Public Quality, Safety and Experience Committee

Tue 27 August 2024, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:10
10 min

1. Standing Items

Ceri Phillips

1.1. Welcomes & Introductions

1.2. Apologies for Absence

1.3. Declarations of Interest

1.4. Minutes of the QSE Committee Meeting held on 16.07.2024

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

1.5. Actions from the QSE Committee Meeting held on 16.07.2024

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

1.6. Chair's Action taken since last meeting

14:10 - 15:05
55 min

2. Items for Review & Assurance

2.1. PCIC Clinical Board – Assurance Report

30 mins *Anna Llewellin*

2.1 - PCIC Clinical Board Assurance Report.pdf (12 pages)

2.2. Annual Quality Report Update

10 mins *Alexandra Scott*

2.3. Internal Audit Report – Medical Records Tracking (CD&T CB) "These are the actions"

5 mins *Sion O'Keefe*

2.3 - CD&T CB Medical Records Tracking Follow Up Final Report_.pdf (16 pages)

2.4. Update on Neonatal Mortality Data and Improvement Actions – Verbal Update

10 mins *Richard Skone*

15:05 - 15:10
5 min

3. Items for Approval / Ratification

3.1. Policies

5 mins

3.1.1. UHB 068 – Blood Component Transfusion Policy

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

15:10 - 15:15
5 min

4. Items for Noting & Information

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

Jason Roberts

- 4.1a - C&W QSPE Minutes 23.04.2024.pdf (13 pages)

4.2. Joint Commissioning Committee - Quality Patient Safety Committee Minutes 16.07.2024

Ceri Phillips

- 4.2 - Quality Patient Safety Committee.pdf (6 pages)

15:15 - 15:15
0 min

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

Ceri Phillips

15:15 - 15:15
0 min

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

Ceri Phillips

i) Private Minutes

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

15:15 - 15:20
5 min

7. Any Other Business

Ceri Phillips

15:20 - 15:20
0 min

8. Review of the Meeting

Ceri Phillips

15:20 - 15:20
0 min

9. Date & Time of Next Meeting:

Ceri Phillips

8th October 2024 at 2pm

Via MS Teams

15:20 - 15:20
0 min

10. Declaration

Ceri Phillips

“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 16th July 2024

Via MS Teams

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

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

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

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

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

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

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

Action Log

Public Quality, Safety & Experience Committee

Update for meeting 27th August 2024
(Following the meeting held on 16th July 2024)

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

Report Title:	Primary, Community & Intermediate Care (PCIC) Clinical Board Assurance Report			Agenda Item no.	*2.1*
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	27th August 2024
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive Title:	Executive Nurse Director				
Report Author (Title):	Director of Nursing, PCIC				

Main Report
Background and current situation:

Current Assurances

Duty of Candour

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect from Spring 2023 and has imposed several new duties on all Clinical Boards, including PCIC, particularly around the Duty of Candour (DoC) aspects. The Act applies to both managed and commissioned services which adds greater complexity to effective implementation within PCIC. The Quality and Safety team has worked with the Patient Safety Team to implement an appropriate process for managing DoC declarations. There has been a total of 9 DoC declarations within the health board since April 2023. These include 8 avoidable pressure damage and 1 delayed skin cancer diagnosis. All cases have been discussed with the redress team. To date, one case has been refereed for compensation under redress.

Mortality Reviews

There is currently no mortality review data to present from a PCIC perspective. Following the legislative requirement changes for Primary Care deaths in September 2024 data will be able to be collated from this date. The Quality and safety team are however supporting Secondary Care mortality review cases where there is a primary/ community care element.

Inquests

The are 12 open coroners' cases with PCIC, the next upcoming case is due in 10th September 2024. There are monthly tracker meetings embedded in practice in conjunction with the Q&S team to ensure staff support is maintained.

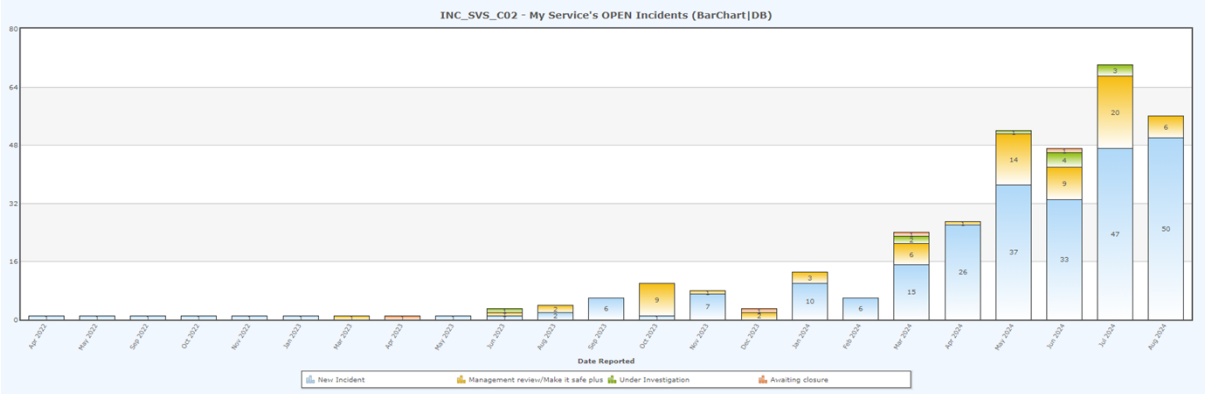
<u>Safe Care</u>

Nationally Reportable Incidents (NRI)

There is currently 1 NRI within the clinical board. This is sitting with PCIC however involves Primary Care, Secondary Care and Shared Services. This was reported on 12th July 2024 and is due for submission to the NHS executive on 18th November 2024.

Datix Management

There are currently **336** open Datix incidents (as of 9/8/24) that are being managed by PCIC. The current position is illustrated below.

