Public Quality, Safety & Experience Committee

Tue 16 July 2024, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:10
10 min

1. Standing Items

10 mins

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee Meeting held on 21.05.2024

Ceri Phillips

1.4 - Final QSE Public Minutes 21.05.2024.pdf (7 pages)

1.5. Action Log – Following the meeting held on 21.05.2024

Ceri Phillips

1.5 - Public QSE Action Log following for 16.07.2024.pdf (1 pages)

1.5.1. Royal College of Psychiatrists feedback

1.5.2. Consent to Examination and Treatment

1.6. Chair's Action taken since last meeting

Ceri Phillips

14:10 - 15:45
95 min

2. Items for Review & Assurance

2.1. CD&T Clinical Board – Assurance Report

30 mins *Adam Christian / Sarah Lloyd / Helen Luton*

2.1 - CDT QSE Annual Report.pdf (23 pages)

2.2. Quality Indicators Report

20 mins *Alexandra Scott*

2.2 - Quality Indicators report.pdf (18 pages)

2.3. Never Events Deep Dive

15 mins *Alexandra Scott*

2.3 - QSE committee - Never Events - 2.pdf (6 pages)

2.4. Update on Neonatal Mortality Data and improvement actions

10 mins *Richard Skone*

2.5. Update on the Hepatitis B/C Recovery Plan

10 mins *Claire Beynon*

2.5a - 20240716 Hep B_C Update _QSE.pdf (3 pages)
2.5b - Cardiff and Vale UHB Hepatitis (B and C) Joint Recovery Plan 2024_25 MASTER FINAL V1.pdf (31 pages)
2.5c - 202406 Hep BC Plan EHIA FORMATTED.pdf (16 pages)

2.6. JICPA Update

10 mins *Jason Roberts*

2.6 - Cardiff JICPA Report Final - ENGLISH - PDF.pdf (34 pages)
2.6 - Cardiff JICPA Report Final - WELSH - PDF.pdf (36 pages)

15:45 - 15:50
5 min

3. Items for Approval / Ratification

3.1. Policies

No policies for approval.

3.2. Patient Safety Notice 066 (Safer Identification of Unknown Patients)

5 mins *Matt McCarthy*

3.2 - Unknown Patient PSN066 - 20240705 (1).pdf (3 pages)

15:50 - 16:00
10 min

4. Items for Noting & Information

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

0 mins

4.1a - C&W QSPE Minutes 30.01.2024.pdf (11 pages)
4.1b - C&W QSPE Minutes 27.02.2024.pdf (10 pages)
4.1c - CD&T QSE Minutes 18.4.24.pdf (13 pages)
4.1d - CD&T QSE Minutes 23.5.24.pdf (14 pages)
4.1e - Medicine CB QSE Minutes 17 Apr 24 v2.pdf (6 pages)
4.1f - PCIC QSE minutes 14May2024.pdf (7 pages)
4.1g - SSG -Final Minutes 17.05.24.pdf (6 pages)

4.2. Research and Development Update

10 mins *Sarah Martin / Matt Wise*

4.2a - Research and Development Update.pdf (2 pages)
4.2b - R&D Report on Participant Satisfaction.pdf (34 pages)

16:00 - 16:00
0 min

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

16:00 - 16:00
0 min

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

i) Private Minutes

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

iii) Ophthalmology WET AMD

16:00 - 16:00
0 min

7. Any Other Business

16:00 - 16:00
0 min

8. Review of the Meeting

16:00 - 16:00
0 min

9. Date & Time of Next Meeting:

27th August 2024 at 2pm

Via MS Teams

16:00 - 16:00
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 Public Quality, Safety & Experience Committee

Held on 21st May 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		
Emma Cooke	EC	Interim Director of Therapies & Health Science
Andy Jones	AJ	Director of Nursing / Midwifery – Children & Women's Clinical Board
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	Interim Executive Medical Director
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Suzanne Rees	SR	Lead Nurse – CD&T
Francesca Thomas	FT	Head of Corporate Governance
Tara Cardew	TC	Head of Patient Safety
Catherine Wood	CW	Director of Operations – Children & Women's Clinical Board
Oliver Williams	OW	Specialist Registrar in Public Health
Abigail Holmes		
Observers		
Urvisha Perez	UP	Audit Wales
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Matt Phillips	MP	Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Angela Hughes	AH	Assistant Director of Patient Experience

QSE 24/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QSE 24/05/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 24/05/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 24/05/004	**Minutes of the Committee meeting held on 26.03.2024** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=71	

	The minutes of the Committee meeting held on 26.03.2024 were received. **The Committee resolved that:** a) The minutes of the meeting held on 26.03.2024 were approved as a true and accurate record of the meeting.	
QSE 24/05/005	**Action Log following the Meeting held on 26.03.2024** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=136 The Action Log following the Meeting held on 26.03.2024 was received. QSE 23/12/005 – Action Log: - The CC confirmed that actions assigned to the future could be added to the Forward Plan and marked on the Action Log as complete. QSE 23/12/007 – Royal College of Psychiatrists (RCP) Review: - The END and I-EMD informed the Committee that they were still awaiting a response from the RCP, and that they would reach out to the RCP. QSE 24/03/009 - Consent to Examination and Treatment: - the END reminded the Committee of his concerns regarding the changes to the Welsh Risk Pool (WRP), and there may be a financial impact due to compliance issues with consent training. The Exec colleagues were having urgent discussions on how to progress this work forward. The I-EMD added that this had been brought to Senior Leadership Board (SLB), where a decision was taken that regardless of any other training undertaken outside of the UHB, there should be mandatory internal consent training. **The Committee resolved that:** a) The Action Log from the meeting held on 26.03.2024 was noted.	
QSE 24/05/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QSE 24/05/007	**Children & Women Clinical Board – Assurance Report** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=434 The DON-C&W presented the Assurance Report which provided the Committee with a summary of their 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 also described the key residual risks and their mitigating actions to carry forward into 2024/25. The IM-C asked for the key reasons behind staff leaving, and for more detail on the risks scored above 20. The DON-C&W responded that approximately 400 letters had been sent to staff leaving to understand why they left the organisation. The key issues identified included communication, leadership and management, supervision, and support. A piece of work was being developed to support staff on these key issues.	

	In regards to the risk register, the DON-C&W summarised that the Clinical Board had struggled with the maternity lifts, staffing constraints, and particular demand and capacity issues in services (e.g. the neurodiversity service). The DO-C&W provided assurance that the Clinical Board team met monthly to review the risks to ensure that they were content with the level of mitigation and action to bring them to safe conclusion. These risks were also presented in their Executive Performance Reviews every month to ensure that everybody was cited on the risks. The EDPH asked for more detail around the pain data in their Civica results. The DON-C&W responded that the Civica data was updated on a weekly basis, and that it presented a challenge in compiling the individual patient comments. Specific areas were being targeted for improvement based on feedback, and pain management was one particular focus. He added that this issue was relatively new, but that efforts were being made to apply the PDSA (Plan-Do-Study-Act) cycle for necessary improvements. The COO noted that the Children & Women's Clinical Board had the most developed risk register, which was reviewed every month in Executive Reviews. In addition, they had a comprehensive maternity dashboard to help benchmark against other organisations. He concluded that whilst a lot of improvements had been made, there was still a way to go. The CC concluded that the work demonstrated was very positive. **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 C&W Clinical Board was noted.	
QSE 24/05/008	**Deep Dive – Nationally Reportable Incidents (NRIs)** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=2300 The HPS presented the NRI reporting Cardiff and Vale 2023-24 Report and slides to the Committee which provided an overview of the NRI Management Process, NRI Performance and improvements, learning from the NRIs and emerging themes, and further action to be taken in 2024/25. The END emphasised the importance of timely review, investigation, and resolution of NRIs, and acknowledged the significant increase in both open and overdue cases. He noted that Clinical Boards would undertake a deep dive that week for the Executive reviews to discuss open cases. The I-EMD noted significant improvements in the organisation's approach to the post-NRI closure process, particularly in terms of learning and follow-up actions. **The QSE Committee resolved that:** a) The information was noted for awareness.	
QSE 24/05/009	**Prison Inquest Update** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=3072 The END provided the report and highlighted the following:	

	- The unfortunate passing of an individual at HMP Cardiff 2021 and the subsequent coronial process resulted in the outcome of a combination of misadventure, self-neglect, and neglect. - This led to the implementation of Regulation 28, which prompted the UHB to take actions to prevent future occurrences. - Since the incident, a Prison Improvement Oversight Group had been established, led by the Deputy Director of Nursing, to work with the healthcare team and the Prison Governor at HMP Cardiff. - Six weeks ago, the case was presented to the coroner, who was assured that the health board had diligently worked on an improvement plan since the incident. - The intention was to bring it to the Public QSE Committee and a future Board session to provide assurance to Mr D's family and the public about the ongoing work. The IM-CE was encouraged by the Coroner commending the improvements made, and asked for more detail regarding the sustainability concerns around overnight staffing and access to GP provision in the long-term. The END responded that: - The sustainability of staffing, particularly at night, was a national challenge. - The environment in prisons and cohort of patients presented significant challenges for nursing and patient care. - The issue had been discussed at length in Executive Reviews, and efforts had been made to utilise agency staff as a temporary measure. - A meeting had been organised between the END, the COO, and the Clinical Board triumvirate to create a sustainable model. - A GP practice had expressed interest in taking ownership of the service. - They had invested in a Head of Healthcare for the prison who had been instrumental in pulling the Improvement Plan together. The COO added that nursing staff provision was problematic, however, he was more optimistic about GP cover and primary care within the prison service. The I-EMD highlighted that the challenge faced by teams in caring for the prison population were significant due to their unique and diverse needs. The proposal to have a consistent practice take over the healthcare sessions was seen as a positive step in the right direction. The CC noted that the Regulation 28 PFD Improvement Plan would be brought to QSE in November 2024. **The QSE Committee resolved that:** - The inquest findings and subsequent improvement plan was noted.	
QSE 24/05/010	**Clinical Effectiveness Committee** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=3494 The CBD-M presented the Clinical Effectiveness Committee Bi-Annual Report which provided the Committee with an overview of highlighted data from several national audits which were of particular interest to Clinical Boards, specialities, and clinical audit leads to help scrutinise and improve services. The CC asked what learning was being taken from the audits generally. The CBD-M responded that the audits provided the opportunity to discuss the data around where to grow or focus their services.	

	The I-EMD explained that the audits were useful in providing a sense of benchmarking. However, a limitation as that the results were delayed and provided them with a sense of what they were doing a year ago. The ADQPS highlighted the potential of using data proactively to drive improvements in healthcare services. The I-EMD emphasised the need to be judicious in responding to the retrospective data, and to learn how to apply the information effectively without unnecessary diversions. **The QSE Committee resolved that:** 1) The Headline data and some of the areas of improvements covered in the report were noted.	
	Items for Approval / Ratification	
QSE 24/05/011	**Equity, Equality, Experience and Patient Safety Action Plan** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=4107 The EDPH explained that in 2023, the Board approved the Equity, Equality, Experience and Patient Safety Framework. The team had developed an Action Plan and a support tool for staff to consider how they could impact on reducing health inequalities across their service. The Special Registrar in Public Health (SRPH) presented the Action Plan slides which set out the 24 initial action areas agreed upon in 2023, a snapshot of progress made over the past six months, and the next steps. The IM-C asked what practical steps were being taken to collect data and increase engagement. The EDPH responded that: - A survey had been undertaken across Clinical Board teams the previous year to measure how they saw their progress against collecting data amongst the protected characteristics. - Basic information like date of birth and postcode was well collected, whilst data on ethnicity, sexuality, and other protected characteristics saw a significant drop in collection rates, down to about 30%. - Efforts were being made to utilise the available data (e.g. analysis of inpatient and outpatient waiting lists using the Welsh index of multiple deprivation linked to postcodes). - The initiative aimed to stimulate discussions on further necessary commitments against equality legislation. - Alternative sources of information, such as census data, was being considered to compensate for the gaps in data collection. - The report emphasised the need to improve data collection and integration across primary, secondary, tertiary, and prevention care to enhance service delivery. The IM-C suggested meeting outside of the Committee to discuss how he could help to improve engagement and communication with community leaders and events. He suggested the possibility of developing a project with Cardiff University to analyse the key questions. The EDPH added the following: - An analysis of the vaccination data collected during COVID had been conducted, and there was an ongoing effort to link this data to other vaccination types to identify which groups were being missed across Wales.	

	- The Vaccine Equity Group (chaired by the EDPH) had requested more detailed data connections. - To further support community engagement, funding from the Prevention and Early Years pot had enabled the hiring of an Ethnic Minority Connector within the local council. This would facilitate conversations and connections with the communities to improve co-creation sessions and understanding barriers and facilitators for change. - While current data connections may not be robust, there was optimism for future improvements and support for this work. **The QSE Committee resolved that:** 1) The actions underway in the action plan to address health inequities in Cardiff and the Vale of Glamorgan was supported; 2) The six-month progress that had been made against the actions, including the challenges around health inequality data availability, was acknowledged; and 3) The receipt of a further update in another six months was agreed.	
	Items for Noting & Information	
QSE 24/05/012	**Minutes from Clinical Board QSE Sub-Committees and the Safeguarding Steering Group (SSG)** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=4828 The Minutes from the Clinical Board QSE Sub-Committees were noted. The END informed the Committee that the timing of the SSG meeting did not align with QSE, and the minutes would be brought to the following Committee. **The QSE Committee resolved that:** 1) The minutes from the Clinical Board QSE Sub-Committees and the Safeguarding Steering Group were noted.	
QSE 24/05/013	**Minutes from the WHSSC Quality Patient Safety Committee (QPSC)** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=4877 The CC informed the Committee that WHSSC had asked for the minutes to be brought to QSE for information. **The QSE Committee resolved that:** 1) The minutes from the WHSSC Quality Patient Safety Committee (QPSC) were noted.	
QSE 24/05/014	**Chair's Report Radiation Protection Group** To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=4895 The I-EDTHS took the report as read. **The QSE Committee resolved that:** 1) The summary of the key issues from the meeting were noted.	
QSE 24/05/015	**COVID-19 Investigation Programme**	

	To view the minute: https://youtu.be/czH_7z4NFXc?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=4910 The ADQPS informed the Committee that the COVID-19 Investigation Programme was completed on the 31st March 2024, with all cases of nosocomial COVID-19 having been investigated. There was still a small number which remained in the Putting Things Right Process. The END thanked the ADQPS and the COVID Investigation Team for the significant amount of work undertaken. **The QSE Committee resolved that:** 1) The assurance provided by the completion of reviews against the programme framework was noted.	
	Items to bring to the attention of the Board / Committee:	
QSE 24/05/016	*No items.*	
	Agenda for Private QSE Meeting	
QSE 24/05/017	*i) Minutes and Action Logs from the Private QSE Committee on 26.03.2024* *ii) Any Urgent / Emerging Themes – Verbal Update* *iii) Plans/Trajectories for Overdue Follow Ups* *iv) Ophthalmology WET AMD* *v) Discharge Advice Letters – Update* *vi) 2023/24 Annual Quality Plan*	
	Any Other Business	
QSE 24/05/018	*No items.*	
	Date & Time of Next Meeting:	
QSE 24/05/019	Tuesday 16th July 2024 at 2pm via MS Teams	

Action Log

Public Quality, Safety & Experience Committee

Update for meeting 16th July 2024
(Following the meeting held on 21st May 2024)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions					
QSE 23/12/007	**Mental Health Clinical Board – Assurance Report**	Report back on the feedback from the Royal College of Psychiatrists review.	**16.07.2024**	Richard Skone / Jason Roberts	*Update to be provided at the 16th July 2024 QSE during the 'Action Log' section*
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.	**16.07.2024**	Melanie Bostock Richard Skone Jason Roberts	*Update to be provided at the 16th July 2024 QSE during the 'Action Log' section*
QSE 24/05/011	**Equity, Equality, Experience and Patient Safety Action Plan**	For an update to be brought back to the Committee in 6 months.	**26.11.2024**	Claire Beynon / Oliver Williams	**COMPLETED** *Item added to the Forward Plan for 26.11.2024*
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					
AAC 24/07/006	**Internal Audit Progress Report – Medical Records Tracking (CD&T CB)**	QSE Committee to consider report to ensure recommendations were being implemented	**27.08.2024**	Ian Virgil / Matt Phillips / Emma Cooke	**COMPLETED** *Action from Audit & Assurance Committee - Item added to the Forward Plan for 27.08.2024*

Report Title:	*Clinical Diagnostics and Therapeutics Clinical Board Assurance Report*					Agenda Item no.	*2.1*
Meeting:	Quality, Safety and Experience Committee		Public	X		Meeting Date:	16.07.24
			Private				
Status *(please tick one only):*	Assurance	x	Approval			Information	
Lead Executive Title:	Executive Director of Nursing						
Report Author (Title):	Director of Nursing & Multi-professional Teams CD & T Director of Operations CD & T Clinical Board Director CD &T						

Main Report
Background and current situation:

Background:

This report details the arrangements, progress and outcomes taking place to improve quality, safety and patient experience within the Clinical Diagnostics and Therapeutics (CD&T) Clinical Board. It outlines the achievements and innovations leading to improved quality and care for patients. It also describes some key challenges, risks and the mitigations we have in place in order to continue into 2024/25.

The Clinical Diagnostics and Therapeutics Clinical Board provides a wide range of diagnostic and therapeutic procedures on a local, regional and UK wide basis. Collectively these services underpin, and are core components of, almost every aspect of clinical activity undertaken within the UHB.

During the financial year 2023/24 the Clinical Board consisted of 6 directorates and had a budget of £120 million.

1. Laboratory Medicine
2. Radiology, Medical Physics and Clinical Engineering
3. Medical Illustration
4. Outpatients/Patient administration
5. Therapies
6. Pharmacy and Medicines Management (including All Wales Therapeutics & Toxicology Centre (AWTTC))

From September 2023 Clinical Coding was transferred from the corporate department to CD&T Clinical Board. In April 2024 Paediatric Therapies transferred from Children and Women Clinical Board and the Rehab to Prehab team transferred from Surgery Clinical Board to CD&T. Whilst we welcomed teams into the Clinical Board, we also said goodbye to the team in Glan Ely who transferred back to Medicine Clinical Board in November.

The Clinical Board spans diverse services and is delivered by a variety of professions. There are 2706 staff in post across all professional groups.

Staff Group	Headcount
Add Prof Scientific and Technic	279
Additional Clinical Services	574
Administrative and Clerical	472
Allied Health Professionals	905
Estates and Ancillary	16
Healthcare Scientists	321
Medical and Dental	79
Nursing and Midwifery Registered	60
Grand Total	**2706**

Quality, safety and patient experience is a core component of all we do. Over the last 12 months we have begun to embed the health and care quality standards across the clinical board in line with the duty of quality statutory guidance 2023.

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

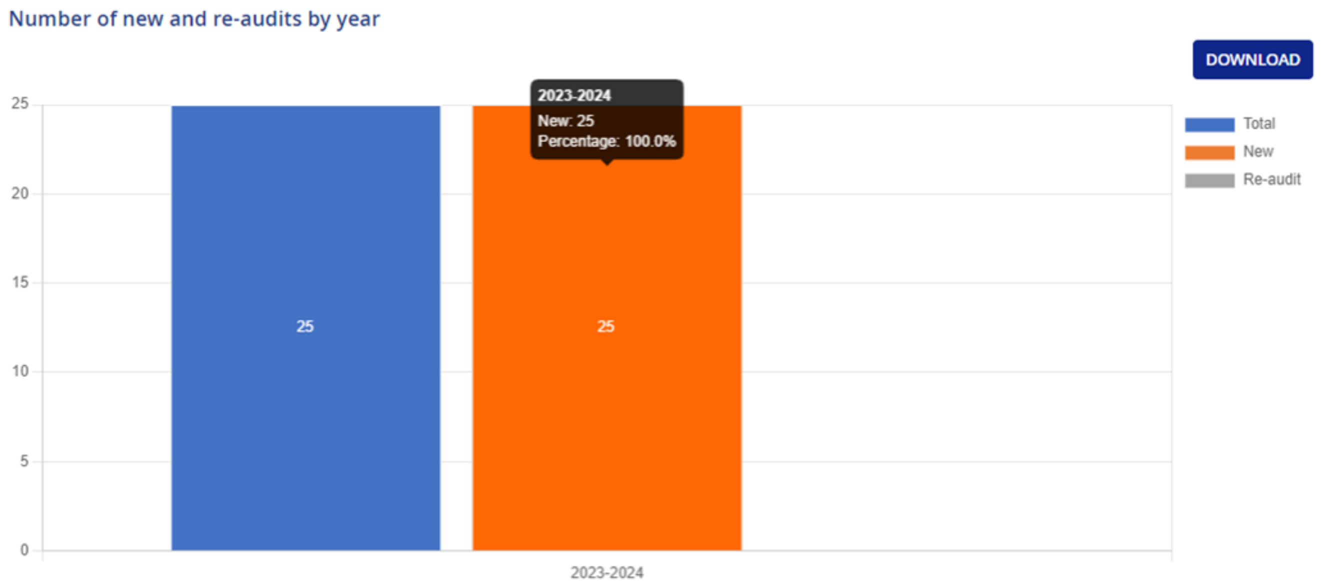
- The Welsh Government Quality Delivery Plan for NHS in Wales
- The Clinical Board's Operational Plan and IMTP
- Quality, Safety and Patient Experience agenda
- Management and monitoring arrangements related to risk
- Health and Care Quality Standards
- Financial and information Governance
- Organisational Development and Workforce planning
- Regulatory Compliance

Safe Care

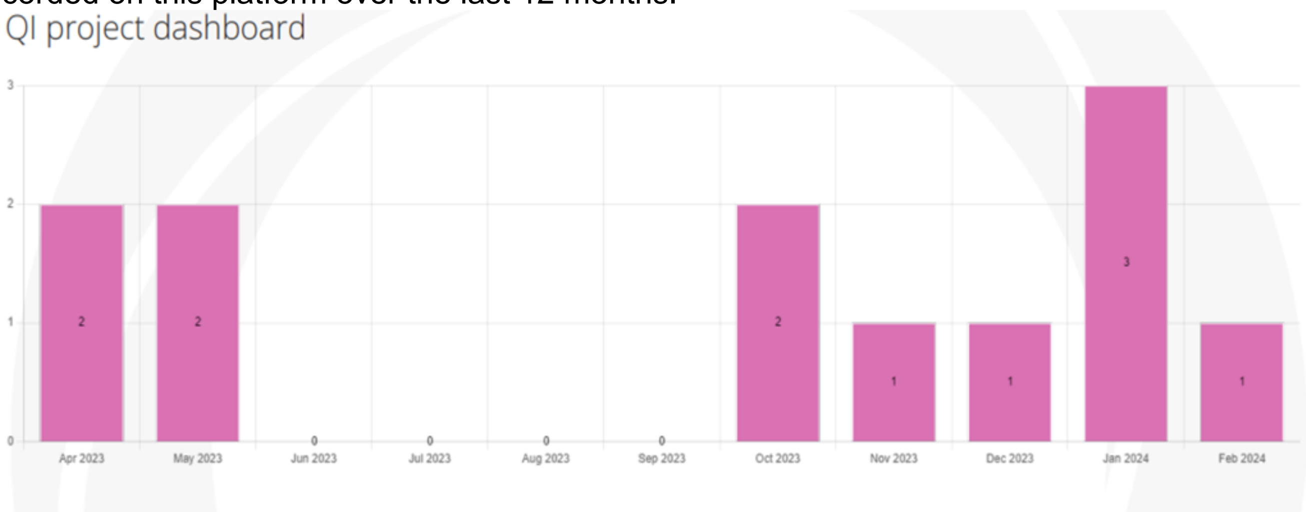
The Clinical Board has an agreed agenda and comprehensive work plan for the next 12 months. The plan includes monitoring service delivery against required standards, monitoring and managing risks through the e-Datix reporting system, regulatory compliance and the risk register.

The Quality, Safety and Patient Experience (QSPE) agenda is a key priority for the Clinical Board. QSPE meetings are held monthly, with terms of reference reviewed annually. The QSPE agenda is aligned to the 6 health and care quality standards. There is good attendance and representation from across the Clinical Board.

Assurance is received through QSPE group and other formal meetings. Quality Managers in Laboratory Medicine, Radiology and Pharmacy are key members of the team and support those areas to deliver safe, effective and quality care to patients in addition to complying with legislation that regulate those areas. Q-pulse is a well-used electronic platform for storing policies, incidents, audits and action plans that provides assurance to the Clinical Board and our regulators.
The adoption of AMAT outside of these areas has been a focus over the last 12 months, using it to record actions from investigations and inspections and track progress against them. This work will continue into 2024/25. In addition, AMAT is used for audit activity and we have seen an increase in its use from the previous year where we had a total of 5 recorded compared to 25 in 2023/2024 period.



Teams are also utilising AMAT to record QI projects and again we have seen an increase being recorded on this platform over the last 12 months.



Projects vary, with laboratory medicine, therapies and pharmacy utilisng the platform for QI projects in the last 12 months.

The QSPE group has sub-groups that report to it.

- Health and Safety Group meets bi-monthly. Health and safety issues, risks and incidents are discussed. RIDDOR reportable incidents are shared in this forum to ensure wider learning from events. Training compliance is also a focus.
- Regulatory Compliance meets monthly, with a minimum of 9 meetings per year being convened. The function and purpose is to ensure governance arrangements are operating effectively to provide high quality and safe healthcare. To provide assurance to the Clinical Board of compliance with regulatory requirements through reviewing quality indicators.
- Research and Development group meet every 2 months. Reports on research and development activities across the Clinical Board. It provides a forum for the exchange of

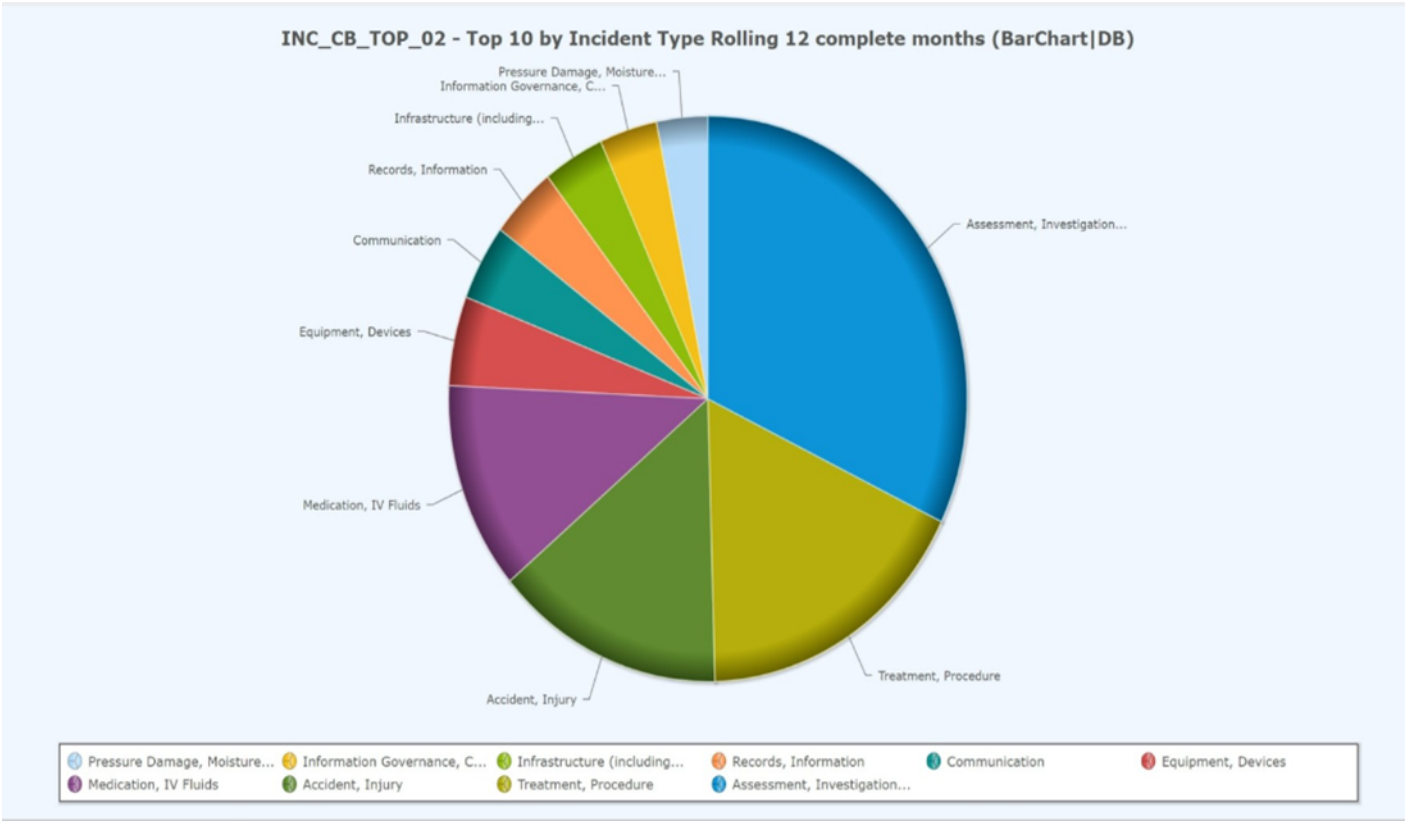
information on R&D issues between directorates leads. Supporting collaboration with other Clinical Boards, university research groups and other partners.

Through all groups the aim is to identify themes and share learning from incidents, inspections and action plans.

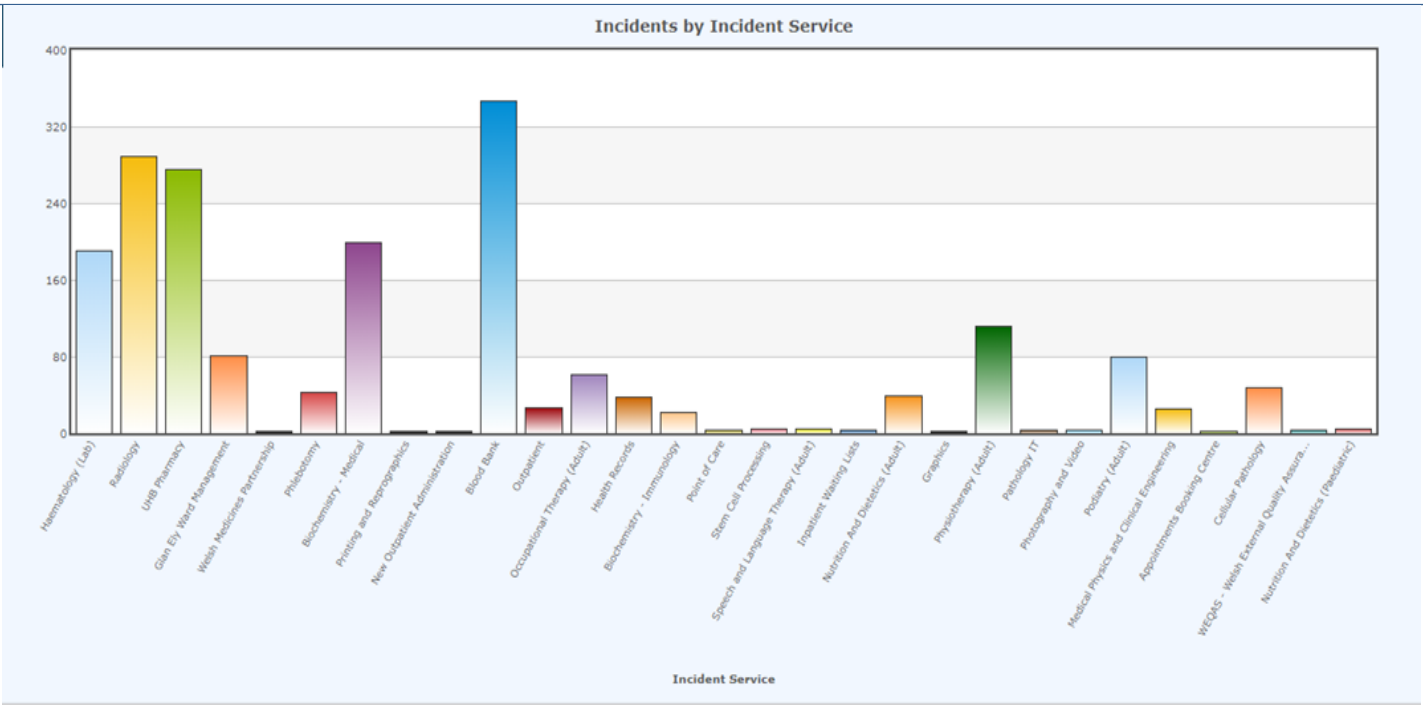
Incident Reporting

The total number of incidents reported by the Clinical Board using the RLDatix system during the period 1st April 2023 to 31st March 2024 was 1,904 compared to 1,657 the previous year, demonstrating a strong reporting culture across the board. Data is taken from RLDatix system and is from the same period.

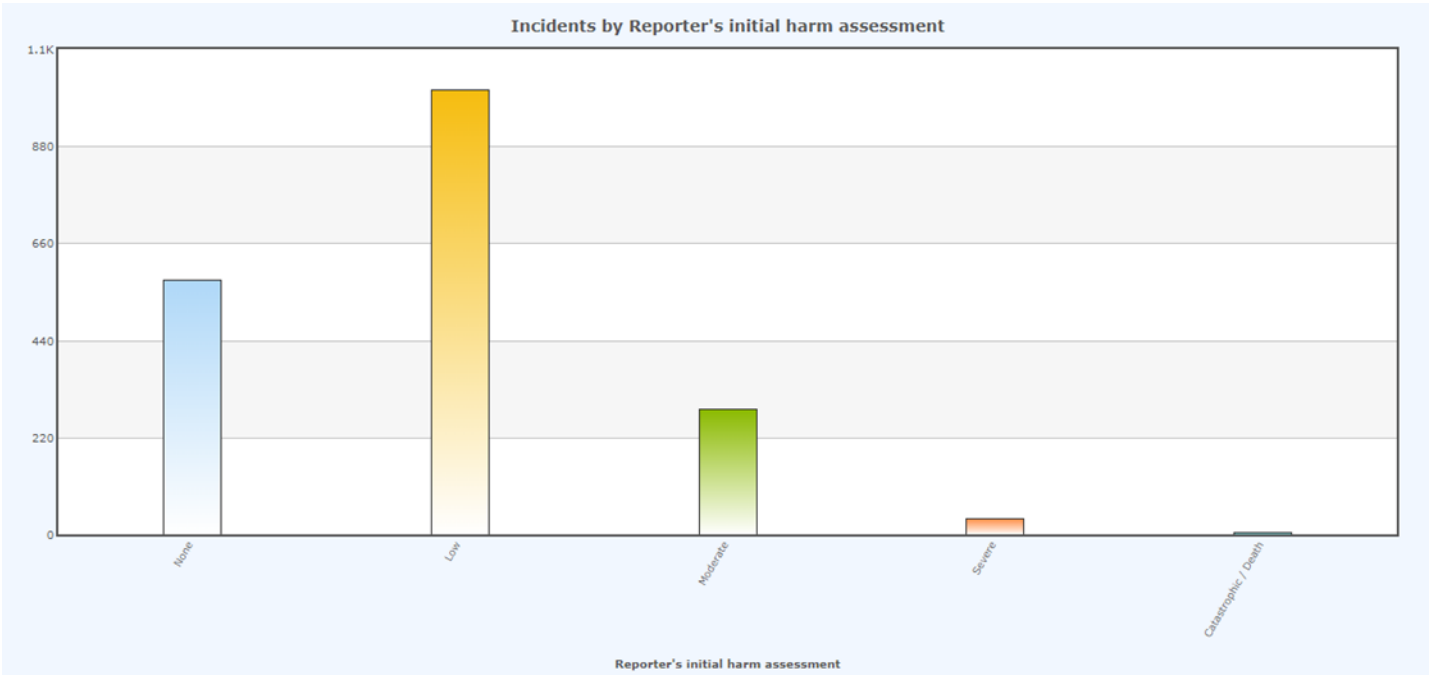
The top 10 incident types are outlined below.



The majority of incidents are reported under the assessment, investigation & diagnosis category - this is not unexpected as diagnostic testing would cover all of our laboratory services and Radiology, which as you can see from the graph below have the largest number of incidents reported.



The vast majority of incidents reported are no or low harm and often represent a near miss. In the next 12 months work to review near miss incidents is planned to review trends and themes and where possible put preventative actions in place.



Of the 3 incidents initially classified as catastrophic, following review they were all assessed as low harm. The 36 first assessed as moderate harm, 75% were re-classified following review as no or low harm. Of the low and no harm fewer than 1% were re-classified to increase the level of harm.

Timely closure of incidents remains a challenge for our teams, those categorised as moderate or above are prioritised. Since the 1st April 2023, all no harm to moderate harm incidents are reviewed by the Duty of Candour Team and those reported as severe of catastrophic are reviewed by the patient safety team.

From the 1st April to 31st March, we reported 8 nationally reportable incidents compared to 6 in the previous 12 months.

33435 June 2023	Patient attended OPD for podiatry review and discovered to have unstageable pressure ulcer to heel. Previous visit wound documented as neuro-ischaemic diabetic foot ulcer measuring 0.4x0.8cm. On inspection today found to be 4.3x4.2cm, necrotic tissue present. Focused review completed in collaboration with PCIC colleagues as patient was under care of DNs. Pressure damaged determined to be avoidable. Following completion of the pressure damage focused review tool, the following actions were identified - accurate patient assessment and regular review to ensure accurate and up to date risks identified, consideration of removal of heel cast in patients who are unable to comply. Improve communication between health care professionals.
33499 June 2023	Patient has a 12 x 10mm excision of erythematous plaque on 3rd January 2023. Reported 11th April 2023 concluding a thick melanoma. Delay of 3 months for diagnosis to be received and therefore delay in treatment commencing. Due to delays within the Cellular Pathology department the sample was sent to external company for reporting but despite this took 3 months to be reported. The improvement plan included work to increase capacity of Cellular Pathology laboratory to minimise delays in reporting (7 day working, installation of 3rd IHC platform, explore implementation of digital pathology) robust tracking in Dermatology of patients treated, improved tracking of patients on treated suspected lists within Cellular Pathology.
43651 October 2023	Patient had unwitnessed fall, sustaining head injury. Patient known risk of falls and was in a cohort bay. Unfortunately, the HCSW assigned to the bay left briefly to attend to another patient, on their return the patient was found sitting on the floor. Sadly, patient passed away as a result of the injury sustained. CT scan showed large left intra and extra axial haemorrhage. Actions following the combined falls review included education regarding enhanced supervision and falls prevention.
44771 October 2023	Patient attended outpatient clinic and referral made for CT scan. The scan was completed and reported with advice that they should be discussed in Lung MDT. It appears no follow up was completed and results not shared with GP practice. Patient was admitted to hospital 7 months after the scan at which time a further CT scan was completed and showed extensive malignancy. The improvement plan included a review of how the outpatient clinic reviews results reporting system, exploration of an electronic radiology workflow system for receipt of reports and an alert system where incidental abnormal findings are flagged to referrers. In the absence of this system Radiology e-mail the referring clinicians.
47616 November 2023	A patient was admitted to University Hospital Wales last year following necrotising pancreatitis and following a long stay on ITU for multi-organ failure, underwent an Endoscopic Retrograde Cholangiopancreatography (ERCP) following hospital discharge in August 2022. During the procedure a fully covered metal stent was fitted that should be removed within 3 months as per its licence. It has been found following further procedures earlier this year that the original stent was not removed and is now irremovable following surgical attempts. This incident is still under investigation.
46767 November 2023	A new referral was received from the patient's GP for chronic hepatitis B infection. The referral was requested as urgent and triaged into the urgent Hepatology pool the same day. The patient was also referred to Radiology for an ultrasound scan of abdomen and given an appointment for 3 months later but they cancelled this appointment as they were unable to attend. The patient was reviewed in Hepatology clinic 10 months after the referral and the ultrasound scan performed. The scan revealed a large hepatocellular carcinoma, suggestive of primary liver cancer. Earlier specialist clinic review and imaging may have resulted in early diagnosis and potentially easier to manage disease. The improvement plan includes a review of Radiology booking processes, Hepatology waiting times, ultrasound capacity and a review of health pathways for abnormal LFTs.
52109 January 2024	The patient was referred by her GP to the Emergency Unit as she had been experiencing chest pain and was discharged following an x-ray, which was normal. A year later the symptoms she experienced reoccurred and a further x-ray was requested at that time which identified cancer. A review of the earlier X-ray by a Radiologist confirmed there was a 20mm nodule that was identifiable at the time. This reporting error has been identified as a perception error which has led to the delay in diagnosis and treatment for this patient. The improvement plan includes learning from this incident via the REALM meetings and to consider how the reporting environment could be improved.

54501 February 2024	An ultrasound scan was requested by the patient's GP and this was performed. The findings were suspicious of a renal cell carcinoma (RCC). A CT chest, abdomen and pelvis was also performed which confirmed the diagnosis. On reviewing previous imaging it was identified that the largest mass on the pole of the left kidney was present on a CT colon scan performed in 2015.This is a reporting error and has been identified as an error of interpretation. The improvement plan includes learning from this incident via the REALM meetings and to consider how the reporting environment could be improved.

The clinical board has a robust process for managing reportable incidents, supported by the Patient Safety Team. Each report is presented in QSPE to share any learning across the Clinical Board. Between 1st April and 31st March all except one NRI has been completed within the timescales set by the NHS Wales Delivery Unit.

Of the NRIs listed above 6 have been taken to re-dress.

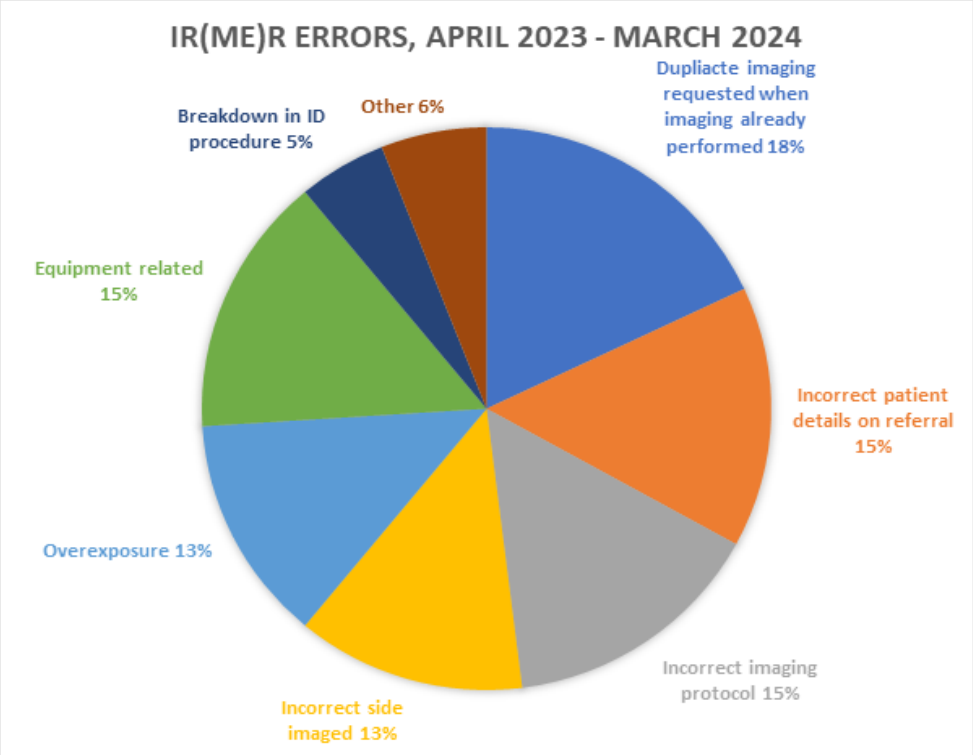
Ionising Radiation (Medical Exposure) Regulations (2017) Report

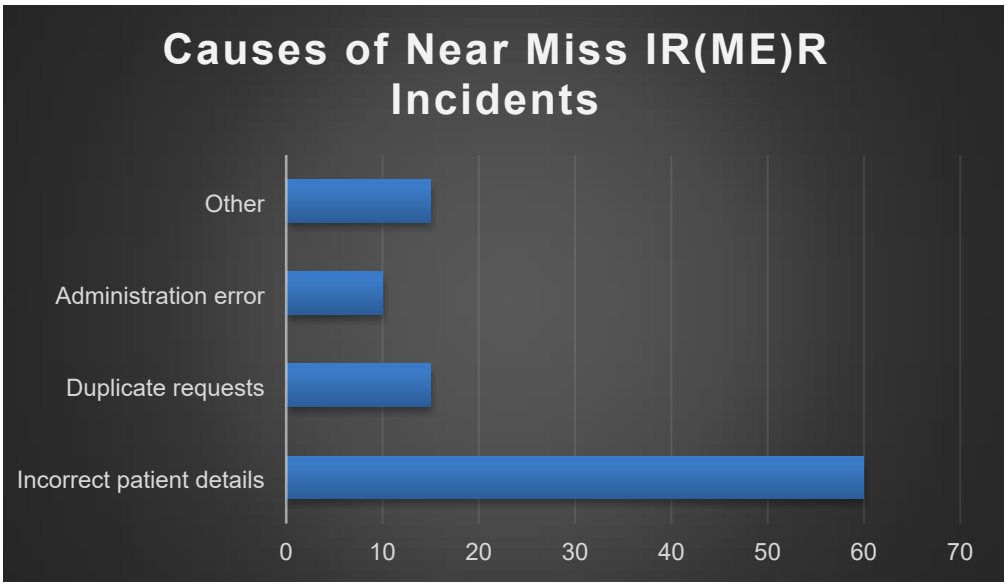
The Ionising Radiation (Medical Exposure) Regulations, (IR(ME)R), provide safeguards for individuals exposed to ionising radiation from medical equipment for imaging, treatment or research purposes. The regulations set out a requirement that any accidental or unintended exposure to radiation is recorded and reported to the appropriate enforcing authority, in this case, Health Inspectorate Wales (HIW). The regulations require the employer to carry out a detailed investigation and share the outcome with the enforcing authority. The patient safety learning review template is used for these investigations and include an improvement plan to demonstrate actions taken to minimise the chance of a similar incident in future. Patients, where appropriate, are always notified of the incident and asked if they have any questions they would like addressed as part of the review.

Between the 1st of April 2023 and 31st March 2024 there were 423,474 examinations involving ionising radiation. Excluding near misses, there were a total 68 IR(ME)R incidents, 21 of which were reported to the HIW in line with IR(ME)R legislation. Proportionally the incident rate is similar to 2022/23.

Overall incident rate occurrence is less than 0.001% of all applicable examinations.

Causes of IR(ME)R incidents are outlined in the graph below





A summary of all IR(ME)R incidents will be shared across the UHB.

Regulatory Compliance
The governance arrangements for regulation and accreditation is through the Clinical Board Regulatory Compliance Group which uses a combination of metrics to drive the compliance dashboard, ensuring appropriate senior management oversight, escalation of issues, and monitoring of performance.

Many areas in the Clinical Board are tightly regulated and subject to regular inspection and assessment against legislation, regulation and standards. In 2023/24 the following inspections took place:

MHRA Inspection of Aseptic Unit UHL, 9-11th May
The inspector noted the efforts of the team in a challenging environment and recognised improvements made from 2019, however there were 3 major findings. The general fabric of the ageing estate was noted including air handling units and age of isolators used. There was also work to improve the quality management system to ensure effective monitoring and control for process performance and product quality. Decisions around the long-term future of the unit are related to the regionalisation of aseptic services as part of the transforming access to medications programme (TrAMS), which will see a move of production to a regional hub. A timeframe for this is unclear, but significant investment would be

required into PSU to address this inspection's findings. Contingency plans for the activity taking place in the unit are being reviewed. Remedial works to improve the unit have been explored with CEF and a review of the air handling unit has been commissioned

UKAS Accreditation Cellular Pathology 13th and 30th June 2023
ISO accreditation maintained at 2012 standard, minor findings noted in assessment, evidence supplied and all actions closed with UKAS. A further assessment in April 2024 recommended transition to the 2022 UKAS standards.

HTA Inspection of Stem Cell Laboratory (as part of Haematology inspection) 25th July 2023
The Stem Cell Laboratory was inspected as part of an inspection to Haematology. There was one finding relevant to the laboratory in relation to documentation of a new process which has since been rectified.

MHRA Inspection of Radiopharmacy 2nd October 2023
Significant concerns were raised regarding the facility by the inspector. 1 critical and 1 major finding were noted at which point the inspection was paused. Critical finding posed a significant risk to the product and therefore patient safety. Failure to act on previous commitments to a new build was also noted, this work had not progressed within CAV as a result of WG plans for TrAMS. As a result of the findings and the significant investment required to bring the department up to the MHRA standard and in light of the regional plan, the decision was taken to cease production. A regional business continuity group was formed to manage the Radiopharmaceuticals supplied by SBUHB. A location for a new regional Radiopharmacy has been progressed through WG with a proposed start date early 2025.

All Wales Quality Assurance of St Mary's Production Unit, 5th October 2023
The inspection demonstrated improvement in the PQS from the previous audit. Of the examples reviewed they were well managed; however, oversight and awareness were an issue as there were some examples of PQI's not being managed in a timely manner. This has since been addressed through improved role clarity and responsibilities within the aseptic and QA teams with regular meetings to review performance. It was also identified that the environment was cluttered and the positioning of the compounder was too far forward and the critical connections are outside of the air flow. The areas have been reviewed and de-cluttered as far as possible given the space constraints. There is a programme in place to replace cabinets which would address the critical connections.

British Standards Institute inspected Clinical Engineering, **30th October 2023.**
Three non-conformances were identified but re-certification was recommended.

HTA Inspection of Mortuary 7th and 8th November
Under the Human Tissue Act 2004 the HTA has a statutory responsibility to assess whether the conditions of a licence and licensing standards are met, in relation to the suitability of the DI, licence holder, premises and practices. The HTA also visited the unlicensed body store at the request of WG to review the premises and processes in place there in light of the Fuller Inquiry initial recommendations. It was a positive visit on both sites. In relation to the premises there was 1 shortfall against the standard which is testament to the hard work of all staff under the licence. The Inspector's particularly noted the care and dignity provided to the deceased. They highlighted the documentation designed by the team and asked for copies to share with other departments. Tissue traceability and of the deceased found no anomalies, which demonstrates the huge progress made by the team since the 2017 inspection. The planned refurbishment was also discussed during the visit.

All Wales Quality Assurance of Aseptic Preparation Services UHL 13th and 14th November 2023
The inspection highlighted issues relating to the facility's age, including general fabrication and the air handling units. Improvement in the PQS was noted from the previous inspection but issues of timeliness of raising change controls and failure to undertake effective root cause analysis were identified as areas for improvement. Decisions around the long-term future of the unit are related to the regionalisation of aseptic services as part of the transforming access to medications programme (TrAMS), which will see a move of production to a regional hub. A timeframe for this is unclear, but significant investment would be required into PSU to address this inspection's findings. Contingency plans for the activity taking place

in the unit are being reviewed. Remedial works to improve the unit have been explored with CEF and a review of the air handling unit has been commissioned

HIW Inspection of Radiology UHW against IR(ME)R regulations 14th and 15th November 2023
Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection diagnostic imaging at UHW. HIW reported that staff had a good awareness of their roles and responsibilities in line with IR(ME)R 2017. There were 17 recommendations including suggestions to amend documentation, use a standard template for audits including who is responsible and timeframes and some observations about the general environment including 3 chairs that were damaged and a flickering light. That said they noted most areas were tidy and free from hazards. An action plan to address the feedback has been submitted and progress is tracked on AMAT.

UKAS Accreditation Biochemistry 18th January 2024
Re-accreditation visits against ISO15189 2012 and the new 2022 standards in Biochemistry resulted in successfully maintained accreditation and recommendation to transition to the 2022 standards. Accreditation ensures safe delivery of services, technical competence, timely, accurate and reliable results, and good quality management. There were minimal findings and all low risk. The assessors noted the emphasis on the risk management approach that was already well-embedded within the team which was positive as that approach is the focus in the new 2022 standards.

MHRA Inspection of Blood Transfusion 30th January 2024
Inspected against the BSQR 2005 and Good Practice Guidelines. Positive inspection with only 1 major deficiency and 1 other identified. The major deficiency was in relation to the QMS and the volume of overdue documents, audits and change controls. This was as a result of a focus on training which had meant the team were behind on QMS. A robust action plan was submitted to the MHRA with quarterly updates to be submitted to demonstrate progress on closing those that are overdue. A risk-based approach to completion has been taken to prioritise the workload. The team also received positive feedback in relation to their knowledge, completion of RCA and risk assessments. The qualification and validation documents were some of the best the inspector had seen.

UKAS Accreditation Haematology 24th April 2024
Re-accreditation visits against ISO15189 2012 and the new 2022 standards in Haematology resulted in successfully maintained accreditation and recommendation to transition to 2022. The UKAS Quality Manager and the peer reviewers were very complimentary and reflects again the efforts made by the team in this service.

Risks For Escalation

The Clinical Board continues to work with services to review risks held on the register to ensure continued appropriate action and mitigation against all held risks.

The key risks from the risk register include:

<u>IT/Digital</u> Risk rating 16

Impact from aging hardware and software and slow delivery of key IT systems, some on-going stability issues.

The Clinical Board is fully engaged with the National Programme to work towards standardisation and interoperability, e.g. LIMS and RISP. The timescale for implementation of LIMS is May 2025
RISP deployment is likely February 2026 for Cardiff and Vale UHB.

<u>Estates and Facilities</u> Risk Rating-20

The fabric of some estate is suboptimal to delivery of modern, safe and sustainable healthcare with potential to fail to meet regulatory requirements.

We continue to engage with schemes to update/replace our aging estate and equipment, e.g. The business case for the refurbishment of the mortuary was approved by Welsh Government with work commenced in April for a 10-month programme. The refurbishment will also increase the capacity of the mortuary which was tested during the previous winter when business continuity plans were enacted to provide additional capacity.
The equipment in Neurovascular Interventional suites has been approved for replacement, with a project group managing the replacement programme and mitigations whilst work is underway. The planned start of replacement is Summer 2024.

The air handling units and isolators in both Aseptic Pharmacy Production Units are not fit for purpose and would require significant investment if they were to remain within CAV UHB. With the UHL unit at particular risk due to ageing infrastructure. The strategy to regionalise the aseptic production through the TrAMS programme in an, makes local investment in these areas challenging. However, there is a risk that high-cost equipment or remedial estates works will be required whilst awaiting the transfer of services, with delays already incurred in the TrAMS programme. Delivery of all these schemes will be essential to satisfy the regulating bodies. Progress in relation to the regionalisation of Radiopharmaceuticals has progressed in part due to the cessation of production in Cardiff and Vale as referenced above.

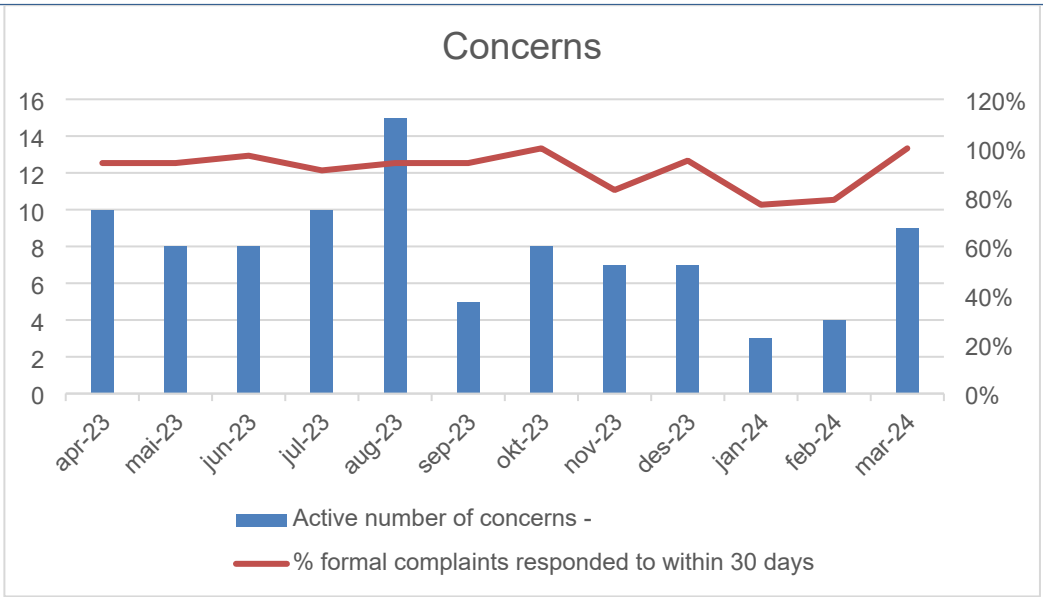
Backlog of Diagnostics (as a consequence of Covid19) in Cellular Pathology. Risk Rating 20

The department of Cellular Pathology has a backlog of pathology cases, resulting in risk of increased morbidity and mortality due to a suboptimal turnaround time. This could lead to a delay in cancer or critical illness diagnosis and has inevitably led to an increase in concerns. Backlogs had accrued in all areas within the cellular pathology pathway, at one point seeing a backlog in the microtomy section (the area in the laboratory where slides of tissue are sliced and prepared onto slides for reporting) build up again as a result of vacancies and sickness in that team. There had been significant improvement due to the focused efforts of the team and the introduction of 7-day working which has resulted in the workload reducing to a manageable operational level. However, issues remain in later stages of the Cellular Pathology pathway. There is a robust action place in place to improve the position and get a sustainable workforce to manage the increasing demand through the laboratory. There is work to do to support the reporting element of the pathway and outsourcing will continue to manage the workload. The role of Reporting Scientists to support Pathologists is being developed further alongside implementation of digital pathology

Backlog of Diagnostics (as a consequence of Covid19) in Radiology. Risk Rating 20

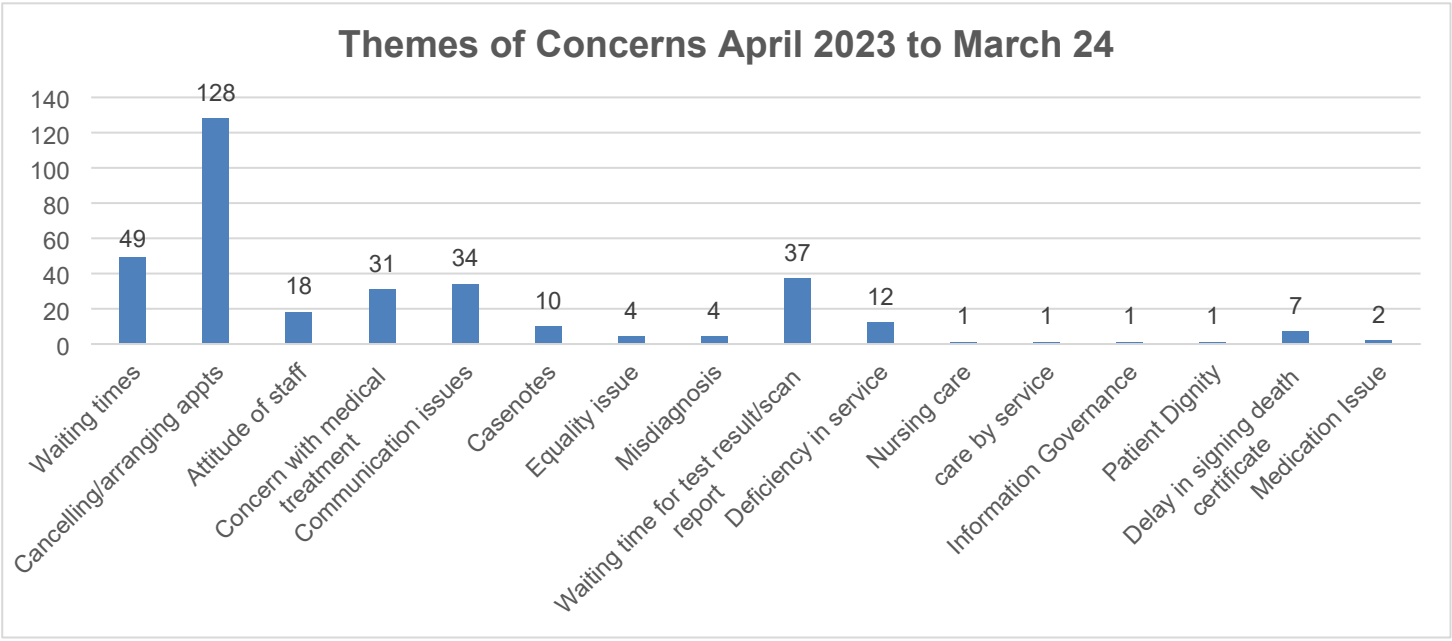
There is a backlog within Radiology in particular in non-obstetric Ultrasound resulting in long waits for routine referrals. This could lead to a delay in cancer or critical illness diagnosis. There is a robust action plan in place to increase the capacity for 2024/25 in order to improve the position, which includes several initiatives, both to reduce demand and increase capacity. Further detail on waiting times is outlined in performance section later on in this report.

Concerns and Compliments
340 concerns were received during April 2023 to March 2024, a reduction of 150 in the previous 12-month period. 46 were managed through the formal concern process and 294 were managed via early resolution. On average across the year, 83% of formal concerns responded to within 30 days.



The top 3 themes of concerns received for 2023/24 were:

- Difficulties cancelling/arranging appointments – 37.6%
- Waiting times – 14.4%
- Waiting times for test results/scan reports – 11%



In relation to the difficulties in cancelling/ arranging appointments we are looking at how automated systems may be implemented to address these challenges.
Waiting times for appointments and results are also being reviewed regularly through performance meetings. We know we have some hot spots where our patients are waiting longer than we would want. Teams are working hard on action plans to make improvements.

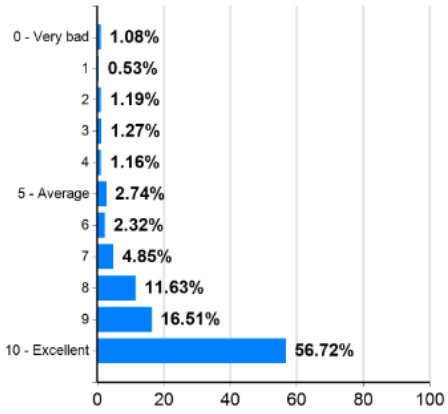
96 compliments were received by the Clinical Board in the same period, a reduction from 104 in the previous 12-month period. It is pleasing to note the positive reports received from patients for all of our services.

Patient Experience Data

During 12 months from 1st June 2023 to 31st May 2024, data has been collated from Civica in relation to services across Clinical Board. Largely this data comes from outpatient settings in particular Physiotherapy, Occupational Therapy and Phlebotomy clinics.

Question 5: Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

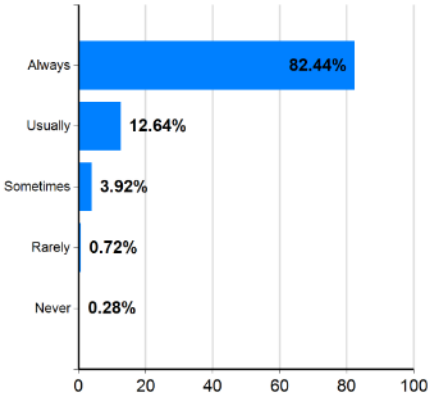
Available Answers	Responses	Score (%)
0 - Very bad	41	1.08%
1	20	0.53%
2	45	1.19%
3	48	1.27%
4	44	1.16%
5 - Average	104	2.74%
6	88	2.32%
7	184	4.85%
8	441	11.63%
9	626	16.51%
10 - Excellent	2151	56.72%
Total	3792	100%



Question 3: Were staff kind and caring?

Available Answers	Responses	Score (%)
Always	3221	82.44%
Usually	494	12.64%
Sometimes	153	3.92%
Rarely	28	0.72%
Never	11	0.28%
Total	3907	100%

Create new action

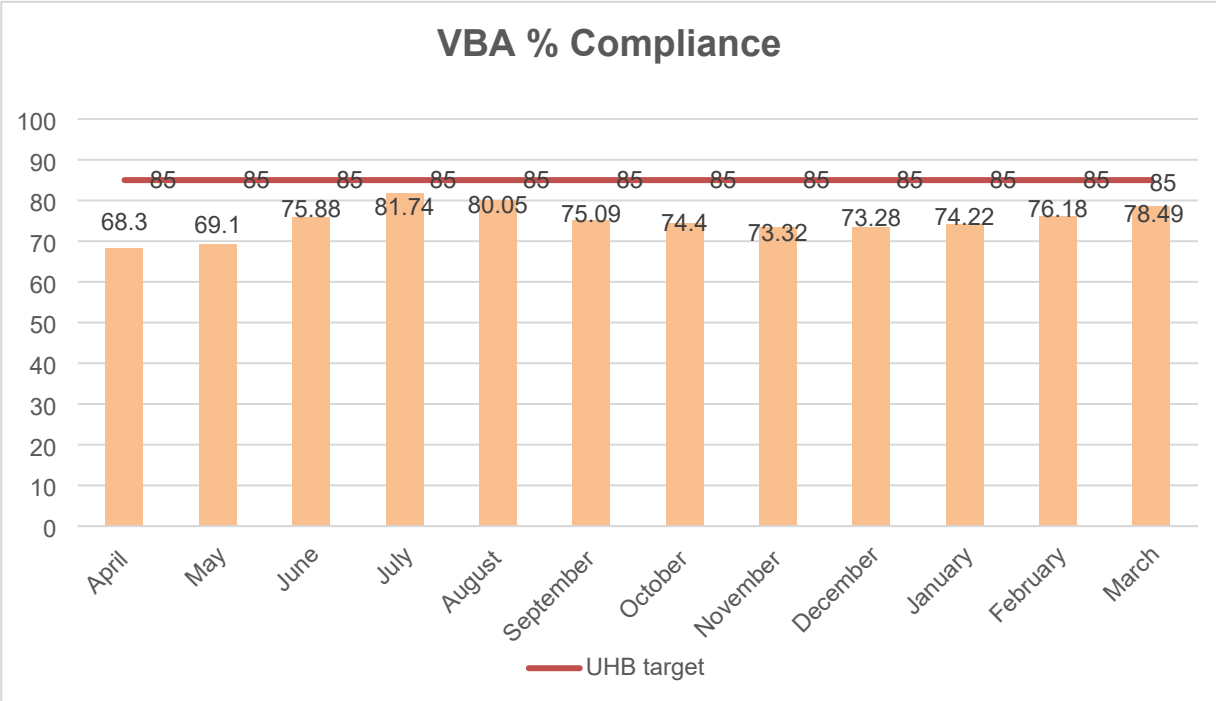


It is pleasing to note that the majority of patients rate their overall experience as 8 or above and that 82% replied that our teams were kind and caring always.

