Quality Committee

Tue 07 January 2025, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

Ceri Phillips

1.1. Welcome & Introductions

1.2. Apologies for Absence

1.3. Declarations of Interest

1.4. Minutes of the QSE Committee Meeting held on 26.11.2024

00 - Draft QSE Public Minutes 26.11.2024 (1).pdf (9 pages)

1.5. Action Log – Following the meeting held on 26.11.2024

00 - QSE Public Action Log following 26.11.2024 (1).pdf (1 pages)

1.6. Chair's Action taken since last meeting

14:05 - 15:35
90 min

2. Items for Review & Assurance

2.1. Medicine Clinical Board – Assurance Report

20 mins *Medicine Clinical Board*

2.1 - Medicine Clinical Board Assurance Report 2024.pdf (21 pages)

2.2. Quality Indicators Report

15 mins *Alexandra Scott*

2.2a - Quality Indicators Report 20241231.pdf (2 pages)
2.2b - Quality Indicators ReportJuly 2024.pdf (15 pages)

2.3. Infected Blood Inquiry - High-Level update on work being undertaken

20 mins *David Fluck / Richard Skone*

2.4. JICPA Update - Improvement Plan

10 mins *Jason Roberts / Andy Jones*

2.5. Healthcare Associated Infection (HCAI) Measures

10 mins *Jason Roberts / Yvonne Hyde*

2.5 - _20240918 - WHC-2024-038 - HCAI & AMR - English Final version.pdf (7 pages)

2.6. Hepatitis B/C Recovery Plan Update

5 mins *Claire Beynon / Annie Ashman*

- 2.6a - Hep B_C Update _Covering Report.pdf (3 pages)
- 2.6b - Cardiff and Vale UHB Hepatitis (B and C) Joint Recovery Plan 2023-25 FINAL.pdf (29 pages)
- 2.6c - 202406 Hep BC Plan EHIA FORMATTED.pdf (16 pages)

2.7. Gastro Surveillance Verbal Update

10 mins *Paul Bostock*

15:35 - 15:50
15 min

3. Items for Approval / Ratification

3.1. Policies

i) UHB 322 - Ultrasound Clinical Governance Policy & Procedure

ii) UHB 282 - CAVUHB Reusable Medical Device Decontamination Policy and Procedure

- 3.1a - US Clinical Governance Policy and Procedure UHB322.pdf (2 pages)
- 3.1b - Ultrasound Clinical Governance Policy - FINAL 2024 (1).pdf (6 pages)
- 3.1c - UHB 282 2024 policy.pdf (83 pages)

3.2. Update of Healthy Eating Standards for Hospital Restaurant & Retail Outlets

10 mins *Claire Beynon / Suzanne Wood*

- 3.2a - Update for Healthy Eating Standards - QSE Paper November 2024 V6.pdf (5 pages)
- 3.2b - Appendix A - Healthy Eating Standards for Hospital Restaurant Retail Outlets - updated Nov 2024 v1.pdf (15 pages)

15:50 - 15:50
0 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees

Jason Roberts

- Medicine Clinical Board
- CD&T Clinical Board

- 4.1a - MCB QSE Minutes 16 October 2024 v2.pdf (7 pages)
- 4.1b - CD&T Att 1 - Minutes 25.11.24.pdf (12 pages)

15:50 - 15:50
0 min

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

Ceri Phillips

No items.

15:50 - 15:50
0 min

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

Ceri Phillips

i) Private Minutes & Actions

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

iii) Discharge Advice Letters (DALs)

15:50 - 15:50
0 min

7. Any Other Business

Ceri Phillips

15:50 - 15:50
0 min

8. Review of the Meeting

Ceri Phillips

15:50 - 15:50
0 min

9. Date & Time of Next Meeting:

Ceri Phillips

18th February at 2pm via MS Teams

15:50 - 15:50
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 26th November 2024

Via MS Teams

To view the meeting: CAVUHB Public Quality, Safety & Experience Committee Meeting 26.11.2024 (youtube.com)

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
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
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Matt Phillips	MP	Director of Corporate Governance
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Andy Jones	AJ	Director of Nursing/Midwifery – Children & Women CB
Mark Doherty	MD	Director of Nursing – Mental Health Clinical Board
Eloise Hamon	EH	Public Health Wales – Specialist Training (ST3)
Abigail Holmes	AH	Director of Midwifery and Neonatal Services
Katrina Griffiths	KG	Associate Director of People and Culture
David Fluck	DF	Executive Medical Director
Neil Jones	NJ	Clinical Board Director – Mental Health
Lauranne Cullen	LC	Llais Regional Director
Laura McLaughlin	LML	Risk Manager – Obstetrics and Gynaecology
Timothy Banner	TB	Clinical Director Pharmacy & Medicines Management
Observers		
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Angela Hughes	AH	Assistant Director of Patient Experience
Akmal Hanuk	AH	Independent Member – Community
Richard Skone	RS	Deputy Executive Medical Director

QSE 24/11/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QSE	**Apologies for Absence**	

24/11/002	Apologies for absence were noted.	
QSE 24/11/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 24/11/004	**Minutes of the Committee meeting held on 08.10.2024** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=130 The minutes of the Committee meeting held on 08.10.2024 were received. **The Committee resolved that:** a) The minutes of the meeting held on 08.10.2024 were approved as a true and accurate record of the meeting.	
QSE 24/11/005	**Action Log following the Meeting held on 08.10.2024** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=156 The Action Log following the Meeting held on 08.10.2024 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 08.10.2024 was noted.	
QSE 24/11/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QSE 24/11/007	**Mental Health Clinical Board – Assurance Report** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=220 The Director of Nursing – Mental Health Clinical Board (DoN-MHCB) presented the Assurance Report which provided the Committee with a summary of the arrangements, progress and outcomes within the Mental Health Clinical Board. This included: • National Reportable Incidents / Sentinels • Risks • Tendable • Audits • Improvement Plan Compliance • Health Inspectorate Wales (HIW) reports • Primary Mental Health performance • Clinical Risk Management / Patient Safety • Invited Review Service Report May 2024 of Hafan y Coed, Mental Health Services CAVUHB site visits carried out: 25-26th October 2023 • All Wales In-Patient Safety Programme • The National Confidential Inquiry into Suicide and Safety in Mental Health • Quality Network for In-Patient Working Age Mental Health Services	

- Safety Incident Response Accreditation Network
- Workforce
- Developments
- Concerns and Compliments

Royal College of Psychiatrists (RCP) Review

The Clinical Board Director for Mental Health (CBD-MH) provided a summary of the RCP review:

- The RCP conducted a service review which was presented to the UHB in July 2024. It was an independent critique which followed a three phased approach to consider the standards of care provided.
- During the COVID pandemic (2021-22) there was a higher-than-expected number of CAVUHB Mental Health Hospital suspected suicides (5 inpatients, 1 patient within an hour of discharge)
- Six online interviews were conducted with members of the investigation team, the relevant wards in Hafan-Y-Coed (HYC) were visited, and they interviewed over 70 staff and Executives.
- Judgement was based on the standards outlined in the QWNA standards (standards for acute inpatient service for working age). Investigations were reviewed against the standards for serious incident reviews (commonly referred to as SIRAN).
- Identified themes included: risk assessments, care planning and formulation, therapeutic engagement, continuity of care, diagnosis and treatment, use of the MHA, observation levels, response to concerns raised by families, and serious investigations.
- They strongly noted the following comments by the RCP:
  - Many recommendations were about ensuring current policies were implemented and carried out well, that there was continuity of care, and staff had sufficient time and expertise to engage well with patients and their families.
  - Improvements required good clinical leadership at all levels. Skill mix reviews would help to identify faps in capacity and expertise. Supervision, appraisals, mentoring, and time off for training would help to maintain professional skills.
  - Many of the appropriate inpatient standards were identified within QWNA standards.
- A subsequent meeting was planned with the Executives for February 2025.
- Work undertaken so far: -
  - Risk assessments – WARNN ((Purpose Wales Applied Risk Research Network) had already been introduced and they continued to work with mental health partners in the development of those tools.
  - Care planning and formulation –
    - Spot audits had been undertaken - it was clear there was confusion in inpatient spaces around the interpretation of the Mental Health Measure and the code of practice. The expectation was that in all inpatient treatment wards, all individuals should have a valid and complete care and treatment plan within 72hrs of transfer/admission.
    - On all wards, levels of nursing observation engagement should be recorded in case notes and intervention plans at the point of admission. Ward rounds should be comprehensive and include reference to observation levels.
    - All patients should have weekly 1 hour time booked to discuss their care plan and progress.
  - The skill mix of staff was ongoing.
  - Continuity of care – An outlier policy was already in place before the RCP recommendation. Staff were finding the time expectations difficult.