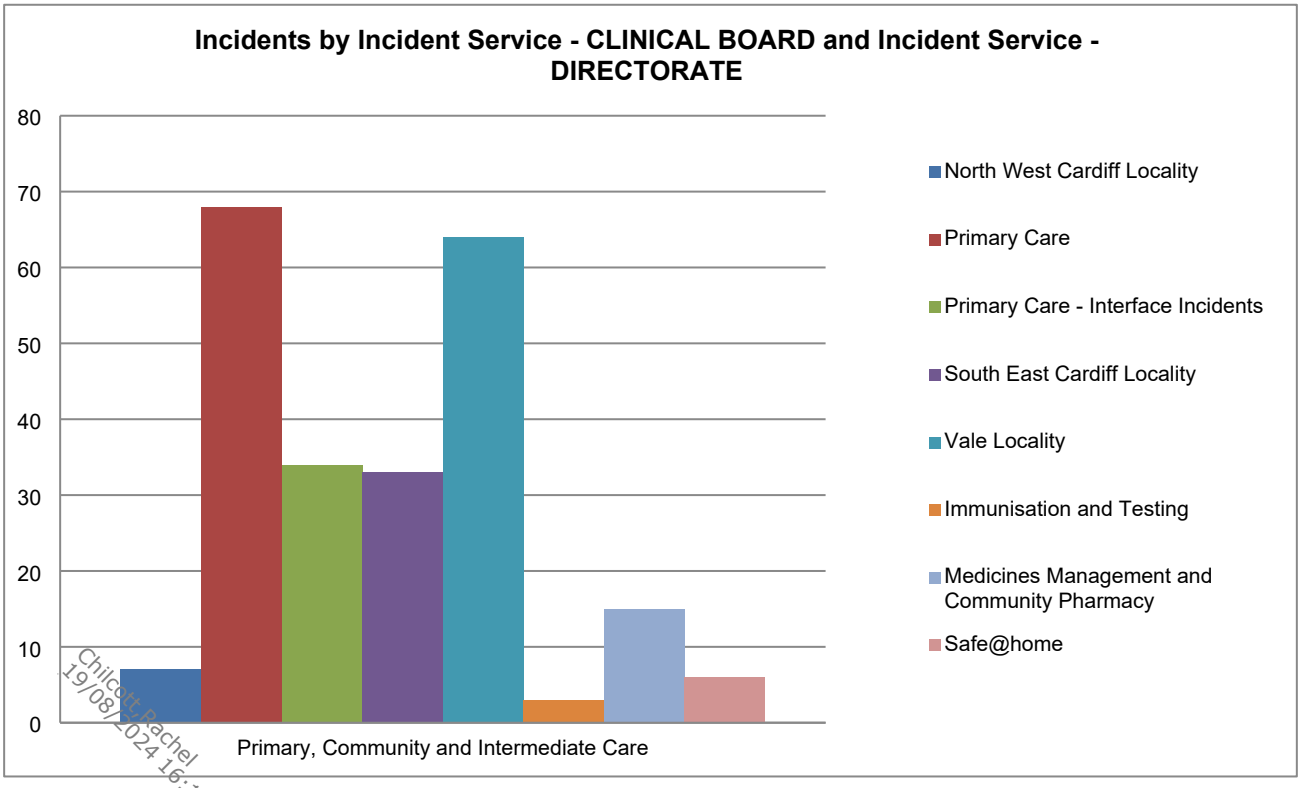


Pre-investigation harm is broken down as follows: -

None	Low	Moderate	Severe	Catastrophic	Total
77	172	71	15	1	336

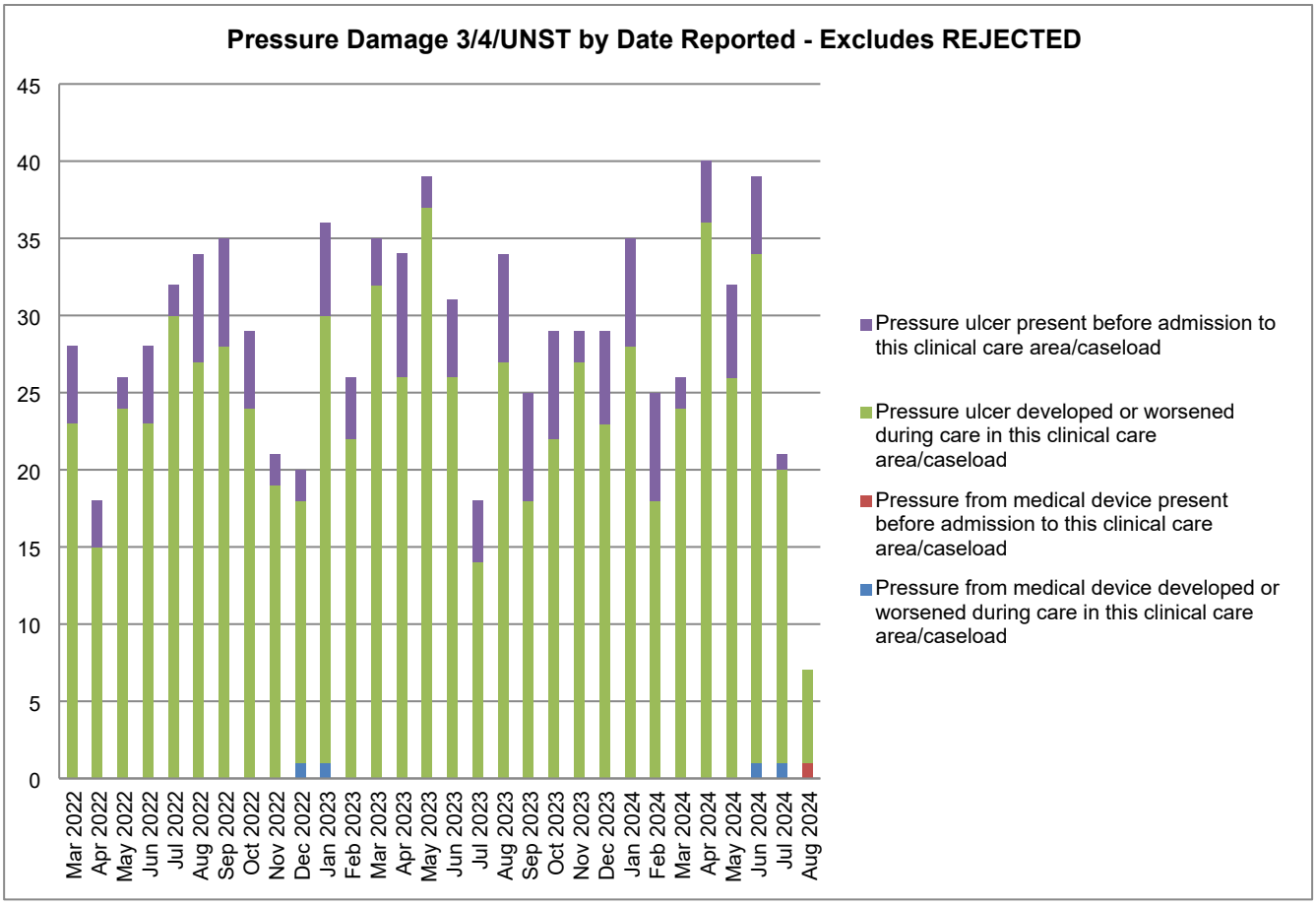
This indicates that 51% of all incidents managed by PCIC are identified as Low harm. The hot spots continue to be incidents that remain open from 2022. There are currently only 5 (previously 9) that remain open from this time period. Of the 5 incidents 4 are complex incidents and have been passed to teams from staff who have left the organisation which has impacted on the delay. This number has reduced significantly with support provided to the teams from the Quality and Safety and Patient Safety Team. Thanks to clinical teams for support.

Of the 336 incidents, 231 remain open over the 30-day target as indicated below. The South & East who previous had the highest proportion have made great improvement. Within the Vale locality the highest proportion are within the Barry 1&2 District Nursing teams. Primary care incidents are currently the highest proportion and include multiple services including, OOH's and immunisation incidents reported via GP practices. Weekly scrutiny of open Datix incidents are undertaken by the Quality and safety team to support staff undertaking investigation, management and closure and ensure correct allocation if incidents.

