduced Sustaining Resilience at Work Practitioners
- RCM Caring for You Charter Signed

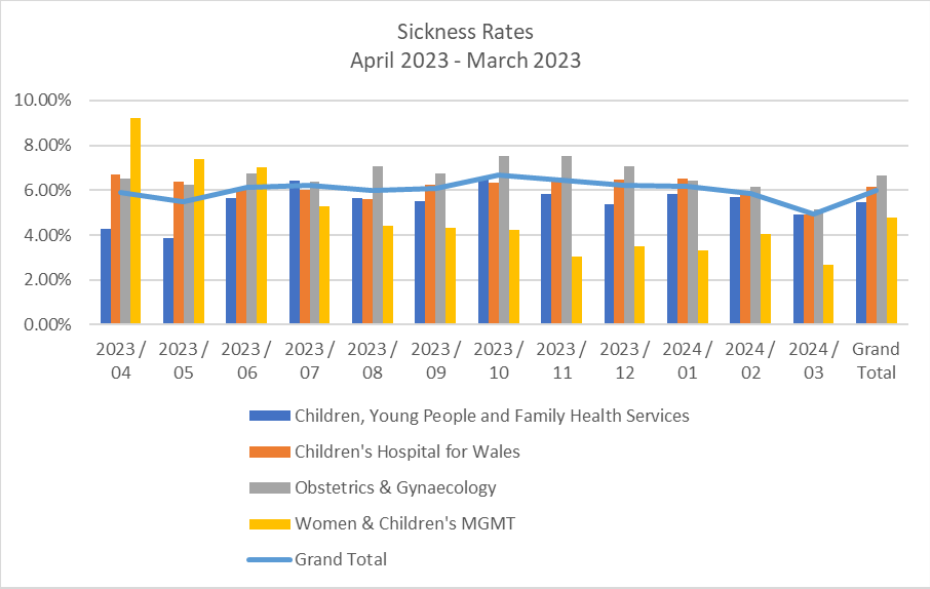
Leadership:
- Lunchtime Leadership Sessions – covering Civility Saves Lives, Inclusive Leadership, Psychological Safety, Compassionate Leadership and Leadership for Improvement
- Meet the Manager Days for new starters
- Substantive appointment of Director of Midwifery
- Clinical Lead for Neuro Developmental programme
- Establish Weekly Listen and Learn Visits
- Roath Park Walk and Listen Sessions
- Senior Clinical Leadership attendance at every handover
- Led and Implemented Organisational Change Process and embedding strengthening Senior Manager on Call arrangements across the UHB

Digital Safety
- First Maternity Unit in Wales to implement Safe Care
- An initiative automate administrative processes in maternity. This was achieved by maximizing the functionality of existing digital systems and building new digital solutions within Microsoft 365. This has resulted in **15-34 hours of clinical time saved per day** that can be redirected back to patient care.
- The digital process that was developed in Cardiff for women to digitally self-refer into maternity services has been adopted in CTMUHB and Swansea Bay.
- Introduced Maternity dashboard and working towards a Peri-natal dashboard.
- Introduced Tendable Summer 2022
- Health Roster and Safecare adopted across all areas Summer 2023
- Cardiff Maternity Safecare System adopted by WG to be rolled out across all Health Boards in Wales
- AMAT and Q-pulse systems used to log audits and action plans following inspections and NRI's
- School In-Reach - move to digital referrals

- digitised referral process from schools
- School Nursing - entirely digitised paper consent process for school immunisations
- Use of Attend Anywhere across all services to support the delivery of a blended offer children, young people and families. Supports work/life balance for staff allowing for offsite / homeworking as appropriate

Sickness absence

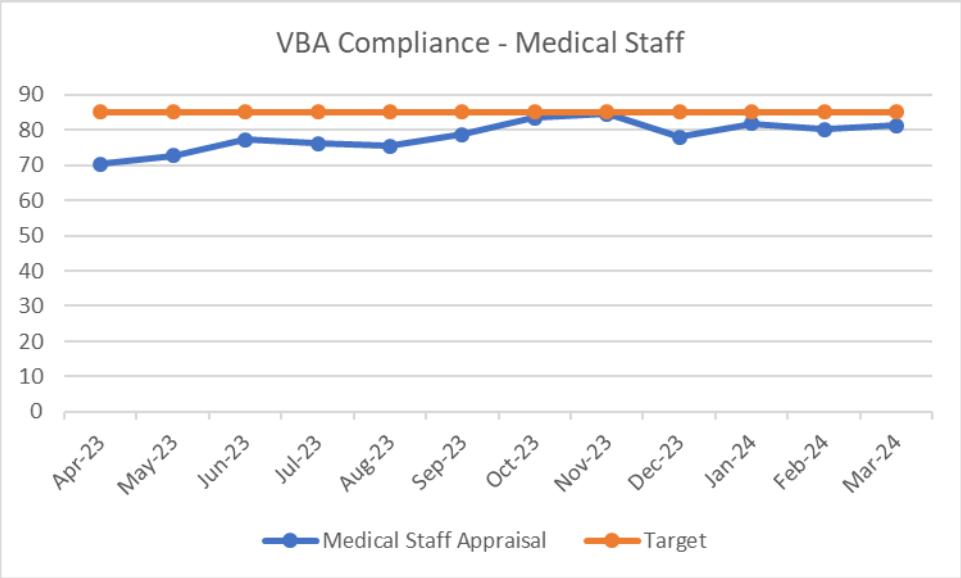
The Clinical Board has initiated sickness surgeries in collaboration with People Services to support manager in the consistent application of the managing attendance policy. We have of seen an overall drop in sickness, but the overall reduction in sickness masks some real challenges in hotspot areas such as Paediatric Intensive Care (PICU), Neonatal Intensive Care, Owl Ward, Community care Nursing and Maternity. Our sickness data is displayed below;

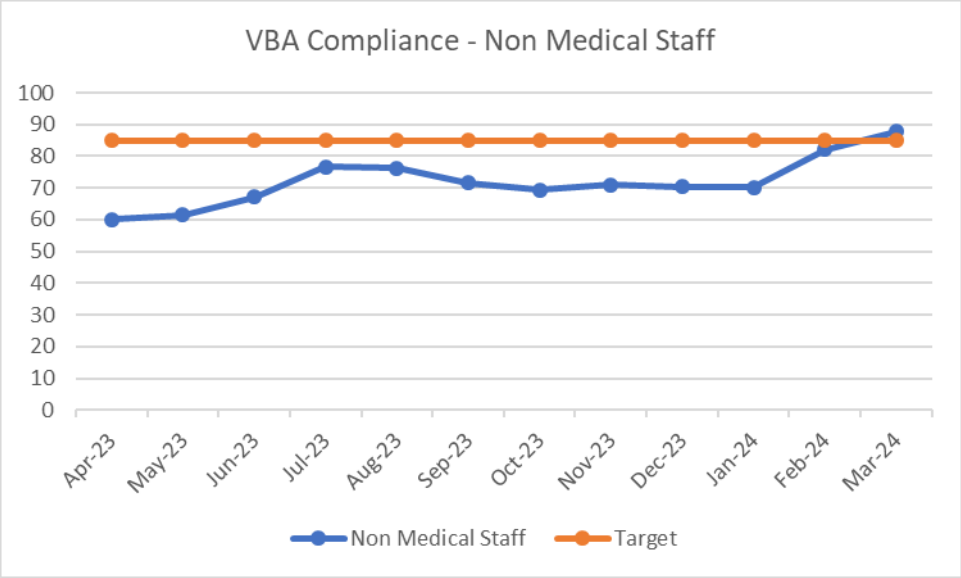


The Clinical Board recognises that recruitment alone will not be sufficient to support our workforce as services develop, and alongside an active recruitment strategy have made significant efforts to support the retention and wellbeing of our staff as outlined below

- Wellbeing champions
- Wellbeing Packs for Staff
- Psychology support and debriefing for staff
- Staff Recognition Awards
- Staff Voices App - a confidential QR code that allows staff to anonymously feedback anytime of night or day how it feels to work in our services and what we can do to improve
- Sustaining Resilience at Work Practitioners appointed
- Lunchtime Leadership Sessions, covering Inclusivity, Compassionate Leadership, Civility Saves Lives Initiatives
- Director of Nursing has written personally to over 400 leavers and new starters to understand what could improve their experience of working within Children and Women
- Newsletters developed and shared with directorates
- Partnership working with union colleagues to listen to staff and develop improvements together
- Staff rotations to develop a career pathway and also provide respite from acute areas when needed (tailored to individual plans).

Congruent with the Clinical Boards belief that the workforce is our most important asset, we have made significant progress in ensuring our Staff have an Annual Value Based Appraisal, progress toward which is described below.





Risks

The Clinical Board currently has 15 risks with a rating of 20 or above on the Clinical Board Risk Register spanning across the three clinical directorates. The risk registers and risk assessments are regularly reviewed to ensure that they accurately reflect the controls and mitigations in place to manage these risks, as well as ensuring that any required actions are escalated as appropriate. The risk register is a standing item on the Clinical Board QS&PE Meetings so that any new or existing risks can be discussed and escalated where necessary.

ASSURANCE is provided by:

- The governance processes embedded in the core business of the Children & Women's Clinical Board and its Directorates
- Evidence of regular performance management reporting
- Monthly review of Clinical Board Risk Register by Clinical Board Team

- Independent review of the business of the Clinical Board by internal and external bodies such as Internal audit, CHC, HIW, Welsh Risk Pool, Welsh Government
- Temperature gauge activities such as Cancer peer review, local audits (IPC, environmental), Clinical Board walkabouts, benchmarking, unannounced inspections, acuity audits, healthcare standards, patient experience questionnaires and kiosks
- Nursing dashboard overview
- The Clinical Board recognizes the key areas of improvement and actions required to further improve quality, safety, and patient experience and is committed to delivering these

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

The Assurance provided by Children & Women Clinical Board to improve and enhance services across a breadth of complex specialties.

Recommendation:

The Committee is requested to:

- NOTE the progress made by the Clinical Board to date
- NOTE the content of this report and the assurance given by the C&W Clinical Board

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	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

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

Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a

Legal: Yes/No	
n/a	
Reputational: Yes/No	
n/a	
Socio Economic: Yes/No	
n/a	
Equality and Health: Yes/No	
n/a	
Decarbonisation: Yes/No	
n/a	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	NRI reporting Cardiff and Vale – 2023-2024					Agenda Item no.	2.2
Meeting:	QSE Committee		Public	X		Meeting Date:	21st May 2024
			Private				
Status *(please tick one only):*	Assurance	x	Approval			Information	
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Head of Patient Safety						

Main Report
Background and current situation:

NRI Management Process

A Nationally Reportable Incident (NRI) is a patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm for one or more patients, staff or members of the public, during NHS funded healthcare. All Heath Boards are required to externally report such incidents to the NHS Executive within seven working days of the incident (or knowledge of the incident). External reporting to the NHS Wales Executive provides assurance of openness and transparency. It ensures that patients and relatives who have or may have come to harm receive the information and answers they deserve and helps us to learn both locally and nationally from such incidents thus reducing future harm. NHS Wales Executive monitor the performance of Health Boards, in particular ensuring they meet the agreed timeframes for completing reviews and the submission of the Review Outcomes form. Minimizing any delays during this process will improve our compliance as well as reduce the time that patients and families wait for the outcome of a review.

Health Boards must ensure a robust and detailed review (investigation) of the incident. Cardiff and Vale implement the Just Culture Framework to ensure that reviews will not focus on individual staff members or seek to apportion blame. Instead, the review will focus on the systems and processes that led to the incident to better understand why it occurred and lead to organisational wide learning and improvement, thus reducing future risk.

On completion of the review, an NRI outcome form (previously known as a closure form), summarising the findings of the review, recommendations, and actions taken, is submitted to NHS Wales Executive.

Between 1st April 2023 and 31st March 2024, Cardiff and Vale University Health Board reported 134 Nationally Reportable Incidents (NRIs) to NHS Executive (see Figure 1) and the broad categories of themes of these incidents is detailed in figure 2.

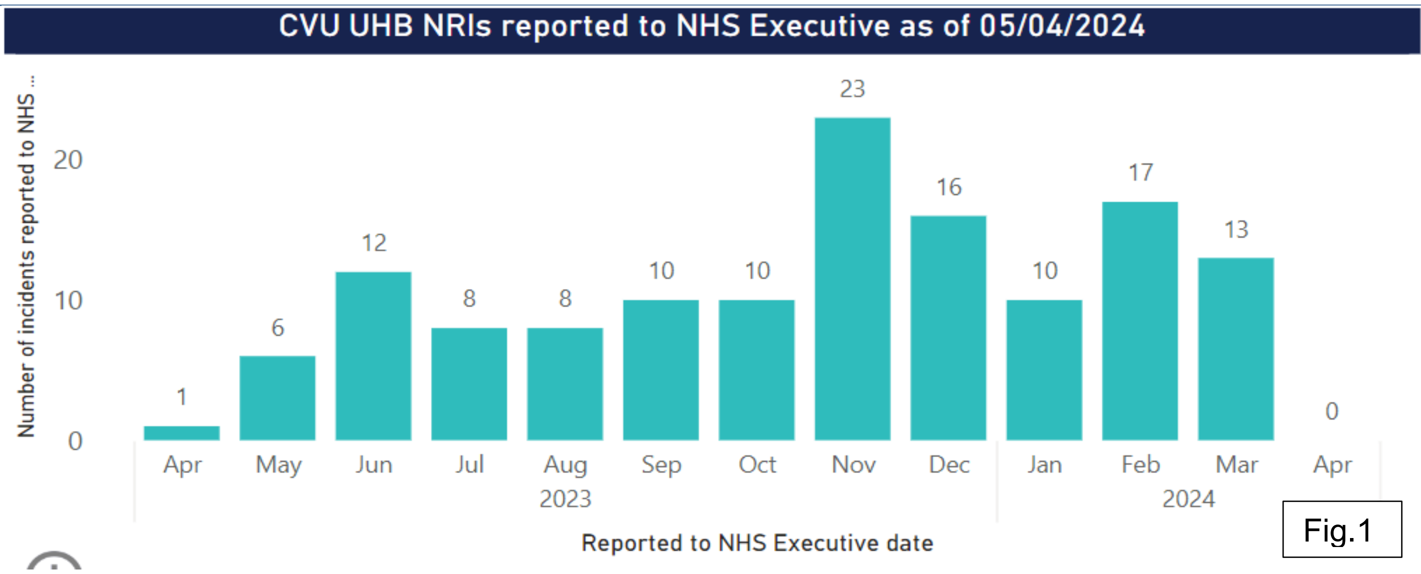


Fig.1

Figure 2 shows the top 5 NRI categories by classification reported in that timeframe;

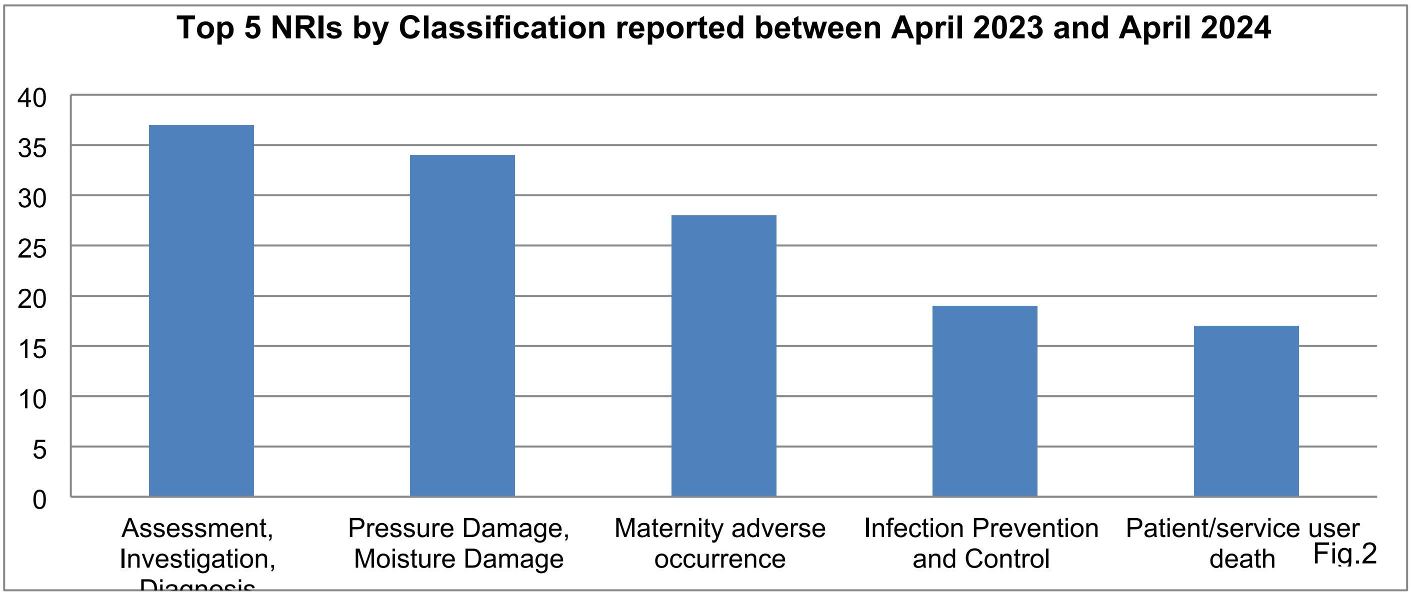


Fig.2

Examples of these categories are explained below;

<u>Assessment, Investigation, Diagnosis</u>
This covers incidents relating to any delays in clinical assessment or diagnosis, including patients who are on a screening and surveillance pathway and errors in diagnosis resulting in delays in treatment. This is the most prevalent reported NRI, there is a variety of improvement workstreams across the Health Board looking at improving this position and these will be showcased in this year's WHO **World Patient Safety Day taking** place in September 2024, the topic is *Improving Diagnosis for Patient Safety*.

<u>Pressure damage/moisture damage</u>
This includes hospital acquired pressure damage of grade 3 or above.

<u>Maternity adverse occurrence</u>
This relates to maternal and neonatal incidents; this category is not usually in the top 5 however the rate of reporting has increased since a change in national guidance from NHS Executive to NRI report all MBRRACE incidents to help improve the national picture on perinatal incidents. This change requires all Health Boards to report as an NRI any stillbirths (after 24 weeks gestation) or neonatal deaths (after 20 weeks gestation) regardless of the presence or absence of any concerns over care delivery. These are extremely tragic losses of babies whilst in utero, and include those sadly not deemed to be viable pregnancies.

Infection, Prevention and Control
These incidents include healthcare acquired (nosocomial) infections and increased incidences or outbreaks, including cases of Covid-119 contracted as an inpatient. It includes patients who may have had a nosocomial infection listed on their death certificate even if not directly causative or contributory.

Patient/Service User Death
This relates to the unexpected death of patients/service users which as an adverse outcome is then reviewed to determine whether there are any causative or contributory factors.

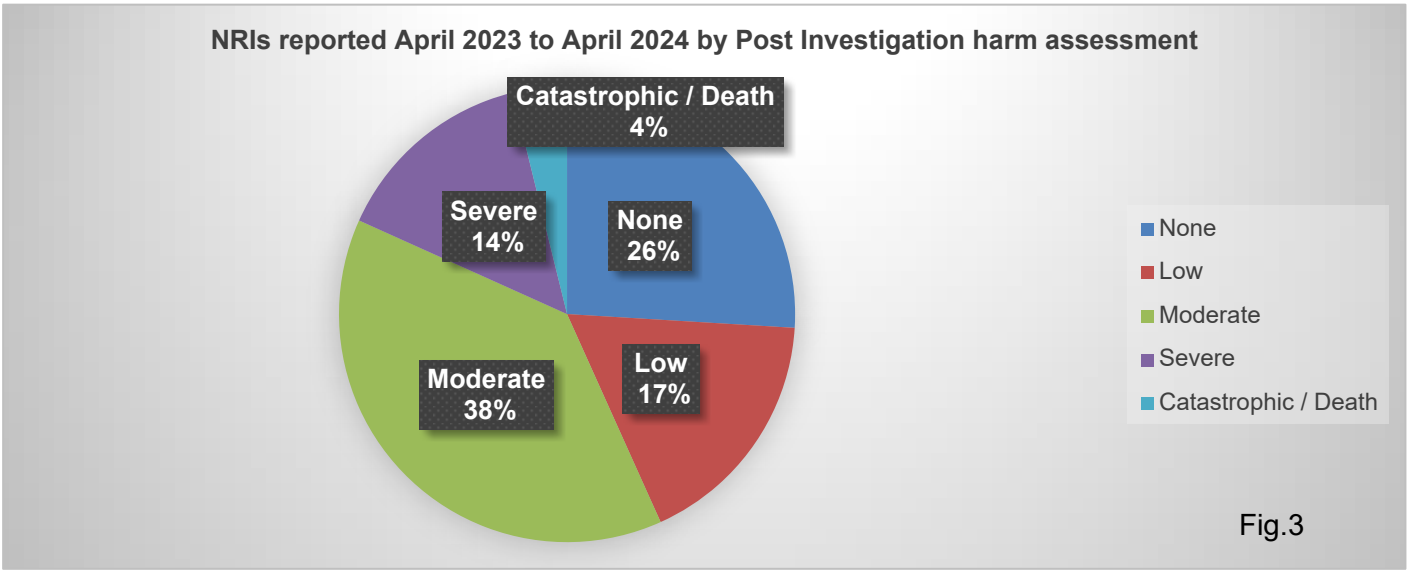


Fig.3

Figure 3 shows that despite the criteria for an NRI to be related to 'severe or catastrophic harm', the largest proportion of harm categories reported is subsequently re-categorized as 'moderate harm' once fully reviewed. Whilst an NRI typically refers to severe or catastrophic harm, following an investigation, if it is identified that the health care was not causative or contributory, the post investigation harm is amended to 'low' or 'none'.

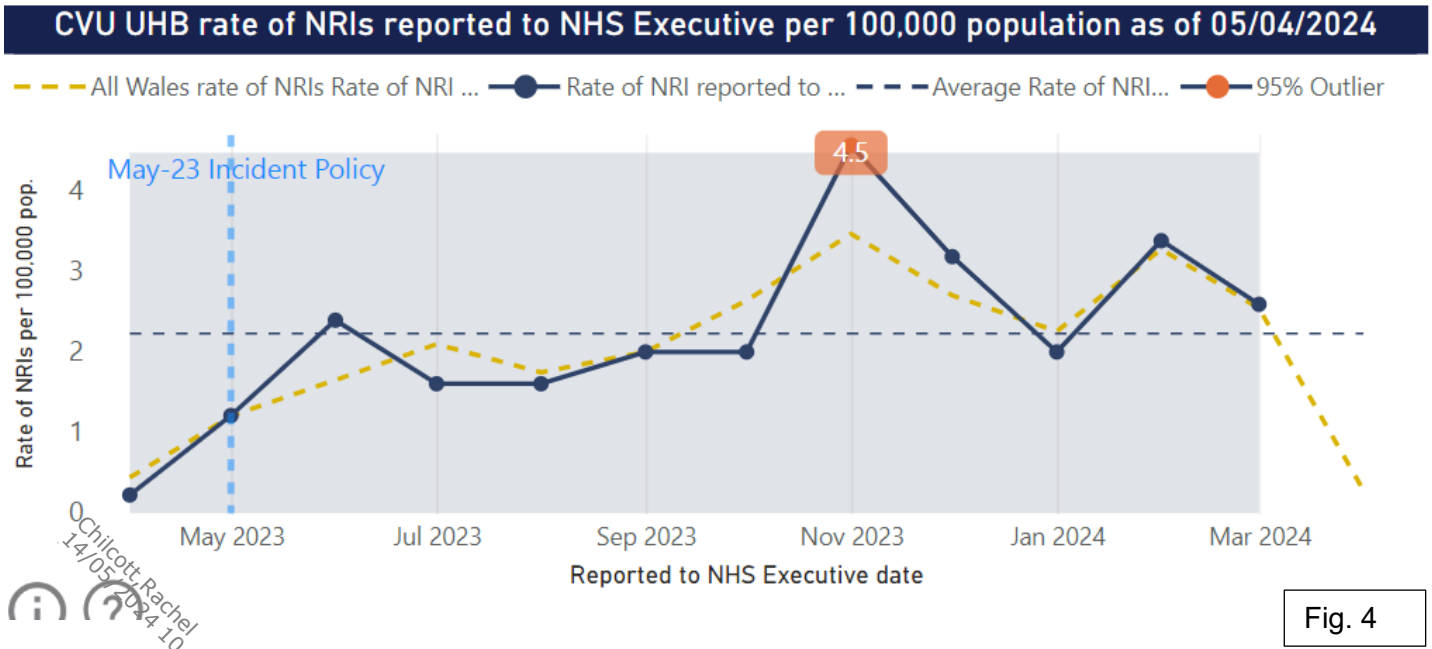


Fig. 4

Figure 4 shows how Cardiff and Vale NRI reporting follows that of the All Wales trend. Our outlier position in November reflects the change to include the MBRRACE NRIs in a month where Cardiff had a higher number of intrauterine deaths (with no care concerns found on review). The implementation of the Medical Examiner Service adds an extra layer of assurance that any hospital

deaths (community deaths to be included at a later stage) are reviewed and can lead to NRI reporting if appropriate. Cardiff and Vale UHB has an open and transparent reporting culture, there is a keenness to be open and report any concerns nationally with the option to downgrade at a later stage if appropriate following review.

Never Events

During the period of April 2023 to end of April 2024, Cardiff and Vale reported *6 Never Events*, these are incidents that are wholly preventable due to the level of safeguarding pathways and protocols in place. A breakdown of this total indicates that 2 were related to wrong site surgery (blocks), 3 are for retained foreign object post procedure, and 1 for administration of medication via the wrong route. The harm levels for these incidents are usually low but national reporting is required as they should not happen. Surgery Clinical Board are leading on the 'Five steps to Safer Surgery' and there is a Health Board Never Event improvement plan.

NRI performance

The total number of NRIs reported for the period of 1st April 2023 to 30th April 2024 is 134.