	▫ Use of MHA and diagnosis and treatment – all medical staff had been written to regarding confusing statements around mental health which may be construed to be de facto detentions, and regarding good practice around diagnosis and treatment. ▫ Serious investigations – CAVUHB had become the first organisation in Wales to become SIRAN accredited. • No organisation in Wales currently met the QNWA standards. • The RCP issued 41 recommendations, of which 20 were complete. The Chief Operating Officer (COO) thanked the MH team for their work and highlighted that it was the CBD-MH's last week as Clinical Board Director. The CC thanked the CBD-MH for their work as clinical lead for the Clinical Board. The Executive Medical Director (EMD) asked for a clear timeline on the remaining actions for assurance, and for clarity on when they would complete the RCP recommendations. The CBD-MH responded that each ward would apply for the QNWA accreditation process with the RCP. The first year would involve building a plan to meet the 206 standards for the accreditation, and the second year would focus on completing the accreditation process. The CC asked when an updated self-assessment would be expected, as the work reflected the situation 12 months ago. The CBD-MH responded that it could be undertaken within three months. The END highlighted the exceptional performance of the mental health team in the nursing awards. The Committee Vice Chair (CVC) reflected on the estate's risks outlined within the report and expressed concern about the environmental issues flagged and the impact these conditions had on both patients' and staff's safety. She asked about the mitigations being implemented to address these risks. The DoN-MHCB responded with the following: • The remoteness of some of the wards was a challenge as decay could go unnoticed. This would have an impact on patients who were already under stress, and it did not send a good message to their staff. • Cedar Ward – it took time for estates to diagnose the problems. One of the difficulties was that the assessment ward gave patient's a poor first experience, but that they hoped this would be fixed within a few weeks. **The Committee resolved that:** 1) The progress made by the Clinical Board to date was noted; 2) The content of the report and assurance given by the Mental Health Clinical Board was noted.	
QSE 24/11/008	**Deep Dive - Perinatal Mortality Review Tool (PMRT)** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=2489 The Director of Midwifery and Neonatal Services (DMNS) presented the Perinatal Mortality Review Tool (PMRT) – Deep Dive report to the Committee which provided an	

	overview of the systematic review process for maternal and neonatal deaths. She also reported on the improvements in neonatal death rates and the ongoing work to address care concerns and improve outcomes. The EMD suggested that more work was needed around health inequity to provide valuable information and help to understand regional disparities to identify potential areas for intervention. The DMNS agreed and highlighted the success of the ELAN team in demonstrating that antenatal continuity of care improved outcomes. The challenge lay in achieving this within the current community model and emphasised the importance of engaging with vulnerable and hard-to-reach communities to build trust with a named midwife, which could significantly improve outcomes for these groups of women. **The Committee resolved that:** 1) The contents of the report was noted.	
QSE 24/11/009	**Equity, Equality, Experience and Patient Safety Action Plan - Update** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=3941 The Executive Director of Public Health (EDPH) reminded the Committee that the framework/support tool/guiding principles were introduced to make the organisation more equitable and deliver excellent preventative and clinical services. The Public Health Wales – Specialist Training (PHW-ST) provided the Committee with a six-month update on the Equity, Equality, and Patient Safety Action Plan and highlighted the progress made in various areas such as Planned Care, Equitable Employee Experience, Unscheduled Care, Maternity Care, Prevention, Analytics, Primary Care, Representation, Mental Health, and Patient Safety. She also noted the challenges related to data availability and staffing. The CC noted that they needed to get more granular data in relation to inequalities and deprivation and suggested that the EDPH meet with the Director of Digital & Health Intelligence (DDHI) to move this forward. The EDPH responded that she had regular conversations with the DDHI around this and highlighted a lack of resources in the central team and the need to connect data more widely, including using more regional information sharing system data to address these issues. **The QSE Committee resolved that:** a) The update was noted.	
QSE 24/11/010	**Regulation 28 PFD Improvement Plan** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=4447 The END informed the Committee that the plan addressed the aftermath of a high-profile case involving the death of an inpatient prisoner, which was covered widely in the media and went through the coroner court.	

	The END highlighted the following points: 1. The Head of Prison Health and the senior nurse had both changed roles. The new senior nurse had a background in mental health and prison care, and the new Head of Healthcare came from the A&E department at UHW. 2. They were conducting a gap analysis on the nursing team's ability to identify deteriorating patients. 3. They had started to use Tendable to audit the quality metrics in the prison, despite initial security challenges. 4. They had improved GP coverage by collaborating with PCIC and clusters of GPs which had resulted in a more robust rota than before. **The QSE Committee resolved that:** 1) The update was noted.	
QSE 24/11/011	**Sexual Safety** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=4602 The Associate Director of People and Culture (ADPC) presented the report and slides to the Committee which provided a summary of the new legal duty on employers to prevent sexual harassment in the workplace and outlined the steps taken by the health board to comply with the regulations. This included targeted training, clear reporting pathways, and enhanced well-being support for colleagues. The Independent Member – Trade Union (IM-TU) asked how many sexual harassment cases there had been within the UHB over the past 6-12 months. The ADPC responded that she would investigate the number of cases and share with the Committee. The CC noted that the NHS Staff Survey results and responses around this were included in the paper, and that even one negative response is too many. He commended the plan and asked for an update in the future once the Action Group had reported. The ADPC agreed and noted that a Task & Finish Group (T&FG) had been established to develop an All-Wales Policy which may take some time, and therefore the UHB policy was likely to be finished first. The CVC asked whether there was an initiative which focused on empowering staff to manage unacceptable patient behaviour. The ADPC responded that the policy specifically addressed colleague-to-colleague behaviour. However, if there was an incident involving patient-to-staff behaviour, they would refer to the appropriate process to support colleagues in handling these situations. The Director of Corporate Governance (DCG) noted that this discussion tied into the broader work on defining a quality management system and eradicating avoidable harm. **The QSE Committee resolved that:** 1) The contents of the report was noted.	
QSE 24/11/012	**Medical Examiners (Wales) Regulations 2024 and Care After Death**	

	To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=5116 The Assistant Director of Quality and Patient Safety (ADQPS) presented the report to the Committee which provided a summary of the new Medical Examiners (Wales) Regulations 2024, the All Wales Learning from Mortality Review Framework, and the death certification process. The COO asked whether there had been any pushback. The ADQPS responded it had been the opposite. Consultant colleagues provided feedback that the volume of emails had significantly decreased and made communication more targeted. Additionally, recent data from the Concerns team indicated that there had been a significant reduction in the number of concerns raised. The ADQPS noted that it was heading in the right direction. The Associate Medical Director Patient Safety and Clinical Effectiveness (AMDPSCE) added that there was nothing negative about the new digital care after death process, and that the rates of engagement with the digital pathways would increase. **The QSE Committee resolved that:** 1) The assurance around UHB processes to consider Medical Examiner Referrals was noted; and 2) The assurance provided around the revised Care After Death processes was noted.	
QSE 24/11/013	**Controlled Drugs Accountable Officer Annual Update April 2023 – March 2024** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=5717 The Clinical Director Pharmacy & Medicines Management (CDPMM) presented the Controlled Drugs Accountable Officer (CDAO) Annual Update April 2023 - March 2024 to the Committee which provided a comprehensive overview of the management and use of controlled drugs (CD) within CAVUHB. The report also detailed the following: • The responsibilities of the CDAO • The establishment of the Cardiff and Vale Local Intelligence Network and the submission of quarterly occurrence reports • The Medicines Code • Self-Declarations • CD Destructions and Authorised Witnesses (AW) • Monitoring • National Prescribing Indicators • Licenses • Next steps The CDPMM suggested bringing this report back to the QSE Committee annually for assurance. The EDPH asked whether all pharmacies within CAVUHB needed to be licensed to issue CDs and whether this licensing requirement would impact the equity of access.	