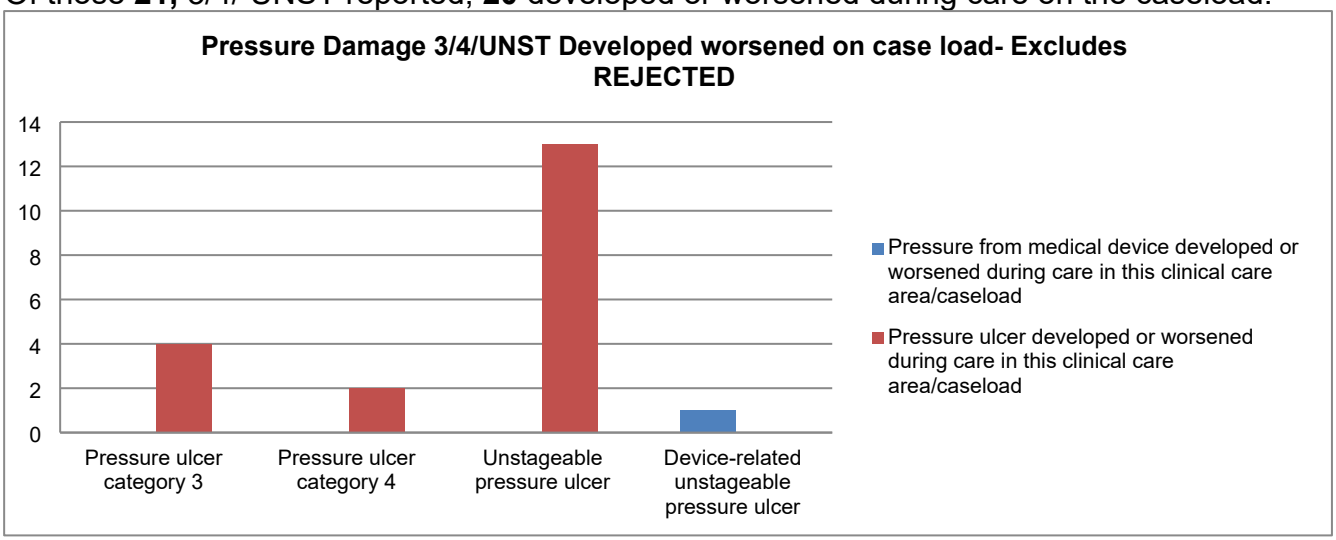


Pressure Damage

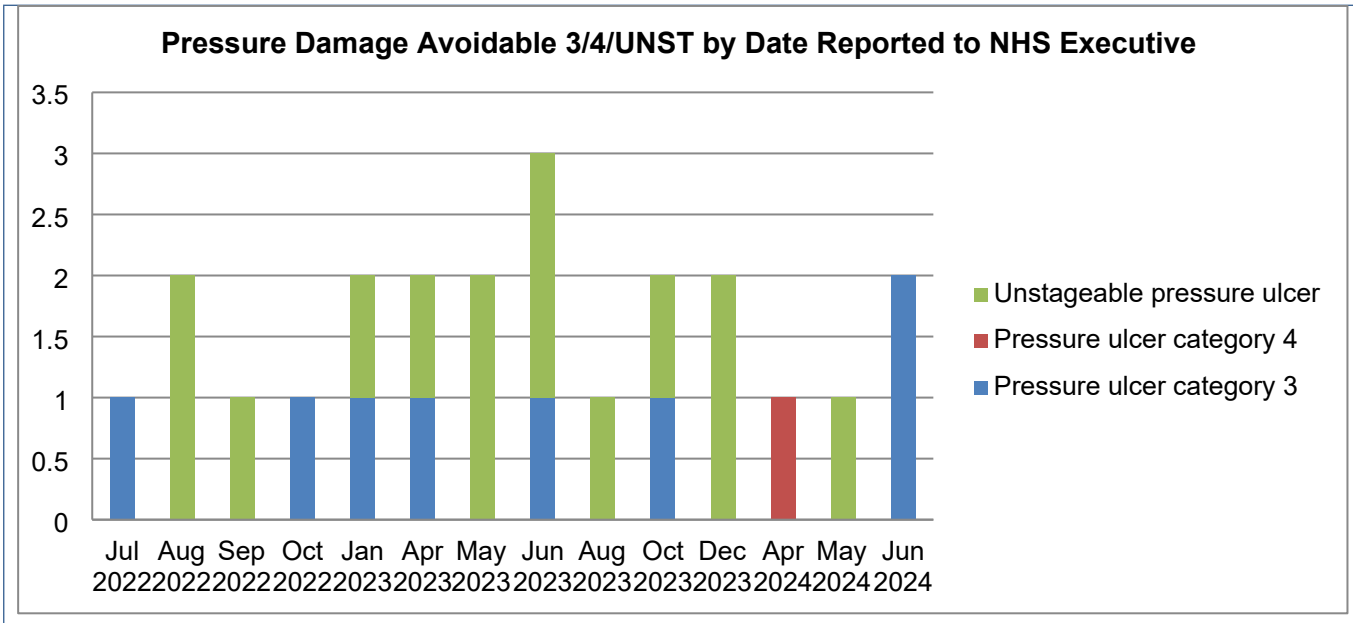
In July 2024, there were a total of **124** (excluding rejected) pressure damage incidents reported within the Clinical Board. Of those **21** incidents reported were categorised as stage 3,4 or unstageable pressure damage, highlighting a significant reduction. The data below illustrates the rolling position across the clinical Board.



Of those **21,** 3/4/ UNST reported, **20** developed or worsened during care on the caseload.



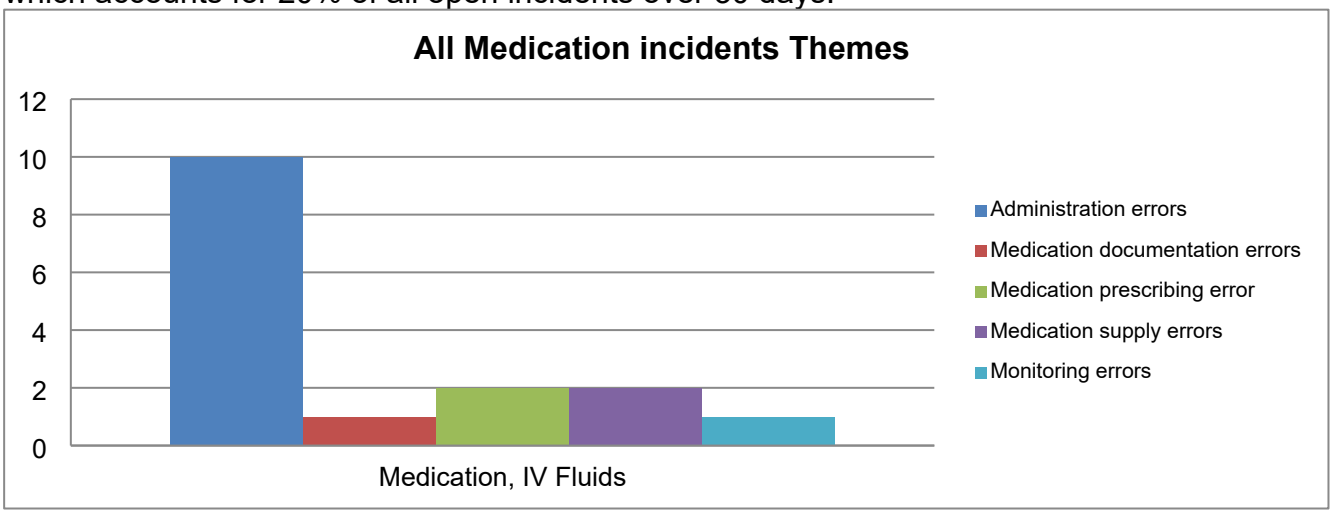
In July, **0** incident were identified as avoidable and reported as an NRI. The data below indicated the monthly position in relation to avoidable pressure damage. *Datix is not currently able to provide updated dashboard, the issue has been raised.*



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

Medication incidents

In July, there were a total of **16** medication incidents reported across the PCIC clinical board. There are no clear hotspots to identify in terms of incidents. Administration incidents continue to be identified as the main themes of those reported. In total, there are **48** medication incidents that remain open which accounts for 20% of all open incidents over 30 days.



Infection prevention and control (IP&C) - Waiting for July Data

There is now a dedicated part time IP&C nurse supporting PCIC and part of their role includes supporting the Root Cause Analyses (RCA) investigation process for Clostridium difficile. The investigative requirements are shared with the relevant GP practices for action; there has been a robust engagement since the re-introduction of the requirement in February 2022. The IP&C nurse also investigates the PCIC attributed Staphylococcus aureus bacteraemia source to identify if there is any health care contact attributed to these, thus identifying areas for targeted training and support. MSSA bacteraemia are a particular area of concerns as we have seen an increase in cases across all of Wales compared to pre-pandemic cases.