The word cloud below is created by collating comments taken from free text boxes in the Civica system, the larger the word the more frequent it was mentioned.

Whilst this is largely positive, where patients are describing an experience that falls below what we would expect, wherever possible this is investigated further with the teams involved. In the next 12 months we would like to further refine how we can record patient experience data in more detail and include other areas not currently included in the Civica system.

Workforce



Despite an encouraging trajectory during the summer, the momentum has not been sustained and we have seen operational pressures and the focus on delivering clinical care impact further improvement. From April 2024, compliance with value-based appraisals is now being monitored on a weekly basis and the compliance rate is currently at 80%.

Performance March 2024					
Turnover	Cumulative Sickness	VBA	Medical Appraisal	e-Job Planning	Stat and Mand
11.95%	4.97%	78.49%	89.61%	48.05%	86.86%

Turnover reduced to 11.95% from 13.24% reported in the same period as last year and is steadily reducing further with the current rate at 11.68%. During the summer turnover reached its highest level and a deep dive was undertaken to understand the reasons for staff leaving. The analysis identified that:

- All leavers resigned voluntarily.
- Relocation is the main reason staff are leaving:
  - Staff are relocating from Cardiff to other areas in Wales/UK where it is less expensive to live.
  - Students taken on following their graduation, are moving to be nearer to their families.
  - Staff originally from other parts of the UK are moving to be nearer to their families for help with child support.
  - To go to University or retrain in another profession
- Staff were being promoted internally in the Health Board or elsewhere in the NHS or moving into the private sector
- Staff were leaving to go travelling.

Diwylliant
Culture

There are a number of initiatives across the Clinical Board to support staff engagement and well-being. There is a fortnightly team brief, via teams, for staff to join to get updates from the Clinical Board and the wider UHB, an opportunity for teams to raise any questions or concerns.

Within Pharmacy directorate a Yoga breakfast club in Pharmacy at UHL gained funding from the Staff Lottery to fund a breakfast club where a yoga teacher attended a session in the early morning. This was a success and there are plans to continue on a regular basis. In UHW the team have recently undertaken a team steps challenge to improve fitness across all staff and been holding regular lunchtime wellbeing walks. A wellbeing newsletter is also produced and shared across the directorate.

Within Physiotherapy an Equality and Diversity champion role has been developed.

In Medical Illustration there are a number of Mental Health champions and one of them collates Wellbeing links from EWS and emails the whole team.

Within the laboratories supported by Staff Side, there have been several sessions on disability awareness in the workplace, the feedback from colleagues has been positive following the sessions.

Several departments have taken part in Project Search and have found the experience positive for both the substantive team and the project search candidates.

During the last 12 months the opportunity has been taken to celebrate the variety of professions across the Clinical Board, including World Radiography Day, International Nurses' Day, Healthcare Scientists and AHPs.



HealthRoster has been rolled out in outpatients, therapies, pharmacy and laboratory medicine. Further roll out is planned for the next 12 months.

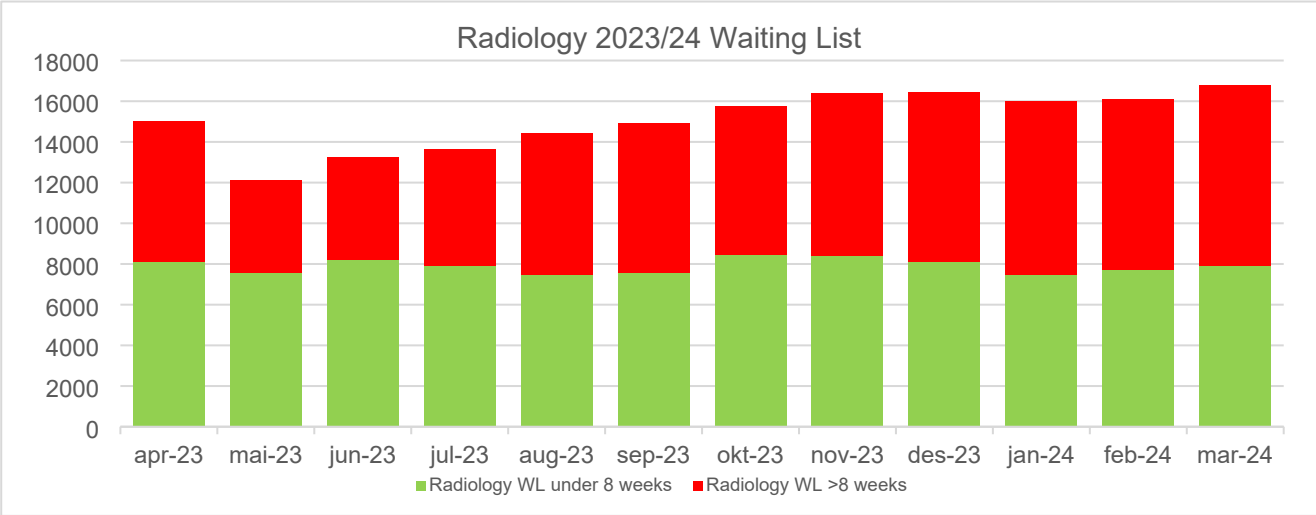
The Clinical Board also has a staff recognition award scheme which runs over 12 months with the aim to acknowledge and celebrate the dedication and contribution of our teams.
Some of our winners in the past 12 months

Category	Winner
Living our Values	Tracy Turnball
Quality, Safety & Patient Experience	Jo Fleming
Outstanding Team	Mortuary Team
Making it Better	Cellular Pathology Laboratory team
Equality, Diversity, Inclusion & Welsh Language	Sarah Clements and Hawys Waddington
Green sustainability award	Sian Jones

Performance Against National Standards

Diagnostic & Therapeutic Standards

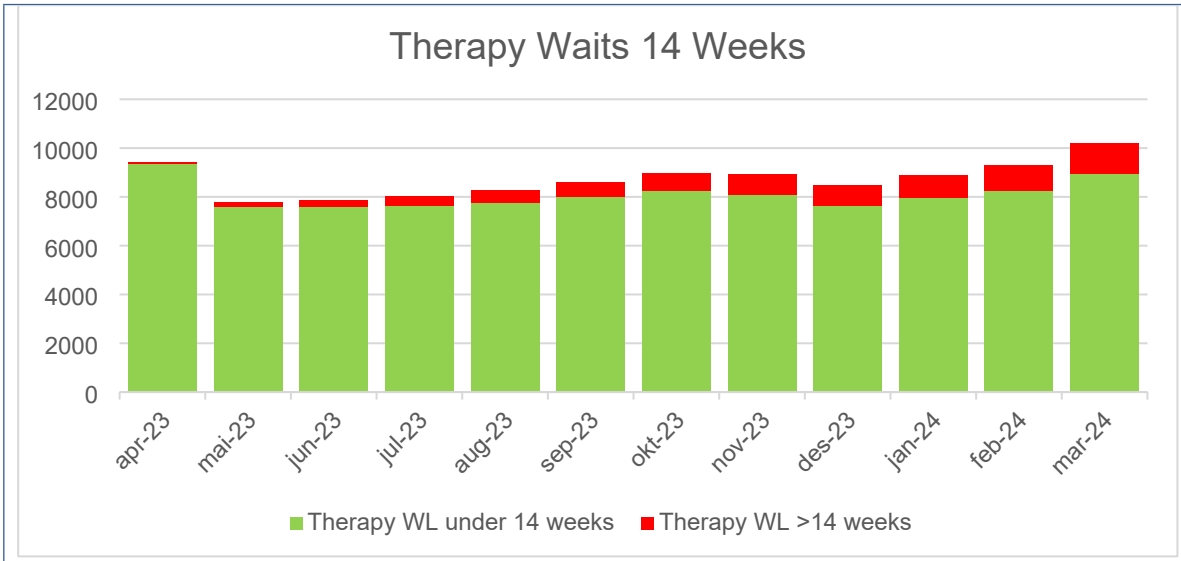
2023/24 has been a challenging year in terms of providing timely care to patients.
In relation to the 8-week diagnostic turnaround, the performance has deteriorated in year after making significant improvements at the latter stages of the previous year.



The waiting list information in the table shows the nationally reportable modalities (CT, US, MRI, NM, Fluoroscopy), split by those waiting fewer than 8 weeks and those that had waited in excess of 8 weeks. To provide context, Radiology delivered in the region of 73,000 CT scans, 27,000 MRI and 48,000 Non-Obstetric Ultrasound scans in 2023/24.

The deterioration in the waiting list is primarily due to insufficient capacity within Ultrasound. Sonographers are in short supply nationally, and are difficult to both recruit and retain. Despite adopting an insourcing arrangement throughout 2023/24, it was not sufficient to meet the considerable demand, which had increased by 4% from the previous year's referrals. There is a robust action plan in place to increase the capacity for 2024/25 in order to improve the position, which includes several initiatives, both to reduce demand and increase capacity.
Significant action has also been taken in CT and MRI to reduce the number waiting over 8 weeks. The diagnostic hub at UHL increased capacity from September for CT and MRI which will run into 2024/24.

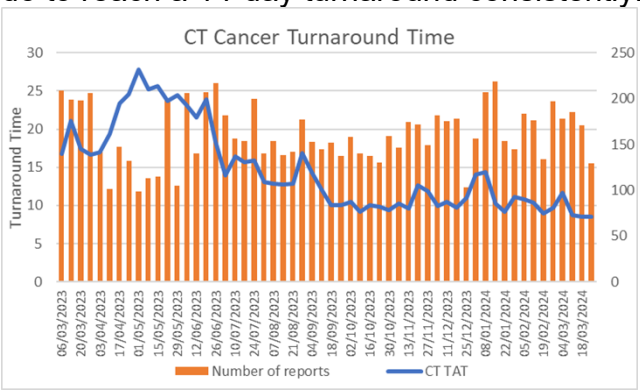
The 14week standard for therapies was met consistently in a number of therapeutic specialties.

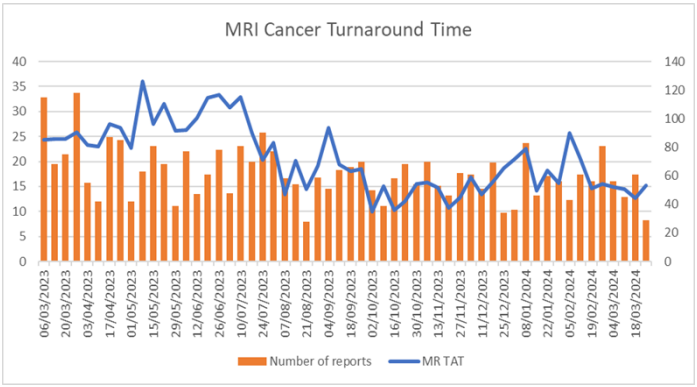


However, within Dietetics, the demand for weight management services has increased considerably, without reciprocal increase in service provision, with the number waiting more than 14 weeks for first appointment increasing each month. Given the high-profile nature of the newly licensed weight loss drug and an increase in the number of patients returning from having bariatric surgery elsewhere requiring dietetic support, this will be a key area of focus in 2024/25. Similarly, the transgender SLT service has seen increases in demand and will be an area of focus for the coming year.

Cancer

In addition to formal reportable standards, improvements have been made to the diagnostic pathway within the 62-day cancer pathway.
The turnaround time from referral to report for CT reduced significantly in year and for the last quarter averaged at a 10-day turnaround. The turnaround for MRI has improved but there is still some work to do to reach a 14-day turnaround consistently.





The following section of the report outlines how each of the directorates are contributing to the 6 domains of quality and the 6 enablers

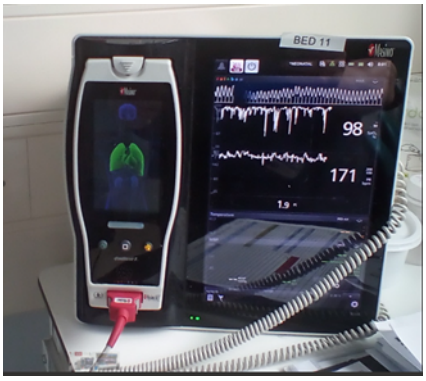
Radiology, Medical Physics & Clinical Engineering

Tendable has been adapted to use within Radiology and provides assurance in relation to IPC practices.

Within the non-ionising department of Medical Physics, the extension to UHL of Doppler Ultrasound DVT and acute arterial service is underway. This will be an improvement in service from current arrangements and provide an improved patient experience. The Doppler team are also putting more SOPs and documents onto Q-pulse for audit and improved governance.
Ultrasound users now have an Ultrasound Mandatory Training module that they need to do as a minimum educational requirement.
In the ionising section of the department a new section head has been appointed providing leadership to the team. They have been reviewing entitlements and planning to implement Q-pulse. SLAs have been revised to reflect latest guidance on MPE levels for Nuclear Medicine services regionally.

Clinical Engineering and Masimo worked together with colleagues from NICU to install a new central monitoring system (Patient Safety Net).
This project focused on the NICU, Daisy 1 and Daisy 2 with 19 connected beds in total across 2 central monitoring screens. It also focused on Owl ward with 24 connected beds across 2 central monitors. Across the large wards, particularly in areas with side rooms, the new system will improve work flow for the teams but most importantly enhance patient safety.
This system provides the following benefits:

- Previously it was necessary to run overnight recordings of oxygen saturation to ensure a safe discharge. The new system provides a retrospective view of trends, therefore it speeds up discharge of patients.
- Provides the groundwork for a paperless electronic patient record integration.
- Patients can be monitored centrally reducing staff workload and increasing safety.
- Data collected can be used for research



Patient SafetyNet is a supplemental remote monitoring and clinician notification system which displays near real-time information from any connected Masimo device at a central station and allows alarms and alerts from bedside devices to be sent directly to clinicians. The key benefit of this type of system is to provide and additional layer of monitoring safety ensuring when a clinician leaves the room there is still monitoring.

CEDAR

CEDAR has implemented a complete review of the Quality Manual and documentation for all the work themes (Research, Health Economics, Health Technology Assessment, Service Evaluation, Value-based Healthcare), with involvement from all the team. An all-day working session was led by the working group, and involved all the theme leads to finalise documents and decide on processes.

Medical illustration

Around 20,000 teledermatology referrals are reviewed by dermatology consultants in Cardiff and Vale University Health Board (UHB) each year, including urgent suspected cancer (USC) referrals. Following a successful pilot of a teledermoscopy service in November 2022, a service which reduces the need for all referrals to have a face to face appointment, this has now become a substantive service directly contributing to the decrease in dermatology waiting lists.

To support the workforce Medical Illustration have provided protected time for the designers to develop skills in order to meet the future needs of the service. Photography clinical audits are held in line with UHB timelines and this is used as an opportunity to hold workshops, image audits and critiques in order to facilitate the teams ongoing development. The department's appraisal approach encourages the team to be proactive in determining areas for their growth. The team are set objectives that will ensure their ongoing development to meet the needs of the service. A proactive approach to appraisals ensures that the team are invested in their ongoing development and feel supported.

Pharmacy

KidzMedz is an initiative to support Children and Young People in Wales to switch liquid medication for pills and capsules as part of an innovative new programme. After a successful application to Spread and Scale Academy, KidzMedz Cymru was launched last year from Noah's Ark Children's Hospital for Wales. The project aims to teach children over the age of four to swallow tablets. By teaching children how to swallow tablets and capsules from a young age, we are hoping to initiate a change in the culture of prescribing to reduce the volume of liquid medicines prescribed by 20% over the next year. Leading clinicians report pills have numerous advantages over liquid medicine for all concerned. The Cardiff and Vale University Health Board based initiative successfully obtained a grant from the Staff Lottery to kickstart this project. This funding has helped to develop education kits for healthcare professionals, parents and carers which contain practice kits, information leaflets and questionnaires. The outcomes from this project are being shared with other UHBs across Wales and this month the project won a NHS Wales Sustainability Award for its success.

Nitrous Oxide and Entonox Pharmacy has been part of a team reviewing the use of nitrous oxide and Entonox across the UHB which has resulted in two nitrous oxide (UHW and UHL) manifolds being decommissioned with a plan to remove the remaining ones at Dental and St David's over the coming months. Entonox use has been reviewed and various issues with the pipelines have been resolved also one of the Entonox manifolds have been decommissioned and use of the remaining two are being investigated. This work is part of a multi-disciplinary team with colleagues from Estates, Anaesthetics and Clinical Engineering. This is an important piece of work from both a financial and decarbonisation point of view.

Pharmacy were part of the Bevan Exemplar Cohort this year. The project scoped the patient medicine journey from admission to inpatient to discharge being clear of medication requirements and source/supply of the medicines. Eliminating waste within the medicine flow and address inefficiencies in supply alongside delivering a sustainable strategy for medicines management. The main aims were reducing waste, harm and variation and prescribing prudently across the barriers by improving co-production with patients. The results of the project were presented to the Senedd on 18th June.

UHW has been successful in obtaining its CD licence and UHL are currently in the final stages of applying for Wholesaler Dealer Authorisation licence.

Tendable has also been adapted to provide audit templates for use across dispensaries and distribution, monitoring the environment and key medicines processes.

Therapies

Therapies have recruited co-production leads who support the Directorate to co-produce their services with those who use them. They have been focusing on specific work streams around long- term conditions and waiting well. They run a regular on-line co-production forum which has been in place for over a year now. It has in excess of 350 contacts in the network and approximately 40 regular attenders.
The production of Stepping Stones is a notable achievement which is a co-produced self-help toolkit to support people to live well and live the life they want to lead discovering what is possible. The tool kit is a personal record of things individuals can do to keep well, designed to help discover a new

normal to maintain a fulfilling and happy life. This is available in printed format as well as online via our Keeping Me Well website.
The Cardiff and Vale Live Well Service was the winner of the Award for Excellence in Rehabilitation at the 2023 Cymru Advancing Healthcare Awards in October 2023 for their submission titled 'Community Cure in Action' describing a service working with leisure and third sector as well as individuals with lived experience to co-deliver psychologically informed, activity-based health behaviour change programmes for people with long term health conditions.
In the UK Advancing Healthcare Awards dietitian Catherine Washbrook-Davies won the award for value-based care for her work on type 2 diabetes remission and Helen Nicholls, the recently retired Head of Nutrition and Dietetics, won the AHP Clinical Leadership award which was a very fitting close to an esteemed career.
Therapies has really driven its sustainability agenda with its Sustainability Strategy, Sustainability Plan and Sustainability Champions. This is already showing its success with 6 projects shortlisted for the NHS Sustainability Awards held at the Vale Hotel in June and walking aid refurbishment winning its category.
There is a thriving research agenda in the directorate with 10 projects with therapists as the principal investigator and two therapists starting doctoral studies in 2023 with a further 2 progressing to this in 2024.
The AHP and HCS conference was held in March, showcasing work across these professional groups. There was a packed programme of presentations aligned to the UHB strategy as well as posters and awards to colleagues.
Quick Change, a collaboratively produced interactive animation enhancing the promotion and encouragement of daily movement, helping to build and maintain strength and balance in children aged 4-6 years has been shortlisted in the NHS Wales award in the NHS whole systems approach award.

Laboratory Medicine

The Laboratory Medicine directorate has worked hard to reduce the impact they have on the environment. They have joined the Laboratory, Efficiency Assessment Framework (LEAF) programme, run by UCL. The programme provides a framework that guides you through actions that can be taken to save water, plastics and energy, there is also an online toolkit and resources available. The directorate has achieved bronze level due to the actions they have taken to improve sustainability and are working towards the silver level.

All the laboratories within the directorate have maintained United Kingdom Accreditation Service (UKAS) accreditation to the 2012 standard but have all been recommended by the assessors to transition to the new 2022 standards. This is a great achievement. Accreditation by UKAS demonstrates the competence, impartiality and performance capability of the laboratories against national and international standards.

The mortuary refurbishment has commenced and will take up to 10 months to complete. This has led to some changes to how our teams work across different sites but maintaining the dignity of those in their care is always the priority.

Outpatients and Patient Administration

Patient Participation Booking (PPB) has now been rolled out to almost all acute specialties. Those outstanding do not fit the current model due to clinical or operational nuance. PPB offers digital new appointment letters and text messages, providing patients with more timely and easier ways to confirm, change or cancel their appointment.
For those unable or not wishing to use technology, traditional hard copy letters will be sent, though in a more standardised way with an optimum notification period. The blended approach leads to a significant reduction in DNAs - often less than the 5%,(the national target) - greater clinic utilisation, as well as inherent benefits to patient experience.

The PPB team and specialties are now reviewing uptake rates with a view of allocating more new appointment slots to PPB and increasing the benefits to patients and the UHB. The sustainable and cumulative benefits of PPB will see waiting times reduce i.e. more timely care, with hope that the model can be extended to secondary appointments (follow ups) and other services.

In November 2023 the Outpatient Nursing team commenced the Cultural & Leadership programme with the support from colleagues in ECOD. This was in response to a series of relatively recent circumstances which had dramatically impacted on the culture of the department and relationships at all levels within the team. There have been 5 sessions since, supported by ECOD, People and Culture and CD&T Clinical Board colleagues which have built on a response from a bespoke anonymised staff survey. The outputs of the session have been a greater understanding of aspects that the team and/ or individuals work well or not so well and which can and should be improved.
As part of this there is an ongoing service review (due Sep 2024), which will propose, after input from all the team, the optimum workforce shape needed in the coming years to meet the needs of patients and to have colleagues working at the top of their licence.
It is needs-focused; from the patients' perspective first but also clinical and staff views. It will look at the roles needed now, as well as those of the future e.g. Registered Nursing Associates. The work is also recording and addressing common challenges and solutions to them. A comprehensive Improvement Plan has been developed.
There are several patient experience actions e.g. to ensure adequate hydration for patients attending clinic. A vending machine is now in place in UHL but IP&C advice is awaited on water stations.
Another larger and more complex issue has resulted in a task and finish group being established with the NEPT team to address transport delays for non-ambulatory patients.

Clinical Coding
Clinical Coding transferred to CD&T in September 2023 with coding completeness at **66.7%** (target = 95%). The current compliance with coding completeness has seen some improvement to 75.5 %. Further work to do to get nearer the 95% target. This performance was largely due to significant and longstanding vacancies and recruitment & retention issues.
With support from the executive workforce, remodelling was instigated, with eight band 5 WTE Senior Coding posts created (within budget), with a view to attracting experienced coders. Unfortunately, this wasn't as successful as hoped despite several attempts, although this did provide opportunities for internal recruitment and promotion for some of the team. This reflects a national picture, further complicated by the limitations of the ongoing widespread usage of paper medical records, rendering unviable a more attractive homeworking option that is offered in Health Boards / Trusts with a fully digitised records service.
A different approach was developed which switched to recruiting Band 3 trainees. This has proved successful, however, the lead time to having experienced fully productive staff is 12 to 18 months.
A department improvement plan has been created, with several changes made including digital coding of some Obstetrics and Gynaecology activity, leading to the inception of a small-scale working from home rota. These will align to the work of the newly established National Clinical Coding Improvement Initiative (CCII) and the UHB's Clinical Information Programme.
Despite these challenges, the department's accuracy of coding has not faltered. An intensive two-week external audit undertaken in March, saw the department surpass the national 90% accuracy target for procedures and diagnosis, both primary and secondary.

Resource
At the end of the financial year the board reported an almost breakeven position. An operational underspend compensated for a CRP shortfall of £557K. The majority of the shortfall consists of unidentified schemes in Workforce and Procurement.

	Month 12 YTD	Month 11 YTD	In Month Movement	Forecast
Operational Variance	(551)	(322)	(229)	(551)
CRP Variance	557	555	2	557
Total	**6**	**233**	**(227)**	**6**

Work is continuing this year to identify savings and opportunities to re-shape the workforce. The quality impact assessment template will be used where appropriate to demonstrate decisions are made through a quality lens in line with the duty of quality.

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

Recommendation:

The Committee is requested to:

a) Note the progress made by the clinical board to date
b) Note the content of the report and assurance given by Clinical Diagnostics and Therapeutics Clinical Board

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

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

Five Ways of Working (Sustainable Development Principles) considered

*Please place an "**X**" in the below boxes as relevant*

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

Report Title:	*Quality Indicators Report*			Agenda Item no.	*2.2*
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	16th July 2024
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive Title:	Executive Nurse Director and Executive Medical Director				
Report Author (Title):	Assistant Director of Quality and Patient Safety				

Main Report
Background and current situation:

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

The report provides oversight of data up until the end of June 2024 with details of actions that are being undertaken to drive the requisite improvements.

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

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

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

- Fourteen Nationally Reportable Incidents were reported in June 2024 two relate to patient safety incidents associated with follow up care, 1 was a Never Event (retained foreign object) and four reflect the new MBRRACE reporting criteria for intrauterine deaths from twenty two weeks gestation and neonatal deaths up to twenty eight days after birth.
- The UHB started the current financial year with 16 more cases of *C.Difficile* than the equivalent period last year, 22 cases in April and 14 were reported in May 2024.
- Between 1st April 2023 - 31st March 2024, 1809 medication incidents were reported via the Datix Cymru system. This represents a 38% increase against the previous year. Of those incidents, 761 were recorded as administration errors, with the most commonly reported error being administration of an incorrect strength/dose.
- The UHB has achieved compliance with all issued safety solutions (alerts and notices).
- An unannounced follow up inspection of maternity services in UHW was undertaken in March 2024 and published in June 2024. The inspection resulted in one immediate concern relating to baby security tags that was resolved on the day. A further five immediate assurance recommendations were made.
- Updates on the IRMER and Island ward inspections improvement plans demonstrated good progress in addressing the recommendations.

- Tier one mortality indicators are reported. Work is underway to establish an adjusted all wales mortality measure. A recent presentation to the UHB learning from mortality group gave oversight of excess mortality in 2023
- Oversight of NICE guidelines demonstrates that of 136 NICE guidance statements circulated 50 responses remain overdue. A presentation at the Clinical Effectiveness Committee broke response rates down by clinical Board and there was discussion about oversight of compliance and risk associated with non-implementation

- Seven wards are currently working towards achieving bronze accreditation
- 1073 Concerns were raised between April and June 2024 82% were closed within 30 working days and 35% under Early Resolution
- The UHB has 414 inquests currently being managed.
- 19242 Civica survey have been sent with and 18% response rate 89% of responders stated they were satisfied with the care that they received.
- 76% of CIVICA Emergency Department responses stated that people were satisfied with the care that they received
- 70% of CIVICA mental health survey responses state that the patients were satisfied with their overall experience

Recommendation:

The Committee is requested to: **NOTE** the assurance provided by the quality indicators

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

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

Five Ways of Working (Sustainable Development Principles) considered
*Please place an "**X**" in the below boxes as relevant*

Preventi		Long term		Integration		Collaboration		Involvement	

o n										

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*Comment here*

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

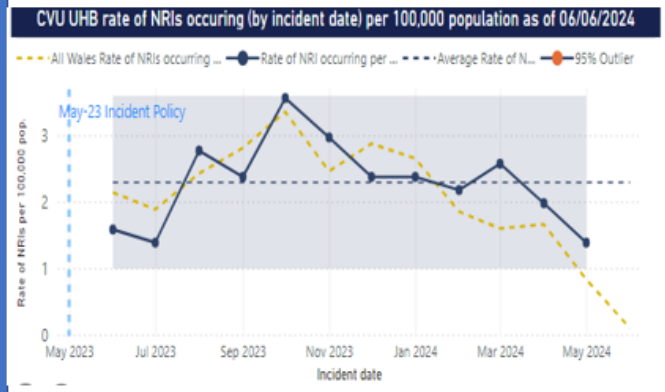
Quality Indicators Report

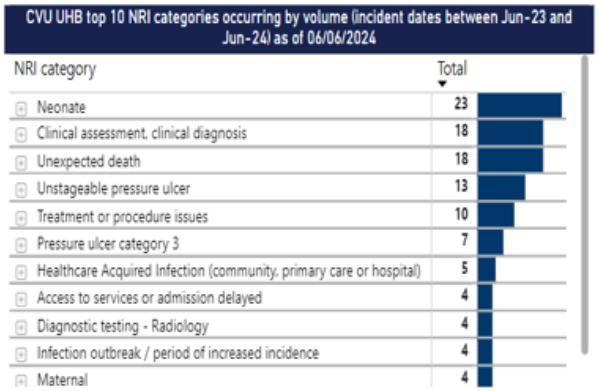
Quality Safety and Experience Committee

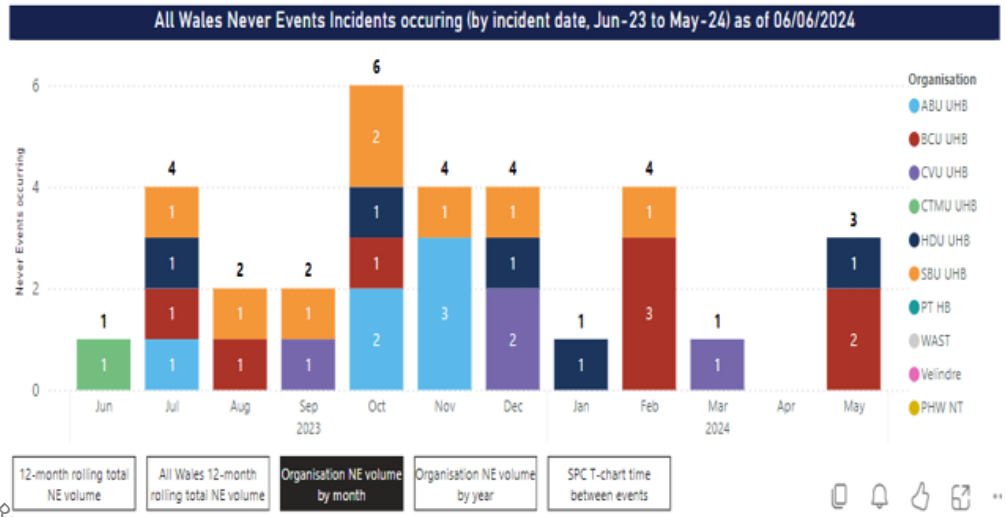
July 2024

National Reportable Incidents and Never Events

Safe Care







Fourteen NRIs were reported in June 2024; two relate to patient safety incidents associated with follow up care, 1 was a Never Event (retained foreign object) and four reflect the new MBRRACE reporting criteria for intrauterine deaths from twenty two weeks gestation and neonatal deaths up to twenty eight days after birth, these usually have no care concerns associated but are still reported as NRIs. This change in reporting criteria is shown in the top 10 NRI categories; neonatal incidents are now the highest reported category. Cardiff and Vale's NRI rate follows the All Wales trend which is showing a decline in monthly reporting rates.

Actions

Work is underway to further explore patient safety incidents relating to follow up care to better understand possible causes and to direct improvement actions.

Surgery Clinical Board has ongoing work to reduce the risk of Never Events; work on an Fascio-iliac block LocSSIP, the Five Steps to Safer Surgery work continues Some focussed work on culture and leadership within theatres is underway.

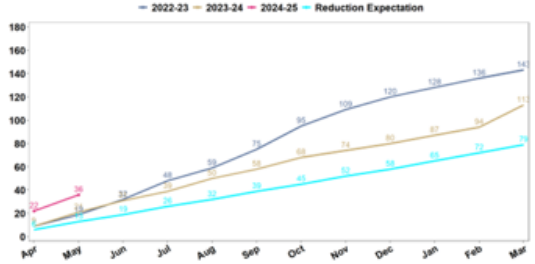
Cardiff and Vale NRI reporting of operational Pressures leading to Welsh Ambulance delays impacting on 999 response times has reduced significantly. A lot of work has been undertaken to reduce these delays and therefore reduce risk.
The onboarding initiative is one such piece of work.

Diogel
Safe

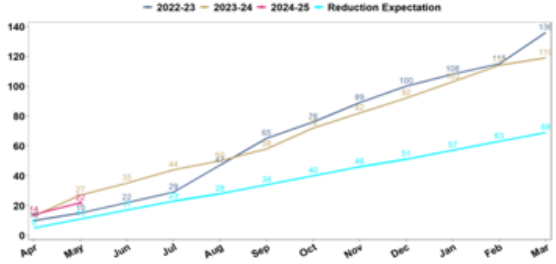
Safe
Care

Infection Prevention and Control

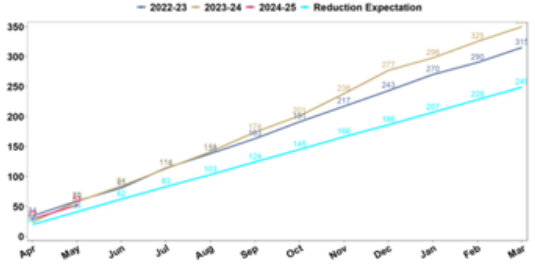
Graph 2: C. difficile Cumulative Monthly Numbers & Reduction Expecations for Cardiff & Vale UHB



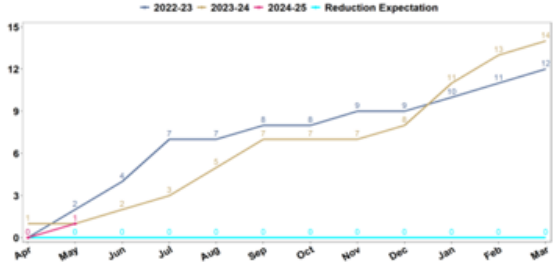
Graph 2: Klebsiella Spp Bacteraemia Cumulative Monthly Numbers & Reduction Expecations for Cardiff & Vale UHB



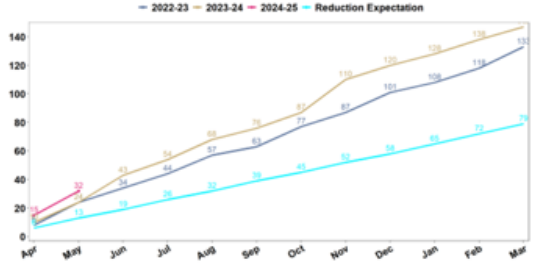
Graph 2: E. coli Bacteraemia Cumulative Monthly Numbers & Reduction Expecations for Cardiff & Vale UHB



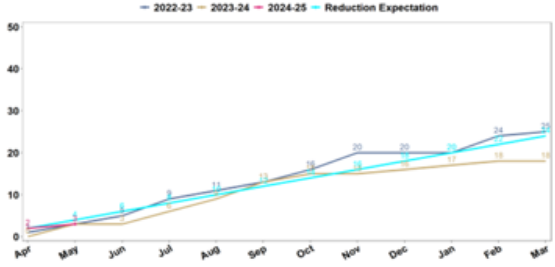
Graph 2: MRSA Bacteraemia Cumulative Monthly Numbers & Reduction Expecations for Cardiff & Vale UHB



Graph 2: MSSA Bacteraemia Cumulative Monthly Numbers & Reduction Expecations for Cardiff & Vale UHB



Graph 2: P.Aeruginosa_Bacteraemia Cumulative Monthly Numbers & Reduction Expecations for Cardiff & Vale UHB



C. Difficile
The UHB started the current financial year with 16 cases more than the equivalent period last year, 22 cases in April and 14 were reported in May. The WHC has not yet been received by the Health Board.

Klebsiella Spp Bacteraemia
The UHB has reported 5 fewer cases compared to the same period in 2023, 14 cases in April and 8 in May

E. Coli Bacteraemia
CAV continues to reduce the number of E.coli bacteraemia. Cumulative cases are below the same period last year with 29 cases in April and 23 in May.

MRSA Bacteraemia
One MRSA case was reported during May, giving the same cumulative total as May 2023 and a lower total than May 2022.

MSSA Bacteraemia
The UHB has reported 32 cases during April and May 2024, 8 more than during the same period in 2023 and 2022.

P. Aeruginosa Bacteraemia
As of May 2024, the UHB has 83% fewer cases than the same period last year and 88% less than the 2023 with 2 cases in April and 1 case in May 2024.

Safe
Care

Patient Safety Solutions

CVU UHB Outstanding PSS (17/06/24)			CVU UHB current compliance of all safety solutions to date (17/06/24)	CVU UHB compliance at deadline of all safety solutions to date (17/06/24)
0 Alerts	0 Notices	0 Total PSS	81 of 81 (100.0%)	53 of 81 (65.4%)

Current Compliance Status of outstanding PSS references (17/06/24)

PSS	ABU UHB	BCU UHB	CVU UHB	CTMU UHB	HDU UHB	SBU UHB	PT HB	WAST	Velindre	PHW NT	Total
Alerts	0	0	0	0	0	1	0	0	0	0	1
PSA008											1
Notices	1	0	0	0	0	0	0	0	0	1	2
PSN026											1
PSN066											1
Total outstanding PSS	1	0	0	0	0	1	0	0	0	1	3

As of 17th June, the UHB has achieved compliance with all issued safety solutions (alerts and notices).

Considerable work is underway in relation to **Patient Safety Notice 017**, which highlights safety risks with the Euroking maternity information system.

The Euroking system has been used to record information regarding maternity care of pregnant patients. The system is also used by a large number of Trusts in NHS England.

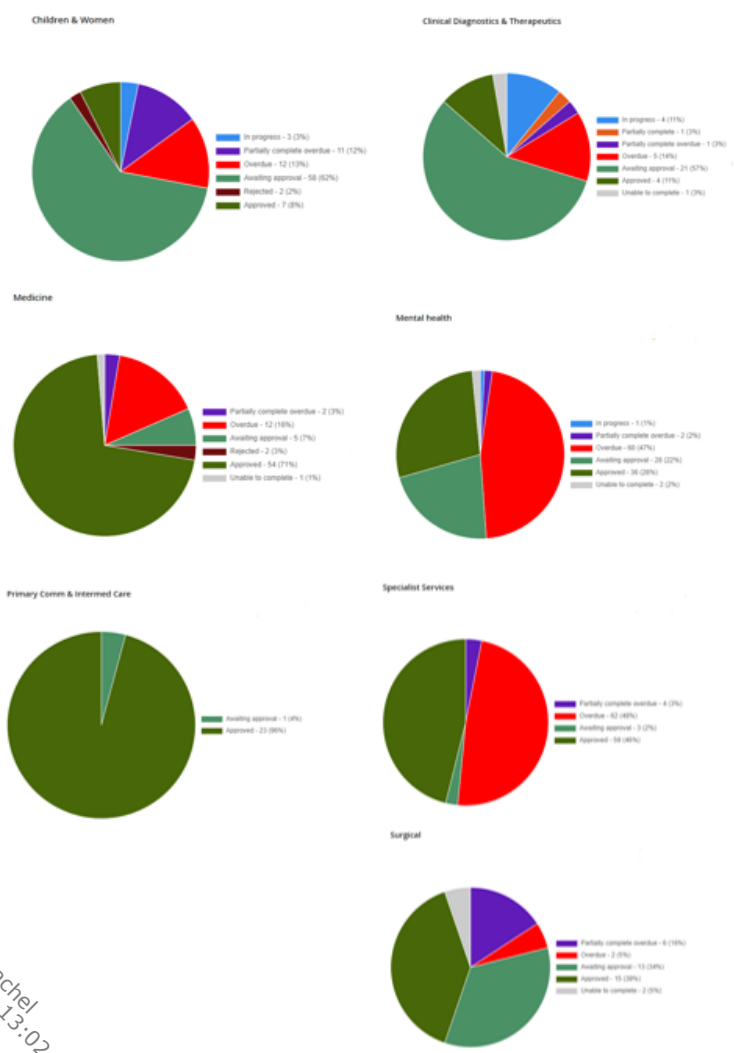
It was identified that due to technical issues with the system, some information may be unintentionally copied back or forward between an individual's pregnancy records, creating a risk of incorrect information being recorded and used.

Immediate safeguards have been put in place to minimise the potential impact of these technical issues.

The software supplier has been unable to rectify the problems and therefore a decision has been taken to procure a replacement maternity information system. This system is due to be implemented later in the year.

Safe
Care

HIW



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

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

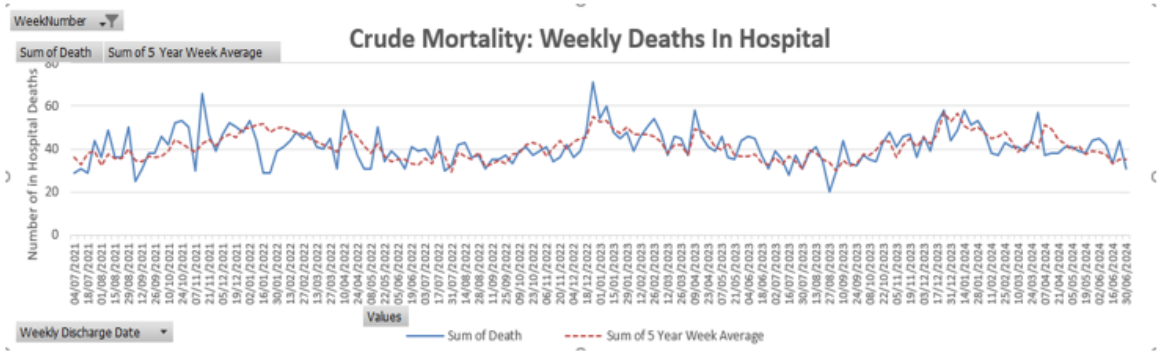
A Diagnostic Imaging Department Inspection was undertaken by HIW on 14 and 15 November 2023 and an update of the improvement actions was completed in May 2024. All but three improvements were complete. The three remining actions were :

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

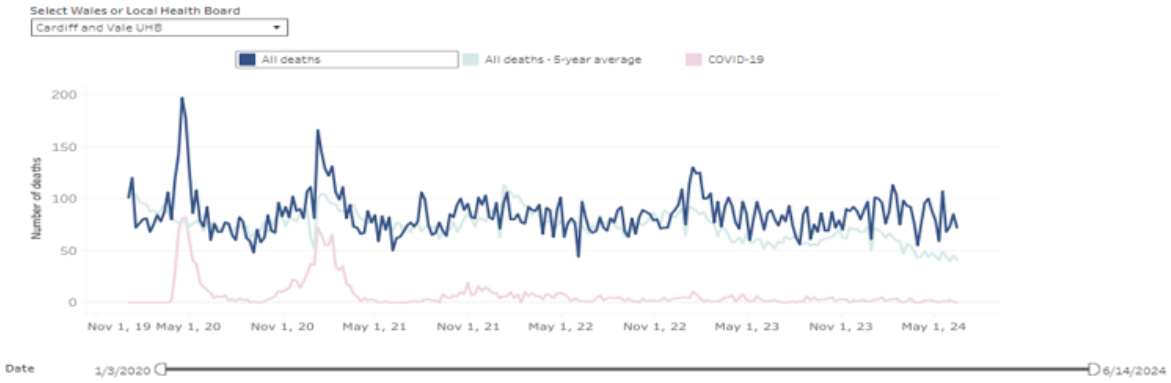
Effeithiol
Effective

Effective Care

Mortality



Weekly number of deaths registered, all deaths, COVID-19 deaths (any mention) and 5-year average*, week ending 3 January 2020 (Week 1) to week ending 14 Jun 2024 (Week 24), Cardiff and Vale UHB



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

Chilcott Rachel
09/07/2024 13:02:37

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

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

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

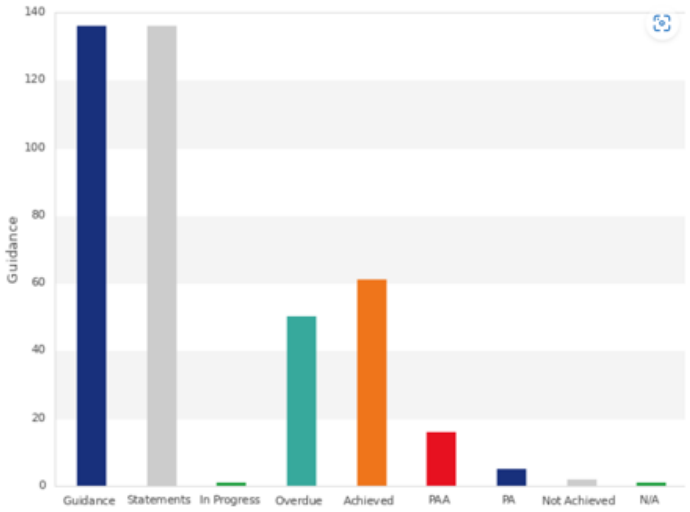
Comparisons with the European Age Standardised Mortality Rate per 100 000 persons of all ages between 2020 and 2023 demonstrates that there has been a significant increase in diabetes and liver disease featured on deaths certificates. The current method for calculating excess deaths does not account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

Effeithiol
Effective

Effective Care

Clinical Effectiveness

Guidance overview



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

▲ Guidance overview 2023/24

Circulated Guidance April 24 -

Title

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

Endometriosis: diagnosis and management

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

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

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

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

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

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

Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma

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

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

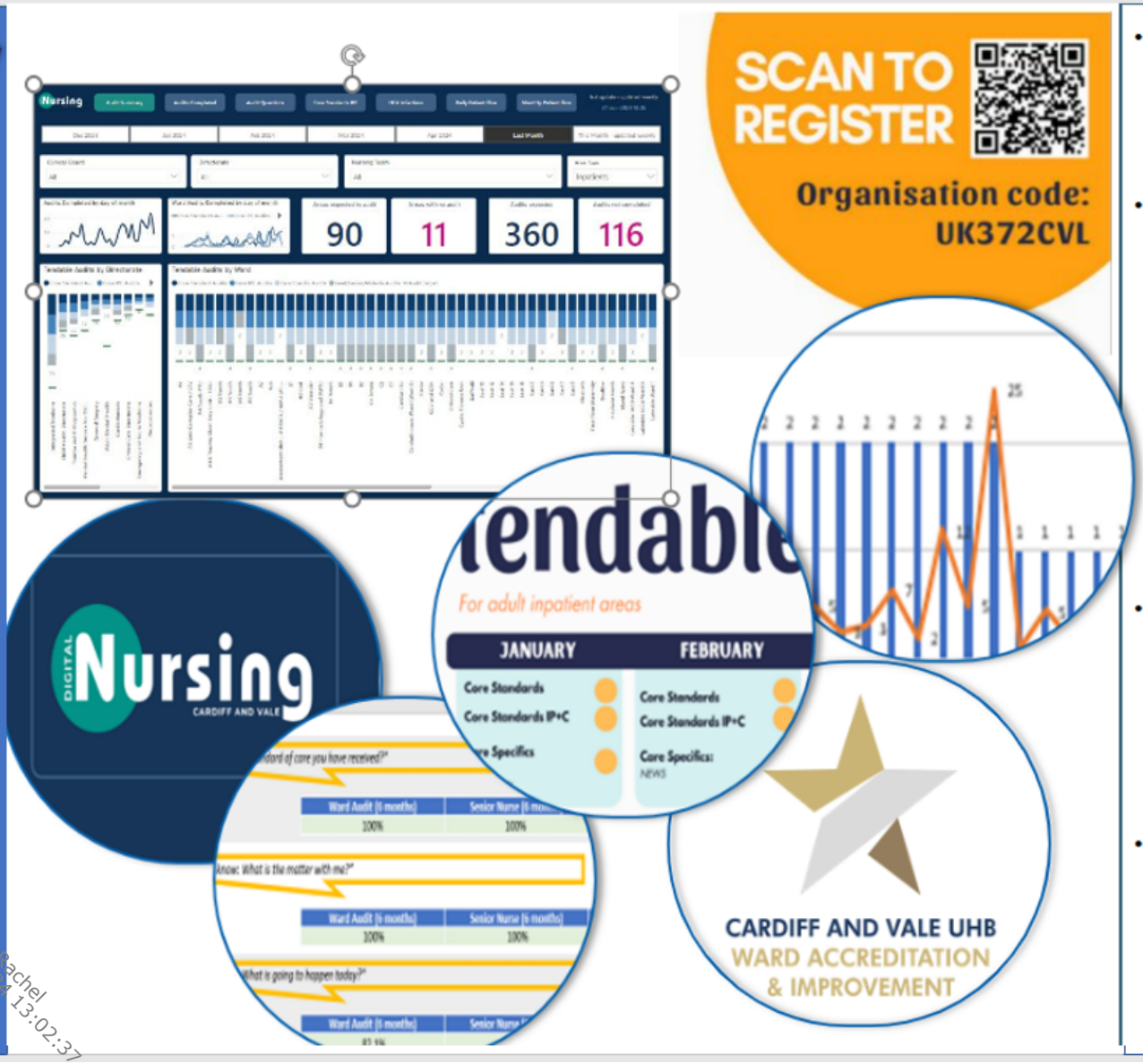
Cabozantinib with nivolumab for untreated advanced renal cell carcinoma

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

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

Effeithiol
Effective

Effective Care



- Tendable is being used in over 230 clinical areas across the UHB to review quality standards, drive improvements, demonstrate good practice.
- Nursing teams complete a structured monthly audit programme which is aligned to their individual and Clinical Board priorities. In addition, there are a range of audit topics that can be utilised on an ad hoc basis by both nursing teams and increasingly, the wider multi-disciplinary team. This collaborative way of auditing, reviewing and sharing of data is supportive of achieving outcomes that matter to our patients and staff within the health board.
- The Ward Accreditation and Improvement (WAI) programme for Adult Inpatient wards continues to grow, with 7 wards currently working their way through obtaining bronze accreditation. A WAI programme for Paediatrics is also in development.
- PowerBI dashboards support ward teams and colleagues across the organisation to track their audits and progress in real time. There is ongoing work to further develop our reporting capabilities in nursing to demonstrate quality, efficiency and best practice, using a range of digital data as part of the WAI programme

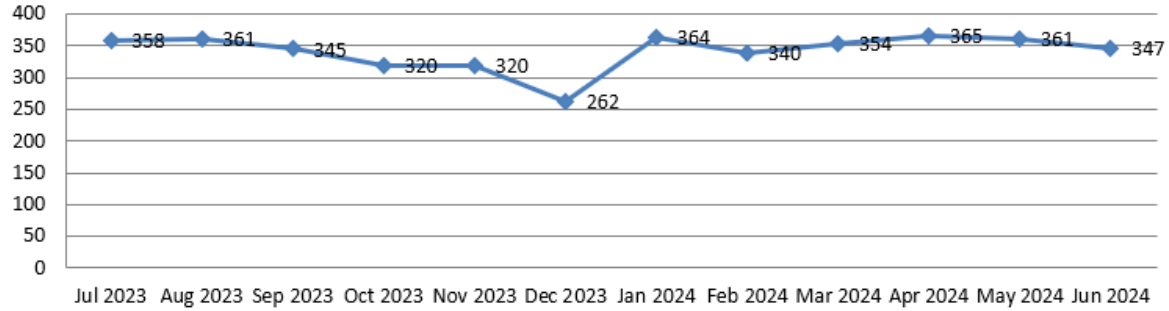
Person Centred Care

Patient Experience

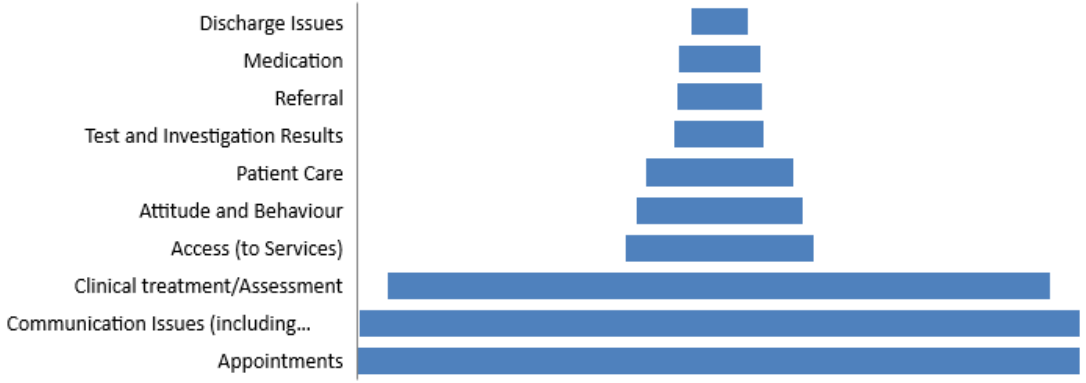
CONCERNS

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

Concerns received by month - last 12 complete months



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



During April, May and June 24, the Health Board:

- Received 1,073 Concerns
- Closed 1,021 concerns
- Closed 82% within 30 working days (including Early Resolution)
- 35 % closed under Early Resolution (within 2 days including day of receipt)
- 337 Enquiries
- 121 Compliments

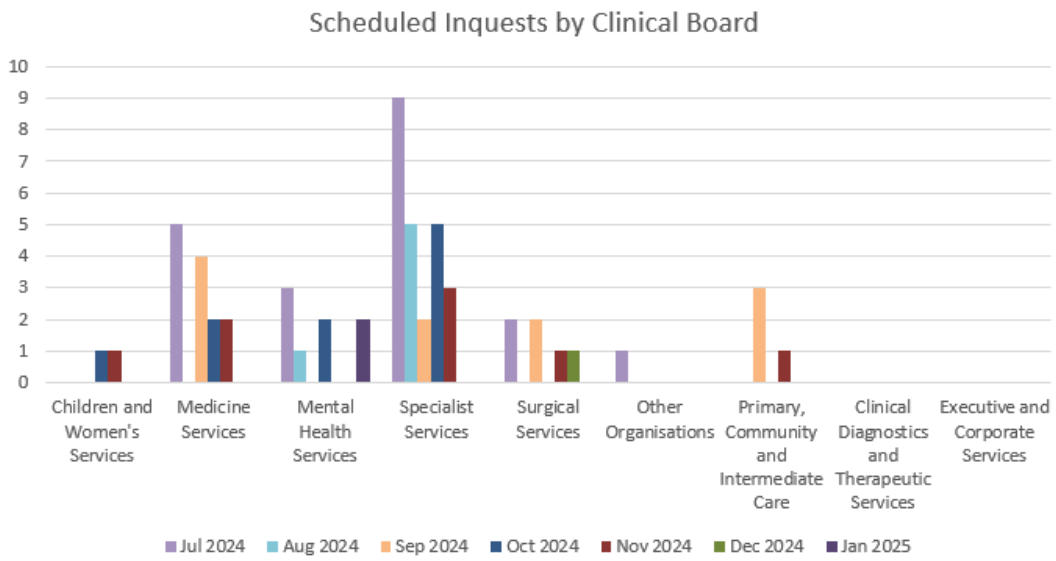
We currently have 312 active concerns

Top 3 themes and trends

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

Person Centred Care

Patient Experience



The numbers of inquests is increasing and the complexity is challenging

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

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

We have 414 Inquests managed through Patient Experience

Focus upon

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

Person Centred Care

Patient Experience - CIVICA

Tell Us in 2 Survey

SMS sent: 19242

Survey responses: 3548

Response rate: 18%

Bedside responses: 106

89% were satisfied with their overall experience.

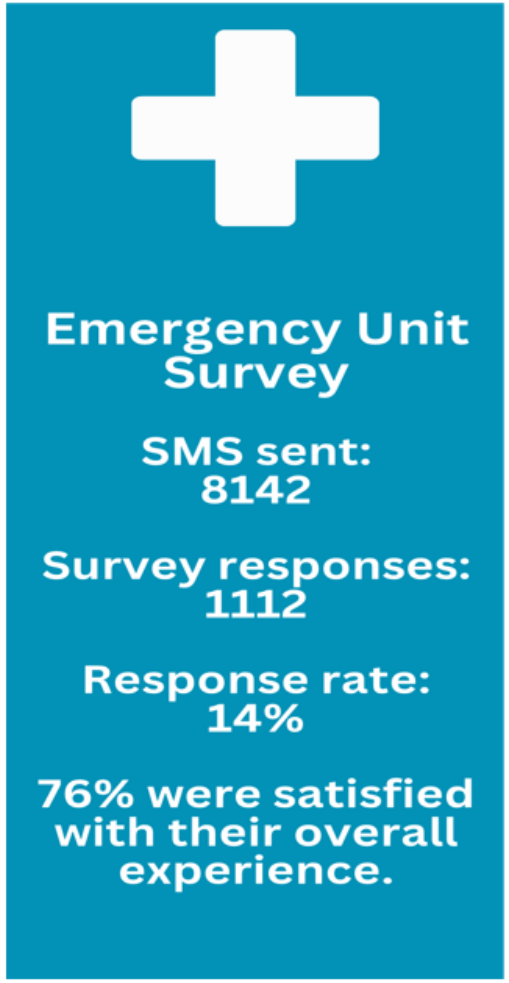
Tell Us in 2 Survey results (combined SMS and Bedside).

Based on **3,654** partial/full survey completions (1st April – 31st May 2024 discharges /attendees).

- Whilst in our care did you feel safe? **84%** of respondents answered *'Always'*.
- Were staff kind and caring? **83%** of respondents answered 'Always'.
- Did you feel involved when decisions were made about your care and/or treatment? **71%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- **89%** were satisfied with their overall experience.

Person Centred Care

Patient Experience - CIVICA



Emergency Unit Survey results

Based on **1,112** partial/full survey completions (1st April – 31st May 2024 discharges).

- Did you feel that you were listened to? **68%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **31%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **61%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **64%** of respondents answered 'Always'.
- Were things explained to you in a way that you could understand? **72%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **67%** of respondents answered 'Always'.
- **76%** were satisfied with their overall experience.

Person Centred Care

Patient Experience - CIVICA

Mental Health Survey

SMS sent: 3090

Survey responses: 248

Response rate: 8%

70% were satisfied with their overall experience.

Mental Health Survey results

Based on **248** partial/full survey completions (1st April – 31st May 2024 discharges).

- Did you feel that you were listened to? **63%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **38%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **60%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **59%** of respondents answered 'Always'.
- Were things explained to you in a way that you could understand? **63%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **56%** of respondents answered 'Always'.
- **70%** were satisfied with their overall experience.

Effeithlon
Efficient

Efficient Care

Safe Care

- This infographic provides overview for all 25B wards under the Nurse Staffing Levels (Wales) Act. The dashboard can focus down into each area.
- SC compliance since June recorded for 25B wards. This continues to be monitored monthly.
- Both professional judgement and red flags are recorded, providing overview across the Health Board.
- Increasing compliance in SafeCare over the last 6 months, has increased the number of acuity scores recorded. Monitoring of trends of acuity levels using Welsh Levels of Care continues.
- Nurse staffing levels for both registered and unregistered against planned shifts is recorded in the final graph. Nurse staffing levels across 25B wards are being met during the night with an improving picture for day shifts in October and November.

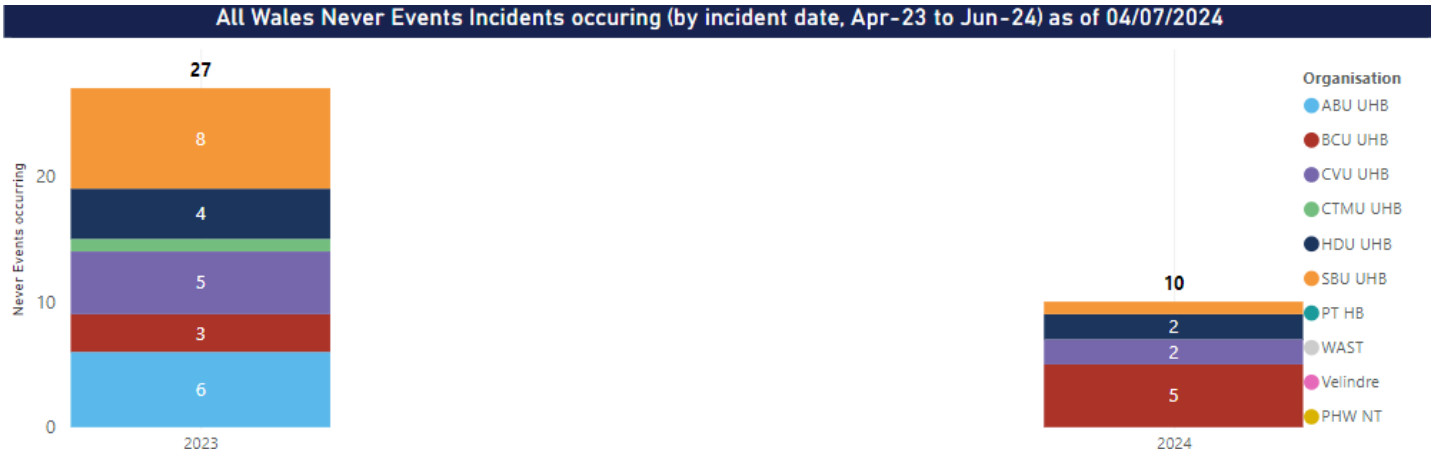
Report Title:	*Never Events Deep Dive*					Agenda Item no.	*2.3*
Meeting:	Quality Safety and Experience Committee		Public	x		Meeting Date:	16th July 2024
			Private				
Status *(please tick one only):*	Assurance	X	Approval			Information	
Lead Executive Title:	Executive Nurse Director						
Report Author (Title):	Head of Patient Safety and Director of Nursing Surgery Clinical Board						

Main Report Background and current situation:

Never Events are largely preventable patient safety incidents that should not occur if the necessary preventative measures have been implemented. All Never Events are reported to NHS Executive as Nationally Reportable Incidents (NRIs) as each one has the potential to cause serious patient harm or death regardless of whether they meet the usual NRI criteria of causing serious or catastrophic harm. The majority of the Never Events that the UHB has reported have had resulted in low or no harm.

Never Events require full investigation under the NRI framework. This includes the need to fully and meaningfully engage with staff as well as patients, families and carers at the beginning of and throughout any investigation. Learning from what goes wrong is crucial to preventing future harm.

Between 1st April 2023 and 31st May 2024, Cardiff and Vale reported 7 Never Events to NHS Executive. Of these, 3 related to retained foreign objects post-operatively, 1 was administration of medication via the wrong route and 3 were wrong site surgery. The chart below shows the Cardiff and Vale Position in reporting Nevers compared with health organsiations across Wales, with retained foreign objects and wrong site surgery being the most commonly occurring never events.



For the same period the year prior (01.04.22 to 31.05.23), C&V reported 7 Never Events to NHS Executive; 3 were wrong site surgery, 1 wrong site prosthesis, 1 retained foreign object, 1 misplaced gastric tube and 1 administration of medication via the wrong route.

The definitions of Never Event categories are listed below:

<u>Administration of Medication via the wrong route</u>
The patient is given one of the following:
- Intravenous chemotherapy by the intrathecal route.

• Oral/enteral medication or feed/flush by any parenteral route.
• Intravenous administration of an epidural medication that was not intended to be administered by the intravenous route.

Retained Foreign Object Post Procedure
Retention of a foreign object in a patient after a surgical/invasive procedure. 'Surgical/invasive procedure' includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside the surgical environment – for example, central line placement in ward areas. 'Foreign object' includes any items subject to a formal counting/checking process at the start of the procedure and before its completion (such as for swabs, needles, instruments and guidewires).

Wrong Site Surgery
An invasive procedure performed on the wrong patient or at the wrong site (e.g. wrong knee, eye, limb). The incident is detected at any time after the start of the procedure. Includes: Interventions that are considered to be surgical but may be done outside a surgical environment – for example, wrong site block (including blocks for pain relief), biopsy, interventional radiology procedure, cardiology procedure, drain insertion and line insertion (e.g. peripherally inserted central catheter (PICC)/ Hickman lines).

Five of the six incidents reported occurred within Surgery Clinical Board and one within Mental Health. Three of the six investigations have been completed and the outcome reported to the NHS Executive and three remain under review.

Of the Never Events reported between April 2022 and May 2023 one resulted in no harm, five in low harm and one in moderate harm as defined by the All Wales Harm Framework. However, these levels of harm do not undermine the significance and seriousness of the incidents or the level of scrutiny they receive and the efforts put into ensuring the necessary improvements are implemented.

Thematic analysis

These are relatively low numbers and as a result a thematic analysis is limited. Having reviewed the investigation findings for the 7 NRIs, there was no one single cause in each. Generally, there were multiple factors that all contributed together to the outcome. The common themes arising were external equipment issues (in 3), junior/inexperienced staff (in 3), implementation of the Swab Count policy (in 2), implementation of the 5 steps to safer surgery (in 1), a busy and rushed environment (in 2), team function (in 1) and the interface between communication systems (1).