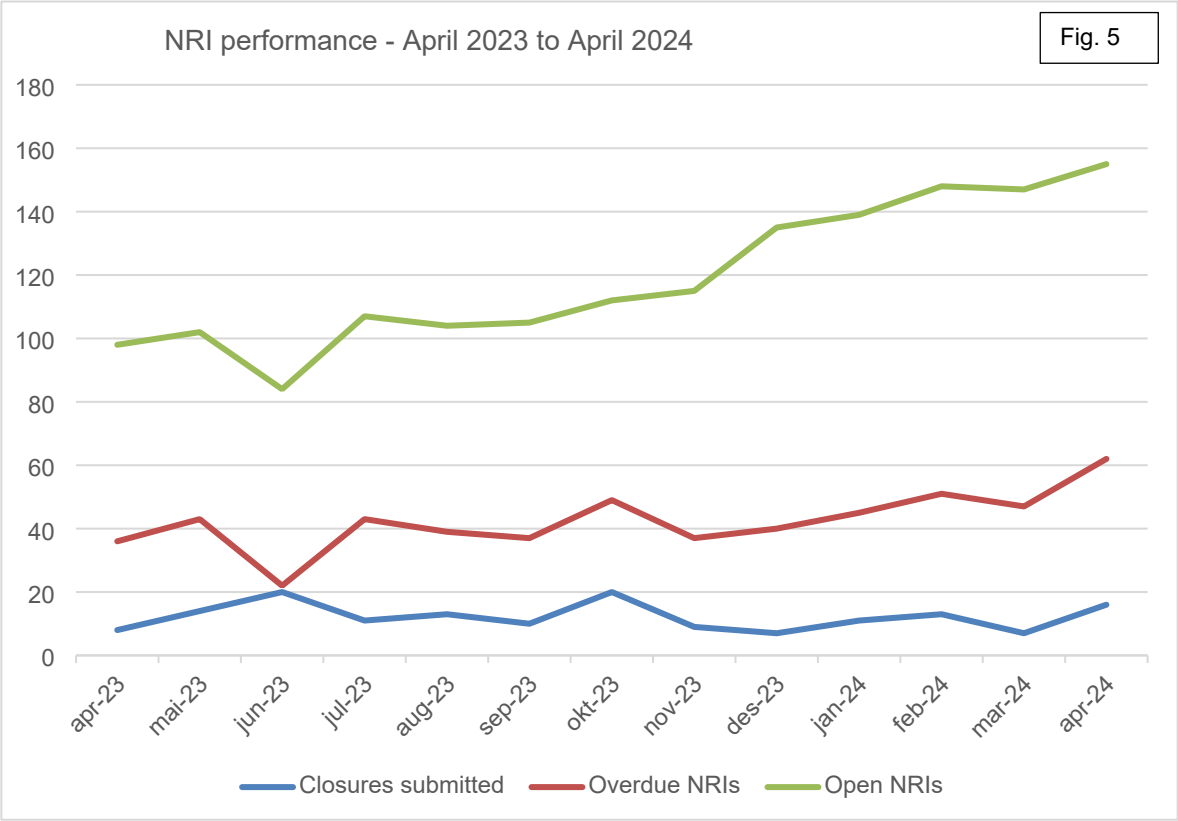


Figure 5 shows that the number of open and therefore overdue NRIs is increasing. We know that we are reporting higher numbers of NRIs, particularly with the MBRRACE incidents, and this is impacting on the timeliness of review completion. As already highlighted, Cardiff and Vale have an open reporting culture and the NRIs reported by the Health Board can be complex involving multiple internal and external stakeholders due to its role as a tertiary referral center. This can impact on the ability to fully review and close within the allocated timeframe. The corporate Patient Safety Team, ensure that all reports are written to a high standard to maximise learning and improvement and to ensure that patients and their families get the information and answers that they deserve in a format that is appropriate. However, families and patients' should not be waiting any longer than necessary for their reports as this can add additional stress at an already difficult time. Performance at the end of April 2023 had improved significantly with the numbers of overdue NR the lowest since June 2023.

Timeliness of NRI closure

To help improve the overdue position, the Patient Safety Team have implemented a new investigation (review) tool which is simpler and more aligned to learning with a bigger emphasis on systems and processes. The report template focusses on the key questions taken from the After Action Review methodology and includes the questions *what happened, what should have happened, what were the differences, did the differences contribute to the outcome* and *what can be learned*. There is an online training package to be completed prior to attending a face to face session with the Patient Safety Team. The previous RCA training was suspended during Covid-19 and not reinstated due to the move towards PSIRF methodology in NHS England. Therefore, we know that a significant proportion of the reviewers undertaking NRI investigations had not been trained in how to write a robust but proportionate report. It is hoped that the use of a simpler tool with reviewers (investigators) who are appropriately trained and supported, will lead to more timely and higher standard reports improving closure timeframes. NRI reviewers complete these reviews alongside their clinical roles and this impacts on the time they have to dedicate to this which again impacts on timeliness.

The Patient Safety Team is exploring the use of After-Action Reviews (AARs) as an alternative to a formal written investigation report; these are in use in NHS England. An After-Action Review (AAR) is a facilitated discussion following an event to understand what happened and why and its origins lie in the America military. AARs involve key stakeholders involved in the incident and provide insight into how improvements could be made to help deliver safer care for patients. It is considered that this process could improve timeliness of closures, improving the experience for the patient and their family, as well as reducing the time taken to identify any necessary improvement actions. This will help support the safe and timely elements of the Duty of Quality.

The *Duty of Quality* came into being in April 2023 and put in statute, the requirement for government ministers and Health Boards to demonstrate that improving quality is at the heart of everything that they do. The overall aim of this Duty is to improve the quality of services provided by Health Boards to achieve better outcomes for people.

The *Duty of Candour* process has been embedded into the NRI management process and a redress pathway has been devised to simplify this process for the Clinical Boards to ensure equity through the PTR process for incident as well as concerns management. The Duty of Candour is a legal requirement for all NHS organisations in Wales to be open and honest with service users when they experience harm whilst receiving health care.

Internal Audit Assessment
An audit of the Patient Safety Incident Management was completed at the end of March 2024, we received substantial assurance for corporate NRI management processes and reasonable assurance for the management of general patient safety incidents across the clinical boards and for the Health Boards incidents management policies and procedures.

Emerging Themes

Closures of NRIs is not the end of the process, as well as consideration for Redress and Duty of Candour, there has been a move towards all improvement plans being uploaded to AMaT (clinical audit management system) to ensure a 'live' document that can be added to and updated as actions are completed. The case findings are presented at various forums to ensure widespread learning. Improvement initiatives are developed through the findings and recommendations of NRIs, a few examples are listed below.

Critical Time Medications
A critical time medication task and finish group has been implemented in response to two NRIs relating to the omission of hydrocortisone in patients with adrenal insufficiency, this work includes the development of standardised education pathways, patient and staff information resources, and considering how time critical medications can be aligned to Electronic Prescribing and Medicines

Administration. Until this is fully implemented the group has proposed risk mitigation strategies for use with paper medication charts. This aligns to the Safe and Timely domains within DoQ.

Inpatient Suicides – WARRN

Following a cluster of inpatient suicides in Mental Health, a review of the risk assessment process was undertaken and a new formulation-based risk assessment process implemented. WARRN 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. It has been gradually adopted as the risk evaluation and safety-planning technique for all seven health boards in Wales. This was implemented alongside an education package and nationally the feedback on the use of this tool is very positive, with clinicians reporting 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. Following the implementation of this tool, inpatient suicides have reduced, whether this is due solely to the tool, or the associated learning from the reviews as well as that from the WARRN training, it is hard to say. This initiative supports the person centered and efficient standard and the workforce enabler in the Duty of Quality.

Fetal monitoring within the Midwifery Led Unit (MLU)

In response to a number of patient safety incidents, changes to the Health Board’s approach to Cardiotocography (CTG) monitoring has brought it in line with changes at a national level (NICE and WRP guidance). From 1st February 2024, CTG monitoring for intrapartum fetal heart concerns has been ceased within the Midwifery Led Unit. All patients requiring this will be transferred to the Consultant Led Unit to expedite any necessary escalation in care. This supports the safe and effective elements of the Duty of Quality.

Cancer Tracking

In response to a number of patient safety incidents relating to follow up care, diagnosis and the identification of incidental findings of cancer, some innovative improvement work is underway in cancer services to mitigate the risks.

Collaborative working with Radiology has extended the **cancer initiative; this should now be reported on all radiology findings with suspicion of cancer. This flag generates a report to cancer services who are then able to track the patient’s pathway and refer on to a relevant speciality as required. This report is checked daily until they are either discharged or commence treatment to ensure no one gets ‘lost’ in the system. This also extends to incidental findings of cancer. Once the current radiology information database is changed in a couple of years, the ** flag will be replaced by the push of a button. However, this process mitigates the risk until this is in place.

Similar work has been undertaken with Pathology; all pathology results and reports are scanned for cancer codes with patients being merged onto the cancer lists and then followed up in the same way.

In addition, cancer services cross reference every Multi-Disciplinary Team records, the Oncology database and children's cancer records with the cancer database to ensure that every patient is followed up throughout their diagnostic pathway and until treatment commences.

This initiative aligns to the safe and timely care domains of the DoQ as well as the whole system approach enabler.

Hospital Acquired Pressure ulcers

These are the most frequently reported general patient safety incident as well as the second highest NRI category reported. The Health Board Pressure Damage Collaborative was established in 2021 in place of the pre-pandemic Pressure Damage Task and Finish Group. The target aim of the Collaborative was to reduce healthcare acquired pressure damage by 25% and to improve the

adoption of innovation into practice to improve clinical outcomes and patient experience. This was a multidisciplinary forum which encompassed both primary and secondary care with input from the Patient Safety, Improvement and Organisational Learning Teams. The Collaborative reported a reduction of 24%. Unfortunately, the collaborative has temporarily paused due to a change in leadership, however it is recognised that given the continuing numbers of hospital acquired pressure damage, there is a need to refresh and reinstate this group.

The implementation of *Scrutiny Panels* across the Clinical Boards has helped provide another level of review and assurance that thorough pressure damage investigations are completed and the associated improvement actions are robust. These panels consist of the Clinical Board Director of Nursing, the Quality and Safety Lead, Senior and Lead Nurses, the Patient Safety Lead for that Clinical Board and the individuals who have completed the review. The findings are presented and reviewed and there will be agreement on whether it is deemed to be avoidable or unavoidable. The avoidable hospital acquired pressure damages are then reported as an NRI to NHS Executive on a combined reporting and closure form. The scrutiny panels are beneficial forums for shared learning. This aligns to the Learning, Improvement and research as well as the Information enabler and Whole Systems Approach within the DoQ.

Falls

Whilst not featuring in the top 5 NRI categories, falls, alongside pressure damage, is in the top 2 for most frequent reported patient safety incidents. Significant work is underway with the newly appointed corporate falls leads, improving education and leading on falls prevention initiatives. A multidisciplinary team has developed a training programme for staff on the prevention and management of falls. This has been piloted in Mental Health and Medicine Clinical Board, with very positive feedback. Further spread to other areas is being planned. The falls risk assessments are also under review in order to better support staff in reducing falls risks for patients.

A Falls Learning Group has been established to explore falls-related themes and trends from incident reporting and to share good practice and innovative approaches to reducing avoidable falls. This work supports the Safe and efficient domain as well as the workforce enabler.

Endoscopy Surveillance

The impact of the Covid-19 pandemic on the endoscopy waiting lists has been significant and this has further impacted on Endoscopy Surveillance. Patients within this category are at increased risk of Gastro-oesophageal disease, including Cancer, and require regular endoscopies to monitor for deterioration. Due to several patient safety incidents related to the impact of the increased waiting times for this cohort of patients, a number of actions have been identified which include reviewing the current risk stratification process for clinical validation to ensure it is based on disease specific national guidance. Other actions include reviewing the current clerical validation process and ensuring standardisation across clinical and clerical prioritisation, undertaking job planning to ensure clinicians have the appropriate number of sessions allocated for surveillance activity and ensuring theatre room utilisation is appropriate with the capacity for surveillance lists meeting demand. This meets the Safe, Efficient and Timely elements of the Duty of Quality.

Moving forwards 2024 to 2025

* Implementation of After-Action Reviews to assist with the timely closure of NRIs.
* World Patient Safety Day showcasing workstreams aligned to improving safer diagnosis.
* Development of Human Factors Syllabus training which builds on existing resources.
* Implementation of Improvement Plan training and updating Improvement Plan templates to ensure they incorporate the 12 standards within the Duty of Quality.

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

- There has been changes to the national NRI reporting criteria to include MBRRACE incidents (even if no care concerns) which has impacted on the number of NRIs reported by Cardiff and Vale.

- The rates of NRIs being reported are increasing. This is impacting on the number of overdue NRIs within the Health Board.
- The Patient Safety Team are looking to introduce more proportionate approaches to help reduce closure timeframes.
- Moving towards reviewing themes and trends and undertaking thematic analysis of groups of incidents will help improve the quality of learning to reduce risk.
- There are a number of improvement workstreams across the Organisation to focus on specific areas.

Recommendation:

The Board / Committee are requested to: note this information for awareness.

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/No
N/A
Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Report Title:	Inquest Review and Regulation 28 Notification HMP Cardiff				Agenda Item no.	2.3	
Meeting:	Quality Safety and Experience	Public	X		Meeting Date:	21/05/2024	
		Private					
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Assistant Director of Patient Experience, Director of Nursing for PCIC						

Main Report

Background and current situation:

In February 2024, the Health Board was among the nine interested parties involved in an inquest. The Inquiry centred on the death of Mr D, who was held at HMP Cardiff from 2 September 2021, to 12 September 2021 and had been intentionally refusing food and fluids for a period of time. There were concerns raised regarding the standard of care provided to Mr D both prior to and during his confinement at HMP Cardiff. Sadly, Mr D passed away on 12 September 2021.

Key aspects investigated during the inquest included the circumstances surrounding:

- Mr D's discharge to HMP Cardiff from Caswell Clinic, where he had been treated prior to his discharge back to prison.
- Mr D’s treatment and management whilst in HMP Cardiff.
- Mr D’s collapse and subsequent demise.
- The promptness and efficacy of the emergency response by healthcare and prison staff on 12 September 2021.

Inquest Conclusion:

The conclusion was conveyed in a narrative fashion, with the medical cause of death attributed to cardiac arrest in the context of starvation and dehydration.

The narrative conclusion delivered by the jury was as follows:

Mr D's demise stemmed from a combination of misadventure, self-neglect, and neglect. While Mr D intentionally abstained from food and fluids, his aim was not to end his life; rather, his passing was an unforeseen consequence of his refusal.

Furthermore, deficiencies were noted in the handling of Mr D's transfer to the hospital, as well as in the management, coordination, and communication of his care within the prison and healthcare system.

Observational practices were deemed inadequate in detecting signs of Mr D's deteriorating condition, and the events spanning from 10-12 September 2021 were considered highly unacceptable.

In conclusion, the Coroner issued a Regulation 28 - Prevention of Future Death notice. Regulation 28 pertains to a specific aspect of the Coroners (Investigations) Regulations 2013 in the United Kingdom, outlining the Coroner's duty to prevent future deaths. This report outlines what, if any, actions they believe should be taken to prevent similar deaths from occurring in the future.

The purpose of Regulation 28 is to ensure that lessons are learned from deaths that occur in certain circumstances. This might involve highlighting areas where there were failings in systems, procedures, or regulations that contributed to the death, and making recommendations to address those issues. These recommendations could range from changes in legislation, improvements in procedures, or enhancements to safety measures.

Overall, Regulation 28 is a key tool in the coronial process to promote public safety and prevent future loss of life by identifying and addressing systemic issues that may have contributed to a death.

During the course of the inquest, evidence emerged highlighting concerns that could lead to future deaths if not addressed. The matters of concern included:

- There was limited communication between the Caswell clinic and HMP Cardiff following the s117 meeting until Mr D's discharge to the care of HMP Cardiff.
- Lack of clear and easily understandable discharge information and assessment provided to HMP Cardiff.
- The transfer of Mr D to prison without accompaniment by Caswell Clinic staff led to insufficient information for prison reception staff.
- Inadequate consideration was given to the complexity of Mr D’s needs.
- There was a lack of clear planning regarding Mr D’s transfer between prisons.
- There was an absence of a clear plan to promote Mr D’s engagement with prison medical services or assess his mental and physical condition.
- Absence of a clear plan for assessing capacity to refuse food or fluid.
- Absence of a food and fluid refusal policy to guide healthcare staff.
- Insufficient number of GPs working in HMP Cardiff and Vale University Health Board
  Healthcare staff working long shifts without rest breaks.
- Lack of clear information provided to staff regarding Mr D’s conditions and risks.
- Overheard statements indicating the reluctance of senior staff to assist Mr D in healthcare.

The Health Board responded to the Regulation 28 on 17 May 2024 and a specific improvement plan will be developed to support the response and actions.

The circumstances surrounding Mr D's care and death had already been subject to a UHB internal NRI review and a NRI improvement action plan was put in place in 2021 prior to the inquest outcome and Regulation 28 notice which already highlighted and identified actions to address a number of the concerns raised. (See attached)

Specific actions and improvement already in place in relation to the themes identified in the Reg 28 notice include:

- The introduction of a Head of Healthcare position which is responsible for the management of staff across mental and general health reducing silo working and bringing all staff under the same Clinical Board and governance structure.
- The development of a standard operating procedure for referrals between Prison Health and hospital systems with partners to ensure inter-prison and hospital to prison transfer is appropriate, will meet the person's health needs and that appropriate information is shared.
- Daily team briefings with the team in healthcare of any anticipated transfers with involvement of the Prison staff where appropriate
- The development and implementation of a food and fluid refusal policy.
- Delivery of and monitoring of update training for staff on Mental Capacity Act assessments.
- Increased core health staff establishment to support better staffing overnight – recruitment difficulties has limited the ability to deliver sustainable increase in night staffing levels as quickly as would be desirable.
- Improved and sustainable access to GP provision – HMP Cardiff are trialling a different model of employment, using a local GP practice on a Service Level Agreement basis, which should provide some sustainability.

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

- Many of the issues identified during the Inquest had been part of an overall Prison Improvement plan which has progressed since 2021 and was shared with the Coroner as part of the UHB's submission and evidence. (See attached)
- Since 2021 the whole staffing and structure of delivery model structure in HMP has changed with the introduction of an integrated Head of Healthcare and a defined governance structure under the auspices of PCIC Clinical Board.

Recommendation:

The Board / Committee are requested to: note the inquest findings and subsequent improvement plan.

The Regulation 28 PFD Improvement plan will be shared with QSE in November 24 for assurance of completion of all actions.

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	
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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/No
N/A
Safety: Yes
Lack of communication can affect the individual safety
Financial: Yes
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes
Decarbonisation: Yes/No
N/A

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

Report Title:	Clinical Effectiveness Committee Bi-annual Report			Agenda Item no.	2.4
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	24th May 2024
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Executive Medical Director				
Report Author (Title):	Deputy Head of Quality Assurance / Assistant Director of Quality and Patient Safety				

Main Report
Background and current situation:

Background and current situation:

The Health Board Clinical Effectiveness Committee was established in December 2019 and has strengthened since 2022 to ensure greater involvement from Clinical Boards, specialties and clinical audit leads. The National Clinical Audit and Outcome Review Programme is a mandated programme of 40 national clinical audits that support measurement of quality against defined evidence-based standards, national benchmarking and quality improvement. The Clinical Effectiveness Committee

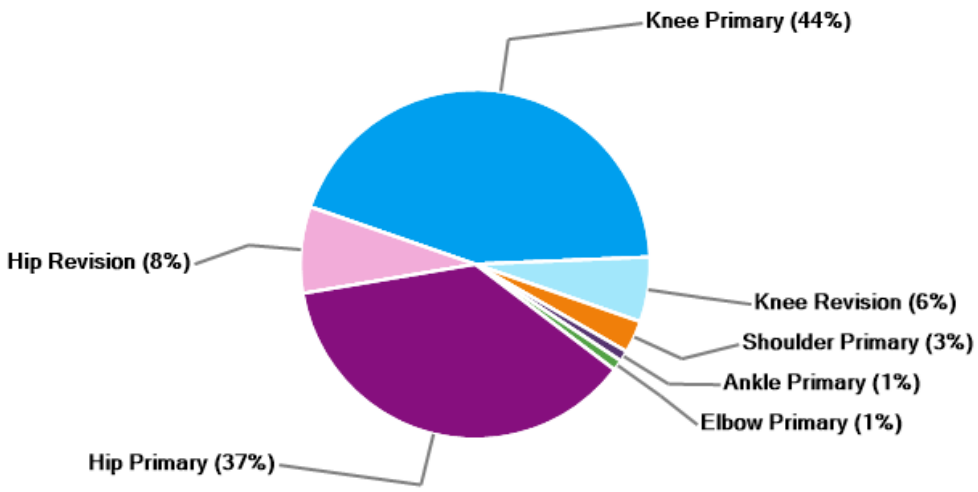
The National Joint Registry - The 20th Annual report 2023 NJR 20th Annual Report 2023.pdf (njrcentre.org.uk)

The National Joint Registry (NJR) contains details relating to over three million primary joint replacement procedures and outcomes including revision rates. The registry collects data on joint replacement outcomes and monitors the performance of these and the effectiveness of their use. A key focus of the registry is patient safety and improving clinical standards which subsequently benefits, patients, clinicians and the orthopaedics sector as a whole.

The 20th Annual NJR report presents data of clinical activity between January 2022 to December 2022, however the registry provides more prospective data and it is this that is used to explore UHB performance in the context of the national report. Each annual report provides an overview of primary and revision replacement surgery, the reason for revision, mortality after primary replacement, rates of revision and 90-day mortality after hip, knee, elbow, shoulder and ankle replacement surgery. Revision Data has identified that safety and clinical outcomes have continued to improve, which has been acknowledged through the reduction of revision surgery and 90% of primary hip replacement will still be functioning after 20 years.

NJR contains information relating to procedures undertaken in both UHL and UHW however the vast majority of activity is undertaken in UHL with over 948 procedures during the reporting period. The most common procedures being primary knee replacements (365) and then primary hip replacements (350) between April 2022 and April 2023.

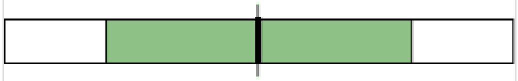
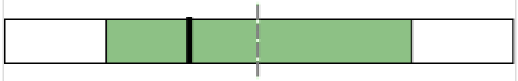
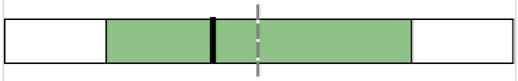
University Hospital Llandough Practice profile April 2022-April 2023:



Patient Outcomes Knee procedures UHL May 2013 -May 2023

Patient Outcomes Quality Measure	This Hospital	Patient Records Analysed	This Hospital Ratio	National Ratio	Worse than Expected / EXPECTED RANGE / NATIONAL AVERAGE / Better than Expected
90 Day Mortality: Operations May18-May23	OK As Expected	1862	1.42	1.00	
Revision Rate All Knees: Operations May13-May23	OK As Expected	5089	1.25	1.00	
Revision Rate Total Knee replacement: Operations May13-May23	OK As Expected	4198	1.35	1.00	
Revision Rate Unicondylar Knees: Operations May13-May23	OK As Expected	784	0.85	1.00	
Revision Rate All Knees: Operations May18-May23	OK As Expected	1999	1.31	1.00	

Patient Outcomes Hip UHL May 2013 -May 2023

Patient Outcomes Quality Measure	This Hospital	Patient Records Analysed	This Hospital Ratio	National Ratio	Worse than Expected / EXPECTED RANGE / NATIONAL AVERAGE / Better than Expected
90 Day Mortality: Operations May18-May23	OK As Expected	1479	0.85	1.00	
Revision Rate: Operations May13-May23	OK As Expected	4210	1.16	1.00	
Revision Rate: Operations May18-May23	OK As Expected	1660	1.21	1.00	

Cardiff and Vale Health Board revision rates for hips and knee replacement surgery exceeds the national average, however, should be caveated with the knowledge that a proportion of revisions undertaken in Cardiff and Vale are done so when the primary procedure was undertaken in other health originations. Due to clinical expertise the Health Board accepts and undertakes revision surgery for patients from surrounding Health Boards who did not received their primary procedure in Cardiff and Vale UHB. The case mix of patients receiving primary hip procedures is slightly younger than the average with 25% of patients being under 60 compared with 21% nationally and 19% of patients are severely obese compared with 13% nationally. Similar trends were noted with primary knee procedures, with 31% of patients undergoing knee surgery classed as severely obese compared with 23% nationally

Cardiff and Vales UHB has seen an improved performance in relation to hip replacement 90-day mortality which is in line with the national average.

NJR data for the past 10-year period demonstrate that local knee revision rates have remained outside the expected range when compared to national data. Although patient review outcome measures are not captured within the NJR, local data indicates that 1 in 10 patients report ongoing symptoms following their knee replacement surgery. Local surgeons are reported to have a low threshold for undertaken knee revisions for patients who continue to experience issues following their initial knee replacement surgery. In addition, poor implant choice has also been reported as a factor for increased number of knee revision surgery undertaken within Cardiff and Vale, however, the directorate has recognised this and taken steps to reduce variation in implant prothesis options. These improvements have been reflected in the previous 5-year data capture which has demonstrated that these improvements have reduced the number of knee revisions and Cardiff and Vale UHB now falls within the expected range of knee revisions when compared to the UK.

Infection prevention and control remains an area of focus and plans to reconfigure orthopaedic theatres at UHL will provide an improved environment in keeping with other orthopedic theatres nationally.

The 2023 National Audit of Inpatient Falls (NAIF) [REF-415-NAIF-2023-report_FINAL-1.pdf (hqip.org.uk)]

The National Audit of Inpatient Falls (NAIF) is a component of the Falls and Fragility Fracture Audit Programme and presents data on post-fall management and tracks performance against National Institute of Health and Care Excellence (NICE) Quality Standards.

NAIF report 4 key performance indicators which include:

1. Multi-factorial risk assessment (MFRA) prior to the fall

2. Checking the patient for injury before moving a patient
3. Using safe equipment to move patients post fall
4. Ensuring a timely medical assessment post fall

In Cardiff and Vale UHB data is as follows:

A number of workstreams are being implemented across the UHB to reduce avoidable community and inpatient falls, with three workstreams initiated. The first is the revision of the Community Falls Workstream with a multidisciplinary team progressing this work with involvement from the Local Authorities. The second is the Falls Education and Training Workstream which provides standardised training in falls prevention and post-fall management for staff, focusing on fall risk awareness and assessment and supports the implementation of actions to mitigate these risks. The final workstream is the Falls Learning Group which focuses on data analysis to provide themes and trends to inform the development of strategy, this replaces the Falls Scrutiny Panel.