- 150 days since last MRSA Bacteraemia (05/02/2024)

- 5 days since last MSSA Bacteraemia (29/06/2024)
- 5 days since last *C difficile* (29/06/2024)
- 10 days since last E. Coli bacteraemia (24/06/2024)
- 13 days since last Pseudomonas Bacteraemia (21/06/23)
- 8 days since last Klebsiella bacteraemia (26/06/2024)

HCAI Reduction Surveillance June 2024

	C. *diff*	MRSA	MSSA	E.coli	Pseudo aerug	Klebsiella sp.
Reduction Expectation (cases annual)	**<20**	**0**	**<30**	**<144**	**10**	**<28**
Cases in June 2024	5	0	3	14	2	7
Total for Year	12	0	16	42	4	20
Total same period 2023/24	10	0	17	43	1	15
Cases compared to equivalent period in 2023/24	**18% More**	**Same**	**6% Less**	**2% Less**	**120% MORE**	**29% MORE**
C&V UHB Monthly Total 2024/25	**57 (38 over)**	**1 (1 over)**	**46 (27 over)**	**67 (5 over)**	**8 (2 over)**	**32 (15 over)**

PCIC Clinical Board have a reduction on the number of cases for MSSA and E.coli bacteraemia compared with the same period in 2023/24.
PCIC Clinical Board are currently on trajectory to meet the reduction expectation for Pseudomonas aeruginosa bacteraemia only.
No concerns with hotspots at present, April annual report circulated previously for 2023/24 Staph aureus bacteraemia and C. difficile case review, next report due October 2024.

IP&C Training compliance – eLearning

IP&C training compliance remains consistent at **87.65%** across the clinical board. groups. A similar picture with the overall Health Board compliance at 87.32%. Along with safeguarding training compliance the detail below indicates individual staff group compliance in particular for Medical and Dental teams.

Competence Name	Clinical Board	Staff Group	Sum of Assignment Count	Sum of Achieved	% Compliance
⊟NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	⊟Primary, Community Intermediate Care	Add Prof Scientific and Technic	55	53	96.36%
		Additional Clinical Services	183	173	94.54%
		Administrative and Clerical	230	205	89.13%
		Allied Health Professionals	120	113	94.17%
		Estates and Ancillary	65	61	93.85%
		Medical and Dental	81	30	37.04%
		Nursing and Midwifery Registered	432	387	89.58%
	Primary, Community Intermediate Care Total		1166	1022	87.65%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years| Total			1166	1022	87.65%
Grand Total			1166	1022	87.65%

Risk Register

The Q&S safety team are currently undertaking a review of the risk register to support Business Units seamlessly update their risks. There is an ongoing work stream to produce an updated risk register early September.

The Health Board will be changing the IT platform that supports the risk registers. The intention is that AMaT will be used. The Health Board are undertaking a pilot with the intention for clinician boards to

utilise this IT solution platform by the end of 2024. This will require a planned roll out and education support.

Community Pharmacy

In relation to community pharmacy independent contractors, pharmaceutical service contracts are managed and regulated against the NHS Wales Act 2006, NHS pharmaceutical services regulations (Wales) 2020, Pharmacy Order 2010 and GPHC standards. The introduction of Once for Wales Datix reporting system and Duty of Candour Act in community pharmacy during 2022 and 2023 has placed an increased pressure on the PCIC community pharmacy team to support the process and follow up incident reports in accordance with regulation, although the responsibility to report and investigate lies with the individual pharmacy.

There is a current risk included in the PCIC risk register relating to changes to the medication policy which will impact on the ability to support people with medication in their own homes and could also potentially impact on discharges from hospital. There is also an impact on community pharmacies which will require funding for them to provide monitored dosage systems (MDS).

General Medical Services (GMS)

GMS sustainability remains a risk. The main contributing factors that affect GMS sustainability are:

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

Steps taken by the Primary Care Team in response to growing concerns around sustainability have included;

- Reviewing and delivering a quality assurance framework and process that provides us with a clear perspective on how practices are delivering the GMS contract, how delivery may be impacted by the factors referred to above, and to support any improvement actions identified.
- Recruited a multi-professional team to support our quality assurance processes and drive service improvement
- Reviewed our approach to GMS escalation to ensure that we are aware of where short-term issues for practices are reflective of more deep-rooted problems so we can offer support at the earliest stage.
- Developed a proactive and reactive approach to supporting service sustainability as follows

Reactive Response

- Peer support and advice to practice teams provided by our multi-professional team
- Refreshed the model of support offered to practices to comprise a three Stage Intervention – diagnostic analysis, reporting points identified and making recommendations for improvement and supporting the implementation of improvement actions.

Pro-active measures

- Increased incentivisation of practice merger payment scheme
- GPN Nurse scheme – improving recruitment and retention of skilled GP Nurse workforce
- Primary Care Apprenticeship Scheme – linked to development of skilled management workforce in general practice.
- Funded training opportunities for new practice managers

- Programme of Service Improvement projects to help improve e.g. patient management, workforce and retention, workload management.

Effective Care

Enhanced Community Care

As part of the further faster funding, we have successfully embedded the new Safe@Home service across both Cardiff and the Vale of Glamorgan. The soft launch of the team commenced in January 2024 and is currently taking on average 20 patients per week. The multidisciplinary team aims to prevent avoidable hospital admissions by providing rapid intervention in an individuals own home. The team is working in collaboration with our Community Resource Team, Vale Community Resource Service and Acute Response Team. We are currently in the process of developing a business case to offer further integration and expansion of the service.

District Nursing (DN)

All DN teams have been reporting escalation 3 level and occasionally level 4 for a number of months. Staffing has been managed across the teams depending on the level of risk.

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

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

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

Dignified Care

Complaints/Concerns

There are currently **8** Formal concerns managed under PTR – x **2** remain overdue due their 30-day response due to complexity of concern. Holding letters have been sent in line with PTR.
In July 2024 there were:
4 concerns managed under PTR and x **1** closed.
4 under early resolution that were actioned and
28 enquires logged on Pals

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

Themes include

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

- Care provision and funding

Compliments

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

Individual Care

Safeguarding

Mandatory and Statutory training across the clinical board identified within the People Analytics and Planning is currently **83.87 %.** A similar picture with the overall Health Board compliance at 83.19%. The detail below indicates individual staff group compliance in particular for Medical and Dental teams. A focus approach is required to support teams to increase compliance.