Challenges associated with team function, safety culture and adherence to national standards has been picked up as areas for improvement work, their focus for risk reduction are

- safety culture and leadership in theatres
- 5 Steps to Safer Surgery-a core set of safety checks undertaken at key points through the patient's perioperative care
- development of Local Safety Standards for Invasive Procedures (LocSSIPs)- standardised protocol and checklists
- A focus on 'Stop before you Block'- following completion of the WHO checklist and immediately before needle insertion in the nerve block process everything stops to check the site of the procedure again.

QI work to reduce future risk

Recognising that Surgery Clinical Board, and in particular, the Perioperative Directorate, are the predominant reporters of Never Events, the Perioperative Care Directorate have developed a number of improvement actions to help reduce future risk of Never Event occurrence, however the

benefits of these actions are often experience din wider departments. Based on the findings of the Never Event investigations, the areas being focused on are;

National Safety Standards for Invasive Procedures (NatSSIPs)

NatSSIPs were originally introduced in 2015 and focused on standardizing the approach to invasive procedures and developing local protocols and checklists to support the delivery of these standardised processes. NatSSIps2 continues to recognise the important of these measures but also recognizes the importance of team working and efficiency with focus on education, use of data, human factors understanding and scheduling and governance. A refresh of the Health Board NatSSIPs group will include involvement from Education Culture and Organisational Development (ECOD), the health Board digital team as well as colleagues from across perioperative department and other clinical specialties.

In response to two incidents relating to the administration of fascia Iliaca compartment blocks (FIB) for patients presenting with hip fractures, a local safety standard for invasive procedures (LocSSIP) has been developed. This process standardises the approach to delivering a nerve block regardless of who undertakes the procedure. In addition a hip fracture pathway was developed to reduce delays in care provision. This pathway includes the requirement for Emergency Deprtament Consultants to provide support to junior doctors who are undertaking this procedure within the department. Education relating to the administration of FIB is being amended to included the use of the LocSSIP.

Digital Information

Two Incidents related to errors in transcribing information from one system to another. Multiple systems interfaces increase the risk of errors. The currently perioperative pathway is reliant on multiple patients' systems including more than one digital system and paper records completed in pre-assessment clinic. There are plans to implemented a revised surgical database that will incorporate all parts of the patient pathway thereby reducing the need to transcribe procedure etc. In the interim a protocol is being developed to standardise the approach to communicate amendments and cancellations to planned interventional procedures.

Procurement

Procurement of equipment has an important role to pay in the eradication of never events, ensuring equipment that supports standardised check lists and clinical investigation.

Procurement of radio opaque neurology swabs has been implemented to ensure that these products can be identified on radiological examination. A revise protocol was implemented to safeguard against the potential for retained non-radio opaque swabs while an alternative product was being sourced. A procurement exercise within dental services has standardised the dental swabs used, ensuring that all staff are aware of the number of swabs available and utilised.

Medical devices

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

The WHO checklist also supports a systematic check of equipment and devices to ensure that if a products is not intact following an invasive procedure follow up checks and investigations are undertaken to establish is any part of the device had been retained. A wound drain removal protocol has been developed to support full inspection of the device by the clinician removing the drain on completion of the task, where ever this occurs in the Health Board.

Culture and Leadership

A Culture and Leadership program is being implemented across the Perioperative Care Directorate, one theatre suite at a time. This program is a body of work that seeks to improve the working environment in the operating theatre. It is widely researched that a positive organisational culture,

with an engaged workforce positively impacts patient outcomes, improving patient safety and reducing never events. This program has 4 key stages;

1. The scoping phase to decide where this work is required.
2. The assessment phase of the current climate through staff surveys, focus groups and data reporting.
3. The design phase where a multi professional working group design actions that require implementing in the 4th phase.
4. The implementation phase

University Hospital Llandough theaters are currently at the design phase and the University Hospital of Wales in the assessment phase in UHW Main theatres.

Five Steps to Safer Surgery

Reviewing, updating and embedding of the 5 Steps to Safer Surgery procedure as part of the World Health Organisation initiative has been an important part of work undertaken by the Perioperative Care Directorate, as non-adherence to this procedure was a cause in one of the Never Events but this also links in to the culture and leadership work. Procedures have been updated to embed and improve culture regarding the 5 steps process. Within this process, it is required that all members of the surgical team must be present and fully participative in the team brief and if this is not possible due to conflicting demands the brief must not commence/be stopped by the team brief lead until such time they are present. All individual team members must be given the opportunity to assert any concerns and the theatre culture must support this.

The 5 steps include;

1- briefing
2- sign in
3- time out
4- sign out
5- debrief

Each stage allows the theatre team to enhance patient safety during the peri-operative phase of patient care. These steps within the procedure are now inputted into theatre man as they occur which helps monitor adherence to the process and enables audit for ongoing monitoring and assurance. Compliance with the Five Steps to Safer Surgery is collected for each surgical procedure and is audited on a regular basis to provide oversight of compliance.

The culture work that is ongoing will support with empowering theatre staff to follow these steps, ensure the team brief is productive and that staff are given the opportunity to escalate noncompliance concerns. Audits are carried out regularly with regards to compliance of the 5 steps to safer surgery and improvement plans are embedded based on these findings. These are stored on AMAT for ongoing review and action.

We can continue to monitor the number of days between Never Event occurrence to help determine the effectiveness of the improvement actions taken.

Wrong Route Medication

Following the administration of medication by the wrong route in Mental Health Clinical Board a poster was developed and displayed on all medication cupboard to prompt all staff to undertake the necessary checks and to support them in differentiating between oral and subcutaneous and intramuscular administered medications.

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

Never Events are a type of Nationally Reportable Incident which usually are associated with low or no harm but will undergo the same rigorous investigation as incidents with severe and catastrophic harm. Never Event occurrence is something which is being monitored on an All Wales basis with a look at national thematic analysis. Retained foreign objects and wrong site surgery are the most commonly occurring never events.

The most common causes of Never Events are substandard team function, safety culture and adherence to national standards. The Peri-operative Directorate have implemented some ongoing improvement actions to reduce future risk.

Recommendation:

The Committee is requested to: NOTE the assurance provided improvements being implemented to eradicate Never Events.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

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

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

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*Comment here*

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

Report Title:	Update on the Hepatitis B/C Recovery Plan				Agenda Item no.	*2.5*	
Meeting:	Quality, Safety and Experience		Public	X	Meeting Date:	16 July 2024	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive Title:	Executive Director of Public Health						
Report Author (Title):	Consultant in Public Health Medicine						

Main Report
Background and current situation:

Background

Hepatitis B and C are infections of the liver caused by the hepatitis B and C viruses, which can lead to significant liver damage and adverse health impacts.

Hepatitis B is less common in the UK than in other parts of the world. There is currently no cure, but vaccination against it has been part of the routine childhood vaccination schedule 6-in-1 vaccine since 2017. The vaccination can also be given for close contacts of confirmed cases of hepatitis B, with extra doses also given to babies born to parents with hepatitis B. Routine screening for hepatitis B has been part of the antenatal screening programme since the early 2000s. Due to these interventions, acute hepatitis B in children in Wales is now rare, but it remains a problem among unvaccinated adults.

Hepatitis C was present in an estimated 12-14,000 individuals in Wales in 2015, with an estimated half of people who inject drugs being infected. Injecting drug use, current or previous, accounts for the majority of new and ongoing hepatitis C infections in the UK. There is currently no vaccine to prevent it, but it is curable with a treatment that is over 90% effective. Current treatments have completely transformed the approach to treating hepatitis C due to improved acceptability and effectiveness. However, reinfection is possible even after a successful treatment programme.

Prevention and elimination of hepatitis B and C has significant benefits for the individual, population health and wider society. The benefits of prevention and treatment to individuals are clear in terms of their longer term physical and mental health. Preventing onward transmission of the virus to other individuals results in wider societal benefits. Elimination is highly cost effective as it prevents development of hepatitis related liver disease and all of its complications: end-stage liver disease (cirrhosis) and hepatocellular carcinoma which are extremely costly to manage, and require utilisation of scarce resource. As well as the cost savings that are realised, prevention and treatment of hepatitis B and C frees up hospital beds and liver transplants for people with other conditions.

Welsh Government (WG) is committed to preventing and eliminating hepatitis B and C as a public health threat by 2030 at the latest. A Welsh Health Circular was released in October 2017 setting out measures to be put in place to achieve this. A further Welsh Health Circular was released in January 2023 to refresh the WG commitment to elimination and outline key actions required by Health Boards, Area Planning Boards and Public Health Wales for 2022-23 and 2023-24.

Current situation

Quality, Safety and Experience (QSE) Committee received the Hepatitis B and C Recovery Plan 2023 to 2025 on 18 July 2023. Following its ratification by QSE, it was sent to Welsh Government, with a request from QSE for an annual update.

Much has been achieved since ratification of the Plan. In feedback to Welsh Government, at their request in March 2024:

- 100% of actions now have action owners in the Plan

- We have reinstated hepatitis C testing in HMP Cardiff since February 2024, with a view to achieving micro-elimination in our prison
- Cardiff and Vale Drug and Alcohol Service now has a mobile outreach van, we are developing an operational plan to commence delivery
- Opt-out blood-borne virus testing protocols are in place for all substance misuse services
- Video-observed therapy is in place
- Phase 1 of the re-engagement list is complete; and phase 2 has commenced with regular monitoring and evaluation of the list
- We have a Communications Plan in place for hepatitis B and C elimination

Within the same letter, dated 6 February 2024, Welsh Government attached an assessment of our Recovery Plan and made a request for us to refresh the existing Plan by 31 May 2024. This has since been refreshed in line with Welsh Government recommendations, and is attached for reference (Appendix 1). It was submitted to Welsh Government by the deadline.

The work programme for elimination of Hepatitis B and C elimination is overseen by the Cardiff and Vale of Glamorgan Hepatitis B and C Elimination Oversight Implementation Group. This is a multi-agency forum, which feeds into the Health Protection Forum and meets bi-monthly.

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

1. Elimination of hepatitis B and C is health promoting and cost-saving.
2. The funding for the elimination of hepatitis B and C is core funded, with some additional funding from the Health Protection budget towards elimination. This needs to be maintained if we are to achieve elimination of hepatitis B and C in our region.
3. The work programme is monitored and evaluated by a Programme Manager, from the Health Protection Team and this is critical to the functioning of the work, and therein the elimination of hepatitis B and C.

Recommendation:

The Committee is requested to:

a) NOTE the progress to date
b) NOTE the content and ambition of the Hepatitis B and C Elimination Plan 2024/25

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

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

Quality Impact Assessment Completed?:

*Please place an "**X**" in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*

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

Impact Assessment: *Please state **yes** or **no** for each category.* ***If yes please provide further details.***
Risk: Yes
Elimination of hepatitis B and C will reduce the risk of impact of these illnesses on our population.
Safety: Yes
Implementation of this plan will improve safety for people at risk of hepatitis (B and C) by reducing their risk of adverse health impacts as a consequence of these infections.
Financial: Yes
The implementation of the Plan in full will require additional resources. These will be met within existing departmental budgets where possible or brought to Investment Group where this is not possible.
Workforce: Yes/No
Implementing this Plan will require some changes to working processes for involved services and likely require additional workforce roles.
Legal: No
Reputational: Yes
This Plan is required following a Welsh Health Circular from Welsh Government, and there is a reputational risk if we do not deliver against it.
Socio Economic: No
Equality and Health: Yes
An EHIA was undertaken in June 2024, and showed a positive impact on the following groups: • People of all ages • People with a disability • Male, female and trans people • People of a different race • People with different religions • People regardless of sexuality • People according to where they live • People being able to access the service offered • People being able to improve healthy lifestyles • People in terms of social/community influences on their health No negative impacts were noted.
Decarbonisation: Yes
The elimination of hepatitis B and C will save on hospital costs and therefore decrease carbon emissions.

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

Chilcott Rachel
09/07/2024 13:02:37

Cardiff and Vale of Glamorgan

Hepatitis (B and C) Elimination Plan 2024/25

Finalised May 2024

Part of the Cardiff and Vale of Glamorgan Health Protection Plan

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

Cardiff & Vale APB
Achieving better substance misuse outcomes

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Contents

Foreword

This is our second Plan for Hepatitis B and C elimination in Cardiff and the Vale of Glamorgan. It covers the period 2024/25 building on work from previous years.

We are committed to the World Health Organisation target of Hepatitis B and C elimination by 2030. These are viral infections that live in our blood and target our livers. Long term they can impair our quality and longevity of life. They are infectious to those around us. BUT we can prevent over 99% of new hepatitis B infections through vaccination and treat up to 98% of those who are living with hepatitis C.

We are working in partnership with the NHS, Welsh Government and third sector organisations to deliver elimination.

Over the past 12 months we have:

- Identified at risk groups in Cardiff and Vale of Glamorgan through a mapping exercise
- Restarted Hepatitis C testing in HMP Cardiff from February 2024, with microelimination on the horizon.
- Supported Cardiff and Vale Drug and Alcohol Service in the purchase and kitting out of a mobile outreach van allowing delivery of testing, vaccination and treatment for Hepatitis across Cardiff and Vale of Glamorgan
- Instigated opt-out testing protocols for all substance misuse services to ensure that no one misses an opportunity to be tested for hepatitis
- Developed a re-engagement process that identifies those who have been lost to follow up: phase 1 is complete and phase 2 has commenced with regular monitoring in place
- Created a Communications and Engagement Plan for Hepatitis B and C elimination

This Plan will be overseen by the Cardiff and Vale of Glamorgan Hepatitis B and C Oversight Implementation Group, a partnership formed of key stakeholders working in this area. Let's eliminate infectious hepatitis #Love your Liver.

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Glossary of Key Abbreviations

APB – Area Planning Board

BBV – Blood Bourne Virus

CAVDAS – Cardiff and Vale Drug and Alcohol Service

CAVHIS – Cardiff and Vale Health Inclusion Service

DoSH – Department of Sexual Health

MDT – Multidisciplinary Team

NICE – National Institute of Clinical Excellence

NSP – Needle Syringe Programme

PHW – Public Health Wales

SMTF – Substance Misuse Treatment Framework

SVR – Sustained Virological Response

UHB – University Health Board

WCP – Welsh Clinical Portal

WDS – Welsh Demographic Service

WHDM – Welsh Health Data Mart

WHO – World Health Organisation

1 Background and context

In line with the World Health Organisation (WHO) target, we are working to prevent and eliminate infectious hepatitis. The WHO global hepatitis strategy, endorsed by all WHO Member States, aims to reduce new hepatitis infections by 90% and deaths by 65% between 2016 and 2030[1].

Hepatitis B and C are infections of the liver caused by the hepatitis B and C viruses, which can lead to significant liver damage and health implications.

Hepatitis B is less common in the UK than in other parts of the world. Approximately 95% of new hepatitis B diagnoses in the UK are amongst people who acquired the infection outside of the UK in their country of origin, either at birth or in early childhood[2]. The virus is predominantly transmitted via unprotected intercourse, blood-to-blood contact (such as sharing of needles and needlestick injuries), and perinatal transmission from mother to child[3]. There is currently no cure, but vaccination against it has been part of the routine childhood vaccination schedule 6-in-1 vaccine since 2017. The vaccine should also be given for close contacts of confirmed cases of hepatitis B, with additional early doses also given to babies born to parents with hepatitis B. Routine screening for hepatitis B has been part of the antenatal screening programme since the early 2000s. Due to these interventions, acute hepatitis B in children in Wales is now rare, but it remains a problem among unvaccinated adults.

Hepatitis C was present in an estimated 12-14,000 individuals in Wales in 2015, with an estimated half of people who inject drugs being infected[4]. Injecting drug use, current or previous, accounts for the majority of new and ongoing hepatitis C infection in the UK[5]. There is currently no vaccine, but it is curable with oral treatment that is over 90% effective[5]. Past infection provides no significant lasting immunity, therefore reinfection, particularly amongst individuals who continue to participate in high risk behaviours, poses a significant problem.

Prevention and elimination of hepatitis B and C has significant benefits for the individual, population health and wider society. The benefits of prevention and treatment to individuals are clear in terms of their longer term physical and mental health. Preventing onward transmission of the virus to other individuals results in wider societal benefits. Elimination is highly cost effective as it prevents development of hepatitis related liver disease and its complications; end-stage liver disease (cirrhosis) and hepatocellular carcinoma. Both are extremely costly to manage, and require utilisation of scarce resource. In addition to the direct economic benefits, prevention and treatment of hepatitis B and C frees up limited resource, including inpatient hospital beds and liver transplants.

During the COVID-19 pandemic, Blood Borne Virus (BBV) screening, diagnosis and treatment rates across Wales fell, due to staff redeployment and reduced laboratory capacity. By the end of 2022 however these had returned to pre-pandemic levels[6].

Welsh Government is committed to eliminating hepatitis B and C as a public health threat by 2030 at the latest[4]. A Welsh Health Circular was released in October 2017 setting out measures to be put in place to achieve this[7]. A further Welsh Health Circular was released in January 2023 to refresh Welsh Government's commitment to elimination and outline key actions required by health boards, Area Planning Boards and Public Health Wales for 2022-23 and 2023-24[4].

Welsh Government has established a Hepatitis B and C Elimination Programme Oversight Group to provide a renewed strategic focus on elimination. Chaired by the Welsh Government, membership includes relevant policy leads within Welsh Government, representatives from Public Health Wales, clinical services within NHS Wales, key services outside the NHS, such as specialist substance misuse services and third sector organisations. The group reports to the Chief Medical Officer and to the Minister for Health and Social Services.

The 2023 Welsh Health Circular set out 13 actions for Health Boards for achieving elimination of hepatitis B and C, the first of which was to develop Joint Recovery Plans in each health board for submission to Welsh Government by mid-July 2023[4].

2 Where we are now

Regional partner organisations are working collaboratively to develop the strategic and operational elements required to establish an integrated and sustainable health protection partnership. In line with Welsh Government requirements, this partnership approach will have an 'all hazards' remit, and build upon the learning from the pandemic response to enhance pre-existing arrangements. It will also align to a nationally agreed health protection framework, and roles and responsibilities, both of which are currently in development. Planning for the integrated model is underway with the aim of being fully operational for 2024/25.

The Cardiff and Vale Eliminating Hepatitis (B and C) Joint Recovery Plan Oversight Group was established in March 2023 to facilitate the development of the 2023-2025 Hepatitis (B and C) Joint Recovery Plan for Cardiff and Vale University Health Board. A further Oversight Implementation Group was formed in August 2023 in order to implement actions within the Recovery Plan. This revised 2024/25 annual Plan was created in May 2024 in line with the Health Protection Plan. This will be overseen by the Oversight Implementation Group.

In order to identify 'where we are now' in Cardiff and Vale University Health Board (UHB), identification of our current position in terms of structures and processes (inputs) and outcome data (outputs) for hepatitis (B and C) was completed by the group. This was based on the Donabedian approach for evaluating quality of care[8].

2.1 Structures and processes (inputs)

2.1.1 Infection prevention

Infection prevention action is in the form of hepatitis B vaccinations and Needle Syringe Programmes (NSP).

Hepatitis B vaccination is part of the childhood immunisation programme, given by a General Practitioner (GP) or Practice Nurse, or at a maternity unit after birth for children born to mothers with hepatitis B. It should also be offered to individuals at high-risk, such as prisoners and service users of Substance Misuse Service, close contacts of acute cases, and people who care for high-risk individuals. It can be provided at GP surgeries, the Department of Sexual Health (DoSH), His Majesty's Prison (HMP) Cardiff, Cardiff Addictions Unit (CAU), the Drug and Alcohol Treatment Team (DATT), and maternity units for individuals at high risk.

NSPs are the first line service to prevent infections by enabling the provision of single-use sterile injecting equipment (and sharps' disposal bins) for every injecting event. Attendance is anonymised, open access, and non-conditional in line with National Institute of Clinical Excellence (NICE) guidelines[9]. NSP paraphernalia and sharps bins are drawn from the All Wales Paraphernalia contract managed by NHS Wales Shared Services Partnership, specified in line with NICE/Welsh Government Substance Misuse Treatment Framework[10]. BBV testing is provided at Specialist NSP sites, with a pilot running testing in 2 Pharmacy NSP sites; from these, individuals are signposted to substance misuse services, specialist NSPs or DoSH.

Needle Syringe Programmes (NSP) are located at 19 different sites:

- 4 Specialist sites (Riverside, Huggard, Barry, Cardiff Royal Infirmary) delivered via frontline substance misuse teams.

- 13 non-specialist providers in Pharmacies, with Pharmacist/Technician.

- 2 resident-only services located within third sector hostels, delivered via hostel staff

2.1.2 Case-finding and testing

A mapping exercise of service structures involved in testing and/or treatment was completed (*Figure 1, Figure 2*).

Figure 1: *Services in Cardiff and Vale UHB providing hepatitis C testing and/or treatment.*

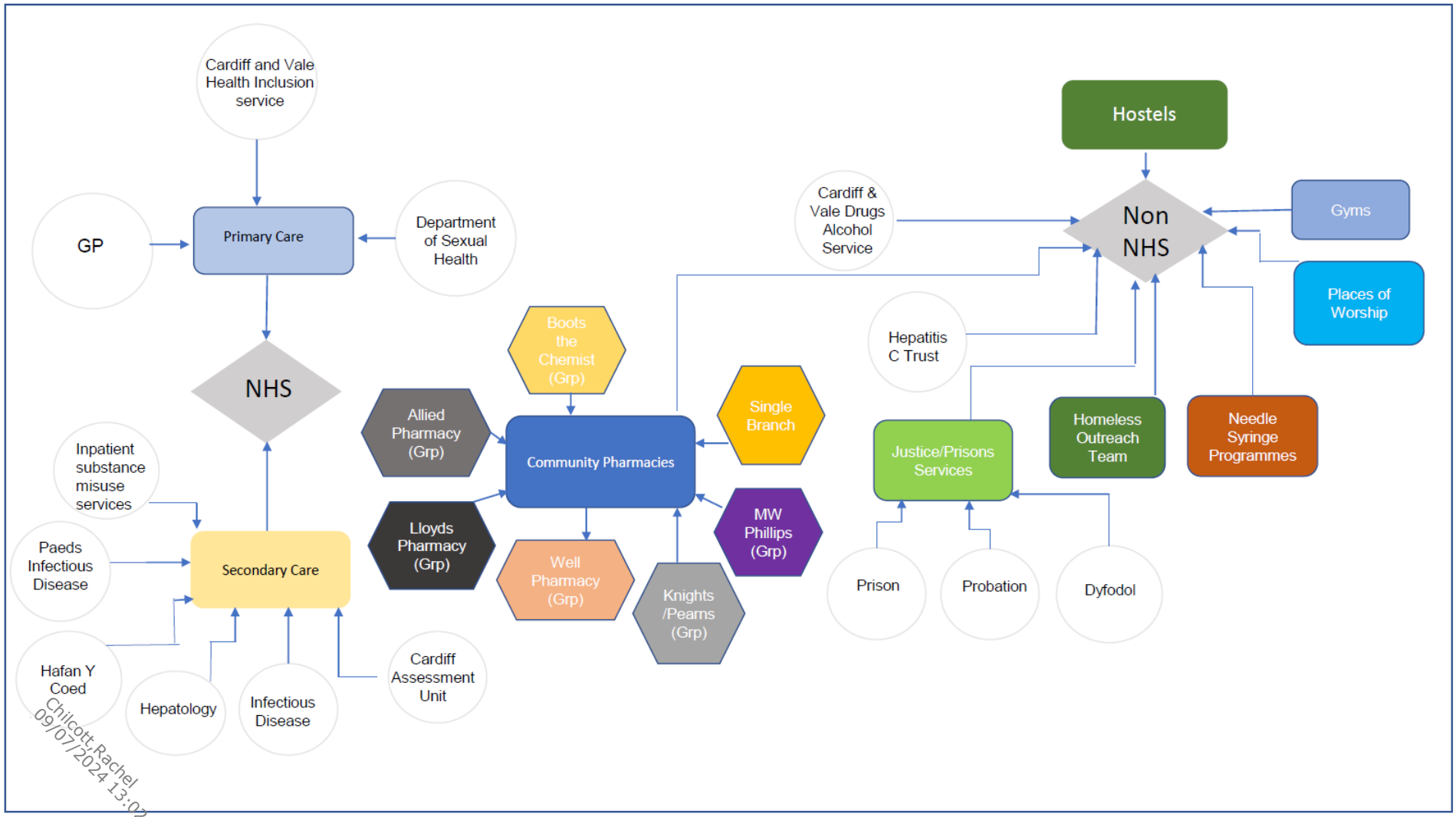
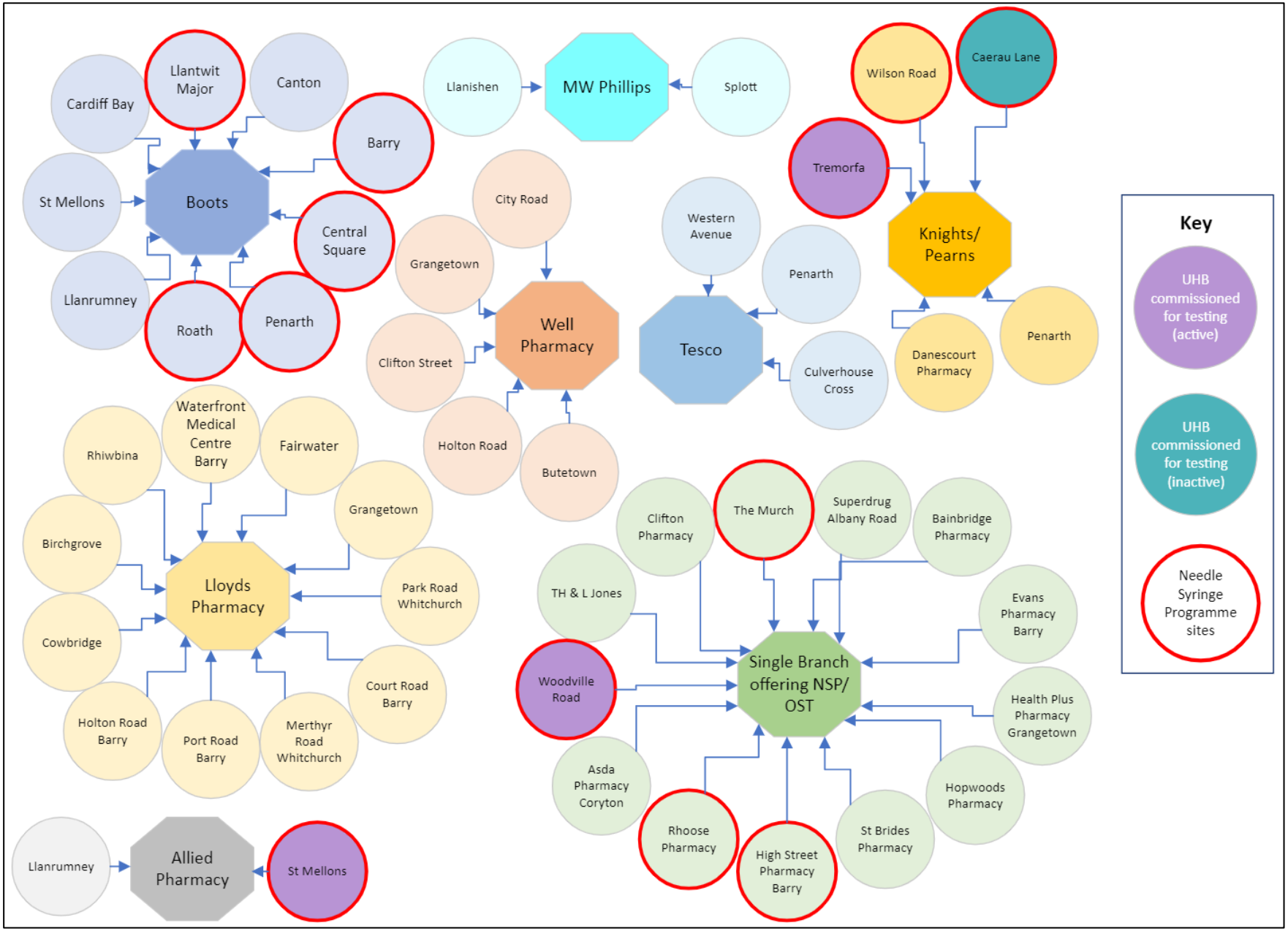


Figure 2:
Community pharmacy sites with links to hepatitis work in Cardiff and Vale UHB, including those currently commissioned for BBV testing and Needle Syringe Programme sites.



The Infectious Diseases service, based at University Hospital of Wales, provides a core group of clinicians that make up the BBV team. The BBV Team are the primary service for hepatitis (B and C) activity, alongside their wider BBV work, with clinics and outreach activities. Current staffing for the infectious diseases service includes 5 Consultants in Infectious Disease (2 with a hepatitis focus); approximately 3 Specialty Registrars at any given time; 3 Specialist Nurses (2.2 WTE); 2 Clinical Pharmacists (0.2-0.4 WTE time for hepatitis C work); a Data Manager; and 2 Hepatitis C Trust Peer Co-ordinators/Leads.

High-risk individuals for screening are identified from high-risk populations and groups[11 12 13 14 15], as mapped in *Figure 3*.

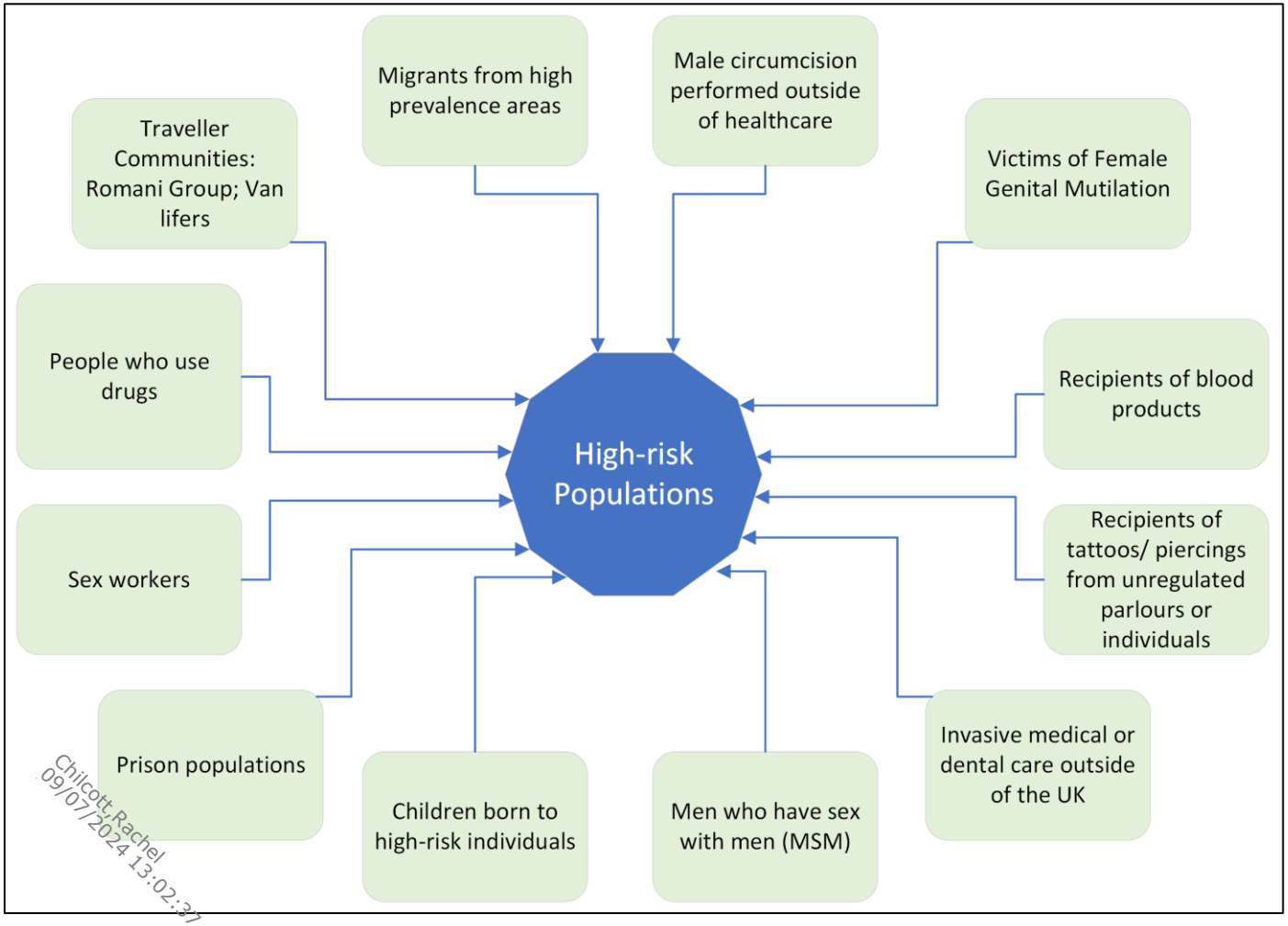


Figure 3: *Hepatitis (B and C) high-risk populations[11 12 13 14 15].*

Screening for hepatitis C virus (HCV) infection is a two-step process. Identification for markers of anti-HCV reactivity (hepatitis C antibody positive) indicate evidence of exposure to the virus. Reactive anti-HCV samples are then tested for presence of viraemia (HCV-RNA), and if positive, the patient is diagnosed with active infection requiring treatment. A weekly report is collated by Public Health Wales containing all tested individuals' results.

Current test methods include the following, with turnaround times indicated:

- Venepuncture (28-72 hours)
- Point of Care Testing (POCT) mouth swab for antibodies (20min wait)
- Polymerase Chain reaction (PCR) bloodspot (7 day wait)
- POCT Cepheid machine (1 hour wait)

Testing is accessed and completed via the following routes:

- HMP Cardiff: opt-out testing programme. Recommenced in February 2024.
- Substance Misuse Treatment and Support Services: opt-out (including Criminal Justice Intervention Teams, and NSPs).
- Cardiff and Vale Health Inclusion Service (CAVHIS): offer BBV screening as part of the initial assessment of asylum seekers and refugees for both adults and children.
- Hepatitis C Trust Peer-to-Peer Follow-Me scheme.
- Health Board BBV community clinic/outreach service.
- Public Health Wales Laboratory: high intensity testing events.
- Community pharmacy sites: 4 commissioned sites, with 3 active (see *Figure 2*). National service review has been completed, and national specification updated. The CAVUHB peer support pilot appendix has been approved with a total of 8 sites identified.
- Screening of blood, organ and tissue donations.
- Test and post scheme: Public Health Wales, in collaboration with Welsh Government and Health Board sexual health services, established a postal testing service for BBVs and sexually transmitted infections. Tests are requested online via questionnaire completion and guidance. Turnaround times are approximately 7 days, but often less. Negative results are notified via text message. People screened positive are referred to appropriate specialist services for confirmatory testing and treatment (if indicated).
- Sexual health clinics: BBV testing may be offered if an individual is symptomatic or at risk.

Negative test results are notified to patients along with harm reduction advice. Positive results are given to patients verbally, along with commencement to the treatment pathway. All HCV-RNA positive cases are referred for clinical assessment and treatment.

Testing activity is recorded on the Harm Reduction Database, with the exclusion of: HM Prison, sexual health clinics, the test and post scheme, and screening of blood, organ and tissue donations.

2.1.3 Treatment

A mapping exercise of service structures involved in testing and/or treatment was completed (*Figure 1, Figure 2*).

The BBV Team are the primary service for hepatitis (B and C) treatment, with clinics and outreach activities. Staffing levels are provided in section 2.1.2.

Treatment is offered to all patients testing positive for current active hepatitis C. They will receive a clinical assessment, followed by individualised treatment plans dependent on various patient and disease factors such as chronicity of infection, liver staging, genotyping, contraindications to drugs and appropriateness. If the clinical case is straightforward, treatment is usually 8 or 12 weeks in duration, which may or may not be monitored. If the case is not straightforward, additional tests will take place.

At 12 weeks post treatment completion, an SVR test will take place. If SVR is achieved, the patient is deemed 'cured' and discharged with advice. A certificate of achievement is given, and they are encouraged to join a peer-support group.

Rapid treatment pathways are in place for those unwilling or unlikely to attend further assessments after the initial contact. If appropriate, these individuals will be provided with their full prescription at contact.

If treatment is unsuccessful, or there is past history of treatment, resistance testing will be performed, and more complex therapy options explored.

Treatment activity is recorded on the E-form database, which then feeds into the Welsh Clinical Portal (WCP) and Welsh Health Data Mart (WHDM).

2.1.4 Re-engagement

The Public Health Wales Hepatitis C Re-engagement Programme is currently in place for the identification of positive cases who have not completed treatment. A re-engagement list (Phase 1) was produced by Public Health Wales and acted on by the BBV Team. The list is created from the E-form database and cross-referenced with the Harm Reduction Database, and the Phase 2 list came out in 2023.

There is a mix of service teams and databases involved in re-engagement activity: the BBV Team, Public Health Wales, ICNET, the Harm Reduction Database, the E-form Database, and the Welsh Health Data Mart (WHDM).

Re-engagement with individuals is attempted with the following process:

1. Attempt to locate via the Welsh Demographic Service (WDS) or other engaged services.
2. Make contact.
3. Deploy Outreach team, peers and wider multidisciplinary team to help engage.
4. Consultation: repeat full BBV screen and assessment.
5. Review and treat as per pathway. If cirrhotic refer to the Hepatology team for ongoing surveillance.

2.2 Outcomes

Outcome data on testing, treatment and infection prevention activity were obtained from the BBV annual report 2023 (Public Health Wales CDSC)[6], for Cardiff and Vale UHB and Wales, and from clinical teams within the Health Board. The 2024 BBV annual report is due in July 2024.

2.2.1 Infection prevention

Childhood vaccination uptake data is available from the Public Health Wales quarterly COVER report. For the latest quarter (Oct-Dec 2023) for age 1 children, hepatitis B vaccination uptake via the 6 in1 childhood vaccine was 92.8% in Cardiff and Vale (92.4% in Cardiff Local Authority; 94.1% in Vale of Glamorgan Local Authority).

Table 1 presents the latest annual data available on hepatitis B vaccination uptake in children born to mothers with hepatitis B, in Substance Misuse Services, and in prisons[6]. It is important to note that the recording and reporting mechanisms may not currently be accurate or up to date, with improvements to outcome data reporting being one of the key action areas set out in this plan.

Table 1: *Hepatitis B vaccination uptake in the childhood immunisation programme, Substance Misuse Services and prisons in Cardiff and Vale UHB and Wales[6]. Grey indicates data not provided. Note: Cardiff and Vale UHB substance misuse service immunisation data may not be up-to-date or reported correctly due to difficulties in extracting the data from local systems.*

Outcome	Cardiff and Vale UHB	Wales
Uptake of 3 doses of hepatitis B immunisation in children born to hepatitis B positive mothers reaching their 1st birthday 01/04/2022 to 31/03/2023 and resident in Wales on 31/03/2023	100%	100%
Immunisation of service users engaged with substance misuse services: Number of individuals given a hepatitis B vaccination or referred for one, 2022	0	243
Hepatitis B vaccination coverage in prisons, 2017		*1st dose:* 55.1% (95% CI 53.5 – 56.8) *Full course:* 39.6% (95% CI 38.0 – 41.2)

In HMP Cardiff, as at 16 May 2024, there were 162 (21.7%) men fully vaccinated including booster for Hepatitis B. There were also 249 men (33.3%) who were partially vaccinated. The turnover of men is approximately 800 every 12 weeks. The low Hepatitis B vaccination uptake in HMP Cardiff, is largely due to the remand nature of the prison as the men are often moved on or released before they can finish the course. Having extra staff would improve the issue.

NSP data is presented in a quarterly Harm Reduction Interventions Activity report, produced by the APB Support Team. Figure 4 presents the latest annual data available on NSP activity from the BBV-PET tool. In 2023 there were 188 sterile injecting syringes issued to PWID, per client, per year for Cardiff and Vale residents versus 134 for Wales.

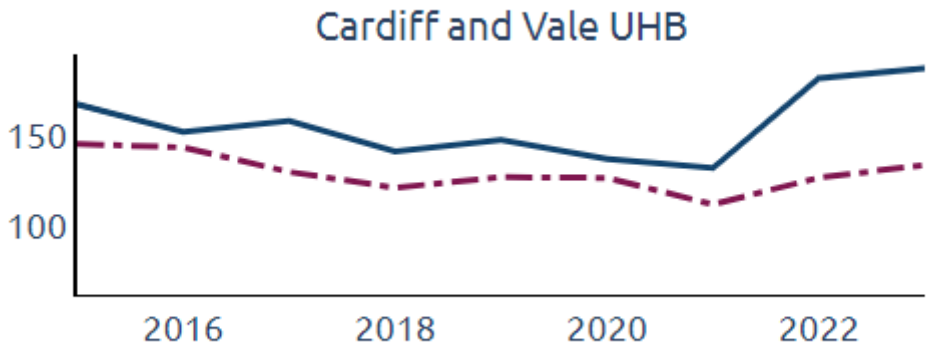


Figure 4: *NSP activity in Cardiff and Vale UHB and Wales, 2016 to 2023. Source: BBV PET tool, February 2024. Wales = Pink line; Cardiff and Vale UHB = Blue line*

2.2.2 Case-finding and testing

Data on hepatitis B and C testing activity for 2022 in the general population in Cardiff and Vale UHB and Wales is shown in *Table 2*[6]. Both the proportion of individuals testing positive for hepatitis B, and the rate per 100,000 population reactive for hepatitis C antibodies, were higher in Cardiff and Vale than for Wales. Annual testing rates for hepatitis C (per 100,000 population) increased each year from 2015 to 2019, before dropping in 2020 and 2021 due to the COVID-19 pandemic, but in 2022 they returned to higher levels than 2019 (*Figure 5*)[6]. We will increase case-finding during 2024/25 with an ambition to conduct outreach in other areas such as the South Asian community and for those who inject performance enhancing drugs using innovative methods.

Table 2: *Hepatitis B and C testing activity and outcomes for Cardiff and Vale UHB and Wales, 2022*[6]*. Grey indicates data not provided.*

	Outcome	**CaV**	**Wales**
Hep B	Number of unique individuals tested for reactive anti-HBc	3773	21,098
	Number and proportion of unique individuals testing positive for reactive anti-HBc (proportion is of those tested)	286 (7.6%)	1036 (4.9%)
	Number of unique individuals tested for hepatitis B surface antigen	14,486	84,025
	Number and proportion of unique individuals testing positive for hepatitis B surface antigen (proportion is of those tested)	421 (2.9%)	1204 (1.4%)
Hep C	Rate per 100,000 population tested for HCV (anti-HCV or HCV-RNA)	3224	
	Rate per 100,000 population anti-HCV reactive	94.1	53.6
	Proportion of unique individuals tested with at least one reactive result (annual prevalence)		3%
	Proportion of anti-HCV reactive individuals receiving HCV-RNA confirmatory test	81%	73.4%
	New HCV-RNA cases	66	607

All individuals who are anti-HCV reactive should have a confirmatory HCV-RNA test, but in Cardiff and Vale the proportion meeting this was 81% (although higher than the Wales proportion of 73.4%).

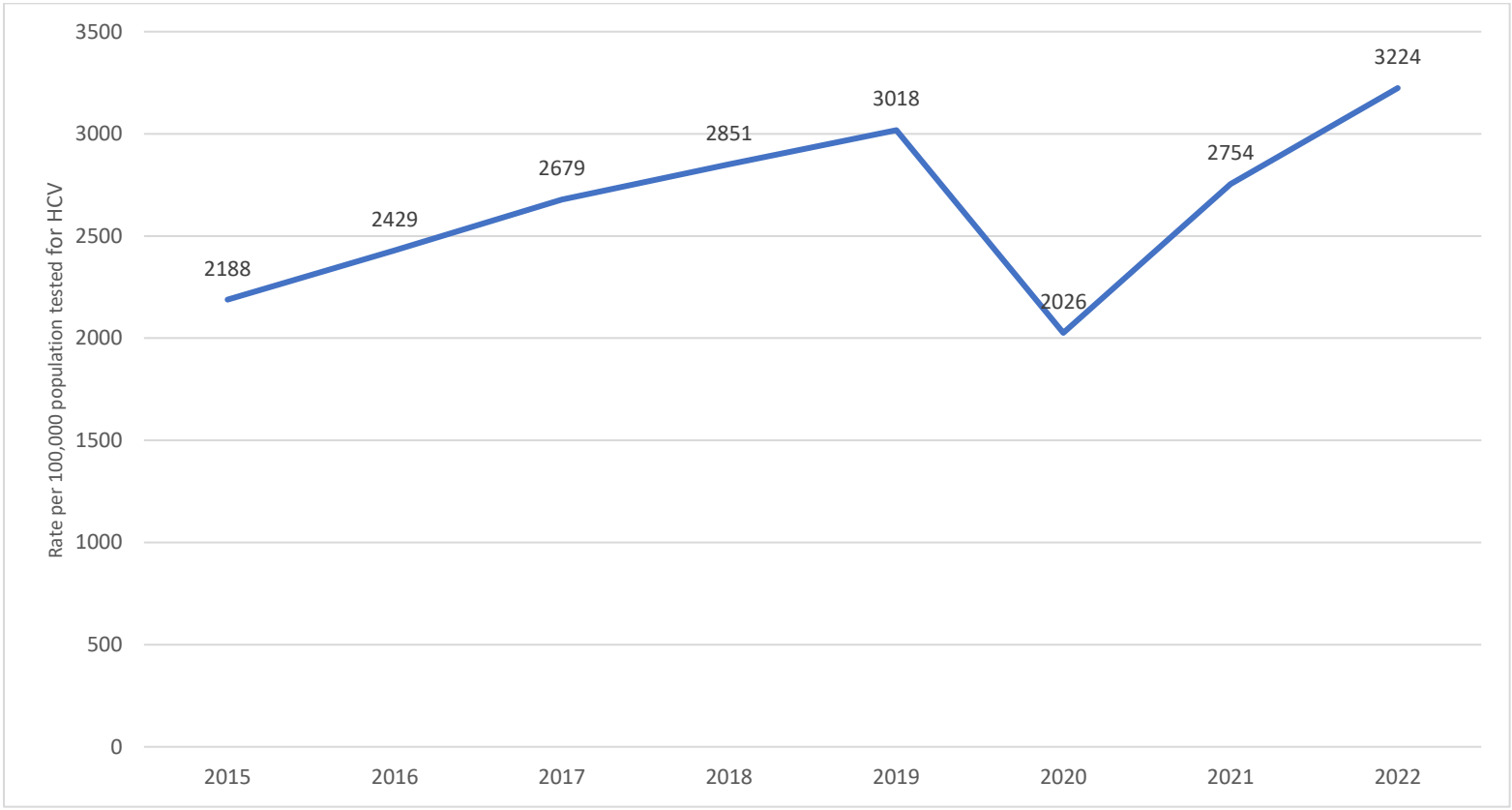


Figure 5: *Rate per 100,000 population tested for HCV (anti-HCV or HCV-RNA) resident in Cardiff and Vale UHB by year, 2015-2022*[6]*.*

Data on Substance misuse service (SMS) testing is shown in *Table 3*[6]. Testing coverage for the offer of a hepatitis C test in 2021-22 was 26.1% in Cardiff and Vale, with 21.5% being tested. This coverage was higher than that of Wales as a whole. Of all those screened for hepatitis C via SMS in 2018-22, 13.1% had a reactive result. This rose to 40.5% amongst those who currently or previously (in the last 12 months) injected drugs, indicating a higher prevalence amongst this subgroup and highlighting the need for targeted actions with this population.

Table 3: *Testing activity and outcomes for Substance Misuse Services in Cardiff and Vale UHB and Wales*[6]*.*

Outcome	CaV	Wales
Number of individuals receiving a HBV test, 2022	1032	3298
Number of individuals receiving a HCV test, 2022	1053	3376
Testing coverage in terms of those offered a HCV test, 2021-22	26.1%	16.2%
Testing coverage in terms of those HCV tested, 2021-22	21.5%	13.5%
Number anti-HCV screened, 2018-22	2406	9,246
Number anti-HCV reactive (and as proportion of those screened), 2018-22	314 (13.1%)	1,612 (17.4%)
Number of anti-HCV reactive receiving confirmatory PCR (and as proportion of those anti-HCV reactive), 2018-22	198 (63.1%)	1,199 (74.4%)
Number HCV PCR/RNA positive (and as proportion of those receiving confirmatory PCR), 2018-22	98 (49.5%)	603 (50.3%)
Proportion of current and recent PWID (injected in last 12months) anti-HCV screened with a reactive result, 2018-22	40.5%	34.7%

Data on HM Prison testing and outcomes is shown in *Table 4*[6]. Testing coverage was lower in Cardiff and Vale than in Wales in 2021, but the proportion testing reactive and positive for hepatitis C in 2022 was higher. During the period of May-October 2022 at HMP Cardiff there were 1100 Point of Contact Tests (POCT) completed, leading to 18 individuals being treated for hepatitis C (data from BBV Team). Routine opt-out testing stopped in HMP Cardiff in October 2022, so coverage is likely to be low in 2023. However, Hepatitis C testing recommenced in February 2024. Results so far in 2024 (19 February to 1 May) indicate that 533 men received the test and there were 21 positive cases.

Table 4: Testing activity and outcomes in prison settings in Cardiff and Vale and Wales[6]

Outcome	Cardiff and Vale UHB	Wales
Prison BBV testing numbers, 2022 (HMP Cardiff for Cardiff and Vale UHB data)	HBsAg: 321 Anti-HCV: 318 HCV-RNA: 123	HBsAg: 2,869 Anti-HCV: 2,830 HCV-RNA: 735
Prison testing coverage, 2021	46.4%	54.3%
Prison reactivity and positivity of individuals tested, 2022	Anti-HCV: 13.5% HCV-RNA: 27.3%	Anti-HCV: 9.8% HCV-RNA: 23.8%

Testing activity via the Department of Sexual Health (DoSH) clinics in 2022 was 3,562 tests for any BBV in Cardiff and Vale, and 12,452 in Wales[6]. Cardiff and Vale had 6,293 BBV tests completed in 2022 via the Test and Post Scheme, with 1% testing positive for hepatitis B and 0.3% receiving a positive or reactive result for hepatitis C[6].

Testing in community pharmacies has received low engagement and uptake to date, with only two tests completed in 2022-23 at a single pharmacy site (Source: Harm Reduction Database via Community Pharmacy service). A recent peer support pilot visit to the first site saw 8 individuals identified via OST scripts, 6 tests completed and 1 follow up peer support visit arranged. No one collected NSP during this visit.

2.2.3 Treatment

The BBV Team is able to produce outcome reports from the Welsh Health Data Mart (WHDM) on an ad hoc basis in-house. There is currently no routine reporting to identify numbers being referred to treatment, commencing treatment, completing treatment and achieving Sustained Virological Response (SVR). Currently there are also variations in completeness of data recording, meaning that outcomes may be under-reported.

The number of individuals commencing hepatitis C treatment in Cardiff and Vale and Wales from 2015 to 2022 is shown in *Figure 6*[6]. These data should be used with caution however, and it is not known what proportion of those commencing treatment went on to complete treatment under current data reporting formats. The current treatment target is 205 per annum; however, there is a backlog of treatment numbers from previous years.

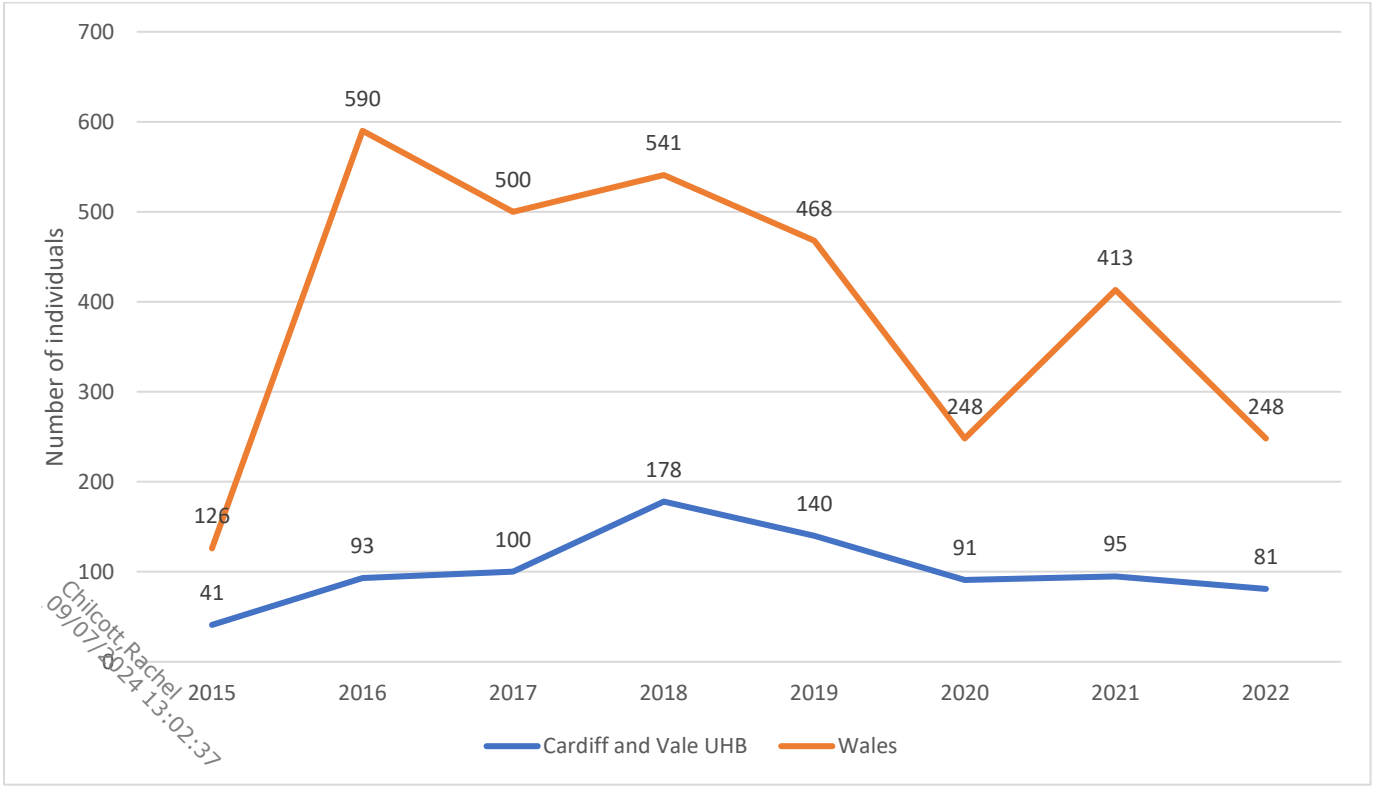


Figure 6: *Number of individuals commencing HCV treatment in Cardiff and Vale UHB and Wales, by year, 2015-2022*[6].

2.2.4 Re-engagement

Phase 2 of the re-engagement programme is under way, with a re-engagement list from Public Health Wales sent in 2023. Cardiff and Vale UHB are expected to have 297 individuals on the list for re-engagement (figure obtained from Public Health Wales re-engagement programme team).

2.3 Current issues and mitigations

Following completion of the mapping of current services and identification of our Structures, Processes and Outcomes, the following issues and mitigations to elimination of hepatitis (B and C) were identified by the group:

Area 1: Infection prevention

Issue	Mitigation
1. The hepatitis B childhood vaccine (6 in 1) uptake is currently <95% in Cardiff and Vale UHB.	Cardiff Met Report outlining the local barriers to uptake in childhood vaccines (including 6 in 1), being utilised to review pathway and increase uptake of 6 in 1
2. For babies born to parents at high-risk of hepatitis B, mothers with hepatitis B are successfully and efficiently identified and managed, however, if the father has hepatitis B, this is not identified at an early stage.	Issue being worked through with primary care.
3. Improvements are required regarding accessibility, coverage and attendance at Needle Syringe Programme sites, with the reasons behind a decrease in attendance being observed since the COVID-19 pandemic requiring further investigation.	Plan to scope gaps of greatest need, working with the Community Pharmacy Team. Plan to collaborate with the Substance Misuse Team, PHW as this is a national issue.

Area 2: Case-finding and testing

Issue	Mitigation
1. Identification of individuals at high-risk is challenging due to gaps in data and awareness of different sub-populations in the area and the prevalence of hepatitis amongst these groups.	BBV-PET tool is being developed nationally. Locally, a Communications and Engagement Plan is being rolled out.
2. There is a lack of awareness of all those at high-risk for case finding, amongst both healthcare staff and the public.	A Communications and Engagement Plan is being rolled out locally to raise awareness of Hepatitis B and C. There is also a national campaign rollout expected in due course. Potential for service improvement work with maternity services to test for Hepatitis C antenatally when risk factors have been identified.
3. There are issues regarding the supply chain of resources for staff to undertake testing	Supply chain of resources for staff to undertake testing is being explored by a national sub-group set up by the National Oversight Group. This will look to remedy supply chain issues with central procurement of dry blood spot testing cards. There is work currently ongoing to put the cards onto Oracle so NHS services can order direct; however, third sector services will continue ordering through Orion.
4. Not all those at high-risk who are offered testing will accept it.	High-risk groups to be offered testing at all opportunities e.g. in prison, on first assessment in CAVHIS, in substance misuse services. The rationale surrounding this issue will be multi-factorial and will depend on population group and setting. Reasons will include the way it is offered by professionals. Settings that have normalised the screening process, and embedded it as a part of routine assessments/engagements have had the greatest uptake.
5. There is a lack of accessible testing pathways outside of those that are perceived to be high-risk.	This includes the South Asian Community and those that inject performance enhancing drugs. The Clinical Lead for Infectious Diseases is working on an outreach project to address this.
6. There is a reluctance to perform testing in generically accessed healthcare settings such as out-of-hours services, GP services and Emergency Departments.	We are working with Primary Care to address this issue. There is a proposal with Welsh Government for a prevalence study in Emergency Department.
7. There is low engagement with testing at community pharmacy sites, both from pharmacy staff and from service users	This is being addressed through a Community Pharmacy pilot including a peer support worker to support testing.

8. There is a gap between the number of individuals with reactive anti-HCV tests and the proportion of these that receive a confirmatory HCV-RNA test.	Potential service improvement initiative needed to look at sites doing bloods and also to streamline the testing process.

Area 3: Treatment

Issue	Mitigation
1. Tracking individuals to provide test results, treatment, and engagement can be difficult due to the chaotic lifestyles of some individuals.	Peer support and the re-engagement programme should support the mitigation of this issue.
2. Some substance misuse services are unable to access timely results, and hard copies of results are at risk of going missing. Third sector services don't have access to Welsh Clinical Portal, and as such are reliant on paper results via post or other services to provide them with results.	There is ongoing liaison between Information Governance and Digital Health and Care Wales nationally to identify possible solutions.
3. Treatment compliance, in terms of commencement, adherence, and completion, is not always achieved, leading to disengagement from the treatment pathways	Incentivisation through Love to Shop vouchers has helped maintain treatment adherence.

Area 4: Re-engagement

Issue	Mitigation
1. There can be challenges with engagement/re-engagement with services and support by individuals at high-risk.	The re-engagement programme is in phase 2, and will support this.

Area 5: Data

Issue	Mitigation
1. Recording of data on the Harm Reduction Database and E-form database is not always complete.	There are national initiatives working towards making it simpler to input data.
2. The identification of individuals at each stage of the test/treatment pathway (for monitoring and re-engagement purposes) is not routinely possible or complete.	This remains a challenge and will be escalated nationally.
3. There is no single accessible source of outcome data for hepatitis (B and C) evaluation either locally or nationally.	BBV-Progress to Elimination Tool is working towards this.

3 Where we want to be

Where we want to be, in terms of our aim and objectives, is outlined below in *Figure 7*.

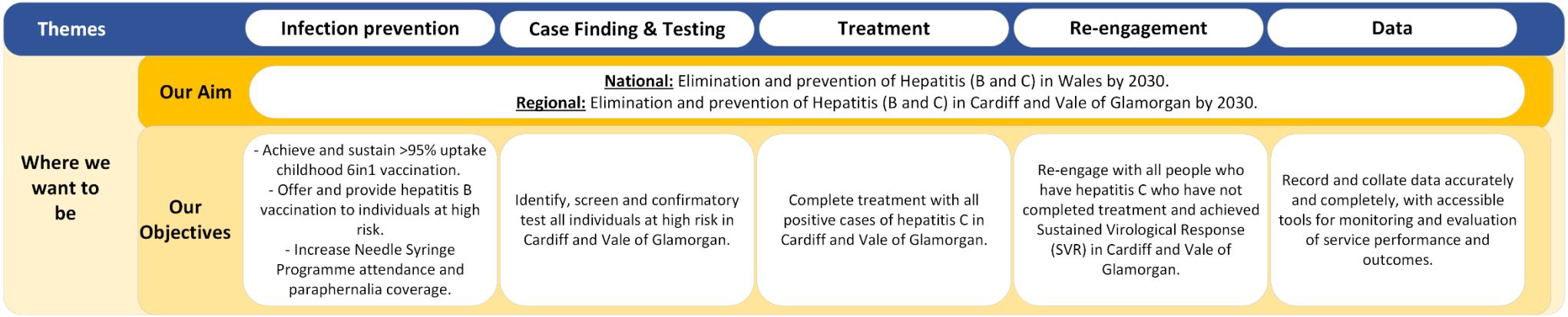


Figure 7: *Where we want to be: our aim and objectives for the prevention and elimination of hepatitis (B and C).*

4 How we will get there

4.1 Action Areas

Following a review of 'where we are now', and the challenges areas for getting to 'where we want to be', we have identified a number of actions across five action areas to facilitate the achievement of our aims and vision:

- Action Area 1: Infection Prevention
- Action Area 2: Case-finding and testing
- Action Area 3: Treatment
- Action Area 4: Re-engagement
- Action Area 5: Data

The work on these action areas will form part of the Cardiff and Vale Integrated Health Protection Partnership's new system model for an integrated and sustainable health protection approach in Cardiff and Vale, which is currently in development.

Some aspects of the action areas will require collaborative partnership working on a national level with the other Health Boards, Public Health Wales and the Cardiff and Vale Area Planning Board (APB), whilst others are specific actions for Cardiff and Vale UHB, with partners at the regional level.

The timescale for the identified actions is over 2024/25, following publication of this Plan.

4.2 Action Plan

Details on the five action areas are outlined below in our action plan. This will be a live document forming the basis of the implementation group's activities, with further details added to it as the work progresses. This will include further details around the measures of success provided.

Action area	Action	Lead	Timescale	Measure of success
1. Infection Prevention	**1.1** Development of operational plan for, and launch of mobile outreach van to support NSP services with exploration include exploration of how it can be used in collaboration with peers, and primary care settings.	CAVDAS	By 31/3/25	Operational mobile outreach van.
	1.2 Progress implementation of NSP peer-to-peer delivery, including succession planning for training of peers.	Substance Misuse Service/CAVDAS	By 31/3/25	Increased peer-to-peer delivery of NSP services achieved. Plan developed to ensure cycle of peer training.
	1.3 Widen provision of NSP within hostel settings.	Local Authority with APB Support Team/CAVDAS	By 31/9/24	Increased NSP provision in hostels achieved.
	1.4 Explore the reasons for decreased NSP attendance and opportunities to increase provision to targeted subgroups of people who inject drugs (PWID), and improve/widen promotion of NSP locations, hours and services offered.	APB Support Team/Harm Reduction Group/Substance Misuse Service	By 31/6/24 & Ongoing	Report on NSP attendance explanations with actions. Increased NSP sites/hours of operation achieved.
	1.5 Accurately record activity on the Harm Reduction Database and ensure quality assurance.	Substance Misuse Service	By 31/3/25	Data recording standards agreed with audit tools.
	1.6 Gain an understanding of the barriers to hepatitis B childhood vaccination uptake being <95% for Cardiff and Vale UHB.	Mass Imms & Testing	By 31/7/24	Report on the barriers to vaccination completed.
	1.7 Identify a source of vaccination history information that can be accessed by BBV staff in outreach services. This may be in the form of access to Welsh Clinical Portal data, or exploring the use of Health Passports.	Digital (Senior Business Analyst - Digital Care Region)	By 31/3/25	BBV staff having access to vaccination history data.
	1.8 Explore options for referral pathways for hepatitis B vaccination for identified high-risk individuals, including close contacts of cases and those providing care to high-risk individuals, such as through the Mass Immunisations Team.	Mass Imms & Testing with collaboration from local authority/CAVHIS etc.	By 31/3/25	Agreed referral pathway for vaccination produced.
	1.9 Explore the potential for a sustainable hepatitis B vaccination model with the mass imms team and health board Occupational Health team.	Mass Imms & Testing with collaboration from occupational health	By 31/3/25	Agreed referral pathway for vaccination produced.