	The CDPMM responded that community pharmacies were registered pharmacies regulated by the General Pharmaceutical Council (GPC) and were exempt from needing a license. Because hospital pharmacies were not registered with the GPC, they needed a separate license from the Home Office. The CC asked about the national prescribing indicators and the opioid burden, specifically regarding the data collection on high-strength opioid prescribing. The CDPMM responded that he would liaise with his team around what was being done to address the data problem regarding monitoring opioid prescribing, and feed back to the Committee **The QSE Committee resolved that:** 1) The progress that has been made during the last 12 months was noted.	
QSE 24/11/014	**Director of Public Health Annual Report** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=6289 The EDPH presented the Director of Public Health Annual Report and summarised the following: • The theme of this year's report was child health, which focused on children aged 0-5 years. This aligned with the development of the Babies, Children, and Young People's Plan • There was a two-pronged approach to address health inequalities and improve health across CAV • It covered four themes: childhood vaccination, good food and movement, oral health, and breastfeeding. Each chapter included recommendations • The report was independent and applied to multiple organisations • It aimed to highlight important health issues such as poverty, tooth decay, and obesity amongst children • Iinput from the Youth Board using the Thorn, Bud and Rose model to identify problems and solutions was included. **The QSE Committee resolved that:** 1) This year's Director of Public Health Annual Report: Prioritising the early years- investing for the future was noted.	
	Items for Approval / Ratification	
QSE 24/11/015	**Policies** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=6571 The following policies were discussed: 1) UHB 519 - Request for approval of the 'Development and Approval of UHB Procedure Specific Consent Forms Principles and Framework' **The QSE Committee resolved that:** a) The policies were approved.	
	Items for Noting & Information	

QSE 24/11/016	**Minutes from Clinical Board QSE Sub-Committees and the Safeguarding Steering Group (SSG)** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=6755 **The QSE Committee resolved that:** 1) The minutes were noted.	
QSE 24/11/017	**Joint Commissioning Committee Quality and Patient Safety Committee (QPSC) Chairs Report – 12.11.2024** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=6776 **The QSE Committee resolved that:** 1) The Joint Commissioning Committee Quality and Patient Safety Committee (QPSC) Chairs Report – 12.11.2024 was noted.	
	Items to bring to the attention of the Board / Committee:	
QSE 24/11/018	*No items.*	
	Agenda for Private QSE Meeting	
QSE 24/11/019	*i) Minutes and Action Logs from the Private QSE Committee on 08.10.2024* *ii) Any Urgent / Emerging Themes – Verbal Update* *iii) Ophthalmology WET AMD*	
	Any Other Business	
QSE 24/11/020	*No items.*	
	Date & Time of Next Meeting:	
QSE 24/11/021	Tuesday 7th January 2025 at 2pm via MS Teams	

Action Log

Public Quality, Safety & Experience Committee

Update for meeting 7th January 2025
(Following the meeting held on 26th November 2024)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions					
QSE 24/11/009	**Equity, Equality, Experience and Patient Safety Action Plan - Update**	For the EDPH and the DDHI to discuss how to improve their inequity data.	**07.01.2025**	Claire Beynon / David Thomas	*Update to be provided in January 2025's QSE meeting in the Action Log section.*
QSE 24/11/009	**Equity, Equality, Experience and Patient Safety Action Plan - Update**	For an update on the Action Plan to be provided to the Committee in six months' time.	**24.06.2025**	Claire Beynon / Eloise Hamon	**COMPLETED** *Added to the Forward Plan for June 2025's meeting.*
QSE 24/11/012	**Sexual Safety**	For the statistics on sexual harassment cases within the UHB to be shared with the Committee.	**07.01.2025**	Katrina Griffiths	
QSE 24/11/014	**Controlled Drugs Accountable Officer Annual Update April 2023 – March 2024**	For the Clinical Director Pharmacy & Medicines Management to liaise with his team around what was being done to address the data problem regarding monitoring opioid prescribing, and feed back to the Committee.	**07.01.2025**	Timothy Banner	**COMPLETED** *Information circulated with Committee members on 28.11.2024*
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					

Report Title:	QSE Medicine Clinical Board Assurance Report				Agenda Item no.	*2.1*	
Meeting:	QSE Committee Meeting		Public	x	Meeting Date:	7th January 2025	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive Title:	Executive Nurse Director						
Report Author (Title):	Clinical Board Director, Medicine Interim Director of Nursing, Medicine						

Main Report

Background and current situation:

This report details the clinical governance arrangements within Medicine Clinical Board in relation to Quality, Safety and Patient Experience (QSPE). It sets out achievements, progress and planned actions to maintain the priority of QSPE. It is aligned to the UHB's Shaping Our Future Well Being Strategy 2015 – 2025, that underpins the development of our service, and the Quality, Safety and Patient Experience Framework 2021-2026.

Medicine Clinical Board offers high quality clinical care for people with multiple, complex health needs, minor injuries and serious disease. It includes services for the wider regional and Welsh population such as Infectious Diseases, Welsh Gender, Stroke, Diabetes, Dermatology and Gastroenterology. The Clinical Board also provides emergency and secondary care services to the local Cardiff and Vale population.

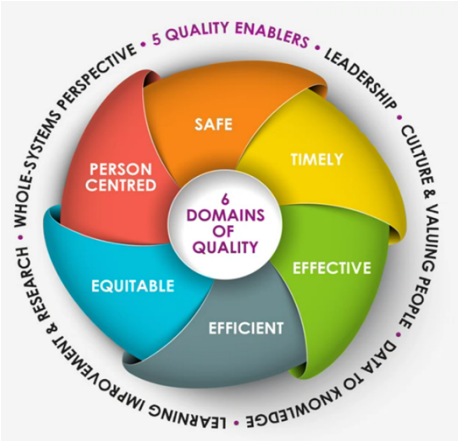
The Clinical Board has a current workforce establishment of 2175 WTE staff in post which includes: 964 WTE Registered Nurses, 650 WTE Health Care Support Workers, 243 WTE Admin and Clerical, 264 WTE Medical and Dental staff, 24 WTE Additional Prof Scientific and Technic, 18 WTE Allied Health Professionals, Estates and Ancillary 1, and 11 WTE Health Care Scientists. It has an inpatient bed base of 674 beds which include 30 winter beds on East 4 UHL, within this bed base there is capacity which is not fully funded and is open as a balance of risk for patient safety, three Day Units and several outpatient suites.

Secondary to the diversity and high activity provided across the Clinical Board, it is essential that robust governance and risk management arrangements are in place to reduce the risk of harm to our staff and service users.

The aim of the Medicine Clinical Board in summary is to:

- Ensure there is a process in place to continually monitor and review its risk register, acting to mitigate quality and safety risks on an ongoing basis;
- Maintain an open culture of improving quality, safety and patient experience across all teams and all staff;
- Promote a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care and
- Foster a culture of psychological safety within Medicine Clinical Board in order to promote collaboration, trust, innovation and personal growth.

Quality, Safety and Patient Experience (QSPE) is the highest priority for the Clinical Board and its governance structures and oversight has developed significantly. The Clinical Board Director, Director of Nursing and Head of Quality and Clinical Governance lead the agenda which is aligned to the six Domains of Quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these Domains.



Clinical Board QSPE Committee meetings are planned every month, and are well represented by medical, nursing and managerial staff across all Directorates, as well as other multi-disciplinary colleagues from across the Health Board, all of which take an active part in the meetings and shape the overall agenda. The Committee Terms of Reference and Work Plan are reviewed annually and it is supported by sub groups covering Infection, Prevention and Control (IP&C), Health and Safety Professional Nursing Board and Medicines Governance and Access.

Each Directorate holds monthly Quality and Safety Groups, and further work is underway to strengthen this structure and reporting to the Clinical Board QSPE Committee.