In addition, work being overseen by the Falls Delivery Group includes a review of the Multifactorial Risk Assessment, a small task and finish group is being formed with representation UHB wide including pharmacy to develop a medication risk assessment for patients at high risk of falls, a review of falls sensors and a refresh of the Falls Framework to reflect ongoing work.

National Hip Fracture Database 2023 The National report. NHFD-2023-annual-report.pdf (hqip.org.uk)

The National Hip Fracture Database (NHFD) 2023 report is the 15th annual report which is designed to support local hip fracture teams to monitor and improve care to patients in recovery with hip fractures. The national audit programme collects data on all aspects of care given to hip fracture patients 60 years and over in England, Wales and Northern Ireland.

The National Hip Fracture Database key performance indicators for patients with hip fractures include:
1. Prompt admission
2. Prompt orthogeriatric review
3. Prompt surgery
4. NICE complainant surgery
5. Prompt mobilisation
6. Post-operation delirious assessment
7. Return or original residence
8. Bone protection medication

National data collection for the 2023 report illustrates that Cardiff and Vale performance for these indicators are equal to and in areas better than the UK average, as shown below.

KPI overview: UHW. University Hospital of Wales

Annualised values based on 554 cases averaged over 12 months to the end of July 2023.

0. Admission to specialist ward	1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
15%	91%	68%	75%
NHFD overall: 7%	NHFD overall: 86%	NHFD overall: 58%	NHFD overall: 69%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence	7. Bone medication
78%	54%	69%	69%
NHFD overall: 80%	NHFD overall: 64%	NHFD overall: 71%	NHFD overall: 38%

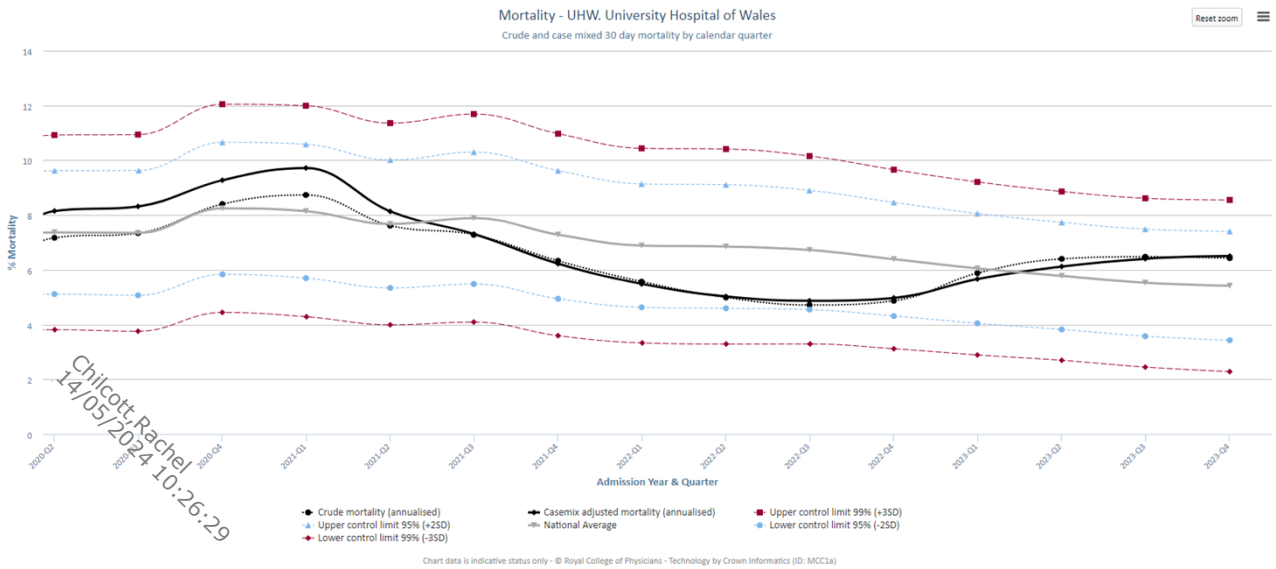
KPI overview: UHW. University Hospital of Wales

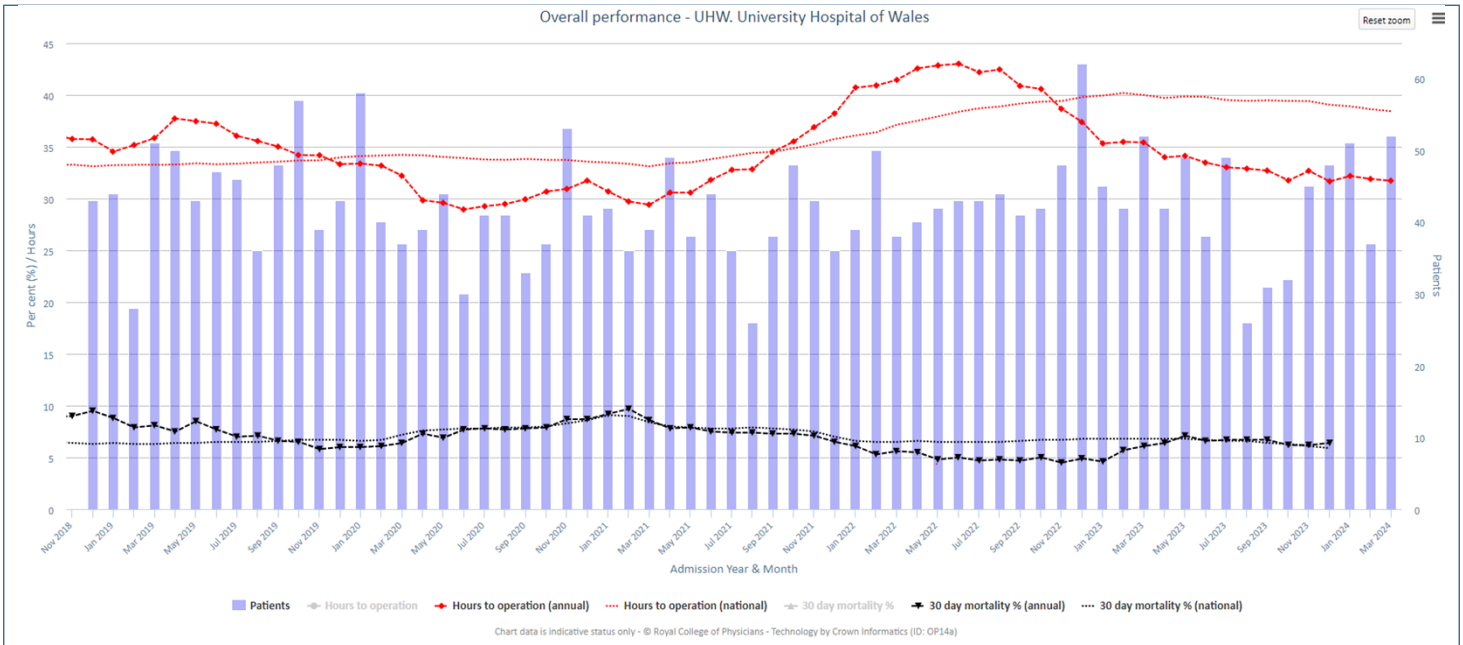
Annualised values based on 500 cases averaged over 12 months to the end of March 2024.

0. Admission to specialist ward	1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
42%	91%	64%	68%
NHFD overall: 9%	NHFD overall: 87%	NHFD overall: 58%	NHFD overall: 68%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence	7. Bone medication
84%	54%	73%	68%
NHFD overall: 81%	NHFD overall: 65%	NHFD overall: 72%	NHFD overall: 43%

Previous UHB performance relating to delivery of a nerve block and admission to a specialist ward within four hours was poor and prior to the pandemic was only achieved in 14% of patients with similar performance noted in 2023. However, in 2023 a hip fracture pathway was implemented supported by ring fenced beds and this has supported significant improvements in performance as indicated in the data to March 2024 with compliance increasing to 42%.





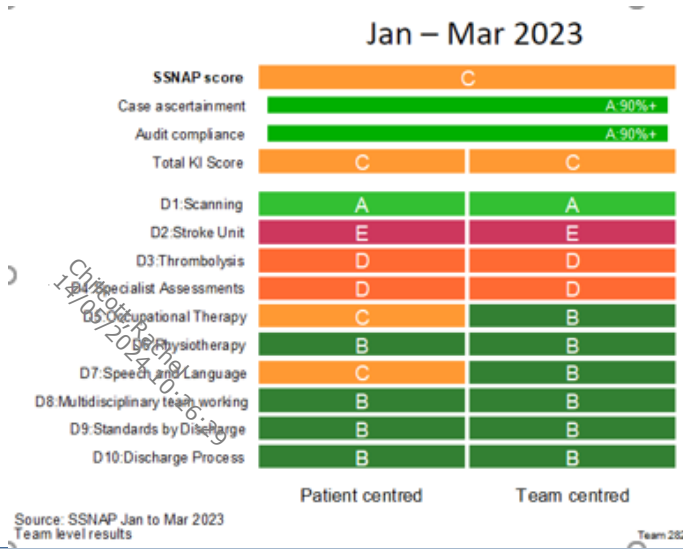
NICE guidelines recommend that surgery should take place on the day of admission to hospital or the following day. This is because it is uncomfortable, undignified and distressing to be confined to bed with a hip fracture and patients are unable to get up out of bed until they have had the operation. This recommended time for surgery may not be possible for some patients – for instance if they have medical problems which need other treatment first to make them well enough for surgery. The NHFD measures compliance with surgery under 36 hours, and since November 2022 the time to surgery has reduced below the national rates and since January 2023 UHB has achieved a monthly average time to surgery which is consistently under 36 hours.

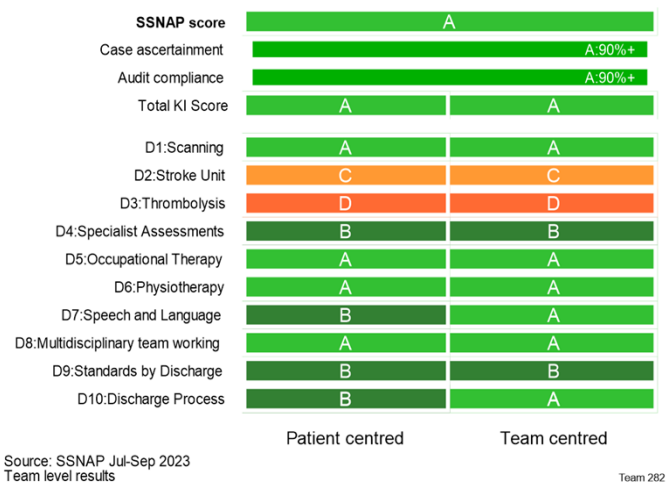
Future work is planned to enhance delirium screening post operatively for hip fracture patients and an improved bed management process for elderly and frail patients.

Sentinel Stroke National Audit Programme (SSNAP) The Road to Recovery Ninth Annual report April 2021 - March 2022 [Annual report 2023 (hqip.org.uk)]

The SSNAP is a national quality improvement programme which is aimed to measure the quality of stroke care in the NHS across England, Wales and Northern Ireland. The program measures the processes of care provided to stroke patients as well as the structure of stroke services against a number of evidence-based standards.

SSNAP reviews 10 domains of care: Results for UHW.





The development of a stroke pathway and ring-fenced stroke beds has supported ongoing quality improvement. The most recent quality data indicates an overall improvement of the SSNAP score from a C to A grade. (SSNAP grade A-B score is indicative of 'first class quality of care' and a 'good or excellent service in many aspects respectively.

The health board has recently launched two digital innovations 'Brainomix' and 'VisionableONE' and a single stroke pathway is currently under development in collaboration with the emergency unit which will be based on a new clinical model.

Cardiac Rhythm Management (Ablations and Device Implants) 2023 Summary report. National Audit of Cardiac Rhythm Management (NACRM) - NICOR

The National Audit of Cardiac Rhythm Management (CRM) collects information about all implanted cardiac devices and all patients receiving interventional procedures for the management of cardiac rhythm disorders in the UK. The audit aims to improve the care of patients who undergo pacemaker, implantable cardioverter-defibrillator (ICD), cardiac resynchronization therapy (CRT) and cardiac ablation procedures in the UK through the collection, analysis and dissemination of data relating to centres across the UK.

During 2022, over 150 ablation procedures were performed, the outcomes of these procedure were comparable to other UK originations. A total 108 simple ablations and 56 complex ablations were completed in 2021/22 and very similar rates in 2022/23. Nationally, simple ablations during the reporting period remain below the pre-pandemic rate, while complex ablations exceeded the pre-pandemic rate. The British Heart Rhythm Society (BHRS) standards recommend that ablation centers undertake a minimum of 100 ablations procedures a year.

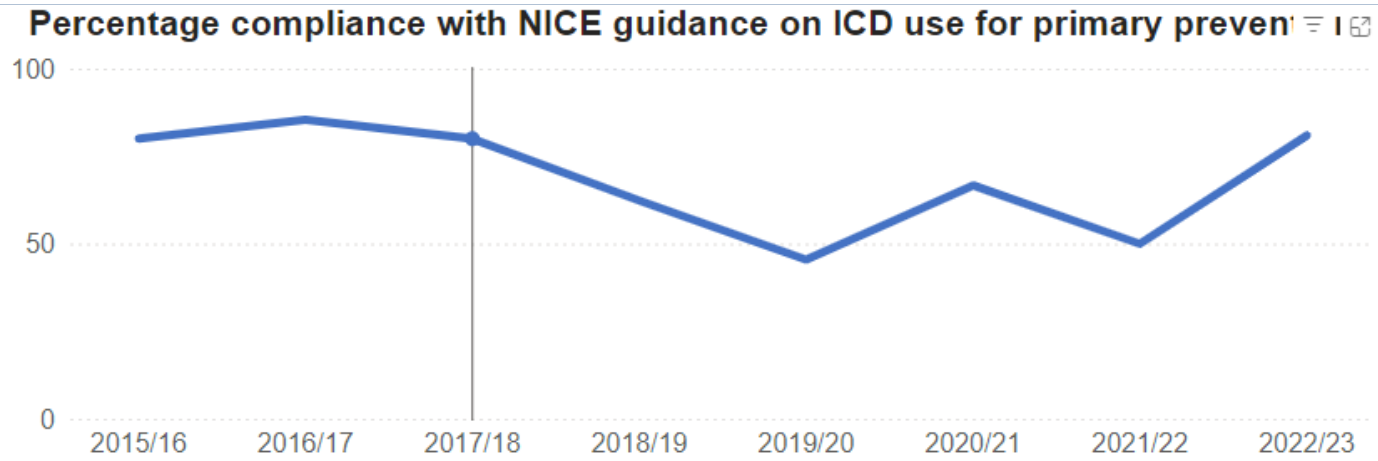
Theatre catheter laboratory availability has been limited with CaVUHB impacting the number of ablation procedures that can be undertaken, this limited laboratory availability is also impacting recruitment. As result patients continue to receive medical therapy, increasing the risk of permanent AF and reducing the viability of ablation as a future treatment.

The national audit programme has identified that re-intervention rates are low in CaVUHB when compared nationally. The health board is only able to offer ablations for patients following failing drug therapy, which is contradictory to national guidance, which advocates an ablation should be available to patient without previous medical therapy, however, this is currently not occurring in Wales.

There is a wide variation in the rate of pacemaker procedures per million across health organisations. In 2022/23 the overall rate for procedures in England and Wales was 681 procedures per million in Cardiff and Vale this was comparable with a rate of 686.93 per million.

Cardiac resynchronization therapy pacemakers are inserted at a rate of 263 procedures per million across England and Wales and this compares to 254.04 in Cardiff and Vale UHB

Implantable Cardioverter Defibrillators (ICD) are implanted at a rate of 106 per million in England and Wales while in Cardiff and Vale exceeds this rate with 166.65 procedures per million in 2022/23. NICE guidance recommends that an implantable cardioverter defibrillator (ICD) should be implanted for primary prevention when a patient is deemed at risk but has not yet suffered a cardiac arrest that could be life threatening. The NICOR audit target for compliance is 80% and average national compliance is 50%. The UHB increased from 50% compliance in 2021/22 to 80.95% in 2022/23.



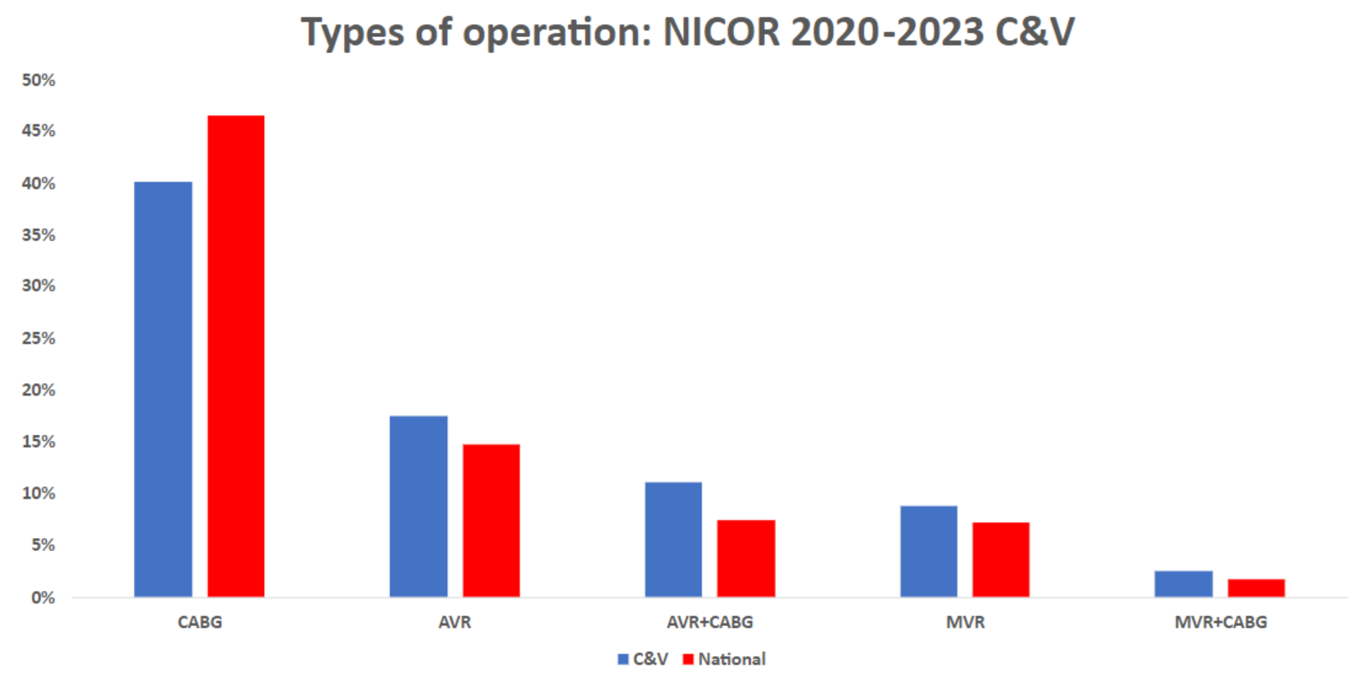
Percentage compliance with NICE guidance on ICD use for primary prevention by hospital (2022/23)

National Audit of Adult Cardiac Surgery (NACSA)- National Adult Cardiac Surgery summary report 2023

Adult Cardiac Surgery includes all procedures performed on patients aged 18 or over that involve the heart or structures attached to the heart. For the purposes of this Audit we report on operations that involve surgically opening the chest wall and usually the pericardium (the sac around the heart). The most common of these procedures are: Coronary Artery Bypass Grafts (CABG), Valve surgery, operations on the Thoracic Aorta, or a combination of these.

The NACSA Audit looks at all procedures undertaken in NHS cardiac surgery centers in the UK, as well as six private hospitals and one from the Republic of Ireland over a three-year period, between 1st April 2019 to 31st March 2022**.** This provides an overview of the state of cardiac surgery in the UK during this timeframe (such as activity and trends), as well as reporting on several Quality measures.

The 2023 report contains data from the period 2020-2023 and includes 1397 Cardiff and Vale UHB submissions. EuroSCORE risk stratification figures consistently demonstrate that patients operated on at Cardiff and Vale are a higher risk cohort when compared to national averages. The UHB has continued to be well above average in terms of risk adjusted in-hospital survival rates. In addition, the UHB performed better than average in terms of mortality after elective and urgent CABG procedures recording no deaths during this three-year period. Re-opening rates following isolated CABG were significantly lower at Cardiff and Vale compared with the national average.



No Cerebral Vascular Accident's (strokes) 's or Transient Ischaemic Attacks (TIA) were noted in the post-operative period for patients undergoing CABG surgery within the UHB. Post-operative complications after CABG were also lower than national averages. Waiting times for elective and urgent CABG procedures have reduced during the last three years, however, the waiting time is still above that recommended, however, this issue is not unique to Cardiff and Vale. Fragility of service delivery is impacted by numbers of cancellations due to infrastructure and resource issues (theatre availability, ITU bed capacity, staffing and limited ward beds) and that MDT time available is currently inadequate for the complexity of the service provided.

Myocardial Ischaemia National Audit Project - Myocardial Ischaemia Report 2022

The Myocardial Ischaemia National Audit Project (MINAP) measures the timeliness of primary percutaneous coronary interventions (PPCI) as a treatment for higher risk heart attacks (STEMI), angiography for lower risk heart attacks (NSTEMI) , the provision of specialist cardiac care and compliance with prescribing recommendations and referral to rehabilitation.

286 NSTEMI heart attacks and 477 STEMI heart attacks were treated and included in 2022/23 national audit which translates to a rate of 157.07 per 100 000 population for the UHB.

To achieve the best possible outcomes a patient should receive a PPCI as quickly as possible. Call to balloon time relates to the length of time from calling ambulance services to starting the PPCI procedure and door to balloon time relates to time from arrival at a heart attack center to commencing the procedure. Door to balloon time (DTB) should not exceed 90 minutes and should ideally be less than 60 minutes. The UHB mean time was 48 minutes and 28.29% of patients exceeded the 90-minute target. However, Call to Balloon time (CTB) exceeded the national target of 150 minutes with the UHB mean time being 176 minutes and

International guidelines states that patients presenting with NSTEMI should undergo an angiography imaging prior to discharge and ideally within 72 hours of admission. 11.74% of patients did not receive angiography before discharge in 2022/23 in the UHB.

After a heart attack all patients should undergo an investigation to evaluate their left ventricular function, this is most commonly performed by echocardiography. In Cardiff and Vale this 86.79% of patients are appropriately assessed, below the 90% target

National Heart Failure Audit [National Heart Failure Audit (NHFA) - NICOR]

The National Heart Failure Audit measure performance across a number of metrics including, specialist care provision, prescribing and follow up and rehabilitation in 2022/23.

Cardiff recorded an admission rate 94.3 per 100 000 of population in 2022/23 with rates nationally varying from 40 to 146 per 100 000 population.

49.10 % of patients admitted to UHW with heart failure were admitted to cardiology wards below the target of 60% and 68.6% of patients were seen a specialist heart failure team compared with the target of 80%

Nationally only 51% of hospitals achieved the standard of 90% of their patients having echocardiograpy during admission, in Cardiff this was achieved in 73.9% of patients.

All patients regardless of age should be considered for treatment with disease modifying drugs and Cardiff exceeded the target for effective prescribing of these medications, with the exception of prescribing of mineral corticoid receptors where the organization did not achieve the 90% standard.

Case ascertainment for the National Heart Failure Audit fell in 2022/23 and the focus in 2024 is to achieve 80 % compliance with this measure to allow the organization to use this data effectively.

National Audit of Care at the End of Life (NACEL) - [Care at the End of Life 2022/2023]

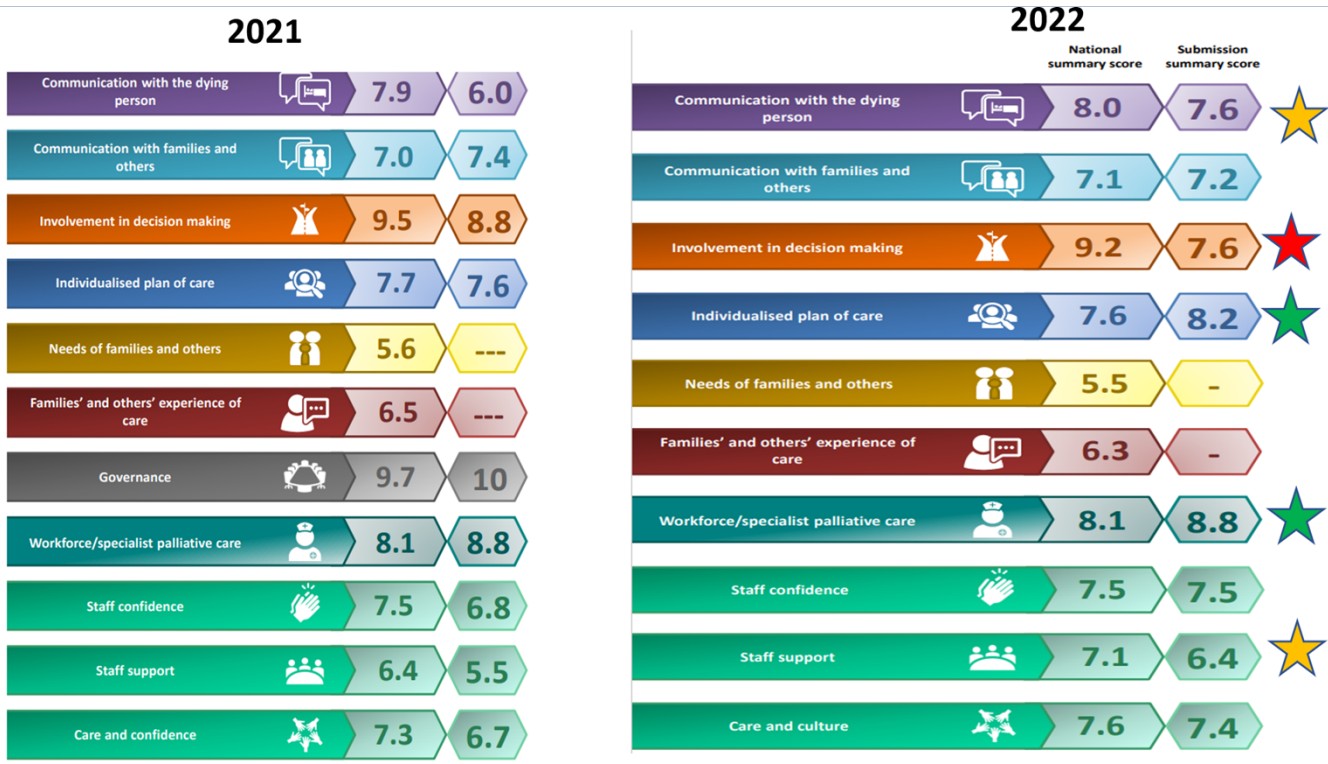
This report sets out the findings of the fourth round of NACEL which took place in 2022. Where possible, the results are compared to previous findings from round three (2021) and round two (2019).
The audit comprised:

- an Organisational Level Audit covering hospital/site 2021/22;
- a Case Note Review (CNR) which reviewed either:
- 25 consecutive deaths between 1st April 2022 and 14th April 2022 and 25 consecutive deaths between 9th May 2022 and 22nd May 2022 for acute providers

The audit included two categories of deaths:

- Category 1: It was recognised that the patient may die.
- Category 2: The patient was not expected to die, however clinical staff were not surprised
- a Quality Survey (QS) completed online, or by telephone, by the bereaved person; and
- a Staff Reported Measure (SRM), completed online.