2. Case-finding and testing	**2.1** Improve understanding of high-risk populations in Cardiff and Vale, in terms of numbers, demographic details and point prevalence surveys, building on the high-risk populations mapping work undertaken to date and linking with the inclusion health, substance misuse, DoSH and other relevant teams. This action area will include exploration of methods for identifying pregnant women where the father has hepatitis B, prior to birth.	Cardiff and Vale UHB (Consultant in Public Health)	By 31/3/25	Report on the make-up of populations at high risk in Cardiff and Vale, including mapping illustrations.
	2.2 Advocate for an awareness campaign in conjunction with the Hepatitis C Trust, nationally, to raise awareness amongst both healthcare staff and the public of who is at risk of Hepatitis (B and C) and how they can access support; with a focus on countering the misperception that it is only those who inject drugs who are at risk.	C&V Comms with PHW	By 31/3/25	Active awareness campaign launched in Cardiff and Vale and Wales.
	2.3 Ensure website improvements for signposting information for testing.	C&V Comms	By 31/3/25	Clear testing signposts online are operational and monitored.
	2.4 Explore the potential of increasing the number of community pharmacy test sites; provided either by pharmacy staff or via in-reach peer-to-peer provision within pharmacy settings. Identification of additional sites will require investigation of the most effective locations to facilitate.	PCIC/Community Pharmacy	By 31/3/25	An increased number of active community pharmacy test sites.
	2.5 Explore potential of test kits to support Hep B/C elimination, dependant on findings.	Community Pharmacy	By 31/3/25	Completed report on feasibility with recommendations.
	2.6 Explore options for BBV team having access to community Cepheid machines for outreach testing.	Infectious Diseases team	By 31/3/25	Completed report on feasibility with recommendations.
	2.7 BBV screening to be implemented as part of substance misuse service harm reduction initiatives.	Substance Misuse Service/Hep C Trust	By 31/3/25	Successfully implemented BBV screening in substance misuse service initiatives.
	2.8 Investigate/Develop resource to manage POCT testing in HMP Cardiff (once POCT team withdraw), and resource to follow up with those released from HMP Cardiff into the community (for treatment/vaccination/screening).	Infectious Diseases team	By 31/3/25	Active BBV testing in HMP Cardiff with data, and development of process following release.
	2.9 Seek to identify opportunities to source funding for expansion of the Hepatitis C Trust Peer support services, with a remit across wider populations.	PCIC/CAVHIS/Local Authority	By 31/3/25	Completed report on options for expansion with recommendations.
	2.10 Implement opt-out induction testing across hostels and homeless services, as per current process in the Salvation Army hostel with the Hepatitis C Trust.	Local Authority	By 31/3/25	Achievement of opt-out testing processes in hostels and homeless services.

	2.11 Explore new settings for POCT that are not currently used, based on the findings of action 2.1.	Infectious Diseases team	By 31/3/25	Completed report on potential sites for POCT with recommendations.
	2.12 Explore the potential for Emergency Department opt-out testing by performing a pilot at the University Hospital of Wales Emergency Department.	Infectious Diseases team	By 31/3/25	Completed pilot of emergency department testing with write-up and recommendations.
	2.13 Explore potential for expansion of both vaccination and screening pilots running in Probation services (looking at opportunities with other at-risk groups).	Infectious Diseases team & Mass Imms	By 31/3/25	Completed pilot of Probation vaccination/screening with write-up and recommendations.
	2.14 Explore testing of those using injectable performance enhancing drugs.	Infectious Diseases team	By 31/3/25	Completed report on potential process for testing/outreach with recommendations.
3. Treatment	**3.1** Develop robust processes for ensuring that non-UHB providers are able to access results in a timely and sustainable manner.	Infectious Diseases team	By 31/3/25	Processes in place for non-UHB providers to access results.
	3.2 Raise awareness of the effectiveness, side-effects and requirements of treatment, and dispel myths around these (linked with action 2.2).	National/Local Comms	By 31/3/25	Active awareness campaign launched in Cardiff and Vale and Wales.
	3.3 Increase use of Video-observed therapy (VOT): This is live now as an All-Wales approach. It is for patients that fail first line therapy for hepatitis C through poor compliance. As a result, VOT will aim to improve adherence to therapy and achievement of SVR.	Pharmacy (Rhys Oakley)/Local Authority	By 31/12/24	Completed evaluation of impact of VOT, with recommendations for further use.
	3.4 Incentivise test completion via £10 'Love to Shop' vouchers, with subsequent incentive vouchers for completing treatment and attending an SVR test.	Infectious Diseases team	By 31/3/25	Active incentive scheme in place.
	3.5 Evaluation/Review for use of Hepatitis C Trust Peer Support services to support treatment adherence.	Substance Misuse Service	By 31/3/25	Completed review of Hepatitis C Trust peer support service activity.
4. Re-engagement	**4.1** On completion of the re-engagement project (based on the list received by PHW), a plan is to be developed to ensure continued engagement.	Infectious Diseases team	By 31/3/25	Development and implementation of plan.
	4.2 Use of Hepatitis C Trust Peer Support services to improve re-engagement.	BBV Team/Substance Misuse Service	By 31/3/25	Hepatitis C Trust peer support services in place with re-engagement work. (Ongoing after completion)

	4.3 Regular monitoring and evaluation of the re-engagement list.	Infectious Diseases team	By 31/3/25	Completed report on re-engagement activity. (Ongoing after completion)
5. Data	**5.1** Ensure improved recording of data at point of testing and treatment on the E-form database and Harm Reduction Database Wales, including quality assurance measures for completeness of data inputs.	Substance Use Services/BBV Team/Hep C Trust	By 31/3/25	Agreed quality standard in place with processes for audit.
	5.2 Improve data availability and accessibility, working collaboratively with the other health boards in Wales and Public Heath Wales Communicable Disease Surveillance Centre (CDSC) to develop indicators (based on the WHO 'progress to elimination targets'[16]), and scope out an information tool to monitor this going forwards.	PHW (StR in Public Health)	By 31/12/25	Active data tool available to Health Boards in Wales.

4.3 Resources required

The facilitation and implementation of the actions outlined in the 5 action areas will require resources for delivery. Current resource from the Area Planning Board (APB) includes £260,000 of Substance Misuse Action Fund (SMAF) funding per annum aimed directly at the prevention, diagnosis and treatment of Hepatitis C. This includes: needle and syringe programme consumables, dried blood spot testing kits, and specialist peer support services (Hepatitis C Trust). In addition, SMAF funding has purchased a Cepheid machine to support rapid confirmatory testing in the community, community sharps bins and needle and syringe vending machines. The Integrated Health Protection Team is supporting the process through time in kind via a Health Protection Manager and Programme Manager. They are supporting pathway development and the program approach towards elimination. Further resource from the Health Protection budget has been utilised to purchase mobile outreach vans for both CAVHIS and CAVDAS.

This approach will require a combination of using current services and staff within the system to incorporate the additional pieces of work, as well as likely requiring additional new staff and other resources on top of these. The work on these action areas will form part of the Cardiff and Vale Integrated Health Protection Partnership's new system model for an integrated and sustainable health protection approach in Cardiff and Vale.

In terms of current system resources, the services and teams involved, or who could be involved, in the Cardiff and Vale hepatitis work are outlined in *Figure 1*, along with the following key stakeholders including:

- Cardiff and Vale Area Planning Board (and Support Team)
- The Integrated Cardiff and Vale Health Protection service
- Cardiff and Vale Health Inclusion Service (CAVHIS)
- The BBV Team
- Substance Misuse Services (Third Sector, Health Board and Criminal Justice)
- The Department of Sexual Health

- Primary Care services
- His Majesty's Prison Services
- Public Health Wales
- The Mass Immunisation and Testing team
- Community Pharmacies
- Hepatitis C Trust Peer Support Services
- Potential (tbc): Shared Regulatory Services Health Protection Officers

In addition to these current resources, the implementation plan will require the following additional posts and roles, with funding from the Health Protection Budget for 2024/25:

- Prison site staffing for test and treat services: in the form of a POCT worker
- Peer Support Workers: for outreach services and POCT
- Potential: additional community pharmacy support

We are working through how we might best deploy the people and resources we currently have in the system to support the health protection action required, including delivery of the hepatitis (B and C) plan. This could include use of vaccination staff.

4.4 Implementation, monitoring and reporting mechanisms

The implementation of the actions set out in this plan will be taken forward by a hepatitis (B and C) implementation group, which will form a subgroup of the Cardiff and Vale Integrated Health Protection Partnership. The reporting mechanisms are shown in *Figure 7*, which highlights where this work will sit within the overarching health protection work.

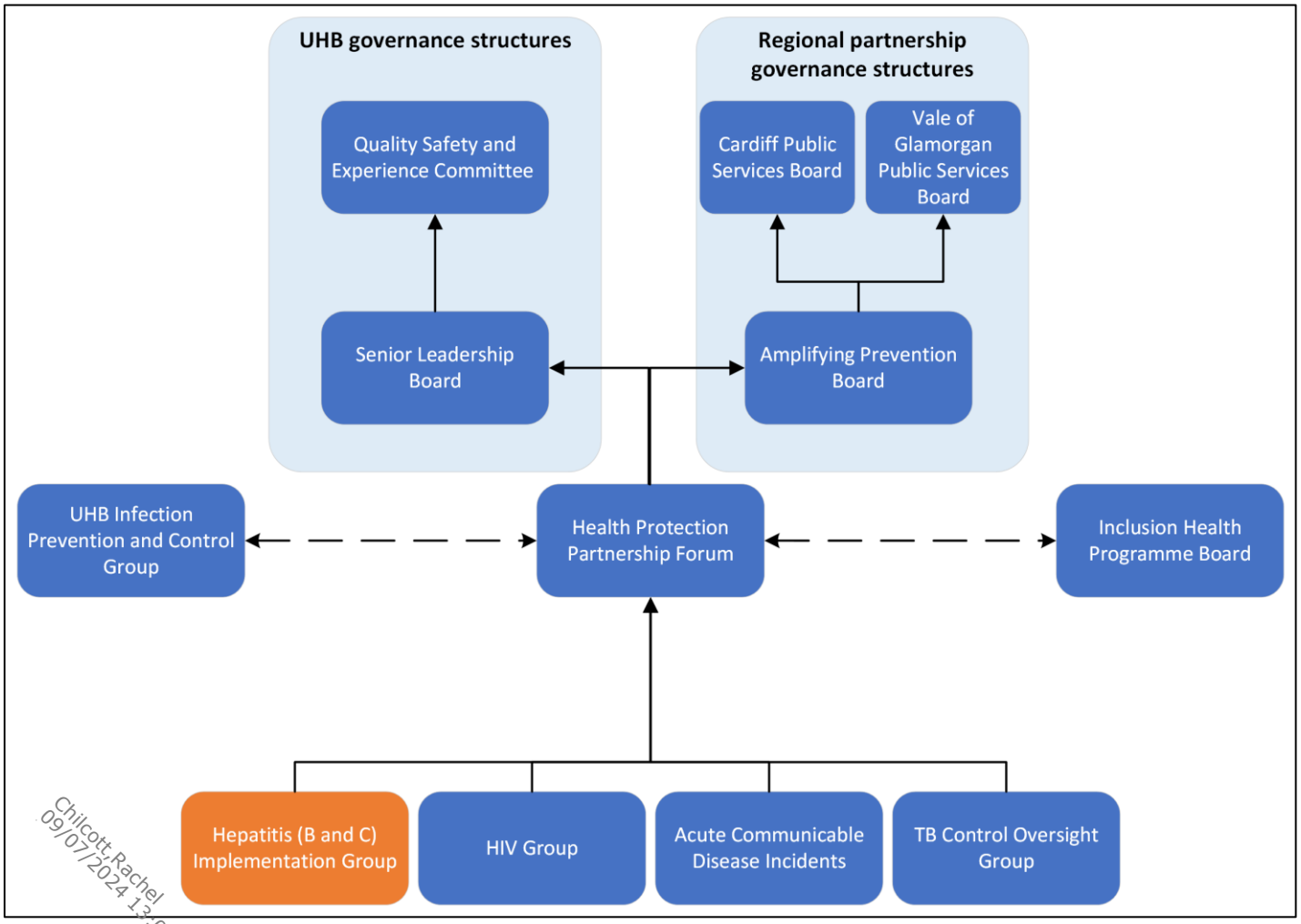


Figure 7: *The reporting mechanisms for the hepatitis (B and C) implementation group.*

Progress of the implementation group against the action areas, and the broader prevention and elimination targets, will ultimately be monitored and reported via the information tool to be developed as part of action 5.2 nationally, and the internal data reporting processes already available within the Health Board regionally.

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Equality & Health Impact Assessment for the Cardiff and Vale of Glamorgan Hepatitis B and C Elimination Plan 2024/25

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Cardiff and Vale of Glamorgan Hepatitis B and C Elimination Plan 2024/25
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Public Health/ Primary Community and Intermediate Care Consultant in Public Health Medicine/ Hepatitis B and C Programme Manager Suzanne.wood@wales.nhs.uk and Rhianna.matthews@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service Policies and Procedures - Home (sharepoint.com)	Elimination and prevention of Hepatitis B and C in Cardiff and Vale of Glamorgan by 2030.
4.	Evidence and background information considered. For example • population data • staff and service user's data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge	Population data was considered from the BBV-PET tool (February 2024), and a mapping exercise conducted within the last year. Secondary research was utilised to consider what the possible positive or negative impacts might be for each protected characteristic and wellbeing goal. The search strategy for this can be found in Appendix A, and references in the References section to the rear of the document.

	• list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the design and development stages Public Health Wales Observatory Cardiff and Vale of Glamorgan Population Needs Assessment - Cardiff & Vale Integrated Health & Social Care Partnership (cvih (1)sc.co.uk) CAVUHB - Home (sharepoint.com)	The Cardiff and Vale of Glamorgan Hepatitis B and C Elimination Oversight Implementation Group were involved in the production of the Hepatitis B and C Elimination Plan 2024/25. This was to ensure inclusivity and that appropriate actions were taken forward. Key members of this group include: • Cardiff and Vale Area Planning Board (and Support Team) • Cardiff and Vale Health Inclusion Service • The Infectious Diseases Team • Substance Misuse Services (CAVDAS) • Primary Care services • Public Health Wales • The Mass Immunisation and Testing team • Community Pharmacies representation • Hepatitis C Trust Peer Support Services The Welsh Health Circular on hepatitis B and C elimination was taken into account, in coordinating the Elimination Plan 2024/25.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	In the main, service users / patients will be affected. However, in some instances staff members might be affected, for example if they have a needlestick injury.

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

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

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
6.1 Age *For most purposes, the main categories are:* • *under 18;* • *between 18 and 65; and* • *over 65*	**Under 18s** Hepatitis B in children is commonly transmitted from mother to baby or from child to child (1) (2). However, it is largely preventable in children via a Hepatitis B vaccination. Hepatitis B is also a part of the routine vaccination schedule of the 6 in 1 at 8, 12 and 16 weeks old (3). There were no incidences of Hepatitis C in 0-14 year-olds during 2023, according to the BBV-PET tool. The Plan will have a positive impact on children as there is an emphasis on increasing uptake of the Hepatitis B vaccination in infants. **Adults aged between 18 and 65** According to the BBV PET tool (dated February 2024), the highest age group for Hepatitis C incidence was 35-44, at 36.46/100,000 population in Cardiff and Vale UHB (2023).	**Under 18s** There is already a plan in place to improve uptake of the 6 in 1 uptake in infants within the Plan. No further action needed **Adults aged between 18 and 65** The plan addresses the need to target adults in a variety of situations, who are at high risk. No further action needed.	**Under 18s** No further action needed **Adults aged between 18 and 65** No further action needed

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
	The Plan will have a positive impact on adults who are at high risk of Hepatitis B or C due to targeting multiple high-risk groups. **Adults aged over 65** The Hepatitis C incidence in those aged over 65 is much lower than the general adult population at 2.39/100,000 population according to the BBV-PET tool for 2023. Adults aged over 65 will be included in the Hepatitis B and C Elimination Plan. There is a therefore a positive impact of the Plan on this age group.	**Adults aged over 65** The Plan addresses the need to target older adults in a variety of situations, who are at high risk. No further action needed.	**Adults aged over 65** No further action needed.
6.2 Persons with a disability as defined in the Equality Act 2010 *Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes*	It is noted in the Green Book that people with a learning disability are less likely to have had a 6-in-1/hepatitis B vaccination, and are a high-risk group for contracting hepatitis B (4). The prevalence rate of chronic hepatitis C is up to 9 times higher for someone with a mental health condition than without (5). The Elimination Plan includes all people with a disability; so, will	The Plan is inclusive of those people who have a mental health condition or learning disability. No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
	likely make a positive impact on their health.		
6.3 People of different genders: *Consider men, women, people undergoing gender reassignment* ***NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender* *Stonewall* *Gender Identity Research & Education Society – Improving the Lives of Trans People (gires.org.uk)* Chilcott Rachel 09/07/2024 13:02:37	The incidence of hepatitis C is greater in males than in females. For example, in 2023, for Cardiff and Vale UHB area, the incidence of hepatitis C in men was 16.62/100,000 population; whereas in women it was 4.25/100,000. This was according to the BBV-PET tool. Trans-women in one cross-sectional analysis had the highest prevalence of hepatitis C (0.7%) and hepatitis B (0.4%), as compared to their cis-gender counterparts (6). This Elimination Plan includes all people, including male, female and trans. It therefore, will have a positive impact on their health outcomes.	The Plan is inclusive of males, females and trans people. No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	Anyone who is co-habiting and in a sexual relationship is at an increased risk of contracting either hepatitis B or C (2). People who are married or who are in a civil partnership would be as likely to contract hepatitis B or C or if they contract hepatitis C, to obtain the necessary treatment. Therefore, this Plan would have a neutral impact on those married or in a civil partnership.	No further action needed.	No further action needed.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. *They are protected for 26 weeks after having a baby whether they are on maternity leave.* Chilcott Rachel 09/07/2024 13:02:38	Pregnant women should routinely receive antenatal screening for hepatitis B at around 10 weeks gestation. If they test positive they will have specialist care and their baby will need to have 6 hepatitis B vaccinations (7). This Plan will include all pregnant women, and antenatal screening is universal, so the Plan overall will have a neutral impact.	No further action needed.	No further action needed.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-	An opt-out testing programme in 33 England Emergency Units showed that the highest	No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
English speakers, gypsies/travellers, migrant workers The Runnymede Trust	proportion of new diagnoses of hepatitis B were among people of black African ethnicity, and for hepatitis C, it was among people of white ethnicities other than white British (8). Within the action plan, we hope to do anonymous blood testing for hepatitis B and C in Emergency Unit, which may in the future become opt-out testing if viable in Cardiff. Therefore, it will be a positive impact within the Plan.		
6.7 People with a religion or belief or with no religion or belief. *The term 'religion' includes a religious or philosophical belief* Chilcott Rachel 09/07/2024 13:02:37	The literature search did not reveal any conclusive evidence of an effect of religion on hepatitis B or C prevalence/incidence. However, one article mentioned it can either bring on a duty to care for oneself; or a fatalistic approach to hepatitis (9). The Plan aims to work with centres of religion to increase Hepatitis C screening. Therefore,	No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
	there should be a positive effect for some religious groups.		
6.8 People who are attracted to other people of: • *the opposite sex (heterosexual);* • *the same sex (lesbian or gay);* • *both sexes (bisexual)* *Stonewal*	Communities at higher risk of getting hepatitis B in the UK include: gay, bisexual and men who have sex with men who are having sex with multiple partners. Gay, bisexual and other men who have sex with men who are having condomless sex with multiple partners or injecting chems are at increased risk of hepatitis B and C (10). The Plan is inclusive of sexuality, and will therefore provide a positive health benefit.	No further action needed.	No further action needed.
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design *Well-being Goal – A Wales of vibrant culture and thriving Welsh language*	The active offer of the Welsh language is practised within Cardiff and Vale UHB. This is a part of the Welsh language legislation (11). The offer shows that you are treating people with dignity and respect. The British Liver Trust have a range of resources in the Welsh language.	No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
	The Plan will have a neutral impact on Welsh speakers.		
6.10 People according to their income related group: *Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health*	The literature search did not reveal any differences on income-related group and hepatitis B or C. This Plan will have a neutral effect on income-related groups.	No further action needed.	No further action needed.
6.11 People according to where they live: *Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities*	The screening programme within the Plan, will be local, and have an outreach approach using a mobile outreach van. There is also a test and post scheme for dry blood spot testing. Overall, the Plan is likely to increase testing for hepatitis B and C, as it operates at a local area. Therefore, it will have a positive effect on health outcomes.	No further action needed.	No further action needed.
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	N/A		

HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on? -	**Potential positive and/or negative impacts and any groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Refer to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: *Consider access for those living in areas of deprivation and/or those experiencing health inequalities*	The Plan highlights the work ongoing to ensure easy access to Hep C screening. This includes but is not limited to mobile outreach vehicles offering screening in areas of deprivation and high population, pilots for screening in probation services, POCT testing in HMP Cardiff, and the availability of home screening kits in community pharmacies. There is likely to be a positive impact on people being able to access the service offered.	No further action needed.	No further action needed.
7.2 People being able to improve /maintain healthy lifestyles: *Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (e.g., immunisation and vaccination, falls prevention). Also*	The Plan will support people to have healthier livers through hepatitis B vaccination prevention and hepatitis C testing and treatments (2). The Plan looks to improve access to screening and vaccination, including a focus on cohorts using	No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts and any groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Refer to where the mitigation is included in the document, as appropriate
consider the impact on access to supportive services including smoking cessation services, weight management services etc. Creating healthier places spaces.pdf (wales.nhs.uk)	Needle and Syringe Programmes to support infection prevention. The use of peers in support services will improve awareness within cohorts that are utilising drug and alcohol services/health inclusion services. Overall, the Plan should have a positive impact on healthy lifestyles.		
7.3 People in terms of their income and employment status: *Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions*	The literature search did not reveal any differences on income or employment status and hepatitis B or C. The Plan will likely have a neutral impact on people in terms of their income and employment status.	No further action needed.	No further action needed.
7.4 People in terms of their use of the physical environment: *Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff, and visitors; on air quality, exposure to pollutants; safety of*	The plan focuses on delivery of screening, vaccination and treatment in a range of locations to ensure access is maximised for eligible cohorts. This includes staff being able to access vaccination through occupational health services, those using NSP services having access to test kits	No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts and any groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Refer to where the mitigation is included in the document, as appropriate
neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces	in community pharmacies, and outreach services taking mobile units direct to communities, all ensuring services required (screening/vaccination etc.) are available in locations which are already safe and familiar and utilised by the relevant cohorts. The Plan is therefore likely to have a neutral impact on the physical environment.		
7.5 People in terms of social and community influences on their health: *Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos* Chilcott Rachel 09/07/2024 13:02:37	The Plan highlights the importance of the use of peers in the delivery of NSP services, in pharmacy settings to support testing, and in the Hepatitis C Trust peer support services for treatment adherence/re-engagement. These trusted voices are hoped to positively impact these areas, and are trained to provide information that certain cohorts would not be receptive to coming from medical professionals. The Plan is likely to have a positive impact on community influences on health.	No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts and any groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Refer to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: *Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate*	The policy does not directly address environmental or sustainability factors, but there is an expectation for these aspects to be considered by stakeholders during planning of local actions. The Plan is likely to have a neutral impact on macro-economic, environmental and sustainability factors.	No further action needed.	No further action needed.

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summaries the potential positive and/or negative impacts of the strategy, policy, plan, or service Chilcott Rachel 09/07/2024 13:02:37	The following positive impacts of the Plan are noted: • People of all ages • People with a disability • Male, female and trans people • People of a different race • People with different religions • People regardless of sexuality • People according to where they live • People being able to access the service offered • People being able to improve healthy lifestyles • People in terms of social/community influences on their health There were no negative impacts.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	No further actions were identified.			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? *This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?*	No, a more comprehensive Impact Assessment is not required.			

8.4 What are the next steps?
Some suggestions: -
• *Decide whether the strategy, policy, plan, procedure and/or service proposal:*
  ○ *continues unchanged as there are no significant negative impacts*
  ○ *adjusts to account for the negative impacts*
  ○ *continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)*
  ○ *stops.*
• *Have your strategy, policy, plan, procedure and/or service proposal approved*
• *Publish your report of this impact assessment*
• *Monitor and review*
	The current Plan will remain unchanged. However, as it will be renewed next year, it may be advisable to do a more in-depth EHIA at that time.			

Appendix A: Search strategy

For Sections 6 and 7, the following searches took place on Google in June 2024:

- (Hepatitis B or C) AND child AND UK
- (Hepatitis B or C) AND adult AND UK
- (Hepatitis B or C) AND disability AND UK
- (Hepatitis B or C) AND Mental health AND UK
- (Hepatitis B or C) AND trans AND UK
- (Hepatitis B or C) AND ethnicity AND UK
- (Hepatitis B or C) AND religion AND UK
- (Hepatitis B or C) AND Welsh language AND UK
- (Hepatitis B or C) AND healthy lifestyle AND UK
- (Hepatitis C) AND Access to screening AND UK
- (Hepatitis B) AND Vaccination AND UK

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Cardiff Council, Cardiff and Vale University Health Board, South Wales Police

Report of Joint Inspection of Child Protection Arrangements

January 2024

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

 WG49764 Digital ISBN 978-1-83577-888-3

Introduction

Between 15 and 19 January 2024, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and His Majesty's Chief Inspector of Education and Training in Wales (Estyn) carried out a joint inspection of the multi-agency response to abuse and neglect of children in Cardiff.

This report outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Cardiff.

Scope of the inspection

The Joint Inspection of Child Protection Arrangements (JICPA) reviewed:

- the response to allegations of abuse and neglect at the point of identification
- the quality and impact of assessment, planning and decision-making in response to notifications and referrals
- protecting children aged 11 and under at risk of abuse and neglect
- the leadership and management of this work
- the effectiveness of the multi-agency safeguarding partner arrangements in relation to this work

We have endeavoured to use plain language to describe the findings from the JICPA. We refer to several terms throughout the report which are defined as follows:

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Term or Phrase	Definition
ALN	Additional Learning Needs
CAMHS	Child and Adolescent Mental Health Services
Care First	Children's Services IT data base
CASPP	Care and Support Protection Plan
CLA	Children Looked After
CP/ CPR	Child Protection/ Child Protection Register
CPCC	Child Protection Case Conference
CVUHB	Cardiff and Vale University Health Board
DSL	Designated Safeguarding Lead is the person appointed to take lead responsibility for child protection issues in schools and Pupil Referral Units (PRUs).
DSP	Designated Safeguarding Person is a school or PRU's lead person on safeguarding and child protection
EHE	Elective home education
ELSA	Emotional Literacy Support Assistant is a social and emotional intervention programme delivered by trained staff in primary, secondary schools and PRUs.
IDVA	Independent Domestic Violence Advisors (IDVAs) are trained to provide specialist advice and support to victims of domestic abuse
PCC	Police and Crime Commissioners (PCCs) aim to cut crime and deliver an effective and efficient police service within their police force area. They are elected by the public to hold Chief Constables and the force to account, making the police answerable to the communities they serve.
MARAC	MARACs are Multi Agency Risk Assessment Conferences. They are regular meetings of professionals who discuss how to help individuals who are most at risk of serious harm due to domestic violence and abuse.
MARF	Multi Agency Report (Referral) Form
MASH	Multi Agency Safeguarding Hub - A single point of contact for all new safeguarding concerns.
NICHE	The police intelligence and information system
Operation Encompass	Operation Encompass is a partnership between police, schools and PRUs. One of the principles of Operation Encompass is that all incidents of domestic abuse are shared with schools and PRUs, not just those where an offence can be identified.

PLO	The Public Law Outline (PLO) process takes place when the Local Authority is concerned about a child's well-being and unless positive steps are taken to address and alleviate those concerns, the Local Authority may consider making an application to the Court. (Family Law Group)
PPN	Public Protection Notices
PRU	A Pupil Referral Unit (PRU) is a type of school established and maintained by a local authority to provide suitable education for children and young people who, by reason of illness, exclusion or otherwise, may not receive such education (section 19 of the Education Act 1996)
RSB	Regional Safeguarding Board
Section 47 (S47)	Under Section 47 Children Act 1989, a local authority has a duty to investigate if it appears to them that a child in its area is suffering or is at risk of suffering significant harm.
Signs of Safety	Signs of Safety approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children.
TAC	Team around the Cluster (TAC) model aims to support schools and PRUs to identify and support families earlier when the needs arise by collaboration with key partners.
THRIVE	Thrive offers a trauma informed, whole school or setting approach that helps to improve the mental health and well-being of children and young people.
VAWDASV	Violence Against Women, Domestic Abuse and Sexual Violence. A VAWDASV Strategy 2022 to 2026, was launched in May 2022
Wales Safeguarding Procedures	Wales Safeguarding Procedures detail the essential roles and responsibilities for practitioners to ensure that they safeguard children and adults who are at risk of abuse and neglect.

Summary

The current children's safeguarding context is one of persistently high levels of demand and increasing complexity. The local authority reports a 44% increase in strategy discussions undertaken in 2022/2023 compared to 2019/2020. This is consistent with a similar increase in Section 47 enquiries (46% increase in the same period), reflecting the increase in demand across services.

Budget challenges, deficits in the number of practitioners and a competitive market, have resulted in an increasing proportion of newly qualified and inexperienced workers across partner agencies. This exacerbates the challenge of safeguarding children across multi-agency activity.

There is, however, a positive focus on safeguarding across the local authority, local police force and health board. A culture of safeguarding is promoted as everyone's collective responsibility. Professional relationships across agencies are positive with professional differences easily resolved between senior safeguarding leads. Leaders and managers, particularly in the local authority, have a good understanding of the experiences of children and families that need help and protection in the area and the prevalence of need and risk. Cardiff and Vale University Health Board (CVUHB), however, needs to strengthen its governance arrangements to support safeguarding practice and report on and scrutinise key safeguarding data.

Local partnership working is supported by the regional safeguarding board. There have been recent changes to board governance arrangements with the introduction of a safeguarding delivery group which aims to strengthen monitoring, accountability and improved coordination across the partnership. This has helped promote the message that safeguarding is everybody's business and a collective responsibility.

Practitioners mostly understand their roles and responsibilities in the context of protecting children and maintain a positive focus and commitment. Information is generally shared appropriately and in a timely manner when concerns are identified about children's safety and well-being.

There is good multi-agency attendance and participation in child protection meetings arranged under the Wales Safeguarding Procedures. Partners understand their roles and responsibilities in relation to safeguarding children. It is positive that following a targeted increase in resources, police attendance at review child protection conferences is significantly improved.

The multi-agency response to safeguarding referrals is generally proportionate to the presenting risk. Child protection enquiries are thorough with a focus on the needs of the child, involvement of relevant agencies and with mostly timely action to reduce

the risk of harm to children. Sometimes there can be delay in progressing assessment and plans, despite managerial oversight.

Children and their families' views are heard. This is evident in the developing practice approach adopted in Cardiff which is strengths-based and solution-led. This provides good opportunity for families to be involved in the design and delivery of care and support protection plans (CASPP).

Children and their families benefit from evidence-based approaches which reduce risks and meet their needs. There are a range of services supported by agencies, for example the Goleudy service, which provides a multi-agency crisis response to emotionally distressed children. The Police and Crime Commissioner (PCC) funds a range of initiatives supporting children and families affected by violence and harm. Some of these initiatives include hospital and community-based provision.

There are areas of immediate concern identified by HIW in relation to CVUHB's safeguarding of children arrangements that could pose an immediate risk to their safety. HIW has requested CVUHB provide an immediate improvement plan for the actions it has taken and/or intends to take, to address these issues to ensure children and young people are safeguarded and their safety is maintained. The concerns are referenced later in this report.

Safeguarding of pupils is a high priority in schools and the pupil referral unit (PRU) and as a result, they are safe places for pupils to learn. Schools and the PRU know pupils and their families well and respond to meeting their needs. There are lots of opportunities for children to be involved in plans for them and decisions that are made.

Schools and the PRU are significant and effective contributors in the multi-agency response to ensure children get the right help and protection at the right time. They identify children in need of help or protection and make timely referrals to children's social care when appropriate, although awareness and access to external early help services could be improved. Children receive appropriate support within the school or the PRU, with a comprehensive range of programmes used to promote health and well-being.

Key findings and evidence

Well-being

Partnership Arrangements - Strengths

Changes to the Cardiff and Vale of Glamorgan Regional Safeguarding Board (RSB) governance arrangements, forming a delivery group, present as positive in terms of efficiency and clarity in communication, although it is early in the process of change. Tracking of recommendations of adult and child practice reviews is improving.

A training needs analysis undertaken by way of a self-assessment across the partnership is recognised as a positive development, although all agencies need to engage with this. It is important this leads to a practice focused joint training programme. Shared resources and provision of training are being developed, with multi-agency training already delivered as part of National Safeguarding Week at the end of 2023.

Partner organisations are successful in collaborating, commissioning and delivering safeguarding services. The local authority's Corporate Safeguarding Policy 2022–2025 includes clear objectives and guidance to ensure safeguarding is everyone's business.

Illustrative examples of partners collaborating include South Wales Police attending the CVUHB internal bi-monthly safeguarding meetings, with the local authority receiving minutes of these meetings. This means partners can be made aware of safeguarding issues within CVUHB and opportunities taken up to manage challenges together.

The Goleudy service provides a crisis response to emotionally distressed children presenting in hospital and coordinates the planning for ongoing support. The team comprises clinical psychologists, mental health staff, occupational therapists, social worker assistants and education coordinators. Children's services have a CAMHS/crisis pathway consultant social worker who does not hold primary care planning responsibility. This post sits across health and social services and is highly regarded by staff in enabling closer links across services.

There are examples of collaborative working where domestic abuse is a concern. In the Multi Agency Safeguarding Hub (MASH), daily joint multi-agency arrangements provide opportunity to review high risk circumstances. CVUHB based Independent Domestic Violence Advisors (IDVAs), funded by the PCC, include an IDVA specifically to work with young people aged 11 to 17 years. A dedicated domestic abuse lead in social care has established positive links across other services including third sector partners. The post holder is a qualified and experienced social

worker who is; non-case holding in leading practice, developing practice tools and delivering training.

There is a focus on strengthening practice in Cardiff regarding children who go missing. This is supported by a strategic commitment to working with partners. There are procedures in place and a designated missing persons coordinator based in the Safeguarding Adolescents from Exploitation (SAFE) service, acting as link for partners. There is a commitment to achieving consistent application of a missing persons protocol in practice, supported by an improving focus on performance oversight. For example, practice has been strengthened through development of a data visualisation tool to capture information relating to missing persons, provision of weekly data to operational managers for young people deemed most at risk, and fortnightly strategic missing persons meetings involving the SAFE service and Police Missing Team.

Professionals identify children in need of help and protection and report their concerns accordingly. Partners value the accessibility of practitioners in the MASH and the opportunity to discuss their concerns with front door practitioners prior to completing the Multi Agency Report (Referral) Form (MARF). One partner commented '*we can easily access advice from MASH which is useful and supports the safeguarding process*.'

What needs to improve

The practice of single agency Section 47 visits by social workers is a recognised practice response across Wales, but this should not be a response routinely led by capacity. For example, delay was identified in responding to a child protection incident evident partly because a single agency recommendation was made, and communication between social services and police faltered thereafter. Partners said the decision to undertake such single agency visits is partially related to the increase in referrals relating to the change to physical chastisement law and police capacity to respond. There is also a noted lack of relevant experience, confidence and potential delay in recourse to police uniform response for these types of concerns.

The local authority is reviewing the process for outcome strategy meetings, which generally involve the police and children's services with information shared across email communication. This includes consideration to the child protection medical process. Wider contribution from partner agencies would improve understanding of the circumstances of children and the quality of the care and support protection planning process.

Individual Agency - Strengths

Cardiff and Vale University Health Board

CVUHB staff are aware of the processes to follow when a child at risk attends their services, although, this could be strengthened by the implementation of an organisational safeguarding policy. Staff are confident they can access safeguarding advice in a timely manner from the safeguarding team. Regular meetings are in place within CVUHB to review child safeguarding decision making. Examples include weekly paediatric emergency department (ED) meetings and monthly child protection medical peer review. These provide an additional safety net and oversight of safeguarding referrals (the duty to report) and an opportunity to learn and improve practice.

There are positive examples of services supporting the safety and well-being of children and working across disciplines. CVUHB links with primary care colleagues is positive. A digital safeguarding health pathway has recently been developed to support GPs in safeguarding decision making and processes.

There is a Frequent Attender staff member based in the ED to follow up cases of multiple admissions and where appropriate, this can be discussed in the paediatric ED meetings. The CAMHS Crisis service is available until midnight, and this can be accessed by paediatric ED.

In midwifery, the Named Safeguarding Midwife provides consistent support across maternity services. The Pre-Birth Team is working well, with excellent multi-agency working relationships identified in this area.

There are two emotional wellbeing nurses which support children in the PRU and the Elective Home educated children. These are valued by schools and the PRU.

Education

Cardiff schools and the PRU seek to develop and encourage a continuous improvement culture to secure high standards of school governance, operation, and safeguarding. In doing so they are committed to working collaboratively, and with openness, with partners in the education system.

Officers from a range of teams share intelligence around individual schools and the PRU at the All-Schools Risk meetings which are held termly. This enables the local authority to understand the needs of Cardiff schools and the PRU and provide support as required.

School staff at all levels understand their roles and responsibilities in respect of keeping learners safe. Use of a digital platform for all schools, the PRU and service

areas across the education department is improving consistency in recording and reporting concerns. This also improves communication and sharing of information between schools, the PRU and service providers and is beginning to be used to monitor trends from which targeted intervention can be identified.

There are regular opportunities for designated safeguarding persons (DSP) in schools and the PRU to meet and have professional dialogue as part of the DSP forums. DSPs respond quickly to safeguarding concerns and follow correct referral procedures. They share child protection information appropriately, but sensitively, with key school staff.

School and PRU staff have a secure knowledge and understanding of the chronology of pupils who have been named on the child protection register (CPR). There is evidence of multi-agency referral forms (MARFs) being submitted by school and PRU staff in a timely manner.

The roll out of the Whole School Approach to Emotional and Mental Wellbeing has continued, in partnership with Public Health Wales. Schools and the PRU provide vulnerable pupils with a high level of emotional and wellbeing support through Emotional Literacy Support Assistants (ELSA), THRIVE and wellbeing classes.

Cardiff meets the statutory requirement set out in the School Standards and Organisation (Wales) Act (2013) through provision of a face-to-face service school-based counselling service, operating in every Cardiff maintained secondary school and in Year 6 in primary schools, alongside an internet chat message-based service. Many schools adopt Nurture Principles approach that helps pupils develop vital social skills, confidence, and self-esteem, and become ready to learn.

There are identified trusted adults in schools for pupils to turn to if they are worried about something. Pupils say they are well supported and listened to by these people if they are distressed or anxious.

Within the local authority Digital Team, a comprehensive set of online safety resources are made available to all schools and the PRU in Cardiff via Hwb and the Curriculum Teams online learning platform.

The local authority is continuously reviewing the well-being class provision across the city and have aligned the provision with the Additional Learning Needs (ALN) code and processes. The local authority has a dedicated team of ALN transition workers who support children and young people from birth to 25 years. They provide a high-quality service, adopting a person-centred approach in line with the local authority's statutory duties. The team maintain collaborative partnerships with stakeholders.

There are over 500 elected home education (EHE) learners in Cardiff, and anxiety is the second highest reason given for exiting schools. The EHE local authority fund supports officers to track and support pupils. This helps strengthen safeguarding arrangements, where appropriate, for this group of children and young people.

The Education Welfare Service (EWS) has a robust Children Missing Education (CME) procedure and plays an important role in tracking all pupils leaving schools in year, Year 6 to 7 pupils at transition, and children arriving in the area to ensure they arrive safely at their next destinations.

The prevalence of Anxiety Based School Avoidance (ABSA) has increased since the return to schools and the PRU following the pandemic. The Cardiff Educational Psychology Service has produced guidance and training for schools and information leaflets for parents and carers and young people.

The Ethnic Minority and Traveller Achievement Service (EMTAS) have an established working relationship with the Gypsy Traveller community and have developed the respect and the trust of families. Targeted support is provided for Year 6 to 7 transition and enrolment at primary schools, for example by supporting families to complete school applications and transition to high school. The targeted support is having a positive impact.

South Wales Police

We found good use of flags and warning markers by officers to highlight vulnerable children, such as those who have been reported as missing. Call handlers in the Public Service Centre use these flags and markers to quickly identify and assess level of risk, so as to inform the type of response to an incident. This helps to make sure children are safeguarded quickly.

The Force has recently revised and strengthened its policy on responding to missing children. Incidents involving children aged 11 and under, when missing, are treated as high-risk. Most incidents we sampled were assessed and graded appropriately, although the force acknowledge this to be a work in progress.

Police reports for initial case conferences are thorough. Minutes are detailed and are recorded on the force's systems, Niche.

Children's Services

Generally, safeguarding practice led by children's services is underpinned by consideration of risks relating to children's safety, balanced with consideration of the strengths within their families. There are examples of thorough explanation of complex family situations in assessments which provide clarity of the family situation and who is in the children's immediate and wider family circle.

Referrals and duty to report records are screened, RAG (red, amber, green) rated to indicate assessed priority level, and triaged at MASH. During this process there is consideration and focus on parental consent. Potential risks to siblings are generally considered as part of the safeguarding process. There is also consideration of contextual safeguarding factors, although some records would benefit from more

detail to demonstrate practitioners' consideration of the wider risks associated with children and / or vulnerable adults.

Families are regarded as central to safety plans and achieving desired outcomes. There are good examples of safety plans being used, setting clear expectations of parents in terms of managing risks. There could be improved consistency in how these are recorded to ensure there is clarity about risk, safety and what needs to happen to be assured about safety.

There is a strong emphasis on transformational planning activity for positive reasons with a clear practice focus. For example, reconfiguration of panels, which is being positively received by staff. Also, a new escalation policy in Child Protection Case Conference process and a new management oversight policy has been developed.

Individual Agency - What needs to improve

Cardiff and Vale Health Board

Whilst reviewing health board documents to gain an understanding of the governance arrangements in place, a concerning incident was identified regarding a child who had developed grade three skin pressure damage as an inpatient. HIW was informed that following the incident investigation, the pressure damage was deemed to be unavoidable, because all risk assessments had been completed. However, HIW was not assured that the information provided by the health board demonstrated the child was appropriately safeguarded. This, therefore, highlighted concerns with the recognition of, and actions taken by the health board to safeguard children from developing skin tissue damage.

The numbers of children looked after (CLA) who do not receive an initial health assessment within the statutory timescale is high, reaching 95% in November 2023. This is a longstanding risk. Compliance data for statutory review health assessments was not available to inspectors.

School health nurses are not undertaking health assessments for school-aged children who are subject to an initial child protection conference. In addition, most school nurses do not have access to GP records and so may be unaware of a child's health care needs. It is recommended a comprehensive health assessment is completed for every school aged child to identify if there are any health needs to inform the CASPP.

In light of the issues highlighted above, HIW issued an Immediate Assurance letter to the health board requesting an urgent response and an improvement plan to address the areas of concern. HIW has since accepted the improvement plan.

The number of different Health Board IT systems in use impedes the timeliness of information gathering and sharing. Key safeguarding documentation is not always recorded or logged, and other records provide only limited information. This means important details about care and support plans and multi-agency meetings are not always available to inform progress about a child's safety and well-being.

The safeguarding lead midwife role is the responsibility of one practitioner, a large remit which is disproportionate to the remainder of the safeguarding team. Areas of services previously offered by the safeguarding team to maternity staff have been discontinued (supervision and Level 3 training to hospital midwives). This is a potential risk that needs revisiting.

Education

No specific areas to record under this section.

South Wales Police

There was a backlog in the processing of domestic violence disclosure scheme (DVDS) applications at the time of the inspection. This has been recognised by the force who are working to reduce it, however, decisions about sharing safeguarding information to victims who are responsible for protecting children is delayed in some cases.

Children's Services

The 2022/2023 Annual Welsh Government Performance Submission by the local authority records 44% of contacts where a decision was not made by the end of the next working day. The same data set records high numbers of children not seen as part of a well-being assessment. This is an area for the local authority to address and better understand. In MASH, however, referrals are screened with practitioners applying ratings to determine priority level (low, medium, significant). This is an important process against the context of increasing demand.

There is inconsistent compliance with statutory timeframes for Section 47 enquiries, the timeliness of visits to CLA and children named on the CPR. These areas require improvement as essential elements of safeguarding processes. Records should clearly record the rationale for any deviation to relevant timeframes. The timeliness of the first core group following initial CPCC also needs to be addressed. Some core groups are postponed at short notice, and this can mean important updates to CASPP can be delayed.

Strategy discussions and core groups would be strengthened by ensuring key documents are shared with attendees and absent partners. This would enable all

staff to be aware of updates to plans and their role in the protection of children. It is reassuring to note children's services have introduced a new Core Group Resource Project which will bring the required focus on core group practice.

Overall, systems support decision making within the public law outline (PLO). This ensures leaders have line of sight on the lived experience of children. However, there are situations where there are significant delays within PLO. Leaders should ensure timely oversight of such instances to prevent delay in meeting children's needs for safety and permanence. This has commenced with the reconfiguration of a panel, actions being logged and business support resource dedicated to ensure there is no drift and delay towards permanence planning.

Practitioners generally use strengths-based approaches when responding to risk. In a few situations, we have found staff would benefit from training on exploitation, safeguarding adolescents, and culturally harmful behaviour.

Use of genograms, ecomaps and chronologies is variable, which practitioners told us was impacted by allocated worker capacity. These are important tools in understanding context and helping practitioners rationalise decision-making.

People

Partnership arrangements - Strengths

This year Cardiff has been named the UK's first child friendly city. This is a global award celebrating cities where children's rights are a part of decisions and policy made by local government. Since 2017, the local authority has worked with organisations across the city to help children and young people contribute to areas such as leadership, communication, culture, and education.

Overall, practitioners work well with families and involve them in decisions about their lives. There is strengths and outcome focused practice evident in CPCC. Best practice examples include the use of plain language in communication with parents and a clear focus on what parents need to change. The use of scale questions helps the multi-agency group focus on what they are worried about.

What needs to improve

There is recognition by partners of the importance of understanding the individual circumstances of the child, but capturing and or recording the voice of the child requires strengthening.

The recording of ethnicity and language in health and police records could improve. This is significant in responding appropriately to the diverse population in Cardiff. Leaders should ensure accurate and clear record keeping of important demographic information.

Individual Agency - Strengths

Cardiff and Vale University Health Board

CVUHB has a well-established Youth Board which is consulted for relevant initiatives, policy development and pertinent staff interviews. A representative from the safeguarding team attends some meetings.

CVUHB and GP practice staff value the support and advice from the CVUHB's safeguarding team, though it is evident the volume of calls can at times, impact the timeliness of the response.

The voice of the child is generally well evidenced but could be strengthened in some records. There are examples of children being involved in their health assessments and their health care planning when they are CLA. This involves 'what matters' and strengths-based conversations and wishes and feelings captured. The relationship

between healthcare staff and children is collaborative with evidence of young people being involved in decision making in relation to health matters.

Staff generally access safeguarding support and supervision in a timely manner when making important decisions in relation to safeguarding children. Leaders and managers use their knowledge to challenge and support practitioners and promote continuous improvement.

Education

Safeguarding is central to the work of leaders and officers within the education directorate and is always placed on the agenda of the Senior Leadership Team (SLT) and other meetings. Senior education officers meet with colleagues from the Children's Services Directorate monthly to discuss a broad range of current issues around safeguarding.

The Director of Education and Lifelong Learning has a good understanding of the importance of establishing and supporting a strong safeguarding culture, processes and systems at both corporate and school level. There are strong links with the Children's Services Directorate and especially the Education Safeguarding Team, which sits within this directorate.

The elected member for education is highly committed to safeguarding. All elected members complete the corporate safeguarding training upon appointment.

Leaders value improvements in multi-agency working which strengthen safeguarding arrangements in schools and the PRU. The Education Safeguarding Team provide schools and PRUs with a high level of support. This includes timely advice, regular safeguarding updates and high-quality training for DSPs and governors.

The Youth Service vulnerability assessment profile (VAP) tool is distributed to schools three times a year, where a risk status is populated with a focus on specific data such as number of school moves, exclusions, free school meals and CLA status to identify the most vulnerable learners. Schools and the PRU review and update the pupils' status to identify those most at risk of exploitation, becoming disengaged from education, or being vulnerable in the community. Cases are triaged by the Performance and Governance Team so that targeted support for transition can be implemented. Support is provided for pupils in Years 7 to 11 in mainstream, special schools and EOTAS (Educated other than at school).

The local authority has funded the roll out of a common electronic system for recording safeguarding concerns across all schools and the PRU which has improved the recording of information. Many schools are also beginning to use this system appropriately to report incidences of bullying. Officers have worked alongside school leaders to produce useful guidance on recognising, recording and dealing with allegations of bullying.

Most schools and the PRU report the Education Safeguarding Team (EST) organises regular and useful training for schools and governors on child protection as well as holding a wider range of contextual safeguarding sessions. Relevant staff access a range of worthwhile training for example on, Prevent and Violence against women, domestic abuse, and sexual violence (VAWDASV). The local authority, in partnership with Central South Consortium, organises an annual programme of governor training.

Advocates are used appropriately; they visit pupils in school to record pupils' views on important matters. Pupils feel adults listen to them and provide them with support and a voice. There are generally positive relationships between schools and parents.

Schools and the PRU have a good understanding of the issues faced by pupils and their families in their individual communities, for example the impact on families of the aftermath of the community unrest in Ely in 2023. Targeted support for communities is delivered in part through the youth service. As an immediate response to the disturbances in the Ely community, the youth service increased the street-based support, to gather the opinions and thoughts of young people and the wider community.

South Wales Police

Vulnerability is a clear focus for force leaders. There are a number of structured force governance meetings in place to manage child protection and wider vulnerability. There are local domestic abuse performance meetings in each BCU, including one for Cardiff; actions appear clear and focused on understanding how qualitative data might impact children. For example, managers use their dashboard to identify any missed public protection notices (PPNs) and use this process to ensure they are completed expeditiously and shared with partners. This is positive as it means the force's partners have the necessary information to make timely decisions.

Children's Services

Senior managers have a good understanding of the population needs, and services are aligned in response. There is an experienced senior management group, with positive feedback overall from staff about the support they receive.

Management support and supervision is evident, again with positive feedback across staff groups. There is managerial oversight of safeguarding decision-making and opportunities for practice consultation. Management oversight provides guidance and support to practitioners with reflection about complex family circumstances.

The staff group is dedicated and committed and a focus on safety and well-being is evident. The local authority has had to rely on a high number of temporary staff (agency workers) to maintain team complements and support workforce resilience. It

is positive to note vacancies are reducing and more permanent staff are in post. This is significant as it will help strengthen continuity of practitioners for children and families, which in turn will enhance trust and confidence in relationships.

Leaders and senior managers are committed to making improvements to support children's well-being. There continues to be a strong focus to secure and monitor improvements in children's services. Improved systems have been implemented to monitor compliance with legal requirements and good practice standards. The approach to quality assurance (QA) and auditing, whilst still in development, is effective with an improvement in compliance. There is a genuine commitment to working towards "what good looks like" and what is important in practice. Sharing and dissemination of learning via the QA team is beginning to be productive. There is positive work being undertaken by the practice leads and practice matters events for example.

Practitioners have access to a performance data dashboard. This is beneficial in providing an overview of work to be completed and timescales. This data is reviewed by managers for their ongoing monitoring of practice and compliance with statutory timescales and can be used to identify where resources are needed.

There is recognition of the importance of obtaining parental consent, where appropriate, notably in relation to referrals received in MASH. Generally, the voice of the child and parents is promoted within MASH, including consideration of the circumstances of siblings.

There are excellent examples of child centred work with children, to build trust and ensure they are involved in their plans. In the best examples, practitioners have been caring, persistent and creative to ensure the voice of the child is heard and understood. This includes circumstances where direct work has taken place with large sibling groups, to understand their individual needs. Practice would be strengthened by records being more consistent in capturing the work undertaken with children.

In most assessments and plans, practitioners identify what matters to people and record this clearly by sharing what is working well, any worries, and what needs to happen. Parents and children are positively included in their CASPP. This includes frequent participation in core groups and CPCC. All CPCC start with a pen picture of each child, and there are good examples of the conference chair summarising conference outcomes in the first person. Most Section 47 enquiries evidence the lived experience of the child and have good analysis, to support proportionate decision making.

Children do not always receive information from their social worker, such as reports, and conference chairs do not always meet with children prior to CPCC. High

workload is the main factor for this. Parents and children, however, describe practitioners as supportive and communicative. Conference chairs consistently meet with parents at least the day before the conference to explain what will happen, prepare them and answer any questions.

The local authority has recently started using social work assistants (SWAs) to undertake key roles previously undertaken by qualified social workers. This includes case management lead for CLA. This works satisfactorily when appropriate levels of supervisory support, co-working and mentoring are in place. We received mixed feedback about this, with positive feedback from a partner agency who said that with SWA support, there was less change of workers and more consistency for the CLA child. Conversely, some feedback indicated complexity in some situations was challenging for SWAs to address.

Generally, there is a commitment and emphasis in children being supported by advocacy. Time and resources have been invested in working with the advocacy provider regarding the active offer which was evident. In some instances, advocacy could have been better promoted to enable peoples' voice to be better understood. An App is available to encourage children and young people to engage, although its use across practitioners is inconsistent, partially driven by some children not wishing to use an App for this purpose.

Practitioners and partners demonstrate a good understanding of the cultural needs of the children and families they work with and awareness of the importance of culturally sensitive practice balanced with the need to protect and safeguard children from harm. 'Culturally competent practices' has been a training focus, and families have access to translation services, although finding interpreters for some languages can be a challenge.

The local authority oversees the Welsh language proficiency of its workforce to be able to deliver an active Welsh language offer. It is committed to strengthening this through a focus on workforce and service planning, auditing, data collection and staff development. There are Welsh speaking practitioners working across children's services.

Individual Agency - What needs to improve

Cardiff and Vale University Health Board

CVUHB's compliance with mandatory safeguarding training is 75%. This is not aligned to the National Training, Learning and Development standard of 85%. The health board should therefore reconsider its local target to comply with the national standard of 85%.

CVUHB does not mandate Level 3 safeguarding training. This is out of step with the Chief Nursing Officer for Wales' recommendation outlined in the Safeguarding Children and Young People: Roles and competencies for healthcare staff: intercollegiate document. Some staff groups complete Level 3 training, but this data is not recorded centrally, therefore no reliable data is currently available. Some staff groups appear unaware of the level of safeguarding training they require for their role. There is no data to identify if board members are compliant with safeguarding training. HIW issued an Immediate Assurance letter to the health board requesting an urgent response and an improvement plan to address this area of concern and has since accepted the plan for improvement.

In the 2023/2024 training schedule, 50% of safeguarding children Level 3 training was cancelled due to workload pressures in the Safeguarding Team. Numbers of staff attending the training that did take place were very low, some staff shared there is a lack of training available to support their role.

The sharing of information from the Safeguarding Steering Group (SSG) at Clinical Board meetings is limited. Safeguarding assurance data reported to the SSG is lacking with the Safeguarding Team unsighted on some safeguarding risks (for example, pressure damage on Paediatric Intensive Care Unit (PICU) and CLA statutory health assessment compliance). Senior Clinical Board representatives are not consistently in attendance. CVUHB should assure itself that robust governance arrangements are in place to report, scrutinise and disseminate safeguarding information and learning, and safeguarding assurance and risks are routinely shared at executive level.

The increased volume and complexity of safeguarding cases, coupled with the expanding safeguarding agenda, is impacting the Safeguarding Team's ability to provide assurance of safeguarding practice across all areas of CVUHB.

Although some specialist areas follow governance processes relating to policy development, a significant number of the documents shared by the CVUHB, lack dates, author, ownership details, version controls and review dates. To avoid confusion and to ensure staff are following correct processes, the governance, and monitoring of such documents requires significant improvement.

In the absence of an overarching CVUHB safeguarding policy, some Clinical Boards have developed their own policies and guidance documents. This poses a risk that safeguarding practice may be disjointed with services working differently across the organisation. This issue was addressed within the Immediate Assurance letter highlighted earlier, and the health board has since provided assurance to HIW on its plans to consider the implementation of an organisation safeguarding policy.

Data for safeguarding supervision compliance is not currently collated. It is recommended this is addressed for the CVUHB to assure itself all staff working closely with children where there are safeguarding concerns, are attending regular supervision.

The child's voice and viewpoint are inconsistently evident in healthcare professional records.

Education

The local authority does not require schools or the PRU to submit an annual or regular safeguarding audit. As a result, they do not have sufficient overview of the outcomes of audits or if schools or the PRU complete them on a regular basis. Officers do not know schools' or the PRU's strengths and areas for development well enough in relation to safeguarding.

The local authority collects bullying data when it is recorded on the electronic safeguarding system. However, officers do not currently analyse the data to identify trends and do not challenge schools or the PRU if they do not submit data.

South Wales Police

The force needs to develop how it collates and makes use of demographic data in a qualitative way to understand children's experiences and to reduce risk to children. For example, data on crime and incidents, complimented by demographic information such as languages spoken, disability, or neurodiversity factors. We found minimal evidence of this data (ethnicity, disability or language for example) recorded.

The force is not properly capturing whether children have been seen or spoken to; meaning their voice is not being documented in some cases. It is often not clear from a PPN whether a child was present at an incident and whether they were seen or not. Where there is a clear investigation by the child abuse team, the voice of the child is evident.

Children's Services

No specific areas to record under this section.

Partnership and Integration

Partnership Arrangements - Strengths

UNICEF's recent recognition of Cardiff as the first Child Friendly city in the UK reinforces ambition and commitment to the children and young people across the city. This recognition is achieved by strong partnership working across the city.

There is a commitment by partners to work together in the interests of safeguarding children at risk of harm and abuse. This is evident through positive participation by partners in important multi-agency meetings and discussions, with an explicit focus on strengths and worries in families**.**

Some systems for information sharing could be improved to ensure all agencies can make informed and timely decisions. Looking ahead, however, the Single View is a local authority led project which will collect data from a range of sources including Children's Services, Education and the Youth Justice Service (YJS) into one system to create a single record for a child. The project team hope to have a viable product ready for piloting by schools in 2024.

Partnerships contribute effectively to safeguarding decision making and have confidence constructively challenging each other. There is evidence of healthy discussion and challenge in core groups and conferences. There is a RSB protocol for the resolution of professional difference and practitioners are generally aware of this and feel confident in challenging decision making and/or seeking advice from their managers. Consideration could be given to capturing and recording differing professional views that do not fall under the scope of the protocol, to inform learning and continuous improvement.

MASH arrangements are multi-disciplinary, and this is highly valued by partners. When safeguarding information needs to be shared (including the duty to report) this is generally completed in a timely manner. For example, there is prompt information sharing between agencies at the daily multi-agency domestic abuse meetings. At these forums there is effective use of time with strategy discussions incorporated into the agenda.

A process exists to ensure domestic abuse risk assessments and information sharing is consistent across teams. Managers use an internal data dashboard to identify any missed PPNs and use this to ensure they are completed expeditiously and shared with partners.

There is strong partnership working and the use of specialist teams to support the well-being needs of pupils in Cardiff. This includes initiatives such as School Around the Cluster Meetings, the SAFE Project, the virtual CLA Headteacher, and EMTAS.

This promotes contextual safeguarding, the emotional well-being of pupils, and good opportunity to improve outcomes.

A model of working that identifies and addresses contextual harm in communities has been developed in Cardiff. The SAFE model recognises children and young people can be at risk of or subjected to harm through exploitation and abuse from adults and / or other peers outside of their family network. The local authority has been successful in securing Youth Endowment Funding (YEF) to deliver The Keeping and staying SAFE project which aims to tackle youth violence and criminal exploitation.

A range of senior education officers support the children's services / YJS high risk panel to consider risk reduction for young people considered to be at high risk, including exploitation. Partnerships across the local authority support delivery of SAFE Curriculum Collaboration. This has a range of multi-agency partners collaborating to ensure cohesive and impactful resources, tools and interventions are in place to embed the core SAFE messages into the curriculum area of health and well-being. A range of relationships and sexuality education (RSE) training is provided to schools and the PRU, including delivering and creating an appropriate RSE Curriculum.

School projects include Mini Police, which introduces children to positive experiences of policing in partnership with South Wales School and Community Police Officer team as well as well as extensive work on Knife Crime across the city.

What needs to improve

Some staff have suggested there should be further thought given to convening in person/ hybrid/ virtual meetings, notably in CPCC and core groups. Key stakeholders have highlighted the importance of and need to have clarity in approach. Feedback highlights the importance of meeting in person when complex and sensitive issues are being considered.

The CLA Nursing Team report they do not receive notification of placements in a timely way, and this is impacting their compliance with statutory timescales. GPs are not routinely invited to CPCC or asked to provide reports for conference. CPCC minutes are not routinely sent to GPs. This means essential information can be missed.

Emergency Duty Team (EDT) arrangements are in place for responding to safeguarding concerns outside of normal working hours. This is a regional arrangement. There are varied experiences reported in terms of EDT accessibility. There are reported issues around the team recording directly into CareFirst. The

local authority should review the arrangements in place to access EDT, and how important information is being recorded by EDT.

Leaders and partners should work together to ensure there is a clear understanding of thresholds for MARF submissions to ensure an efficient and proportionate response to managing demand. Partnership data from 2022/2023 identified 82% of contacts were directed to MASH and 18% to early help services. Senior managers have previously identified this as an imbalance. ‘Referral guidance’ is already available, but despite multi-agency input in its development the guidance is not embedded in practice. This means key partners such as schools’ staff are consistently reporting many concerns directly to MASH and not utilising the support of early help services where it may be appropriate.

Referring partners should be consistently notified in a timely manner of the outcome of safeguarding reports. This will help promote a shared understanding about decision making and rationale.

Operation Encompass notifications are being received promptly by schools and the PRU. Sometimes additional information would benefit school staff to be better informed. This impacts school’s ability to support children appropriately Given some partners report there can be delays when trying to contact children’s services staff at MASH for further information or updates, this can be an impediment to school staff for example, supporting children and taking appropriate action. Part of the issue here is that the police no longer send full PPNs to schools due to some challenges in complying with GDPR. School staff would benefit from receiving updates from the police, for example, whether an arrest followed the PPN report and other relevant information that could be helpful in supporting pupils. Partners have not agreed a process to make Operation Encompass more effective in Cardiff.

The partnership is currently reviewing the MASH arrangements and part of this should include an evaluation of the benefits of professionals being co-located and based in person at one location. This will ensure the benefits of working together, whether it be remotely or in person, can be realised.

Individual Agency - Strengths

Cardiff and Vale University Health Board

CVUHB commitment to continuous improvement is evident by its contribution in safeguarding board business, including the scrutiny and learning processes from child practice reviews.

Safeguarding Nurse Advisors are located in MASH each day and attend all strategy discussions and meetings as well as high risk domestic abuse safety planning

meetings. In addition, they place alerts for high-risk cases onto health board patient management systems. All PPNs submitted are researched holistically and discussed at the daily meeting. Emotional Well-being Nurses also provide School Nursing support to children attending the two pupil referral units, anxious school attenders and home educated children.

In the development of safety plans healthcare staff can constructively challenge where appropriate. Healthcare staff said their views were listened to and respected.

There is good understanding of the pathways for requesting a child protection medical, these are undertaken in a timely way and outcomes communicated to partner agencies. A sample of reports reviewed were clear and comprehensive.

Education

Schools and the PRU benefit from the exceptional support they receive from a range of teams such as Educational Psychologists, the Emotional Health and Wellbeing team and EMTAS. This helps them provide beneficial support for vulnerable pupils.

The local authority uses a 'Team around the School' approach in schools and 'Team around the Cluster' meetings where professionals discuss how they can provide bespoke support for vulnerable pupils. For example, schools in Ely benefitted from discussions on how the local authority could support them to deal with growing concerns of social unrest in the area.

Schools and the PRU have sound strategies to improve pupils' attendance. They work well with the education welfare service to support this work. There are good examples of significant improvement in vulnerable pupils' attendance over the last 12 months. The local authority's Fresh Start panel is very effective in supporting these vulnerable pupils.

The local authority provides a valuable range of support and interventions to underpin the delivery of the health and well-being curriculum in schools and the PRU. They fund six well-being classes to support the individual needs of vulnerable pupils. Following support, many of these pupils transfer back successfully to mainstream education. The Community Teaching Team, Team @Severn, with the recent appointment of eight skills and support officers (SAS), strengthens the development of personalised curriculum opportunities with a clear focus on health and well-being.

In response to the increasing need to support pupils' mental health and emotional well-being since the pandemic the local authority has targeted support for schools and the PRU. For example, the educational psychology service provides support, training, and guidance for schools and the PRU around Anxiety-Based School Avoidance (ABSA). School In-Reach and Emotional Wellbeing and Mental Health

Services work to increase the skills and confidence amongst education staff, providing access to specialist support and direct intervention work.

The local authority is successfully piloting a Welsh Government initiative, the Children Looked After Virtual School (CLA VS) team. Led by the CLA VS headteacher, the team provides support for CLA to ensure these vulnerable pupils have a voice and their needs are met.

South Wales Police

The force supports the RSB with dedicated leads at both strategic and operational levels, including sub-groups. There is consistent attendance at partnership meetings, and the force chairs one of the sub-groups (Case Practice Review Group).

Children's Services

Whilst the practice model used in Cardiff is evolving, there is a long-term commitment to strength-based approaches. Practitioners consistently use solution focused thinking to work with families to identify solutions. This is evidenced by the regular use of family group conference and safety planning meetings, which promote the involvement of families in decisions about their lives. This is illustrated by parent feedback; "*Social workers have been helpful and have done what they have said, we understand clearly what we need to do as parents in order to get the family back on track*."

Strengths based and outcome focused practice is evident within CPCC. Conference chairs ask agencies to score risk, and this is used as guide to help practitioners determine whether children's names should be included on the CPR. This also supports families to understand professionals' views of the risks and what needs to happen to improve and provide assurance about safety.

Relationships between children's services and third sector partners are positive, there are named children's services leads who are their main point of contact, this is well received and underpins good communication.