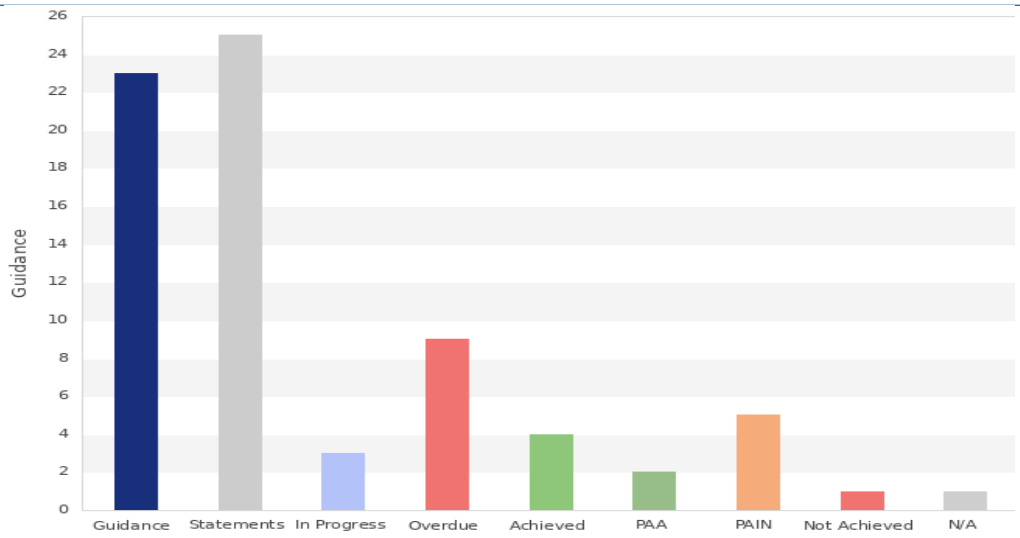
Safe Care

Patient Safety Alerts

The Clinical Board has a robust management system in place for Patient Safety Alerts, working in conjunction with the Patient Safety Team. An identified member of staff is responsible for all alerts received, and for their dissemination and tracking of actions where applicable. All alerts and notices are shared at both Clinical Board and Directorate QSPE meetings.

National Guidance

The Clinical Board has reviewed its compliance with national guidance and the position as outlined below has been reported through the QSPE structure. There are currently 9 pieces of overdue guidance and 5 where improvement is required despite being partially achieved. The Clinical Board is working with the UHB Clinical Effectiveness Team and its clinical leads to follow up on those outstanding and understand any barriers to achieving compliance.



Peer Review

Peer review of the Skin Cancer Service took place in April 2024. The skin cancer service in Cardiff and Vale delivers comprehensive care to a population of 500,000, addressing suspected and confirmed cases of skin cancer, including malignant melanoma and squamous cell carcinoma. Additionally, it offers tertiary care to patients with complex basal cell carcinomas (BCC), serving as the sole centre in Wales to provide MOHS surgery.

A number of areas of good practice were noted including the implementation of teledermoscopy, good clinical leadership and team cohesion, CNSs exclusively treating skin cancer, MacMillan nurses dedicated for Patient Centred Care and efficient use of protocols for streamlining patients for discussion at MDT which have been shared across Wales.

An action plan is in place to progress the areas for improvement identified and a one stop clinic will commence in January 2025 to book patients for simple procedures straight from teledermatology along with trial of a “see and treat” service in a single clinic; cancer tracking has been amended to track all patients from the point of referral and accurately reflect demand on the service. Work continues with partners to initiate weekly MDT, and expansion of the MOHS service to 5 days a week will form part of the demand / capacity review which is underway. In terms of pathway delays (pathology, radiology), a same day staging pathway is not yet achieved but pathology reporting times have significantly improved.

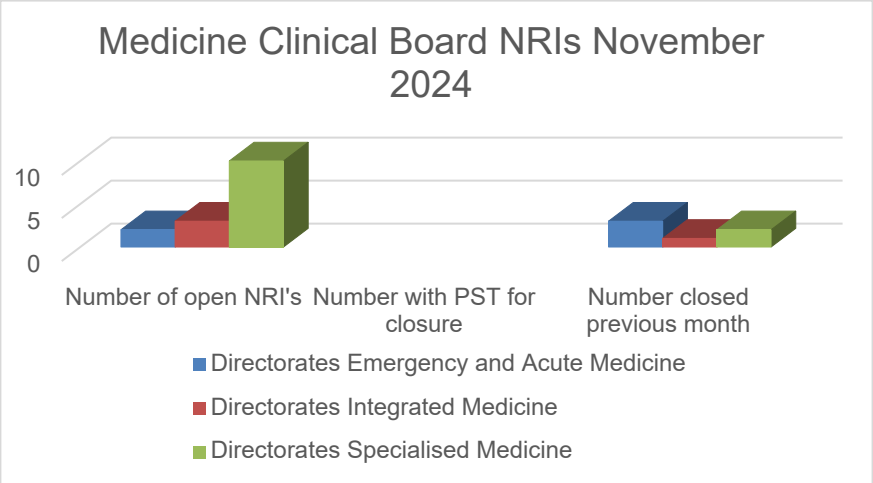
Educational Governance

Throughout 2024 the Clinical Board has continued to engage with Health Education and Improvement Wales (HEIW) in respect of the training opportunities, education and support provided to its trainees.

The most recent visit to Gastroenterology in December 2024 recognised improvements made however action is still required to ensure access to induction, sufficient number of clinics, timely allocation of educational supervisors, sufficient training capacity for colonoscopy and that consultants are able to balance service delivery with training and other interests.

The commitment made by the Clinical Board to complete consultant job planning (as summarised later in the report) and the implementation of the Acute Gastroenterology model will further enhance opportunities for our trainees and ensure a more manageable workload.

NRI (National Reportable Incident) Management



The Clinical Board is currently investigating 16 NRIs:

- One missed opportunity to refer to Diabetes
- Two potential delay in a Stroke diagnosis
- One delayed cancer diagnosis following chest x-ray imaging
- Seven delayed cancer diagnosis (Endoscopy)
- Two delayed therapeutic Endoscopy diagnostics and cancer diagnosis
- One delayed Dermatology review and cancer diagnosis
- Two delays in treatment

The Clinical Board is committed to ensure NRIs are progressed and closed within timescales set by NHS Wales Delivery Unit to ensure patients and families receive feedback in a timely manner. This can prove challenging and 2024 has been focused on improving this by regular meetings with investigators throughout the Patient Safety Learning Review process and supporting areas in formulating their improvement plans. The Clinical Board's Patient Safety Learning Review Approval Process (2024), provides for an improvement plan lead to be identified early on in the process recognizing this aspect is one which areas find difficult to manage; this will continue to be a focus in 2025 to strengthen the formulation, ownership and monitoring of improvement actions.

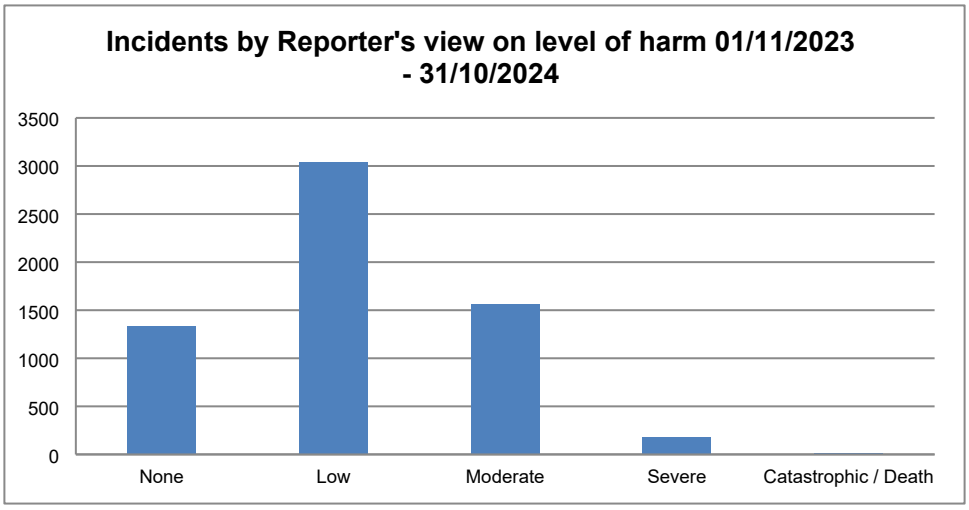
The Clinical Board had 10 NRI related inquests in 2024. It was able to satisfactorily demonstrate lessons learnt to HM Coroner and share these outcomes with families whilst ensuring staff involved in the process received the support needed. Some of the improvements are summarized below.