Competence Name	Clinical Board	Staff Group	Sum of Assignment Count	Sum of Achieved	% Compliance
⊟NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	⊟Primary, Community Intermediate Care	Add Prof Scientific and Technic	55	53	96.36%
		Additional Clinical Services	183	160	87.43%
		Administrative and Clerical	230	206	89.57%
		Allied Health Professionals	120	114	95.00%
		Estates and Ancillary	65	60	92.31%
		Medical and Dental	81	36	44.44%
		Nursing and Midwifery Registered	432	385	89.12%
	Primary, Community Intermediate Care Total		1166	1014	86.96%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years| Total			1166	1014	86.96%
⊟NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	⊟Primary, Community Intermediate Care	Add Prof Scientific and Technic	55	52	94.55%
		Additional Clinical Services	183	156	85.25%
		Administrative and Clerical	230	204	88.70%
		Allied Health Professionals	120	113	94.17%
		Estates and Ancillary	65	57	87.69%
		Medical and Dental	81	27	33.33%
		Nursing and Midwifery Registered	432	377	87.27%
	Primary, Community Intermediate Care Total		1166	986	84.56%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years| Total			1166	986	84.56%
⊟NHS|CSTF|Violence and Aggression (Wales) - Module A - No Specified Renewal|	⊟Primary, Community Intermediate Care	Add Prof Scientific and Technic	55	53	96.36%
		Additional Clinical Services	183	168	91.80%
		Administrative and Clerical	230	208	90.43%
		Allied Health Professionals	120	120	100.00%
		Estates and Ancillary	65	60	92.31%
		Medical and Dental	81	30	37.04%
		Nursing and Midwifery Registered	432	386	89.35%
	Primary, Community Intermediate Care Total		1166	1025	87.91%
NHS|CSTF|Violence and Aggression (Wales) - Module A - No Specified Renewal| Total			1166	1025	87.91%
⊟NHS|MAND|Mental Capacity Act - 3 Years|	⊟Primary, Community Intermediate Care	Additional Clinical Services	120	101	84.17%
		Administrative and Clerical	3	3	100.00%
	Primary, Community Intermediate Care Total		123	104	84.55%
NHS|MAND|Mental Capacity Act - 3 Years| Total			123	104	84.55%
⊟NHS|MAND|Mental Capacity Act - No Renewal|	⊟Primary, Community Intermediate Care	Add Prof Scientific and Technic	6	6	100.00%
		Administrative and Clerical	16	14	87.50%
		Estates and Ancillary	51	44	86.27%
	Primary, Community Intermediate Care Total		73	64	87.67%
NHS|MAND|Mental Capacity Act - No Renewal| Total			73	64	87.67%
⊟NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years|	⊟Primary, Community Intermediate Care	Add Prof Scientific and Technic	55	49	89.09%
		Additional Clinical Services	183	147	80.33%
		Administrative and Clerical	230	189	82.17%
		Allied Health Professionals	120	100	83.33%
		Estates and Ancillary	65	54	83.08%
		Medical and Dental	81	18	22.22%
		Nursing and Midwifery Registered	432	326	75.46%
	Primary, Community Intermediate Care Total		1166	883	75.73%
NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years| Total			1166	883	75.73%
Grand Total			4860	4076	83.87%

Clinical Board Safeguarding Reporting - Cases currently open to PCIC are: -

- Adult safeguarding cases - 10
- AS1 referrals – 1
- MARF referrals – 28
- Professional allegation/concern – 10

Risk Register Score 20 and above

Change to medication policy and impact on supporting patients

Risk: Domiciliary medication administration/support
Source of uncertainty/cause: Change in policy and no formal requirement for community pharmacies

Consequence:
Impact on supporting people with medication at home and possible delay in discharges. Considerable amount of staffing resource used to ring round community pharmacies to try and find one with the capacity and goodwill to supply an MDS. This may be out of the local area to the patient and cause more logistical issues regarding prescription transfer. It also shifts workload to community pharmacies who are willing to provide MDS and could impact on sustainability of their service provision.
To note - discussions are currently ongoing at a national level (29/06/2023) in relation to national specification.

Controls:

- Relying on good will of community pharmacies to provide medication in MDS
- Secondary care and primary care teams working together to negotiate provision of MDS for individual patients if discharge is looking to be delayed – extremely time intensive, requires input from multiple (often senior) staff members and not always successful
- Working with Local Authority to review Regional medication policy to allow administration of medicines by care workers out of original packs with a Medicines Administration Record (MAR) chart

Assurances
Paper was taken to May SLG to agree handling and funding but not supported. Paper being revised and discussions to be held with LA colleagues (Dir of Ops, PCIC to action).

HMP Nurse staffing

Risk:
The Healthcare Dept at HMP Cardiff is unable to meet the needs of patients due to a high number of vacancies in the nursing team. This particularly affects the administration of medication, the assessment of new arrivals and the ongoing triage and care of unwell patients.

Controls:

- Senior management colleagues are working clinically
- Clinicians are being drawn from the in-house mental health, substance misuse and pharmacy teams to support the administration of medication
- Efforts to recruit to vacant posts are ongoing
- A recruitment event was recently held.
- Agency nurses have been utilised.
- Pharmacy Technicians have been recruited to dispense medication.
- Overtime payments are offered to staff.
- Regular support is being provided by PPDNs to train and support new staff.
- Working with the Governor and prison service to manage prison daily regime to support reduced capacity within health care

Assurances:
Staffing and escalation levels are reported on a weekly basis to the Locality Management Team and Clinical Board

<u>Developments</u>

PCIC Academy

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

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

CAV 24/7

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

- 111 press 2 – Mental Health - This service went live via a ''soft launch'' on 1st February 2023. A National launch took place on the 14th June 2023. Challenges continue to include, public communication and recruitment.

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

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

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

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

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

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

Recommendation:

The Committee is requested to:

Note the current position and also the actions taken since the previous report to strengthen assurance and manage risks within PCIC Clinical Board.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please 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. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here: **Quality Impact Assessment Information***				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*Comment here*

Impact Assessment: *Please state **yes** or **no** for each category. **If yes please provide further details.***
Risk: Yes
Risks are highlighted in the main report.
Safety: Yes
Safety issues and action taken or planned is included in the main report.
Financial: No
This report does not have specific finance implications.
Workforce: Yes
Workforce issues and associated actions are included in the main report.
Legal: No
There are no legal implications.
Reputational: Yes
There could be reputational implications if risks are not appropriately managed but this report includes action taken or planned in order to mitigate this.
Socio Economic: Yes
The actions taken or planned referenced in this report relate to the provision of services and how they can be improved. There are a range of services provided by PCIC which aim to improve access or quality of services for more vulnerable groups e.g. prison services, community dental services.
Equality and Health: No
No requirement as a result of this report for an EHIA to be undertaken.
Decarbonisation: No
Not applicable in relation to the content of this report.
Welsh Language: No
Not applicable in relation to the content of this report.

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

Follow-up: Medical Records Tracking (Clinical Diagnostics & Therapeutics Clinical Board)

Final Internal Audit Report

June 2024

Cardiff and Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Report status:	Final
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Draft report issued:	16 May 2024
Management response received:	5 June 2024
Final report issued:	6 June 2024
Auditors:	Olubanke Ajayi- Olaoye, Principal Auditor Lucy Jugessur, Deputy Head of Internal Audit
Executive sign-off:	Paul Bostock, Chief Operating Officer
Distribution:	Sarah Lloyd, Director of Operations CD&T Clinical Board Sion O'Keefe, Directorate Manager CD&T Clinical Board Keeley Baker, Head of Health Records
Committee:	Audit and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cardiff & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the 'Medical Records Tracking, Clinical Diagnostics & Therapeutics (CD&T) Clinical Board' review that was reported as part of our 2022/23 work programme.

Overview of findings

Management have made reasonable progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

Of the seven recommendations made, three of them have been closed, including two of the high priority recommendations. The Health Board's Records Management Policy and Procedure have both been updated and a Health Records Security & Storage action Plan has been developed.

A further two recommendations are partially complete with one of the high recommendations having moved down to medium, and one of the medium recommendations moved to a low priority, as actions have been undertaken within these areas.

The remaining two recommendations, with a high and medium priority, have not moved. Whilst some underlying actions have been undertaken, the new Programme Board is yet to be established and processes to track lessons learned and ensure staff are returning medical records have not therefore been introduced.

Follow-up Report Classification

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Current Priority Rating
1	Policy and Procedure require review	High	Closed
2	Health Records governance requires review	High	Medium
3	Security and storage of medical records	High	Closed
4	Lessons learnt require formal tracking	Medium	Medium
5	Inaccuracies of medical records location	High	High
6	Operational effectiveness to be improved and harmonised	Medium	low
7	Barriers which prohibit the digitalisation of Health Records	low	Closed

1. Introduction

1.1 The follow-up review of 'Medical Records Tracking, Clinical Diagnostics & Therapeutics (CD&T) Clinical Board' was completed in line with the 2023/24 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board'). The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

1.2 This was a follow-up review of the original report that was issued in January 2023. This identified seven issues and resulted in an overall assurance rating of 'Limited Assurance'.