Individual Agency - What needs to improve

Cardiff and Vale University Health Board

Although PPNs are shared by police across partner agencies, and uploaded onto the CVUHB's IT system, school nurses do not receive an alert to notify them of this. They may therefore be unaware of domestic incidents in households, where school age children reside.

Where there are no identified health needs then the school nurse does not routinely attend core groups or review CPCC. This means there are potential gaps in essential information sharing. When the school nurse does not attend core groups or CPCC

then they do not receive the minutes, again this means important information exchange does not take place.

Education

No specific areas to record under this section.

South Wales Police

Child protection data is collected daily for managers. Quantitative figures are available and overall trends show volumes are increasing. A monthly report is also produced for more strategic analysis, but it is not clear how this is used to drive partnership performance.

Children's Services

No specific areas to record under this section**.**

Prevention

Partnership Arrangements - Strengths

It is recognised the pandemic has impacted significantly upon children's emotional health and well-being. As recovery continues, focus has returned to longer term ambitions, detailed within Cardiff 2030 (a ten-year strategy document) with a recovery board initially established, later developed into the Children's and Young People board. This is a cross-directorate board which includes Education, Children's Services, Communities and Housing directorates which aims to ensure an effective, accessible Early Help and Family Support across the city.

Early intervention and prevention services are highly regarded by practitioners. Practitioners said, whilst there is a good range of preventative services, there are waiting lists for some services. Waiting lists are monitored and situations will 'step up' if circumstances change, although it is important these are monitored closely to reduce potential risks of family circumstances escalating.

What needs to improve

Step down support is an area to address. It is noted additional reviewer posts are now in place, and this will help ensure support for families is maintained where appropriate, for example in the post de-registration period.

Whilst emphasis on quality assurance and auditing of practice is very evident in children's services, multi-agency contribution to auditing safeguarding practice is variable. This means multi-agency perspectives are not consistently considered. Regular thematic multi-agency audits, however, have been undertaken in MASH.

Business support changes supporting the RSB will also help track and follow up on actions arising out of child practice review recommendations, some of which were previously delayed.

Individual Agency - Strengths

Cardiff and Vale University Health Board

A multi-agency Violence Prevention Team, funded by the Home Office was set up in 2019. A Health Team comprising a nurse and an advocate, is based in ED, providing support and onward referral for any victim of violence with injury. Home Office evaluation has been positive.

Education

Early intervention is evident when children first start school. Support to children is promptly considered as soon as needs are identified, and various support teams are available as noted earlier in this report. Many schools and the PRU have family

liaison officers in post. Vulnerable pupils are encouraged to play an active part in school life.

School and PRU staff ensure individual pupils have relevant support plans in place and these are regularly reviewed to ensure they are fit for purpose. There are generally positive working relationships with health visitors and other professionals to identify pupils needs when the first arrive at school or the PRU.

South Wales Police

The PCC supports many interventions relating to children and families affected by violence and harm. Some of these initiatives include hospital and community-based provision and are best practice examples of multi-disciplinary approaches to helping vulnerable families.

Children's Services

There is a positive approach to prevent need and risk escalating, for example in relation to raising awareness about risks associated with exploitation and engaging the community more widely to reduce risks. This is a view corroborated by partner organisations who said there was a collaborative approach led by children's services, with emphasis on co-operation across relevant services. Early help services offer a range of interventions and parenting programmes which practitioners highly value.

There are examples of these services making a positive contribution to care and support. The Adolescent Referral Centre (ARC) for example, offers a range of therapies and respite opportunities. Family Support Teams offer interventions to families who require help under care and support and care and support protection plans. Support from Thinksafe (a service offering interventions to children who are at risk of exploitation), and Turnaround is helping to reduce risk of criminal exploitation. There are positive examples of social workers utilising support from the Enfys Team (Clinical Psychologist and Mental Health worker), for example in relation to how to move forward in discussing with a young person the situation about why they are in care.

The Care and Support Plan (CASP) reviewer posts recently introduced, whilst not possible for them to review every family working under a CASP plan, can independently review a proportion of plans, including 'step downs' from CPR and CLA.

Individual agency - What needs to improve

Cardiff and Vale University Health Board

There is no safeguarding business continuity plan in place. This presents a risk that the Health Board may not meet its safeguarding responsibilities in a timely way if usual business is disrupted.

The quality of the action plans arising from child practice reviews is varied. It is unclear how the plans are monitored, and some actions are not completed in a timely manner.

Education

School safeguarding audits currently do not fully capture those pupils who have received exclusions or have a pastoral support plan in place.

The Multi Agency Safeguarding Hub audit in 2022 identified education professionals are referring cases without fully considering alternative referral routes through the Early Help or the Gateway for care and support assessment. Subsequently, children's services led on developing and implementing multi-agency referral guidance. However, this is not always fully understood nor embedded in school practice.

South Wales Police

No specific areas to record under this section.

Children's Services

Delay in accessing services means not everyone is able to benefit from the service they require at the right time. The local authority should continue to closely monitor and review measures for addressing early help waiting lists, to ensure timely access to services to reduce risks of family circumstances escalating.

Records, overall, indicate a timely safeguarding response informed by multi-agency input. In some instances, however, exploration of potential wider safeguarding risks could have been better demonstrated. Records will be enhanced by evidencing all potential wider risks associated with children's safety and well-being are fully considered by practitioners.

The extent of children's names subject to repeat registration on the child protection register is an area to address. The local authority has already undertaken work to better understand this area, with audits completed to help identify remedial actions.

A new panel has also been developed and included in the remit is quality assurance of de-registration decisions and repeat registrations.

Some children have been named on the register for very long periods of time. Managers should assure themselves there are appropriate triggers to review and escalate cases where this is the lived experience of children.

Conference chairs have a key role to play in ensuring the new escalation policy is followed to improve practice standards. They are now using a checklist to identify challenges and support multi-agency improvement in making evidence-based decisions.

Some significant safeguarding decisions or changes to the child protection plan are made without re-assessment or multi-agency decision making. Leaders have recently developed practice guidance for management oversight. This needs to be embedded in practice, to ensure sufficient oversight of critical decision making by management and partners.

Next steps

On behalf of the partnership, the local authority should prepare a written statement of proposed action responding to the findings outlined in this report. This should be a multi-agency response involving Cardiff and Vale University Health Board and South Wales Police. The response should set out the actions for the partnership and, where appropriate, individual agencies. The head of service for children's services should send the written statement of action to CIWLocalAuthority@gov.wales by 17 June 2024. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Methodology

Fieldwork

Most inspection evidence was gathered by reviewing the experiences of people through sampling agency records and file tracking children's care and support arrangements. We case sampled twenty files and tracked six.

Tracking a child's record includes having conversations with the child where appropriate, their family or carers, key worker, the key worker's manager, and other professionals involved.

We held focus groups with staff and two professional groups focused on the working arrangements and outcomes for two of the tracked files.

We visited a small sample of primary and secondary schools where we conducted meetings with the headteacher, the designated safeguarding lead and groups of pupils.

We met with representatives from a range of schools and the PRU including head teachers, DSPs and governors.

We interviewed a range of employees across different agencies.

We interviewed a range of partner organisations, representing both statutory and third sector.

We reviewed supporting documentation sent to the inspectorates for the purpose of the inspection.

We administered surveys to children's services and healthcare staff, third sector organisations, schools and children and family members.

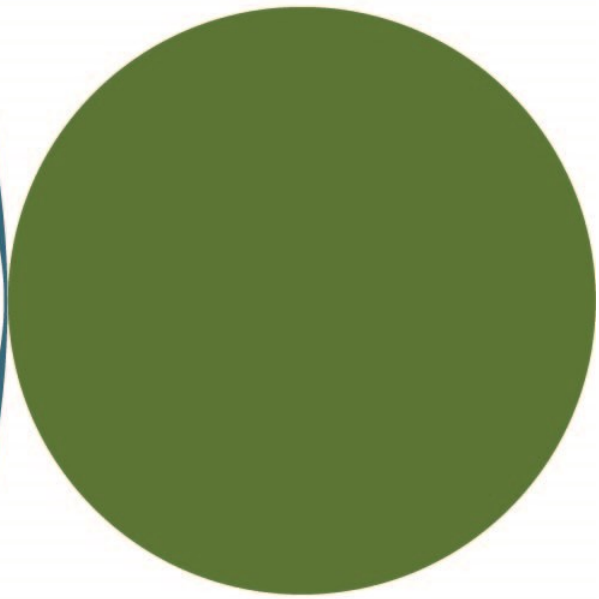
We observed a child protection conference, a child exploitation review strategy meeting and a MASH strategy meeting as part of our inspection activity.

Acknowledgements

The inspectorates would like to thank the people, staff, and partners who gave their time and contributed to this inspection.

Cyngor Caerdydd, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro, Heddlu De Cymru

Adroddiad ar Arolygiad ar y Cyd o Drefniadau Amddiffyn Plant



Ionawr 2024

Mae'r ddogfen yma hefyd ar gael yn Saesneg.
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Cyflwyniad

Rhwng 15 ac 19 Ionawr 2024, cynhaliodd Arolygiaeth Gofal Cymru (AGC), Arolygiaeth Cwnstabliaeth a Gwasanaethau Tân ac Achub Ei Fawrhydi (HMICFRS), Arolygiaeth Gofal Iechyd Cymru (AGIC) a Phrif Arolygydd Ei Fawrhydi dros Addysg a Hyfforddiant yng Nghymru (Estyn) arolygiad ar y cyd o'r ymateb amlasiantaethol i achosion o gam-drin ac esgeuluso plant yng Nghaerdydd.

Mae'r adroddiad hwn yn amlinellu ein canfyddiadau am effeithiolrwydd trefniadau gweithio mewn partneriaeth a gwaith asiantaethau unigol yng Nghaerdydd.

Cwmpas yr arolygiad

Fel rhan o'r Adolygiad ar y Cyd o Drefniadau Amddiffyn Plant (JICPA), adolygwyd y canlynol:

- yr ymateb i honiadau o gam-drin ac esgeulustod pan fyddant yn cael eu nodi
- ansawdd ac effaith gwaith asesu, cynllunio a gwneud penderfyniadau mewn ymateb i hysbysiadau ac atgyfeiriadau
- gwaith i amddiffyn plant 11 oed ac iau sy'n wynebu risg o gael eu cam-drin a'u hesgeuluso
- sut y caiff y gwaith hwn ei arwain a'i reoli
- effeithiolrwydd trefniadau partneriaid diogelu amlasiantaethol mewn perthynas â'r gwaith hwn

Rydym wedi ceisio defnyddio iaith syml i ddisgrifio canfyddiadau'r arolygiad ar y cyd. Rydym yn cyfeirio at nifer o dermau yn yr adroddiad sydd wedi'u diffinio isod:

Term neu Ymadrodd	Diffiniad
ADY	Anghenion Dysgu Ychwanegol
CAMHS	Gwasanaethau Iechyd Meddwl Plant a'r Glasoed
Care First	Cronfa ddata TG Gwasanaethau Plant
CAGCh	Cynllun Amddiffyn Gofal a Chymorth
BIPCF	Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Arweinydd Diogelu Dynodedig	Yr unigolyn a benodir i fod yn bennaf cyfrifol am faterion amddiffyn plant mewn ysgolion ac unedau cyfeirio disgyblion.
Person Diogelu Dynodedig	Arweinydd diogelu ac amddiffyn plant yr ysgol neu'r uned cyfeirio disgyblion.
ELSA	Cynorthwyydd Cymorth Llythrennedd Emosiynol – rhaglen ymyriadau cymdeithasol ac emosiynol a gyflwynir gan staff hyfforddedig mewn ysgolion cynradd, ysgolion uwchradd ac unedau cyfeirio disgyblion.
Cynghorydd Annibynnol ar Drais Domestig	Mae Cynghorwyr Trais Domestig Annibynnol wedi'u hyfforddi i gynnig cyngor a chymorth arbenigol i ddioddefwyr trais domestig.
Comisiynydd yr Heddlu a Throseddwyr	Nod Comisiynwyr yr Heddlu a Throseddu yw gostwng troseddu a darparu gwasanaeth yr heddlu effeithiol ac effeithlon yn ardal eu heddlu. Cânt eu hethol gan y cyhoedd i ddwyn Prif Gwnstabliaid a'r heddlu i gyfrif, gan sicrhau bod swyddogion yr heddlu yn atebol i'r cymunedau y maent yn eu gwasanaethu.
MARAC	Cynadleddau Asesu Risg Amlasiantaeth yw MARACau. Cyfarfodydd rheolaidd rhwng gweithwyr proffesiynol ydynt, a gynhelir er mwyn trafod sut i helpu unigolion sy'n wynebu'r risg fwyaf o niwed o ganlyniad i drais neu gam-drin domestig.
MARF	Ffurflen Atgyfeirio Amlasiantaethol
MASH	Hyb Diogelu Amlasiantaethol – Un pwynt cyswllt ar gyfer pob pryder diogelu newydd.
NICHE	System wybodaeth yr heddlu

Ymgyrch Encompass	Partneriaeth rhwng yr heddlu, ysgolion ac unedau cyfeirio disgyblion yw Ymgyrch Encompass. Un o egwyddorion Ymgyrch Encompass yw y dylid rhannu pob digwyddiad lle ceir achos o gam-drin domestig ag ysgolion ac unedau cyfeirio disgyblion, nid dim ond y digwyddiadau hynny lle y gellir nodi trosedd.
Amlinelliad Cyfraith Gyhoeddus	Rhoddir proses yr Amlinelliad Cyfraith Gyhoeddus ar waith pan fydd yr Awdurdod Lleol yn pryderu am lesiant plentyn ac oni chaiff camau cadarnhaol eu cymryd i fynd i'r afael â'r pryderon hynny a'u lliniaru, gall yr Awdurdod Lleol ystyried gwneud cais i'r Llys. (Family Law Group)
HAC	Hysbysiadau Amddiffyn y Cyhoedd
Uned Cyfeirio Disgyblion	Math o ysgol a sefydlir ac a gynhelir gan awdurdod lleol i ddarparu addysg i blant a phobl ifanc na fyddant, oherwydd salwch, gwaharddiad neu reswm arall, o bosibl yn cael addysg o'r fath (adran 19 o Ddeddf Addysg 1996)
Adran 47 (A47)	O dan Adran 47 o Ddeddf Plant 1989, mae gan awdurdod lleol ddyletswydd i ymchwilio os ymddengys fod plentyn yn ei ardal yn dioddef niwed sylweddol neu'n wynebu risg o hynny.
Arwyddion Diogelwch	Dull o ymdrin ag ymarfer amddiffyn plant sy'n seiliedig ar gydberthnasau ac a drefnir ar sail diogelwch. Cafodd ei greu drwy ymchwilio i'r hyn sy'n gweithio i weithwyr proffesiynol a theuluoedd wrth ddatblygu diogelwch ystyrlon i blant sy'n agored i niwed ac yn wynebu risg.
Tîm o amgylch y Clwstwr	Nod model y Tîm o Amgylch y Clwstwr yw helpu ysgolion ac unedau cyfeirio ysgolion i nodi a chefnogi teuluoedd yn gynt pan fydd yr angen yn codi drwy gydweithio â phartneriaid allweddol.
THRIVE	Mae Thrive yn cynnig dull sy'n ystyriol o drawma ar gyfer yr ysgol neu'r lleoliad cyfan sy'n helpu i wella iechyd meddwl a llesiant plant a phobl ifanc.
VAWDASV	Trais yn erbyn Menywod, Cam-drin Domestig a Thrais Rhywiol. Lansiwyd Strategaeth ar Drais yn erbyn Menywod, Cam-drin Domestig a Thrais Rhywiol ar gyfer 2022 i 2026 ym mis Mai 2022.

Gweithdrefnau Diogelu Cymru	Mae Gweithdrefnau Diogelu Cymru yn nodi rolau a chyfrifoldebau hanfodol ymarferwyr er mwyn sicrhau eu bod yn diogelu plant ac oedolion sy'n wynebu risg o gael eu cam-drin a'u hesgeuluso.

Crynodeb

Mae'r cyd-destun diogelu plant presennol yn un lle gwelir lefelau cyson uchel o alw a chymhlethdod cynyddol. Yn ôl yr awdurdod lleol, bu cynnydd o 44% yn nifer y trafodaethau strategaeth a gynhaliwyd yn 2022/2023 o gymharu â 2019/2020. Mae hyn yn gyson â chynnydd tebyg yn nifer yr ymholiadau Adran 47 (cynnydd o 46% yn ystod yr un cyfnod), gan adlewyrchu'r cynnydd yn y galw ar draws gwasanaethau.

Mae heriau cyllidebol, prinder ymarferwyr a marchnad gystadleuol wedi arwain at gyfran fwy o weithwyr newydd gymhwyso ac amhrofiadol mewn asiantaethau partner. Mae hyn yn dwysáu her amddiffyn plant ar draws gweithgarwch amlasiantaethol.

Fodd bynnag, mae ffocws cadarnhaol ar ddiogelu ar draws yr awdurdod lleol, yr heddlu a'r bwrdd iechyd lleol. Caiff diwylliant o ddiogelu ei hyrwyddo fel cydgyfrifoldeb i bawb. Mae'r cydberthnasau proffesiynol ar draws asiantaethau yn gadarnhaol a chaiff gwahaniaethau proffesiynol eu datrys yn hawdd rhwng uwch-arweinwyr diogelu. Mae arweinwyr a rheolwyr, yn enwedig yn yr awdurdod lleol, yn meddu ar ddealltwriaeth dda o brofiadau plant a theuluoedd y mae angen eu helpu a'u hamddiffyn yn yr ardal, yn ogystal â maint yr angen a'r risg. Fodd bynnag, mae angen i Fwrdd Iechyd Prifysgol Caerdydd ar Fro (BIPCF) gryfhau ei drefniadau llywodraethu er mwyn cefnogi ymarfer diogelu a chofnodi data diogelu allweddol a chraffu arnynt.

Caff gwaith partneriaeth lleol ei gefnogi gan y bwrdd diogelu rhanbarthol. Mae trefniadau llywodraethu'r bwrdd wedi newid yn ddiweddar yn sgil cyflwyno grŵp cyflawni ar gyfer diogelu, sydd â'r nod o wella gwaith monitro, atebolrwydd a chydgysylltiad ar draws y bartneriaeth. Mae hyn wedi helpu i hyrwyddo'r neges bod diogelu yn gydgyfrifoldeb ac yn fater i bawb.

At ei gilydd, mae ymarferwyr yn deall eu rolau a'u cyfrifoldebau yng nghyd-destun amddiffyn plant ac maent yn cynnal ffocws cadarnhaol ar ymrwymiad. Yn gyffredinol, rhennir gwybodaeth yn briodol ac yn amserol pan gaiff pryderon am ddiogelwch a llesiant plant eu nodi.

Ceir presenoldeb a chyfranogiad amlasiantaethol da mewn cyfarfodydd amddiffyn plant a drefnir o dan Weithdrefnau Diogelu Cymru. Mae partneriaid yn deall eu rolau a'u cyfrifoldebau mewn perthynas â diogelu plant. Mae'n gadarnhaol nodi, yn dilyn cynnydd wedi'i dargedu mewn adnoddau, bod presenoldeb yr heddlu mewn cynadleddau adolygu amddiffyn plant wedi gwella'n sylweddol.

Mae'r ymateb amlasiantaethol i atgyfeiriadau diogelu yn gymesur, ar y cyfan, â'r risg a wynebir. Mae ymholiadau amddiffyn plant yn drwyadl, yn canolbwyntio ar

anghenion y plentyn, yn cynnwys asiantaethau perthnasol ac, at ei gilydd, yn arwain at gamau amserol i leihau'r risg o niwed i blant. Weithiau, gall fod oedi cyn cynnal asesiadau a datblygu cynlluniau, er gwaethaf goruchwyliaeth rheolwyr.

Caiff safbwyntiau plant a'u teuluoedd eu clywed. Mae hyn yn amlwg yn y dull ymarfer sy'n datblygu a fabwysiadwyd yng Nghaerdydd, sy'n seiliedig ar gryfderau a datrysiadau. Mae hyn yn rhoi cyfle da i deuluoedd gyfrannu at y broses o ddylunio a chyflwyno cynlluniau amddiffyn gofal a chymorth (CAGCh).

Mae plant a'u teuluoedd yn cael budd o ddulliau seiliedig ar dystiolaeth sy'n lleihau risgiau ac yn diwallu eu hanghenion. Ceir amrywiaeth o wasanaethau a gefnogir gan asiantaethau, er enghraifft gwasanaeth Goleudy, sy'n darparu ymateb amlasiantaethol mewn argyfwng i blant mewn gofid emosiynol. Mae Comisiynydd yr Heddlu a Throseddu yn ariannu amrywiaeth o fentrau sy'n cefnogi plant a theuluoedd y mae trais a niwed yn effeithio arnynt. Mae rhai o'r mentrau hyn yn cynnwys darpariaeth mewn ysbytai a darpariaeth gymunedol.

Mae AGIC wedi nodi nifer o bryderon mewn perthynas â threfniadau diogelu plant BIPCF a allai beri risg uniongyrchol i'w diogelwch. Mae AGIC wedi gofyn i BIPCF ddarparu cynllun gwella ar unwaith yn nodi'r camau y mae wedi'u cymryd a/neu y mae'n bwriadu eu cymryd i fynd i'r afael â'r pryderon hyn er mwyn sicrhau bod plant a phobl ifanc yn cael eu diogelu, a bod eu diogelwch yn cael ei gynnal. Cyfeirir at y pryderon hyn yn ddiweddarach yn yr adroddiad hwn.

Mae diogelu disgyblion yn flaenoriaeth uchel mewn ysgolion ac yn yr uned cyfeirio disgyblion ac, o ganlyniad, maent yn fannau diogel i ddisgyblion ddysgu. Mae'r ysgolion a'r uned cyfeirio disgyblion yn adnabod eu disgyblion a'u teuluoedd yn dda, ac yn diwallu eu hanghenion. Ceir llawer o gyfleoedd i blant gyfrannu at gynlluniau ar eu cyfer a phenderfyniadau a wneir.

Mae'r ysgolion a'r uned cyfeirio disgyblion yn gwneud cyfraniad sylweddol ac effeithiol at yr ymateb amlasiantaethol er mwyn sicrhau bod plant yn cael y cymorth a'r amddiffyniad cywir ar yr adeg gywir. Maent yn nodi plant y mae angen eu helpu a'u hamddiffyn ac yn gwneud atgyfeiriadau amserol at wasanaethau gofal cymdeithasol plant pan fo hynny'n briodol, ond gellid gwella ymwybyddiaeth o wasanaethau cymorth cynnar allanol a mynediad atynt. Mae plant yn cael cymorth priodol yn yr ysgol neu'r uned cyfeirio disgyblion, a defnyddir amrywiaeth gynhwysfawr o raglenni i hybu iechyd a llesiant.

Canfyddiadau allweddol a thystiolaeth

Llesiant

Trefniadau Partneriaeth – Cryfderau

Mae'r newidiadau i drefniadau llywodraethu Bwrdd Diogelu Rhanbarthol Caerdydd a Bro Morgannwg, drwy ffurfio grŵp cyflawni, yn gadarnhaol o ran sicrhau cyfathrebu effeithlon a chlir, er ei bod yn ddyddiau cynnar yn y broses newid. Mae'r broses o olrhain argymhellion adolygiadau ymarfer oedolion a phlant yn well.

Cydnabyddir bod dadansoddi anghenion hyfforddiant drwy gyfrwng hunanasesiad ar draws y bartneriaeth yn ddatblygiad cadarnhaol, ond mae angen i bob asiantaeth ymrwymo i hyn. Mae'n bwysig bod hyn yn arwain at raglen hyfforddiant ar y cyd sy'n canolbwyntio ar ymarfer. Mae hyfforddiant ac adnoddau a rennir yn cael eu datblygu, ac mae hyfforddiant amlasiantaethol eisoes wedi'i gynnal fel rhan o Wythnos Genedlaethol Diogelu 2023.

Mae sefydliadau partner yn cydweithio, yn comisiynu ac yn darparu gwasanaethau diogelu yn llwyddiannus. Mae Polisi Diogelu Corfforaethol 2022-2025 yr awdurdod lleol yn cynnwys amcanion a chanllawiau clir er mwyn sicrhau bod diogelu yn fater i bawb.

Mae enghreifftiau dangosol o bartneriaid yn cydweithio yn cynnwys Heddlu De Cymru yn mynychu cyfarfodydd diogelu mewnol BIPCF, a gynhelir bob deufis, a chyflwyno cofnodion y cyfarfodydd hyn i'r awdurdod lleol. Mae hyn yn golygu y gellir rhoi gwybod i bartneriaid am faterion diogelu yn BIPCF ac achub ar gyfleoedd i reoli heriau ar y cyd.

Mae gwasanaeth Goleudy yn darparu ymateb mewn argyfwng i blant mewn gofid emosiynol sy'n cyrraedd yr ysbyty ac yn cydgysylltu'r broses o gynllunio cymorth parhaus. Mae'r tîm yn cynnwys seicolegwyr clinigol, staff iechyd meddwl, therapyddion galwedigaethol, cynorthwywyr gweithwyr cymdeithasol a chydgysylltwyr addysg. Mae gan wasanaethau plant weithiwr cymdeithasol CAMHS/llwybr argyfwng ymgynghorol nad yw'n gyfrifol am gynllunio gofal sylfaenol. Mae'r swydd hon yn gweithio ar draws gwasanaethau iechyd a chymdeithasol ac mae parch mawr tuag ato ymysg staff o ran galluogi cysylltiadau agosach ar draws gwasanaethau.

Mae enghreifftiau o gydweithio lle ceir pryderon ynghylch cam-drin domestig. Yn yr Hyb Diogelu Amlasiantaethol (MASH), mae trefniadau amlasiantaethol dyddiol yn cynnig cyfle i adolygu amgylchiadau risg uchel. Mae Cynghorwyr Trais Domestig Annibynnol yn BIPCF, a ariennir gan Gomisiynydd yr Heddlu a Throseddu, yn

cynnwys Cynghorydd Trais Domestig Annibynnol sy'n gweithio'n benodol gyda phobl ifanc 11-17 oed. Mae arweinydd cam-drin domestig dynodedig ym maes gofal cymdeithasol wedi meithrin cysylltiadau cadarnhaol â gwasanaethau eraill, gan gynnwys partneriaid yn y trydydd sector. Mae deiliad y swydd yn weithiwr cymdeithasol cymwysedig a phrofiadol heb achosion penodol sy'n gyfrifol am arwain ymarfer, datblygu adnoddau ymarfer a darparu hyfforddiant.

Ceir ffocws ar gryfhau'r ymarfer yng Nghaerdydd mewn perthynas â phlant sy'n mynd ar goll. Caiff hyn ei gefnogi gan ymrwymiad strategol i weithio gyda phartneriaid. Mae gweithdrefnau ar waith ac mae cydgysylltydd unigolion coll dynodedig yn gweithio yn y gwasanaeth Diogelu Pobl Ifanc rhag Camfanteisio (SAFE), sy'n gweithredu fel cyswllt i bartneriaid. Ceir ymrwymiad i sicrhau y caiff protocol unigolion coll ei gymhwyso'n gyson yn ymarferol, wedi'i gefnogi gan ffocws cynyddol ar oruchwylio perfformiad. Er enghraifft, mae'r ymarfer wedi'i gryfhau drwy ddatblygu adnodd delweddu data er mwyn casglu gwybodaeth am unigolion coll, darparu data wythnosol i reolwyr gweithredol ar gyfer pobl ifanc yr ystyrir eu bod yn wynebu'r risg fwyaf, a chynnal cyfarfodydd unigolion coll strategol bob pythefnos yn cynnwys gwasanaeth SAFE a'r Tîm Unigolion Coll.

Mae gweithwyr proffesiynol yn nodi plant y mae angen help a threfniadau amddiffyn arnynt ac yn rhoi gwybod yn briodol am eu pryderon. Mae'r partneriaid yn gwerthfawrogi hygyrchedd ymarferwyr yn MASH a'r cyfle i drafod eu pryderon ag ymarferwyr drws ffrynt cyn cwblhau'r Ffurflen Atgyfeirio Amlasiantaethol (MARF). Dywedodd un partner '*rydym yn gallu cael cyngor yn hawdd gan MASH sy'n ddefnyddiol ac yn cefnogi'r broses ddiogelu*.'

Yr hyn y mae angen ei wella

Mae ymweliadau Adran 47 un asiantaeth gan weithwyr cymdeithasol yn ymateb a gydnabyddir ledled Cymru, ond ni ddylai fod yn ymateb a arweinir gan gapasiti fel mater o drefn. Er enghraifft, nodwyd oedi cyn ymateb i ddigwyddiad amddiffyn plant, yn rhannol am fod argymhelliad un asiantaeth wedi'i wneud, a bod y cyfathrebu rhwng gwasanaethau cymdeithasol a'r heddlu wedi arafu wedi hynny. Dywedodd partneriaid fod y penderfyniad i gynnal y cyfryw ymweliadau un asiantaeth yn rhannol gysylltiedig â'r cynnydd yn nifer yr atgyfeiriadau o ganlyniad i'r newid i gyfraith cosbi corfforol a gallu'r heddlu i ymateb. Mae diffyg profiad perthnasol a hyder hefyd, ynghyd ag oedi posibl cyn troi at swyddogion yr heddlu i ymateb i'r mathau hyn o bryderon.

Mae'r awdurdod lleol yn adolygu'r broses ar gyfer cyfarfodydd canlyniadau strategol, sydd fel arfer yn cynnwys yr heddlu a'r gwasanaethau plant, gyda gwybodaeth yn cael ei rhannu drwy e-bost. Mae hyn yn cynnwys ystyried proses feddygol amddiffyn plant. Byddai cyfranogiad ehangach gan asiantaethau partner yn gwella

dealltwriaeth o amgylchiadau plant ac ansawdd y broses o lunio cynllun amddiffyn gofal a chymorth.

Asiantaeth Unigol – Cryfderau

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Mae staff BIPCF yn ymwybodol o'r prosesau i'w dilyn pan fydd plentyn sy'n wynebu risg yn defnyddio eu gwasanaethau, ond gallai hyn gael ei gryfhau drwy roi polisi diogelu sefydliadol ar waith. Mae'r staff yn hyderus y gallant gael cyngor ar ddiogelu mewn modd amserol gan y tîm diogelu. Cynhelir cyfarfodydd rheolaidd yn BIPCF i adolygu penderfyniadau ynghylch diogelu plant. Mae enghreifftiau'n cynnwys cyfarfodydd wythnosol yr adran achosion brys pediatrig ac adolygiadau gan gymheiriaid misol o archwiliadau meddygol amddiffyn plant. Mae'r rhain yn cynnig rhwyd ddiogelwch a goruchwyliaeth ychwanegol mewn perthynas ag atgyfeiriadau diogelu (y ddyletswydd i adrodd) a chyfle i ddysgu a gwella ymarfer.

Mae enghreifftiau cadarnhaol o wasanaethau yn cefnogi diogelwch a llesiant plant ac yn gweithio ar draws disgyblaethau. Mae BIPCF wedi meithrin cysylltiadau cadarnhaol â chydweithwyr ym maes gofal sylfaenol. Mae llwybr iechyd diogelu digidol wedi'i ddatblygu yn ddiweddar er mwyn helpu meddygon teulu i wneud penderfyniadau ynghylch diogelu a rhoi prosesau ar waith.

Mae aelod o staff sy'n gyfrifol am dderbyniadau mynych yn gweithio yn yr adran achosion brys er mwyn mynd ar drywydd achosion o dderbyniadau niferus, a lle y bo'n briodol, gellir trafod hyn yn ystod cyfarfodydd yr adran achosion brys pediatrig. Mae gwasanaeth Argyfwng CAMHS ar gael tan hanner nos, a gellir cael gafael ar y gwasanaeth hwn drwy'r adran achosion brys pediatrig.

Ym maes bydwreigiaeth, mae Bydwraig Diogelu benodol yn darparu cymorth cyson ar draws gwasanaethau mamolaeth. Mae'r Tîm Cyn-Geni yn gweithio'n dda, ac mae cydberthnasau gwaith amlasiantaethol ardderchog wedi'u nodi yn y maes hwn.

Ceir dwy nyrs llesiant emosiynol sy'n cefnogi plant yn yr uned cyfeirio disgyblion a phlant sy'n derbyn addysg ddewisol yn y cartref. Mae'r ysgolion a'r uned cyfeirio disgyblion yn gwerthfawrogi'r cymorth hwn.

Addysg

Mae ysgolion Caerdydd a'r uned cyfeirio disgyblion yn ceisio datblygu ac annog diwylliant o wella'n barhaus er mwyn sicrhau safonau uchel o ran llywodraethu, gweithredu, a diogelu. Wrth wneud hynny, mae'n yn ymrwymedig i gydweithio'n agored â phartneriaid yn y system addysg.

Mae swyddogion o amrywiaeth o dimau yn rhannu gwybodaeth am ysgolion unigol a'r uned cyfeirio disgyblion yn ystod y cyfarfodydd risg â phob ysgol a gynhelir bob tymor. Mae hyn yn galluogi'r awdurdod lleol i ddeall anghenion ysgolion Caerdydd a'r uned cyfeirio disgyblion ac i ddarparu'r cymorth sydd ei angen.

Mae staff ysgolion ar bob lefel yn deall eu rolau a'u cyfrifoldebau mewn perthynas â chadw dysgwyr yn ddiogel. Mae'r defnydd o lwyfannau digidol ar gyfer pob ysgol, yr uned cyfeirio disgyblion a meysydd gwasanaeth ar draws yr adran addysg yn gwella cysondeb wrth gofnodi pryderon a rhoi gwybod amdanynt. Mae hyn hefyd yn gwella'r cyfathrebu a'r broses o rannu gwybodaeth rhwng ysgolion, yr uned cyfeirio disgyblion a darparwyr gwasanaethau, ac mae'n dechrau cael ei ddefnyddio fel ffordd o fonitro tueddiadau er mwyn targedu ymyriadau.

Mae cyfleoedd rheolaidd i bersonau diogelu dynodedig mewn ysgolion ac yn yr uned cyfeirio disgyblion gyfarfod a chael trafodaeth broffesiynol fel rhan o'r fforwm personau diogelu dynodedig. Mae'r personau diogelu dynodedig yn ymateb yn gyflym i bryderon diogelu ac yn dilyn y gweithdrefnau atgyfeirio cywir. Maent yn rhannu gwybodaeth yn ymwneud ag amddiffyn plant ag aelodau allweddol o staff yr ysgol mewn modd priodol a sensitif.

Mae staff ysgolion a staff yr uned cyfeirio disgyblion yn meddu ar wybodaeth a dealltwriaeth gadarn o gronoleg disgyblion sydd wedi'u henwi ar y gofrestr amddiffyn plant. Mae tystiolaeth bod ffurflenni atgyfeirio amlasiantaethol yn cael eu cyflwyno gan staff ysgolion a staff yr uned cyfeirio disgyblion mewn modd amserol.

Mae'r broses o gyflwyno'r Dull Ysgol Gyfan ar gyfer Llesiant Emosiynol a Meddyliol wedi parhau, mewn partneriaeth ag Iechyd Cyhoeddus Cymru. Mae'r ysgolion a'r uned cyfeirio disgyblion yn cynnig lefel uchel o gymorth emosiynol a llesiant i ddisgyblion agored i niwed drwy Gynorthwywyr Cymorth Llythrennedd Emosiynol (ELSA), THRIVE a dosbarthiadau llesiant.

Mae Caerdydd yn bodloni'r gofyniad statudol a nodir yn Neddf Safonau a Threfniadaeth Ysgolion (Cymru) 2013 drwy ddarparu gwasanaeth cwnsela wyneb yn wyneb mewn ysgolion, a hynny ym mhob ysgol uwchradd a gynhelir yng Nghaerdydd ac ym Mlwyddyn 6 mewn ysgolion cynradd, ochr yn ochr â gwasanaeth negeseua dros y rhyngrwyd. Mae llawer o ysgolion wedi mabwysiadu dull Meithrin Egwyddorion sy'n helpu disgyblion i feithrin sgiliau cymdeithasol hanfodol, hyder a hunan-barch, a bod yn barod i ddysgu.

Ceir oedolion yr ymddiriedir ynddynt dynodedig mewn ysgolion, y gall disgyblion droi atynt os byddant yn pryderu am rywbeth. Dywed disgyblion bod y bobl hyn yn eu cefnogi ac yn gwrando arnynt os byddant yn teimlo'n ofidus neu'n bryderus.

O fewn Tîm Digidol yr awdurdod lleol, darperir cyfres gynhwysfawr o adnoddau diogelwch ar-lein i bob ysgol a'r uned cyfeirio disgyblion yng Nghaerdydd drwy Hwb a llwyfan dysgu ar-lein Tîm y Cwricwlwm.

Mae'r awdurdod lleol yn adolygu'r dosbarthiadau llesiant a ddarperir ar draws y ddinas yn barhaus, ac mae wedi cysoni'r ddarpariaeth â'r cod a'r prosesau Anghenion Dysgu Ychwanegol (ADY) Mae gan yr awdurdod lleol dîm dynodedig o weithwyr pontio ADY sy'n cefnogi plant a phobl ifanc o adeg eu geni hyd at 25 oed. Mae'n darparu gwasanaeth o ansawdd uchel, gan fabwysiadu dull sy'n canolbwyntio ar yr unigolyn yn unol â dyletswyddau statudol yr awdurdod lleol. Mae'r tîm yn cynnal partneriaethau cydweithredol â rhanddeiliaid.

Mae mwy na 500 o ddysgwyr sy'n derbyn addysg ddewisol yn y cartref yng Nghaerdydd, a gorbryder yw'r rheswm mwyaf cyffredin ond un a roddir dros adael yr ysgol. Mae cronfa addysg ddewisol yn y cartref yr awdurdod lleol yn ariannu swyddogion lleol i olrhain disgyblion a'u cefnogi. Mae hyn yn helpu i gryfhau trefniadau diogelu, lle y bo'n briodol, ar gyfer y grŵp hwn o blant a phobl ifanc.

Mae gan y Gwasanaeth Lles Addysg weithdrefn Plant sy'n Colli Addysg ac mae'n chwarae rôl bwysig wrth olrhain pob disgybl sy'n gadael yr ysgol yn ystod y flwyddyn, disgyblion sy'n pontio o Flwyddyn 6 i Flwyddyn 7, a phlant sy'n symud i'r ardal er mwyn sicrhau eu bod yn cyrraedd eu cyrchfannau nesaf yn ddiogel.

Mae nifer y plant sy'n Osgoi'r Ysgol ar Sail Pryder wedi cynyddu ers iddynt ddychwelyd i'r ysgol neu'r uned cyfeirio disgyblion yn dilyn y pandemig. Mae Gwasanaeth Seicoleg Addysgol Caerdydd wedi llunio canllawiau a hyfforddiant i ysgolion a thaflenni gwybodaeth i rieni a gofalwyr a phobl ifanc.

Mae gan y Gwasanaeth Cyflawniad Lleiafrifoedd Ethnig a Theithwyr (EMTAS) gydberthynas waith sefydledig â'r gymuned Sipsiwn a Theithwyr ac mae wedi ennyn parch ac ymddiriedaeth teuluoedd. Darperir cymorth penodol ar gyfer pontio o Flwyddyn 6 i Flwyddyn 7 a chofrestru mewn ysgolion cynradd, er enghraifft drwy helpu teuluoedd i gwblhau ceisiadau am ysgolion a phontio i'r ysgol uwchradd. Mae'r cymorth penodol hwn yn cael effaith gadarnhaol.

Heddlu De Cymru

Gwelsom fod swyddogion yn gwneud defnydd da o faneri a marciau rhybudd i nodi plant agored i niwed, fel y rheini y rhoddwyd gwybod eu bod ar goll. Mae swyddogion ateb galwadau yn y Ganolfan Gwasanaethau Cyhoeddus yn defnyddio'r baneri a'r marcwyr hyn i nodi ac asesu lefel y risg yn gyflym, er mwyn llywio'r math o ymateb i ddigwyddiad. Mae hyn yn helpu i sicrhau bod plant yn cael eu diogelu'n gyflym.

Mae'r heddlu wedi diwygio a chryfhau ei bolisi ar ymateb i blant coll yn ddiweddar. Caiff digwyddiadau sy'n ymwneud â phlant 11 oed ac iau, pan fyddant ar goll, eu trin yn ddigwyddiadau risg uchel. Roedd y rhan fwyaf o'r digwyddiadau y gwnaethom eu samplu wedi cael eu hasesu a'u graddio'n briodol, ond mae'r heddlu yn cydnabod bod hyn yn waith sy'n mynd rhagddo.

Mae adroddiadau'r heddlu ar gyfer cynadleddau achos cychwynnol yn drylwyr. Mae'r cofnodion yn fanwl ac wedi'u cofnodi ar system yr heddlu, Niche.

Gwasanaethau Plant

Yn gyffredinol, mae'r ymarfer diogelu a arweinir gan wasanaethau plant yn seiliedig ar ystyriaeth o'r risgiau sy'n gysylltiedig â diogelwch plant, wedi'i chydbwyso ag ystyriaeth o gryfderau eu teuluoedd. Mae enghreifftiau o esboniadau trylwyr o sefyllfaoedd teuluol cymhleth mewn asesiadau sy'n rhoi eglurder ynghylch sefyllfa'r teulu a chylch teuluol uniongyrchol ac ehangach y plant.

Caiff atgyfeiriadau a chofnodion dyletswydd i adrodd eu sgrinio, eu sgorio gan ddefnyddio sgôr Coch Melyn Gwyrdd i ddangos lefel y flaenoriaeth a aseswyd, a'u brysbennu yn MASH. Yn ystod y broses hon, ystyrir cydsyniad rhieni a rhoddir ffocws ar hynny. Yn gyffredinol, caiff risgiau posibl i frodyr a chwiorydd eu hystyried fel rhan o'r broses ddiogelu. Ystyrir hefyd ffactorau diogelu cyd-destunol, ond byddai rhai cofnodion yn cael budd o gynnwys mwy o fanylion i ddangos ystyriaeth ymarferwyr o'r risgiau ehangach sy'n gysylltiedig â phlant a/neu oedolion agored i niwed.

Ystyrir bod teuluoedd yn ganolog i gynlluniau diogelwch a chyflawni canlyniadau a ddymunir. Mae enghreifftiau da o gynlluniau diogelwch yn cael eu defnyddio, gan bennu disgwyliadau clir rhieni o ran rheoli risgiau. Gellid gwella cysondeb o ran y ffordd y caiff y rhain eu cofnodi er mwyn sicrhau eglurder ynghylch risg, diogelwch a'r hyn y mae angen ei wneud er mwyn rhoi sicrwydd am ddiogelwch.

Mae pwyslais clir ar weithgarwch cynllunio trawsnewidiol am resymau cadarnhaol gyda ffocws clir ar ymarfer. Er enghraifft, ad-drefnu paneli, sy'n cael ei groesawu gan y staff. Mae polisi uwchgyfeirio newydd ym mhroses y Gynhadledd Achos Amddiffyn Plant a pholisi goruchwyliaeth rheolwyr newydd wedi cael eu datblygu.

Asiantaeth Unigol – Yr hyn y mae angen ei wella

Bwrdd Iechyd Caerdydd a'r Fro

Wrth edrych ar ddogfennau'r bwrdd iechyd er mwyn deall y trefniadau llywodraethu a oedd ar waith, nodwyd digwyddiad a oedd yn peri pryder yn ymwneud â phlentyn a oedd wedi datblygu briwiau pwyso graddfa tri ar y croen fel claf mewnol. Dywedwyd wrth AGIC yr ystyriwyd, yn dilyn ymchwiliad i'r digwyddiad, fod y briwiau pwyso yn rhai na ellid bod wedi'u hosgoi, am fod yr holl asesiadau risg wedi'u cwblhau. Fodd bynnag, ni chafodd AGIC sicrwydd bod y wybodaeth a ddarparwyd gan y bwrdd iechyd yn dangos bod y plentyn wedi cael ei ddiogelu'n briodol. Felly, tynnodd hyn sylw at bryderon yn ymwneud ag adnabod niwed i feinwe'r croen a'r camau a gymerir gan y bwrdd iechyd i ddiogelu plant rhag datblygu niwed o'r fath.

Mae nifer y plant sy'n derbyn gofal nad ydynt yn cael asesiad iechyd cychwynnol o fewn yr amserlen statudol yn uchel, gan gyrraedd 95% ym mis Tachwedd 2023. Mae

hon yn risg hirdymor. Nid oedd data ar gydymffurfiaeth ar gyfer asesiadau iechyd adolygu statudol ar gael i'r arolygwyr.

Nid yw nyrsys iechyd ysgol yn cynnal asesiadau iechyd ar gyfer plant oed ysgol sy'n destun cynhadledd amddiffyn plant cychwynnol. At hynny, nid yw'r rhan fwyaf o nyrsys ysgol yn gallu cael gafael ar gofnodion meddygon teulu, felly efallai na fyddant yn ymwybodol o anghenion gofal iechyd plentyn. Argymhellir y dylid cwblhau asesiad iechyd cynhwysfawr ar gyfer pob plentyn oed ysgol er mwyn nodi a oes unrhyw anghenion iechyd i lywio'r CAGCh.

Yng ngoleuni'r materion a nodwyd uchod, anfonodd AGIC lythyr Sicrwydd Ar Unwaith at y bwrdd iechyd yn gofyn am ymateb brys a chynllun gwella i fynd i'r afael â'r pryderon. Ers hynny, mae AGIC wedi derbyn y cynllun gwella.

Mae nifer y systemau TG gwahanol a ddefnyddir yn y bwrdd iechyd yn atal gwybodaeth rhag cael ei chasglu a'i rhannu mewn modd amserol. Nid yw dogfennau diogelu allweddol bob amser yn cael eu cofnodi, a dim ond gwybodaeth gyfyngedig a geir mewn cofnodion eraill. Mae hyn yn golygu nad yw manylion pwysig am gynlluniau gofal a chymorth a chyfarfodydd amlasiantaethol bob amser ar gael i lywio cynnydd mewn perthynas â diogelwch a llesiant plentyn.

Cyfrifoldeb un ymarferydd yw cyflawni rôl y fydwraig diogelu arweiniol. Mae'n gylch gwaith mawr sy'n anghymesur i weddill y tîm diogelu. Rhoddwyd y gorau i feysydd gwasanaeth a gynigiwyd yn flaenorol gan y tîm diogelu i staff mamolaeth (goruchwyliaeth a hyfforddiant Lefel 3 i fydwragedd mewn ysbytai). Mae hyn yn peri risg bosibl ac mae angen ei ailystyried.

Addysg

Nid oes unrhyw feysydd penodol i'w cofnodi yn yr adran hon.

Heddlu De Cymru

Roedd ôl-groniad o geisiadau am gynllun datgelu trais domestig i'w prosesu ar adeg yr arolygiad. Mae'r heddlu wedi cydnabod yr ôl-groniad hwn ac mae'n gweithio i'w leihau. Fodd bynnag, mewn rhai achosion mae oedi cyn gwneud penderfyniadau ynglŷn â rhannu gwybodaeth yn ymwneud â diogelu â dioddefwyr sy'n gyfrifol am amddiffyn plant.

Gwasanaethau Plant

Mae Datganiad Perfformiad Blynyddol 2022/2023 yr awdurdod lleol i Lywodraeth Cymru yn nodi, yn achos 44% o'r cysylltiadau, nad oedd penderfyniad wedi'i wneud erbyn diwedd y diwrnod gwaith nesaf. Mae'r un set ddata yn cofnodi niferoedd uchel

o blant na chawsant eu gweld fel rhan o asesiad llesiant. Mae hwn yn faes y mae angen i'r awdurdod lleol fynd i'r afael ag ef a'i ddeall yn well. Fodd bynnag, yn MASH, caiff atgyfeiriadau eu sgrinio gan ymarferwyr gan ddefnyddio graddfeydd i bennu lefel y flaenoriaeth (isel, canolig, sylweddol). Mae hon yn broses bwysig yn wyneb y galw cynyddol.

Mae anghysondeb mewn perthynas â chydymffurfiaeth â'r amserlenni statudol ar gyfer ymholiadau Adran 47 ac amseroldeb ymweliadau â phlant sy'n derbyn gofal a phlant a enwir ar y gofrestr amddiffyn plant. Mae angen gwella'r meysydd hyn gan eu bod yn elfennau hanfodol o brosesau diogelu. Dylai cofnodion nodi'n glir y rhesymeg dros unrhyw wyriad oddi wrth amserlenni perthnasol. Mae angen mynd i'r afael ag amseroldeb y grŵp craidd cyntaf yn dilyn cynadleddau achos amddiffyn plant cychwynnol hefyd. Caiff rhai grwpiau craidd eu hoedi ar fyr rybudd, a gall hyn arwain at oedi cyn gwneud diweddariadau pwysig i'r CAGCh.

Gellid cryfhau trafodaethau strategaeth a grwpiau craidd drwy sicrhau bod dogfennau allweddol yn cael eu rhannu â'r rhai sy'n bresennol a phartneriaid absennol. Byddai hyn yn galluogi pob aelod o staff i fod yn ymwybodol o ddiweddariadau i gynlluniau a'u rôl wrth amddiffyn plant. Mae'n galonogol nodi bod gwasanaethau plant wedi cyflwyno Prosiect Adnoddau Grwpiau Craidd newydd a fydd yn sicrhau'r ffocws gofynnol ar arferion grwpiau craidd.

Yn gyffredinol, mae'r systemau'n cefnogi'r broses o wneud penderfyniadau o fewn yr amlinelliad cyfraith gyhoeddus. Mae hyn yn sicrhau bod arweinwyr yn ymwybodol o brofiad bywyd plant. Fodd bynnag, mae sefyllfaoedd lle mae oedi sylweddol o fewn yr amlinelliad cyfraith gyhoeddus. Dylai arweinwyr sicrhau eu bod yn goruchwylio achosion o'r fath yn amserol er mwyn atal oedi cyn diwallu anghenion plant am ddiogelwch a sefydlogrwydd. Mae hyn wedi dechrau drwy ad-drefnu panel, cofnodi camau gweithredu a neilltuo adnoddau cymorth busnes er mwyn sicrhau nad oes unrhyw oedi wrth gynllunio sefydlogrwydd.

Yn gyffredinol, mae ymarferwyr yn defnyddio dulliau sy'n seiliedig ar gryfderau wrth ymateb i risg. Mewn ambell sefyllfa, gwelsom y byddai staff yn cael budd o hyfforddiant ar gamfanteisio, diogelu pobl ifanc, ac ymddygiad sy'n niweidiol yn ddiwylliannol.

Mae'r defnydd a wneir o genogramau, ecofapiau a chronolegau yn amrywio, a dywedodd ymarferwyr wrthym fod capasiti gweithwyr dynodedig yn effeithio ar hyn. Mae'r rhain yn adnoddau pwysig i ddeall cyd-destun a helpu ymarferwyr i resymoli'r penderfyniadau a wneir.

Pobl

Trefniadau partneriaeth – Cryfderau

Eleni, cafodd Caerdydd ei henwi'n ddinas ystyriol o blant gyntaf y DU. Mae hon yn wobr fyd-eang sy'n dathlu dinasoedd lle mae hawliau plant yn rhan o'r penderfyniadau a'r polisïau a wneir gan lywodraeth leol. Ers 2017, mae'r awdurdod lleol wedi gweithio gyda sefydliadau ar hyd a lled y ddinas er mwyn helpu plant a phobl ifanc i gyfrannu at feysydd fel arweinyddiaeth, cyfathrebu, diwylliant ac addysg.

Yn gyffredinol, mae ymarferwyr yn gweithio'n dda gyda theuluoedd ac yn eu cynnwys mewn penderfyniadau am eu bywydau. Mae cryfderau ac arferion sy'n canolbwyntio ar ganlyniadau yn amlwg mewn cynadleddau achos amddiffyn plant. Mae enghreifftiau o arferion gorau yn cynnwys y defnydd o iaith syml wrth gyfathrebu â rhieni a ffocws clir ar yr hyn y mae angen i rieni ei newid. Mae'r defnydd o gwestiynau graddfa yn helpu'r grŵp amlasiantaethol i ganolbwyntio ar yr hyn y maent yn pryderu amdano.

Yr hyn y mae angen ei wella

Mae partneriaid yn cydnabod pwysigrwydd deall amgylchiadau unigol y plentyn, ond mae angen cryfhau'r broses o gofnodi llais y plentyn.

Gellid gwella'r broses o gofnodi ethnigrwydd ac iaith mewn cofnodion iechyd a chofnodion yr heddlu. Mae hyn yn bwysig er mwyn ymateb yn briodol i boblogaeth amrywiol Caerdydd. Dylai arweinwyr sicrhau y caiff gwybodaeth ddemograffig bwysig ei chofnodi'n gywir ac yn glir.

Asiantaeth Unigol – Cryfderau

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Mae gan BIPCF Fwrdd Ieuenctid sydd wedi'i sefydlu'n dda, ac ymgynghorir â'r bwrdd hwn ynghylch mentrau perthnasol, gwaith datblygu polisi a chyfweliadau â staff perthnasol. Mae cynrychiolydd o'r tîm diogelu yn bresennol mewn rhai cyfarfodydd.

Mae staff BIPCF a meddygfeydd yn gwerthfawrogi cymorth a chyngor y tîm diogelu, ond mae'n amlwg bod nifer y galwadau yn gallu effeithio ar amseroldeb yr ymateb ar adegau.

Yn gyffredinol, caiff llais y plentyn ei gofnodi'n dda, ond gallai hyn gael ei gryfhau mewn rhai cofnodion. Mae enghreifftiau o blant sy'n derbyn gofal yn cael eu cynnwys yn eu hasesiadau iechyd a'r broses o gynllunio eu gofal. Mae hyn yn cynnwys

sgyrsiau am 'yr hyn sy'n bwysig' a sgyrsiau yn seiliedig ar gryfderau, gan gofnodi dymuniadau a theimladau. Ceir cydberthynas gydweithredol rhwng staff gofal iechyd a phlant ac mae tystiolaeth bod pobl ifanc yn cael eu cynnwys mewn penderfyniadau am faterion iechyd.

Yn gyffredinol, mae'r staff yn cael cymorth diogelu a goruchwyliaeth mewn modd amserol wrth wneud penderfyniadau pwysig yn ymwneud â diogelu plant. Mae arweinwyr a rheolwyr yn defnyddio eu gwybodaeth i herio a chefnogi ymarferwyr a hyrwyddo gwelliant parhaus.

Addysg

Mae diogelu yn rhan greiddiol o waith arweinwyr a swyddogion yn y gyfarwyddiaeth addysg ac yn rhan o agenda cyfarfodydd yr Uwch-dîm Arwain a chyfarfodydd eraill bob amser. Mae uwch-swyddogion addysg yn cyfarfod â chydweithwyr o'r Gyfarwyddiaeth Gwasanaethau Plant yn fisol er mwyn trafod amrywiaeth eang o faterion cyfredol yn ymwneud â diogelu.

Mae'r Cyfarwyddwr Addysg a Dysgu Gydol Oes yn meddu ar ddealltwriaeth dda o bwysigrwydd datblygu a chefnogi diwylliant, prosesau a systemau diogelu cryf ar lefel gorfforaethol a lefel yr ysgol. Ceir cysylltiadau cryf â'r Gyfarwyddiaeth Gwasanaethau Plant a'r Tîm Diogelu Addysg yn arbennig, sy'n rhan o'r gyfarwyddiaeth hon.

Mae'r aelod etholedig dros addysg yn ymrwymedig iawn i ddiogelu. Mae pob aelod etholedig yn cwblhau hyfforddiant ar ddiogelu corfforaethol ar ôl cael ei benodi.

Mae arweinwyr yn gwerthfawrogi'r gwelliannau i waith amlasiantaethol sy'n cryfhau'r trefniadau diogelu mewn ysgolion ac yn yr uned cyfeirio disgyblion. Mae'r Tîm Diogelu Addysg yn darparu lefel uchel o gymorth i ysgolion ac unedau cyfeirio disgyblion. Mae hyn yn cynnwys cyngor amserol, diweddariadau rheolaidd am ddiogelu a hyfforddiant o ansawdd uchel ar gyfer personau diogelu dynodedig a llywodraethwyr.

Dosberthir adnodd proffil asesu bregusrwydd y Gwasanaeth Ieuenctid i ysgolion deirgwaith y flwyddyn, lle y caiff statws risg ei boblogeiddio gan ganolbwyntio ar ddata penodol fel nifer y symudiadau rhwng ysgolion, gwaharddiadau, prydau ysgol am ddim a statws plant sy'n derbyn gofal, er mwyn nodi'r dysgwyr mwyaf agored i niwed. Mae ysgolion a'r uned cyfeirio disgyblion yn adolygu ac yn diweddaru statws disgyblion er mwyn nodi'r rheini sy'n wynebu'r risg fwyaf o ymddieithrio o'r ysgol, bod yn agored i niwed yn y gymuned, neu y bydd rhywun yn camfanteisio arnynt. Caiff achosion eu brysbennu gan y Tîm Perfformiad a Llywodraethu fel bod modd rhoi cymorth pontio penodol ar waith. Darperir cymorth i ddisgyblion Blwyddyn 7 i Flwyddyn 11 mewn ysgolion arbennig prif ffrwd a lleoliadau addysg heblaw yn yr ysgol.

Mae'r awdurdod lleol wedi ariannu'r broses o gyflwyno system electronig gyffredin ar gyfer cofnodi pryderon diogelu mewn ysgolion ac yn uned cyfeirio disgyblion, ac mae hyn wedi gwella'r broses o gofnodi gwybodaeth. Mae llawer o ysgolion hefyd yn dechrau defnyddio'r system hon yn briodol i gofnodi achosion o fwlio. Mae swyddogion wedi gweithio ochr yn ochr ag arweinwyr ysgolion i lunio canllawiau defnyddiol ar adnabod honiadau o fwlio, eu cofnodi a delio â nhw.

Dywed y rhan fwyaf o ysgolion a'r uned cyfeirio disgyblion fod y Tîm Diogelu Addysg yn trefnu hyfforddiant rheolaidd a defnyddiol i ysgolion a llywodraethwyr ar amddiffyn plant, yn ogystal â chynnal amrywiaeth ehangach o sesiynau diogelu cyd-destunol. Mae'r staff perthnasol yn cael amrywiaeth o hyfforddiant gwerth chweil, er enghraifft hyfforddiant ar Prevent a Thrais yn erbyn menywod, cam-drin domestig a thrais rhywiol (VAWDASV). Mae'r awdurdod lleol, mewn partneriaeth â Chonsortiwm Canolbarth y De, yn trefnu rhaglen flynyddol o hyfforddiant i lywodraethwyr.

Defnyddir eiriolwyr yn briodol; maent yn ymweld â disgyblion mewn ysgolion er mwyn cofnodi safbwyntiau disgyblion am faterion pwysig. Mae dysgwyr yn teimlo bod oedolion yn gwrando arnynt ac yn rhoi cymorth a llais iddynt. Yn gyffredinol, ceir cydberthnasau cadarnhaol rhwng ysgolion a rhieni.

Mae gan ysgolion a'r uned cyfeirio disgyblion ddealltwriaeth dda o'r materion a wynebir gan ddisgyblion a'u teuluoedd yn eu cymunedau unigol, er enghraifft effaith yr aflonyddwch yng nghymuned Trelái yn 2023 ar deuluoedd. Darperir cymorth penodol i gymunedau yn rhannol drwy'r gwasanaethau ieuenctid. Fel ymateb uniongyrchol i'r aflonyddwch yng nghymuned Trelái, cynyddodd y gwasanaeth ieuenctid y cymorth ar y stryd, er mwyn casglu safbwyntiau a meddyliau pobl fanc a'r gymuned ehangach.

Heddlu De Cymru

Mae arweinwyr yr heddlu yn rhoi ffocws clir ar fregusrwydd. Mae nifer o gyfarfodydd llywodraethu strwythuredig ar waith yn yr heddlu i reoli achosion amddiffyn plant a bregusrwydd ehangach. Cynhelir cyfarfodydd perfformiad cam-drin domestig lleol ym mhob Uned Reoli Sylfaenol, gan gynnwys un ar gyfer Caerdydd; ymddengys fod camau gweithredu yn glir ac yn canolbwyntio ar ddeall sut y gallai data ansoddol effeithio ar blant. Er enghraifft, mae rheolwyr yn defnyddio eu dangosfwrdd i nodi unrhyw hysbysiadau amddiffyn y cyhoedd a gollwyd, ac maent yn defnyddio'r broses hon i sicrhau eu bod yn cael eu cwblhau cyn gynted â phosibl a'u rhannu â phartneriaid. Mae hyn yn gadarnhaol gan ei bod yn golygu bod partneriaid yr heddlu yn cael y wybodaeth angenrheidiol i wneud penderfyniadau amserol.

Gwasanaethau Plant

Mae uwch-reolwyr yn meddu ar ddealltwriaeth dda o anghenion y boblogaeth, ac mae gwasanaethau yn ymateb mewn modd cyson. Ceir grŵp uwch-reolwyr profiadol, ac yn gyffredinol, cafwyd adborth cadarnhaol gan y staff am y cymorth y maent yn ei gael.

Mae cymorth a goruchwyliaeth y rheolwyr yn amlwg ac, unwaith eto, cafwyd adborth cadarnhaol gan grwpiau o staff. Caiff penderfyniadau ynghylch diogelu eu goruchwylio gan reolwyr a cheir cyfleoedd i ymgynghori ar ymarfer. Mae goruchwyliaeth y rheolwyr yn cynnig arweiniad a chymorth i ymarferwyr wrth fyfyrio ar amgylchiadau teuluol cymhleth.

Ceir grŵp o staff ymroddedig ac ymrwymedig, a ffocws amlwg ar ddiogelwch a llesiant. Bu'n rhaid i'r awdurdod lleol ddibynnu ar nifer mawr o staff dros dro (gweithwyr asiantaeth) er mwyn cynnal tîm sy'n ategu ac yn cefnogi cadernid y gweithlu. Mae'n gadarnhaol nodi bod nifer y swyddi gwag yn lleihau a bod mwy o staff parhaol wedi'u cyflogi. Mae hyn yn bwysig gan y bydd yn helpu i gynyddu parhad ymarferwyr i blant a theuluoedd, a fydd, yn ei dro, yn gwella ymddiriedaeth a hyder mewn cydberthnasau.

Mae arweinwyr ac uwch-reolwyr yn ymrwymedig i wneud gwelliannau er mwyn cefnogi llesiant plant. Mae pwyslais cryf ar gyflawni a monitro gwelliannau mewn gwasanaethau plant o hyd. Mae systemau gwell wedi'u rhoi ar waith i fonitro cydymffurfiaeth â gofynion cyfreithiol a safonau arfer da. Mae'r dull o sicrhau ansawdd ac archwilio, er ei fod yn dal i gael ei ddatblygu, yn effeithiol, ac mae cydymffurfiaeth yn gwella. Ceir ymrwymiad dilys i weithio tuag at “sut beth yw da” a'r hyn sy'n bwysig yn ymarferol. Mae'r broses o rannu a lledaenu gwersi a ddysgwyd drwy'r tîm sicrhau ansawdd yn dechrau dwyn ffrwyth. Mae gwaith cadarnhaol yn cael ei wneud gan yr arweinwyr ymarfer a digwyddiadau materion ymarfer, er enghraifft.

Mae dangosfwrdd data perfformiad ar gael i ymarferwr. Mae hyn yn fuddiol i roi trosolwg o'r gwaith i'w gyflawni a'r amserlenni. Caiff y data hyn eu hadolygu gan reolwyr er mwyn monitro ymarfer yn barhaus, a gellir defnyddio cydymffurfiaeth ag amserlenni statudol i nodi'r meysydd lle mae angen adnoddau.

Cydnabyddir pwysigrwydd cael cydsyniad rhieni, lle y bo'n briodol, yn enwedig mewn perthynas ag atgyfeiriadau a geir yn MASH. Yn gyffredinol, caiff llais y plentyn a rhieni ei hyrwyddo yn MASH, gan gynnwys ystyried amgylchiadau brodyr a chwiorydd.

Mae enghreifftiau ardderchog o waith sy'n canolbwyntio ar y plentyn gyda phlant, er mwyn ennyn eu hymddiriedaeth a sicrhau eu bod yn cyfrannu at eu cynlluniau. Yn yr enghreifftiau gorau, mae'r ymarferwyr wedi bod yn ofalgar, yn gyson ac yn greadigol

er mwyn sicrhau bod llais y plentyn yn cael ei glywed a'i ddeall. Mae hyn yn cynnwys amgylchiadau lle mae gwaith uniongyrchol wedi'i wneud gyda grwpiau mawr o frodyr a chwiorydd, er mwyn deall eu hanghenion unigol. Gellid cryfhau'r ymarfer drwy sicrhau bod y gwaith a wnaed gyda phlant yn cael ei gofnodi'n fwy cyson mewn cofnodion.

Yn y rhan fwyaf o asesiadau a chynlluniau, mae ymarferwyr yn cofnodi'r hyn sy'n bwysig i bobl yn glir drwy rannu'r hyn sy'n gweithio'n dda, unrhyw bryderon, a'r hyn y mae angen ei wneud. Mae rhieni a phlant yn cael eu cynnwys mewn ffordd gadarnhaol yn eu CAGCh. Mae hyn yn cynnwys cymryd rhan mewn grwpiau craidd a chynadleddau achos amddiffyn plant yn rheolaidd. Mae pob cynhadledd achos amddiffyn plant yn dechrau gyda chiplun o bob plentyn, ac mae enghreifftiau da o gadeirydd y gynhadledd yn crynhoi canlyniadau'r gynhadledd yn y person cyntaf. Mae'r rhan fwyaf o ymholiadau Adran 47 yn dangos profiad bywyd y plentyn ac yn cynnwys gwaith dadansoddiad da i gefnogi penderfyniadau cymesur.