Data for all elements of the audit was collected between June and October 2022.



The possibility that the patient may die within the next few hours/days was recognised in 87% of cases audited nationally, consistent with 2021. The median time from recognition of dying to death was recorded as 47 hours (41 hours in 2019), providing a greater opportunity to realise individual wishes for end of life care.

The documentation of conversations with the dying person and with their family nationally remained similar to results in 2021 and pre-pandemic levels. The UHB results demonstrated an improved performance against communication with the family from 2021 and similar performance around communication with the family.

Involving the patients in decision about their care is an important factor in end of life care and is generally well documented nationally, however UHB documentation fell below the national standard and results had deteriorated since the 2021 audit.

Nationality 76% of patients had documented evidence of individualized plans of care, however evidence of advance care planning across the patient population was poor. The UHB demonstrated improved performance around documentation of individualized care plans since 2021 and exceeded national performance in the 2022 audit with 82% of patients having documented plans.

NACEL data has identified improvements in some of the key elements of the audit from the previous year. Cardiff and Vale UHB are planning to work through a number of improvements this coming year to continue to drive further improvements, these include:

- Continue to improve compliance of the symptoms early warning scores and the All Wales care cecisions for the last days of life
- Continue to drive further compliance of the All Wales DNACPR policy and documentation
- Maintain adequate workforce
- Increase the number of training sessions to improve End of Life Care for healthcare professionals across the organisation
- Aim to re-establish the role of Treatment Escalation Plans.

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - National Confidential Inquiry into Suicide and Safety in Mental Health 2024 report

The NCISH database includes a national case series of suicide by patients under the care of mental health services over more than 26 years, with an overall aim of improving safety for all mental health patients. The NCISH collects data from 10 key elements

National the 2024 report identified that there were 69,420 suicides in the general population in the UK between 2011 and 2021, an average of 6,311 deaths per year. The rate of suicide decreased by 4% in the UK in 2020 and 2021, the first years of the COVID-19 pandemic, compared to 2019. The decrease was particularly seen in men.

Nationally there is a concern about the safety of mental health in-patient services and to address this health services must focus on 10 standards:

Within Cardiff and Vale UHB acute mental health in-patient service are as follows:

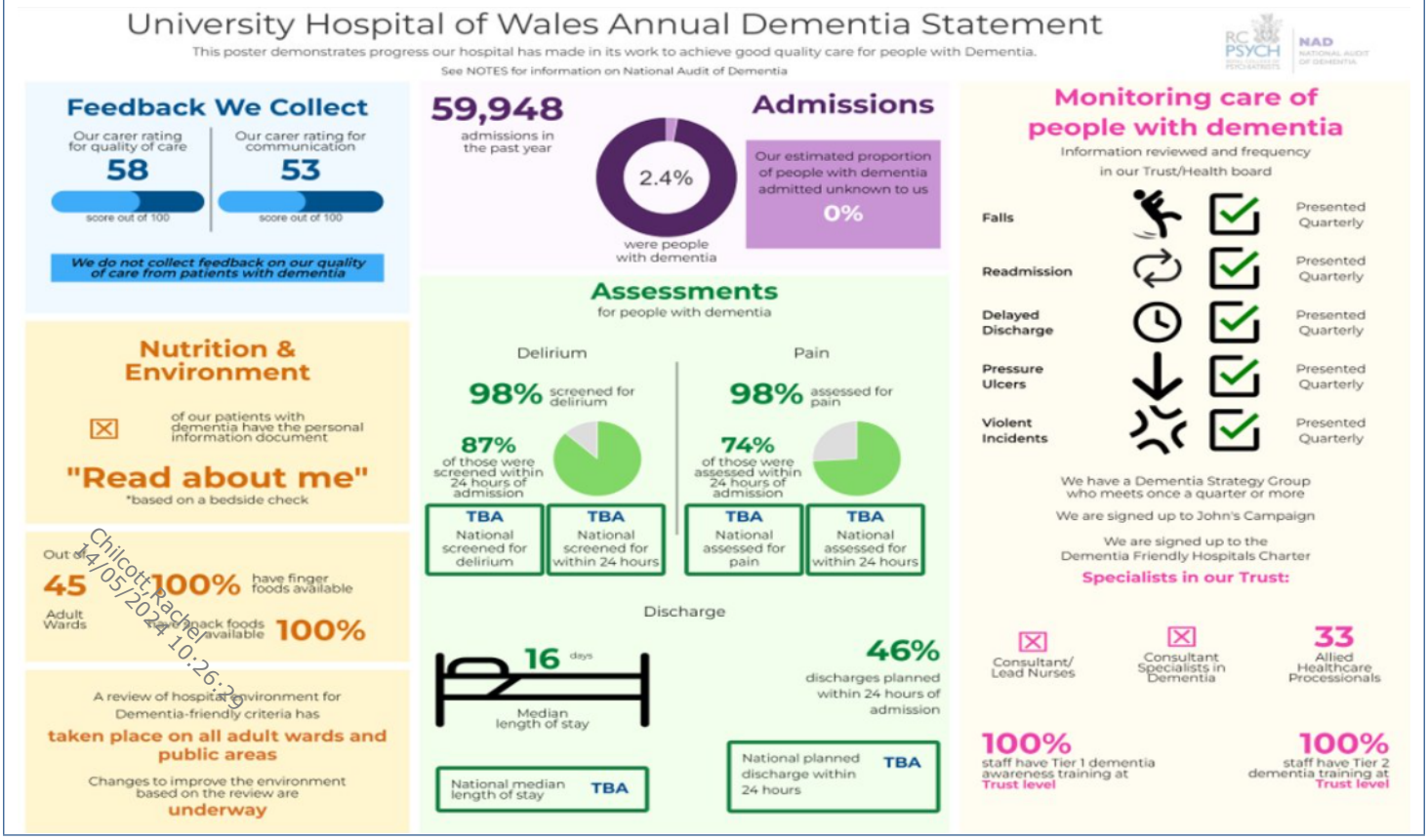
Standard	Achievements	Opportunities
Safer wards	• Yearly ligature audits • Bespoke purpose-built unit • Operational policy to be ratified in Jan 2024 • CCTV and TDSI access at entry and exit points • AWOL policy in place (agreed with SWP) • Extensive Recovery College and inpatient activity programme	• Options appraisal to improve safety of the environment • Strategy and policy for the Lived Experience Team in development • "Safe Wards" approach to be refreshed
Early follow up on discharge (72 hours)	• Practice in place • CRHTTs are configured to support Early Discharge • Initial stages of the development of the PFD (preparing for discharge) 5-day course starting Jan	• Discharge Policy being updated • Paris report not consistent with practice • Variance across localities in practice • Quality Improvement project led by the Recovery College new year to improve discharge pathway
No out of area admissions	• Patient Flow Manager appointed • Daily bed management meetings • Weekly review of delays chaired by DDON • Mind Housing Project	• Section 140 policy in development • OOA bed management policy in development • Demand outstrips capacity
24-hr Crisis Teams	• First 24hr Crisis Service in Wales (enhanced by CRU and CH)	• MHCB have an established CRHTT but does not have practitioner psychologist as part of its MDT • Further work on ensuring that assessments are fully biopsychosocial
Family involvement	• All (probable) suicides are reviewed as per NHS Exec policy • Working towards SIRAN accreditation • First Welsh member of Royal College of Psychiatry accreditation body Siran • WARRN and SAMT training • Solace Carers Support • Dementia CNS and Care Advisors for Inpatient. Advocating for the needs for Carers	• Improve family engagement core action on the CB improvement plan • Ambition for a Carers Lead for Adult Services • Alignment of priorities with Carers forum and MHCB

Standard	Achievements	Opportunities
Guidance on depression	• Patient Safety and Quality team of the UHB issue compliance surveys to relevant clinical boards to report on NCG using AMAT • Local psychological therapies management committee and Health Pathways in PCIC • Interpersonal Therapy (IPT) for depression in addition to CBT. Accessed via PMHSS • GP-Health Pathways software system to refer on. This includes all available services	• PICU - Refresh Health Pathways. Reduced accessed since Covid. Review of whether software in situ. • Last audit date unknown. Opportunity to revisit compliance statement (Nice Guidelines 222). P & PT Lead to requested this from AMAT Lead
Personalised risk management	• WARRN- Dec 2022 Mandated for all MH staff. Form 4 switched off April 23 • SAMT Training to prioritised areas in MHCB • Refresher SAMT training offered • Supervision offered for staff using SAMT	• Quality audit being devised • Plan to widen roll-out to non-prioritised areas. Project to be finalised before wider roll out to non-prioritised areas within MHCB • SAMT not mandated for staff. This may affect engagement with the tool • Limited number of SAMT trainers to deliver training and support • Cardiff have not opted into national Person-Centred Safety Planning project with NHS Exec • Embedding Risk assessment into practice (focus groups/review of approach) • Cultural change of Risk management approach
Outreach Team	• Current service provision rehabilitation focus • 7 day a week service • Some meds support offered	• Service re-design has prioritised recovery ethos over the outreach approach
Low staff turnover	• Development of new roles • Grow your own development programme • Improvement in stability of the workforce. Reduction in agency use • Proactive approach by People Services to follow up leavers and embed learning • Releasing Time to Care on Cedar to improve patient and staff experience and efficiency • Support programme for newly qualified staff including robust mentorship programme • Monthly newly Qualified support sessions • Development of Wellbeing Hub • Development of Ciss and Tim support sessions • Staff Rotation Programme • Enhanced supervision structures • Increased choice of shift patterns • CAAPS (Clinical Associate Applied Psychologists) on the wards. To start January • Trauma Informed Package (TIP) Modules for Nursing Staff (Nurses use this in 1:1 with patients) • Appointed to Consultant Psychologist for Treatment Wards	• Planning, development, efficiency and productivity workstream ongoing • Areas to be identified for Releasing Time to Care
Reducing drug and alcohol misuse	• Existing referral pathways in place for Adult Acute Inpatient/CMHTs to CAU Dual Diagnosis Team • Ongoing work to re-establish Dual Diagnosis Steering Group for Directorate to further develop joint working and monitor performance against targets • Buvidal Psychological Support Service 2-year pilot	• Development of Dual Diagnosis Protocol to be launched May 2024 • New annual training programme for Directorate • CAU from February 2024 will provide Motivational Interviewing training to MH staff • Integration of CAU Psychology Team management role with Dual Diagnosis Team to provide strategic direction and oversight to the service • Buvidal Psychological Support Service funded ends March 25

National Audit of Dementia (NAD) – [National Audit of Dementia Round 5 2022-20223]

The National Audit of Dementia (NAD) measures the performance of general hospitals in England and Wales against standards relating to care delivery which are known to impact people with dementia while in hospital.

Standards are derived from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals Charter, and reports from the Alzheimer's Society, Age Concern and Royal Colleges. Standards are updated for every round of audit.



National Vascular Registry (NVR) - State of the national report 2023

The National Vascular Registry (NVR) was established in 2013 to measure the quality and outcomes of care for adult patients who undergo major vascular procedures in NHS hospitals, and to support vascular services to improve the quality of care for these patients.

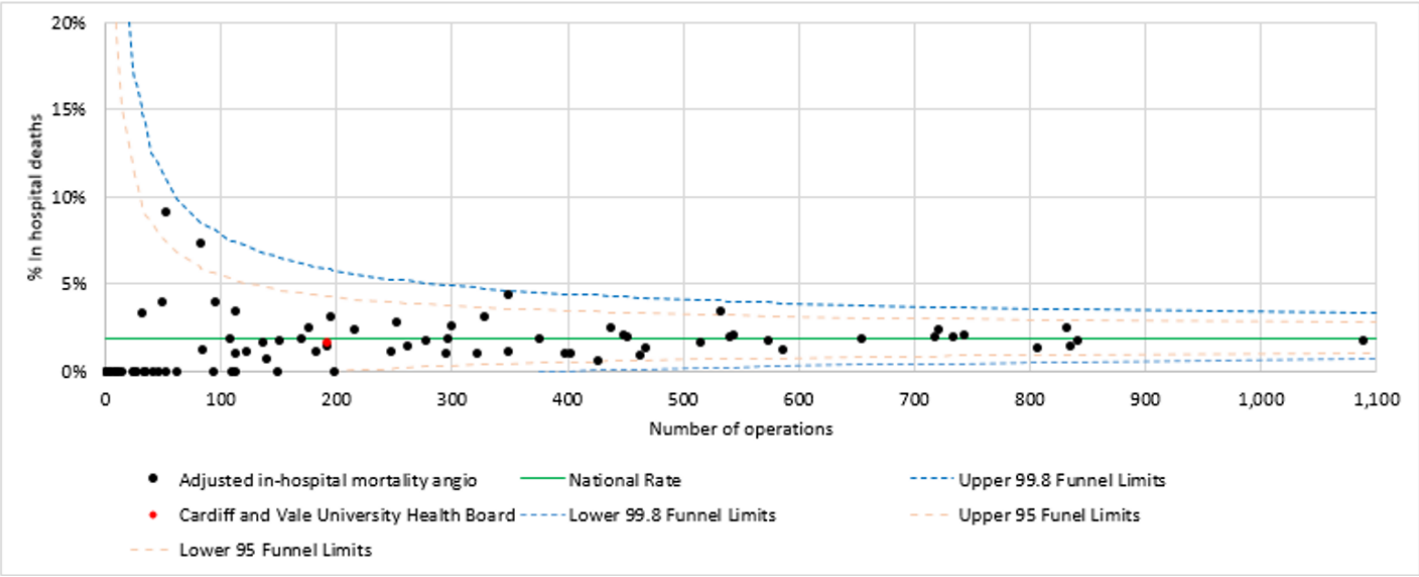
This State of the Nation report for 2023 publishes information on emergency (non-elective) and elective procedures for the following patient groups:

1. patients with peripheral arterial disease (PAD) who undergo either (a) lower limb angioplasty/stent, (b) lower limb bypass surgery, or (c) lower limb amputation
2. patients who have a repair procedure for abdominal aortic aneurysm (AAA)
3. patients who undergo carotid endarterectomy or carotid stenting.

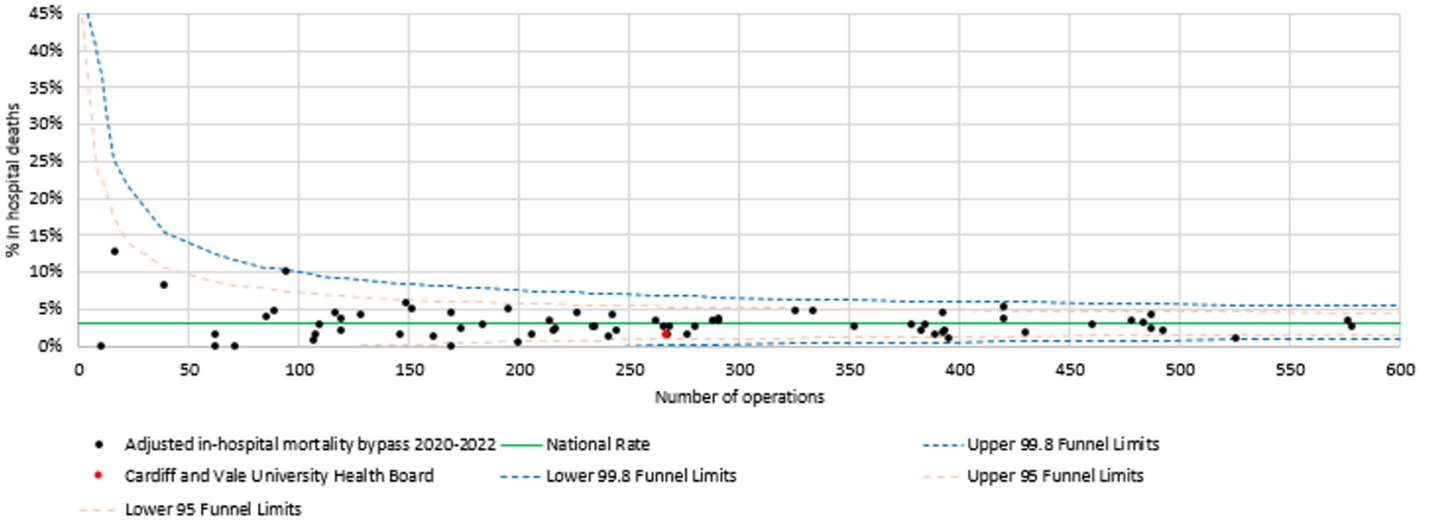
At Cardiff and Vale University Health Board overall performance is in line with other national institutions across the UK. For 89% of amputation cases a consultant was present in theatre which exceeds that of the national average of 74%. However, the number of patients treated via day case surgery for angioplasty cases is currently 6%, nationally 61% of angioplasty patients are treated as day cases.

Peripheral arterial disease (PAD) of the lower limbs causes a range of symptoms extending from lifestyle restrictions due to intermittent claudication, to potential limb loss because of limited blood flow in the lower limb arteries. The proportion of patients revascularized within 5 days was 51% in 2022 and similar performance locally with 52% of patients seen within this time scale. 119 Angioplasty cases were undertaken and recorded on the national vascular registry for 2022, the UHB adjusted in hospital mortality rate was 1.5% compared to a national rate of 1.9% and the 30 day readmission rate was 19% compared to a national rate of 10.7%. The UHB undertook 130 bypasses that were recorded on the NVR and recorded an adjusted mortality rate of 1.6% compared to a national rate of 3.0% and a 30 day readmission rate of 12% compared to a national rate of 11.6%

Angioplasty Mortality

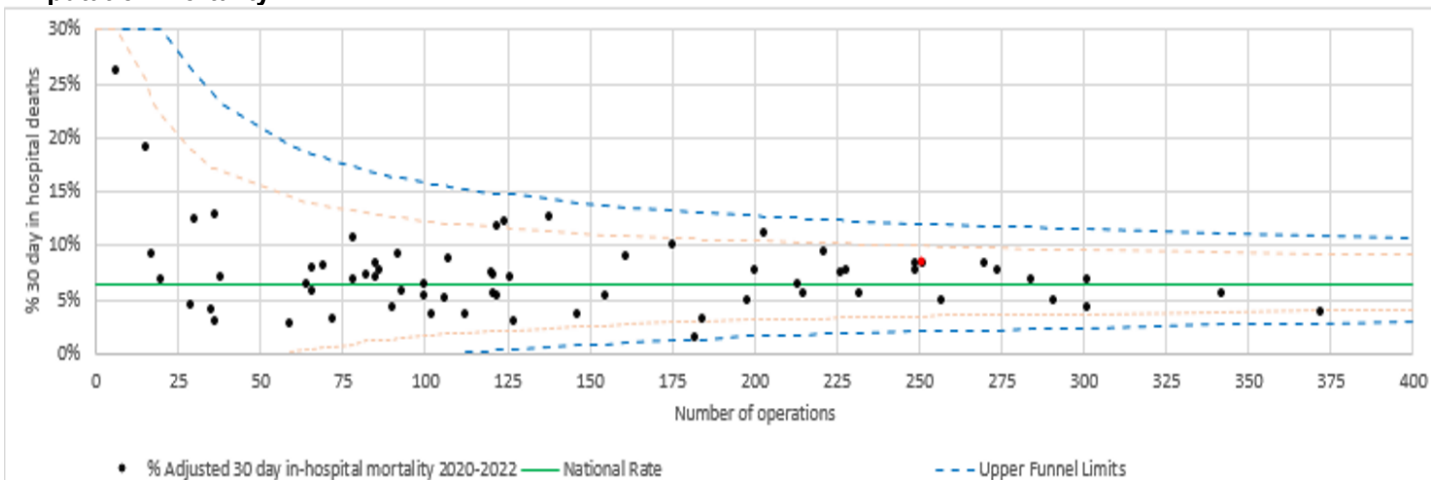


Bypass Mortality



The National Vascular Registry identifies that 84% of amputations are undertaken as non-elective admissions. All patients undergoing major amputation should be admitted in a timely fashion to a recognized arterial center with agrees protocol and units should aim to have an above knee (AKA) : below knee (BKA) amputation rate of below one. The UHB median time from assessment to procedure for non-elective admissions was 10 days, above the national average of 8 days. The overall AKA;BKA ratio nationally was 0.89 and locally 0.58. Prophylactic antibiotics were administered in 10% of patients locally and a consultant was present in theatre in 89%of cases compared to 74% nationally adjusted 30 day in hospital mortality was 8.4% compared to 6.5% nationally.

Amputation Mortality



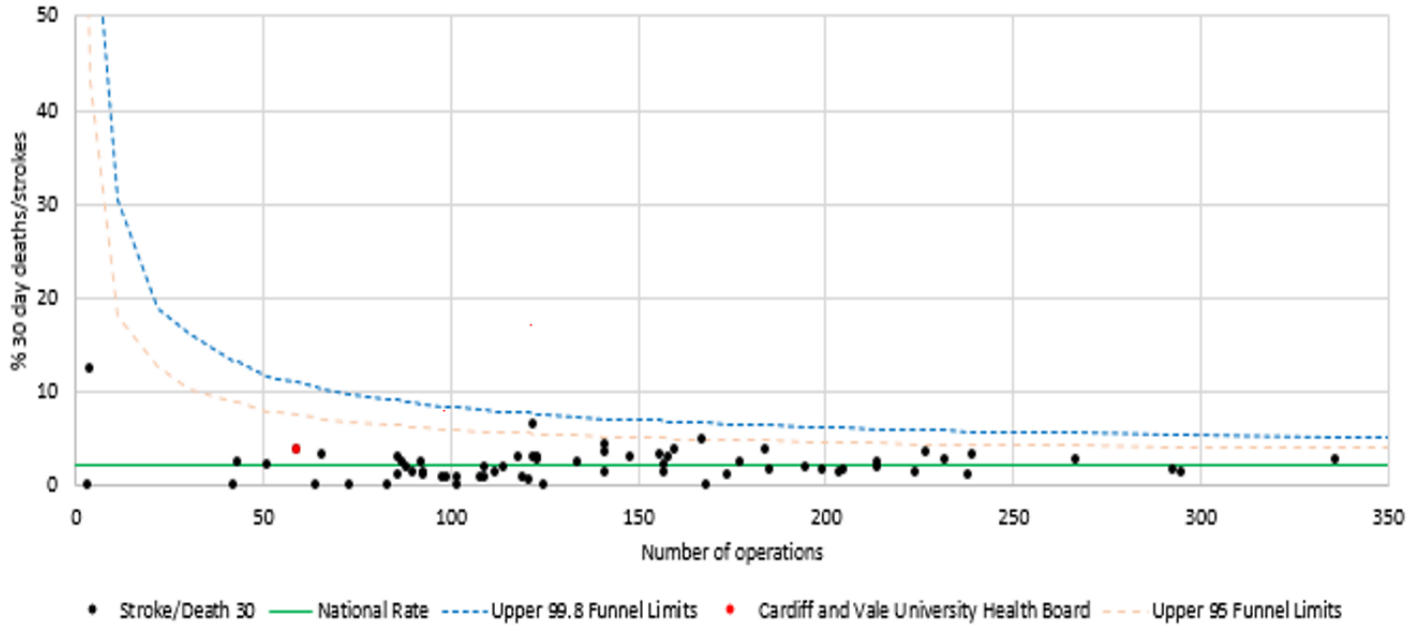
The Vascular Society Abdominal Aortic Aneurysm Quality Improvement Framework established a number of standards for preoperative assessment of patients undergoing AAA repair. Median time from assessment to repair was 12 days locally compared with 8 nationally and only 12% of patients had surgery within 8 weeks compared with 32% nationally. Adjusted In hospital mortality was 1.9% in line the national rate of 1.4%.

In 2022, most patients treated in NHS vascular units for aortic aneurysms received care consistent with the standards:

Metric	Report Year	Trust	Quartile	National
% patients with date of assessment	2021	93%	2	90%
	2022	100%	4	92%
	2023	97%	3	93%
% patients with anaesthetic review	2021	93%	1	97%
	2022	100%	4	97%
	2023	97%	2	97%
% patients undergoing pre-op CT/MR angiogram assessmen	2021	92%	2	91%
	2022	100%	4	92%
	2023	97%	3	94%
%patients discussed at MDT	2021	93%	3	86%
	2022	92%	3	87%
	2023	97%	4	88%

In the UK, around 3,000-4,000 patients undergo a carotid endarterectomy (CEA) each year to remove plaque that has built up within the carotid arteries (the main vessels that supply blood to the brain, head and neck). In 2022, a total of 3,257 carotid endarterectomies (CEAs) were entered onto the NVR. Patients with symptomatic carotid disease should be treated within 14 days, this was achieved for 52% nationally compared with 72%. The median time from initial symptoms to undergoing surgery was 14 days nationally and 12 locally. The adjusted stroke and or mortality rate within 30 days of the procedure demonstrates a rate 3.8% locally compared to 2.1% nationally.