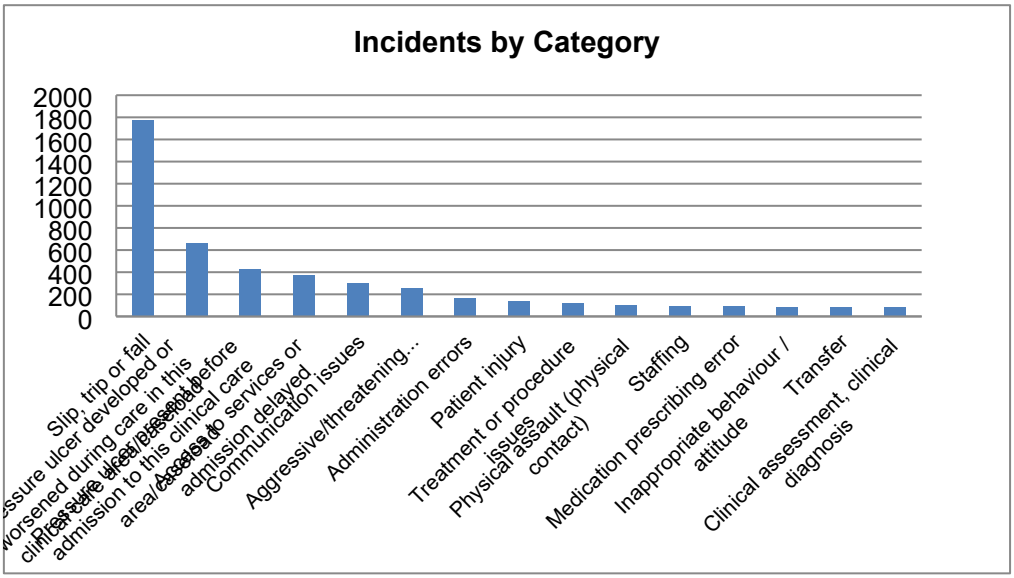
- Paediatric Emergency Department - introduction of age-related observation charts, fluid challenge record for parents / guardians, web-based information for parents / guardians on diagnosis of gastroenteritis and safety netting, Criteria for Discharge Proforma and significant changes in medical and nurse staffing
- Emergency Unit and wards – keeping of hydrocortisone and prednisolone (mainstay treatments for adrenal insufficiency) as stock in all clinical areas, implementation of the EU workstation Task List to identify and action any outstanding time critical tasks and EU Clinical Decision Checklist containing a prompt in line with the Royal College of Emergency Medicine (RCEM) Safety Flash (October 2023) MISSED mnemonic to ensure patients on time critical medications receive them.

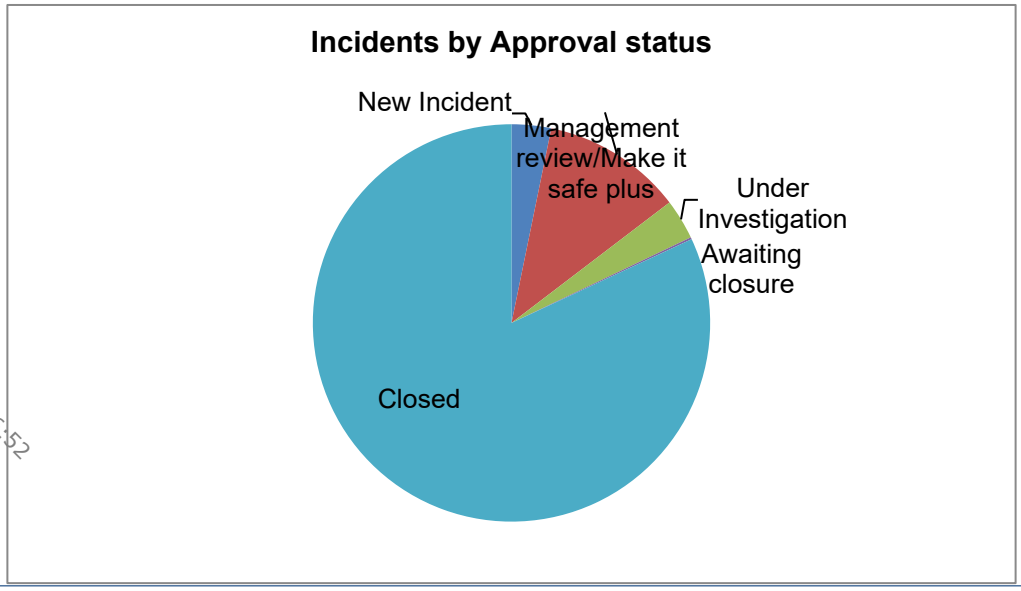
Effective sharing of learning is equally important and the Clinical Board has started presenting via its QSPE a single learning slide for each claim, this has encouraged healthy discussion of cases, how areas can improve and facilitated wider sharing of cases across the Clinical Board. Following on from a recent inquest, clinicians also shared their personnel experience of attendance at Coroner's Court with colleagues at a joint Emergency Medicine / Paediatric Emergency Medicine teaching session in December.

Datix Cymru

The Clinical Board demonstrates an open reporting culture with high numbers of Datix Cymru incidents submitted. The vast majority of these incidents result in no or minor harm. The Clinical Board acknowledges the challenges for timely closure of Datix, and continues to focus on those reporting severe or catastrophic harm. There are Super Users across all Directorates to support staff in how to appropriately manage Datix.

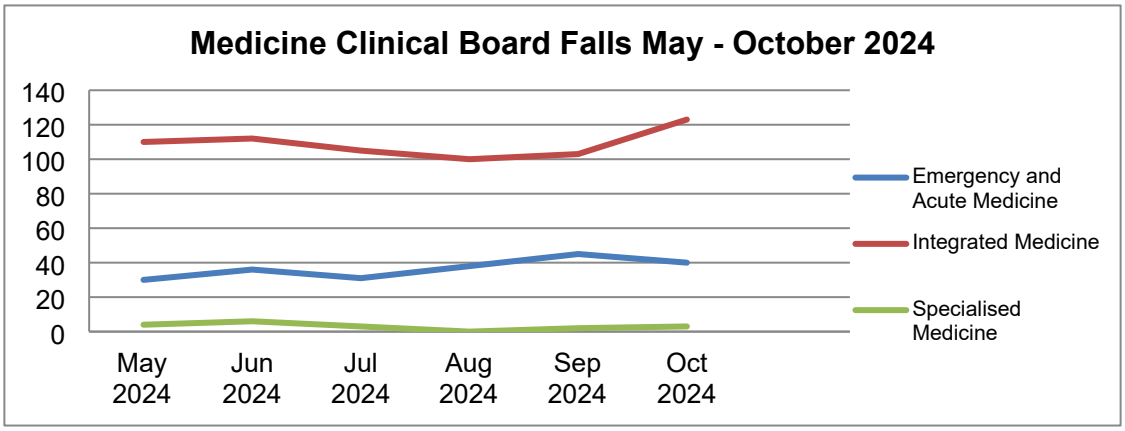






Falls

Falls remain one of the most reported incidents within the Clinical Board via Datix Cymru. The Clinical Board reported 138 – 166 falls per month for the period May – October 2024. This remains on par with what was reported for the same time period for the previous year where 133 – 168 falls were reported. Acuity of patients and an increase in the bed base across the Clinical Board are considered factors for this.



For this time period the Clinical Board reported 19 injurious injuries, 17 fractures and 2 head injuries. To date one injurious fall from a fractured neck of femur was reported to the Delivery Unit, it was agreed there were acts or omissions which contributed towards the fall and subsequent injury. The patient was not adequately monitored by staff following the recognition they were a high risk of falls, and not monitored on a 1:4 ratio in line with the recommended best practice for the clinical area.

The Clinical Board continues to participate in the interactive spread and scale falls training for all staff aligned to the UHB Falls Delivery Group. The training journey for the Clinical Board has so far included University Hospital Llandough, and currently at Phase 6 Community hospitals at St Davids and Barry with sessions undertaken in September and October. 140 staff have undertaken training to date finding the 'face to face' training informative and valuable enhancing knowledge on pre and post falls prevention and assessments to support safe and clinically effective care.