Nid yw plant bob amser yn cael gwybodaeth gan eu gweithwyr cymdeithasol, fel adroddiadau, ac nid yw cadeiryddion cynadleddau bob amser yn cyfarfod â phlant cyn y gynhadledd achos amddiffyn plant. Llwyth gwaith mawr yw'r prif reswm dros hyn. Fodd bynnag, dywed rhieni a phlant fod ymarferwyr yn gefnogol ac yn cyfathrebu'n dda. Mae cadeiryddion cynadleddau yn cyfarfod yn gyson â rhieni ar y diwrnod cyn y gynhadledd o leiaf, er mwyn esbonio'r hyn fydd yn digwydd, eu paratoi, ac ateb unrhyw gwestiynau.

Yn ddiweddar, mae'r awdurdod lleol wedi dechrau defnyddio cynorthwywyr gwaith cymdeithasol i gyflawni rolau a gyflawnwyd yn flaenorol gan weithwyr cymdeithasol cymwysedig. Mae hyn yn cynnwys arweinydd rheoli achosion ar gyfer plant sy'n derbyn gofal. Mae hyn yn gweithio'n foddhaol pan fydd lefelau priodol o gymorth goruchwyliol, cydweithio a mentora ar waith. Cawsom adborth cymysg ar hyn, gydag adborth cadarnhaol gan asiantaeth bartner a ddywedodd fod cymorth cynorthwywyr gwaith cymdeithasol yn golygu bod llai o newid o ran gweithwyr a mwy o gysondeb i'r plentyn sy'n derbyn gofal. I'r gwrthwyneb, nododd rhai fod cymhlethdod rhai sefyllfaoedd yn anodd i gynorthwywyr gwaith cymdeithasol fynd i'r afael ag ef.

Yn gyffredinol, ceir ymrwymiad i gefnogi plant drwy eiriolaeth, a phwyslais ar hynny. Mae amser ac adnoddau wedi'u buddsoddi i weithio gyda'r darparwr eiriolaeth mewn perthynas â'r cynnig rhagweithiol, ac roedd hyn yn amlwg. Mewn rhai achosion, gellid bod wedi hyrwyddo eiriolaeth yn well er mwyn galluogi lleisiau pobl i gael eu deall yn well. Mae Ap ar gael i annog plant a phobl ifanc i ymgysylltu, ond mae defnydd ymarferwyr ohono yn anghyson, yn rhannol am nad yw rhai plant yn dymuno defnyddio Ap at y diben hwn.

Mae ymarferwyr a phartneriaid yn dangos dealltwriaeth dda o anghenion diwylliannol y plant a'r teuluoedd y maent yn gweithio gyda nhw ac ymwybyddiaeth o

bwysigrwydd ymarfer sy'n ystyriol o ddiwylliant wedi'i gydbwyso â'r angen i amddiffyn a diogelu plant rhag niwed. Mae hyfforddiant wedi canolbwyntio ar 'arferion diwylliannol gymwys', ac mae gwasanaethau cyfieithu ar gael i deuluoedd, er y gall fod yn anodd dod o hyd i gyfieithwyr ar gyfer rhai ieithoedd.

Mae'r awdurdod lleol yn goruchwylio rhuglder ei weithlu yn y Gymraeg er mwyn gallu darparu'r cynnig rhagweithiol ar gyfer y Gymraeg. Mae'n ymrwymedig i gryfhau hyn drwy ganolbwyntio ar gynllunio'r gweithlu a gwasanaethau, archwilio, casglu data a datblygu staff. Mae ymarferwyr sy'n siarad Cymraeg yn gweithio ar draws gwasanaethau plant.

Asiantaeth Unigol – Yr hyn y mae angen ei wella

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cyfradd gydymffurfio BIPCF â hyfforddiant gorfodol ar ddiogelu yw 75%. Nid yw hyn yn gyson â'r Safon Hyfforddiant, Dysgu a Datblygu Genedlaethol, sef 85%. Felly, dylai'r bwrdd iechyd ailystyried ei darged lleol i gydymffurfio â'r safon genedlaethol, sef 85%.

Nid yw BIPCF yn mandadu hyfforddiant Lefel 3 ar ddiogelu. Nid yw hyn yn gyson ag argymhelliad Prif Swyddog Nyrsio Cymru, a amlinellir yn y ddogfen ryng-golegol, "Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff". Mae rhai grwpiau o staff yn cwblhau hyfforddiant Lefel 3, ond nid yw'r data hyn yn cael eu cofnodi'n ganolog, felly nid oes unrhyw ddata dibynadwy ar gael. Ymddengys nad yw rhai grwpiau o staff yn gwybod pa lefel o hyfforddiant ar ddiogelu sydd ei hangen arnynt ar gyfer eu rôl. Nid oes unrhyw ddata i ddangos a yw aelodau'r bwrdd yn cydymffurfio â hyfforddiant ar ddiogelu. Anfonodd AGIC lythyr Sicrwydd Ar Unwaith i'r bwrdd iechyd yn gofyn am ymateb brys a chynllun gwella i fynd i'r afael â'r pryder hwn ac, er hynny, mae wedi derbyn y cynllun gwella.

Yn amserlen hyfforddiant 2023/2024, cafodd 50% o hyfforddiant Lefel 3 ar ddiogelu plant ei ganslo o ganlyniad i bwysau llwyth gwaith yn y Tîm Diogelu. Niferoedd bach iawn o staff o fynychodd yr hyfforddiant a gynhaliwyd, a dywedodd rhai aelodau o'r staff fod diffyg hyfforddiant i gefnogi eu rôl.

Prin yw'r wybodaeth a rennir gan y Grŵp Llywio Diogelu yng nghyfarfodydd y Byrddau Clinigol. Prin hefyd yw'r data ar sicrwydd diogelu a gyflwynir i'r Grŵp Llywio Diogelu ac nid yw'r Tîm Diogelu yn ymwybodol o rai risgiau diogelu (er enghraifft briwiau pwyso ar Uned Gofal Dwys Pediatrig a chydymffurfiaeth asesiadau iechyd statudol plant sy'n derbyn gofal). Nid yw uwch-gynrychiolwyr y Byrddau Clinigol yn bresennol yn gyson. Dylai BIPCF fodloni ei hun fod trefniadau llywodraethu cadarn ar waith i gofnodi gwybodaeth am ddiogelu craffu arni a'i rhannu, ac y caiff risgiau a sicrwydd diogelu eu rhannu fel mater o drefn ar lefel weithredol.

Mae nifer cynyddol yr achosion diogelu a'u cymhlethdod, ynghyd â'r agenda diogelu sy'n ehangu, yn effeithio ar allu'r Tîm Diogelu i roi sicrwydd ynghylch ymarfer diogelu ym mhob rhan o BIPCF.

Er bod rhai meysydd arbenigol yn dilyn prosesau llywodraethu yn ymwneud â datblygu polisi, nid yw nifer sylweddol o'r dogfennau a rennir gan BIPCF yn cynnwys dyddiadau, enw'r awdur, manylion y perchennog, rhif y fersiwn na dyddiadau adolygu. Er mwyn osgoi dryswch a sicrhau bod y staff yn dilyn y prosesau cywir, mae angen gwella'r trefniadau ar gyfer llywodraethu a monitro dogfennau o'r fath yn sylweddol.

Yn absenoldeb polisi diogelu cyffredinol yn BIPCF, mae rhai Byrddau Clinigol wedi datblygu eu polisïau a'u dogfennau canllaw eu hunain. Mae hyn yn peri risg y gall yr ymarfer diogelu fod yn anghyson wrth i wasanaethau weithio mewn ffyrdd gwahanol ar draws y sefydliad. Aethpwyd i'r afael â'r mater hwn yn y llythyr Sicrwydd Ar Unwaith y cyfeiriwyd ato yn flaenorol, ac ers hynny, mae'r bwrdd iechyd wedi rhoi sicrwydd i AGIC ynghylch ei gynlluniau i ystyried cyflwyno polisi diogelu sefydliadol.

Ar hyn o bryd, ni chaiff data ar gydymffurfiaeth sesiynau goruchwylio mewn perthynas â diogelu eu casglu. Argymhellir y dylid mynd i'r afael â hyn er mwyn i BIPCF fodloni ei hun fod pob aelod o staff sy'n gweithio'n agos gyda phlant lle ceir pryderon diogelu, yn mynychu sesiynau goruchwylio rheolaidd.

Nid yw llais a safbwynt y plentyn yn gyson amlwg yng nghofnodion gweithwyr gofal iechyd proffesiynol.

Addysg

Nid yw'r awdurdod lleol yn ei gwneud yn ofynnol i ysgolion na'r uned cyfeirio disgyblion gyflwyno archwiliadau diogelu blynyddol na rheolaidd. O ganlyniad, nid oes ganddo drosolwg digonol o ganlyniadau archwiliadau ac ni all wybod a yw ysgolion a'r uned cyfeirio disgyblion yn eu cwblhau'n rheolaidd. Nid yw swyddogion yn gwybod digon am gryfderau ysgolion a'r uned cyfeirio disgyblion na'r meysydd y mae angen eu datblygu mewn perthynas â diogelu.

Mae'r awdurdod lleol yn casglu data ar fwlio pan fyddant yn cael eu cofnodi ar y system diogelu electronig. Fodd bynnag, ar hyn o bryd nid yw swyddogion yn dadansoddi'r data er mwyn nodi tueddiadau ac nid yw'n herio ysgolion na'r uned cyfeirio disgyblion os nad fyddant yn cyflwyno data.

Heddlu De Cymru

Mae angen i'r heddlu ddatblygu'r ffordd y mae'n coladu ac yn defnyddio data demograffig mewn modd ansoddol i ddeall profiadau plant a lleihau'r risg i blant. Er

enghraifft, data ar droseddau a digwyddiadau, wedi'u hategu gan wybodaeth ddemograffig fel iaith, anabledd, neu ffactorau niwroamrywiaeth. Ychydig iawn o dystiolaeth a welsom o'r data hyn wedi'u cofnodi (er enghraifft ethnigrwydd, anabledd neu iaith).

Nid yw'r heddlu yn cofnodi'n briodol a yw plant wedi cael eu gweld neu a oes rhywun wedi siarad â nhw, sy'n golygu nad yw eu llais yn cael ei gofnodi mewn rhai achosion. Yn aml, nid yw hysbysiadau amddiffyn y cyhoedd yn nodi'n glir a oedd plentyn yn bresennol yn ystod digwyddiad a ph'un a gafodd ei weld ai peidio. Lle mae ymchwiliad clir gan y tîm cam-drin plant, mae llais y plant yn amlwg.

Gwasanaethau Plant

Nid oes unrhyw feysydd penodol i'w cofnodi yn yr adran hon.

Partneriaethau ac Integreiddio

Trefniadau Partneriaeth – Cryfderau

Mae cydnabyddiaeth ddiweddar UNICEF i Gaerdydd fel dinas ystyriol o blant gyntaf y DU yn atgyfnerthu ei huchelgais a'i hymrwymiad i blant a phobl ifanc ar hyd a lled y ddinas. Mae'r gydnabyddiaeth hon yn deillio o waith partneriaeth cryf ym mhob rhan o'r ddinas.

Mae partneriaid wedi ymrwymo i gydweithio i ddiogelu plant sy'n wynebu risg o niwed a chamdriniaeth. Mae hyn yn amlwg drwy gyfranogiad cadarnhaol partneriaid mewn cyfarfodydd a thrafodaethau amlasiantaethol pwysig, a'r ffocws amlwg ar gryfderau a phryderon teuluoedd.

Gellid gwella rhai systemau ar gyfer rhannu gwybodaeth er mwyn sicrhau y gall pob asiantaeth wneud penderfyniadau amserol. Fodd bynnag, wrth edrych i'r dyfodol, mae Adroddiad Unigol yn brosiect a arweinir gan awdurdod lleol a fydd yn casglu data gan amrywiaeth o adnoddau, gan gynnwys Gwasanaethau Plant, Gwasanaethau Addysg a'r Gwasanaeth Cyfiawnder Ieuenctid ynghyd mewn un system i greu un cofnod ar gyfer plentyn. Mae tîm y prosiect yn gobeithio creu cynnyrch hyfyw yn barod i'w dreialu mewn ysgolion yn 2024.

Mae partneriaethau yn gwneud cyfraniad effeithiol ar benderfyniadau ynghylch diogelu ac mae ganddynt yr hyder i herio ei gilydd mewn modd adeiladol. Mae tystiolaeth o drafodaeth a her iach mewn grwpiau craidd a chynadleddau. Mae gan y Bwrdd Diogelu Rhanbarthol brotocol ar gyfer datrys gwahaniaethau proffesiynol ac, yn gyffredinol, mae ymarferwyr yn ymwybodol o'r protocol hwn ac yn teimlo'n hyderus i herio penderfyniadau a/neu geisio cyngor gan eu rheolwyr. Dylid ystyried casglu a chofnodi safbwyntiau proffesiynol gwahanol nad ydynt yn rhan o gwmpas y protocol, er mwyn llywio dysgu a gwelliant parhaus.

Mae trefniadau MASH yn amlddisgyblaethol, ac mae partneriaid yn gwerthfawrogi hyn yn fawr. Pan fydd angen rhannu gwybodaeth yn ymwneud â diogelu (gan gynnwys y ddyletswydd i adrodd), caiff hyn ei gwblhau mewn modd amserol ar y cyfan. Er enghraifft, caiff gwybodaeth ei rhannu'n brydlon rhwng asiantaethau yn ystod cyfarfodydd cam-drin domestig amlasiantaethol dyddiol. Yn ystod y fforymau hyn, gwneir defnydd effeithiol o amser a chaiff trafodaethau strategaeth eu cynnwys yn yr agenda.

Mae proses yn bodoli i sicrhau bod prosesau rhannu gwybodaeth ac asesiadau risg cam-drin domestig yn gyson ar draws timau. Mae rheolwyr yn defnyddio eu dangosfwrdd i nodi unrhyw hysbysiadau amddiffyn y cyhoedd a gollwyd, ac maent yn defnyddio'r broses hon i sicrhau eu bod yn cael eu cwblhau cyn gynted â phosibl a'u rhannu â phartneriaid.

Ceir gwaith partneriaeth cryf a defnyddir timau arbenigol i gefnogi anghenion llesiant disgyblion yng Nghaerdydd. Mae hyn yn cynnwys mentrau fel Cyfarfodydd Ysgol o Amgylch y Clwstwr, prosiect SAFE, y Pennaeth plant sy'n derbyn gofal rhithwir, a'r Gwasanaeth Cyflawniad Lleiafrifoedd Ethnig a Theithwyr. Mae hyn yn hyrwyddo diogelu cyd-destunol, llesiant emosiynol disgyblion, a chyfle da i wella canlyniadau.

Mae model gweithio sy'n nodi achosion o niwed cyd-destunol mewn cymunedau ac yn mynd i'r afael â nhw wedi'i ddatblygu yng Nghaerdydd. Mae model SAFE yn cydnabod y gall plant a phobl ifanc gael niwed wrth i oedolion a/neu gyfoedion eraill y tu allan i'r rhwydwaith teuluol gamfanteisio arnynt a'u cam-drin, neu y gallant wynebu risg o hynny. Mae'r awdurdod lleol wedi llwyddo i sicrhau cyllid drwy'r Gronfa Waddol Ieuenctid i gyflwyno prosiect Cadw'n Ddiogel, sy'n anelu at fynd i'r afael â thrais gan bobl ifanc a chamfanteisio troseddol.

Mae amrywiaeth o uwch-swyddogion addysg yn cefnogi panel risg uchel y Gwasanaeth Cyfiawnder Ieuenctid / gwasanaethau plant i ystyried ffyrdd o leihau risg i bobl ifanc yr ystyrir eu bod yn wynebu risg uchel, gan gynnwys risg y bydd rhywun yn camfanteisio arnynt. Mae partneriaeth ar draws yr awdurdod lleol yn cefnogi Cydweithrediad Cwricwlwm SAFE. Fel rhan o'r cydweithrediad hwn, mae amrywiaeth o bartneriaid amlasiantaethol yn cydweithio i sicrhau bod adnoddau ac ymyriadau cydlynol ac effeithiol ar waith i ymgorffori negeseuon craidd SFAE ym maes iechyd a lles y cwricwlwm. Darperir amrywiaeth o hyfforddiant addysg cydberthynas a rhywioldeb i ysgolion a'r uned cyfeirio disgyblion, gan gynnwys creu a chyflwyno cwricwlwm addysg cydberthynas a rhywioldeb priodol.

Mae prosiectau mewn ysgolion yn cynnwys yr Heddlu Bach, sy'n cyflwyno plant i brofiadau cadarnhaol o blismona mewn partneriaeth â thîm Swyddogion Cymuned Ysgol yr Heddlu De Cymru, yn ogystal â gwaith helaeth ar droseddau cyllyll ledled y ddinas.

Yr hyn y mae angen ei wella

Mae rhai staff wedi awgrymu y dylid rhoi ystyriaeth bellach i gynllun cyfarfodydd wyneb yn wyneb/hybrid/rhithwir, yn enwedig mewn perthynas â chynadleddau achos amddiffyn plant a grwpiau craidd. Mae rhanddeiliaid allweddol wedi nodi'r angen am ddull eglur, a phwysigrwydd hynny. Mae adborth yn tynnu sylw at bwysigrwydd cyfarfod wyneb yn wyneb wrth ystyried materion cymhleth a sensitif.

Dywed aelodau'r Tîm Nyrsio Plant sy'n Derbyn Gofal nad ydynt yn cael gwybod am leoliadau mewn modd amserol, a bod hyn yn effeithio ar eu cydymffurfiaeth ag amserlenni statudol. Ni chaiff meddygon teulu eu gwahodd i gynadleddau achos amddiffyn plant ac ni ofynnir iddynt ddarparu adroddiadau ar eu cyfer fel mater o drefn. Ni chaiff cofnodion cynadleddau achos amddiffyn plant eu hanfon at feddygon teulu fel mater o drefn. Mae hyn yn golygu y gall gwybodaeth hanfodol gael ei cholli.

Mae trefniadau Tîm Dyletswydd Brys ar waith i ymateb i bryderon diogelu y tu allan i oriau gwaith arferol. Trefniant rhanbarthol yw hwn. Nodwyd profiadau amrywiol o ran hygyrchedd y Tîm Dyletswydd Brys. Nodwyd materion yn ymwneud â'r ffaith bod y tîm yn adrodd yn uniongyrchol i CareFirst. Dylai'r awdurdod lleol adolygu'r trefniadau sydd ar waith i gael gafael ar y Tîm Dyletswydd Brys, a'r modd y mae'r Tîm yn cofnodi gwybodaeth bwysig.

Dylai arweinwyr a phartneriaid gydweithio i sicrhau dealltwriaeth glir o'r trothwyon ar gyfer cyflwyno Ffurflenni Atgyfeirio Amlasiantaethol er mwyn sicrhau ymateb effeithlon a chymesur i reoli'r galw. Nododd data partneriaeth ar gyfer 2022/2023 fod 82% o'r cysylltiadau wedi cael eu cyfeirio at MASH a bod 18% wedi cael eu cyfeirio at wasanaethau cymorth cynnar. Mae uwch-reolwyr wedi nodi'r anghydbwysedd hwn yn flaenorol. Mae canllawiau ar atgyfeirio eisoes ar gael, ond er gwaethaf mewnbwn amlasiantaethol wrth eu datblygu, nid yw'r canllawiau'n cael eu rhoi ar waith yn ymarferol. Mae hyn yn golygu bod partneriaid allweddol fel staff ysgolion yn rhoi gwybod yn gyson i MASH am lawer o bryderon heb fanteisio ar gymorth gwasanaethau cymorth cynnar lle y gall hynny fod yn briodol.

Dylid rhoi gwybod i bartneriaid atgyfeirio am ganlyniad adroddiadau diogelu mewn modd amserol yn gyson. Bydd hyn yn helpu i hyrwyddo dealltwriaeth a rennir o benderfyniadau a rhesymeg.

Mae ysgolion a'r uned cyfeirio disgyblion yn derbyn hysbysiadau Ymgyrch Encompass yn brydlon. Weithiau, byddai gwybodaeth ychwanegol yn helpu i wella dealltwriaeth staff ysgolion. Mae hyn yn effeithio ar allu ysgolion i gefnogi plant yn briodol. O gofio bod rhai partneriaid wedi nodi y gall fod oedi wrth geisio cysylltu â staff gwasanaethau plant yn MASH am ragor o wybodaeth neu ddiweddariadau, gall hyn atal staff ysgolion rhag cefnogi plant a chymryd camau priodol. Mae'r broblem hon yn deillio'n rhannol o'r ffaith nad yw'r heddlu'n anfon hysbysiadau amddiffyn y cyhoedd llawn at ysgolion mwyach o ganlyniad i heriau yn ymwneud â chydymffurfio â'r GDPR. Byddai staff ysgolion yn cael budd o gael diweddariadau gan yr heddlu, er enghraifft ynghylch a wnaed arestiad yn dilyn yr hysbysiad amddiffyn y cyhoedd a gwybodaeth berthnasol arall a allai fod yn ddefnyddiol i gefnogi disgyblion. Nid yw partneriaid wedi cytuno ar broses i wella effeithiolrwydd Ymgyrch Encompass yng Nghaerdydd.

Mae'r bartneriaeth wrthi'n adolygu trefniadau MASH ac, fel rhan o'r gwaith hwn, dylid gwerthuso manteisionau cyd-leoli gweithwyr proffesiynol wyneb yn wyneb mewn un lleoliad. Bydd hyn yn sicrhau y gellir gwireddu manteisionau cydweithio, boed hynny'n rhithwir neu wyneb yn wyneb.

Asiantaeth Unigol – Cryfderau

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Mae ymrwymiad BIPCF i wella'n barhaus yn amlwg drwy ei gyfraniad at fusnes y bwrdd diogelu, gan gynnwys craffu ar adolygiadau ymarfer plant a dysgu ohonynt.

Mae Cynghorwyr Nyrsio Diogelu yn gweithio yn MASH bob dydd ac yn bresennol ym mhob trafodaeth a chyfarfod strategaeth yn ogystal â chyfarfodydd cynllunio diogelwch cam-drin domestig risg uchel. Maent hefyd yn ychwanegu rhybuddion ar gyfer achosion risg uchel at systemau rheoli cleifion y bwrdd iechyd. Ymchwilir i bob hysbysiad diogelu'r cyhoedd a gyflwynir mewn modd cyfannol a thrafodir pob un yn ystod y cyfarfod dyddiol. Mae Nyrsys Llesiant Emosiynol hefyd yn darparu cymorth Nyrs Ysgol i blant sy'n mynychu'r uned cyfeirio disgyblion, disgyblion pryderus sy'n mynychu'r ysgol a phlant sy'n derbyn addysg yn y cartref.

Wrth ddatblygu cynlluniau diogelwch, gall staff gofal iechyd herio mewn modd adeiladol lle y bo'n briodol. Dywedodd staff gofal iechyd y gwrandewir ar eu safbwyntiau a chânt eu parchu.

Ceir dealltwriaeth dda o'r llwybrau ar gyfer gwneud cais am archwiliad meddygol amddiffyn plant. Caiff y rhain eu cynnal mewn modd amserol a rhennir y canlyniadau ag asiantaethau partner. Roedd y sampl o adroddiadau yr edrychwyd arnynt yn glir ac yn gynhwysfawr.

Addysg

Mae ysgolion a'r uned cyfeirio disgyblion yn cael budd o'r cymorth eithriadol y maent yn ei gael gan amrywiaeth o dimau fel Seicolegwyr Addysgol, y tîm Iechyd a Llesiant Emosiynol a'r Gwasanaeth Cyflawniad Lleiafrifoedd Ethnig a Theithwyr. Mae hyn yn eu helpu i ddarparu cymorth buddiol i ddisgyblion agored i niwed.

Mae'r awdurdod lleol yn defnyddio dull ‘Tîm o amgylch yr Ysgol’ mewn ysgolion a chyfarfodydd ‘Tîm o amgylch y Clwstwr’ lle mae gweithwyr proffesiynol yn trafod sut y gallant ddarparu cymorth pwrpasol i ddisgyblion agored i niwed. Er enghraifft, cafodd ysgolion yn Nhrelái fudd o drafodaethau ar sut y gallai'r awdurdod lleol eu helpu i ddelio â phryderon cynyddol am aflonyddwch cymdeithasol yr ardal.

Mae ysgolion a'r uned cyfeirio disgyblion strategaethau cadarn i wella presenoldeb disgyblion. Maent yn gweithio'n dda gyda'r gwasanaeth lles addysg i gefnogi'r gwaith hwn. Mae enghreifftiau da o welliant sylweddol ym mhresenoldeb disgyblion agored i niwed dros y 12 mis diwethaf. Mae panel Dechrau Newydd yr awdurdod lleol yn effeithiol iawn wrth gefnogi'r disgyblion agored i niwed hyn.

Mae'r awdurdod lleol yn darparu amrywiaeth werthfawr o gymorth ac ymyriadau i ategu'r gwaith o gyflwyno'r cwricwlwm iechyd a lles mewn ysgolion ac yn yr uned

cyfeirio disgyblion. Mae'n ariannu chwe dosbarth lles i gefnogi anghenion unigol disgyblion agored i niwed. Yn dilyn cymorth, mae llawer o'r disgyblion hyn yn dychwelyd i addysg brif ffrwd yn llwyddiannus. Mae'r Tîm Addysgu Cymunedol, sef Tîm @Severn, y penodwyd wyth swyddog sgiliau a chymorth iddo yn ddiweddar, yn atgyfnerthu'r broses o ddatblygu cyfleoedd cwricwlwm wedi'u personoli sydd â ffocws clir ar iechyd a llesiant.

Er mwyn ymateb i'r angen cynyddol i gefnogi iechyd meddwl a llesiant emosiynol disgyblion ers y pandemig, mae'r awdurdod lleol wedi darparu cymorth wedi'i dargedu ar gyfer ysgolion a'r uned cyfeirio disgyblion. Er enghraifft, mae'r gwasanaeth seicoleg addysgol yn darparu cymorth, hyfforddiant a chanllawiau i ysgolion a'r uned cyfeirio disgyblion mewn perthynas ag Osgoi'r Ysgol ar sail Pryder. Mae Mewngymorth Ysgolion a Gwasanaethau Llesiant Emosiynol ac Iechyd Meddwl yn gweithio i feithrin sgiliau a hyder staff addysg, gan eu galluogi i gael gafael ar gymorth arbenigol ac ymyriadau uniongyrchol.

Mae'r awdurdod wrthi'n treialu un o fentrau Llywodraeth Cymru, sef tîm Ysgol Rithwir i Blant sy'n Derbyn Gofal, yn llwyddiannus. Wedi'i arwain gan bennaeth yr Ysgol Rithwir i Blant sy'n Derbyn Gofal, mae'r tîm yn darparu cymorth i blant sy'n derbyn gofal er mwyn sicrhau bod gan y disgyblion agored i niwed hyn lais a bod eu hanghenion yn cael eu diwallu.

Heddlu De Cymru

Mae'r heddlu yn cefnogi'r Bwrdd Diogelu Rhanbarthol drwy ddarparu arweinwyr dynodedig ar lefel strategol a lefel weithredol, gan gynnwys is-grwpiau. Ceir presenoldeb cyson mewn cyfarfodydd partneriaeth, ac mae'r heddlu yn cadeirio un o'r is-grwpiau (Grŵp Adolygu Ymarfer Achosion).

Gwasanaethau Plant

Wrth i'r model ymarfer a ddefnyddir yng Nghaerdydd ddatblygu, mae ymrwymiad hirdymor i ddefnyddio dulliau sy'n seiliedig ar gryfderau. Mae ymarferwyr yn defnyddio meddylfryd sy'n canolbwyntio ar ddatrysiadau yn gyson wrth weithio gyda theuluoedd er mwyn nodi datrysiadau. Mae hyn yn amlwg drwy'r defnydd rheolaidd o gynadleddau grŵp teulu a chyfarfodydd cynllunio diogelwch, sy'n hyrwyddo cyfraniad teuluoedd at benderfyniadau am eu bywydau. Mae adborth rhieni yn dangos hyn; "*Mae'r gweithwyr cymdeithasol wedi bod yn help mawr ac wedi gwneud popeth y maent wedi dweud y byddent yn ei wneud; rydym yn deall yr hyn y mae angen i ni ei wneud fel rhieni er mwyn rhoi'r teulu ar ben ffordd unwaith eto*."

Mae ymarfer sy'n seiliedig ar gryfderau ac ymarfer sy'n seiliedig ar ganlyniadau yn amlwg mewn cynadleddau achos amddiffyn plant. Mae cadeiryddion cynadleddau yn gofyn i asiantaethau sgorio'r risg, ac mae ymarferwyr yn defnyddio'r sgôr hon i'w helpu i benderfynu a ddylid cynnwys enwau plant ar y gofrestr amddiffyn plant. Mae

hyn hefyd yn helpu teuluoedd i ddeall safbwyntiau gweithwyr proffesiynol am y risgiau a'r hyn y mae angen ei wneud i wella diogelwch a rhoi sicrwydd yn ei gylch.

Mae'r cydberthnasau rhwng gwasanaethau plant a phartneriaid yn y trydydd sector yn gadarnhaol, ac mae arweinwyr gwasanaethau plant penodol wedi'u dynodi'n brif bwyntiau cyswllt iddynt. Mae hyn yn cael ei groesawu ac yn ategu cyfathrebu da.

Asiantaeth Unigol – Yr hyn y mae angen ei wella

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Er bod yr heddlu yn rhannu hysbysiadau amddiffyn y cyhoedd ag asiantaethau partner, ac yn eu lanlwytho i system TG BIPCF, nid yw nyrsys ysgolion yn cael hysbysiad i roi gwybod iddynt am hyn. Felly, efallai na fyddant yn ymwybodol o ddigwyddiadau domestig mewn cartrefi lle mae plant oed ysgol yn byw.

Lle na fydd unrhyw anghenion iechyd wedi'u nodi, ni fydd y nyrs ysgol yn mynychu grwpiau craidd na chynadleddau adolygu achos amddiffyn plant fel mater o drefn. Mae hyn yn golygu bod bylchau posibl mewn perthynas â rhannu gwybodaeth hanfodol. Pan na fydd y nyrs ysgol yn mynychu grwpiau craidd neu gynadleddau achos amddiffyn plant, ni fydd yn cael copi o'r cofnodion, ac unwaith eto, mae hyn yn golygu nad yw gwybodaeth bwysig yn cael ei rhannu.

Addysg

Nid oes unrhyw feysydd penodol i'w cofnodi yn yr adran hon.

Heddlu De Cymru

Caiff data amddiffyn plant eu casglu'n ddyddiol ar gyfer rheolwyr. Mae ffigurau ansoddol ar gael ac mae tueddiadau cyffredinol yn dangos bod niferoedd yn cynyddu. Caiff adroddiad misol hefyd ei lunio i'w ddadansoddi'n fwy strategol, ond nid yw'n glir sut y caiff hyn ei ddefnyddio i lywio perfformiad partneriaeth.

Gwasanaethau Plant

Nid oes unrhyw feysydd penodol i'w cofnodi yn yr adran hon**.**

Atal

Trefniadau Partneriaeth – Cryfderau

Cydnabyddir bod y pandemig wedi cael effaith sylweddol ar iechyd a llesiant emosiynol plant. Wrth i'r adferiad barhau, mae'r ffocws wedi dychwelyd at uchelgeisiau tymor hwy, y manylir arnynt yn Caerdydd 2030 (dogfen strategaeth deng mlynedd), ac mae'r bwrdd adfer a sefydlwyd yn wreiddiol wedi'i ddatblygu'n fwrdd Plant a Phobl Ifanc. Bwrdd traws-gyfarwyddiaeth yw hwn, sy'n cynnwys y cyfarwyddiaethau Addysg, Gwasanaethau Plant, a Cymunedau a Thai, a'i nod yw sicrhau Cymorth Cynnar a Chymorth i Deuluoedd effeithiol a hygyrch ledled y ddinas.

Mae parch mawr ymysg ymarferwyr at wasanaethau atal ac ymyrryd yn gynnar. Dywedodd ymarferwyr, er bod amrywiaeth dda o wasanaethau ataliol, bod rhestrau aros ar gyfer rhai gwasanaethau. Caiff rhestrau aros eu monitro a darperir cymorth 'mwy dwys' os bydd amgylchiadau'n newid, ond mae'n bwysig bod y rhain yn cael eu monitro'n agos er mwyn lleihau risgiau posibl y bydd amgylchiadau'r teulu yn gwaethygu.

Yr hyn y mae angen ei wella

Mae cymorth llai dwys yn faes y mae angen mynd i'r afael ag ef. Nodir bod adolygwyr ychwanegol wedi'u penodi, a fydd yn helpu i sicrhau y caiff cymorth ar gyfer teuluoedd ei gynnal lle y bo'n briodol, er enghraifft yn ystod y cyfnod dadgofrestru.

Er bod pwyslais amlwg iawn ar sicrhau ansawdd ac archwilio ymarfer mewn gwasanaethau plant, mae'r cyfraniad amlasiantaethol at archwilio ymarfer diogelu yn amrywio. Mae hyn yn golygu nad yw safbwyntiau amlasiantaethol yn cael eu hystyried yn gyson, Fodd bynnag, mae archwiliadau amlasiantaethol thematig rheolaidd wedi'u cynnal yn MASH.

Bydd newidiadau cymorth busnes sy'n cefnogi'r Bwrdd Diogelu Rhanbarthol hefyd yn helpu i olrhain a mynd ar drywydd camau gweithredu sy'n deillio o argymhellion adolygiadau ymarfer plant, y bu oedi mewn perthynas â rhai ohonynt yn flaenorol.

Asiantaeth Unigol – Cryfderau

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Sefydlwyd Tîm Atal Trais amlasiantaethol, wedi'i ariannu gan y Swyddfa Gartref, yn 2019. Mae Tîm Iechyd, sy'n cynnwys nyrs ac eiriolwr, wedi'i leoli yn yr Adran Achosion Brys, gan ddarparu cymorth ac atgyfeiriadau ar gyfer unrhyw ddioddefwr trais sydd wedi'i anafu. Mae gwerthusiad y Swyddfa Gartref wedi bod yn gadarnhaol.

Addysg

Mae ymyriadau cynnar yn amlwg pan fydd plant yn dechrau yn yr ysgol. Caiff cymorth i blant ei ystyried yn brydlon cyn gynted ag y caiff anghenion eu nodi, ac mae nifer o dimau cymorth ar gael fel y nodwyd eisoes yn yr adroddiad. Mae llawer o ysgolion a'r uned cyfeirio disgyblion wedi penodi swyddogion cyswllt â theuluoedd. Anogir disgyblion agored i niwed i chwarae rhan weithredol ym mywyd yr ysgol.

Mae staff ysgolion a staff yr uned cyfeirio disgyblion yn sicrhau bod gan ddisgyblion gynlluniau cymorth perthnasol ar waith a bod y rhain yn cael eu hadolygu'n rheolaidd er mwyn gwneud yn siŵr eu bod yn addas at y diben. Ceir cydberthnasau gwaith cadarnhaol ar y cyfan ag ymwelwyr iechyd a gweithwyr proffesiynol eraill i nodi anghenion disgyblion pan fyddant yn cyrraedd yr ysgol neu'r uned cyfeirio disgyblion am y tro cyntaf.

Heddlu De Cymru

Mae Comisiynydd yr Heddlu a Throseddu yn cefnogi'r ymyriadau niferus yn ymwneud â phlant a theuluoedd y mae trais a niwed yn effeithio arnynt. Mae rhai o'r mentrau hyn yn cynnwys darpariaeth mewn ysbytai a darpariaeth gymunedol ac maent yn enghreifftiau o arferion gorau mewn perthynas â dulliau amlasiantaethol o helpu teuluoedd agored i niwed.

Gwasanaethau Plant

Ceir dull cadarnhaol o atal angen a risg rhag gwaethygu, er enghraifft mewn perthynas â chodi ymwybyddiaeth o'r risgiau sy'n gysylltiedig â chamfanteisio a chynnwys y gymuned yn ehangach er mwyn lleihau risgiau. Cafodd hyn ei ategu gan sefydliadau partner, a ddywedodd fod dull cydweithredol wedi'i arwain gan wasanaethau plant, gyda phwyslais ar gydweithio ar draws gwasanaethau perthnasol. Mae gwasanaethau cymorth cynnar yn cynnig amrywiaeth o ymyriadau a rhaglenni rhianta, y mae ymarferwyr yn eu gwerthfawrogi'n fawr.

Mae'r rhain yn enghreifftiau o'r cyfraniad cadarnhaol y mae'r gwasanaethau hyn yn ei wneud at ofal a chymorth. Er enghraifft, mae'r Ganolfan Atgyfeirio Pobl Ifanc yn cynnig amrywiaeth o therapïau a chyfleoedd seibiant. Mae Timau Cymorth i Deuluoedd yn cynnig ymyriadau i deuluoedd y mae angen help arnynt o dan gynlluniau gofal a chymorth a chynlluniau amddiffyn gofal a chymorth. Mae cymorth gan Thinksafe (gwasanaeth sy'n cynnig ymyriadau i blant sy'n wynebu risg y gallai rhywun gamfanteisio arnynt), a Turnaround yn helpu i leihau'r risg o gamfanteisio troseddol. Mae enghreifftiau cadarnhaol o weithwyr cymdeithasol yn defnyddio cymorth gan Dîm Enfys (Seicolegydd Clinigol a gweithiwr iechyd meddwl), er enghraifft o ran sut i symud ymlaen wrth drafod â pherson ifanc y rheswm pam y mae mewn gofal.

Gall swyddi'r adolygwyr Cynlluniau Gofal a Chymorth a gyflwynwyd yn ddiweddar, er na allant adolygu pob teulu sy'n destun cynllun gofal a chymorth, adolygu cyfran o'r cynlluniau yn annibynnol, gan gynnwys cymorth llai dwys na'r Gofrestr Amddiffyn Plant a phlant sy'n derbyn gofal.

Asiantaeth Unigol – Yr hyn y mae angen ei wella

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Nid oes cynllun parhad busnes diogelu ar waith. Mae hyn yn peri risg na fydd y bwrdd iechyd yn cyflawni ei gyfrifoldebau diogelu mewn modd amserol os bydd tarfu ar fusnes arferol.

Mae ansawdd y cynlluniau gweithredu sy'n deillio o adolygiadau ymarfer plant yn amrywio. Nid yw'n glir sut y caiff y cynlluniau eu monitro, ac nid yw rhai camau gweithredu yn cael eu cwblhau mewn modd amserol.

Addysg

Nid yw archwiliadau diogelu ysgolion yn nodi'r disgyblion hynny sydd wedi cael eu gwahardd neu sydd â chynllun cymorth bugeiliol ar waith yn llawn ar hyn o bryd.

Nododd archwiliad yr Hyb Diogelu Amlasiantaethol a gynhaliwyd yn 2022 fod gweithwyr addysg proffesiynol yn atgyfeirio achosion heb ystyried llwybrau atgyfeirio amgen drwy gymorth cynnar neu'r Porth ar gyfer asesiadau gofal a chymorth yn llawn. O ganlyniad, mae'r gwasanaethau plant wedi arwain y gwaith o ddatblygu canllawiau atgyfeirio amlasiantaethol a'u rhoi ar waith. Fodd bynnag, nid yw'r canllawiau hyn bob amser yn cael eu deall na'u hymgorffori'r llawn mewn ymarfer ysgolion.

Heddlu De Cymru

Nid oes unrhyw feysydd penodol i'w cofnodi yn yr adran hon.

Gwasanaethau Plant

Mae oedi cyn cael gwasanaethau yn golygu na all pawb gael budd o'r gwasanaethau y gall fod eu hangen arnynt ar yr adeg gywir. Dylai'r awdurdod lleol barhau i fonitro'n fanwl ac adolygu mesurau ar gyfer mynd i'r afael â rhestrau aros am gymorth cynnar, er mwyn sicrhau mynediad amserol at wasanaethau i leihau'r risgiau y bydd amgylchiadau teuluoedd yn gwaethygu.

Yn gyffredinol, mae'r cofnodion yn dangos ymateb diogelu amserol wedi'i arwain gan fewnbwn amlasiantaethol. Fodd bynnag, mewn rhai achosion, gellid bod wedi

dangos ystyriaeth o risgiau diogelu ehangach yn well. Caiff cofnodion eu gwella drwy ddangos bod ymarferwyr wedi ystyried yr holl risgiau ehangach posibl sy'n gysylltiedig â diogelwch a llesiant plant.

Mae'r graddau y caiff enwau plant eu hailgofrestru ar y gofrestr amddiffyn plant yn faes y mae angen mynd i'r afael ag ef. Mae'r awdurdod lleol eisoes wedi gwneud gwaith i ddeall y maes hwn yn well, ac mae archwiliadau wedi'u cwblhau er mwyn helpu i nodi camau unioni. Mae panel newydd wedi'i ddatblygu hefyd sy'n gyfrifol am sicrhau ansawdd penderfyniadau dadgofrestru ac ailgofrestriadau.

Mae rhai plant wedi'u henwi ar y gofrestr ers cyfnodau hir iawn o amser. Dylai rheolwyr fodloni eu hunain bod sbardunau priodol ar waith i adolygu ac uwchyfeirio achosion lle mae hyn yn brofiad bywyd i blant.

Mae gan gadeiryddion cynadleddau rôl allweddol i'w chwarae o ran sicrhau bod y polisi uwchgyfeirio newydd yn cael ei ddilyn er mwyn gwella safonau ymarfer. Maent bellach yn defnyddio rhestr wirio i nodi heriau a chefnogi gwelliannau amlasiantaethol wrth wneud penderfyniadau ar sail tystiolaeth.

Mae rhai penderfyniadau diogelu neu newidiadau pwysig i'r cynllun amddiffyn plant yn cael eu gwneud heb ailasesiad neu benderfyniad amlasiantaethol. Mae arweinwyr wedi datblygu canllawiau ymarfer ar oruchwyliaeth rheolwyr yn ddiweddar. Mae angen i'r canllawiau hyn gael eu hymgorffori yn ymarferol, er mwyn sicrhau bod rheolwyr a phartneriaid yn goruchwylio penderfyniadau pwysig yn ddigonol.

Y camau nesaf

Ar ran y bartneriaeth, dylai'r awdurdod lleol baratoi datganiad ysgrifenedig o gamau gweithredu arfaethedig yn ymateb i'r canfyddiadau a amlinellir yn yr adroddiad hwn. Dylai hwn fod yn ymateb amlasiantaethol sy'n cynnwys Bwrdd Iechyd Prifysgol Caerdydd a'r Fro a Heddlu De Cymru. Dylai'r ymateb nodi'r camau gweithredu ar gyfer y bartneriaeth a, lle y bo'n briodol, asiantaethau unigol. Dylai pennaeth y gwasanaeth ar gyfer gwasanaethau plant anfon y datganiad gweithredu ysgrifenedig i CIWLocalAuthority@gov.wales erbyn 17 Mehefin 2024. Bydd y datganiad hwn yn llywio llinellau ymholi yn ystod gweithgarwch cyd-asiantaethol neu asiantaeth unigol gan yr arolygiaethau yn y dyfodol.

Methodoleg

Gwaith maes

Casglwyd y rhan fwyaf o'r dystiolaeth arolygu drwy adolygu profiadau pobl drwy edrych ar sampl o gofnodion asiantaethau ac olrhain trefniadau gofal a chymorth plant. Gwnaethom edrych ar sampl o 20 o ffeiliau, gan olrhain chwech ohonynt.

Mae'r broses o olrhain cofnod plentyn yn cynnwys sgwrsio â'r plentyn lle y bo'n briodol, ei deulu neu ei ofalwyr, ei weithiwr allweddol, rheolwr y gweithiwr allweddol, a gweithwyr proffesiynol cysylltiedig eraill.

Gwnaethom gynnal grwpiau ffocws gyda staff a chanolbwyntiodd dau grŵp o weithwyr proffesiynol ar y trefniadau gweithio a'r canlyniadau ar gyfer dwy ffeil a gafodd eu holrhain.

Gwnaethom ymweld â sampl bach o ysgolion cynradd ac ysgolion uwchradd, gan gynnal cyfarfodydd â'r pennaeth, yr arweinydd diogelu dynodedig a grwpiau o ddisgyblion.

Gwnaethom gyfarfod â chynrychiolwyr o amrywiaeth o ysgolion a'r uned cyfeirio disgyblion, gan gynnwys penaethiaid, personau diogelu dynodedig a llywodraethwyr.

Gwnaethom gyfweld ag amrywiaeth o gyflogeion ar draws asiantaethau gwahanol.

Gwnaethom gyfweld ag amrywiaeth o sefydliadau partner, yn cynrychioli'r sector statudol a'r trydydd sector.

Gwnaethom edrych ar ddogfennaeth ategol a anfonwyd at yr arolygiaethau at ddiben yr arolygiad.

Gwnaethom anfon arolygon at staff gwasanaethau plant a gofal iechyd, sefydliadau yn y trydydd sector, ysgolion a phlant ac aelodau o'u teulu.

Gwnaethom arsylwi ar gynhadledd amddiffyn plant, cyfarfod strategaeth adolygu camfanteisio ar blant a chyfarfod strategaeth MASH fel rhan o'n gweithgarwch arolygu diweddar.

Cydnabyddiaethau

Hoffai'r arolygiaethau ddiolch i'r bobl, y staff a'r partneriaid a roddodd o'u hamser i gyfrannu at yr arolygiad hwn.

Report Title:	*Patient Safety Notice 066 (Safer temporary identification criteria for unknown patients)*			Agenda Item no.	*3.2*
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	16th July 2024
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Executive Nurse Director				
Report Author (Title):	Interim Head of Safety, Quality and Organisational Learning				

Main Report
Background and current situation:

In February 2023, NHS Executive issued Patient Safety Notice 066, highlighting the risk of harm when unidentified patients arriving together at Emergency Units, such as following an accident or mass casualty situation. The notice required the Health Board to develop a plan for a system for safer identification of unknown patients, to include a non-sequential temporary ID number, estimated DOB/age range, and dummy name based on the edited phonetic alphabet.

The issues identified in the notice had already been raised by the Emergency Unit in Cardiff and Vale and a working group formed to undertake the necessary work. The group involved colleagues from EU, digital, laboratories, blood transfusion, medical records, and patient safety.

An update to EU Clinical Workstation has been developed and tested which will allow generation of these safer temporary identifiers when an unknown patient is admitted to the Emergency Unit.

Examples of the details generated for two unknown patients before and after the update are given below, demonstrating the reduced risk of misidentification:

	Patient A	**Patient B**
	Current system	
ID Number	1025678	1025679
Name	Unknown MALE	Unknown MALE
Date of Birth	01/01/1900	01/01/1900
	Updated system	
ID Number	E567891	E234872
Name	Alpha MERCURY	Quebec UMPIRE
Date of Birth	01/01/1980	01/01/1950

A temporary date of birth is generated from the patient's estimated age at the time of admission. For patients appearing to be under 1 year, this is estimated to the closest month. For patients appearing to be older than 1 year, this is estimated to the closest year.

When a patient is later identified, the temporary E number will be merged with the patient's existing record at the earliest safe opportunity.

Guidance for staff has been developed to supplement the existing Patient Identification Procedure and this will be included within the procedure at the next update.

As this change crosses Clinical Board boundaries - primarily Medicine and CD&T, it is brought to QSE for consideration and approval.

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

NHS Executive issued a patient safety notice highlighting the risk of harm when more than one unidentified patients arrive at an emergency department together.

The patient identification policy has been amended to support a revised process

A working group was formed to develop the necessary improvements to address, membership included ED, digital, laboratories, blood transfusion, patient safety and medical records staff

Updates to EU workstation have been undertaken to allow generation of temporary non-sequential patient identification numbers

Patients will be given an estimated temporary date of birth, for patients under the age of 1 this will be estimated to the closest month

Patients will be given a dummy name based on the phonetic alphabet.

A of desk top exercise was undertaken to test a number of scenarios

Recommendation:

The Committee is requested to:

APPROVE the go-live of the updated process for identification of unknown patients, in line with the requirements of Patient Safety Notice 066.

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

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

Five Ways of Working (Sustainable Development Principles) considered
*Please place an "**X**" in the below boxes as relevant*

Prevention		Long term		Integration		Collaboration		Involvement	

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

Risk: Yes/~~No~~

This change is designed to reduce the known risk of misidentification where two or more unknown patients are being cared for within the emergency department

Safety: Yes/~~No~~

This change is expected to improve safety for patients who cannot be immediately identified on presentation to the emergency unit. Through the use of safer temporary identifiers, the risk of treatment, medication and diagnostic errors is reduced.

Financial: ~~Yes~~/No

The work to develop and implement this change has been undertaken within existing departmental resources. There is a potential positive financial impact through reduction of redress or claims related costs associated with patient misidentification incidents, although this is impossible to quantify.

Workforce: ~~Yes~~/No

None

Legal: ~~Yes~~/No	
None	
Reputational: ~~Yes~~/No	
None	
Socio Economic: ~~Yes~~/No	
None	
Equality and Health: ~~Yes~~/No	
N/A	
Decarbonisation: ~~Yes~~/No	
N/A	
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Chilcott Rachel
09/07/2024 13:02:37

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 30th January 2024 at 8.30am
Via Microsoft Teams

Present:		**Title**
Abigail Holmes	AH	Director of Midwifery & Neonatal Nursing, C&W Clinical Board
Catherine Wood	CW	Director of Operations, C&W Clinical Board
Alison Lewis	AL	Patient Safety Facilitator
Alison Davies	AD	Interim Lead Nurse, CYPFHS Directorate
Anthony Lewis	AL	Clinical Board Pharmacist
Ryan Paxford	RP	Senior Fire Safety Advisor
Suzanne Davies	SD	Senior Nurse, CHFW Directorate
Rachael Sykes	RS	Assistant Head of Health & Safety
Martin Edwards	ME	Asst Clinical Director, CHFW Directorate
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Laura McLaughlin	LM	Risk Manager, O&G Directorate
Tina Freeman	TF	Senior Nurse, CHFW Directorate
Siwan Jones	SJ	Clinical Nurse Specialist, Infection, Prevention & Control
Rim Al-Samsam	RAS	Clinical Director, CHFW Directorate
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer
Jane Jones	JJ	Clinical Director, CYPFHS Directorate
Hannah McLoughlin	HM	Clinical Governance & Risk Lead Midwife
Samuel Barrett	SB	General Manager, CHFW Directorate
Becci Ingram	BI	General Manager, CYPFHS Directorate
In Attendance		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Apologies:		
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board
Sandeep Hemmadi	SH	Clinical Board Director, C&W Clinical Board

Item No	Agenda Item	Action
CWQSE/ 2024/001	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2024/002	**Apologies for Absence** Noted above **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2024/003	**Minutes of the previous Q&S Meeting held on 19th December 2023** The minutes of the meeting were agreed to be an accurate record. **The CWQSE resolved:** a) The minutes were noted and agreed	

CWQSE/ 2024/004	**1.4 To note and update the action log of the meeting of 19th December 2023** The action log was noted and updates provided. **Risk Assessment – Fragility of Consultant Workforce** It was noted that interviews are taking place for x1 consultant, however there is still a gap of 1.5wte. It was agreed that the risk assessment would be completed and shared at the next meeting. It was noted that there is still a risk within the Nephrology Service that will need to be considered as a high-risk area. **The CWQSE resolved:** a) Action log to be updated and final version circulated for noting of updates. b) Risk Assessment for completion and sharing at the next meeting.	**KH** **RAS/SB**
HEALTH & SAFETY		
CWQSE/ 2024/005	**HSE Inspection Visit Update** Visit held on 15th November 2023. Report has been received and a notification of contravention has been received, with x5 breaches of law noted. Report has been shared and a number of actions have been identified, meetings are being arranged to review how the actions can be taken forward and completed. Response to the report to be submitted by 29th February 2024. It was noted that there were no surprises within the areas that were identified for action. The notification of contravention relates to where the law has been breached and requires a form of action to respond. Action plans will be developed and will be submitted. Programme of audit is being developed across the UHB which will monitor the progress of actions associated with the H&S Management System and ensuring they are embedded in practice going forward. Some audits have been completed for manual handing and V&A. Training compliance was also an area that was highlighted as part of the HSE Visit and it was noted that detailed plans for improvement of training compliance will require inclusion as part of the clinical board exception reports submitted to the Operational H&S Group, rather than just assurance that plans are in place. Thanks, were expressed for all the hard work to all for the thorough preparation prior to the visit and impacted positively on the feedback received. Maternity will require support to find a solution to the issue identified with regards to training compliance. Manual Handling and VA are the specific areas to target. The H&S team plan to attend forthcoming audit days to target increased numbers of staff. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/005	**Feedback from last UHB Operational H&S Meeting** • H&S Dashboard – January 2024 • https://nhswales365.sharepoint.com/:p:/r/sites/CAV_Health%20and%20Safety/Shared%20Documents/IMS%2016/H%26S%20Dashboards/2024-01%20H%26S%20Dashboard%20-%20January-	

	%20Completed.pptx?d=wa93f2a09b7ec4bcf8477f5fb07225333&csf=1&web=1&e=n1LChl The dashboard provides an update on the work being taken forward across Health and Safety, along with policies and procedures that are out for consultation. There is data included for all Clinical Boards around training compliance and also H&S training courses. Tunnel Safety Group has been resurrected and plan in place to meet bi-monthly. Access is being reviewed and the tunnels will be locked down, and only essential users will be provided access. Plan to clear the tunnels in the coming weeks and communications will be shared with the Clinical Boards. There will be an area where equipment will be stored for review.	
CWQSE/ 2024/006	**To note the C&W Clinical Board Exception Report – November 2023** Noted for information. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/007	**To note the latest COSSH Report** Noted for information **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/008	**Fire Safety Update** Report was noted for information. X1 deliberate fire reported at Hafan y Coed on 11th January – patient smoking in the room. No intervention required from the fire service for this incident. 78 reported fire signals reported, which is a decrease in previously reported signals. 10% are attributed to cooking across the Health Board. Risk assessment findings note that microwaves and toasters are in place in areas that are no suitable for this equipment. If found, these will need to be removed and all were asked to ensure that these Fire risk assessments are all up to date. 71% Fire Safety Training compliance was noted for C&W Clinical Board. Fire Safety Drop in Sessions planned and a poster has been circulated for information, these sessions will not need to be booked. Fire evacuation drills will be undertaken within the coming months as part of tabletop exercises, further update will be provided as these are progressed. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2024/009	Feedback from H&S Staff Side **The CWQSE resolved:** a) Update was noted.	
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		

CWQSE/ 2024/010	**EIDO Update** Deferred. **The CWQSE resolved:** b) Update was deferred. Further date to be arranged.	**KH**
CWQSE/ 2024/011	**Health & Care Standards Directorate QSE Exception Reporting** The detailed report was shared for information and an update was provided on the key highlights from the report. **CYPFHS Directorate Report** • Generic HV remains on the risk register with a reduced staff plan. National agreement for a joint model of working for Generic and Flying Start HV and work is ongoing regarding this. • Boundary risks, no funding is being received and 6months notice will be provided to AB and Cwm Taf Health Boards. Consultation has taken place with the senior leads within AB and Cwm Taf HB and a letter has now been drafted to serve notice. It was agreed that this would be discussed further outside of the meeting. • Notification received regarding plans for over 200 asylum seekers to be rehomed in the MOD in St Athan for a period of 12-18months. Meeting taking place with MOD to look at plans for the required support. Further update will be provided as this progresses. • Children's Medicines Initiative for teaching paediatric patients how to swallow capsules and tablets in a safe manner. This is part of an initiative to aim to reduce prescribing of liquid medications by 20% over the next year. • Regulation 28 completed regarding sudden infant death for co-sleeping. Improvements are being made with regards to documentation and auditing which will continue to be monitored. • Joint inspection JICPA held 15th-19th January 2024. Report is awaited, however immediate actions have been received and a response is being completed. One area relates to the completion of health assessments, and an improvement plan in place to look to address this. • Healthy Child Wales 2 Programme action plan being worked through. 2year implementation period, and there is a need to review the impact on the population and establishment needs. • All records for legal requests are not to be redacted. SBAR has been completed and circulated to staff informing them of the change in current practice for legal requests. **Timely Access** • Significant increase in referrals for Part 1a compliance. The service is still not achieving compliance for children receiving intervention within 28days. Currently there are 231 children waiting with a longest wait of 29 weeks. Detailed deep dive has been undertaken to identify options for way forward for Part1b target which has been shared with the Clinical Board. • ND performance – over 3000 children on the waiting list with a waiting time of up to 3years. Triage wait has been significantly reduced and new triage process is working well. • Health Assessment for Children Looked After. 355 children waiting, only 250 are placed in Cardiff & Vale. Significant improvements have been made. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Further discussion required regarding serving notice for Boundary issues	**BI/CW**

CWQSE/ 2024/012	**CHFW Directorate Report** • Vaccination pop up clinic held on 19th January 2024 for Flu, COVID and MMR • Draft report received from HIW following the visit. Positive feedback has been received on a number of areas. An action plan has been developed on the recommended actions and all actions have been completed. The action plan is available on AMAT • X3 open NRI's and x1 Patient Safety Learning Review being undertaken. • PICU and NICU continue to be the main areas of risk for the Directorate. • HSE Visit – no immediate concerns were highlighted, and further work is ongoing to take forward the identified actions from the visit. • No immediate H&S issues to note. X1 RIDDOR reported in January 2024 • Training compliance reman areas of concern. Practice educators are working through action plans to increase compliance by the end of March 2024. • H&S risks – pull down beds on the wards. Maintenance contract has now been agreed and will commence on 18th March. • MHRA Patient Safety Alert for bed compliance. Avant guard beds are currently being used across the CHFW which does not feature on the current alert. Meetings arranged with Medstrom to look at to progress for required placement. It was agreed that maternity services would be linked in to ensure that there are robust processes in place. • Tissue Viability – new documentation now live on PICU. X2 pressure damage incidents reported (x1 category 1 and x1 category 2). • Overall tendable audits for December noted at 92.4% • Increased incidence of C Diff on Rainbow Ward with x4 cases reported. The cases were discussed and it was noted that no further meetings are required. • Use of FFP3 masks when caring for patients with measles gas been cascaded to staff. • 100% compliance for hand hygiene and bare below the elbow. • Newly qualified study day completed and a further date arranged for this week. The day was very well received. • CF Study is ongoing and continuous infusion for diabetic patients' study is ongoing. • HIW Assurance audits being built into the tendable schedule to demonstrate compliance as part of the HIW action plan. • Concerns posters are being displayed across the CHFW • No specific themes identified across the informal and formal concerns received in month. X3 formal compliments received. • Recruitment is ongoing across a number of areas within the Directorate. Update provided on the current vacancies being progressed. • Meet the managers day being held on ?? for newly qualified students. **Timely Access** • Aiming to have no patients waiting at the end of March 2024 for inpatient appointment for Paediatric Surgery, and this is on target. • Work ongoing to achieve the target of no children waiting 52 weeks for outpatient appointment at the end of March 2024 for General Paediatrics. • SOS and PIFU continues in General Paediatrics • Cardiology – 34weeks longest wait with an appointment, the next wait is 20 weeks. Target is 12 weeks which is hoped will be achieved by the end of March 2024 • Endoscopy – 88 children on the waiting list with 81 over the 8 week target.	

	Validation work is being completed. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2024/013	**O&G Directorate Report** • Maternal obesity dietician providing support for all women with a BMI of over 40, which includes 1:1 sessions in the antenatal period and up to one year follow up postnatally for nutrition support. • New food wise app is in place for all women. • All smokers are offered serial growth scans in line with national guidance • Perinatal Mental Health, pilot role commenced for any women who do not meet criteria for perinatal mental health services. Ongoing theme in referrals for perinatal mental health relating to traumatization from previous experiences of birth during COVID. • BFI reaccreditation audit is ongoing with a view to sustaining the BFI status in 2024, and infant feeding leads will be supported by 15hrs band 6 midwifery cover which is due to commence in February 2024 • Funding for psychologist for one session per week for Women's Wellbeing Clinic • Induction of Labour (IOL) information has been translated into the top 17 languages for Cardiff & Vale. • Teardrop suite will be relocated to Suite 3 on Delivery Suite • Themes and trends from PMRF has been presented and a thematic analysis of 2022/2023 has been carried out. Themes include reduced fetal movement and delays in attending OAU. • Long acting reversible contraception training is progressing and a plan is in place to offer bridging contraception methods with signposting to consultant midwives. Scope and review protocol has been published which aims to review the literature for postnatal contraception provision to help shape services within maternity. • Bump, Baby and Beyond book has been reviewed and promoted via social media. • New incidents reported for December 165, and closed incidents 207. • X7 ongoing NRI's within Maternity Services. All cases have received rapid reviews and no immediate care concerns noted, the investigations are going forward as part of the MBRRACE reporting system. X2 NRI's within Gynaecology. • Update provided on the current risks detailed on the Directorate risk register and changes noted. • No pressure damage reported and x1 falls reported. No harm caused. • X4 incidents reported for Medicines management. No harm caused for any of the incidents reported. • No pressure damage incidents reported in month, x1 falls incident reported due to wet floor. No harm caused. • 100% compliance with hand hygiene, 100% with Bare Below the Elbow. Full detail included within the report. Clinical environment audit for antenatal clinic was noted as 91%. • X4 incidents reported for medicines management. All have been reviewed and no harm caused. • Safeguarding protocols for maternity amalgamated into one master Safeguarding Maternity Protocol with the exception of domestic abuse • Child Abduction protocol has been revised and further comments are awaited. It was noted that this will need to be distributed corporate wide for consideration and ratification.	

	• Works and estates update provided and maintenance requests have been raised for all. • Fetal Growth assessment guidelines have been updated • Communicating effectively – exploring information and engaging women who don't have English as a first language. • Euroking – successful bid to transfer to the Badgernet System with a roll out programme being confirmed. • Gynae referrals and IOL new system pilot shas been implemented into Microsoft 365. This is auditable and staff feedback has been positive. Rollout will commence imminently. • Electronic digital screen above Omniview screen has been developed to monitor compliance and for equipment checking. This has shown significant improvements in the checking compliance since the launch. • Themes and trends for concerns include ward environment (first floor) lack of information, staffing and communication, endometriosis, waiting lists, ectopic pregnancy. • Recruitment is ongoing across a number of areas within the Directorate. Update provided on the current vacancies being progressed. **Timely Access (taken directly from Directorate Report)** 156 weeks Inpatients/Day cases Qtr 4 (up until 31/3/24) Total 21 Without TCI's 16 104 weeks Inpatients/Day cases Qtr 4 (up until 31/3/24) Total 349 Without TCI's 335 52 weeks Outpatients Qtr 4 (up until 31/3/24) Total 464 Without TCI's 127 December confirmed breach position = 15 c & v patients January predicted breach position = 7 c & v patients **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2024/014	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Request was made for the latest versions of the Directorate Risk registers to be submitted in order for the Clinical Board Risk register to be updated as required in readiness for the next submission. **The CWQSE resolved:** a) Directorate Risk Registers to be submitted to the Clinical Board for review	**ALL**
SAFE CARE		
CWQSE/ 2024/015	**Patient Safety Update** Patient Safety Learning Review training will take place monthly through 2024. Flyer circulated for information on how to book.	