Carotid Endarterectomy Morbidity and Mortality



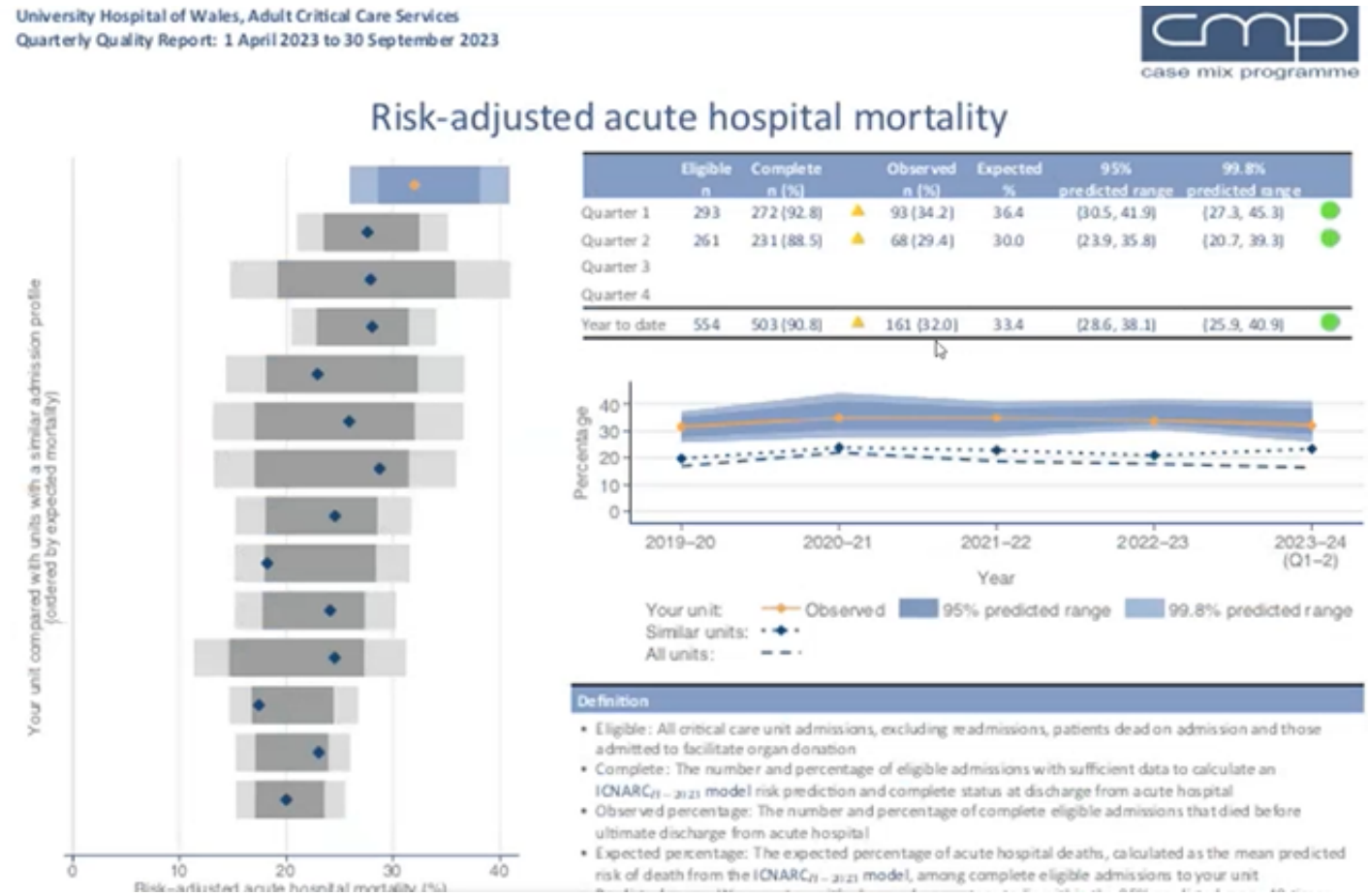
Limited operating theatre time and bed capacity are impacting the timeliness of service provision and in response a business case has been developed to support the development of a hybrid theatre unit.

The Intensive Care National Audit and Research Centre ICNARC

The Intensive Care National collects data from patients who are likely to become, currently are or are recovering from being critically ill. ICNARC supports clinicians to identify best care for patients by facilitating improvements in the structure, processes, outcomes and experiences of critical care. ICNARC will data on all patients that are admitted to the intensive care unit and require patients

physiological score which predicts a risk of death, co-morbidities, diagnosis, data is collected for the durations of a patient's length of stay. Data is shared to organisations quarterly.

Cardiff and Vale UHB ICU Data is currently compared to 15 similar units across the UK and is comparable to that of other centers across the UK. The predicted mortality rate for the UHB Intensive care unit is very high, as the UHB does not include patients cared for in the Post Anaesthetics Care Unit who are lower risk, within its data which therefore this increases the acuity and complexity of the UHB Case mix. Only 2% of patients admitted in Cardiff are as a result of elective surgery compared to 11.9% nationally and 61.4% of patients admitted as mechanical ventilation compared with 51.4% nationally. Cardiff Mortality rates are within the 95% predicted range and the observed mortality rate of 34.2% is just below the expected rate of 36.4%.



ICNARC data has also identified a high proportion of patients are currently being discharged after 5pm when compared to other units, Cardiff and Vale UHB currently recognise the operational and bed management pressures which are currently impacting this.

Data collection for ICNARC is a current concern within Cardiff and Vale UHB due to the volume of data required by the national audit programme, presently and data is purely paper based and requires extensive medical oversight.

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

- National Joint registry continues to demonstrate revision rates above the national average but this is in part because the organisations undertakes revision on patients whose primary procedures have been undertaken elsewhere. Work has been undertaken to standardise prothesis which is resulting in a reduction in knee revision rates

- National Audit of Inpatient Falls – key performance indicators are consistently above the national rate and work is underway across the UHB to improve recognition and mitigation of inpatient falls risks.
- National Hip Fracture Database- improvements in the timeliness of admission to a specialist ward and undergoing surgery have been observed in 2023. Prompt orthogeriatric review has remained very high, exceeding national rates. Mortality associated with hip fracture reduced below the national rate in 2021 but increased above this rate in 2023 although it remains with the 95% confidence interval.
- Sentinel Stroke Audit program- The UHB SSNAP performance increased from a C rating to a in 2023 with wide spread improvements noted. Thrombolysis rates remain below the national rate, however the introduction of Brainomix and the development of a single stroke pathway will support improvements.
- The Cardiac Rhythm Audit – This audit provide oversight of ablation procedures and implantable devices across the UHB.
- Cardiac Surgery Audit – Reopening rates are below the national rates along with post-operative complication rates.
- MINAP- heart attack performance is outline in this audit with door to balloon time noted to be well below the national rate and below the target set by NICOR. Call to balloon time however exceed the target for timely care.
- Heart Failure Audit-49.1% of patients included in the audit data were admitted to a cardiac ward and 68.6% were seen by a specialist cardiac team, both of these indicators fall below the required standard.
- The national audit of care at the end of life illustrates improvements since the previous audit in 2021 with communication and care planning, however performance around involving the patient in decisions around their care was seen to deteriorate.
- The National confidential inquiry into suicide and safety in mental health units makes broad recommendations, and oversight of the Health Board approach to delving these recommendations is detailed.
- The National Vascular registry notes that rates of revascularisation in peripheral arterial disease occurred at similar rates to UK performance and mortality associated with this procedure is in line with national rates. The time from assessment to surgery for patients undergoing lower limb amputation exceed national rates and adjusted 30 day in hospital mortality was 8.4% compared to 6.5% nationally. Time from assessment to surgery for repair of aortic aneurysms exceeds national rates and adjusted mortality is in line with national rates.
- The ICNARC intensive care audit demonstrates variation in intensive care casemix for the national average and the expected range for mortality is very high as a result. Adjusted mortality is within the expected range and is below the expected rate.

Recommendation:

The Committee are requested to: **NOTE** the Headline data and some of the areas of improvements covered in 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/No
N/A
Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

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

Chilcott Rachel
14/05/2024 10:26:29

Report Title:	*Equity, Equality, Experience and Patient Safety Action Plan*			Agenda Item no.	*3.2*
Meeting:	QSE	Public	X	Meeting Date:	21/05/2024
		Private			
Status *(please tick one only)*:	Assurance	X	Approval		Information
Lead Executive Title:	Claire Beynon – Executive Director of Public Health				
Report Author (Title):	Oliver Williams – Specialty Registrar in Public Health				

Main Report
Background and current situation:

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

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

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

Current Situation
The Equity, Equality, Experience and Patient Safety action plan sets out the 24 initial action areas, providing updates approximately six months on from their identification, along with target completion dates. We will provide further updates in six months' time.

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

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

This action plan provides six-month updates on progress across the Health Board on 24 projects of strategic importance to equity, equality, experience and patient safety.

Recommendation:

The Committee is requested to:

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

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

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

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

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

Chilcott Rachel
14/05/2024 10:26:29

Equity, Equality, Experience and Patient Safety
Action Plan

The 3I Framework

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

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

Output – summary of equity and excellence priorities

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

Output – co-produced intervention based on data and evidence

Interventions tailored to need:
Integrate equity, equality experience and patient safety improvements into existing and new work programmes, staff development initiatives and policies

Output – interventions integrated into routine practice

Version 3.0 May 2024

Contents

Introduction

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

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

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

The objectives:

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

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

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

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

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

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

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

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

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

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

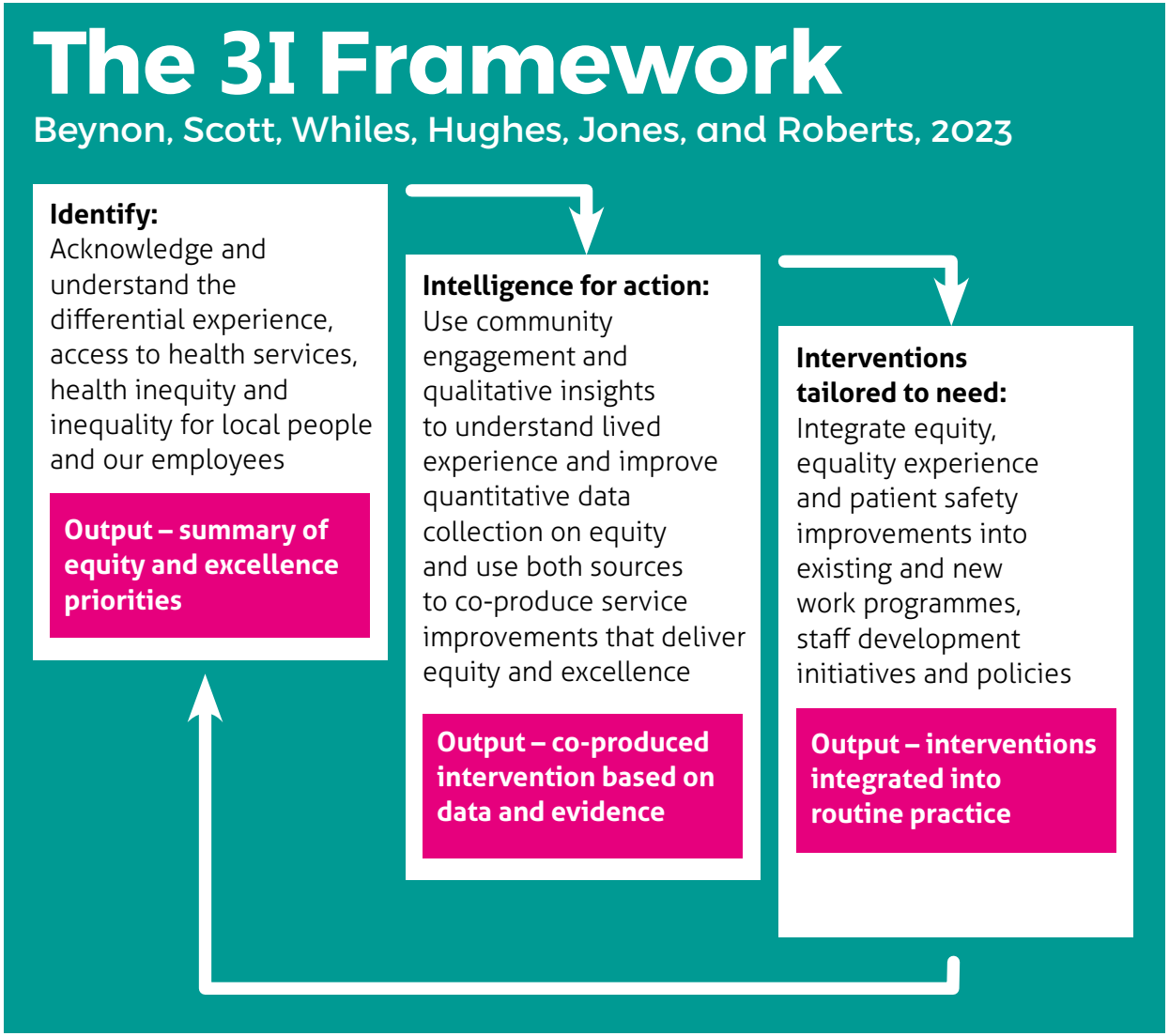


Figure 1: Three I Framework: a three-step tool to support teams in making positive changes to equity, equality, experience and patient safety in Cardiff and Vale University Health Board

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Planned Care	**Adam Wright** *Head of Service Planning (Operations)*	Examining waiting lists by postcode (Welsh Index of Multiple Deprivation – WIMD) to aid prioritisation	We have now received an updated analysis of our inpatient and outpatient waiting lists by Welsh Index of Multiple Deprivation (WIMD) decile. Our next step will be to review the analysis undertaken within our Strategic Planned Care Programme Board to consider how it can shape our approach moving forwards.	***September 2024***	
	Steven Thomson *PROMS Programme Manager (Digital Health and Intelligence)*	Analysis of PROMs by protected characteristics	Currently we are unable to analyse PROMs data by protected characteristics, as protected characteristics data is not currently routinely collected as part of the PROMs or in the Health Boards patient administration systems. PROMs data is also not currently stored in the Cardiff and Vale warehouse with the other Cardiff and Vale data, and so cannot be linked to the PROMs data at present. *To overcome this, we will be doing the following:* • Integration between My Clinical Outcomes (MCO) PROMs data and Cardiff and Vale UHB will allow data to easily flow back to Cardiff and Vale UHB. • Work is underway to store PROMs data in the Cardiff and Vale warehouse. Target date is for current services, with ongoing work as more services come online. • The PROMs Steering Group will discuss options for linking PROMs data to existing data sources in the warehouse for analysis, once the PROMs data is in the warehouse.	Integrating MCO PROMs data with CaV data - ***June 2024*** Storing PROMs data in the Cardiff and Vale warehouse - ***September 2024*** Discussing options for linking data - ***December 2024***	
	Emma Cooke *Deputy Director of therapies and Health Sciences*	Supporting Patients Whilst Waiting work	In August 2023, Welsh Government published the 3Ps Policy (Promote, Prevent, Prepare) which covered intentions previously referred to as Supporting Patients Whilst Waiting within the Planned Care recovery strategy. This policy explicitly requests that all Health Boards establish a single point of contact for patients waiting for treatment. This is modelled on an established service in Hywel Dda (the Waiting List Support Service) that was set up during Covid. CAV UHB's plans are well developed and we have had full engagement and sponsorship from perioperative care. We are aiming to have an established service, with staff in post expected in June/July 2024. This service will not only be a single point of contact but also an opportunity for optimisation of patients that the service will be in contact with. Our pilot pathways are hips, gallbladders and hernias, and there is an expectation from Welsh Government that this is scaled up to cover more pathways.	***July 2024 -*** Staff in post for Single Point of Contact service.	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Equitable Employee Experience	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Embedding and enaction of the Anti-Racist Action Plan (e.g. policy review)	Review of Health Board's Anti-racist Action Plan undertaking by People & Culture. Future reporting and monitoring of plan under discussion.	***Quarter 2 2025/2026***	
	Claire Whiles *Assistant Director (Organisational Development, Wellbeing and Culture)*	Establishing and growing Employee Resource Groups (Networks)	Recruitment drive for LGBTQ+ network undertaken as part of LGBTQ+ History Month. Review of Staff Networks to be undertaken.	***Quarter 4 2024/2025***	
	Claire Whiles *Assistant Director (Organisational Development, Wellbeing and Culture)*	Benchmarking and progress monitoring (e.g. Employers Network for Equality and Inclusion)	Review of membership options for the Health Board to support with benchmarking, including ENEI and Stonewall's Diverstiy Champions programme.	***Quarter 2 2024/2025***	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Unscheduled Care	**Katya Empson** *Consultant (Emergency Unit)*	Examining EU waits by demographics e.g. ethnicity to support 6 goals of urgent and emergency care	e-triage is being introduced in May, which will allow Emergency Unit attendees to self-register on arrival and will include the opportunity for them to record their ethnicity if they choose to. This will in turn allow reviewing of our quality metrics against different ethnicities. It is however yet to be tested and we anticipate that attendees may choose not to register their ethnicity as it will not necessarily be clear to individuals how this information will be used.	Implementation of e-triage ***27/05/24***	
	Katya Empson *Consultant (Emergency Unit)*	Analysis of frequent users by postcode (WIMD)	The Business Intelligence Department hold a Frequent Attendees report that collates by post code, which can be refreshed, but it's not currently scrutinised. This information is available for us by the frequent attenders team who work to put in place management plans for the more complex and/or high frequency attenders.		***10/04/24***
	Katya Empson *Consultant (Emergency Unit)*	New model for inclusion health based on need	The 6G programme board and unscheduled care clinical leads work closely in partnership with the CAV HIS team. This allows alignment of strategic planning across clinical services and also closer operational working with acute changes. The Emergency Unit has a 'Safeguarding Hub' with direct input from specialist nurses from key areas; homelessness, violence prevention, drug and alcohol misuse and close links with the CAV HIS team to include support for asylum seekers and others with potentially complex health needs. The aim is to ensure that, in addition to the medical input from the clinicians in the emergency unit, further consideration is given to individuals' wider health and social care needs and the right experts are available to support when appropriate. This expertise is not available 24/7, but through closer working the knowledge and experience of the clinical team in the emergency unit has broadened.		***10/04/24***

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Maternity Care	**Judith Cutter** *Consultant Midwife (Maternity)*	Understanding needs of ethnic minority people	• Maternity Services has joined the Welsh Government's Diverse Cymru Cultural Competency Scheme to educate staff on cultural inclusivity and to use as a tool to assess and improve all areas of Maternity care for global majority families (from ward decoration to guideline development). • We have introduced 'Inclusivity' sessions in mandatory training days (two speakers: LGBTQIA+, non-English speakers and global majority focus) • We have begun a drive on promoting use of professional interprative services, to aid in reducing barriers to healthcare. • We have continued work with the Birth Partner Project to provide bi-monthly face-to-face sessions in the community, providing opportunity for public health promotion, learning from birth experiences and building trusting relationships with communities. • We have initiated face-to-face antenatal education sessions for non-English speaking women, with use of face-to-face interprative services. • Maternity Services have unveiled a large mural outside the main entrance, which was designed by a local artist using a theme of 'inclusivity'. Similar artwork has also been installed within the maternity unit.	Ongoing. Diverse Cultural Competency Scheme for completion in ***October 2024***	Mural installation completed ***Feb 2024***
	Judith Cutter *Consultant Midwife (Maternity)*	Supporting people with obesity in pregnancy	'Healthy pregnancy clinic' was developed following recommendations from the Healthy Weight, Healthy Wales workstream and obesity strategy group. This clinic offers support for women with raised BMI to deliver key public health messages in pregnancy to maintain a healthy diet and lifestyle. This is a midwife run clinic which offers support form a maternal health dietician, consultant midwife and midwife sonography. Women with BMI 35-39.9 in pregnancy with no further co-morbidities follow a healthy pregnancy pathway, with an aim of birth in the Midwife-led unit. They are supported with healthy eating planning in pregnancy and can attend the foodwise in pregnant course. The Maternal obesity dietician is based in the healthy pregnancy clinic and provides support for all women with BMI over 40; this includes around three 1:1 sessions in the antenatal period and follow up postnatally. This service will be evaluated and outcomes measured through the developemnt of a dataset within the maternity informatics system.	BMI dataset in new maternity informatics system by ***December 2024***	Patient feedback collected via patient feedback survey at healthy pregnancy clinic ***March 2024***

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Prevention	**Suzanne Wood** *(Reduce obesity) Consultant in Public Health Medicine (Local Public Health Team)*	Using 'Amplifying Prevention' to increase immunisation and reduce obesity	**Obesity:** Create and launch the Move More, Eat Well Framework 2024-2030. Cardiff and Vale UHB to work with Cardiff and Vale of Glamorgan Councils to decrease High Fat Sugar Salt (HFSS) advertising across Cardiff and Vale of Glamorgan. This will include completion of the Healthier Advertising evaluation by the NIHR PHIRST Team. Cardiff and Vale UHB to support local authority Local Development Plans (LDPs) development. This includes a Health Impact Assessment Stakeholder workshop for Cardiff LDP Deposit Plan in May 2024, and preparing a UHB response to consultation on the Cardiff Deposit Plan by September 2024. Dates are not yet set for review of the Vale LDP.	***June 2024*** NIHR PHIRST Evaluation to be completed by ***December 2024***	
	Dino Motti *(Increase immunisation) - Consultant in Public Health Medicine (Local Public Health Team)*	Using 'Amplifying Prevention' to increase immunisation and reduce obesity	**Immunisations:** As part of the amplifying prevention work, with a specific focus on vaccinations, there have been a number of engagement events with the Somali community at Grange Pavillion and at Butetown community centre, with the Indian community at India House to educate about the benefits of vaccination and offer an opportunity to ask questions and plan a vaccination for children or adults alike. Materials on vaccination have been translated in the most widely spoken languages in Cardiff and the Vale and interpreters have been present to engagement opportunities. A special event at Cardiff Stadium for the end of Ramadan has focused on screening, vaccination, health professionals have answered questions from the public and the event has had an overwhelmingly positive feedback from 150 among the participants. Insight research has been commissioned and undertaken with ethnic minority groups to understand barriers to vaccination. Training up a group of parents in Cardiff to be 'vaccine champions' is an approach that is being piloted to develop a closer link with school communities and ethnic minority communities in particular to be able to address vaccine hesitancy. A further widening of the model is expected over the coming year on the loose blueprint of the Sandwell experience in the West Midlands. A dedicated role is being recruited jointly by Cardiff Council and the UHB with a strategic and operational function to coordinate activities focusing on engagement with ethnic minorities populations. Collaboration with Directors of education for both Cardiff and Vale of Glamorgan Councils has resulted in further opportunities for engagement with headteachers and schools in order to coordinate the MMR catch-up effort currently underway as per Welsh Health Circular directives.	Health Impact Assessment Stakeholder workshop for Cardiff LDP Deposit Plan - ***May 2024*** Prepare UHB response to consultation on Cardiff Deposit Plan - ***September 2024*** ***July 2024*** - first group of vaccine champion parents trained. ***September 2024*** - widening of model based on the Sandwell experience in the West Midlands ***May 2024*** - Recruitment to joint UHB/Cardiff Council role	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Analytics	**Tom Porter** *Consultant in Public Health Medicine (Local Public Health Team)*	Identification of potential indicators	Potential equity indicators have been identified and shared with the Business Intelligence team. A Digital Service Desk request was sent on 15.04.2024 for development of a Health Equity Indicator dashboard.		***15th April 2024***
	Kerry Ashmore *Head of Business Intelligence (Digital and Health Intelligence)* **David Thomas** *Director of Digital and Health Intelligence* **Dave Price** *Head of Architecture and Analytics*	Development of a Dashboard	Digital Service Desk request for development of a Health Equity Indicator dashboard received from the Public Health team on 15/04/24. Next steps will be for Local Public Health Team representative to work with Digital Services to produce a dashboard.	***December 2024***	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Primary Care	**Sian Griffiths** *Consultant in Public Health Medicine (Local Public Health Team)*	Scope how to identify unmet need e.g. cardiovascular risk	Cluster profiles developed in 2022/23 which informed cluster planning and development and helped identify unmet need, coupled with Population Needs Assessment and Wellbeing Assessments. Public Health Wales (PHW) currently developing a cluster profile tool. Diabetes systems work in progress to strengthen the entire diabetes care pathway following PHW modelling work. Cardiovascular risk assessment currently paused.	***Local work complete*** ***In progress*** ***Paused***	***Q4 2023/24***
	Emma Holmes *Head of Nutrition and Dietetics*	Consider diabetes prevention programme expansion	Cardiff and Vale has rolled out the AWDPP (All Wales Diabetes Prevention Programme) to 5 of the 9 community clusters through short-term mixed funding (awaiting confirmation of South-east cluster funding). Funding is due to end March 2025. Data from participating clusters is being collected and we are contributing to national evaluation through SABU and Public Health Wales. A meeting is to be arranged with PCIC to discuss options of funding at pan-cluster level, but at present no additional funding has been identified.	Report on current clusters at end of each quarter. Meeting to be arranged with wider partners via PCIC to discuss longer term plans. To build into a diabetes programme board as a ***priority for 24-25.***	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Representation	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Understanding current workforce demographics (Workforce Race Equality Standard)	Awaiting further information from HEIW regarding dates and reporting structure for Workforce Race Equality Standards.	***Quarter 2 2024/2025***	
	Jonathan Pritchard *Assistant Director (People Resourcing)*	Proactive community outreach to promote as an employer	A number of initiatives have been implemented to reach out to various groups in the community to promote employment within the UHB. These include: 1. Young adults who have been brought up in care. 2. Those with learning disabilities and/or autism. 3. Minority Ethnic groups. 4. Refugees	This work is ongoing and does not have a completion date	
	Claire Whiles *Assistant Director (Organisational Development, Wellbeing and Culture)*	Listening to understand barriers, challenges and views	Overarching UHB Staff Survey results received February 2024. Further information to be received April 2024 when analysis will be undertaken and Clinical Boards supported in cascade and engagement.	***Quarter 1 2024/2025***	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Mental Health	**Dan Crossland** *Director of Operations (Mental Health Clinical Board)*	Training and self-certification commissioned from Diverse Cymru	There are 20 service areas in the Mental Health Clinical Board undertaking training and self-certification at various stages. As of December 2023, 2 Clinical Board level trainings were completed. We are aiming for submission of the remaining service areas to Diverse Cymru for review by Q1 of 2024-25.	***July 2024***	
	Dan Crossland *Director of Operations (Mental Health Clinical Board)*	Work with Police and Crisis Care Concordat to improve and understand shared ethnicity recording	Police data is far more developed than PARIS reporting, though a 'prompt' screen in PARIS has improved our data set completion significantly.		***October 2023***