1.3 The Lead Executive Director for this review is the Chief Operating Officer.

Audit Risks

1.4 The potential risks considered in the original review were as follows:

- There is a lack of clarity of roles and responsibilities due to out-of-date policy and procedures;
- Governance structures, roles and responsibilities may not be clear or operating effectively;
- Medical records are not adequately managed, leading to risks to patient safety and exposing the Health Board to reputation risk; and
- Learning from past incidents is not taken forward and addressed, resulting in reoccurring issues.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	4	2	1(R2)	1(R5)
Medium	2	0	1 (R6)	1(R4)
Low	1	1	-	-
Total	**7**	**3**	**2**	**2**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

Appendix A: Management Action Plan

Previous Matter Arising 2: Health Records governance requires review (Design)		
Original Recommendation		Original Priority
In alignment with the review of the Records Management Policy and Procedure, the governance arrangements should be redesigned to provide effective oversight of the tracking of health records, to ensure there is a line of sight to the accountable executive of the policy and procedure.		**High**
Management Response	Target Date	Responsible Officer
The Health Board has a monthly Information Governance Sub-group chaired by the SIRO and attended by senior leaders including the Medical Director. Matters relating to the tracking of medical records can be escalated there. The group is linked to the Digital and Health Intelligence Committee (formerly the Information Governance Sub-Committee), and as such relevant points and actions will be raised accordingly at organisational governance fora. It is acknowledged that the mechanism for receiving points of escalation is often responsive in nature. Review of current governance arrangements related to medical records management will be undertaken with recommendations made, and subsequently enacted, to ensure a clearer line of sight to the accountable executive of related policy and procedures and related Heath Board.	31 March 2023	To be determined following wider cross clinical board and corporate function discussions, led by the Director of Operations, Clinical Diagnostics & Therapeutics Clinical Board.
Current findings		**Residual Risk**
The plan is to establish a new forum titled the Clinical Information Management Group and medical records matters will be taken forward in this group rather than through the monthly Information Governance Sub-group as initially stated in the initial management action. The following outlines the activities undertaken to establish the new forum: • The Medical Records Management Group and the Medical Records Operational Group which were responsible for the governance of medical records were disbanded.		Negligence and reputational damage.

- A meeting was held with the previous Medical Director, Head of Information Governance (IG) and Cyber Security and the Directorate Manager for the Clinical Diagnostics and Therapeutics Clinical Board on 8 February 2024 to consider the scope of the group and actions from the audit. A number of changes and proposals were made using the previously dissolved group as a form of reference.
- A meeting has been scheduled with the Interim Medical Director, Directorate Manager for CD&T and Head of IG and Cyber Security to discuss the proposed Clinical Information Group.
- The Head of IG and Cyber Security has also liaised with the Chief Operating Officer in part requesting support for the new Clinical Information Management Group.

Conclusion: This recommendation is partially completed.

New Recommendations		Priority
2.1	Management should ensure that the terms of reference for the new group is produced, and the group is established as soon as possible to provide effective oversight of medical records matters.	**Medium**

Management Response		Target Date	Responsible Officer
2.1	Terms of reference for the Clinical Information Management Group will be agreed by the Interim Medical Director prior to being formally taken to the Group's inaugural meeting. A schedule of future meetings will be arranged, within which the terms of reference will be approved.	31 August 2024	Head of IG and Cyber Security (in conjunction with Directorate Manager, Patient Administration & Outpatients)

Previous Matter Arising 4: Lessons learnt require formal tracking (Operation)		
Original Recommendation		Original Priority
Management should formally track progress of taking forward lessons learnt to mitigate the risk of known issues recurring and to assist in identifying barriers that can be escalated for resolution.		**Medium**
Management Response	Target Date	Responsible Officer
A Health Board 'Tracking of Medical Record Learning and Improvement Proposal' will be developed. This will incorporate the points outlined in the Ombudsman response November 2021. Learning and progress on improvement will be assessed through Clinical Board's Quality, Safety & Patient Experience meetings, with further oversight via the Health Board's Patient Experience function and governance structures, as well as the enhanced governance structures subsequently clarified through the delivery of recommendation 2.	3 March 2023	Directors of Nursing, and to be determined following wider discussion.
Current findings		**Residual Risk**
The intention initially was for the suggested 'Tracking of Medical Record Learning and Improvement Proposal' to be monitored through Clinical Board QSE groups. As a result of recent developments related to medical records governance and management, Executive agreement has been provided to establish a new Clinical Information Programme Board which will encompass and then track associated improvements. As part of this, a new Clinical Information Programme Board is being set up to look at the management of records from a storage, access and distribution perspective. It will be the overarching medium through which the ''Tracking of Medical Record Learning and Improvement Proposal' will be monitored. The soon to be established Clinical Information Management Group will also provide an element of ensuring improvements are complied with. The new Clinical Information Programme Board is in its developmental stages, so work is in progress and may be subject to amendments. **Conclusion:** This recommendation is not completed.		Learning from past incidents is not taken forward and addressed, resulting in reoccurring issues.

New Recommendation(s)			Priority
4.1	Management should ensure that on establishment of the new Clinical Information Programme Board, a system is put in place to oversee the 'Tracking of Medical Record Learning and Improvement Proposal' when the proposal is developed.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
4.1	The improvements within the 'Tracking of Medical Record Learning and Improvement Proposal' will be incorporated within the workstreams of the Clinical Information Programme, with progress against these monitored by the Clinical Information Programme Board.	30/06/2024	Director Of Operations, CD&T Clinical Board

Previous Matter Arising 5: Inaccuracies of medical records location (Operation)		
Original Recommendation		Original Priority
Management should ensure staff are reminded of their responsibilities to return health records once used and the importance of updating PMS or PARIS following a change in location.		**High**
Management Response	Target Date	Responsible Officer
This will be taken forward as part of Agreed Management Action 4, specifically in relation to point 4 of Matters Arising 4. Departmental (Health Records), reinforcement of correct processes and good practice related to storage of medical records, will be undertaken prior to this.	31 March 2023 3 February 2023	As Recommendation 4 Head of Health Records
Current findings		**Residual Risk**
This is being taken forward as a part of matter arising 4. Refer to the current findings under matter arising 4. **Conclusion:** This recommendation is not completed		Medical records are not adequately managed, leading to risks to patient safety and exposing the Health Board to reputation risk.
New Recommendation(s)		**Priority**
5.1	Management, in relation to their previous management response, should ensure that the new Clinical Information Programme Board develop a Communications Strategy to remind staff of their responsibilities to return and record health records, in line with the points within the letter from the Ombudsman.	**High**

Management Response		Target Date	Responsible Officer
5.1	As part of the Clinical Information Programme Board's communication campaign, responsibility for the appropriate handling and transfer of clinical records will be emphasised widely across the UHB. These obligations will also be reinforced through the Medical Director's new Clinical Information Management Group.	31 July 2024	Director Of Operations, CD&T Clinical Board

Previous Matter Arising 6: Operational effectiveness to be improved and harmonised (Operation)		
Original Recommendation		Original Priority
Management should consider enhancing the operational efficiency and effectiveness to track medical records, based on our findings associated with the alternative filing systems in use, the indexing of records, the inconsistencies between UHL and UHW, and random spot checks on locations.		**Medium**
Management Response	Target Date	Responsible Officer
The department will revise its related local Standard Operating Procedures to ensure consistency of practice across sites, particularly in relation to the points outlined. Emphasis will be placed on regular sample location and tracking checks and hierarchy of actions depending on findings. A specific plan to complete the progress made towards a universal filing system (location-based tracking), will be developed. This will link to the Security and Storage action plan aligned to Recommendation 3.	28 February 2023	Directorate Manager Patient Administration and Outpatients
Current findings		**Residual Risk**
The department has revised the local Standard Operating Procedures to ensure consistency of practice across sites. However, the other parts of the Management response have not yet been fully implemented as detailed below: • The spot checks were demonstrated during the COVID investigations. • Spot checks were undertaken as part of training and re-training for the associated audit log. Verbal feedback was given; however, this was not recorded. • We were advised that going forward, the plan is for audit / sample checks to be scheduled weekly. • A specific plan to complete the progress made towards a universal filing system (location-based tracking) will be developed. • There is now consistency of storage across filing libraries, and restricted access to all libraries has been in place since June 2023. The department has embarked on a programme of moving all remaining areas to Location Based Filing (LBF). We were advised that rooms 4 and 5 are progressing with switching to LBF.		Delay in accessing and storing medical records.