	Incidents being moved from New Incidents appropriately. Request for regular review to be undertaken to ensure that these are being actioned appropriately. Discussion ensued with regards and it was noted that assurance was provided that the incidents are being reviewed on a regular basis for any immediate make safe actions, however they are not being moved across to ensure that they are not missed for action by the designated incident manager. Within ACH, thematic reviews will be undertaken of the backlog in order to look at any required actions. A plan will be developed for the new incidents going forward. It was agreed that AL would provide support outside of the meeting. With regards to the ATAIN cases, if there is evidence available to be shared these can then be reviewed and closed accordingly. **The CWQSE resolved:** a) Update was noted. b) Support to be provided by Patient Safety Facilitator for thematic review of ACH (NICU) backlog	**AL**
CWQSE/ 2024/016	**NRI/PSLR/Closure Forms for discussion** **SBAR, PSLR and Improvement Plan Patient AR (Datix Ref 33455)** Case involved Hypoxic ischaemic encephalopathy (HIE) following uterine rupture. Background to the case was shared. Full detail of was included within the supporting SBAR and PSLR shared as part of the meeting papers. As part of the investigation there were 3 direct issues that were identified: Issue 1: Use of interpreters and listening to family concerns Issue 2: No medical review when attended with scar pain Issue 3: Increase in pain not recognised as uterine scar rupture Conclusion on terms of reference and specific review questions *This review has identified several areas where care did not meet the standard expected in national and local guidance. There was not adequate use of the interpreter services required by AR and her family. This led to AR not being enabled to explain her symptoms in a way necessary to make a diagnosis of scar rupture. AR's pain and distress were not managed in a compassionate way and her requests for Caesarean not accepted. Had there been appropriate interpreter services used then it is likely that these wishes would have been facilitated in a timelier manner and the nature of her scar pain elucidated enabling earlier birth of Baby IS. This may have prevented the complete scar dehiscence and hypoxic insult he sustained.* The recommendations identified through the investigation were noted as: 1. Urgent review of provision of interpretation services including notes audit of women on postnatal ward to assess where this provision is deficient, staff survey to understand barriers/enablers in different clinical areas and liaison with Health Board Access to Health Service Department 2. Update SOP on interpreting services to specifically outline steps if language line/Big word interpreter not available incorporating the woman's choice over in-person or virtual services. 3. Audit of adverse perinatal outcomes (stillbirth/early NND/HIE) in line with Each Baby Counts criteria by ethnicity and non-English first language 4. Staff education programme to incorporate diversity training	

	5. Evaluation of WiFi/phone signal in Maternity unit to identify areas where Language line would not be available 6. Case to be used for learning in the department at Clinical Governance Day and shared as a learning vignette. An improvement plan has been developed and actions are progressing for completion. Discussion ensued regarding the improvement plan, and it was agreed that dates of the completed actions would be added to the improvement plan to ensure that this is robust for closure. It was agreed that the report could be progressed. **The CWQSE resolved:** a) Update was noted. b) Completion dates to be added to the improvement plan	**HM**
CWQSE/ 2024/017	**NRI/PSLR/Closure Forms for noting/exception reporting** All cases noted below have been discussed as part of the NRI/RCA Governance Sub Group held on 09th January 2024. There were no specific exceptions to note for this meeting. The minutes will be shared for information following ratification. • SBAR, PSLR and Improvement Plan Patient TS (Datix IN29887) • SBAR, PSLR and Improvement Plan Patient OM (Datix IN42418) • SBAR, PSLR and Improvement Plan Patient CM (Datix 337026) • SBAR, PSLR and Improvement Plan Patient EC (Datix 28871) **The CWQSE resolved:** a) Update was noted	
CWQSE/ 2024/018	**3.5. Infection Prevention Control Update Report** The report was shared for information. X1 Klebsiella and x3 C Diff reported in month. Out of x6 targets, x4 are currently over the expected target for 2023/2024. With regards to the C Diff cases – there have been x4 cases identified (x3 toxin positive and x1 toxin negative). X3 of the patients are not linked through typing and x1 patient is unknown. Positive meeting held with no major issues identified, and some actions have been identified for progressed. No further meeting is required. Reminder with regards to HPV cleaning is required on discharge or transfer of patients who are C Diff or confirmed CRO. Any concerns to be highlighted to IP&C. Ongoing monthly audits are ongoing across NICU and sustaining excellent audit results since the end of the outbreak. X5 outstanding RCA investigations for the Clinical Board and work continues to progress these to completion. Audits ongoing. Joint IP&C audits continuing with Estates & Housekeeping. UHW wide audit undertaken across every ward in UHW. As a Clinical Board the score was 95%. Poor MRSA and CRO audit compliance noted. Teaching is being provided within specifically within Maternity.	

	Recent Public Health briefing received regarding increase in pertussis. Currently there are 135 notified Pertussis cases. No specific causes have been attributed to the increase of cases seen. Any suspected or confirmed cases need to be isolated in single rooms with respiratory precautions in place and liaise with IP&C for patient tracing or staff tracing that will need to be completed. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/019	**Safeguarding** **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/020	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • **National Patient Safety Alert – NatPSA_2023_013 – Valproate** • Safety Memo – Tramadol & Warfarin • UKHSA Health Protection Briefing Note 2024/001: Recall of infant formula product due to possible contamination with Cronobacter sakazakii • PSA017 - Identified safety risks with the Euroking maternity information system • Safety Memo – Sando K & Phosphate Sandoz • WHC/2023/043 – Vaccination of Health Staff to protect against Measles The alerts were noted and have been disseminated widely across the Clinical Board. Compliance forms to be completed as required and returned to the Clinical Board asap. **The CWQSE resolved:** a) Update noted. b) Compliance forms to be completed for submission.	**ALL**
CWQSE/ 2024/021	**NICE Guidance – Update on Progress** Report shared for information. **The CWQSE resolved:** a) Update noted. b) DJ to be invited to a future meeting to discuss best way forward to ensure completion and compliance	
CWQSE/ 2024/022	**Medicines Safety Executive Update** Key updates will be shared regularly from the Medicines Safety Executive Update. **Sodium Valproate Pregnancy Prevention Programme (Report & Action Plan)** Report shared for information. It was noted that this is not the current position and there is a good system in place in conjunction with Adult Neurology. New guidance will require an increase in resource. New NPSA alert has been shared for information. Actions required by the end of January have been completed and further work is progressing. Action plan will need to be developed in relation to the new recommendations and it was agreed that a working group be arranged to take this forward. It was noted that	

	there is no secondary level nursing support in place to ensure that this is closely managed. Second consultant review can be implemented; however, this would require further oversight and tracking going forward. Discussion ensued and it was noted that this is initially prescribed by secondary care, and ongoing by Primary Care. It was agreed that further detailed discussions will need to take place outside of the meeting **Medicines Datix Quarterly Report** Report shared for information. **WCP DALs in Draft** Shared for information. Issues highlighted with regards to the sign off process for the DAL's system. It was noted that this needs to be signed off in order for the GP to receive the information for the patients. Request made to highlight the importance of sign of the DAL's. **The CWQSE resolved:** a) Update noted b) Working group to be arranged outside of the meeting	**AL**
TIMELY CARE		
CWQSE/ 2024/023	**Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:** c) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2024/024	**Mat/Neo Programme Update 16.01.2024** Shared for information. Events being held this week. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/025	**Traceability Non-Compliance Report (December 2023)** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
ANY OTHER BUSINESS		
CWQSE/ 2024/028	**Date and Time of Next Meeting** Tuesday 27th February 2024, 8.30am, Microsoft Teams	**ALL to note**

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

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board
Abigail Holmes	AH	Director of Midwifery & Neonatal Nursing, C&W Clinical Board
Catherine Wood	CW	Director of Operations, C&W Clinical Board
Alison Lewis	AL	Patient Safety Facilitator
Alison Davies	AD	Interim Lead Nurse, CYPFHS Directorate
Rachael Sykes	RS	Assistant Head of Health & Safety
Laura McLaughlin	LM	Risk Manager, O&G Directorate
Sandeep Hemmadi	SH	Clinical Board Director, C&W Clinical Board
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Jane Jones	JJ	Clinical Director, CYPFHS Directorate
Martin Edwards	ME	Asst Clinical Director, CHFW Directorate
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer (DECLO)
Lois Mortimer	LM	Head of Midwifery & Directorate Lead Nurse O&G Directorate
Becci Ingram	BI	General Manager, CYPFHS Directorate
Kerenza Moulton	KM	Lead Nurse, CHFW Directorate
Samuel Barrett	SB	General Manager, CHFW Directorate
In Attendance		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Apologies:		
Rim Al-Samsam	RAS	Clinical Director, CHFW Directorate
Paula Davies	PD	Lead Nurse, CYPFHS Directorate
Siwan Jones	SJ	Clinical Nurse Specialist, Infection Prevention & Control
Anthony Lewis	AL	Clinical Board Pharmacist
Angela Jones	AJ	Senior Nurse, Resuscitation Service

Item No	Agenda Item	Action
CWQSE/ 2024/026	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2024/027	**Apologies for Absence** Noted above **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2024/028	**Minutes of the previous Q&S Meeting held on 30th January 2024** The minutes of the last meeting were shared for information. It was agreed that any comments would shared outside of the meeting. ***Postscript*** *No further comments received following the meeting, therefore the minutes have been accepted as an accurate record.*	

	The CWQSE resolved: a) The minutes were noted	
CWQSE/ 2024/029	**1.4 To note and update the action log of the meeting of 30th January 2024** The action log will follow. The action log will also be available via AMAT for updates to be provided. **The CWQSE resolved:** a) Action log to be updated and final version circulated for noting of updates.	**KH**
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		
CWQSE/ 2024/030	**Update on Review of Governance Arrangements within C&W Clinical Board** Update was provided with regards to the review of governance arrangements within the Clinical Board to ensure that the arrangements that are currently in place are effective in escalating concerns and providing assurance. The rearranged date for the workshop will be circulated in due course to discuss the meeting structures and how these can filter through to update and escalate as appropriate. The exception and assurance reports will be changing to use a standardised version and will be completed via the AMAT audit system. It was agreed that this would be circulated following the meeting for review and completion for future meetings. This will help support in making information more succinct and more robust in providing assurance and escalation. **The CWQSE resolved:** a) Update was noted. b) Link for the Q&S exception and assurance report to be circulated for completion prior to the next meeting.	**KH/ALL**
CWQSE/ 2024/031	**Health & Care Standards Directorate QSE Exception Reporting** The detailed report was shared for information and an update was provided on the key highlights from the report. **CYPFHS Directorate Report** • Phlebotomy Pathway has been developed and a joint phlebotomy service being implemented from April 2024 • Transcribing of medication on MAR charts by GP's are ceasing from April 2024. An SOP has been developed to look at the way forward for transcribing, however it was noted that this will have a significant impact for children with complex needs. • Vacancies within Neurorehab and Trauma is impacting on waiting lists • Review of demand and capacity within the CALDS team being undertaken. • New Clinical Lead commencing in post for Neurodevelopment, as well as additional x2 nurses • WHC Circular for MMR directive to increase uptake to 90-95% in all Cardiff and Vale Schools by July 2024. Joint working being undertaken with PCIC Clinical Board. • Flying Start and Generic Health Visiting are now delivering the full flying start programme. Welsh Government are completing a deep dive into the 3.5year reviews. Positive progress has been made to improve the figures following completion of the reduced staffing plan. • MOD Site in St Athen – It is anticipated that there will be circa 200 families	

	arriving at the end of March 2024. Further information is awaited in terms of required health needs; however, a plan has been developed to offer clinics to the area and further meetings are taking place with regards to any additional health needs requirements. • Unmet needs within the GDD (Global Developmental Delay)/ emerging LD (Learning Disability) population. Pilot of "Thinking Together" conversations has been extremely positive and therefore will continue. • Specialist HV post for Children Looked After has been appointed and anticipated this will improve the current backlog of health assessments for the under 5yr olds. • Risk Assessment has been completed with regards to School Nursing establishment and consideration to be given to impact this will have on the implementation of the Healthy Child Wales 2 Programme. • NRI within Adult Mental Health which is being contributed to. Agreed that following completion this will be presented as part of shared learning. • No reported pressure areas reported in month • No reported medicines management incidents in month. There is a shortage of ADHD medication, of which a new formula has been recommended which is hoped will alleviate some pressure in terms of the supply issues. • JICPA inspection action plan has been developed following identification of some immediate actions required. • MARF's concerns have been escalated to corporate safeguarding teams due to concerns regarding lack of timely action by local authority of MARF's, specifically in relation to eating disorder team where significant risk is held. • CCNS equipment ordering concerns highlighted in relation to equipment for children not on the CCNS caseload. Recent audit highlighted an additional 120 children that equipment orders are being placed for which is impacting on the workload. • Ongoing concerns with transition to adult mental health services. There are also challenges with regards to allocation of young people requiring section 117 aftercare which is impacting on the ability to discharge. Work is ongoing with Local Authority. • Focus Group Meeting arranged to review Section 136 and place of safety for children & young people. • Community connect funded pilot project ends at the end of March 2024 • CYP Looked After Children concerns were raised with neighbouring health boards relating to intervention access from other Health Boards. Focused work required for quality improvement. • Paediatric Continence Audit to review the introduction of TEN's machine. All registered nurses are trained in bladder scanning. • Project Group established for development of Part 1 initial intervention. Initial scoping has been completed and work is ongoing with regards to clinical pathways. • Exploring the use of Jungle Ward for respite for children receiving support within the CCNS team. Consultation session has been undertaken with parents to explore ways of working differently. • STRAW practitioners identified within the CYPFHS Directorate as part of the initiative for provision of support to staff within the workplace. • Review impact of reduced grant funding on Llygad Service as this is heavily reliant on grants and also the impact on the EPAT service. • Transitioned YP from Hafan y Coed from Thornbury Nursing to Medics Pro **Timely Access** • Part 1a compliance reported at 78%, this has been recovered in and currently reporting 92% • Part 1b compliance continue to not achieve the target for children having an	

	intervention within 28 days. Detailed plan for recovery has been completed with a view to improve trajectory from September 2024 due to current backlog. The improvement actions have already commenced, however the impact on the trajectory will not be seen as the actions will affect those that are already waiting over the 28days target. • Over 3000 children on the waiting list for Neurodevelopment. Continual review is undertaken and the Clinical Lead commences at the end of March which is hoped will have a positive impact on the activity. • LAC activity has increased and the backlog has reduced significantly. Work continues Discussion ensued with regards to level 3 safeguarding training (as part of the JICPA review) and it was agreed that this will be reviewed within CYPFHS to ensure appropriate compliance. KM noted that there are currently no available level 3 safeguarding training places left until the beginning of 2025. Contact has been made with the safeguarding team to review possible alternatives to address this. New process for Right Care, Right Person has started with South Wales Police in relation to mental health. Daily meetings are taking place, with Adult Mental Health Services and request was made for any update on any potential impact for CAMHS patients. Discussion ensued with regards to the Looked after Children out of area access and it was noted that it was confirmed from Swansea Bay that there is no Health Board rule to state that CYP cannot access mental health service. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Safeguarding Level 3 training to be reviewed for CYPFHS Directorate	**AD**
CWQSE/ 2024/032	**CHFW Directorate Report** • X2 open NRI's and x2 ongoing PSLR's. • Critical Care (PICU and NICU) remain the areas of significant risk. • Winter plan continues with reduced numbers of elective patients requiring overnight stays. This will be reviewed at the end of March 2024 to increase inpatient surgeries and reducing day surgery to allow for the inpatient surgeries to go ahead. • No specific Datix themes reported in month • Work is ongoing with regards to updating of risk assessments following the recent HSE Inspection Visit • MHRA compliance notice for Bed Rails has been received. The beds insitu are not compliant. UK Benchmarking has been completed, and it seems that there may not be a Paediatric bed available that fits the MHRA description. A working group is being arranged in April 2024 to look at appropriate alternatives for the various needs across Paediatric areas and what can be provided by the current supplier as part of the current contract. Procurement will need to be involved in these discussions and further discussion will take place outside of the meeting. • No pressure damage reported in January • Overall tendable audits reports at 94.7%. • All senior nurses and sisters should complete level 3 safeguarding training and this work is progressing across the Directorate • Review being completed for all long and short term enteral tubes in use across the CHFW following a recent Patient Safety Learning review	

	investigation which is being completed. It was agreed that any learning identified would be shared with CYPFHS Directorate. • New scoliosis pathway, Dietetic Led Coeliac Pathway and NG/NJ Guidelines shared and ratified at Directorate Q&S meeting. • VBA Compliance at currently at circa 80% • Diabetic Study and CF Study are continuing. • Review of all care specifics on tendable are being undertaken to ensure that the audits are more meaningful for each individual areas • Concerns – x6 formal concerns ongoing. Theme for early resolution concerns regarding surgery and outpatient dates. • Recruitment is ongoing and a number of appointments made across a number of areas within the directorate. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Working group for review of Bed Rails MHRA Compliance to be arranged to review options.	**DMT**
CWQSE/ 2024/033	**O&G Directorate Report** • No smoking day on 13th March • Birth Afterthoughts is oversubscribed, with circa 40 families waiting, which is a significant reduction. New appointment to take over the debrief clinic. AH noted that work is also ongoing to look at how this service can be linked to the neonatal team also, which is hoped could prevent formal concerns responses. • MCA drop in clinic commencing on 3rd March 2024 • Midwifery representation at the forthcoming Ramadan Event on 27th March to promote wellbeing • Mural has been erected outside of Antenatal Clinic supporting equality, diversity and inclusion. • Datix Incidents 150-170 being reported each month, drive to review and close the incidents and investigations as soon as possible. • NRI figures. 7 NRI investigations open, 11 MBRRACE Cases reported in line with the NRI reporting criteria. Clarity is being sought with regards to medical terminations and babies that show signs of life and whether these cases will require reporting in line with the MBBRACE criteria. It was noted that currently these cases are reported via a HS4 form, however there is no separate review process. • No pressure areas reported in January • X2 falls reported in January, both have been reviewed and no ongoing harm/injuries reported. • X6 medication errors reported in January. • New substantive safeguarding midwife has been appointed. • Roof leaks in Theatre 1 which is impacting on service delivery. It was noted that T2 theatres will need to be stocked in case of any emergencies. • X1 incident of staff entrapment in the lifts in January, however there have been no further incidents reported and currently all lifts are available and working. • Fetal surveillance and monitoring study day planned for May 2024. Installation of the new machines will commence on 12th March 2024. • Bi weekly events being provided as part of the Mat/Neo Safety Programme with a focus on NEWS and escalation. • ATAIN work is progressing and engagement has been positive in moving forward the cases for closure. • Audit of identification of requirement of interpretation services at booking.	

	This is ongoing and being reported through the AMAT system. • Procurement process to move from Euroking to Badgernet System is progressing • Safe care being used to manage staffing which has been in place since 7th January 2024. • New referral system implemented for new gynaecology referrals and also the follow up for Induction of Labour (IOL) which is being built within the Microsoft 365 system for a live calendar for booking and handover of induction/delays etc. • PADR Compliance has improved significantly and thanks were expressed to all for the work undertaken to improve the compliance. The Directorate are currently reporting 75% compliance, with a push to achieve the 85% target by end of March 2024, specifically for birthrate plus and non birthrate plus staff • Sickness rate at 5.6% and vacancy rate of 4%. Mandatory training compliance total being reported at 84% for staffing. • Recruitment is ongoing and a number of appointments made across a number of areas within the directorate. • Manual Handling compliance needs to be reviewed. Further information is required to feedback to the HSE following the recent visit and it was agreed that further discussions will take place outside of the meeting. **Timely Access (taken directly from Directorate Report)** **Qtr 4 (up until 31/3/24)** Total 11 Without TCI's 2 **104 weeks Inpatients/Day cases** **Qtr 4 (up until 31/3/24)** Total 270 Without TCI's 241 **52 weeks Outpatients** **Qtr 4 (up until 31/3/24)** Total 230 Without TCI's 102 **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Discussion to take place regarding information for feedback to HSE and formulation of a plan for Manual Handling.	**LM/RS/AH**
CWQSE/ 2024/034	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** • Nephrology Consultant Workforce • Gastroenterology Consultant Workforce, 6month secondment • Beds in response to the MHRA Guidelines **The CWQSE resolved:** a) Directorate Risk Registers to be submitted to the Clinical Board for review	**ALL**
SAFE CARE		

CWQSE/ 2024/035	**Patient Safety Update** No update to note for this meeting.	
CWQSE/ 2024/036	**NRI/PSLR/Closure Forms for noting/exception reporting** All cases noted below have been discussed as part of the NRI/RCA Governance Sub Group held on 13th February 2024. SBAR, PSLR and Improvement Plan Patient KH SBAR, PSLR and Improvement Plan Patient LR SBAR, PSLR and Improvement Plan Patient BH SBAR, PSLR and Improvement Plan Patient NS There were no specific exceptions to note for this meeting. Requests were made for improvement plans to be monitored for completion and closure. **SBAR, PSLR and Improvement Plan Patient SV** Factual accuracy now received. This has not changed the outcome, slight amendment to the detail surrounding the second pull of the forceps which has now been included. Agreed that if no further comments were received, this case can progress to closure. **The CWQSE resolved:** a) Update was noted b) PSLR and Improvement Plan for SV (NRI Investigations) can be progressed to closure	**AL**
CWQSE/ 2024/037	**3.5. Infection Prevention Control Update Report** The report was shared for information. There are no significant IP&C concerns to note for this meeting. Audits are ongoing. Considerable improvements made in all areas specifically within NICU. There was an issue relating to infection within Rainbow, however it has been confirmed that the cases are not linked, and are incidental infection cases. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/038	**Safeguarding** • Safeguarding Advice & Support Details • Safeguarding Training Compliance • Wales Safeguarding App • SMM Pilot Phase 2 Update • Published Child Practice Review (CVSB-032019) • JICPA There is a guidance SOP for escalating concerns and provision of care received for comment. It was agreed this would be circulated for review and feedback was requested asap in order that this can be ratified **The CWQSE resolved:** a) Update noted. b) SOP for escalating concerns to be circulated for comment	**AJONES**

CWQSE/ 2024/039	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • NatPSA Bed Rails Guidelines (NatPSA_bed_rails_30_8_23.pdf (publishing.service.gov.uk) Mattresses will also be audited within the CHFW following the mattress training completed, which will be included as part of the bed audit. Currently there are foam mattresses in place within CHFW which should not be used and will need to be changed. It is anticipated that the number required may exceed the number available. This is being added to the risk register once the audit is completed due to current non-compliance. • Safety Memo - Tresiba FlexTouch The alerts were noted and have been disseminated widely across the Clinical Board. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2024/040	**NICE Guidance – Update on Progress** Report shared for information. It was noted that there are a number that are currently outstanding within the report that needs to be reviewed. It was agreed that Debbie Jones would be invited to a future meeting to look at how this can be actioned and timely updates recorded within the AMAT system. **The CWQSE resolved:** a) Update noted. b) DJ to be invited to a future meeting.	**KH**
CWQSE/ 2024/041	**Medicines Safety Executive Update** Shared for information. There were no specific exceptions to note for this meeting. **The CWQSE resolved:** a) Update noted	
TIMELY CARE		
CWQSE/ 2024/042	**Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:** b) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2024/043	**Free Moisture Associated Skin Damage Awareness Week Webinars** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/044	**Surface Selection Teams Session** Shared for information. **The CWQSE resolved:**	

	a) Document noted and shared.	
CWQSE/ 2024/045	**County Lines CPD Opportunities** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/046	**Gynaecology & Maternity Concerns Update** Shared for information. It was noted that there are a high number of 100day plus concerns within the Clinical Board at present, but all three Directorates are fully aware and work is ongoing to progress these to closure as soon as possible. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/047	**Upcoming Project Management Courses from Change Hub** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/048	**Fire Safety PEEP Policy for Consultation** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/049	**Maternity Risk Assessment and Breastfeeding Procedure** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/050	**Supported Lodging Scheme** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2024/051	**Duty of Quality e-Learning** Shared for information. **The CWQSE resolved:** a) Document noted and shared	
ANY OTHER BUSINESS		
CWQSE/ 2024/052	**NLS and Paediatric Resus Practitioner** Feedback has been provided with regards to issues relating to inability for gases to be delivered to the Training rooms. Manual Handling is a risk for staff and is untenable. Even with the appropriate trolleys the trolley is heavy and needs to	

	be "bumped" up the kerbs, across roads and frequently the lift is out of order. Storage of cylinders in the academic building, means this is not safe also. The Resuscitation Service has been working through this situation but wanted to provide an update ahead of an NLS courses this week. Additionally, there are supply issues as cylinders obviously must be prioritised for patients. Query was also raised with regards to any further update on a designated Paediatric Resus Practitioner. It was agreed that further discussion would take place outside of the meeting. **The CWQSE resolved:** a) Update was noted. Further discussion to take place outside of the meeting.	**AJONES/AJ/ KM/EB**
CWQSE/ 2024/053	**Staffing Levels on Oncology Unit** Significant shortages of staff which is impacting on the safety of the patients due to the inability to maintain the roster. Due to the impact there have been x2 cases delayed for chemotherapy. These cases will be completed by the end of the week, but it is a significant risk to staffing and ongoing concerns. This has been highlighted to the executive team and discussions are ongoing to look at alternative options to help support. This has been added to the risk register. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2024/054	**Date and Time of Next Meeting** Tuesday 26th March 2024, 8.30am, Microsoft Teams	**ALL to note**

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

Held on 18th April 2024 Via MS Teams

Present:		
Helen Luton (Chair)	HL	Director of Nursing/Multi Professional Teams
Sarah Lloyd	SL	Director of Operations
Adam Christian	AdC	Clinical Board Director
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
Alison Lewis	AL	Patient Safety Coordinator
Jonathan Davies	JD	Health and Safety Adviser
Mathew King	MK	Therapies Representative
Alun Roderick	AR	Laboratory Service Manager, Haematology
Alana Adams	AA	Principal Pharmacist Medicines Information and Advice
Jo Fleming	JF	Quality Lead, Radiology
Vince Saunders	VS	IP&C Team Representative
Sian Jones	SJ	Directorate Manager, Laboratory Services
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Seetal Sall	SS	Point of Care Testing Manager
Susan Beer	SB	Public Health Wales Representative
In attendance:		
Maria Roberts	MR	Head of Quality Assurance and Clinical Effectiveness
Janet Gibbs	JG	Physiotherapy Clinical Service Lead
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Becca Jos	BJ	Deputy Director of Operations
Rhys Morris	RM	CD&T R&D Lead
Tracy Wooster	TW	Sister, Outpatients
Jamie Williams	JW	Senior Nurse, Radiology
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Suzanne Rees	SR	Lead Nurse
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
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Timothy Banner	TB	Clinical Director, Pharmacy

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 24/120	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 24/121	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 24/122	**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 15th March 2024 were accepted as an accurate record.	
CDTQSE 24/123	**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 23/244 HTA Inspection Feedback* SG to provide feedback to the Group. *CDTQSE 23/323 Booking Lab* Sion O'Keefe will present at a future meeting when the system is live and embedded. *CDTQSE 24/062 R&D Lead in Laboratory Medicine* Sian Jones to provide an update on whether a nomination has been identified for an R&D Lead within Laboratory Medicine. *CDTQSE 24/114 Radiology SOP on Chaperoning* HL to ask JF to present the SOP to a future meeting. **The Group resolved that:** a) The update on the actions outstanding from the previous meeting were noted.	**SG** **SO** **SJ** **HL/JF**

6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 24/124	**Concerns and Compliments Report** In March 2024, the Clinical Board received 24 concerns in total; 1 formal and 23 early resolution concerns. There were 0 breaches against response times and 8 compliments were received. The top 3 reasons for concerns in March related to: • Difficulties cancelling and arranging appointments • Waiting times • Waiting times for test results/scan reports. A new theme has emerged relating to delays in issuing death certificates. Discussions are being held involving the Patient Safety Team to consider how the process can be streamlined. AdC has escalated the challenges for the Bereavement Team to the Clinical Board Directors and also at the Clinical Senate. **The Group resolved that:** a) The information within the concerns report was noted. The report also provides a breakdown of the individual departments' data.	
CDTQSE 24/125	**National Reportable Incidents** HL reported that 2 NRIs are near completion. **The Group resolved that:** a) Findings will be shared with this group when the investigations are concluded and shared with the patients.	
CDTQSE 24/126	**New NRIs** **The Group resolved that:** a) There are no new NRIs to report.	
CDTQSE 24/127	**Duty of Candour Cases** **The Group resolved that:** a) There are no new duty of candour cases to report.	
CDTQSE 24/128	**Duty of Quality** MR, Head of Quality Assurance and Clinical Effectiveness was welcomed to the meeting to present on the Duty of Quality. The duty of quality has 2 aims: • Improve the quality of healthcare services	

	• Improve outcomes for the population. Statutory Guidance has been written and the Statutory Guidance April 2023 is available publicly. Duty of Quality can be summarised into 4 key components: Health and Care Quality Standards Quality driven decision making Quality Management System Quality Reporting Health and Care Quality Standards: The standards are a framework to help plan, deliver and monitor healthcare services. The standards apply to all staff in clinical and non-clinical settings. The standards are made up of the 6 domains of quality and six quality enablers. There are high level definitions behind these that are outlined within the Statutory Guidance and on the NHS Executive website. These standards replace the Health and Care Standards of 2015. Quality Driven Decision Making: It must be ensured that the duty of quality standards are applied when making strategic decisions and planning health services. Assessing strategic decisions against the Health and Care Quality Standards ensures that the impact of decisions is considered for all aspects of quality, including population, workforce and other services and are not just based on financial implications. The outcome of strategic decisions taken by the Executive Board and Independent Members must be recorded and shared in the public domain. Quality Management System: The Duty of Quality requires organisations to establish effective quality management systems and training is being provided to support organisations with this. CD&T Clinical Board has good experience of this within its directorates that are heavily regulated. The regulatory mechanisms pertaining to licensing that are already in place within these directorates are critical and assurance is provided that these quality systems will not be compromised. Quality Reporting: Within Duty and Quality, sharing information relating ot the quality of services with the population is an important expectation. The UHB's Annual Quality Report needs to set out how the organisation has improved the quality of its services and delivered better outcomes for the population. An 'Always On' concept has been developed, which is based on the collecting, analysing, monitoring and making information	

	pertaining to the quality of services readily available, both within and external to the organisation. There are various sources of information and performance measures that can assess and evidence duty of quality and improvement. The public has indicated however that they would like access to less figures and graphs and more patient stories and 'You Said, We Did' type of information. The Health Board is considering how it can signpost information such as via a web page for Duty of Quality. The NHS Executive SharePoint page contains useful resources and MR will circulate the link and the presentation slides. There is a link to a Duty of Quality e-learning programme, but it was noted that at present the Health Board is not mandating this. Work is due to start with Medicine Clinical Board, looking at building a quality and safety framework and mapping in the Duty of Quality components into this. This will then provide a structure that can be shared with other Clinical Boards for them to expand on. The Group thanked MR for giving her time to present to the group and for sharing her expertise. **The Group resolved that:** a) The Clinical Board will look at how Duty of Quality can complement the areas in the Clinical Board where QMS is embedded and learn from the Medicine Clinical Board in other areas where QMS is less well formed.	
CDTQSE 24/129	**Risk Register Updates** MK reported a risk relating to the end of the Attend Anywhere contract, where no replacement provider has been commissioned yet. There is a risk that from 31st September there will be no platform for video consultations across the Health Board, which not only impacts on how care is being provided to patients but will also impact on sustainability plans. **The Group resolved that:** a) MK to email BJ the details relating to this risk and she will escalate concerns to the Director of IM&T. b) Directorates to submit any updates to their risk register to HJ by the end of April.	**MK**
CDTQSE 24/130	**Patient Safety Alerts** **Hyperkalaemia Guidelines** This alert relates to ward areas, prescribers and those treating patients with hyperkalaemia.	

	The Group resolved that: a) The alert has been circulated to the Group for information.	
CDTQSE 24/131	**Medical Device/Equipment Risks** EC advised of 3 notices received relevant to this Clinical Board. The UKHSA has advised that a previous alert relating to carbomer-containing lubricant eye products is no longer in effect. The MHRA are satisfied that these products available in the UK are now safe to use. There are unbranded and counterfeit copies of Life Vac and Dechoker anti-choking devices that may fail to work correctly or worsen choking incidents if used. The MHRA is currently aware that only Life Vac and Dechoker have a valid UKCA or CE Mark. Both these brands are intended to be used only after established Basic Life protocols have been attempted and failed. In Cardiff and Vale UHB these products are not advocated for use in secondary care and are not procured within this Health Board. The MHRA has circulated a recall notice from manufacturer Legency Remedies relating to their 0.9% Sodium Chloride Solutions for irrigation, inhalation and eyewash due to potential microbiological contamination. It was noted that this product is not in use within this Health Board. **The Group resolved that:** a) The alerts will be circulated for information.	**HJ**
CDTQSE 24/132	**Point of Care Testing** POCT have been working with the network team on connectivity issues with blood glucose monitors. Good progress has been made identifying the various reasons why they were not connecting and the majority of issues have been resolved. However, there is further work required with DHCW for some devices. HL advised that there are ward moves planned over the Summer and it is essential that SS is sighted on these in terms of moving devices. **The Group resolved that:** a) HL will send SS details of ward moves as they arise.	
CDTQSE 24/133	**IP&C/ Decontamination Issues** VS reported that the Health Board has met its targets for C-Diff and Pseudomonas but not for MRSA, MSSA and Klebsiella.	

	The Group resolved that: a) VS to inform SR if there are any actions that this Clinical Board can support with to improve performance against the targets.	
CDTQSE 24/134	**Safeguarding Update** Following an audit undertaken in the Health Board, recommendations were made how safeguarding should be discussed within Clinical Boards and learning shared. As this Clinical Board is directly involved in few safeguarding cases, HL has suggested that safeguarding issues will continue to be discussed at this forum as opposed to a separate meeting. There is an expectation that each directorate will present their safeguarding training metrics. **The Group resolved that:** a) HL will give thoughts around how to structure this agenda item.	**HL**
CDTQSE 24/135	**Health and Safety Issues** The Health and Safety Improvement Plans have been updated and each directorate will be required to produce a Health and Safety Plan. The plan will have a focus on KPIs and training compliance. There are vacancies within the Health and Safety Team which is resulting in a delay in environmental monitoring. Any areas where this is of particular concern to contact JD. All directorates have been asked to nominate Deputy Fire Safety Managers for their areas. **The Group resolved that:** a) The health and safety plans will be discussed in more detail at the Clinical Board Health and Safety Group.	
CDTQSE 24/136	**Regulatory Compliance** A UKAS assessment in Haematology was held this week. This has been a positive inspection so far. The outcome will be shared with the department next week. UKAS are also undertaking an assessment within Cellpath at the end of this week. **The Group resolved that:**	

	a) The outcomes will be discussed at the Regulatory Compliance Group and also feedback will be brought to this meeting.	
TIMELY		
CDTQSE 24/137	**Initiatives to Improve Access to Services** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/138	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** **The Group resolved that:** a) The waiting list performance metrics will be discussed in the directorate performance reviews.	
EFFECTIVE		
CDTQSE 24/139	**Feedback from UHB QSE Committee** The minutes of the meeting held on 26th 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 24/140	**NICE Guidance** **The Group resolved that:** a) There was no new guidance to share.	
CDTQSE 24/141	**Research and Development** The first Early Phase Advanced Therapies Neurosurgery Working Group was held last week, involving Radiology and Pharmacy, to work on facilitating more trials of ATMPs in Cardiff & Vale. This is in response to an incident last year where a patient becoming hypothermic in an MRI scanner. Hannah Wilce has been named as the R&D lead for Pharmacy. RM is seeking volunteers for speakers at the next R&D forum. **The Group resolved that:** a) Any nominations for speakers to be submitted to RM.	

CDTQSE 24/142	**Service Improvement Initiatives** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/143	**Information Governance/Data Quality** **The Group resolved that:** a) There was no update to report.	
CDTQSE 24/144	**HIW/LAITH/ DECI (dignity and essential care inspections) reports and improvement plans** **The Group resolved that:** a) There have been no inspections held within this Clinical Board.	
CDTQSE 24/145	**Policies and Procedures** **The Group resolved that:** a) There were no policies or procedures to be received.	
EFFICIENT		
CDTQSE 24/146	**Exception Reports from Directorates** **The Group resolved that:** a) There were no exceptions raised from directorates.	
CDTQSE 24/147	**Clinical/Internal Audits** **The Group resolved that:** a) There were no updates relating to audits to report.	
CDTQSE 24/148	**Waste and Sustainability** The Clinical Board Green Group met in March. This season the group is focusing on reducing use of single use plastics and 10 actions that staff can take were presented. There was also a discussion on the new recycling legislation. Staff will be asked that where they cannot access food waste recycling bins to take home their food waste. The UHB Green Group met in April. A presentation was given on sustainability work undertaken in Critical Care. The team noted that Dietetics has supported a carbon reduction of 630kg per annum by assisting in implementing tap water for patients in Critical Care. Work is also being undertaken by the team to ensure the correct imaging modality is requested to Radiology	

	and that any pathology tests being requested are actually required. The Ask Suzanne session in April discussed the 2024 UHB Decarbonisation Action Plan which has been approved by the UHB. It was noted that significant carbon reductions can be made linked to the prevention agenda and the diabetes avoidance programme is currently a key area of focus. MK reported that Therapies will be presenting at the National AHP Sustainability Conference. **The Group resolved that:** a) All staff are asked to support reducing energy demand; segregating waste appropriately; considering active travel where possible; and to look at their general practices in their everyday work for anything that can be made more sustainable. b) MK to send HL details on the Therapies presentation for her to share at the Clinical Board Executive Performance Review.	**MK**
EQUITABLE		
CDTQSE 24/149	**Feedback from Clinical Board Inclusion Ambassadors Group** **The Group resolved that:** a) There were no updates to report.	
CDTQSE 24/150	**Equality and Diversity Issues** The Health Inequality Newsletter was circulated for information. MK reported that Therapies have automated kiosks for patients to self check-in which are not inclusive. The digital team are working with the directorate to try to address this issue. **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 24/151	**Patient Story** Janet Gibbs, Physiotherapy Clinical Service Lead was welcomed to the meeting to present her mum's story to the Group. This was a very personal and emotive story. The story refers to the various touch points with services that her mother	

	experienced over a period of years between 2019 and 2020 and 2022 to 2024, and documented her falls history. Janet's mum was previously a well person who lived at home. She was an independent and determined lady who did not have carers. Following a succession of falls and admittances with broken bones and fractures, her mobility deteriorated and she deconditioned. During a 5 week stay she was subjected to 10 ward moves. Janet shared how confusing and frightening it was for her mum during her hospital stay. The learning from this story highlights the missed opportunities around the Right Bed First Time initiative. Had the principles been instigated, with interventions put in place at the earliest stage, her mother's outcome could have been very different. Janet was asked the question what needs to be done differently. She responded that focus needs to be placed on the prevention agenda and a systemic and holistic approach taken across the whole of the falls pathway. Every opportunity at every touch point should be taken to make every contact count. The Health Board also needs to learn from concerns that are raised. SS asked if there are any developments around an outreach service to avoid admissions via A&E. She also asked if there is any diagnostic technology or wearables to support people susceptible to falls. Janet noted that work has been undertaken around the falls prevention agenda linked to the CRT, the Elderly Care Assessment Service and a self-referring Falls Service has been set up. One of the first indicators are patients who present with fractured wrists and there are now better plans for referring patients. There is work ongoing around technology and wearables. Community alarms have inclinometers built into them and developments around how these wearables could be adapted as hydration monitors. Predictive software is also being developed that could help predict earlier falls through movement sensors. HL thanked Janet for attending and sharing her story. **The Group resolved that:** a) JG would share the links to the resources from her story into the Teams Channel. b) A monthly schedule for 24/25 has been produced for when directorates are requested to present their patient stories.	
24/152	**Initiatives to Promote the Health and Wellbeing of Patients and Staff**	

	The Staff Lottery Panel approved 2 health and wellbeing bids submitted from this Clinical Board: A bid to support Therapies staff in creating a sustainable, wellbeing garden at UHL. A bid for the Health Board to continue to work alongside the Welsh National Opera to provide people living with long-Covid singing sessions where they can learn breathing techniques. There have been positive outcomes linked to this programme, where through the understanding of breathing techniques has prevented people from attending A&E. The programme has also supported staff with long-Covid being able to return to work. AA reported that lunchtime wellbeing walks have been introduced in Pharmacy. Pharmacy also produce a wellbeing newsletter. **The Group resolved that:** a) AA will send the newsletter to HL for her information.	**AA**
CDTQSE 24/153	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/154	**National User Experience Framework/Feedback from Patient and Service User Surveys** **The Group resolved that:** a) Civica information will be shared when it becomes available.	
CDTQSE 24/155	**Staff Awards and Recognition** The category for this month's Clinical Board Staff Recognition Scheme is the Equality, Diversity, Inclusion and Welsh Language Award **The Group resolved that:** a) Nominations to be received by 26th April.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 24/156	Health and Safety Group Minutes Regulatory Compliance Minutes R&D Group minutes	

ANY OTHER BUSINESS		
CDTQSE 24/157	AA circulated a newsletter relating to lithium. This related to an incident that occurred in a care home which resulted in a patient presenting to secondary care. The Medicines Information Team is not required to link with care homes which have no obligations to engage with the Health Board; however, the team has created a section on its website which collates information relating to care homes to help improve knowledge and usage of medicines in these settings.	
CDTQSE 24/158	**Date & time of next Meeting** 23rd May 2024 at 11am via Teams	

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

Held on 23rd May 2024 Via MS Teams

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

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 24/159	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 24/160	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 24/161	**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 18th April 2024 were accepted as an accurate record.	
CDTQSE 24/162	**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 23/244 HTA Inspection Feedback* SG was not present to provide feedback from the inspection. *CDTQSE 23/323 Booking Lab* Booking Lab has not yet gone live. It was agreed to remove this item from the action log and SO will provide an update at a future meeting when the system has been implemented. *CDTQSE 24/062 R&D Lead in Laboratory Medicine* AdC reported that a consultant will be granted sessions for research. A discussion will be held with the individual around representing the directorate at the R&D Group and if agreed AdC will advise RM. *CDTQSE 24/114 Radiology SOP on Chaperoning* JF advised that the SOP has been implemented in some areas in Radiology and there are some final details that need to be updated. She will present the SOP to the group when finalised. **The Group resolved that:** a) The update on the actions outstanding from the previous meeting were noted.	**SG** **AdC** **JF**

6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 24/163	**Concerns and Compliments Report** In April 2024, the Clinical Board received 20 concerns in total; 4 formal and 16 early resolution concerns. There were 0 breaches against response times and 5 compliments were received. The top 3 reasons for concerns in April related to: • Difficulties cancelling and arranging appointments • Communication issues • Concern with clinical treatment A concern was received relating to a patient receiving text messages for multiple appointments. The issue related to an electronic request form in a GP practice that pre-populated the same telephone number of a patient into the form, so the patient received texts with multiple appointment times that were meant for different patients. Radiology have linked in with the practice to resolve the issue. It was noted that there has been a reduction in the number of compliments received this month. **The Group resolved that:** a) Departments were reminded to submit their compliments.	
CDTQSE 24/164	**National Reportable Incidents** The Clinical Board is reporting 4 NRIs this month. Incident number 57482 relates to Medical Records and an issue with following up on a referral. The initial meeting has not yet been held. This will be a complex investigation involving a number of Clinical Boards with a DHCW element. Incident Number 44284 in Cellular Pathology has been downgraded to an LRI as the harm was less than moderate. An investigation has been completed and is being reviewed Incident Number 46767 is now closed. Incident Number 54051 relates to a miss on a CT performed in 2015. This has been difficult to investigate due to the time that has lapsed, however the investigation is nearing completion and an improvement plan is being drafted. he Clinical Board is keen to resolve this incident within an early timeframe in consideration of the patient and their family. **The Group resolved that:**	

	a) Radiology has also been involved in an incident being led by Surgery regarding the timely removal of stents. This has wider learning for across the Health Board and will be presented to a future meeting.	**JF**
CDTQSE 24/165	**New NRIs** As discussed earlier Incident Number 57482 is a new NRI. **The Group resolved that:** a) The initial meeting has not yet taken place.	
CDTQSE 24/166	**Duty of Candour Cases** **The Group resolved that:** a) There are no new duty of candour cases to report.	
CDTQSE 24/167	**Risk Register Updates** JF noted there are intermittent supplies of IV aspirin that is used in conjunction with other pharmaceuticals. There is no alternative identified and this is being shared with patients. Therapies have raised risks around the expiring contract for Attend Anywhere, the video consultation platform. One of the main impacts will be the need for appropriate physical venues to be identified for patients who would have previously received virtual appointments. HL noted that within the latest comms from the Video Consultation Team. Health Boards have requested a 6- month bridging gap at the end of the contract to allow time to consider a replacement platform. In the interim the Video Consultation team have been tasked by the Executive Team to look at a low-cost option. Physiotherapy also raised a health and Safety risk relating to the TDSI door access at CRI not working. Doors are being wedged open which is posing a risk to staff safety with unauthorised personnel entering departments. The issue has been raised with both the Security and Estates Teams. HL will follow up for support. **The Group resolved that:** a) The risk assessment for the virtual consultations to be submitted to HL to add to the Clinical Board Risk Register. b) SO is a representative on the Virtual Consultation Governance group and if any individuals would be interested in attending to contact SO.	**HR/ HL**
CDTQSE 24/168	**Patient Safety Alerts** **Safety Memo Fiasp FlexTouch Shortage**	

	The alert advised that the insulin pens will be out of stock from January. **The Group resolved that:** a) The alert has been circulated to the Group for information.	
CDTQSE 24/169	**Medical Device/Equipment Risks** JF received a safety alert relating to issues with PCs and potential loss of system functionality that could affect the vascular rooms and cardiac cath labs in terms of delays or termination of procedures. **The Group resolved that:** a) A risk assessment and contingency plans have been updated and shared with staff although no issues have yet been experienced.	
CDTQSE 24/170	**Point of Care Testing** SS was not present. **The Group resolved that:** a) There was no update to report.	
CDTQSE 24/171	**IP&C/ Decontamination Issues** CU was in attendance on behalf of YH. He noted that the findings of the Bare Below the Elbow audit identified non-adherence by some staff in Radiology and Pharmacy. Tendable audits have identified good hand hygiene practice in Radiology, however, JF will escalate the non-compliance with Bare Below the Elbow to the Radiology staff. HL noted that Therapies have also observed non-adherence in some of their services and provided training to those particular staff. **The Group resolved that:** a) HL stated that staff need to ensure they are adhering to Bare Below the Elbow across the Health Board, given the increase in Norovirus cases over recent weeks.	**JF**
CDTQSE 24/172	**Safeguarding Update** **Single Unified Safeguarding Review Briefing** The briefing was shared for information. **Financially Motivated Sexual Extortion**	

	The Weblink was shared for information. A recent audit was held looking at safeguarding processes within the Heath Board, Local Authority, and Police. Feedback was provided to the Health Board and it was recommended that each Clinical Board needed to put in place a monthly Safeguarding Group. As Safeguarding is an agenda item at this meeting, the Clinical Board have decided that it will use this item to capture the key items that would have formed part of the agenda of a separate group. These items will include: • An update on safeguarding training compliance • Any open adult safeguarding cases • Any pressure damage cases • Use of language line • Any use of advocacy services • Raise awareness of any procedures HL will share the document that is being used in the Health Board for directorates to capture this information. For the next meeting each directorate will present an update on their mandatory training for: • Safeguarding training for levels 1,2 and 3 • Violence against women and domestic abuse • Mental capacity training JF raised the issue that recently all staff Band 6 and above are now required to complete Level 3 Safeguarding training and there are challenges in enrolling all staff on the courses. This has impacted on the compliance rates. HL noted that the Safeguarding team are aware that their current capacity for training will not meet the demand and they are looking at alternative methods for delivering the training. There are multiple modules and topics within level 3 and HL will clarify what the requirements are for level 3 training in order to achieve compliance. **The Group resolved that:** a) For the next meeting directorates to advise on whether or not the information is readily accessible to populate the template.	**HL** **All** **HL** **All**
CDTQSE 24/173	**Health and Safety Issues** RB noted that there has been a historic issue with patients climbing onto the roof of the Academic Building at UHL. During working hours, the police and fire service have been alerted and attended on site. However, there is a risk that patients could access the roof out of hours. It was previously requested for a one-way gate to be erected, however this was deemed as a fire	

	risk. It was suggested that as a next step RB contacts the fire safety officer and JD. If necessary, the issue can then be escalated to the UHL Management Team. PW reported a leak in the Mechanical Workshop in Medical Physics whereby a white residue fluid is coming into the department from the laboratories above and staff are concerned that this is asbestos. SJ advised that Estates have collected samples to be sent off for testing to identify what the fluid is. PW will follow up with Estates. If further escalation is needed to contact JD. MM asked if there is any update on a RAAC survey of the Print Room. HL will ask JD for an update. RM suggested that a RAAC survey would be useful for the mechanical workshop. HL will raise the issue with JD. **The Group resolved that:** a) The health and safety risks were noted.	**RB** **PW** **HL** **HL**
CDTQSE 24/174	**Regulatory Compliance** The Blood Transfusion Laboratory have received their first report from the MHRA as part of their inspection and are required to provide a quarterly update. This submission is due at the end of May. The laboratory has also recently completed the annual blood compliance report for both UHW and UHL. **The Group resolved that:** a) The next Regulatory Compliance Group meeting will be held in June.	
TIMELY		
CDTQSE 24/175	**Initiatives to Improve Access to Services** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/176	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** Patients waiting 8 weeks or more for diagnostics in April increased by 469 in April to 9302. A key issue is the lack of capacity for Ultrasound and discussions are being held at Executive level on how to address the position. Patients waiting 14 weeks or more for Therapies reduced by 852 in April to a total of 485. It was noted that the weight	

	management service is no longer included in the waiting time figures. Paediatric Occupational Therapy, Physiotherapy and Speech and Language Therapy figures will be included in the waiting time performance figures going forward. **The Group resolved that:** a) An update on cancer performance will be presented at future meetings.	**BJ**
EFFECTIVE		
CDTQSE 24/177	**Feedback from UHB QSE Committee** The minutes of the meeting held on 26th March 2024 were shared for information. Specialist Services Clinical Board presented their annual report and a patient story of a patient in their Teenage Cancer Trust. An update was provided from the Consent Lead and the need for an action plan relating to consent training. There are reputational and financial risks associated with non-compliance against consent training as this could lead to Welsh Risk Pool withdrawing financial support for any claims. JuD is the Clinical Board Representative on the Consent Group and will provide any feedback to the Clinical Board. An update was provided on the MHRA alert relating to Sodium Valproate and the requirement for dual sign off by clinicians for any new prescriptions. The Committee approved the Optimising Outcomes Policy and Procedure. A link was shared to the Annual Report for Quality, Safety and Patient Experience. **The group resolved that:** a) This Clinical Board will be presenting its annual report and patient story to the Committee in July. Thoughts to a patient story are being considered.	
CDTQSE 24/178	**NICE Guidance** **The Group resolved that:** a) There was no new guidance to share.	
CDTQSE 24/179	**Research and Development** The next Clinical Board R&D Meeting is being held tomorrow.	

	An Advanced Therapies Neurosurgery meeting has been held. There are a number of individuals in the Clinical Board awaiting outcomes from the Integrated Funding Scheme. A number of areas awaiting **The Group resolved that:** a) An update will be presented at the next meeting.	
CDTQSE 24/180	**Service Improvement Initiatives** SO reported on an initiative that is in its early stages for See on Symptoms (SOS) and Patient Initiated Follow Ups (PIFU). Normally reserved for acute appointments, the principle is that if a patient is seen in an appointment and the clinician is not clear if they should be seen again or there is a possibility that they have a reason to be seen within a set period, the patient is given a ticket to return over a period of between 3,6, 9 and 12 months. This empowers the patient to contact the Health Board and come in when they need support or advice or they may be signposted. The idea is that this will lead to less frequent outpatient appointments. A central team is being set up that will support clinical teams and place patients on SOS or PIFU pathways. This is a new team that will sit within the Health Records team and work with services who have established SOS pathways. Key benefits of the service are to take time away from clinicians and answer patients' queries in one contact. A Clinical Information Programme is being developed relating to scanning of records and electronic information for clinical decisions and care. This will involve a number of workstreams and part of this work is to establish a baseline of patient records and understand the level of paper records that are stored on and off site with a view to consolidating where records are stored and exploring digital options. **The Group resolved that:** a) Directorates to advise HJ of the names of their Information Asset Owners in the next few weeks.	**Dirs**
CDTQSE 24/181	**Information Governance/Data Quality** **The Group resolved that:** a) There was no update to report.	
CDTQSE 24/182	**HIW/LAITH/ DECI (dignity and essential care inspections) reports and improvement plans** **The Group resolved that:**	

	a) There have been no inspections held within this Clinical Board.	
CDTQSE 24/183	**Policies and Procedures** **The Group resolved that:** a) There are no relevant UHB policies or procedures out to consultation and no Clinical Board policies or procedures to be received.	
EFFICIENT		
CDTQSE 24/184	**Exception Reports from Directorates** Exception Reports received from directorates were circulated for information. **The Group resolved that:** a) There were no further issues raised from directorates.	
CDTQSE 24/185	**Clinical/Internal Audits** **The Group resolved that:** a) There were no updates relating to audits to report.	
CDTQSE 24/186	**Waste and Sustainability** CD&T noted that projects in Pharmacy and Therapies have been nominated in the NHS Sustainability Awards. JF asked if there is any update on the new segregation of waste. HJ has asked the waste team for an update and a steer and is awaiting a response. **The Group resolved that:** a) The results of the NHS Sustainability Awards will be shared.	
EQUITABLE		
CDTQSE 24/187	**Feedback from Clinical Board Inclusion Ambassadors Group** The next meeting is due to be held next week. **The Group resolved that:** a) There were no updates to report.	
CDTQSE 24/188	**Equality and Diversity Issues** The Clinical Board Staff Recognition Scheme awarded certificates to 2 joint winners this month in the Equality, Diversity, Inclusion and Welsh Language category.	

	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 24/189	**Patient Story** Richard Holford, Radiographer, was welcomed to the meeting. He presented on the development of a Radiographer Led Discharge service for Minor Injuries patients within the Emergency department at UHW. Reporting Radiographers are Advanced Practitioners trained to independently interpret imaging and issue radiological reports inclusive of management recommendations with a very narrow margin for error. Recent national recommendations have emphasised that reporting radiographers should be empowered to operate at the upper limits of their practice to enable improvements in patient care and management. The RLD service is made up of 2 full time and 5 part time reporting radiographers. The majority of minor injury patients attending EU require an x-ray and national guidelines stipulate that ideally all radiographs should be reported on before the patient is discharged or within a 24-hour period. Prior to this service, these targets were seldom met with 11% of musculoskeletal radiographs remaining unreported after more than 10 days, with the potential associated risks of mismanagement of patients. There were recurrent breaches of the 4-hour high standard target from admission to treatment or discharge and despite the high diagnostic accuracy of the reporting radiology team, Radiographer involvement in EU was limited. When patients are referred to the RLD service, they are prioritised based on clinical need and urgency. Patients are x-rayed and receive a near immediate report. Those with normal findings or simple soft tissue or bone injuries are treated and discharged directly without the need to return to EU. Those with more serious conditions or unexpected findings are referred back to the EU clinician for interventional treatment. A significant benefit of the service is that almost all other musculoskeletal radiographs to patients in all areas of the A&E department receive a report within the working day. In order to evaluate the effectiveness of this service, EU workstation time stamp and PACs data were aggregated and compared this to a baseline of patients with equivalent injuries who were not referred to the service. Over 1800 patients were referred to the RLD service during the 10-month trial period with a maximum daily referral frequency of 32. Three quarters of patients had simple soft tissue injuries or negative radiological findings.	

	One of the key performance indicators was reducing length of patient stays and there was a significant reduction for RLD referred patients compared to patients in the conventional pathway. Reports were also compiled 78% more efficiently and patients with soft tissue injuries were treated and discharged on average within minutes and those will simple fractures were managed within an average of 11 minutes. Almost all RLD referred patients met the 4-hour target and the volume of unreported musculoskeletal radiographs waiting for more than 10 days was reduced by two thirds. Patient feedback was collated using a patient care questionnaire and QR codes displayed on posters. Respondents consistently attested to the value of the service and rated the care received from the team as excellent. The primary strength of the RLD service is collaborative, interprofessional working that involves the effective and accurate co-production of diagnosis and treatment plans with emergency department colleagues first time. The integrate of the reporting radiographers in EU not only fostered opportunities for shared learning and development but ensured that the workforce is accessible as a source of immediate advice and consultation. In terms of the future direction, the RLD service is keen to expand its hours of service to 7 day working and incorporate other domains for reporting and to encourage use of the model in neighbouring Health Boards. AdC commented that there is a lack of wide awareness of the RLD service across the Health board and HL and AdC will consider how to raise awareness of the efficiency of this service and celebrate its success. SO asked how the service is viewed in EU and Radiology. RH noted that initially there was reticence from EU clinicians, however after the first few months of the trial there was more and more uptake as the benefits were being realised. Within Radiology, staff are keen to continue to support this service. JW asked what level of staffing would add resilience. It was noted that 2 more staff would add resilience to the service and provide cover for leave. The team are looking at the various different streams for scope for expansion and developing skills in tandem with Radiology consultant colleagues in terms of the supervision they provide. HL asked if feedback from the team is being captured i.e. has job satisfaction and morale increased. RH noted that the data was collated on what was working well and what could be	

	improved. A short questionnaire was issued to clinicians and this being collated and will involve qualitative and quantitative data in a formalised, structured way. This will also involve perceptions around the benefits of the service and risks that may be perceived with expansion of the service. **The Group resolved that:** a) World Patient Safety Day is being held in September and the theme this year is Diagnostics. HL suggested that this service links in with the Patient Safety Team to raise the profile of this service. AL will link in with RH.	
24/190	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** It was noted that the Occupational Therapists in UHL are promoting the use of the wellbeing meadow. **The Group resolved that:** a) Directorates are encouraged to provide feedback on any initiatives to this Group.	
CDTQSE 24/191	**Any Initiatives Relating to the Promotion of Dignity** As discussed earlier, the Chaperone Procedure in Radiology will be presented to a future meeting. **The Group resolved that:** a) There were no other initiatives to report.	
CDTQSE 24/192	**National User Experience Framework/Feedback from Patient and Service User Surveys** HL noted that the Civica data is not refined enough to identify meaningful information specific to services in this Clinical Board, although some data was applicable where patients were complimentary of services they have received in Phlebotomy, Therapies and Radiology. **The Group resolved that:** a) HL will discuss this further with the Patient Experience Team.	**HL**
CDTQSE 24/193	**Staff Awards and Recognition** The Clinical Board Staff Recognition Scheme category for May is the Quality, Safety and Patient Experience Award. **The Group resolved that:**	

	a) Nominations are encouraged from all staff in the Clinical Board.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 24/194	Medical Illustration directorate exception report Therapies exception report	
ANY OTHER BUSINESS		
CDTQSE 24/195	There were no further issues to report.	
CDTQSE 24/196	**Date & time of next Meeting** 25th June 2024 at 9am via Teams	

Minutes of the Medicine Clinical Board Quality, Safety & Experience Committee Meeting Held on 17 April 2024 14:00 – 15:30, Via MS Teams

Present:	
Alun Tomkinson	Clinical Board Director
Barbara Davies	Interim Director of Nursing (joint Chair)
Sian Rowlands	Head of Quality and Clinical Governance (joint Chair)
Alexandra Scott	Assistant Director of Quality Safety
Angela Jones	Senior Nurse, Resuscitation Service
Katie Innes	General Manager, Specialised Medicine
Kath Prosser	Quality & Governance Lead, Medicine
Dave Pitchforth	Lead Nurse, Specialised Medicine
Wayne Parsons	Lead Nurse, Integrated Medicine
Ceri Martin	Lead Nurse, Acute and Emergency 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
Natasha Whysall	Senior Nurse, Specialised Medicine
Nicholas Denny	Organisational Learning Facilitator - Mortality Lead
Lyndsey Cole	Ward Manager, East 2
Sue Eshel	Senior Nurse, Integrated Medicine
Lowri Warren	Senior Nurse, Integrated Medicine
Lisa Green	Senior Nurse, Acute & Emergency Medicine
Pippa Johnson	Mental Capacity Specialist Practitioner
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Louise Platt	Director of Operations
Katja Empson	Consultant/ Deputy Clinical Board Director
Hannah Mastafa	Deputy Director of Operations
Ceri Martin	Lead Nurse, Acute & Emergency Medicine
Gill Spinola	Senior Nurse, Integrated Medicine
Lyndsey MacDonald	Consultant, Emergency Medicine
Dave Mcrae	Lead Pharmacist, Medicine
Harriet Foley	Senior Nurse, Integrated Medicine
Derek King	Clinical Nurse Specialist, Infection, Prevention and Control
Aneurin Buttress	Consultant, Integrated Medicine
Ceri Richards-Taylor	Lead Nurse, Integrated Medicine

Item No	1. Standing Items	Action
MCBQSE/ 2024/0035	**Welcome & Introductions** – were undertaken. **Declarations of interest** – none raised.	
MCBQSE/ 2024/0036	**To receive the minutes of the previous meeting held on 20/3/24** The group resolved: the minutes were agreed and accepted.	
MCBQSE/ 2024/0037	Action Log – was updated.	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2024/0038	**2.1 Patient Story** – presented by Lyndsey Cole Deputy Ward Sister, Integrated Medicine A patient was admitted in June 2023 with shortness of breath and confusion. Prior to hospital admission the patient was living at home with his wife and had a package of care. The patient's wife was finding it hard to look after him at home. A referral was sent for the patient on 26/6/23 when he was clinically optimised to the Social Work	

	department to support discharge planning. On 27/6/23 a community social worker contacted the ward and a best interests meeting was to be arranged for the patient. The meeting did not happen and staff followed up with little success. The patient's behaviour was getting more difficult to deal with and they attempted to leave the ward regularly. The Liaison Psychiatry Team assessed the patient and felt it would be appropriate for him to go into a mental health bed. By the time the patient was clinically stable, his behaviour had improved and it was agreed he would be better managed on the ward. The aim was to arrange a best interest meeting as soon as possible. His social worker changed in August 2023, which delayed matters. A new Social Worker was allocated and a best interest meeting went ahead and it was agreed for his best interests to go to an EMI Nursing Home. There was mention of Court of Protection at that time, however, not progressed. The family started looking at Nursing homes and advised the name of a Nursing home they wanted the patient to be discharged to. The Nursing Home assessed and accepted the patient on 17/10/23. The ward contacted the Social Worker who advised the patient had expressed a wish to return home and RPR was needed. A 72-hour care plan had been prepared by the ward, the Social Worker then asked for a 92-hour care plan and a full assessment of his home was required, as if the Court of Protection agreed he could return home, that would take place. From Nov 23 the Court of Protection process was in place and the Court date was set for 4/3/24. The patient's family wanted him settled in a care home. The patient remained on the ward until the Court agreed he could go to a Nursing home. Plans were made for the patient' s discharge. Unfortunately, the patient contracted Flu and later contracted Pneumonia, deteriorated and sadly died. The patient had been in hospital for approximately 300 days, equating to approximately £100,000 in hospital costs. There is currently no Court of Protection infrastructure within C&V UHB. The MCA Team have written an MCA policy for C&V UHB which is due for consultation shortly. The group resolved: if a situation like this arises in the future, contact Diane Walker and team as soon as possible, who will assist. The MCA Team will offer support and advice. **Actions from discussion**: to note the above.	
MCBQSE/ 2024/0039	**2.2 Concerns, Claims, Compliments** **A1 Link & C4** - please pass on my thanks to all the staff on the A1 Link & C4 Ward for their care & hard work in getting me back on my feet last weekend. It is not until you need hospital care that you experience and begin to understand the dedication and hard work of all the staff on a ward. All the staff I had the pleasure of meeting maintained a positive, helpful and reassuring attitude while working the long shifts often during unsocial hours and many having to balance the pressures of home life. Thank you again for keeping me positive and for the care and support given during my short stay. **LSW Ward 2** - thank you for your letter of 19/3/24 explaining the circumstances of the pressure ulcer I developed whilst in the Health Hospital, and thank you too for your full apology. I am pleased to tell you the Radyr District Nursing Team confirm this has now healed up. The group resolved: keep noting compliments and share with teams. **Actions from discussion:** none.	
MCBQSE/ 2024/0040	**2.3 Infection Prevention and Control update:** no update. The group resolved: N/A. **Actions from discussion**: None.	
MCBQSE/ 2024/0041	**2.4 Safeguarding/MCA/DoLS: Audit into MCA compliance** Pippa Johnson (PJ) shared a presentation. A new MCA Team was set up from August 2023 and carried out a scoping Audit, between Aug – Sept 2023. The aim of the audit was to explore the current level of practice within C&VUHB to prioritise the workplan for the newly formed MCA Team. There are up to 1173 contacts daily with people who might lack capacity to make decisions about their care. There are 3350 people with Dementia living in the C&VUHB community who may lack capacity to make decisions about their care. MCA is a statutory requirement which if not	

	followed will impact quality of care, individual's quality of life and financial risk for UHB. Safeguarding reviews show poor MCA practice and the most common theme is SAR's. Audit Results: - Usually clear documentation of staff doubting a person's mental capacity and the reasons why. - Only two thirds of paperwork documented the decision. - Just under half the cases audited showed staff were using the C&VUHB pro-forma. - Only 1 in ten records evidenced considering, or carrying out, practical steps to support decision making. - Of the 92 sets of records, 62 cases were evidenced where a person treated as lacking capacity to make-a-decision with no documented MCA was found. - Lasting Power of Attorney or Advanced Decision to Refuse Treatments, had not been checked and sighted, or they were in place and were not respected. - Lots of issues with DOL's process. Response to the audit - Developed a training strategy for the financial year just gone and in the first six months, trained 438 staff over 28 sessions and a number of different training packages were created. - Developed a new SharePoint page with information. - MCA Policy has been written and is due for consultation shortly. The group resolved: feedback from MCA training sessions has been positive. **Actions from discussion** – PJ to share the presentation with KP to share with the minutes.	MCA Scoping Audit Writeup FINAL.docx Pippa Johnson/ Kath Prosser
MCBQSE/ 2024/0042	**2.5a Llais Visit to St David's (Lansdowne Ward) 25.10.23** – report received in February 2024. Action plan for noting. **2.5b Llais Visit to Emergency Department 30.03.24** – the visit went well and focused on patient experience. The group resolved: no issues. **Actions from discussion** – none.	
MCBQSE/ 2024/0043	**2.6 HEIW Targeted Visit Report Gastroenterology 01.02.24** Report included with the papers for information. There are some recurring themes to be addressed. The group resolved: to note the report. **Action from discussion** – to note the report.	
MCBQSE/ 2024/0044	**2.7 Schwartz Round presentation** – no update. The group resolved: no update. **Action from discussion** – none.	
3. ITEMS FOR APPROVAL/ RATIFICATION		
MCBQSE/ 2024/0045	**3.1 National Reportable Incidents (NRIs)**, updates and closures: MCB NRI position – there are currently 17 open NRI's. Intergrated Medicine have 4 open, 3 breached closure date, 3 ongoing Covid Investigations. Specialised Medicine have 6, 4 breached the closure date. Acute and Emergency Medicine have 7, 6 breached the closure date. **NRIs for closure:** **Specialised Medicine:** **ID40971** Delayed Colonoscopy surveillance with delayed cancer diagnosis **Investigation findings**: five key issues were identified. 1. There was a delay in adding the patient to the surveillance waiting list. 2. How the service risk stratifies endoscopy patients in endoscopy. 3. Governance of prioritising patient's safety. 4. Providing safety netting advice. 5. Delay between clerical pre-assessment and the booking procedure.	