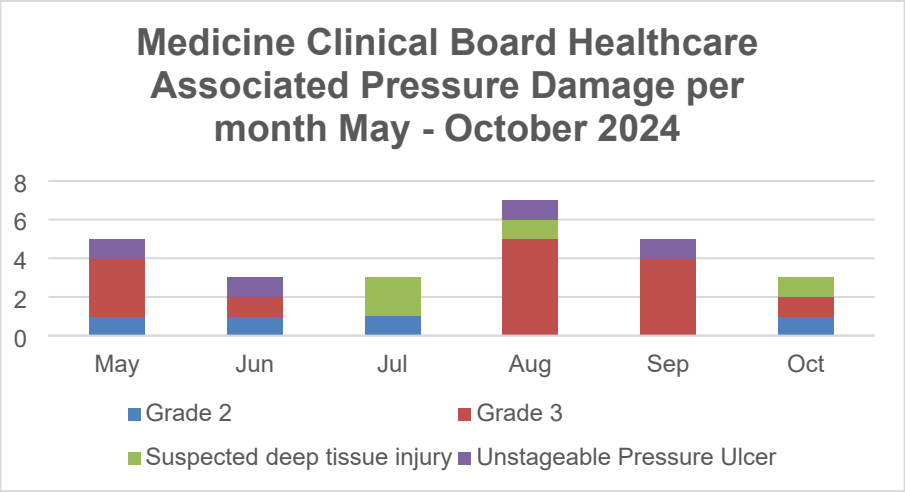
Core Standard Falls Tendable audits for the Clinical Board from May – October 2024 reported an average compliance 91.25%.

Recognising the patient safety concerns for patients within the Emergency footprint and risk of falls low rise trolleys are being purchased.

The Clinical Board are fully engaged with the UHB 'Get up, Get Dressed, Get Moving' campaign which focuses on 3 key areas, making a difference to patients, supporting people to keep moving, and supporting our staff to stay active and well. IACU Lakeside Wing undertake breakfast clubs with the support of volunteers, during the summer months supported by therapies and volunteers' patients are encouraged to participate in group exercise/mobility sessions which also includes outdoor activities. Mental Health Matters have also been key in providing support for patients. Sam Davies Ward in Barry Hospital have transformed a garden to support patients as a means of preventing deconditioning both physically and mentally. Tendable audits have also been introduced within the Clinical Board.

Pressure and tissue damage reduction and prevention

The Clinical Board continues to learn from all avoidable and unavoidable healthcare acquired pressure damage. The Clinical Board's Pressure Damage Learning and Scrutiny Panel is well embedded and supports Ward Sisters/Senior and Lead Nurses to engage in the decision making, and identification of learning to share more widely across the Clinical Board.



From 1st May 2024 to 31st October 2024 the Clinical Board reported 7 avoidable healthcare associated pressure damage with AS1's submitted. The Pressure Damage Focused Reviews are discussed at the Clinical Board's Learning and Scrutiny panel, identifying key learning and themes. Focused work and education have been undertaken to support staff with the correct mattress selection factoring in patients' comorbidities on admission and the completion of Purpose T Risk Assessments to support safe and clinically effective care.

Standards are monitored via Tendable with Clinical Board oversight. On average between May – October 2024 the Clinical Board reported between 87% - 100% overall compliance for the correct treatment, interventions and documentation for pressure damage.

Safeguarding

All safeguarding referrals relating to community concerns, or raised against staff working within the Clinical Board are subject to the required level of investigation and scrutiny to ensure safe care is provided. Investigations are led by Health Lead Professionals (HLP), with appropriate actions taken and shared more widely if required. The Clinical Board is currently investigating 29 safeguarding referrals, 2 of these relate to avoidable healthcare acquired pressure damage. The Clinical Board has key links with the Safeguarding Team to ensure openness and transparency, and safeguarding remains a standing agenda item on the QSPE Committee agenda.

The creation of Cyfannol safeguarding hub within the Emergency Department (ED) has brought together a number of services with the aim of providing holistic patient centre care to support the most vulnerable patients. These services include: Violence Prevention Team, Psychiatry Liaison, Health Independent Domestic Violence (IDVA), Health Young Persons Independent Domestic Violence Advisor (YP IDVA), Frequent Attenders Service, Children and Adolescent Mental Health Services and Red Cross.

The presence of this team in the heart of ED has been extremely beneficial to both staff and patients. Staff are able to drop in for advice and the team is accessible to support patients and their needs. Cyfannol has been further strengthened by the joining of the Homeless Nursing Team. The original cohort of patients was 349 and the new cohort 109 making a total of 458 patients now benefiting from the hub.

- EU visits for original cohort decreased from 741 visits in 2022/2023 to 665 visits in 2023/2024 (**10% decrease**).
- EU did not wait percent has reduced for total cohort from **19.5% to 9.9%** in the second half of 2023/2024.
- Decrease in EU reattendance for initial cohort in second half of 2023/2024 (from **28% to 23%**).

- Inpatient admissions increased for original cohort, but the bed day figure decreased to 1331 (in 2022/2023 this was 1965 - **38% decrease**). Average length of stage reduced from **26.9 days to 7.6**.

Infection, Prevention and Control

The Clinical Board is fully engaged with the expected reduction figures for all healthcare acquired infections and the challenge this brings to promote safe and clinically effective care. Environmental, Hand Hygiene and Bare Below the Elbow, in addition to IP&C audits on Tendable are undertaken monthly to ensure standards are maintained.

The Clinical Boards IP&C Group continues to meet bi monthly with the purpose of driving forward the UHB Infection, Prevention and Control agenda across the Clinical Board with multidisciplinary input. It allows teams to share a patient story, evidence of good practice and the escalation of any IP&C concerns. Current concerns include the IP&C management of patients across the Emergency and Acute footprint and the difficulty in isolating patients, and the increase in the number of C. *Difficile* cases which is reflected globally.

From 1st May – 31st October 2024 the Clinical Board reported 74 healthcare acquired infections.

Clostridium Difficile

31 incidents of C. Difficile were attributed to the Clinical Board from 01st May – 31st October 2024. Based on the same time period in 2023 a 67% increase has been noted. The investigations and discussion with Infection, Prevention and Control identified the increased use of antibiotics and potential associated use of Tazocin, failure to consistently apply universal precautions standards and patient acuity being significant contributory factors. The increase in the number of C. *Difficile* has also been noted globally.

The Clinical Board has an Antimicrobial Lead Consultant supporting antimicrobial stewardship (AMS) initiatives to support the reduction of antimicrobial resistance. Antimicrobial pharmacist/microbiologist led ward rounds in areas focus on the reduction/cessation of broad-spectrum antibiotics and prompt IV to oral switch. The Antibiotic Review Kit (ARK) chart is used and has a dedicated section for antimicrobial prescribing forcing a review and revision approach at 72 hours. Pharmacy led audits of in hospital antimicrobial prescribing against recommended standards are conducted on a quarterly basis and provide benchmarking. These audits are shared across the Clinical Board QSPE structures. SSTF audits reported in October 2024 note 93% compliance for antibiotic review within 72 hours, 84% compliance for the indication recorded and 82% prescribed within guidance. Further improvement is required for the duration of antibiotics documented noting 57% compliance.

MSSA

11 incidents of MSSA were attributed to the Clinical Board from 01st May – 31st October 2024. The investigations and discussion with Infection, Prevention and Control identified the main causes were secondary to PVC, chest/cardiac, urinary/renal and skin/wound. Tendable Peripheral Vascular Cannulae Audits are well embedded across the Clinical Board, whilst there is evidence of good practice noting the continuing clinical indication for a cannula, and VIP scoring being documented within the 24-hour period, further improvement is required around the documentation of the PVC insertion sticker and the indication for removal.

MRSA

1 incident of MRSA was attributed to the Clinical Board in August 2024. The investigation noted this is likely to have been from a skin contamination with the patient having a previous history of MRSA. The investigation noted learning with no evidence of PVC insertion on two occasions and VIP

scoring on two occasions. The patient's previous history of MRSA was not well documented which would have prompted staff to MRSA screen on admission in line with guidance. 100% compliance for Hand Hygiene and BBE.

E Coli

16 incidents of E Coli were attributed to the Clinical Board from 01st May – 31st October 2024. Based on the same time period in 2023 this is a significant 63% reduction. Investigations and discussion with Infection, Prevention and Control identified these are mainly attributed to urinary/renal and biliary/abdomen sources.

Klebseilla

11 incidents of Klebseilla were attributed to the Clinical Board from 01st May – 31st October 2024. Based on the same time period in 2023 this is a significant 33% reduction. Investigations and discussion with Infection, Prevention and Control identified these are mainly attributed to urinary/renal, PVC/CVC and chest/cardiac.

Pseudomonas

4 incidents of Psuedomonas were attributed to the Clinical Board from 01st May – 31st October 2024. Based on the same time period in 2023 a 50% increase has been noted. Investigations and discussion with Infection, Prevention and Control identified these have all been attributed to PVC/CVC.