Conclusion: This recommendation is partially completed			
New Recommendation(s)			**Priority**
6.1	Management should ensure the scheduled periodic checks are undertaken on a regular basis. Acknowledging the progress highlighted, management should ensure a 'specific plan' detailing the progress of the universal filing system is developed.		**Low**
Management Response		**Target Date**	**Responsible Officer**
6.1	A plan for achieving full LBF in rooms 4 and 5 will be updated, including presenting options to improve timelines. Progress against this will be outlined at the monthly Directorate Performance reviews with the CD&T Clinical Board, as will quality control metrics; principally results of spot check audits. It will link into the Clinical Information Programme as part of its 'Consistency of Approach' workstream where assessment of practice occurs and where recognised good exemplars are shared.	30 June 2024	Directorate Manager, Patient Administration and Outpatients

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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

Main Report
Background and current situation:

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

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

Recommendation:

The Committee is requested to:

a) Review the Blood Component Transfusion Policy and ratify.

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please place an "X" in the relevant box below ***(this section must be completed)***

Prevention		Long term		Integration	X	Collaboration		Involvement	

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

Risk: Yes/No

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

Safety: No
Financial: No
There are no financial implications associated with this policy.
Workforce: No
Legal: No
Reputational: No
Socio Economic: Yes/No
This policy applies irrespective of low income of any individual concerned.
Equality and Health: Yes/No
Addressed in the main body of the policy.
Decarbonisation: Yes/No

Approval/Scrutiny Route: ***Please insert any previous meetings where this paper has been received***	
Committee/Group/Exec	Date:

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

Blood Component Transfusion Policy

Policy Statement

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

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

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

Policy Commitment

We will ensure

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

transparently.

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

Supporting Procedures and Written Control Documents

This Policy is supported by one procedure

- UHB Transfusion Procedure

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

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

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

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

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

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

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

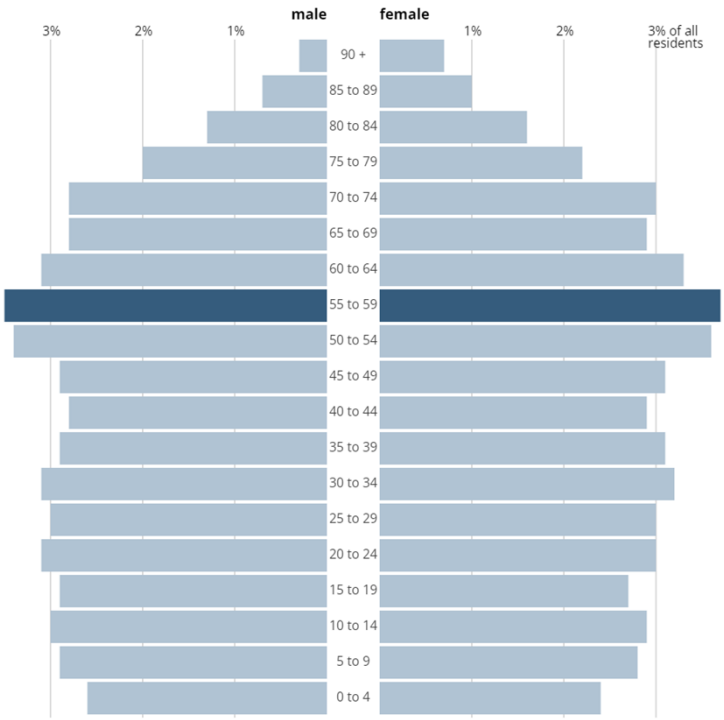
Summary of reviews/amendments

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

Equality & Health Impact Assessment for

Blood Component Transfusion Policy

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

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

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Refer to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of age.	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	This policy applies to all employees and organisational partners (e.g. our contractors, suppliers and joint venture partners) when undertaking services for, or on behalf of CVUHB. The policy applies equally to physical and emotional wellbeing.	Copies of the policy can be made available in alternate formats (e.g. electronic or paper copies).	Specific policies and procedures exist to account for all disability groups and the necessity to make reasonable adjustments accounted for. Examples include potential protected disability characteristics through the wellbeing policy and safe access through normal and emergency situations in the fire safety policy.

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

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

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

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

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	The aim of this policy is to enable blood/components to be transfused safely, in particular to minimise the risk of giving blood/components of the wrong group to a patient in error and to avoid unnecessary transfusion in general. It is based on national multidisciplinary guidelines [(2)] and informed by local experience. Red cells are the most commonly transfused blood component; however, the principles described in the policy apply to all blood components (e.g. platelets and plasma).	N/A	N/A

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
	Right Patient Right Blood [3]. Managing, investigating and reporting adverse events and reactions. Encouraging clinical staff to consider the appropriateness of transfusion and to explore alternatives. Promoting safer transfusion as part of clinical governance responsibilities and highlighting Good Manufacturing Practice (GMP) and the organisation's regulatory responsibilities.		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built	For this policy, there will be no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos		Evidentiary record can be seen that the Jehovah Witness committee members have close links with the Transfusion Practitioner team and support patients within the Cardiff and Vale UHB. Representatives from the JW committee frequently attend and present on Link Nurse groups.	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	This policy has a positive impact by ensuring that the same processes are followed irrespective of macro-economic, environmental or sustainability factors		

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

Action Plan for Mitigation / Improvement and Implementation

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

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

	Action	Lead	Time scale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions: - • Decide whether the strategy, policy, plan, procedure and/or service proposal o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so). • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	The policy and EHIA have been discussed and agreed by the Hospital Transfusion Team, presented and ratified at Transfusion group. It has been approved by the Transfusion Group, and will continue to be reviewed every 6 months as part of the groups Terms of Reference. When this policy is reviewed, this EHIA will form part of that consultation exercise. The policy will be published on the CVUHB intranet site and made available through SharePoint. The policy and EHIA will be reviewed every three years after ratification unless changes to legislation, or best practice determine that an earlier review is warranted. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).	Dr Andrew Goringe	6 months 3 years	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Susan Elsmore**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**24 June 2024**

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

1. CARDIAC PATIENT SOTRY

Members received an informative patient story about a gentleman who had suffered a sudden cardiac arrest. Members noted the challenges that the patient faced at the outset and how a range of JCC services and the public saved his life. The patient and his family praised the care that they had received throughout this traumatic event. The patient story highlighted the positive impact that the EMRTS service and the cardiac services had made to the patient's quality of life.

2. WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales and a summary of the highest scoring risks was provided.

3. COMMISSIONING TEAM AND NETWORK UPDATES

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

3.1 Cancer & Blood

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

- **South Wales Plastic Surgery**
  Members noted that this service provided by SBUHB remained at Level 2 of the Escalation process and was the only NWJCC commissioned service where patients were waiting over 104 weeks. The JCC made a choice around not accelerating improvements but within the ICP for 2024/2025 it was agreed to continue with this steady improvements towards the target. However, following approval of the ICP, WG published targets to achieve

104 weeks by March 2025. These were further revised in a letter received from the Deputy General/CEO NHS Wales on 7 May 2024 outlining revised Ministerial targets of no patients waiting over 104 weeks by the end of December 2024. This will require a decision to be made by the NWJCC in July 2024 and the NWJCC is undertaking further work currently with SBUHB to understand the demand, activity and efficiency assumptions in this delivery plan and trajectory, and engaging with Health Boards on the approach to the balance between the financial position and performance.

- **Plastic Surgery Outreach at BCUHB**
  This service was currently within the Welsh Government escalation/ special measures framework for BCUHB as the quality issues concern the operational responsibility of BCUHB for the provision of clinic administration and facilities under a Service Level Agreement between the Health Board and MWL. WG have acknowledged that there was evidence of improvement. Since the last meeting the harms review had been completed and it was presented to BCUHB QPSC Committee in June 2024. The report provides assurance that no evidence of patient harm was found. Despite this being a retrospective review, these issues have been mitigated as the level of service support, administration, quality reporting process, activity and waiting times reporting and ongoing monitoring arrangements have been strengthened. In addition, they have also funded waiting list initiatives to address the backlog and there were fewer patients on the waiting list compared to when the review was started.

3.2 Cardiac

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

- Although the two service providers in South Wales following a Getting it Right First Time (GIRFT) review have been in escalation for some time, they have been on a de-escalation trajectory for most of that time and both services have engaged well with the escalation process. Swansea Bay Cardiac Surgery Service was de-escalated from Level 2 to 0 of the Escalation Framework in May 2024 and was now out of escalation completely. The Cardiff and Vale Cardiac Surgery Service has been de-escalated to Escalation Level 1 pending receipt of an audit report.
- An update was provided on the exercise into any unreported cases of Mycobacterium Chimera. This bacteria is associated with water heater cooling systems used in cardiac surgery. They undertook an extensive piece of work in terms of a look back and this work has concluded with no new cases having been reported within the last 8 years. This extensive work seems to be working as there had been no recent reported cases.

3.3 Neurosciences

Members received an update of the quality issues for services relating to the neurosciences Team Portfolio.

- NWJCC had reallocated funding to address the Neurosurgery risk and agreed additional money within the ICP for 2024-2025.

- There were two service related risks which were being managed in line with the engagement for service change guidance issued by Welsh Government and the NWJCC were keeping in close contact with Llais.

3.4 Women & Children

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

Paediatric Surgery

Members noted the positive progress and good evidence of operational improvement underpinning a reduction in the waiting times and the waiting list in line with the accelerated target over and above the ministerial measures of 52 weeks that the JC agreed last year. The HB was not able to achieve the target by the end of March 2024 due to the industrial action but assurance has been received that the target will be achieved by the end of June 2024. Based on this assurance, the Commissioning Team agreed to de-escalate the service to Level 0 and the service has returned back to normal performance monitoring arrangements. The letter confirming the de-escalation was sent to the provider last week. The JCC ambition for this year was to maintain that 52 week wait.

Wales Fertility Institute

Members noted the positive progress with the Fertility service issues. Due to regulatory issues following an inspection by the HFEA the service was placed in escalation Level 4 with regular reporting through the NWJCC via the Performance Report. A positive inspection report from the HFEA had recently been received and reported through the escalation meeting. There had been good progress in the appointment of a Person responsible (PR) with the intention to appoint more than one person to perform the PR role to ensure sustainability going forward. Following confirmation of the above progress, the Commissioning Team agreed to de-escalate the service to Level 3 and remove the service from the critical escalation Level 4.

Neonatal Care (NICU) and Paediatric Intensive Care (PICU)

Members noted that there was less assurance in relation to Paediatric Intensive Care (PICU) and Neonatal Care and as commissioners it was noted that the same level of progress had not been made within these service areas. A decision was taken to reset the process at executive level and move towards a more outcomes and objectives based escalation. Whilst most of the services have been on a de-escalation trajectory, progress within these two service areas was complicated

due to some underlying themes such as the scarcity of specialist workforce. The NWJCC understood the complexities and this was the reason for the reset approach to try and achieve a better outcome for the population of South Wales.

Members discussed the new approach and questioned how these services would be measured going forward. Members were assured that the NWJCC would be using national benchmarks and metrics and monitoring those together with the Health Board and addressing access to those really highly specialised services to ensure that we are assured on the quality management systems and workforce availability within these two areas.

3.5 Mental Health

Members received an update of the quality issues for services relating to the Mental Health and Vulnerable Groups for the former WHSSC Commissioning Team Portfolio.

Members noted that there had been little change to the commissioning risks since the last report. Funding to address the Neuropsychiatry sustainability risks was approved and was included in the ICP for 2024/2025 with the aim to bring the business case seeking funding release to the Management Group meeting in July 2024.

Members noted the comprehensive summary regarding Gender Development Service (GIDS) for Children and Young People, the Cass review, the new legislation around prescribing puberty supressing hormones and the progress that has been made on Phase one and Phase two of the NHS England transformation programme.

Members were made aware of some issues in relation to a specialist eating disorder provider.

3.6 Intestinal Failure (IF) – Home Parenteral Nutrition

Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio. Members noted that the Independent Provider Framework Agreement with the independent sector for the provision of home care and parenteral nutrition products ended on 30th June 2024. A procurement process was undertaken by the NHS Wales Shared Services Partnership (NWSSP) to renew the Framework agreement. The three open risks were linked to this issue and will be de-escalated following the renewal of this Framework agreement.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary

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

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

4.2 Quality and Safety Report (Former EASC)

Members received a report providing an update on quality and safety matters for the Emergency Ambulance Services Committee (EASC) commissioned services. Members noted that this report was usually considered under the EASC Management Group before being presented to the EASC Joint Committee.

A range of the measures were presented and discussed. Members provided useful feedback on what information they would find useful for future reports.

4.3 Mental Health and Vulnerable Groups Commissioning Management Team Report

Members received a report providing an update on issues for services relating to the MHVG Commissioning Management Team. Due to the transition of work from the former Quality Assurance Improvement Service into the new NWJCC, the service portfolio reported was focused on the 'National Collaborative Framework for the provision of services for Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals', with a view to presenting a fully integrated MHVG report for the next QPSC meeting.

Members provided useful feedback on what information they would find useful for future reports.

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

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

4.5 Incident and Concerns Report

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

4.6 Policy Group Report

Members received an update on activity and output from the NWJCC Policy Group during the period 1 January 2024 – 31 March 2024 together with an updated overview of all NWJCC policies and service specifications including those published during the current financial year, together with the rationale for their development.

5. ITEMS FOR INFORMATION

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee April 2024;
- Welsh Health Circular: NHS Wales National Clinical Audit and Outcome review plan: Annual Rolling Programme from 2024/2025; and
- QPSC Distribution List.

6. ANY OTHER BUSINESS

Members provided useful feedback on the quality newsletter.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above and summarised below;

- The general concerns with paediatric services in CVUHB.
- Ensuring future reports are aligned to the new duty of quality.
- Ensuring concerns report contain some trends and themes as well as capturing patient experience/stories.

Summary of services in Escalation

- Attached (***Appendix 1***)

Matters requiring Committee level consideration and/or approval

None

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	2 September 2024