	Learning: There is now an overarching updated improvement plan in place with ongoing review as to how the service risk stratifies all patients awaiting endoscopy/colonoscopy procedures **ID40174** delayed OGD and cancer diagnosis. Patient due to have follow up OGD Jan 2022 secondary to a history of previous gastric cancer. OGD not undertaken until August 2023. **Investigation findings**: there were missed opportunities to follow up the patients delayed OGD and safety netting advice was not clear. **Learning:** There is now an overarching updated improvement plan in place with ongoing review as to how the service risk stratifies all patients awaiting endoscopy/colonoscopy procedures **ID36629** delayed surveillance OGD resulting in a cancer diagnosis. The patient underwent an OGD surveillance in 2021 and biopsies showed a low grade pre-malignant change to be kept under surveillance. Requested a repeat procedure in April 2022, however, the patient did not have the procedure until June 2023 which showed a malignant looking module in the patient's lower Oesophagus and treatment was started. **Investigation findings**: missed opportunities, safety netting advice was not clear. **Learning:** There is now an overarching updated improvement plan in place with ongoing review as to how the service risk stratifies all patients awaiting endoscopy/colonoscopy procedures The group resolved: the three cases above were addressed at a Redress meeting and due to the Covid element and risk stratification they will be shared with the Legal and Risk Team. This a large piece of work and for the Directorate and the Clinical Board. **Actions from discussion:** DP will share the Action Plan with KP who will share with the minutes.	Endoscopy Improvement Plan W Dave Pitchforth/ Kath Prosser
MCBQSE/ 2024/0046	**3.2 Learning from Events Reports (LEFR)** CLA7A4-0633/JP – relates to a 39-year-old male who attended A&E during Covid on 7/5/20. The patient was assessed by a junior doctor and noted to have severe cramping, dull chest pain, shortness of breath and a diagnosis of acute coronary syndrome. Investigations were put in place; however, it was considered to be a failure on the part of the junior doctor to do a swift referral to Cardiology. **Learning**: this has been shared with A&E QSE meeting and assurance has been provided to Welsh Risk Pool was since this incident RATZ has been implemented. The group resolved: the report is for noting. **Actions from discussion:** to share this information with Teams.	ALL
MCBQSE/ 2024/0047	**3.3 Ombudsman Report Summary 202300537** – historic case from 2021 relating to a closed area, so cannot enact the actions in that area. There is a reminder to staff about their obligations relating to the completion and accuracy of records and relevant policies and processes in place for mental health advice and input and referrals. Also, noted was staff's obligation in relation to DOLs and applying the policy in the correct way. The group resolved: to note the above. **Actions from discussion:** to share this information with Teams.	ALL
4. ITEMS FOR NOTING AND INFORMATION		
MCBQSE/ 2024/0048	**4.1 Patient Safety Alerts/MDAs/ISNs:** **4.1aSafety Memo: Hyperkalaemia; update to acute treatment pathway in adults** – this update relates to the treatment pathway, when insulin is used to treat Hyperkalaemia, there is a requirement to monitor blood glucose.	

	4.1b 2024-04-09 JP to HB CEs re Measles – currently an outbreak in Aneurin Bevan and also in C&VUHB. Staff in high risk areas, needs to understand if they are vaccinated with the MMMR. The group resolved: to note the above and share as appropriate. **Action from discussion**: none.	
MCBQSE/ 2024/0049	**4.2 Medicines Management** – no update. The group resolved: update at the next meeting. **Action from discussion:** LV to add the minutes shared at this meeting to the SharePoint page.	Liz Vaughan
MCBQSE/ 2024/0050	**4.3 Minutes from Directorate QSE Groups and Chairs Reports/Exceptions, for noting:** **4.3a Emergency and Acute Medicine** **4.3b Integrated Medicine** (awaiting minutes UHL next meeting 18th April) **4.3c Specialised Medicine** - Dermatology - Rheumatology - Gastroenterology The group resolved: minutes to be emailed to KP regularly. **Action from discussion:** Highlight Reports will be requested to provide Highlight Reports regarding high level to be highlighted and shared at these meetings.	Barbara Davies
MCBQSE/ 2024/0051	**Feedback from UHB QSE Committee dated 26/3/24** – noted at the previous MCB QSE Meeting. The group resolved: to note the above. **Action from discussion:** there was reference to digital stories. SR will extract these and contact Alex and Team to see what can be gleaned as they were very interesting.	Sian Rowland
MCBQSE/ 2024/0052	**Minutes from QSE Sub Groups:** **4.4a IP&C meeting** (02/02/24) **4.4b H&S meeting** (07/02/2024 awaiting minutes) **4.4c Medicines Access and Governance Group** (15/03/2024 awaiting minutes) The group resolved: to note the above. **Action from discussion:** none.	
5. **ANY OTHER BUSINESS**		
MCBQSE/ 2024/0053	**5.1a Risk of delayed follow up for patients diagnosed with a PE** – no update. **5.1b EMAD Education Framework** – updated by Lowri Warren. This is an update of a current framework. The aim is to provide a structured, clear pathway for professional development. Shows band by band what is expected of staff and what is essential. **5.1c Infectious Disease Student Pack** – for information. **5.1d PPDN Newsletter March 2024** Action: a top down approach is required to releasing staff for training. **5.1e Clinical Safety Group** – resuscitation reports are being presented in a slightly different format with a breakdown per Clinical Board. The data is more meaningful. **5.1.f Diabetes Accreditation Programme** – has undergone as assessment which identified some aspects of improvement were required. **5.1.g Skin Cancer Peer Review** – very positive feedback has been received with some areas of improvement required. The formal report will be shared when received. **5.1.h. Statutory Death Certificate Reform** – the start date is 9/9/24. Therefore, any patient deaths which are not going to Inquest will follow the usual route. Any patient deaths going through the Medical Examiner process, community as well, may lead to requests from Coroner's as they may feed into the hospital system. There is a working group looking at death certification and timescales. **5.1.i. Civica System** – positive and negative feedback received. If anyone interested in following up on family feedback, please contact Nicholas Denny.	Lead/ Senior Nurses

	The group resolved**:** to note the above. **Action from discussion**: to note the above.	
7. DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2024/0054	15/5/24, 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 14TH MAY, 2024, 11 AM
Venue: MS TEAMS

Attendees	
Anna Llewellin	Director of Nursing (Chair)
Anna Mogie (AM)	Deputy Director of Nursing (Chair)
Helen Kemp (HK)	Deputy Clinical Board Director Clinical Director for Quality, Safety and Governance
Sarah Griffiths (SG)	Interim Assistant Director, 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
Clare Clement (CC)	Head of Medicines Management
Lisa Waters (LW)	Senior Nurse for Quality and Education
Helen Earland (HE)	Clinical Operational Lead, GP Out of Hours
Jayne Gay (JG)	Clinical Manager, Out of Hours
Andrea Rich (AR)	Lead Nurse, Palliative Care
Ellen Davies (ED)	Clinical Nurse Specialist in Infection Prevention & Control
Chisom Uwaezuoke (CU)	Senior Nurse for 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
Versha Sood (VS)	Improvement and Development Manager – Dementia
Georgina Davis (GD)	Safeguarding Nurse

Janice Aspinall (JA)	Health and Safety Representative
Chloe Neave (CN)	Cardiff Safe @ Home Nurse Team Lead (Attending to present patient story)
Helen Cordy (HC)	Consultant in Chemical Pathology with Metabolic Medicine (Attending to present POCT within PCIC)
Oliver Williams (OW)	Speciality Registrar in Public Health (Attending to present Equity, Equality, Experience and Patient Safety Framework)
Louise Thomas (LTh) (minutes)	Quality & Safety Officer

Apologies	
Clare Evans (CE)	Director of Operations Primary Care (Interim)
Jane Brown (JB)	Head of Dental and Optometry
Lynne Topham (LTop)	Locality Manager, South and East Locality
Sian Griffiths (SGr)	Public Health Wales representative
Angela Jones (AJ)	Senior Nurse Resuscitation
Rachel Armitage (RA)	Quality and Safety Manager
Maria Dyban (MD)	Community Director Health Care Pathways
Lorna McCourt (LMc)	Staff Side Trade Union Representative

ITEM NO.	**TITLE**	**ACTION**
05/24/01	AL welcomed everyone to the meeting. Chisom Uwaezuoke, Senior Nurse for Infection, Prevention & Control was introduced to the group.	
05/24/02	Apologies of absence were noted as above.	
05/24/03	No declarations of interest were raised.	
05/24/04	<u>Minutes</u> The minutes of the meeting held on 12th March, 2024 were referred to. Please inform LTh of any inaccuracies or amendments. There were no other matters arising.	

	AL informed the group that she had reviewed the structure and timeliness of the PCIC QSE meetings in relation to the Executive Review meetings and proposed holding monthly PCIC QSE meetings with a shortened agenda. The group discussed the frequency of preparing Business Unit reports along with the alignment of the PCIC QSE meetings with individual Business Unit QSE meetings. AL will give consideration to the discussion and inform the group of her decision.	
05/24/05	Action Log Please refer to item 5.	
05/24/06	Patient story (North and West Locality) CN presented a patient story regarding an acute clinical concern referral that was received from a patient's GP following on from a visit by an Advanced Practice Paramedic. Please refer to the patient story (item 6) filed on the Teams channel.	
05/24/07	Dementia Programme RC and VS presented the Dementia Programme. Please refer to the presentation slides in item 7. AM queried RC and VS's views on integrated teams working in communities. RC believed that these teams need to be more cluster based and did not feel that the memory assessment service based in Llandough was the correct location for these patients. However, a Memory Assessment Service Team Leader with a flexible and adaptable approach to the service had recently been employed. Memory link workers had begun to step out into the community and were working more agilely and RC had tried to encourage Memory Link Workers to attend cluster MDMs (there were concerns regarding time). Memory Link Workers had a connection with Liaison Psychiatry who attended the cluster MDMs but RC would ideally like them to attend. NM agreed with RC and pointed out that Memory Link Workers were not seen in the community and staff had no awareness of their role. He felt the model would be more integrated if they were brought into the locality or cluster as the current service fe fragmented. KR pointed out that it may be beneficial for Memory Link Workers to attend the virtual Care at Home meetings to help them gain a knowledge of deteriorating patients. AL thanked RC and VS for their informative presentation.	
05/24/08	Risk Register Update Please see item 8. Three new risks had been added to the Clinical Board risk register, one being the risk related to the Overseas Workforce in Domiciliary Care (which affected Community Domiciliary Care Packages commissioned via CHC), and the other was the Video Consultations Programme. There was a risk of the CAV UHB Video Consultation Programme ceasing with no safe video consultation software option available for Clinical Services after 30th September, 2024. The latter particularly affected HMP Cardiff and DoSH. The third new risk related to diabetic community nursing clinical space.	

05/24/09	Business Continuity An audit on Business Continuity arrangements was anticipated, TB awaits further detail. Plans must be reviewed and updated regularly. TB noted that she was happy to support the group with their plans but had not received the level of engagement required. There are a number of areas that PCIC would not be able to evidence should the Clinical Board be audited. This would be taken to the SMT meeting scheduled on 15th May.	
05/24/10	PCIC Quality Report Please refer to item 10. LW pointed out that there was one open NRI which would hopefully be closed by the end of May. There were two avoidable pressure damage incidents which were in the process of being taken through redress and the Duty of Candour process and would be presented at the next meeting in July. The highest theme in medication incidents was administrative error, however there was no discernible pattern. LW noted that she would be looking at the way in which data was presented in the PCIC Quality Report in order to present the data in a more meaningful format and in line with the Duty of Quality workstream.	
05/24/11	ICO guidance to improve transparency in Health and Social Care Please refer to the link embedded in the agenda. The guidance document is intended to help decide what information can and cannot be legitimately shared, and under what circumstances.	
05/24/12	Other Information Commissioner Guidance Please refer to the links embedded in the agenda from the ICO which provide information and themes that have been identified when the ICO has issued reprimands.	
05/24/13	Removal from the Medical Performers List on grounds of Lack of Activity HK provided background to item 13 explaining that Shared Services manage and monitor the Medical and Dental Performers List on behalf of Health Boards. They provide the Health Boards with a list of GPs who had not worked in their MPL area over the last year. Dr Gneeta Joshi produced item 13 looking at the way in which GPs who had not worked clinically in general practice for a period of time are managed. The document had been shared with the All Wales AMD group. HK noted that the document was guidance only, not a policy and could not therefore be enforced. There were no objections to the document.	
05/24/14	IPC update ED informed the group that PCIC met the reduction expectation for pseudomonas bacteraemia only over the last financial year, this was the same for the rest of the Health Board. The Clinical Board made a 49% reduction on Cdiff. The reduction expectation level was not met, but a large reduction in the number of cases was seen. PCIC came the closest in the UHB to meeting the reduction. CAV UHB saw the highest number of both CDiff reductions and pseudomonas reductions out of all Health Boards in Wales.	

	The RCA return rate last year was 68%, this was a huge improvement on the previous year. ED thanked Amanda Wood and Louise James (ART team) who spoke at the recent IPC Link Practitioner study day on 25th April. She thanked CAVIS staff for their help with the recent audit undertaken which highlighted storage issues. Hand hygiene auditions were carried out along with hand hygiene training with both staff and patients as part of World Hygiene Day. The next Link Practitioner study day will be on 4th July. There were 37 attendees at the first full PCIC IPC training day. ED referred to the high level of measles and pertussis cases in the community and reminded colleagues to ensure staff were wearing the appropriate PPE.	
05/24/15	<u>POCT within PCIC</u> Helen Cordy introduced herself to the group and provided a presentation on 'POCT within PCIC'. Please refer to item 15 filed in the Teams channel.	
05/24/16	<u>SOP – Paediatric Integrated Clinic New Patient Waiting List Review for approval</u> Please refer to item 16.	
05/24/17	<u>Safeguarding</u> GD, Safeguarding Nurse, introduced herself to the group. She explained that an adult practice review had recently been published and revealed that staff were not aware of the difference between the UHB safeguarding team and the Local Authority safeguarding team. GD provided clarity to the group and explained that the UHB safeguarding team was available Monday – Friday, 9 am – 5 pm in an advisory capacity for UHB staff. They could help staff assess risks and look at all health records to scrutinise the risk in relation to the concern being raised by the practitioner. They could produce next steps and action plans for the practitioner working directly with the patient. Completed AS1 forms would be sent to the Local Authority safeguarding team who would carry out any necessary investigations. The UHB did not case load hold. Open cases were open to the Local Authority Social Worker who was the best point of contact for updates. All level 2 and 3 safeguarding training is delivered in person. Violence against women training and level 3 legal aspects training is delivered via Teams. Level 2 child and adult safeguarding training, and violence against women training is mandatory for all UHB staff. Level 3 training is mandatory for all band 6 staff and above, and all F1 doctors and above. Training should be completed every three years and is bookable via ESR. A Single Unified Safeguarding Review had recently been introduced, the purpose of the review was to incorporate established review processes, i.e. adult practice reviews, child practice reviews, domestic homicide reviews, offensive weapon homicide reviews and mental health homicide reviews. The review would continue to be a multi-agency approach and intended to avoid work duplication, provide an understanding of the case outcome along with an understanding of what could be done to improve future practice. The pilot review carried out in CAV UHB had been completed and signed off by the Regional Safeguarding Board. The process was now more streamlined and prevented the need for three separate reviews (previously there would have been an adult practice review, mental health homicide review and a domestic homicide review). Information would be stored in the Wales Safeguarding and Records Repository to inform future reviews and changes in practice. Any new reviews at	

	the year end would be conducted as a single unified safeguarding review. Please contact GD should you have any queries.	
05/24/18	MCA/DoLs There was nothing to report.	
05/24/19	Ombudsman report 202204315 Please see items 19a and 19b.	
05/24/20	CPET and Health Pathways Please refer to item 20.	
05/24/21	HIW – 03396 – Llantwit Major and Coastal Vale Medical Practice Please refer to the link included in the agenda. All actions had been agreed with HIW and the GMS team had developed checklists for practices undergoing HIW reports involving Infection Control.	
05/24/22	A Single Process for Mortality Review in General Practice in Wales HK explained that as of 9th September, 2024, every death in both the community and hospital setting that was not referred to the Coroner would be scrutinised by the Medical Examiners Service (MES). Item 22 described what Health Boards and General Practices should do when a referral was received from the MES. The document had been created to learn from experiences of undertaking mortality reviews.	
05/24/23	Equity, Equality, Experience and Patient Safety Framework Oliver Williams, Speciality Registrar in Public Health gave a presentation on 'Equity, Equality, Experience and Patient Safety Framework'. Please refer to item 23 filed in the Teams channel. An action plan would be taken to the QSE meeting scheduled on 21st May. OW noted that he was happy to add any further actions should members of the group be involved in any work that addresses inequalities.	
05/24/24.1-24.8	Sub Group reports Please refer to items 24.1 – 24.8	
05/24/25 05/24/26 05/24/27	Any Other Business Diabetic Eye Screening for Wales Please refer to items 25a and 25b. Right Care, Right Person – Police response to 'concern for welfare' calls Please see the link embedded in the agenda. Community Nursing DNA procedure LW explained that item 27 was updated in response to a recent Coroner's inquest. A District Nurse attended a patient's home but no response was received when she arrived. The following day, the patient was sadly discovered to have passed away. The guidance documents what should be done when visiting patients who are not at home as expected. The document had been returned to the Coroner with comments. Anaesthesia Associates and Physician Associates Legislation passed 26/02/24	

05/24/28	HK referred to the link she added to the chat bar and also embedded in the agenda. She also noted that the GMC had an open consultation regarding the role of Physicians Associates which closed on 20th May. Please refer to the link added in the Teams chat.	
PART 2	Please note the papers submitted for information (parts 2.1 – 2.48)	
Date and time of next meeting: Tuesday 16th July, 2024 at 11.00 am.		

Safeguarding Steering Group Meeting
Friday 17th May 2024
Via Teams

Present:

Jason Roberts –	Executive Nurse Director
Jane Murphy –	Interim Deputy Executive Nurse Director
Linda Hughes-Jones -	Head of Safeguarding
Bethan Williams	Named Paediatrician for Children Looked After and Adoption
Katina Kontos	Named Dr for Safeguarding Children
Andy Jones	Director of Nursing, Children & Women Clinical Board
Fiona Bullock	Senior Nurse, Safeguarding
Anna Mogie	Deputy Director of nursing - PCIC Clinical Board
Chris Davies	Cardiff Local Authority Safe Service Manager for Exploitation and Missing Children
Judith Cutter	Consultant midwife
Helen Luton	Interim Director of Nursing, CD&T Clinical Board
Pippa Johnson	Mental Capacity facilitator (MCA)
Rachel Rushforth	Lead nurse for Adult Mental Health, Mental Health Clinical Board
Faye Protheroe	Bereavement Lead Nurse
Helen Whalley	Deputy Bereavement Nurse
Ceri Lovell	Senior Nurse for CAMHS
Gabriela Bezerra	Cardiff Local Authority YEF MDT Project Manager
Linda Anderton	PHW, National Safeguarding Service,
Catherine Twamley	Interim Director of Nursing – Specialist Services Clinical Board
Fiona Sullivan	Spire, Safeguarding Lead
Jeff Morgan	Consultant Paediatrician Emergency Department
David Pitchforth	Lead Nurse Integrated Medicine Clinical Board

	PART 1: PRELIMINARIES *(Chair)*	**ACTION BY**
1.1	**Welcome**	
1.2	**Apologies for Absence** Bev Oughton, Angela Stephenson, Chloe Evans, Mel Bostock, Claire Wade, Mark Doherty, Georgie Davies, Lisa Green, Rachel Raymond, Sarah Pippen	
1.3	**Approval of SSG Minutes from the previous meeting**	
1.4	**Action Log**	
PART 2: STRATEGIC DIRECTION AND SERVICE IMPROVEMENT		
2.1	**Update from Andy Jones on JIPA actions:** The 3 main areas of concern for C&W were pressure damage, training and CLA. A presentation on the full JICPA report was presented, which outlined the UHB learning, good practice and areas of improvement.	2.1 - Report of Joint Inspection of Child I

	Update to Members on new proposal for the governance of Cardiff and Vale University Health Board, Safeguarding Steering Group Meeting arrangements. Discussion held around the development of Clinical Board Safeguarding Groups (CBSG), monitoring, compliance and sharing of data. CBs will report at each SSG meeting. Final report / action plan from the UHB is due for submission on the 17th June 2024. Cardiff Children's Services will submit the report on behalf of all partner agencies. **Action: School Health Nurse Health Assessment, Paula Davies to update SSG at the next meeting**	
2.2	**Update: Contextual Safeguarding – Chris Davies:** Chris shared his presentation on "Keeping and staying SAFE" project funded through the Youth Endowment Fund. Chris expressed how well the working partnerships between Health and Police are, in developing the work across the Cardiff region. Charlotte Westacott – UHB Safeguarding Nurse Advisor has been seconded to the team for two days per week in a strategic, advisory role. Charlotte is the health contact for any departments that would consider linking in with SAFE. Chris has asked if they could be invited to any UHB events to promote their team. CW will be linking in with UHB service areas such as Violence Prevention Team, Emergency Dept, GPs etc in the next few weeks. **Action: SAFE to be invited to return to the SSG in 9 months to discuss progress**	YEF Presentation to CAVUHB SSR meetin ***Feb 25***
2.3	**Clinical Board Governance Reports:** The new governance arrangements for CB reporting discussed, Terms of Reference, Monitoring Form and a CB Self-Assessment form was shared at the meeting and approved. The CB self-assessment will assist with the UHB completion of the PHW Safeguarding Maturity Matrix Assessment. Areas of CB reporting are: compliance of safeguarding training, AS1 and MARF referrals, pressure damage requiring UHB reporting, the use of language line, information assurance, the information of monitoring patients placed outside of C&V and the number of open professional allegations. Promoting the Wales Safeguarding Procedures (2019) app on staff mobiles and computer desktops is a priority across the UHB. JR is proposing a dashboard would be more beneficial to use rather than the CB's self-assessments. **Action: LHJ and JR to meet to agree a priority list of reporting** **LHJ and Aron White to meet regarding creating a dashboard share at SSG** **Action: Update ToR, CBs Monitoring Reports to be sent to Natalie in advance of SSG meeting** **<u>UHB Safeguarding Training Compliance from April 24</u>** Level 2 Adult: 80.19% Level 2 Children: 78.98% VAWDASV (G1) 75.3%	***July 24*** ***July 24***
PART 3: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
3.1	**Emergency Department Safeguarding Meetings Update:** Presentation on a complex case following discharge	**Deferred**

3.2	**Children Looked After Update: CLA Health Assessments compliance:** A presentation demonstrated that the team will be monitoring the number of children who remain on the paediatric ward or in ED once they are medically fit for discharged due to no possible placement for the child with their family. Discussion held in respect of the number of health assessments completed for CLA children in placements or adopted. There is a Wales Statutory Placement survey underway. In addition, there is a UK consent initiative to be rolled out with accompanying training considering capacity. There is a gap in the recruitment of medical advisors for the service. CLA nurses are currently managing 140 cases each, the advised amount is 100. The backlog in health assessments within the statutory timeframe is gradually decreasing.	SSG LAC Upda Presentation M
3.3	**Update: PRUDiC Dr Jeff Morgan:** Short discussion due to clinical duties. There are 20 cases awaiting presentation**.** Two cases are open whilst awaiting the Coroner's investigations. There are challenges obtaining documentation form the Coroner's office to close the M&M process. There is new PRUDIC documentation Appendix 3 for clinicians to complete, this is not being completed in a number of cases. The Child Death Review panel require the information, this will require promotion across the Paediatrician workforce. **Action: PRUDIC to be revisited at next meeting. Appendix 3 to be shared and promoted with Paediatricians.** **Update: Bereavement Service:** Faye Protheroe shared information that between January -March 2024, the team has supported 882 families. A poster with a QR code has been developed to raise awareness of the team and how to refer. The care of families who have experienced early pregnancy loss will be supported by the wider Health Board services. A new pathway is being developed for families. There will also be a pregnancy and baby loss pathway from the WG as part of the wider framework. A pilot palliative care team in Marie Curie are working with the bereavement team. Volunteers will attend to UHW initially and provide additional support and companionship to patients / families with a terminal diagnosis. Training requests have increased. The mortuary is undergoing refurbishment and will have limited capacity until approximately October 2024.	**July 24**
PART 4: GOVERNANCE		
4.1	**MCA / DoLs Assessments:** Consent training will be mandatory as advised by the WG. **Action: Feedback to be shared across CBs**	SSG Feedback.
PART 5: REPORTS/ MINUTES FROM OTHER GROUPS/COMMITTEES		
5.1	**RSB Update**: - A single view of the child IT system is being developed by Cardiff LA in conjunction with the UHB IT Department. The information will allow practitioners to see who the child is open to and in which teams - The Right Care, Right Person information shared in the RSB meeting - There will be a child and adult neglect toolkit released shortly from the RSB.	
5.2	**NHS Safeguarding Network:**	April update Network and NSS .d

	- The PHW workplan has been signed off and approved. Focus is on assurance and partnership working. - Mandatory training around PREVENT - On-going work around new Standard Operating Procedure regarding the process in relation to death that are due to suicide. - Dr Claire Thomas has developed new leaflets to support the PRUDIC process. - Restorative supervision work is on-going **Action: PRUDiC Leaflets to be circulated**	
PART 6: FOR INFORMATION		
6.1	• NHS Right care Right person toolkit • Development day summary report • WSAS Newsletter • RSB Annual report 23-24 • SBAR – to agree a consistent or mandated approach for prevent awareness training • Restorative supervision experience • Wales Safeguarding Procedures Newsletter • Resources to identify YP of risk of exploitation • CV UHB SOP Prudic Concise CPR report CYSUR 03/2021	
PART 7: ANY OTHER BUSINESS		
7.1	• Terms of Reference Safeguarding Steering Group signed off for 2024 • Internal Audit Safeguarding Final Report. New audit to be undertaken 2024/25. • UHB Safeguarding allegation concern 2021 • Annual Safeguarding Maturity Matrix July 2023 • SSG Attendance from Clinical Boards • Cardiff and Vale University Health Board Safeguarding Training Strategy 2024 • NHS Safeguarding Network Bulletin – Jan 24 • Professional Concerns questionnaire https://forms.office.com/e/QuC4K2WMfj	
PART 8: KEY MESSAGES FROM MEETING		
PART 9: NEXT MEETING OF THE UHB SAFEGUARDING STEERING GROUP		
	FURTHER SAFEGUARDING STEERING GROUP DETAILS 30th July – Nant Fawr Un, Woodlands House | 9.30-11.30 hrs	

ACTION LOG

MINUTE POINT	ACTION 17th May 2024	PERSON RESPONSIBLE	TIMESCALE
2.1	**Action: School Health Nurse Health Assessment, Paula Davies to update SSG at the next meeting**	AJ/PD	September 2024
2.2	**Action: SAFE to be invited to return to the SSG in 9 months to discuss progress**	LH-J/ CD	March 2025
2.3	**Clinical Board Reporting:** **Action: LHJ and JR to meet to agree a priority list of reporting** **LHJ and Aron White to meet regarding creating a dashboard share at SSG** **Action: Update ToR, CBs Monitoring Reports to be sent to Natalie in advance of SSG meeting**	LHJ / JR LHJ	September 2024 COMPLETED
3.3	**Action: PRUDIC to be revisited at next meeting. Appendix 3 to be shared and promoted with Paediatricians.**	LH-J/ JM	September 2024
4.1	**Action: Feedback to be shared across CBs**	All CBs to give Assurance	July 2024
5.2	**Action: PRUDiC Leaflets to be circulated**	LH-J/ CT	July 2024

MINUTE POINT	ACTION 15th March 2024	PERSON RESPONSIBLE	TIMESCALE
3.4	NRI to be shared at SSG once completed. The business plan to be brought to SSG in July 2024	**Ceri Lovell**	**July 24**

Rolled over from previous meetings

MINUTE POINT	ACTION 25th January 2024	PERSON RESPONSIBLE	TIMESCALE
4.2	Mel to meet with Linda to discuss mandatory training for safeguarding and consent	**MB & LHJ**	**July 2024**
5.2	Annette will speak to her Welsh counterparts regarding Spire accessing the Welsh nursing care records	**AB**	**July 2024**

	ACTION 23th November 2023		
2.5	RR to return in May to update SSG on the pilot	**Rachel Raymond**	**September 2024**

	ACTION 28th September 2023		

3.2	Dr Bethan Williams to work together with Dr Zoe Roberts and Adele around amalgamating the health care needs form and the acute emergency care form	Bethan Williams/ Zoe Roberts/ Adele Watkins	**On-Going July 2024**

	ACTION 28th JULY 2023		
3.1	Safeguarding to consider monitoring the AS1 referrals and feedback to MH Clinic Board in November through SSG.	**Safeguarding Team/ MH HLPs**	**Completed**

	ACTION 17th March 2023		
2.1	Undertake rolling programme of evaluation of training on a 6-12-months basis. (Feedback on training)	**NJ/ SJ safeguarding team**	**Annual update**

	ACTION 26th January 2023		**TIMESCALE**
3.3	Action: Lisa to share an update at the next meeting on a complex case following discharge	**Lisa Green**	**September 2024**
7.1	Residential placements for C&Y people that are commissioned by the NHS where there are concerns - LHJ to feedback at next SSG	**Linda HJ/ Laura Hutchinson**	**July 2024**

	ACTION 25th November 22		
3.6	BW to feedback to the SSG the continuity of records for adopted children when resolved	Bethan Williams	With National Safeguarding Service

Report Title:	*Research and Development Update*			Agenda Item no.	4.2
Meeting:	QS&E	Public	X	Meeting Date:	16.07.2024
		Private			

Status *(please tick one only)*:	Assurance		Approval		Information	X
Lead Executive Title:	Richard Skone					
Report Author (Title):	Sarah Martin – R&D manager					

Main Report

Background and current situation:

Report is to supplement presentation from R&D giving an update on activity in 23/24 and plans for 24/25.

Attached report provides report on outcome of the patient satisfaction survey completed by the research team September to December 2023

Report on Participant Satisfacti

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

Recommendation:

For information only to demonstrate feedback and view of patients who have participate in research. Demonstrating that patients saw being involved in research was a positive experience and want more information about what research is available and how they can get involved.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

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

Five Ways of Working (Sustainable Development Principles) considered

*Please place an "**X**" in the below boxes as relevant*

Prevention		Long term		Integration		Collaboration		Involvement	X

Quality Impact Assessment Completed?:

*Please place an "**X**" in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*

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

Impact Assessment:

*Please state **yes** or **no** for each category. **If yes please provide further details.***

Risk: No

Safety: No	
Financial: No	
Workforce: No	
Legal: No	
Reputational: No	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Cardiff and Vale Research Delivery Team
Tîm Cyflawni Ymchwil Caerdydd a'r Fro

Report on Participant Satisfaction

"Everyone has been absolutely amazing. Caring, considerate and empathetic. Always available for support and have helped me beyond my expectations. Thank you!" – *MP18 participant*

"The study is a life line after there were no treatment options left so I greatly appreciate the opportunity to take part in the study to hopefully help me get better and in some way help with data collection to help other patients. The staff on the unit are amazing and very professional" – *AGAVE participant*

The staff. All of them. The consultants, admin, reception and nurses are great, friendly and welcoming. They made me feel really relaxed and make awesome tea" – *Odyssey participant*

Report on Participant Satisfaction:

Delyth Braim, Research Delivery Manager

DB 31/01/2024

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

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Cardiff and Vale Research Delivery Team
Tîm Cyflawni Ymchwil Caerdydd a'r Fro

Table of Contents

Background

Cardiff & Vale University Health Board (CVUHB) has a mixed model of research delivery structure which includes a Research Delivery Team (RDT) under the direct line management of R&D. This team consists of just over 100 research delivery staff comprising of research nurses, research officers and trial administrators who support a number of clinical areas both within the Clinical Research Facility (CRF) and across the UHB. The team has been set up to ensure they have the skills to support a diverse portfolio of studies from intensive early phase studies to large scale later phase studies. There are currently dedicated teams in a number of specific areas of local strength which include:

- Surgery
- Medicine
- Infectious Disease
- Mental Health
- Early phase
- Critical Care
- Obstetrics and Gynae
- Cystic Fibrosis
- University Hospital of Llandough – generic team

Whilst the RDT are an expert workforce delivering high quality participant care and ensuring participant safety is paramount, the service provided has not been evaluated from a participant perspective or formal participant feedback sought. Therefore, a decision was made to create a research participant feedback questionnaire and run a pilot scheme for 3 months.

C&V UHB have a continuous programme for patient satisfaction questionnaires, that can be sent electronically or in paper form. The RDT developed the research participant satisfaction questionnaire in collaboration with the UHB's Patient Experience Team utilising their knowledge and expertise in devising a questionnaire and interpreting the results.

Objectives

- Create a research participant satisfaction questionnaire and run a pilot for 3 months from September 2023 to December 2023
- Evaluate what participants think of the service we provide
- Disseminate results within the RDT and identify any areas for improvement
- Create a poster on Research Participant Satisfaction questionnaire

Method

Two of the RDT Team Leads arranged a meeting with the Patient Experience Team Manager to discuss how to create a research participant satisfaction questionnaire and the practicalities on delivering the questionnaire including receiving the forms and producing the results. The meeting was productive and very informative.

An internet search was performed reviewing examples of participant satisfaction questionnaires, including the NIHR – PRES survey, the John Hopkins research participant satisfaction survey and the TransCelerate Study Participant Feedback Questionnaire (SPFQ). Following the review, a decision was made to utilise some of the most appropriate questions but also develop a number of our own. The questionnaire was shared with other Team Leads for feedback before finalising the format.

The pilot phase was conducted administering the questionnaire in paper form only offering the questionnaire to all participants that attended research visits at outpatient clinics, inpatients on ward, participants in the Clinical Research Facility (CRF) and those in their own homes.

50 questionnaires were initially distributed between 7 research delivery teams. Stamped addressed envelopes were provided and a secure box was placed on the reception desk in the CRF for completed questionnaires. Further questionnaires were printed and supplied to the teams as required.

The pilot ran from Monday 11th September to Friday 11th December 2023. It was quickly realised that the team needed to record how many questionnaires were distributed, therefore all teams were notified to keep a tally from the 25th September 2023.

Questionnaires were returned on an ad-hoc basis and the RDT PA/Administrator was responsible for collecting the questionnaires. Due to their experience of satisfaction surveys, they also reviewed the questionnaires for any comments/feedback which may have needed addressing immediately.

Results

During the pilot dates of 11th September 2023 to 11th December 2023, approximately 58 questionnaires were distributed to research participants (the number of questionnaires handed out between 11th September 2023 and 25th September 2023 had not been recorded). The number of completed and returned questionnaires was 58.

This was extremely promising, due to the fact that the Patient Experience Team response rate for the UHB was approx. 19%. The response rate noted may have been biased due to the fact most research participants are invested in the research study that they are taking part in due to altruism or finding new treatments.

Generally, the overall results were positive indicating that:

- 98% of participants would take part in future research studies
- 88% of participants felt the study visits were well organised
- 100% of participants were aware their participation was voluntary & that they could withdraw at any time

However, feedback received also highlighted:

- Better directions/signage to the CRF facility was required
- 63% of participants would not know how to access further information on other research studies that they may be able to participate in.

Action Plan

A patient satisfaction group was convened comprising of staff representatives from all the teams within the RDT.

The main remit of the group was to review the results and agree subsequent actions as below:

- Establish future dates for survey delivery - 3-month survey Aug-Nov 2024, annually
- Potentially reformat questions based on SPSS analysis
- Explore other modes of questionnaire delivery- liaise with Patient Experience Team to develop an online questionnaire
- Provide better signage to the Clinical Research Facility from within the UHB and improve directions via updating the map
- Liaise with the Joint Research Office and the UHB Communications team to raise the profile of research within the health board
- Develop FAQs for patient travel re-imbursement for staff and patients
- Produce a poster for various conferences

If you require any further information or wish to discuss, please contact:

Delyth Braim, Research Delivery Manager

delyth.braim@wales.nhs.uk

Appendix 1. Research Participant satisfaction questionnaire

GIG CYMRU NHS WALES
Cardiff and Vale Research Delivery Team
Tîm Cyflawni Ymchwil Caerdydd a'r Fro

Cardiff and Vale University Health Board

Research participant experience questionnaire

In order to improve the service we provide we would be grateful if you could complete this short questionnaire regarding your experiences of taking part in a **research study**.

The questionnaire should take around 3 **minutes** to complete, is voluntary and all the results are anonymous.

When answering the questions, please help us by giving your honest opinion and please do not include anything personal that you do not wish being made public, as on occasion we might wish to share your anonymised feedback.

If you are helping someone complete this questionnaire, please ensure that it is the patient's opinion that is recorded.

Thank you in anticipation, your contribution is greatly appreciated.

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1. What is the name of the research study you are currently taking part in?

.....

2. Is this the first research study you have taken part in?

- ☐ Yes
- ☐ No

3. How long have you been taking part in this study?

- ☐ Less than 6 months
- ☐ 6 months - 1 year
- ☐ 1 - 2 years
- ☐ 2 - 3 years
- ☐ More than 3 years
- ☐ Not sure

Appendix 1. Research Participant satisfaction questionnaire

4. The following questions are about your experience of taking part in the study.

When answering, please say how strongly you agree or disagree with the statement.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Not applicable
a. The information I received before taking part, prepared me for my experience in the study.	☐	☐	☐	☐	☐	☐
b. It was clear from the beginning the level of commitment required from me.	☐	☐	☐	☐	☐	☐
c. I feel comfortable asking questions about the study.	☐	☐	☐	☐	☐	☐
d. I am satisfied with the answers I have received to my questions during the study to date.	☐	☐	☐	☐	☐	☐
e. The consent process was clearly explained and I felt supported in agreeing to participate.	☐	☐	☐	☐	☐	☐
f. I am fully aware that my participation is voluntary and that I can withdraw at anytime.	☐	☐	☐	☐	☐	☐
g. I know how to contact someone from the research team if I have any questions or concerns.	☐	☐	☐	☐	☐	☐
h. My study visits are well organised.	☐	☐	☐	☐	☐	☐
i. My study visits are scheduled at a time convenient to me.	☐	☐	☐	☐	☐	☐
j. Clear instructions are provided on how to find the location of my appointment.	☐	☐	☐	☐	☐	☐
k. I feel research staff value my taking part in this research study.	☐	☐	☐	☐	☐	☐

Appendix 1. Research Participant satisfaction questionnaire

5. Tell us something positive about your experience taking part in a research study?

.....

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6. How could we have made taking part in a research study better for you?

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.....

.....

7. Would you consider taking part in a research study again?

☐ Yes
☐ No

8. If yes, would you know how to access information about other studies you may be able to take part in?

☐ Yes
☐ No

Thank you for completing this questionnaire.

Please post this questionnaire back in the pre-paid envelope provided. No stamp is needed.

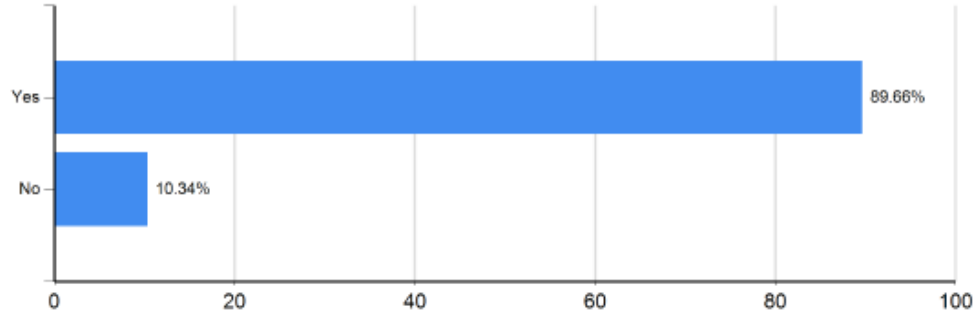
If you are interested in finding out more about other research studies that are being run in Cardiff and Vale, please contact: **researchdelivery.cav@wales.nhs.uk**

Appendix 2. Questionnaire results

Question 2: Is this the first research study you have taken part in?

Create new action

Available Answers	Responses	Score (%)
Yes	52	89.66%
No	6	10.34%
Total	**58**	**100%**



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Appendix 2. Questionnaire results

Survey Summary Report

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

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

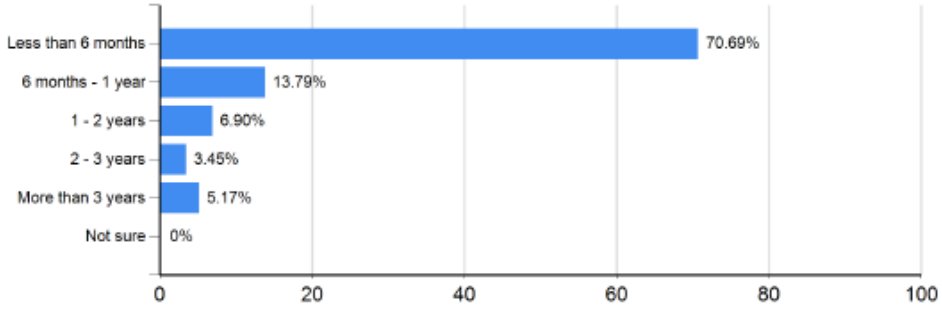
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 3: How long have you been taking part in this study?

Create new action

Available Answers	Responses	Score (%)
Less than 6 months	41	70.69%
6 months - 1 year	8	13.79%
1 - 2 years	4	6.90%
2 - 3 years	2	3.45%
More than 3 years	3	5.17%
Not sure	0	0.00%
Total	**58**	**100%**



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CIVICA

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

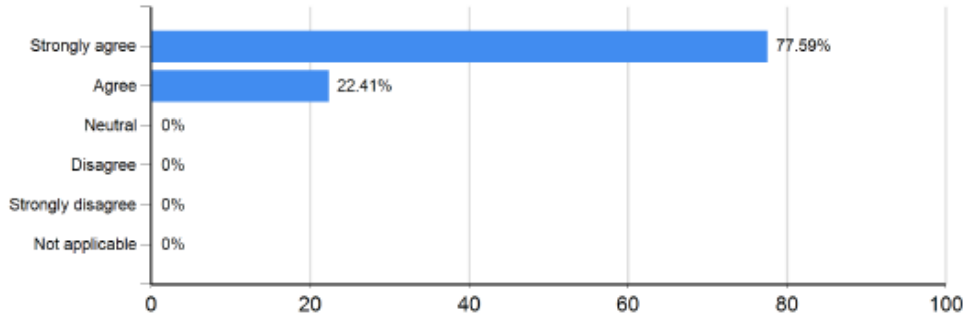
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: I am fully aware that my participation is voluntary and that I can withdraw at anytime.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	45	77.59%
Agree	13	22.41%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly disagree	0	0.00%
Not applicable	0	0.00%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

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

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

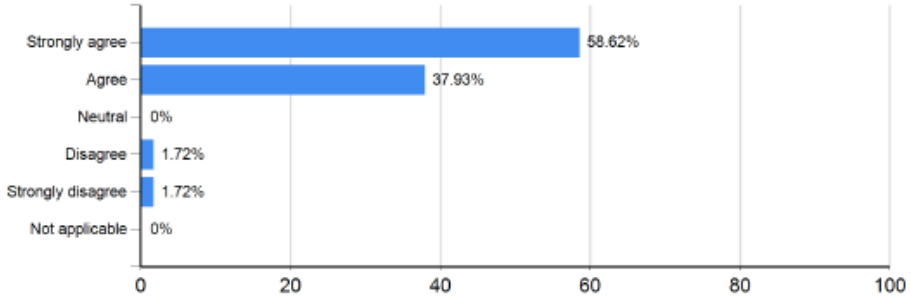
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: I know how to contact someone from the research team if I have any questions or concerns.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	34	58.62%
Agree	22	37.93%
Neutral	0	0.00%
Disagree	1	1.72%
Strongly disagree	1	1.72%
Not applicable	0	0.00%
Total	**58**	**100%**



Report Generated: 2/1/2024 3:44:36 PM

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CIVICA

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

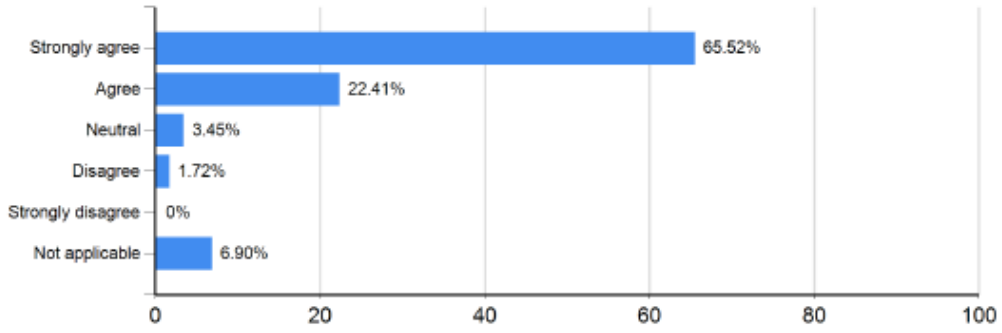
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: My study visits are well organised.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	38	65.52%
Agree	13	22.41%
Neutral	2	3.45%
Disagree	1	1.72%
Strongly disagree	0	0.00%
Not applicable	4	6.90%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

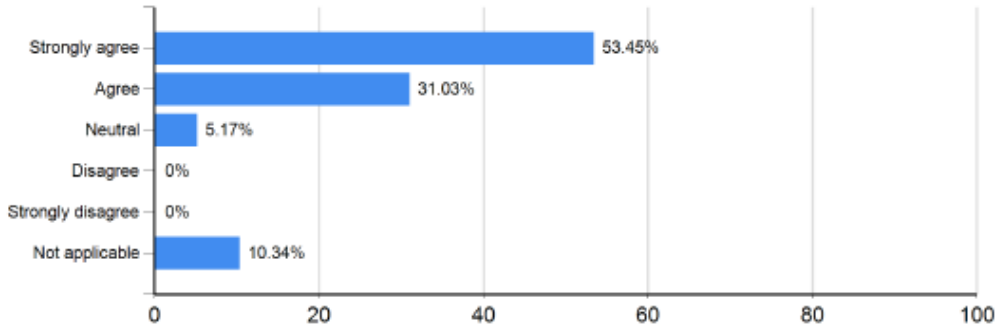
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: My study visits are scheduled at a time convenient to me.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	31	53.45%
Agree	18	31.03%
Neutral	3	5.17%
Disagree	0	0.00%
Strongly disagree	0	0.00%
Not applicable	6	10.34%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

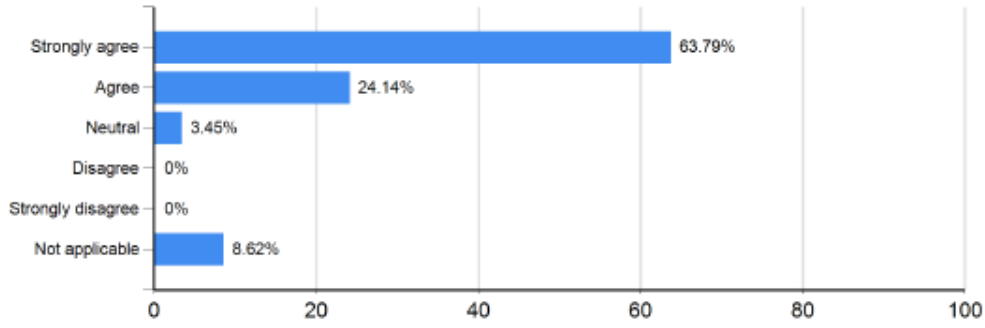
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: Clear instructions are provided on how to find the location of my appointment.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	37	63.79%
Agree	14	24.14%
Neutral	2	3.45%
Disagree	0	0.00%
Strongly disagree	0	0.00%
Not applicable	5	8.62%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

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

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

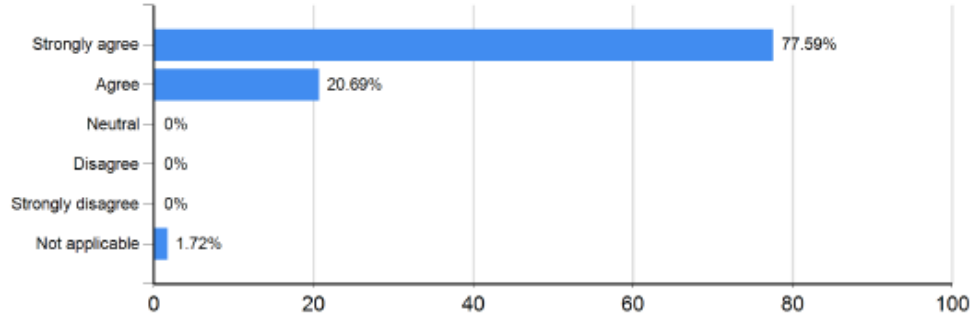
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: I feel research staff value my taking part in this research study.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	45	77.59%
Agree	12	20.69%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly disagree	0	0.00%
Not applicable	1	1.72%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

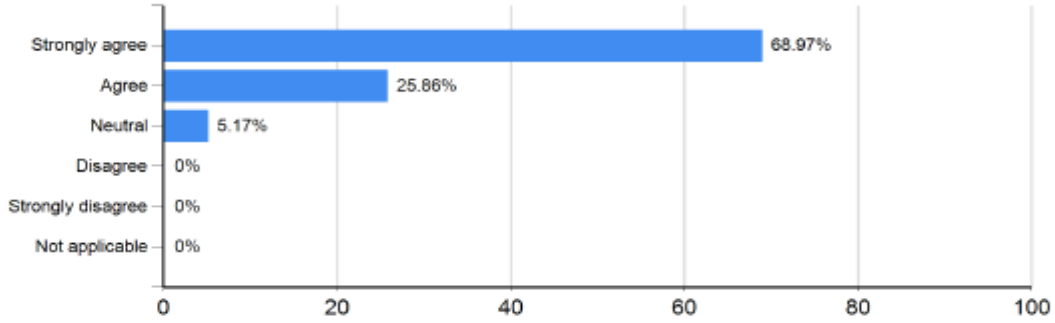
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: The information I received before taking part prepared me for my experience in the study.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	40	68.97%
Agree	15	25.86%
Neutral	3	5.17%
Disagree	0	0.00%
Strongly disagree	0	0.00%
Not applicable	0	0.00%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

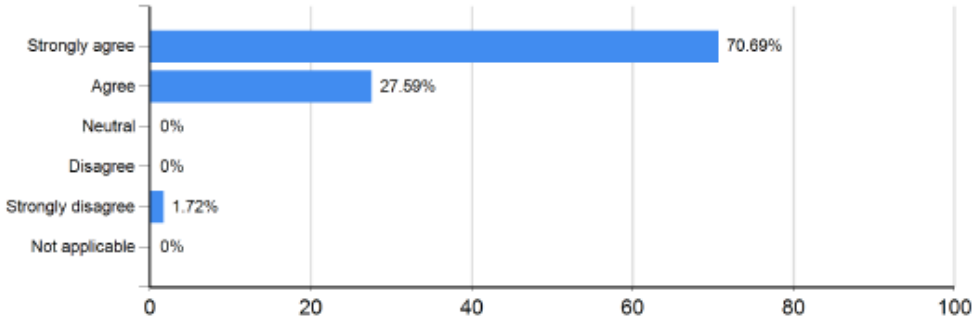
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: It was clear from the beginning the level of commitment required from me.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	41	70.69%
Agree	16	27.59%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly disagree	1	1.72%
Not applicable	0	0.00%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

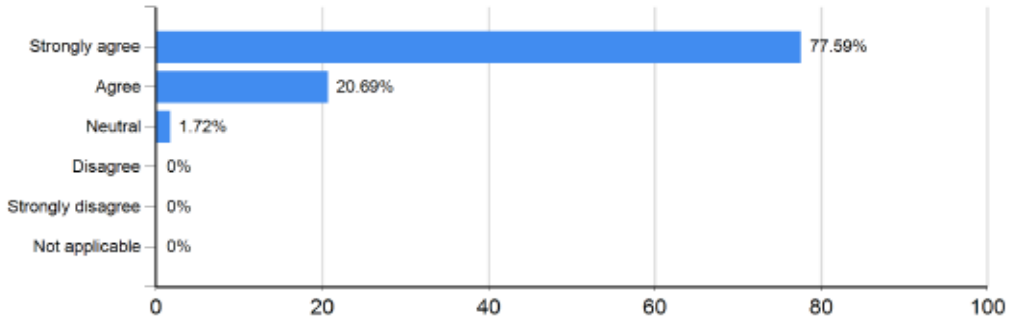
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: I feel comfortable asking questions about the study.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	45	77.59%
Agree	12	20.69%
Neutral	1	1.72%
Disagree	0	0.00%
Strongly disagree	0	0.00%
Not applicable	0	0.00%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

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

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

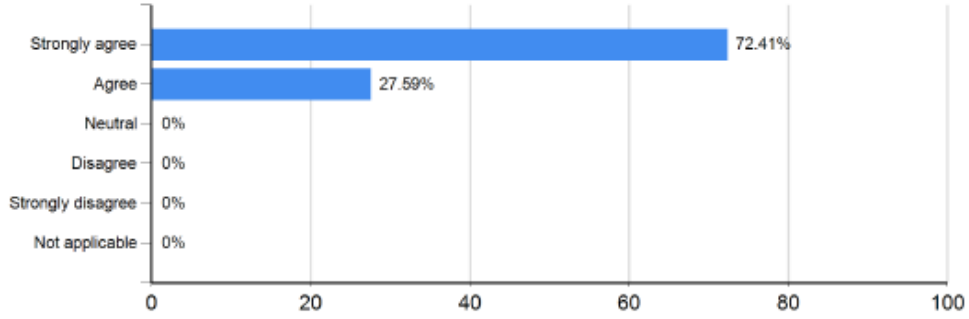
Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 4: I am satisfied with the answers I have received to my questions during the study to date.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	42	72.41%
Agree	16	27.59%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly disagree	0	0.00%
Not applicable	0	0.00%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

Survey: Patient Questionnaire (RP)

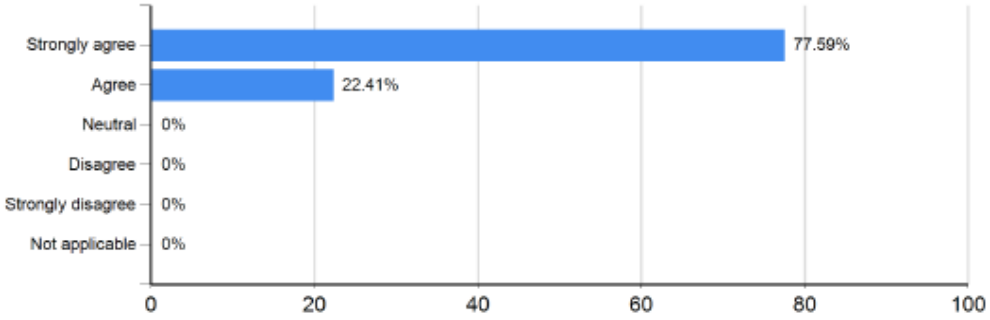
Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

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

Question 4: The consent process was clearly explained and I felt supported in agreeing to participate.

Create new action

Available Answers	Responses	Score (%)
Strongly agree	45	77.59%
Agree	13	22.41%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly disagree	0	0.00%
Not applicable	0	0.00%
Total	**58**	**100%**



Question 5: Tell us something positive about your experience taking part in a research study?

Create new action

Unknown	On my first visit the consultant added 1 further medication to help with my cholesterol levels, something I probably wouldn't have had via my GP.	b4614bc3 / 2024-01	Create new actions
Unknown	Very well organised, staff were great	a19b3ebd / 2024-01	Create new actions

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey I

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:0

Unknown	Time was convenient for the appointment due to easier parking. I was also accompanied by a student who helped explore the way through the maze of corridors
Unknown	The staff are very kind and attentive
Unknown	Hopefully my taking part may benefit others. Staff were friendly and helpful
Unknown	It gives me confidence for the future and hope the research helps others
Unknown	Really pleasant, feel very valuable to the study
Unknown	The staff are very friendly and helpful
Unknown	Lovely staff and I felt my contribution was valued
Unknown	The team has been lovely. Very supportive and welcoming, explaining all aspects of the process clearly
Unknown	The staff are all very helpful and pleasant
Unknown	A feeling of heling in clinical study
Unknown	Really lovely environment & feels very worthwhile. Straight forward.
Unknown	Staff were incredibly friendly and helpful
Unknown	Easy to participate
Unknown	Very welcoming and feel comfortable to ask questions
Unknown	Friendly and supportive staff
Unknown	Staff are supportive and informative

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey I

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:0

Unknown	Friendly staff
Unknown	It has reassured me that I have been on the right track regarding medication and has helped me focus on returning to full health. As this is the only major illness in my lifetime.
Unknown	I like to think I am helping with medicine research which can benefit all. I am interested in the subject matter of the study and am enjoying the participation
Unknown	I've enjoyed trialing important vaccines and it's a passive way of telling anti vaxers where to go.
Unknown	Friendly staff and flexible when needing to change appointment
Unknown	The nurses treating me have been great and so chatty. I can't quite remember all of their names. Lizzie, the one with glasses and light brown hair and the younger one with dark hair.
Unknown	The staff. All of them. The consultants, admin, reception and nurses are great, friendly and welcoming. They made me feel really relaxed and make awesome tea.
Unknown	Well organised

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:0

Unknown	Everyone has been absolutely amazing. Caring, considerate and empathetic. Always available for support and have helped me beyond my expectations. Thank you!
Unknown	Hospital patients have had improved care during their stays, leading to better patient satisfaction and sometimes better recovery times. People feel listened to and that is a good thing.
Unknown	Everything explained. No pressure. Staff polite.
Unknown	I think it will help others.
Unknown	My medication was always ready for me at my appointments. Staff very professional, polite and friendly. Thank you. Always available with any enquiries.
Unknown	10/10 Nurses. Excellent contact with diabetes specialists. The sense of doing something important.
Unknown	I can see how much I have improved compared to previous visit.
Unknown	Everything is explained fully and I am well looked after whilst i'm at the hospital. All the staff are friendly and professional.
Unknown	Laughing and staff

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:

Unknown	From day one, Nadine and Sally were brilliant. At each visit everything was ready prepared. It's been three monthly visits, now i'm past STC and although some staff members have changed, each one is still as professional as my first visit. I have had cause to ring and speak to someone and each time the support has been first class. Special mention to Sarah for the telephone support.
Unknown	The study is a life line after there were no treatment options left, so, I greatly appreciate the opportunity to take part in the study to hopefully help me get better and in some way help with data collection to help other patients. The staff on the unit are amazing and very professional
Unknown	By taking part in the study more people coming through the system will benefit from this study
Unknown	Simple trial - Daily supplements (or placebo) Friendly team Professional team Hopefully will benefit others/treatment options Simple/economic trial
Unknown	It's good to feel that you are taking part and it may benefit others in the future.
Unknown	The staff were very supportive. The researchers were gentle in their communication

Report Generated:

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:

Unknown	I feel I am helping future in med care
Unknown	Staff are very knowledgeable and informative, answering any questions and if they were unable to answer they would go and find it. Timing was very flexible around my schedule. Lauren and Diego are very friendly and accommodating whilst also being very professional.
Unknown	I feel that by being part of a study of this type, 2 things are happening: I'm being closely monitored, which can only be a good thing in my opinion. This gave me reassurance. I'm helping advance knowledge and hopefully treatments for other women with my type of breast cancer in the future.
Unknown	It felt good to be helping with the research to help the scientists to learn more about the treatment of cancer and hopefully improve the prognosis and treatment for future cancer patients.
Unknown	Good information provision. Quicker appointment/waiting time
Unknown	Hopefully resolved all issues! Care has always been excellent
Unknown	I have no complications and it was successful

Report Generated:

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:0

Unknown	The ladies are very friendly and allow me to take time to answer so they can gather their information
Unknown	Helping either myself or others.
Unknown	It's too early to tell
Unknown	You feel by participating in the research that at some point in the future you are making a difference to the people who will follow you.
Unknown	Has given me the opportunity to learn more about my diabetes and to access support from the team when I needed it.
Unknown	I volunteered to participate in this study because if this research can benefit future patients to receive early diagnosis of cancer, that would be fantastic.
Unknown	I hope the research proves to be successful and my taking part has been useful.

Appendix 2. Questionnaire results

Question 6: How could we have made taking part in a research study better for you?

Create new action

Unknown	I can't think of any improvements that can be made.	b4614bc3 / 2024-01
Unknown	No improvements required	a19b3ebd / 2024-01
Unknown	I could see no improvements could be made as it was my first time doing a study	15732abe / 2024-01

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00

Unknown	Things are fine
Unknown	Wasn't given advance notice of being asked to participate, which was fine for me but might not be convenient for others.
Unknown	n/a
Unknown	More notice/ information on payment schedule
Unknown	I can't really fault the experience. Maybe receiving information prior to first appointment about how to access the hospital via public transport would have been useful. Maybe receiving pay slips for each payment as it's a bit vague.
Unknown	Chocolate biscuits.
Unknown	Notification about locations closer to me sooner so I wouldn't have to travel so far
Unknown	N/A
Unknown	I was content with the procedures followed.
Unknown	All good.
Unknown	Happy as it is going.
Unknown	N/A
Unknown	Not applicable, the research team have been first class in their support.
Unknown	You couldn't - everything has been perfect
Unknown	N/A
Unknown	N/A

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00

Unknown	I don't think things could be better, from my perspective. Although i've mentioned some names in my above comments, all staff, nurses and doctors have been brilliant. It's the one unit that I enjoy visiting.
Unknown	Please provide better coffee as the coffee here is pretty bad if you're here for hours :)
Unknown	N/A
Unknown	N/A
Unknown	Earlier disclosure of personal position re: placebo or not.
Unknown	Make more private places for it
Unknown	I don't believe it could have been any better.
Unknown	N/A
Unknown	Digitise study diary
Unknown	Proper guidance.
Unknown	Not sure.
Unknown	I'd like to know, at some point, which procedure I had
Unknown	N/A
Unknown	Perhaps further information on the surgery aspect, what was removed, blood loss etc
Unknown	Nothing in my case, everything perfect
Unknown	I was pleased with the research study throughout. I would make 10/10

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00

Unknown	N/A
Unknown	You couldn't
Unknown	N/A
Unknown	Probably by arranging the study to be on the same day and similar time to other appointments/scans etc.
Unknown	The room was a little cold but staff were fantastic.
Unknown	As I understand, from my own recent research online, this particular study ends in December of this year (2023). I'm very interested in the outcomes, findings etc so I hope I will be updated on this at some point.
Unknown	N/A
Unknown	Being my first trial, I can't think of anything that would make taking part better.
Unknown	Nothing
Unknown	Provided a map but better signage would be amazing and map particular to the nearest/all the entrances.
Unknown	On the 1st visit I wanted a better map but all good now
Unknown	Nothing :)
Unknown	N/A
Unknown	N/A
Unknown	N/A
Unknown	N/A

Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

Survey: Patient Questionnaire (RP)

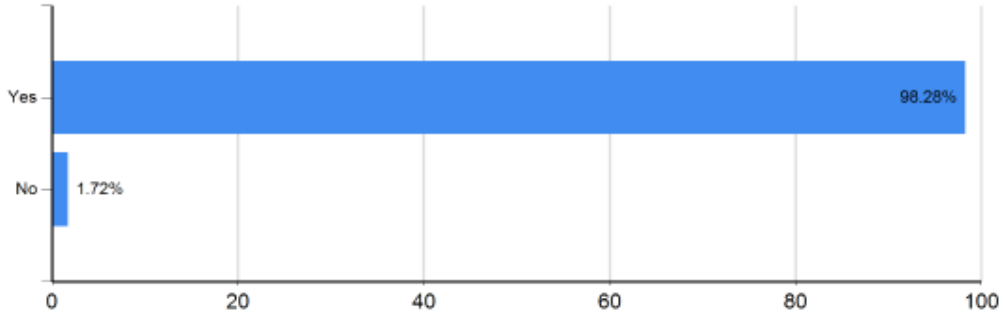
Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Unknown	Possibly more appointments outside 'normal' work hours	ccb81e60 / 2023-12	Create new actions
Unknown	There's been delays or appointment cancellations while in attendance. I don't really mind but better internal communication between pharmacy and research team would be great.	acadf2f8 / 2023-12	Create new actions

Question 7: Would you consider taking part in a research study again?

Create new action

Available Answers	Responses	Score (%)
Yes	57	98.28%
No	1	1.72%
Total	**58**	**100%**



Appendix 2. Questionnaire results

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 58

Survey: Patient Questionnaire (RP)

Start Date: 01/12/2023 12:00:00 AM **End Date:** 31/01/2024 12:00:00 AM

Question 8: If yes, would you know how to access information about other studies you may be able to take part in?

Create new action

Available Answers	Responses	Score (%)
Yes	21	36.84%
No	36	63.16%
Total	**57**	**100%**