The Clinical Board continues to see incidents/outbreaks of patients and staff testing positive for Covid-19 and other winter respiratory viruses such as Flu. Any potential healthcare associated Covid-19 death is investigated in line with UHB and Delivery Unit guidance. To date the Clinical Board have undertaken 5 investigations, all of which concluded the level of healthcare associated harm as low. Evidence of high standards of Hand Hygiene, the appropriate use of PPE, no other staff or patients testing positive at the time.

Infection Prevention Control will remain an area of targeted attention for the Clinical Board, with a focus on basic principles, environmental cleaning and antimicrobial stewardship.

Staffing

Safe Nurse staffing is a priority within the Clinical Board. This includes reviewing ward establishments every six months through triangulation of information on quality indicators, acuity data and professional judgement. There is also focus on improved rostering and processes to manage unavailability of staff and the associated risks. Mitigation includes a well embedded vacancy panel within the Clinical Board which supports the authorisation of vacancies reviewed efficiently, with posts advertised in a timely manner. Recruitment events are undertaken, with ongoing recruitment, adaptation programmes, student streamlining and staff return to practice. A staff risk framework is completed daily and Safecare is used to record actual staffing on wards and to raise red flag alerts where staffing is considered suboptimal for delivery of safe patient care. Senior nurses mitigate staffing risks with internal moves and information is shared at daily OPAT UHB meetings. Exit questionnaires are completed with no recurrent themes.

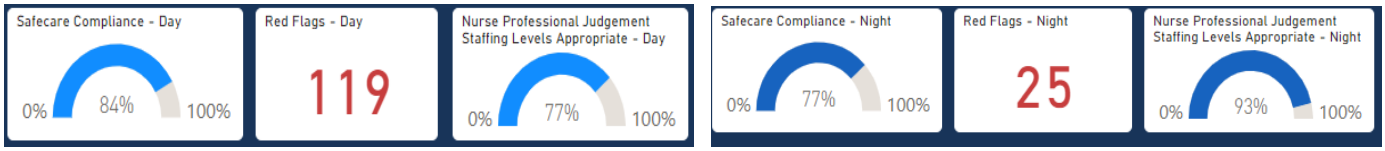
'Stay Questionnaires' have been introduced as a means of supporting staff to remain within the department. There are recognised workforce challenges within Gastroenterology/Endoscopy with recruitment ongoing for clinician posts to support the acute Gastroenterology model. In addition, secondary to the growing number of patients within the Endocrine Service a nursing service review is being undertaken and the Diabetes service will be an area of focus in the coming year.

The Clinical Board consists of 2175 WTE staff and currently has an 7.99% turnover rate, with a cumulative sickness rate reported for November as 6.95%. There are hotspot areas where the sickness rate is higher, which in the main is within the Additional Clinical Services staff group, including Health Care Support Workers with a sickness rate of 9.92% reported in November. A Clinical Board sickness scrutiny panel is held monthly to support teams to manage sickness management. The Registered Nurse vacancy rate reported in September was 6%.

Some examples of staff experience feedback in Tendable for October include:

- 96% of colleagues reported they could take a break during their last shift
- 95% of colleagues reported they had enough clinical items/equipment available to do their jobs effectively
- 97% of colleagues report they were satisfied with the standards of care they provided during their most recent shift
- Examples where staff have reported they were not satisfied with the standard of care they have been able to provide on a particular shift, and struggled to take a break centred around the pressures within the clinical areas at the time.

The Clinical Board inpatient wards are reviewed against the All Wales Nurse Staffing acuity data. Health Roster Standards and Measures are in place with Safecare. Safecare is a tool used to monitor how many staff are on the ward and identifies gaps and risks, as populated by each clinical area, completed twice a day and monitored for compliance. An example taken from CAV Nursing Safecare Dashboard for September:



Workforce model updates include a new weekend medical model which commenced in September 2024 to support 7 day working. This aims to improve patient experience and safety and also seeks to reduce the number of medical outliers.

Within Medicine there are several wards who have introduced the Assistant Practitioner (AP) role. The APs are, in the main, destination Registered Nurse, meaning that they are Registered Nurses who are working towards gaining their NMC registration. With the all Wales development of Registered Nurse Associates (RNA), we are now in a transition phase with limited opportunities to progress with the AP role. Furthermore, nurse led clinics exist in many areas in Medicine through our Clinical Nurse Specialist Workforce who are running complex services. There is currently one Consultant Nurse in post within the Emergency and Acute Medicine Directorate and another Consultant Nurse Job Description being developed for Gastroenterology with view to this role being progressed to recruitment in 2025.

Other multidisciplinary roles utilised to support the safe delivery and maintenance of care which is bringing real benefit include; Pharmacy Technicians to support medicines administration in non-acute areas, Dietetic Assistants to support nutrition and hydration management on wards, Physician Assistants (PAs) supporting patient care with the Medical Teams and Prescribing Pharmacists within our Specialised Services. The Clinical Board will continue to look at opportunities to reshape our workforce to enhance patient care and safety.

The importance of staff appraisal cannot be underestimated. The Clinical Board and Directorates continue to work hard to improve compliance with Values Based Appraisal and pay progression. The current position is as follows:

Emergency and Acute Medicine:	76.27%
Integrated Medicine:	77.22%
Specialised Medicine:	74.73%

Medicine Clinical Board Management:	76.92%
Clinical Board Total	**76.55%**
Medical Staff Appraisal	**75.61%**

Uptake of mandatory training is monitored via Directorate monthly reviews. The Clinical Board is focused on improving medical compliance with statutory and mandatory training in 2025 (which currently stands at 47.49%) along with completing the review and sign off of all Consultant job planning which has progressed throughout 2024.

Statutory Mandatory Training October 2024 Position

Emergency and Acute Medicine	639	77.03%
Integrated Medicine	1140	75.85%
Medicine Clinical Board Management	12	70.86%
Specialised Medicine	384	80.83%
Total	**2175**	**77.03%**

Medicine Job Planning Summary of Progress 1st December 2024

		Total Clinicians (Cons & SAS)	Status								Compliance	
	Department		Not Publishe	Discussi	Locked Dov	Awaiting Sign Off - Consultant	Awaiting 1st Sign Off Manager	Awaiting 2nd Sign Off Manager	Signed Off	Signed Off (Over 12 months)	Compliance (inc expired)	Compliance (exc expire
Medicine	Emergency and Acute Medicine	50	1	14		4	1	4	16	10	52%	32%
	Integrated Medicine	75		23	1	2	10	2	22	15	49%	29%
	Specialised Medicine	51	2	19	1	5	5		14	5	37%	27%
Grand Total		**176**	**3**	**56**	**2**	**11**	**16**	**6**	**52**	**30**	**47%**	**30%**

Staff engagement

The Clinical Board is fully engaged with the UHB's values and behavours and has strategies in place to manage staff who fail to meet the expected standard. The Clinical Board supports the UHB's commitment for talent management and leadership and recognises the importance of creating the right vision and environment for change to enable teams to improve the experience of patients and staff. Some examples of this include:

- Dr Adenwalla (Consultant Geriatrician) won the high profile Majory Warren Lifetime Achievement Award 2024 by the British Geriatrics Society
- HCC team winners of the Moondance Cancer award in Innovation and Improvement Category
- Stroke Physician Dr Shetty named in New Year's Honours list
- Dr A Tabasum – UNIVANT Health Care Excellence Award (Chicago) Early diagnosis of Type 1 and Type 2 Diabetes

The Clinical Board encouraged completion of the UHB 2024 Staff Survey across all Directorates and will feed back the results and agree actions to be taken forward with all its areas as it did with last year's results.

The Clinical Board recognised success at its Celebration Event held in July. Many excellent examples of innovative practice were shared demonstrating improvements in the quality and safety of the care we provide with staff presenting posters for the first time highlighting their services. One special award 'certificate of appreciation' went to Maggie (therapy dog) and her human companion Stuart for providing unconditional comfort to patients and staff.

Mortality Reviews

The Clinical Board is represented at both the UHB Mortality Screening Panel and Learning from Mortality Group. It supported the development of the Business Intelligence System (BIS) Mortality Dashboard which is now live and work continues to standardize mortality reviews within the Clinical Board. A Learning from Mortality Case Review template has been provided to areas to assist with this and Specialised Medicine will be piloting the AMaT Morbidity and Mortality module throughout 2025. The capturing of Medical Examiner feedback via Civica has enabled the Board to display themes via word clouds at its QSPE providing a powerful, visual way of sharing family experiences.