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Patient Safety	**Alexandra Scott** *Assistant Director of Quality and Safety (Patient Safety team)*	Understand variation in quality and patient safety reporting	Progress has been made in putting information through the datix system through the data warehouse which will then allow analysis through power BI.	***October 2024***	
		Scope a pilot of variation in Medical Examiner Referrals by postcode	Dicussed with medical examiner but they are not unable to progress. To consider potential to progress within the UHB once power BI analysis of datix information is enabled.	***October 2024***	
		Undertake a baseline assessment of National audit data set to identify measures of inequity	This piece of work has begun and is currently in progress.	***July 2024***	

Next Steps

Work to be undertaken to complete the actions outlined above

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

Quality, Safety and Experience Committee

21st May 2024

Equity, Equality, Experience and Patient Safety Action Plan

Oliver Williams, Specialty Registrar in Public Health

The 3I Framework

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

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

Output- summary of equity and excellence priorities

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

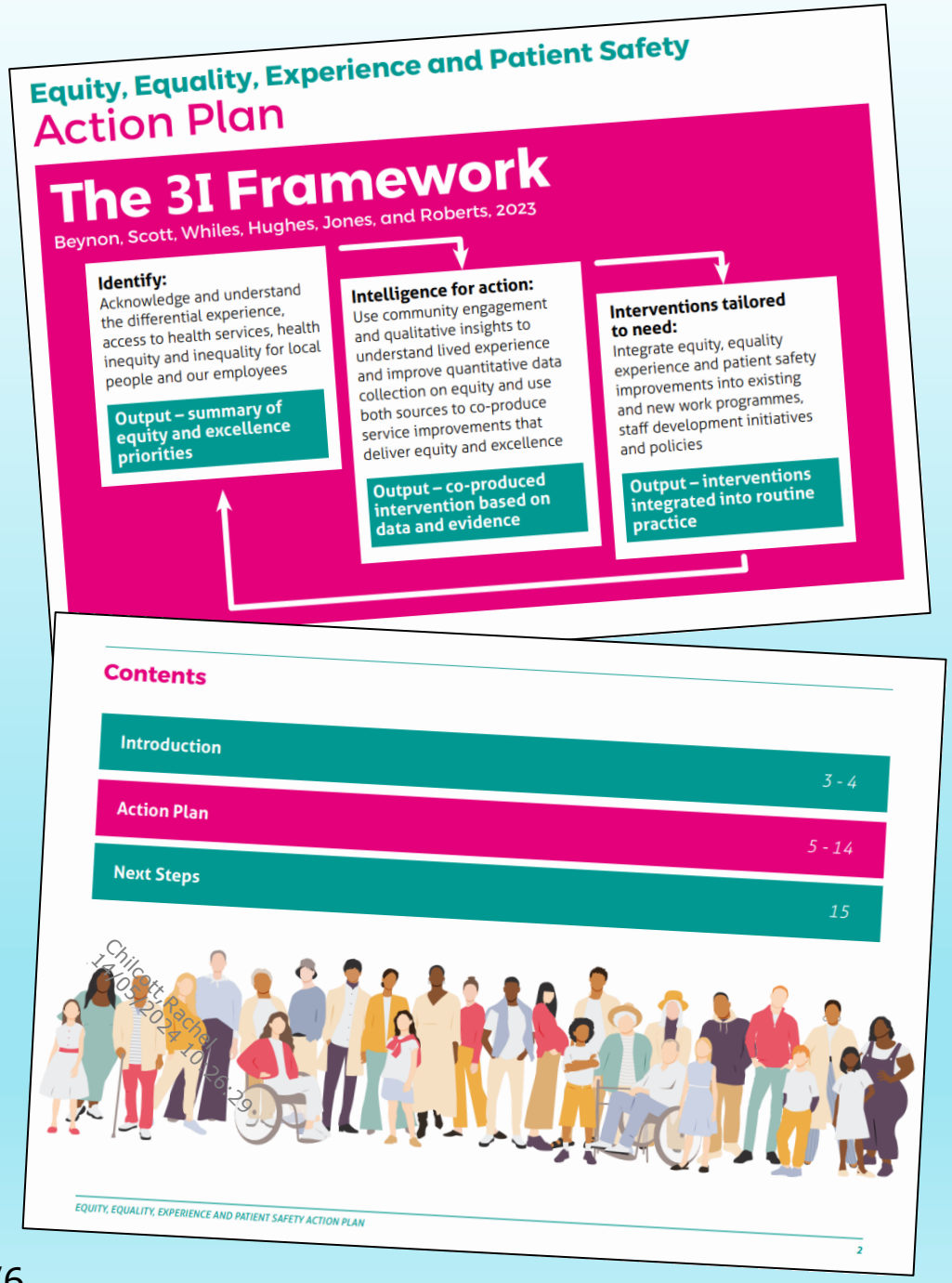
Output- co-produced interventions based on data and evidence

Interventions tailored to need:
Integrate equity, equality experience and patient safety improvements into existing and new work programmes, staff development initiatives and policies

Output- interventions integrated into routine practice

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

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



Action Plan

Equity, Equality, Experience and Patient Safety

Purpose:

The action plan sets out the 24 initial action areas agreed in 2023, providing six month updates, along with target completion dates.

Action areas

- Prevention
- Unscheduled Care
- Planned Care
- Mental Health
- Maternity Care
- Patient Safety
- Analytics
- Representation
- Primary Care
- Equitable Employee Experience

Snapshot

Equity, Equality, Experience and Patient Safety

Going well…	Struggling with…
Maternity services has joined Welsh Government's Diverse Cymru Cultural Competency Scheme for staff education	Data collection
Immunisations engagement events in central Cardiff with Somali and Indian communities	Data availability
Equity indicators identified for development of a dashboard in the UHB	Data linkage
UHB employment promoted at events for refugees, minority ethnic groups, those with learning disabilities, young adults who have been brought up in care	Data analysis
Analysis of staff survey results underway	Long-term funding

Next steps

The Committee is requested to:

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

b) **Acknowledge** the six-month progress that has been made against the actions, including the *challenges around health inequality data availability*.

c) **Agree** to receiving further updates in another six months.

Thank you for listening

Any questions or comments?

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

Held on 15th March 2024 Via MS Teams

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

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 24/081	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 24/082	**Apologies for Absence** The apologies for absence were noted.	
CDTQSE 24/083	**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 16th February 2024 were accepted as an accurate record.	
CDTQSE 24/084	**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 24/056 Pharmacy Nomination for R&D Lead* TB will discuss with RM. *CDTQSE 24/062 HTA Inspection* SG to provide feedback to the Group from the HTA inspection. *CDTQSE 23/323 Booking Lab* SO to provide a demonstration at a future meeting when the system is live. *CDTQSE 24/050 IR Room Replacement Work* AC to provide an update should the replacement work become a risk to the service being provided to Swansea Bay. *CDTQSE 24/056 Stairwell in Pharmacy* Estates require a period of dry weather to fix the issue. This is a UHB priority. *CDTQSE 24/056 Temperature Issues in Academic Building* There are ongoing temperature issues in rooms within the Academic Building. RB to escalate to HL if support is needed in resolving the issues.	**TB/RM** **SG** **SO** **AC** **RB**

	CDTQSE 24/062 Nomination for R&D Lead in Laboratory Medicine SJ to follow up. *CDTQSE 24/074 Review of Catering Services* HR will ensure HN is aware of the review. **The Group resolved that:** a) The update on the actions outstanding from the previous meeting were noted.	**SJ** **HR**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 24/085	**Concerns and Compliments Report** In February 2024, the Clinical Board received 19 concerns in total; 1 formal and 18 early resolution concerns. There was 1 breach against response times and 4 compliments were received. The top 3 reasons for concerns in January related to: • Delays in issuing death certificates • Waiting times • Communication issues • Medication issues HL thanked directorates for their efforts in compiling responses to concerns within the required timeframes. **The Group resolved that:** a) The concerns report was received. The report also provides a breakdown of the individual departments' data.	
CDTQSE 24/086	**National Reportable Incidents** The Clinical Board has 3 open NRIs currently under investigation. ID 44284 relating to a delay in a result has been downgraded to an LRI. An investigation is being undertaken to identify learning and any themes. The other 2 NRIs relate to an ultrasound follow up not being undertaken in a timely manner and a miss on a CT colon from 2015. A further NRI is being reported under Surgery Clinical Board that also requires input from this Clinical Board relating to a fully	

	covered metal stent that should have been removed within a set time period, however the patient was lost in the follow up stage. **The Group resolved that:** a) Findings will be shared with this group when the NRI investigations are concluded.	
CDTQSE 24/087	**New NRIs** **The Group resolved that:** a) There are no new NRIs to report.	
CDTQSE 24/088	**Duty of Candour Cases** A concern was received relating to a miss on a CT scan. The patient has been written to with the response to their concern and also as part of the duty of candour. **The Group resolved that:** a) There are no duty of candour cases to report.	
CDTQSE 24/089	**Health and Care Quality Standards** A link has been circulated relating to duty of quality learning. Duty of Quality learning (sharepoint.com)	
CDTQSE 24/090	**Risk Register Updates** MM has escalated concerns to Estates relating to the ceiling in parts of Lakeside. MM to feedback to HL if no response is received. **The Group resolved that:** a) Risks registers have been received.	
CDTQSE 24/091	**Patient Safety Alerts** A Field Safety Notice received relating to an AGFA digital radiography mobile X-ray system that is booked in for remedial work 18th -19th June relating to an issue with the cable catching into the head of the unit. There is a shortage of Jext auto-injector pens which are out of stock from week commencing 25th March. Health Boards are being advised to dispense an alternative brand which is the Epi Pen. AA noted that a weekly shortages meeting is being held in Pharmacy and at these meetings it is agreed where in the	

	organisation information on national shortages need to be circulated. Information is captured in a Pharmacy newsletter and AA will arrange for this to be sent to HJ. **The Group resolved that:** a) The updates on the Safety Notices received were noted.	**AA**
CDTQSE 24/092	**Medical Device/Equipment Risks** A HIW inspection was undertaken in the Emergency Unit last week. Issues were raised that stickers on medical equipment were out of date. EC noted that the process for safety testing of medical equipment has been changed internally for equipment that is not on a planned maintenance schedule, and the equipment is tested every 3 years which is standard practice internally. This was not communicated widely and this will be corrected and communications will be circulated to advise of this change. It was noted that the final report has not yet been received, however planned actions have been agreed. **The Group resolved that:** a) Comms will be circulated via AMAT to inform staff of the change in process for equipment not on a planned maintenance schedule. b) A list of unobtainable and out of date equipment will be circulated quarterly to the EU and the service will be asked to either make the equipment available or Clinical Engineering will document that they were unable to access it.	
CDTQSE 24/093	**Point of Care Testing** **The Group resolved that:** a) There were no updates to note.	
CDTQSE 24/094	**IP&C/ Decontamination Issues** **I**t was noted that Norovirus cases are increasing across sites. **The Group resolved that:** a) Clinical services were asked to be mindful of the increase in Norovirus cases, particularly on inpatient wards at UHW and UHL.	
CDTQSE 24/095	**Safeguarding Update** A new Senior Nurse has joined the Safeguarding Team.	

	Spaces are available on 25th March for staff to undertake the violence against women/domestic violence training. **The Group resolved that:** a) HL will circulate the link to the training.	**HL**
CDTQSE 24/096	**Health and Safety Issues** A number of departments are raising issues with rain water leaks coming into their departments. **The Group resolved that:** a) The issues have been raised with Estates	
CDTQSE 24/097	**Regulatory Compliance** A recent MHRA inspection was undertaken in Blood Transfusion. The team are currently under pressure as they are preparing for a UKAS assessment, however this was a positive inspection with only 2 findings issued. **The Group resolved that:** a) The minutes of the Regulatory Compliance Group meeting were circulated for information.	
TIMELY		
CDTQSE 24/098	**Initiatives to Improve Access to Services** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/099	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** BJ noted that a lot of work has been undertaken in Radiology to reduce their waiting times and backlogs , particularly with the opening of the diagnostics hub at UHL and the Cardiac outsourcing to St Josephs. Dietetics have received additional support to reduce their breaches in response times and a plan is in place going forward to improve the waiting times position. In terms of cancer performance and the 14 days turnaround times for MR and CT, CT is achieving 94% and MR 70%. **The Group resolved that:** a) The waiting list performance metrics for March are not yet released.	

EFFECTIVE		
CDTQSE 24/100	**Feedback from UHB QSE Committee** The minutes of the meeting held on 5th March 2024 are not yet available. **The group resolved that:** a) CD&T Clinical Board will be presenting to the UHB Committee in July. b) HL will request for information from directorates to feed into the annual report to the QSE Committee	
CDTQSE 24/101	**NICE Guidance** **The Group resolved that:** a) There was no new guidance to share.	
CDTQSE 24/102	**Research and Development** RM is seeking volunteers for speakers at the next R&D forum. **The Group resolved that:** a) Any nominations to be submitted to RM.	
CDTQSE 24/103	**Service Improvement Initiatives** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/104	**Information Governance/Data Quality** **The Group resolved that:** a) There was no update to report.	
CDTQSE 24/105	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** EC had provided feedback on the HIW inspection in EU earlier in the meeting. **The Group resolved that:** a) The UHB is awaiting the final report.	
CDTQSE 24/106	**Policies and Procedures** **The Group resolved that:** a) There were no policies or procedures to be received.	

EFFICIENT		
CDTQSE 24/107	**Exception Reports from Directorates** Exception reports were received from Radiology and Medical Illustration. **The Group resolved that:** a) A reminder was issued to directorates to either share their QSE Group minutes or submit exception reports.	
CDTQSE 24/108	**Clinical/Internal Audits** Pippa Johnson, Mental Capacity Act Specialist Practitioner, was in attendance to feedback on the scoping audit undertaken to explore the current level of MCA practice within the UHB. The audit results will be used to inform the workplan of the newly formed MCA team. The audit involved 25 inpatients and 144 staff members across sites through a combination of face to face visits and a Microsoft Forms questionnaire. 92 sets of medical records were reviewed along with Paris records for mental health directorate inpatient stays. The overall results of the audit identified that there is much improvement needed across the UHB. The questionnaire results were broken down by staff group and for this Clinical Board meeting, the therapies staff results were presented. The results indicated that only 1 in 3 staff had recently carried out a capacity assessment. Nurses, healthcare support workers and other allied health professionals commented that they either had not completed a capacity assessment recently or it was not a task they completed as part of their practice. In terms of the overall UHB results, feedback indicated that more guidance was needed on completing the MCA assessment form, more space was required for writing up information and digital integration would be of benefit. A key theme that was prevalent was that there is a view from staff that the capacity assessment is a medic's responsibility. In terms of the results relating to records, issues were raised around the need to improve the quality of assessments undertaken to reflect the documentation standards set out in the Code of Practice. Where LPA and ADRTs are in place, that these powers are respected. In response to the results, the team has developed an MCA training strategy and the monthly foundation training package has been updated focusing on theoretical knowledge of the legislation. A 7-minute briefing has been produced introducing the new team, the 5 key principles of the Act and signposting to	

	the other training available. In addition, a new specialist training package has been developed focusing on practical skills. A new MCA SharePoint page has been created containing training information, links to adjacent teams and access to forms and useful resources. An MCA Policy has been drafted which is due for consultation. A Focus Group is being created within the UHB to review the proforma and forms. An MCA Mentor/supervision structure is being developed. There are plans to implement partnership working with the Local Authority around the DoLs process. PJ noted that whilst there no figures available for benchmarking purposes with other Health Boards, discussions between Health Boards indicate that the same themes and issues are raised across NHS Wales. The lack of a digital solution to the paper form has been raised as a particular issue. HL asked if there is any bespoke training that could be provided to a group of staff such as Therapies. PJ noted that she can attend meetings in terms of providing a Q&A session and provide advice to specific queries. **The Group resolved that:** a) PJ will circulate the slides from the presentation to the group.	**PJ**
CDTQSE 24/109	**Waste and Sustainability** The next CD&T Green Group is being held next week. The area of focus this month is on reducing the use of single use plastics/items. The UHB has developed monthly sustainability pledges for staff to sign up to and March will also focus on reducing the use of single use plastic. **The Group resolved that:** a) Feedback from the Green Group will be shared at the next meeting.	
EQUITABLE		
CDTQSE 24/110	**Feedback from Clinical Board Inclusion Ambassadors Group** **The Group resolved that:**	

	a) There were no updates to report.	
CDTQSE 24/111	**Equality and Diversity Issues** There were no updates to report. **The Group resolved that:** a) The Speech and Language Therapy will be presenting on the equality, diversity and inclusion work that they have undertaken at the meeting in June.	
PERSON CENTRED		
CDTQSE 24/112	**Patient Story** There was no patient story presented at today's meeting. **The Group resolved that:** a) A new scheduled for directorates to present patient stories to this group will be produced and circulated.	**HJ**
24/113	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** **The Group resolved that:** a) There were no new initiatives to report.	
CDTQSE 24/114	**Any Initiatives Relating to the Promotion of Dignity** Radiology have produced an SOP on chaperoning in Ultrasound. **The Group resolved that:** a) HL to ask JF to present at a future meeting.	**HL**
CDTQSE 24/115	**National User Experience Framework/Feedback from Patient and Service User Surveys** There was no feedback from surveys to report. **The Group resolved that:** a) Civica information from March will be shared when it is available.	
CDTQSE 24/116	**Staff Awards and Recognition** The Clinical Board Monthly Staff Recognition Scheme is continuing in 2024. The category for March is the 'Making it Better' Award.	

	The Group resolved that: a) Nominations are to be submitted by the deadline for the end of March.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 24/117	Regulatory Compliance Minutes Medical Illustration Exception Report	
ANY OTHER BUSINESS		
CDTQSE 24/118	A survey is being circulated to obtain healthcare professionals' views on HIV. HL will circulate the QR code. The AHP and Health Science Conference was held this week. Useful resources including the brochure from the day will be made available on a SharePoint site.	**HL**
CDTQSE 24/119	**Date & time of next Meeting** 18th April at 2pm 2024 via Teams	

Minutes of the Medicine Clinical Board Quality, Safety & Experience Committee Meeting Held on 20 March 2024 14:00 – 15:30, Via MS Teams

Present:	
Alun Tomkinson	Clinical Board Director
Katja Empson	Consultant/ Deputy Clinical Board Director
Jane Murphy	Director of Nursing (joint Chair)
Barbara Davies	Deputy Director of Nursing (joint Chair)
Sian Rowlands	Head of Quality and Clinical Governance
Kath Prosser	Quality & Governance Lead, Medicine
Dharmaraj Durai	Consultant Gastroenterologist, Specialised Medicine
Marianne Jenkins	Consultant Nurse Practitioner, Emergency Medicine
Ceri Richards-Taylor	Lead Nurse, Integrated Medicine
Dave Pitchforth	Lead Nurse, Specialised Medicine
Wayne Parsons	Lead Nurse, Integrated Medicine
Catherine Evans	Interim Deputy Head of Patient Safety, Patient Safety Team
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Liz Vaughan	Professional & Practice Development Nurse
Harriet Foley	Senior Nurse, Integrated Medicine
Derek King	Clinical Nurse Specialist, Infection, Prevention and Control
Natasha Whysall	Senior Nurse, Specialised Medicine
Nicholas Denny	Organisational Learning Facilitator - Mortality Lead
Nathan Williams	Endoscopy Service Manager, Specialised Medicine
Andrew Brown	Ward Manager, A7
Sarah Cornes-Payne	Senior Nurse, Diabetes, Integrated Medicine
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Louise Platt	Director of Operations
Lyndsey MacDonald	Consultant, Emergency Medicine
Hannah Mastafa	Deputy Director of Operations
Ceri Martin	Lead Nurse, Acute & Emergency Medicine
Angela Jones	Senior Nurse, Resuscitation Service
Dave Mcrae	Lead Pharmacist, Medicine
Sian Brookes	Senior Nurse, Integrated Medicine
Beth Jones	Senior Nurse, Specialised Medicine
Aneurin Buttress	Consultant, Integrated Medicine

Item No	1. Standing Items	Action
MCBQSE/ 2024/0018	**Welcome & Introductions** – were undertaken. **Declarations of interest** – none raised.	
MCBQSE/ 2024/0019	**To receive the minutes of the previous meeting held on 18/1/24** The group resolved: the minutes were agreed and accepted.	
MCBQSE/ 2024/0020	Action Log –SR and BD will review the action log prior to the next meeting.	Sian Rowlands & Barbara Davies
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2024/0021	**Patient Story** – presented by Andrew Brown, A7, Specialised Medicine An 18-year-old girl (X) with severe Anorexia Nervosa, had been in various mental health units and specialist eating disorder units over the past few years, however, had she failed to gain weight and became physically unwell and weighed approximately 4 stone on being admitted for NG feeding. X did not want to be fed.	

	Staff had not had a lot of experience of dealing with patients with Anorexia Nervosa. X had to be NG fed against her will with restraints which was unnerving for staff. X was nursed with a 1:4 nurse ratio at all times and was monitored 24/7 by a specialist team. The Eating Disorder Team primarily took the lead in her care; however, they were not based at UHW. X was under the Psychiatric Team for her mental health needs and was under the UHW medical team for her Gastroenterology issues. Taking routine observations was very time consuming for staff who had to 'talk X into' having them done. Initially there was a lot of staff anxiety, NG tube insertions proved challenging and X removed 7 out of 8 tubes daily, which needed re-inserting. X was a chronic exerciser and found ways to exercise. The Eating Disorder Team asked the A7 team to limit the amount of exercise that X undertook. Staff developed a very good rapport with X. Twice weekly MDT's took place. Support sessions from the health team were run for staff. The patient's parents were very concerned and were sometimes intense, wanting regular updates. The patient is now in a specialist eating disorder unit in England as there are currently none in Wales. There is no clear pathway for eating disorders in place. Jason Roberts is leading on this at present. During X's stay on A7, support was provided to staff by: Rachel Rushforth - who ran wellbeing sessions. Wellbeing Service - came to the ward a couple of times and made themselves available to staff at drop in sessions as required. Jackie, Wellbeing link on the ward - had a series of different contacts as required for staff. The group resolved: Thanks, were given to the A7 team, Dave Pitchforth and Natasha Whysall who looked after the patient, their work was outstanding and the team responded well to the challenge and the patient gained weight. **Actions from discussion**: none.	
MCBQSE/ 2024/0022	**Concerns, Claims, Compliments** **Pressure Damage** – For information when presenting healthcare acquired avoidable pressure damage to redress, a lot of findings and learning are identified as the same such as incorrect mattress selection. Whilst under Duty of Candour an apology is given under Regulation 33 there is a risk where financial redress is identified Welsh Risk Pool could pick up on the regular themes. Currently significant educational work being undertaken by Practice Development Nurses and Tissue Viability Teams to improve staff knowledge and education for pressure damage prevention and treatment. **Compliment, Ward B7 – Integrated Medicine** 'I wanted to thank you for your care of Mum over the last few weeks. She really did cling on for a long time, but when she finally died she was peaceful and comfortable. I know how challenging looking after medical relatives can be and your team were caring and compassionate with us. Please pass on my thanks to Dr Pink and to all of your team and staff on B7 who all work incredibly hard'. The group resolved: keep noting compliments and share with teams. **Actions from discussion:** none.	

MCBQSE/ 2024/0023	**Infection Prevention and Control update:**
	54 days since last MRSA bacteraemia (SDH Glan Ely)
	31 days since last MSSA bacteraemia (UHW A1N)
	9 days since last *C difficile (UHL E2)*
	6 days since last E. *Coli* bacteraemia (UHW A7)
	183 days since last Pseudomonas bacteraemia (UHW A7)
	20 days since last Klebsiella bacteraemia (UHW LSGF1)
	
	• There are 2 outbreaks within the MCB, affecting 13 patients, 1 staff member, resulting in 39 bed days lost.
	• DMT scores – All wards within MCB remain compliant for the last 4-week period.
	• HCAI reduction goals – there were no new cases of C. difficile, MRSA and Pseudomonas in February 2024.
	• MCB position based on same period 2022-2023:
	  ○ 3% (+1) increase with *C. difficile.*
	  ○ 21% (+11) increase with *E. coli.*	

	○ 33% reduction with *Pseudomonas.* ○ 29% reduction with SAUR Bacteraemias. ○ 33% reduction has been seen *with Klebsiella* ○ 14 less bacteraemia's which represents a significant improvement to patients journey and outcomes. ○ 60% of E.coli bacteraemia's were as a result of UTI, 12% CAUTI. Need to increase catheter care awareness, implementation of urinary catheter bundles, hydration. • There are 5 outstanding RCA's. • The recent CPO audit was poor. DK has sent posters to all areas at UHW (UHL to follow), requesting the issues are highlighted at safety briefings. • Overall audit results have improved. • IP&C follow up meeting held for C7 secondary to recurring Norovirus and Covid-19 infection outbreaks. Issues with Housekeeping have been resolved. IP&C standards noted to have significantly improved. • DK has carried out formal teaching regarding back to basics and good attendance. • Covid and Flu are at a low level in the community. The group resolved: to note the above. **Actions from discussion**: Action 1: DK will share the current IP&C report. Action: JM, DK, CM and team to meet to discuss managing IP&C in an assessment type unit.	Derek King Jane Murphy Derek King Ceri Martin
MCBQSE/ 2024/0024	**Safeguarding** In February 24 Phase 1 of the NHS Right Care, Right Person was introduced which has a tool kit provided by South Wales Police and gives an overview of what different organisations should be doing. Currently, Police are called to many mental health calls where the Police may not be the most appropriate agency to respond. If there is a threat to life, the Police should be involved immediately, using the procedure in place at present. Phase 1 – introduced in February 2024. Concerns about patient's welfare. Phase 2 – this will be rolled out in four to six months-time. Absent without leave (AWOL) from a mental health establishment or a relevant facility, housing custody, or healthcare premises. The toolkit shares actions that should be carried out before contacting the Police. Two further phases will then follow. **Safeguarding Committee in C&VUHB** - meets every 6 weeks. The expectation going forward is that MCB present a paper to Jason and Linda. MCB will then be called to Board to present the Safeguarding paper regarding MCB performance. **Safeguarding Newsletter** – will be circulated. A new Senior Nurse, Fiona Bullock, commenced in Safeguarding from 4/3/24. **Safeguarding supervision** – takes place at Woodlands House in a group setting. Dates for April and May 24 have been circulated. **MCB Safeguarding cases** – there are currently quite a few open which JM is working through. The Safeguarding Team have been unable to close as many cases as hoped. The group resolved: to read the NHS Right Care, Right Person policy. **Actions from discussion** – all to read.	
MCBQSE/ 2024/0025	**Mandatory Training** - violence against women, domestic abuse, sexual violence Ask and Act Training is now mandatory. JM will circulate information on this. The group resolved: to note the above. **Actions from discussion** – all to advise teams that this training is now mandatory.	ALL
MCBQSE/ 2024/0026	**Llais Visit to St Davids, Lansdowne Ward on 25/10/23** - an action plan has been prepared from the provisional findings. The summary of the visit showed 3 positive and 17 negative findings. The Inspection Team were very happy with staff, however, they felt staff were shadowing them and following them around. Main points for improvement were signage on and off the ward; lift issues; communication styles of staff; assistance with washing and food.	

	Staff have since carried out an IP&C audit which showed 100% for hygiene; 90% for equipment and 100% on mattresses. Clutter on the ward has been dealt with. A full sickness review has been carried out. The letter from Llais with recommendations was received in February 2024, therefore, the improvement plan was developed from provisional findings. A walkaround with the improvement plan has taken place. It would be good to share the learning regarding themes from various inspections to highlight key areas to look at. The group resolved: thanks, were given to the team for their work. **Actions from discussion** – none.	
MCBQSE/ 2024/0027	**HIW Visit to Emergency Unit on 4/3/24 at approx. 8pm Inspection finished 6/3/24.** This was a thorough inspection. The Inspection Team wanted to inspect the Emergency Unit (EU)and the Assessment Unit, however, as the footprint has now changed, only EU was inspected. Areas of concern highlighted as below: - Fridge in Majors. - Fluids. - Concern around equipment. Even though a robust system was in place, some equipment had out of date inspection stickers. - Notes were not always legible and signed. - An onboarding audit to be carried out. - Poor ventilation in the male staff changing room. - Impressed with the use of QR codes; notice boards were informative; very happy with the Red Cross. Very impressed with the work done by Jenna in collaboration with the team – retaining agency staff, have a good recruitment process in place. The inspectors acknowledged how busy the EU was when they arrived, however, noted how calm and professional the teams were. The full report will be received in 12 weeks. The group resolved: very pleased with the visit. **Action from discussion** – JM will share the slides shown in the meeting and is happy for staff to share these with their teams.	Jane Murphy
3. ITEMS FOR APPROVAL/ RATIFICATION		
MCBQSE/ 2024/0028	**National Reportable Incidents (NRIs)**, updates and closures: 3.1a MCB NRI Position – there are 19 open NRI's, 12 have breached Delivery Unit time for submission. Some are complex and it is challenging for staff to work on NRI's along with operational pressures. Integrated Medicine have 3 (all have breached) Specialised Medicine have 9 (6 have breached and 3 have gone for closure today) Acute & Emergency Medicine 7 (3 have breached). Patient Safety Learning Review Training is being held monthly at UHW, UHL and on-line. Patient Safety info has been updated on SharePoint. 3.1b NRIs for closure: **Emergency and Acute Medicine – presented by Marianne Jenkins (MJ)** **ID30345** – MO carried out the investigation into the death of a 20-month-old child in Paediatrics in 2023. The patient had been vomiting, had seen his GP and presented to the EU later that day. The patient had a period of observation and was then discharged in the early hours of the morning. The patient deteriorated at home and was found unresponsive and despite best efforts, was pronounced dead at home and brought to the EU for a Prudic assessment. **Observations** – it was unclear if these were accurate and unsure if they were taken by someone skilled to take paediatric observations. The patient was in the department for 5 to 5.5 hours. The patient was triaged and had been assigned as category two, which meant he should have been seen within 15 minutes. A second set of observations were carried out by an Adult Health Care Support Worker, who had not appreciated the heart rate she noted as 54 was abnormal in paediatrics. It was concluded the discharge was not safe. There was no indication of the child's hydration status prior to discharge.	

	The family asked if their child had stayed in the department would the outcome be different. MO advised if their child had stayed in hospital any deterioration would have been dealt with promptly. **Learning** – now preparing for Coroner's Court. A pre-court meeting has taken place. MO added a pdf version of the presentation into the meeting chat for further reading. **ID31066** – - presented by Katja Empson (KE) A 74-year-old lady had come into the department and had previously attended EU and had chest X-rays on two separate occasions. There was a failure to follow up on the findings of the X-rays, leading to a delay in the patient having a CT scan. There was a delay in recognising this patient had lung cancer and a delay in the intervention and management of the condition. The patient is now on a palliative care programme. **Summary** – Radiology report on chest X-rays can take up to 3 to 4 weeks after the X-ray has taken place to be formally reported. Often the patient has left the Department. Ownership of the patient and their results is then unclear. There was not a satisfactory process in place to ensure the X-ray was reviewed by the clinicians and appropriate action carried out and followed up. Radiology's perspective on this is the responsibility for formal review of the report sits with the clinician who should then act in a timely manner. Radiology do not currently have a good system in place to safety net and support the actioning of critical findings. **Learning** – some clear and specific actions for Acute Medicine. There are now additional clinicians who require administrative support to follow up on patients. There is still some work to be done, however, ideas and plans are in place to improve the process. Additional services are in place via a Cancer Support Team and will now be followed up by the Team who will chase up, ensuring a safety net is in place. On Welsh Clinical Portal there is now a red dot which appears against a person's name if they have had an investigation with a time critical finding. Further plans are in place with Acute Medicine. An improvement plan is in place regarding this investigation. Clear lines of communication between clinicians and the Radiology Department reporting on scan results is required. If a clinician has not reviewed a report, it will 'fall off' the clinician's electronic notification system after 30 days. Therefore, unless reports are signed off on a weekly basis, or if a clinician is away for four weeks, the notification will be missed and this is a significant problem. Radiology could directly refer to a cancer MDT which is a generic place to send this, however, not all Radiologists are comfortable with referring patients. Continued conversations need to take place regarding this to look at processes and systems and then take the findings to Radiology. The following five NRI's relate to pressure damage: Emergency and Acute Medicine: ID44890 Integrated Medicine: ID43855; ID46251; ID26400; ID52836 The main themes are mattress selection. Regular teaching has been available. Regarding the pressure damage on OPSU, discussions are ongoing with Lisa, Cerys and the Education Team to amend the PART A booklet to include more than one Purpose T Risk Assessment. The group resolved: to note the above. **Actions from discussion:** none.	
4. ITEMS FOR NOTING AND INFORMATION		
MCBQSE/ 20240029	**Patient Safety Alerts/MDAs/ISNs:** 4.1a PSN0206 Positive Patient Identification – to be promoted and shared widely. 4.1b pH Strips Oracle ordering guide 4.1c Safety Memo – VR111 Fluids Jan 2024 4.1d Tramadol and Warfarin Safety Memo 4.1e PSD for use of Lidocaine 1% and Adrenaline 1:200,000units Dermatology 4.1f Safety Memo – Tresiba FlexTouch Feb 2024 The group resolved: to note the above and share as appropriate. **Action from discussion**: none.	

MCBQSE/ 2024/0030	**Falls Delivery Group update** – all to read the Falls Delivery Group Terms of Reference. **Decision on Movement Sensors** – ensure the information is circulated widely. Patients should no longer be nursed on sensor mats. If sensor mats are required a robust risk assessment should take place. The group resolved: to note the above. **Actions from discussion:** none.	
MCBQSE/ 2024/0031	**Medicines Management** 4.2a Medicines related Datix quarterly queues. 4.2b Medicines Safety Briefing for Healthcare staff. 4.2c Non-CDs managing lack of medicines in Community hospitals. The group resolved: to note the above. **Action from discussion:** see above.	
MCBQSE/ 2024/0032	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions, for noting:** 4.3a IP&C meeting (December 2023) minutes currently not available 4.3b H&S meeting (06.12.23) 4.3c Medicines Access and Governance Group (16.02.24) The group resolved: to note the above. **Action from discussion:** none.	
5**. ANY OTHER BUSINESS**		
MCBQSE/ 2024/0033	5.1a Tissue Viability Pro Mattress Check – for information. 5.1b Bed and Mattress Movement Guidelines – for information. 5.1c Chronic Non-Malignant Pain – following an Ombudsman review of a concern of the lack of chronic pain management of a patient who had an extended length of stay in hospital. All to read the Chronic-non-malignant pain info. 5.1d Equality Inclusion Calendar 2024 – for information. The group resolved: all to read for information and share as required. **Action from discussion**: KP to carry over to the next meeting the following 'Risk of delayed follow up for patients diagnosed with a PE'- Dr Buttress to update.	Kath Prosser
7. DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2024/0034	17/4/24, 14:00 – 15:30 via MS Teams	

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

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
HELD AT 11 AM ON 12TH MARCH, 2024, 11 AM
Venue: MS TEAMS

Attendees	
Anna Llewellin	Director of Nursing (Chair)
Anna Mogie (AM)	Deputy Director of Nursing (Chair)
Sarah Griffiths (SG)	Head of Primary Care
Helen Donovan (HD)	Locality Lead Nurse, North & West Locality
Neil Morgan (NM)	Vale Locality Manager
Kate Roberts (KR)	Vale Interim Lead Nurse
Carol Preece (CP)	Lead Nurse, South and East Locality
Brooke Clark (BC)	Vale Triage Nurse
Clare Clement (CC)	Head of Medicines Management
Kate Morris (KM)	Medicines Management – Primary Care Pharmacist – Team Lead for Clinical and Governance Workstream
Rachel Armitage (RA)	Quality and Safety Manager
Lorna McCourt (LMc)	Staff Side Trade Union Representative
Helen Earland (HE)	Clinical Operational Lead, GP Out of Hours
Andrea Rich (AR)	Lead Nurse, Palliative Care
Ellen Davies (ED)	Clinical Nurse Specialist in Infection Prevention & Control
Victoria Whitchurch (VW)	Head of Operations, Mass Imms
Theresa Blackwell (TB)	PCIC Business Manager
Ruth Cann (RC)	Consultant Nurse Older Vulnerable Adults
Jessica Pinfold (JP)	Professional Practice Development Nurse
Maria Dyban (MD)	Community Director Health Care Pathways
Pippa Johnson (PG)	Mental Capacity Specialist Practitioner

Louise Thomas (LTh) (minutes)	Quality & Safety Officer

Apologies	
Lisa Dunsford (LD)	Director of Operations
Clare Evans (CE)	Assistant Director Primary Care
Jane Brown (JB)	Head of Dental and Optometry
Helen Kemp (HK)	Deputy Clinical Board Director
Lisa Waters (LW)	Senior Nurse for Quality and Education
Lynne Topham (LTop)	Locality Manager, South and East Locality
Rebecca Gill (RG)	Senior Nurse, Primary Care
Janice Aspinall (JA)	Health and Safety Representative
Justine Cosby (JC)	Head of Healthcare, HMP
Sian Griffiths (SGr)	Public Health Wales representative
Matthew McCarthy (MMc)	Interim Head of Safety, Quality and Organisational Learning
Melanie Bostock (MB)	Consent Lead Manager
Georgina Davis (GD)	Safeguarding Nurse
Laura Mackenzie (LM)	Clinical Director for Primary Care Improvement
Angela Jones (AJ)	Senior Nurse Resuscitation

ITEM NO.	**TITLE**	**ACTION**
03/24/01	AL welcomed everyone to the meeting.	
03/24/02	Apologies of absence were noted as above.	
03/24/03	No declarations of interest were raised.	
03/24/04	<u>Minutes</u> The minutes of the meeting held on 16th January, 2024 were accepted as accurate. There were no other matters arising. AL pointed out that representation from each Business Unit is essential, noting that auditors will be looking at individual business reports.	

03/24/05	Action Log Please refer to item 5.	
03/24/06	Patient story (Community Pharmacy) CC presented a Community Pharmacy patient story. She explained that a patient had a 10 am appointment booked with a Community Pharmacy as she was unable to secure an appointment with her GP. The lady arrived ten minutes early and appeared to be well. When her appointment commenced, her speech was slurred and the Pharmacist was unable to ascertain her name or date of birth. The Pharmacist contacted the patient's family by utilising the face recognition technology on the patient's mobile phone. An ambulance was called but there was a six hour wait. By this time, the patient had lost use of one side of her body. The patient's elderly mother and nephew arrived at the Pharmacy and decided to put their relative in the nephew's car to transfer to hospital, but were unable to do so. Fortunately, a stranger with a seven seater car drove past at the time and offered to take the patient to hospital. The Pharmacy was not equipped to transfer the incapacitated patient to the vehicle who was carried by her legs and shoulders. The patient's sister returned to the Pharmacy two weeks later to thank the staff for all of their wonderful efforts and help given to her sibling who remained in ICU with a diagnosis of bacterial meningitis. The patient has since fully recovered. Independent contractors were not previously eligible for the Health Heroes Award; HK successfully challenged this and the Pharmacist was presented with the award in recognition of her efforts. Independent contractors can now be nominated for the Heath Heroes Award each month. It was noted that the Prescriber was the only trained Prescriber on site at the time of the incident, and appointments were fully booked that day. There was no recovery time for the shaken up staff before they resumed work after witnessing such a stressful situation. A Datix was raised following on from the incident. CC noted that the GP practice had reported there were 78 GP appointments available on the morning of the incident and no patients were redirected to Pharmacy. It was suggested that there could have been miscommunication between the GP practice and the patient. Any patient providing concerning information would not have been signposted to Pharmacy. CC was not aware of any WAST feedback at the time. HE will make enquiries with WAST regarding the incident. KR pointed out that indemnity and manual handling issues, etc should be made clear to staff who find themselves involved in such incidents, and suggested this is included in the escalation process. A separate meeting will be held in order to discuss learning and to understand what is expected of staff.	HE AL
03/24/07	Risk Register Update RA noted the significant change of risk register versions. Two more risks are to be added to the register (keto monitoring and PARIS shelf life/maintenance cost pressure) before sending to SMT.	
03/24/08	Business Continuity The position remains unchanged since January's meeting. The reporting alignment will change and reporting arrangements will be formalised.	
03/24/09	PCIC Quality Report	

	There are 458 open Datix incidents, 348 of which are new incidents. 17 incidents have been open since 2022. No incidents have been closed without using the Yorkshire Contributory Factors. All District Nursing teams continue to report at levels 3 and 4 with challenging sickness levels contributing to this. Three cases under the Putting Things Right process have been closed, five informal early resolution cases have been actioned and twenty cases have been logged on PALS. There are three active independent practitioner governance cases within GMS, one in dental and one in optometry. Three Duty of Candour reports have been raised since April and a further one is pending, all of which are due to pressure damage. The Senior Nurse is working with the Patient Safety team to develop a communication process between patients and relatives. Eight lovely compliments were received. IRMER report for ID 36933 has been included with the meeting papers. RA explained that the report is in relation to a patient with an incorrect radiological investigation whereby the GP accepted responsibility due to the way in which referrals were managed that day. The incident was attributed to human error. NRI ID 11088 is included with the papers for noting.	
03/24/10	<u>Quality and Safety audit feedback</u> Pippa Johnson, Mental Capacity Specialist Practitioner shared the Mental Capacity Audit that was carried out last summer. The audit looked at patients with impaired capacity who needed to be considered under the Mental Capacity Act when making a decision regarding their health care. PJ explained that the Mental Capacity Act was put in place 17 years ago in order to protect people with impaired decision making from harm, and to support people when making decisions. The Health Board has employed a new Mental Capacity Team with Melanie Bostock employed into the role of Consent Lead, Chloe Evans and Judith Hill are the Mental Capacity Leads along with two Mental Capacity Specialist Practitioners. When conducting the audit, the team spoke with staff, 25 patients, issued questionnaires and reviewed inpatients' medical records and mental health digital records. Leaflets are being developed in relation to common myths surrounding next of kin versus power of attorney, as highlighted by the audit. A training strategy has been developed in response to the survey findings. The staff questionnaire revealed that all staff were aware of the Mental Capacity Act, 82% of whom felt confident that they knew of the five key principles. One in five staff recently completed the Mental Capacity assessment as part of their practice and the large majority of staff had heard of the LPA (Lasting Power of Attorney) and knew when it became applicable. Just 4 out of 144 staff had positive comments about the existing Mental Capacity Act proforma. Less than 1 in 5 records contained evidence that thought was given or practical support was provided to help a person make a decision. There were 5 cases where a person's inability to make a decision was documented but the	

	assessment did not go on to take place, and just 6 out of 92 records reviewed reflected documentation standards in the Mental Capacity Act code of practice. A Mental Capacity Act policy has been written for the Health Board and is under review and a Mental Capacity Act Focus Group is being initialised. The 'Practical Application of the MCA: How to assess and support decision making' training package has been developed, training dates have been arranged and two new competency recourses are available. A training strategy has been developed in response to the survey findings. Monthly Mental Capacity Act training has been updated, a new training package focusses on practical skills and a new SharePoint page has been created. MD noted that the pathway on the Mental Capacity Act could be used as part of CPD and agreed that the CPET team will advertise the training. AL thanked PJ for her presentation to the group.	
03/24/11	<u>IPC update</u> ED reported that the CDiff reduction expectation had not been met although a 49% reduction was seen compared to this time last year. MD noted that a CDiff Health Pathway has been created and was presented at a recent conference. There has been a 73% increase of MSSA bacteraemia cases compared to the same period in 2022/2023; it was noted that 40% of the MSSA bacteraemia cases within South and East locality are from known people who inject drugs (PWID), this is compared with 8% in North and West locality, and 8% in the Vale locality cases. ED explained that she was not aware of dental antibiotic prescribing; CC encouraged ED to link in with her team who have been working closely with dental advisors, analysing prescribing data. The RCA rate is 71%, compared to 47% this time last year. The South and East completion rate is running at 100%, North and West is 50% and the Vale completion rate is 57%. There have been queries regarding the appropriateness of Clinell wipes and hand hygiene. ED emphasised that they are appropriate for this purpose and new packs will state so on the packaging. There is an IPC study date on 24th April, 2024. ED will circulate future dates to CC and KR so that they can present on their areas.	ED
03/24/12	<u>POCT within PCIC</u> This item will be deferred to the next meeting due to absence of the representative.	LTh
03/24/13	<u>Safeguarding</u> Please refer to item 13 in GD's absence.	
03/24/14	<u>Patient Group Directions (PGDs) Health Board Policy</u> The PGD policy has been approved by the Corporate Medicines Management Group and is ready to be promoted in PCIC. Business Units will set up a PGD working group which will consist of a doctor or dentist, pharmacist or other health care professional who will be utilising the PGD.	

	It was suggested that PGDs are brought to the QSE meeting for ratification before being uploaded onto the PGD database. KM added SharePoint links in the meeting chat bar.	
03/24/15	<u>Resuscitation Trolley Checklist</u> Please note item 15.	
03/24/16	<u>CPET and Health Pathways</u> Please note item 16.	
03/24/17	<u>Dementia programme</u> This item was deferred to the next meeting and will be placed at the top of the agenda. RC will share her slides with the group.	LTh RC
03/24/18	<u>Patient Participation Group (PPG)</u> Please refer to the link embedded in the agenda.	
03/24/19	<u>GPN video link – A day in the life of a general practice nurse.</u> AL recommended viewing the link embedded in the agenda and noted that it would be beneficial to produce similar videos for other PCIC roles. The group was informed that the Chief Nursing Officer is planning an engagement event with practice nurses.	
03/24/20.1-20.8	<u>Business Unit reports</u> Please refer to items 20.1 – 20.8. Item 20.4 (S&E Locality & HMP Business Report was outstanding) – LTop/CP to send to LTho. AL asked the group to consider how they would like to see the agenda managed. AL and AM will discuss how to streamline.	LTop/CP AL/AM
03/24/28	<u>Any Other Business</u> There was no other business.	
PART 2	Please note the papers submitted for information.	
Date and time of next meeting: Tuesday 14th May, 2024 at 11.00 am.		

WHSSC Joint Committee
23 April 2024
Agenda Item: 3.1.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Carolyn Donoghue**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**19 February 2024**

Summary of key matters considered by the Committee and any related decisions made

1.0 MENTAL HEALTH UPDATE (INCLUDING NEUROPSYCHIATRY PATIENT SOTRY)

Members received a comprehensive presentation and an update on developments within Mental Health. The presentation delivered by David Roberts (DR) provided updates on the following key areas;

- Mental Health Strategy
- Secure Services
- CAMHS
- Eating Disorders
- Mother & Baby Unit (MBU)
- Neuropsychiatry

The Interim Business Manager for the Wales Neuropsychiatry Service provided members with a presentation containing an outline of the Neuropsychiatry service in Wales and it was noted that the sustainability of the service was highlighted as a risk on the CRAF.

Members received an informative patient story about a gentleman who had sustained a serious brain injury at the age of 59 and how a technique called "Rich Pictures" was used to obtain his thoughts and feedback. Members noted the challenges that the patient faced at the outset and how the Neuropsychiatry service helped the patient and his family to obtain much needed support. The patient story highlighted the positive impact that the Neuropsychiatry services had made to the patient's quality of life.

2.0 WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales. Some queries were raised on the new WKN risks which included Interventional Radiology and the Financial risk and growth within the Integrated Commissioning Plan (ICP).

In terms of interventional radiology, it was noted that this was not a WHSSC commissioned service, but it has an impact on renal service provision as there is

a need to often access urgent treatments for patients following complications from kidney biopsies, urgent and elective vascular access procedures. Members were assured that all Chief Executives were currently aware of the issues and significant work was underway to address the sustainability of the service. Members of the committee asked for this to be highlighted to the JC.

3.0 COMMISSIONING TEAM AND NETWORK UPDATES

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

3.1 Cancer & Blood

Members received an update of the quality issues for services relating to the Cancer and Blood Commissioning Team Portfolio.

- The All-Wales Lymphoma Panel (AWLP) service was removed from the WHSSC escalation process in November 2023 due to implementation of the agreed action plan and an improvement in immunohistochemistry turnaround times.
- The Burns service has been de-escalated from Level 3 to Level 2 due to the capital case having been approved by Welsh Government. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete.
- Plastic Surgery outreach in BCUHB remains in Welsh Government escalation/special measures framework and the next escalation meeting is due to take place in March 2024. WHSSC is contributing to the Welsh Government escalation arrangements and continue to attend the Task and Finish Group as an advisor. There has been some progress on some of the Commissioning and operational arrangements.
- South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continued to breach the Ministerial measures waiting times for treatment at Swansea Bay UHB but there has been some improvement. The service will remain in escalation level 2 to ensure this continued improvement. The Health Board shared the plastic surgery delivery plan and trajectory at the escalation meeting in October 2023.
- An update on the BCUHB plastics surgery and the harms review was provided. The interim report found no evidence of patient harm but once completed, the report will the shared with WHSSC QPSC after it has been through BCUHB QPSC. Members requested that this be highlighted to the JC.

3.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio and noted that two new risks for the portfolio had been added to the Risk Register since the last report.

- The first risk relates to waiting times for patients from BCUHB and North Powys awaiting obesity surgery procedures in Salford Royal Hospital. The waiting times were unlikely to reduce in the short to medium term. Since writing the report, a pathway has been agreed and the pathway is open for patients to travel to south Wales to access treatment at the Welsh Institute of Metabolic and Obesity Surgery (WIMOS).

- The second risk relates to a cyber-security attack on the Trauma Audit Research Network Database (TARN) which resulted in the database being taken offline. A sustainable long-term solution for this data collection which will support the ability of the Network to benchmark performance is delayed. TARN has issued a standardised spreadsheet for interim data collection, but this will not be sufficient to undertake national benchmarking and WHSSC will be unable to monitor performance against the business case. A letter has been written to NHS England and this has been escalated and a response is awaited. There is also clinical concern as the data is also used for clinical audit.

- Both cardiac services remain in escalation level 2. In terms of CVUHB the planned repatriation of cardiothoracic surgery to UHW has been delayed until April 2024. An escalation focused review meeting with the Health Board was convened on in January 2024, at which progress against those outstanding escalation actions was noted with a follow up meeting arranged for March 2024.

- Swansea Bay Cardiac Surgery Service continues to make progress against its planned escalation actions as assessed by means of its performance dashboard. A report providing an update on the status of the remaining actions was delayed as a result of the HB reconvening its Gold Command meetings and the need for the report to be subject to internal governance and oversight. NJ provided members with assurance that the Gold command meetings were not as a result of cardiac surgery – the Gold command was instigated in response to very high levels of emergency pressures across the Health Board during December 2023 and January 2024.

3.3 Neurosciences

Members noted one new risk and one increased risk relating to neurosurgery waiting times in both south Wales and north Wales. Both are being managed through the Performance Management Framework and were being closely monitored.

Concerns with the Deep Brain Stimulation (DBS) service in Bristol were highlighted. Concerns had been raised around communication with referring clinicians and patients but there had been no engagement and no improvement despite repeated efforts. As a result, expressions of interest were requested for a new provider to support the south Wales gatekeeper.

The ALAC service review around Micro Processor Knee (MPK) was also highlighted, and it was noted that this will be fed into Individual Patient Funding Requests (IPFR) as part of the outcomes work.

3.4 Women & Children

Members received an update on the quality issues for services relating to the Women & Children Commissioning Team Portfolio. The risks largely mirror the services in escalation, and it was acknowledged that the volume of risks and escalation issues within the portfolio are concerning and make this a complex and challenging area.

Members were informed that the Paediatric Cardiac Surgery service in University Hospital Bristol had shown improved performance against waiting times. There had been a notable decrease in the number of children breaching their recommended treatment date and the length of time patients were waiting beyond their recommended treatment date had also decreased. The risk was reduced, and the service de-escalated to Level 2 in January 2024.

There remain three services in escalation Level 3 and one in escalation Level 4. Three of the services (Paediatric Surgery, PICU and Neonatal Intensive Care) are at Level 3 and are provided by Cardiff and Vale University Health Board. The escalation continues to be managed as a 'Triple Escalation'. Due to the complexity of managing all three escalations together there are two Executive Leads from the Health Board and two Executive Leads from WHSSC involved.

Neonatal Care

Members were informed that an escalation meeting took place this morning and WHSSC will consider the next steps following this meeting.

Paediatric Surgery

Members received an update following the Joint Committee workshop that was held in November 2023 in which Paediatric Surgery was discussed. Members were informed that a commitment was made by the HB to deliver against a target of zero paediatric patients waiting over 52 weeks by the end of March 2024. This was to be delivered to through a hybrid model of additional lists within the Health Board and continued outsourcing to Nuffield. There is evidence of improvement and there is a high confidence rating that the service will deliver. Joint Committee also agreed with a recommendation in the ICP 2024/25 that the 52 week is maintained now that the backlog is reduced.

Paediatric Intensive Care

Financial support has been provided to the HB to support winter pressures by increasing the workforce to support the unit. Despite previous assurance received from the Health Board regarding pressure area concerns WHSSC has been notified that a Joint Review of Child Protection Arrangements (JIGPA) that was undertaken in December 2023 has highlighted concerns which need to be

readdressed. A letter has been received from the CVUHB Director of Nursing on the 9th February outlining the request for the Acute Child Health Directorate to undertake a retrospective audit of the care of thirty children in PICU since September. The results of this audit will be shared with WHSSC on completion and brought back to the QPS committee. Assurance has also been given that the CVUHB Executive Team are sighted on the concerns and work needed to review the cases.

The Committee were informed that since writing the report a letter had been received from the DoN in CVUHB and this provided detail of the actions that they were taking. It was agreed to highlight these continued concerns to JC in the QPSC Chairs Report and await an update on the further actions currently being undertaken.

Wales Fertility Institute
Despite the service remaining in escalation Level 4 there has been some recent progress with securing a new Person Responsible (PR). The HB have nominated a number of staff to sit the HFEA exams ; this will enable each site Neath and Cardiff to have their own PR, with staff ready to step up should they become unavailable to fulfil the statutory requirements of the role of PR. The PR had been a single point of failure and the intention to have more than one PR will help mitigate this risk in the future.

3.5 Mental Health
The Mental Health and Vulnerable Groups update was provided during the presentation.

3.6 Intestinal Failure (IF) – Home Parenteral Nutrition
Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio and noted that no new risks for the portfolio had been added to the Risk Register and since the report had been written a letter of assurance had been received outlining measures for the sustainability for the service going forward. They will be appointing a local consultant, and it is likely that on the basis of this letter of assurance the risks will be reduced at the next commissioning team meeting.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary
Members noted the content of the report and the three Paediatric services in escalation Level 3 were noted and were discussed in detail above under the Women and Children's Report.

A copy of each of the services in escalation is attached to the report at **Appendix 1.**

4.2 CRAF Risk Assurance Framework

Members received a report outlining WHSSC's current risks scoring 15 or above on the commissioning teams and directorate risk registers. Members noted the updates in red.

One new organisational risk was highlighted and this related to the formation of the new JCC and the business continuity risk associated with this. The mitigations required will be critical as we are close to the go live date for the new JCC and a lot of the detail was still unclear. Members requested for this to be highlighted as a matter of concern to the JC.

4.3 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update

A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period July 2023 to January 2024 was presented to the committee.

4.4 Incident and Concerns Report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

4.5 Service Improvement and Innovation

Members received a report providing an update on the Service Improvement and Innovation Days and similar externally organised events relating to specialised services.

Members noted the content of the report, the summary of activities, aims and key points of learning and sharing. The report demonstrated the positive work that had been achieved and undertaken by clinicians. Members also noted the comprehensive update following the WHSSC QPSC development day.

4.6 Duty of Quality

Members received a report providing the steps taken by the organisation to meet the requirements of the Duty of Quality Act and to consider the revised templates to support the reporting mechanisms in accordance with the Act. Members noted that the report and the template was developed following the work undertaken in the Development Day.

5.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee November 2023,
- Oversight and Escalation Framework – NHS Wales Organisations; and
- QPSC Distribution List.

6.0 ANY OTHER BUSINESS

There was no other business.
Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above and summarised below; • The Interventional Radiology risk and impact on the renal service provision. • The outstanding Harms review and BCUHB plastics. • The pressure issues and Paediatric Intensive Care and general concerns with paediatric services CVUHB • Approval of proposed templates to meet Duty of Quality Act • The Business Continuity Risk on the CRAF Members continued to express concerns regarding the number of services that were in escalation in the Women & Childrens portfolio and asked that these were escalated for the attention of the Joint Committee.
Summary of services in Escalation • Attached (***Appendix 1***)
Matters requiring Committee level consideration and/or approval None
Matters referred to other Committees As above.
Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	TBC

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

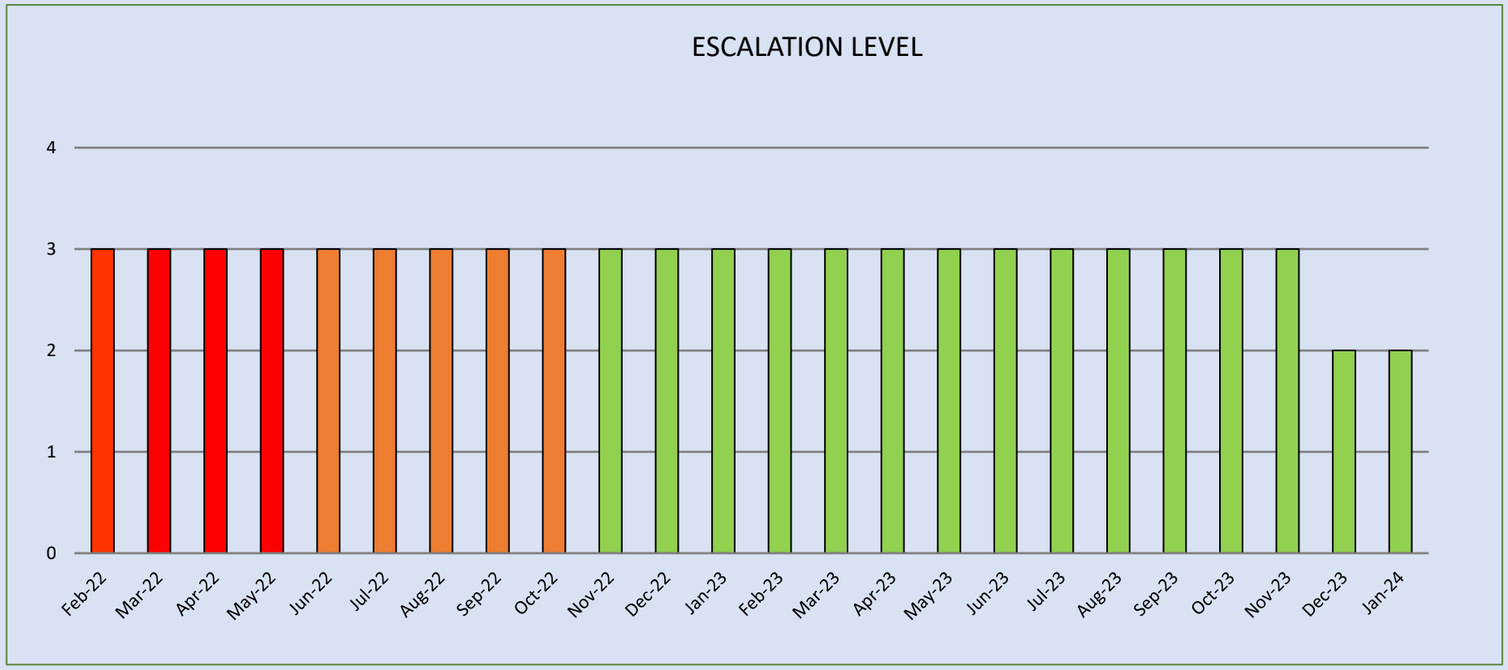
Service in Escalation: Burns

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ December 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**
December 2023 – WHSSC escalation	**2**

Rationale for Escalation Status :
De-escalated to 2.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is Autumn 2024.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed

To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed
SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	Completed
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	Completed
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which went to their Investment in Infrastructure Board on 22nd June; it had been hoped that the works would commence in May. There may, therefore, be a 2 month or so departure from original timelines. At the SLA with Swansea on 5th June, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	Completed
The capital case has now been approved by Welsh Government. The capital programme has commenced and is due to complete by October 2024. In view of this, the level of escalation has been reduced from level 3 to level 2. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete. Level 2 escalation has been maintained in case issues or risks arise during the implementation of the capital development.	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

- **July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22nd the outcome is not confirmed as yet.**
- **October 2023 The capital case has been approved by Welsh Government. Timeline tbc.**

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023, 26/07/23, 12/09/23, 10/10/23 & 19/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

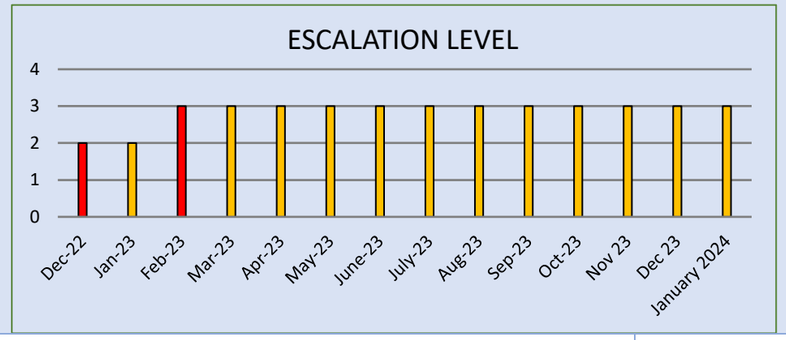
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:
There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The original plan did not deliver contracted volume,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

High – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in implementation. The service has committed to deliver a 52-week inpatient waiting list position by year end. The delivery of this is against a robust plan of increasing day case surgery and outsourcing 37 cases to Nuffield. Monitoring progress on a monthly basis and the >52 weeks position is improving as set out in the trajectories.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	Completed 06/10/23
Special Executive to Executive meeting scheduled with provider.	Director of Planning & Performance	23 October 2023	Completed 23/10/23
Triple escalation meetings established to monitor progress of all three services in escalation against overarching objectives.	DOP and DON	23 January 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.
May 2023 – A number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23 & 19/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

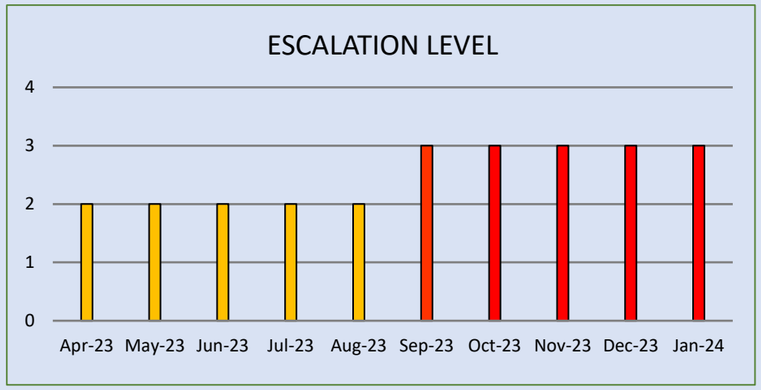
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2023	**2**
September 2023 – Increased level from 2 to 3	**3**

Rationale for Escalation Status :

Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:
There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of WHSSC through various routes including HiW and the daily SITREP.

WHSSC assurance and confidence level in developments:
Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital. WHSSC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Further work is required on the Pressure area concerns following a JIGPA review undertaken in December 2023.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	23 January 2024	
Requested action plan to be developed against the escalation objectives.	Senior Planning Manager	31 October 2023	Completed 19/12/23
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Director of Nursing	Ongoing	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	Completed

Issues/Risks:

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23 & 19/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

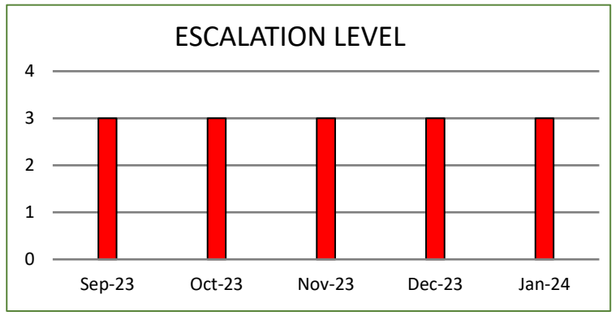
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	**3**

Rationale for Escalation Status :

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

WHSSC assurance and confidence level in developments:

Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Develop agreed objectives for escalation	Planning Manager	31 October 2023	Completed 19/12/23
Health Board to develop detailed action plan against the agreed objectives	Planning Manager	14 November 2023	Completed 19/12/23
Special Executive to Executive meeting scheduled with provider	Director of Planning	Date currently being agreed	

Issues/Risks:

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 14/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/2023

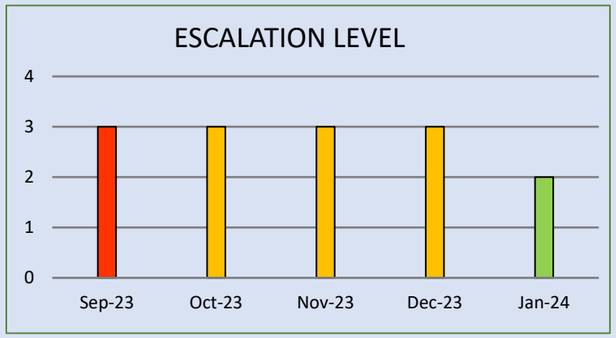
Service in Escalation: Paediatric Cardiac Surgery

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	**3**
January 2024	**2**

Rationale for Escalation Status :

A number of waiting were breaching the recommended date for treatment as set by the Joint Cardiac Committee. The period of time people were breaching was far in excess

Background Information:

Paediatric Cardiac surgery was placed in escalation level 3 due to the number of patients waiting in for surgery and those breaching their target date by over 200 days. Formal escalation meetings were established in September 2023 with Executive leadership from both the Trust and WHSSC.

WHSSC assurance and confidence level in developments:

High – Service de-escalated to level 2, robust reporting mechanisms have been established and the waiting list position has improved. There are currently only two patients that are breaching their recommended surgery date.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Escalation meeting to discuss progress and trajectories	Director of Nursing & Quality	14 December 2023	Completed 14 December 2023

Issues/Risks:

Executive Director Lead: Iolo Doull
Commissioning Lead: Dominique Gray-Williams
Commissioning Team: Women and Children
Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

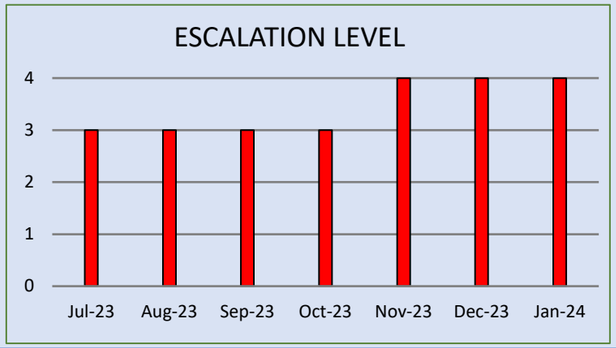
Service in Escalation: Wales Fertility Institute

Current Escalation Level 4

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ November 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	**3**
November 2023 – WHSSC escalation	**4**

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

WHSSC assurance and confidence level in developments:
Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to WHSSC data submissions, however, the service need to ensure time is given both internally and to WHSSC to allow for review and consideration of documentation.
The service submitted an audit of notes to the HFEA at the end of December, they are awaiting feedback from this submission.
The service have identified a number of suitable staff members to prepare and take on the role of PR. The intention is for all staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot. Neath Port Talbot are due to be inspected in March 2024 and Cardiff in January 2024.
A review of the HB escalation process has been undertaken and reconfigured to form a WFI sustainability group which feeds into the WFI Assurance, Recovery and Accountability Board.
The Directorate Manger and Associate Directorate managers have left and being replaced with a clinical manager.
The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. This review is due to be completed by the end of January and identify if any outsourcing is required.

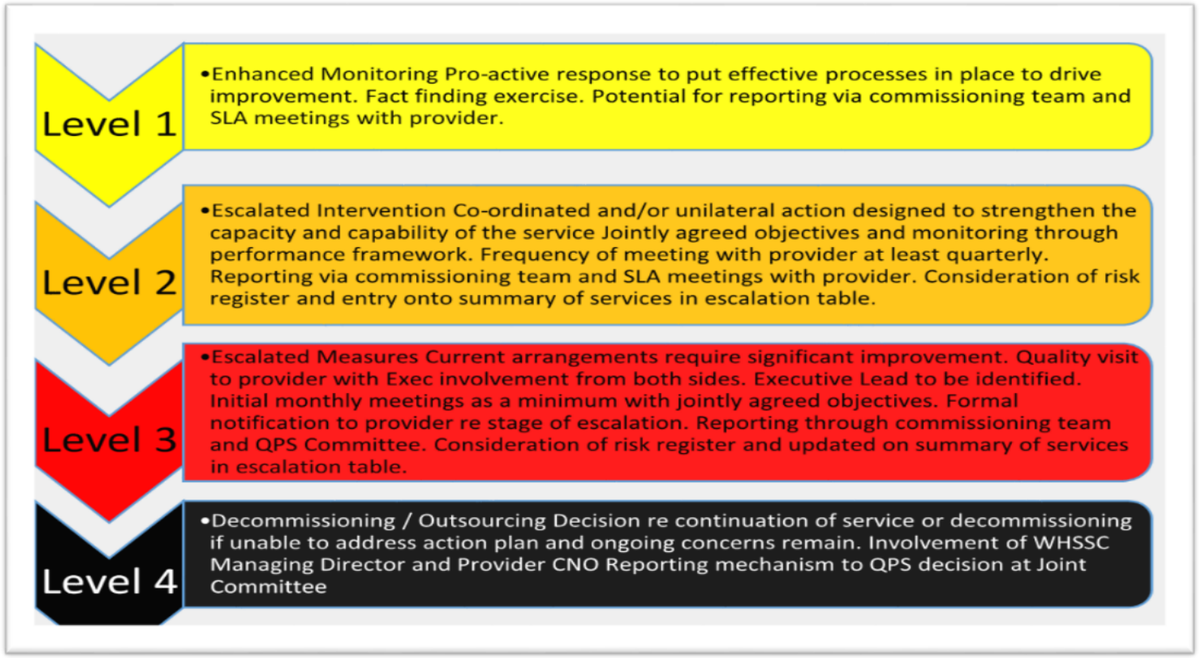
Actions:

Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to Exec	Assistant Specialised Planner	7th August 2023	7th August 2023
Monthly escalation meeting to review progress against Action Plan, Escalation meeting 19th September 2023, 10th October 2023, 7th December 2023	Assistant Specialised Planner	Monthly	Ongoing
Quality visit, this has been temporarily paused due to increase in escalation level to escalation level 4	Assistant Specialised Planner	14th November 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7th August 2023	7th August 2023
SMART Action plan reviewed and agreed	Service Manager	19/09/2023	19/09/2023
Regular Executive to executive meetings 16th November 2023, 21st November 2023, 1st December 2023, 7th December 2023, 21st December 2023	Executive lead SBUHB/ Medical Director WHSSC	16th November	Ongoing

Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 **DECOMISSIONING/OUTSOURCING**	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing /

Report Title:	Chair's Report Radiation Protection Group				Agenda Item no.		
Meeting:	UHB QSE Committee	Public			Meeting Date:		
		Private	x				
Status *(please tick one only):*	Assurance		Approval		Information	x	
Lead Executive:	Executive Director of Therapies and Healthcare Sciences						
Report Author (Title):	Professional Head of Radiography UHL/Chair of Radiation Protection Group						

Main Report
Background and current situation:

This report is a summary from the UHB Radiation Protection Group held on 23rd April 2024and highlights the key issues that were raised.

There is ongoing work to complete the process of all areas providing assurance that their Employers Procedures, Local Rules, Radiation Risk Assessments and Dosimetry Administration and Monitoring Procedures have been reviewed a Medical Physics Expert.

The Group is seeking assurance around the process of entitlement of referrers and it has been agreed that each department will undertake an audit by selecting a sample of referrers to their services and checking that they have received entitlement and entitlement letters. This will inform a decision on whether the process is fit for purpose or needs to be refined.

There are ongoing communications with ARSAC. Notification was submitted of a change in radiopharmaceutical supplier for UHW and UHL and this has been approved. Currently notification has been submitted of the Interim Medical Director arrangements following the retirement of Prof Meriel Jenney, as she was the signatory for the ARSAC applications. ARSAC have acknowledged receipt but approval has not yet been received back. There are no concerns to suspect that this will not be forthcoming.

The LPA has undertaken laser audits to commission 2 new lasers in SSSU and an audit was also undertaken in the Ophthalmology clinic and safety concerns were noted relating to training of staff and departmental processes. The main reporting group for medical equipment is via the Medical Equipment Group and the LPA will produce a paper for that group to escalate the risks. The Surgery Clinical Board Representative for the Radiation Protection Group will also discuss the issues with the LPA and escalate the risks within the Surgery Clinical Board for actioning.

It was noted that there has been an increase in referrals for imaging for incorrect patients being submitted to Radiology. The department will be collating a 6 monthly report that it will circulate UHB wide to raise awareness.

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

As highlighted above.

Recommendation:

The QSE Committee are requested to:

Note the summary of the key issues from the meeting.

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

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

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

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

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

Chilcott Rachel
14/05/2024 10:26:29

Report Title:	**Nosocomial Covid-19 Investigations End of Programme Update**			Agenda Item no.	4.4
Meeting:	**Quality, Safety & Experience Committee**	Public	X	Meeting Date:	**21st May 2024**
		Private			
Status *(please tick one only):*	Assurance	**X**	Approval		Information
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Head of Covid Investigations**				

Main Report
Background and current situation:

The publication of the NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of Covid-19 (the framework) supports the Communicable Disease Outbreak Plan for Wales (2020) by providing a consistent approach for NHS Wales organisations to identify, review and report patient safety incidents following nosocomial transmission of COVID-19 in compliance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR).

These reviews are under the umbrella of the final 'NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of Covid-19 (2021) which supports the Communicable Disease Outbreak Plan for Wales (2020) by identifying, reviewing and reporting patient safety incidents, complaints or claims relating to nosocomial transmission of Covid-19 in line with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR).

On 26 January 2022, the Welsh Government announced £9 million investment over 2 years to support delivery of the framework, this programme concluded on 31 March 2024.

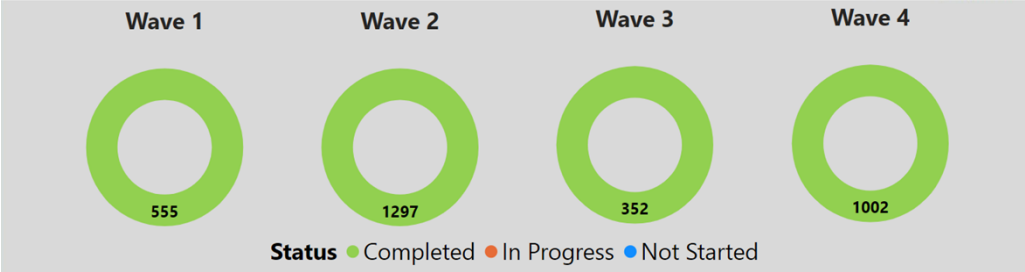
Cardiff and Vale UHB established a Covid Investigation Team which implemented all aspects of the National framework. The investigations into indeterminate, probable and definite Health Care Associated Covid -19 Infections (HCAI) as defined by the 4-Nations HCAI Surveillance group are in progress. The definitions are shown below.

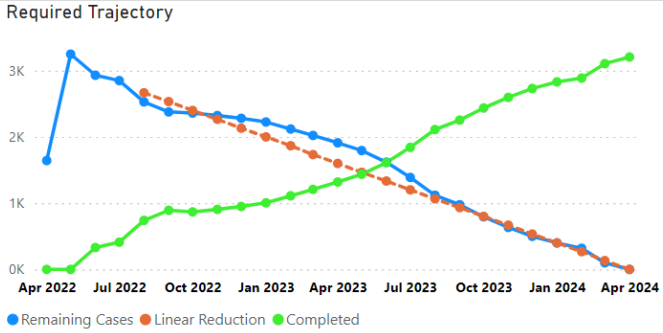
HCAI category	Criteria
Community onset	Positive specimen date ≤2 days after admission
Indeterminate healthcare-associated	Positive specimen date 3-7 days after admission
Probable healthcare-associated	Positive specimen date 8-14 days after admission
Definite healthcare-associated	Positive specimen date 15 or more days after admission

Criteria for determining if Covid-19 infection is healthcare associated following post discharge is shown below.

HCAI category	Criteria
Community onset **Possible** healthcare-associated*	Positive specimen date ≤14 days post-discharge, or within 2 days after hospital admission, with discharge from hospital in 14 days before specimen date.

There were 3206 patients who received care in the Health Board and who fit into the indeterminate, probable and definite categories of nosocomial Covid-19. As of the 31 March 2024 the Covid-19 Investigation Team have undertaken proportionate investigations and reviews of those 3206 patients as demonstrated in the tables below.





Weekly Scrutiny clinic chaired by Associate Medical Director for Clinical Effectiveness & Safety and the Assistant Director of Quality and Patient Safety were established to provide oversight of the outcomes of every review and to agree if further scrutiny is required. Scrutiny panels convened monthly to consider all elements of the Covid investigations, to establish if the care provided to each patient considered was in line with the evidence base at that point of time in the pandemic.
There are currently 6 cases remaining that continue n the Putting Things Right process.

The Health Board nosocomial review programme was governed by the UHB Nosocomial C&V UHB Programme Board which reports into the Quality Safety and Experience Committee. The Programme Board was chaired by the Executive Nurse Director who is the Programme's Senior Responsible Officer with Health Board representatives, Welsh Health Specialised Services Committee and Llais Cymru as key stakeholders

End of Programme communication continues via the dedicated Health Board web page and is further shared / supported though Llais Cymru.

Learning fits into four broad overarching themes, Infection, Prevention and Control, Operational, Patient/Family Experience and Estates and Environment. On the back of this learning the SAFE 2 MOVE framework and risk assessment were developed. This framework was implemented organisation wide, reassessed as guidance change and shared nationally through partnership working, through NHS Executive and Welsh Health Specialised Services Committee for use.

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

The programme concluded all reviews at the end of March 2024, however as anticipated a small number of cases remain within the Putting Things Right process including the involvement of Legal and Risk, and the Ombudsman.

Recommendation:

The Board / Committee are requested to: **NOTE** the assurance provided by the completion of reviews against the programme framework

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

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

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

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

Chilcott Rachel
14/05/2024 10:26:29