National Audit

The Clinical Board has participated in the following National Audits in 2024:

- National Paediatric Diabetes Audit
- National Pregnancy in Diabetes
- National Diabetes Core Audits
- National Diabetes Inpatient Safety Audit
- National Asthma and Chronic Obstructive Pulmonary Disease Audit
- National Hip Fracture Database
- National Audit of Inpatient Falls
- Sentinel Stroke National Audit Programme (SSNAP)

The Clinical Board also undertakes a considerable amount of Tier 2 audits, some examples are provided below. The focus in 2025 will be on supporting areas to register these on AMaT to ensure action plans follow when appropriate, re-audits are conducted and outcomes shared.

- Audit of Dementia Management in Parkinson's
- Hypoglycaemia and its Management
- Management of Self-harm in Children and Young People Presenting to A&E
- Re-Audit on the Efficacy of Daylight Photodynamic Therapy in the Management of Actinic Keratosis
- Resuscitation Trolley Checklist (Adult Acute)

Audit activity increased in 2023-2024 (total of 29 previous year).

Number of new and re-audits by year

Year	Division	Total	New	Re-audit	Re-audit %
2023-2024					
	All	344	323	21	6.1%
	Children & Women	64	55	9	14.1%
	Clinical Diagnostics & Therapeutics	25	25	0	0.0%
	Corporate	7	7	0	0.0%
	Medical Genetics	4	4	0	0.0%
	Medicine	40	38	2	5.0%
	Mental health	11	11	0	0.0%
	Primary Comm & Intermed Care	18	18	0	0.0%
	Specialist Services	75	69	6	8.0%
	Surgical	100	96	4	4.0%

Patient Safety Advancements

Brainomix e-stroke Artificial Intelligence decision tool is well embedded within the Stroke Service. This support clinicians in providing real-time interpretation of brain scans to help guide treatment and transfer decisions for Stroke patients allowing more patients to get the right treatment in the right place at the right time. To support compliance with NICE and SSNAP the Stroke business case has been approved to support the revision of triage and assessment process and imaging pathways as a means of providing safe, timely and clinically effective care. This also includes access to Thrombectomy services supported by WHSSC. The Stroke CNS bleep holder is protected whilst on duty to drive the Stroke pathway.

Within Respiratory lung cancer screening is on the horizon following The Lung Health Check pilot in CTM.

E-Triage launched in July within Emergency Medicine, this has reduced triage times with the clinical team having a better awareness of what patients are in the waiting room and feels safer. A 3-month review is currently being undertaken.

Person Centred Care

The Clinical Board use Civica Once for Wales Patient Experience platform as a means of sharing patient feedback. Examples of responses are noted below:

Based on the feedback received from patients discharged/attended from 1st May - 31st October 2024.

When patients were asked to rate their experience on a scale of 0 – 10, overall, 78% (EU: 71%, Random: 89%) gave a rating of 7 or more.

When patients were asked if they felt well cared for or if staff were kind and caring, overall **71%** (EU: 62%, Random: 86%) answered

A selection of comments left by patients within Medicine Clinical Board:

> As a patient and initially very unwell I was well supported and monitored. In my 10 day stay I would say 98% of all staff doctors through to catering were excellent. I cannot thank them enough. Although there were some supplies shortages at certain points they just made do to get through, very resourceful.

> There were no or limited doctors on the weekend, people don't stop being ill or getting worse on a weekend. I found I had to wait a very long time to see a doctor when I was in a lot of pain, the nurses couldn't do anything more for me and I needed to see a doctor but I was left in a tremendous amount pain until a doctor could come and observe me

> Everybody involved in my Husband's cancer treatment and continuing care have been very kind and caring. Thank you.

With the support of the Patient Experience team the following bespoke projects are being undertaken:

- Paediatric EU survey
- Paediatric EUT survey which is focusing on feedback from patients regarding the new E-triage system
- Inpatient Diabetes Management survey
- Pleural Team survey
- Same Day Emergency Care Unit survey

Concerns

The management of concerns remains a key priority for the Clinical Board. Tracker meeting are well embedded across all Directorates. The Clinical Board aims to resolve all concerns by Early Resolution with contact from the relevant Ward Sister/Charge Nurse/Manager, Senior/Lead Nurse or clinician. For September the Clinical Board reported 57 open concerns under Putting Things Right with 78% compliance for 30-day response. There were 27 overdue concerns reported in September with the main reasons for the delay around unprecedented demand and access to medical notes.

Common themes and trends focus around communication, inappropriate discharge, delays/comfort issues, waiting times and cancelled appointments.

Patient Experience

All areas of the Clinical Board are engaged with the Patient Experience Framework.

The Clinical Board shares a patient story and compliments at each QSPE to share good practice and highlight areas for improvement and learning outcomes.

A recent patient story presented by Ward East 2 UHL shared steps it had taken to improve the surroundings and comfort of patients at the end of their life and their relatives following a family concern. The Ward Manager described how they created a safe space for relatives to use on the ward for rest, privacy and religious observance; provided a trolley of facilities and resources for relatives at the bedside to include teamaking equipment, tissues, information leaflets, toiletries; highlight end of life patients at safety briefings and via workstation to ensure regular checks on the patient and visiting relatives and ensure property bags are available to respectfully store patient belongings.

An example of a compliment recently shared at QSPE:

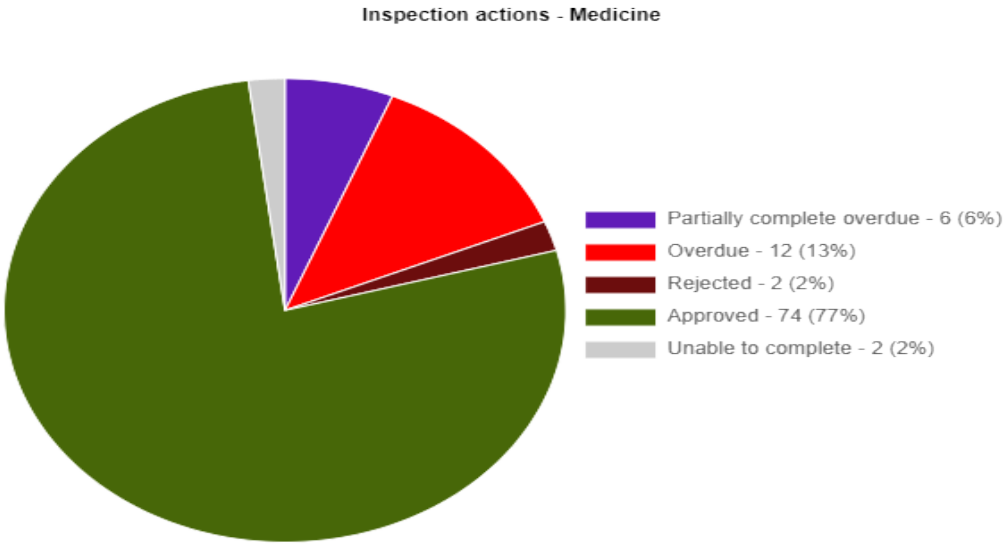
"My father was admitted on the 2nd July via A&E. That evening at home my father had considerable back pain. He got out of bed and fell sustaining a head injury. His catheter was also blocked. My sister and brother-in-law took my father quickly to A&E at UHW. Although it was extremely busy in the department the staff took great care of my father. They treated him with respect and kindness. It was a very worrying time for my sister and she felt reassured the staff were doing everything they could for my father. The level of care was excellent.

He was admitted to A1 ward and again we were so impressed with the level of care my father received. All the nurses, doctors, carers, physiotherapists and OTs on the ward were wonderful. The communication from staff was also excellent. We felt fully informed on my father's progress during this time. His platelets dropped significantly at one point and the quick action from the medical team I believe saved his life.

My father has told me how great the staff were on A1 and he really enjoyed every meal as well. He said the food was delicious and he looked forward to his meals".

Healthcare Inspectorate Wales (HIW) Reports

Following its inspection of the Emergency Department in March 2024, HIW reported that the results demonstrated good practice and considerable improvement since its previous inspection in 2022. It commented that despite the department being extremely busy, it felt calm and that the Rapid Assessment and Treatment Zone (RATZ) was a commendable initiative aimed at reducing waiting times and ensuring that where appropriate patients received rapid assessment, investigation, diagnosis and treatment by a Senior Emergency Department doctor. HIW concluded that staff were committed to providing a high standard of care to patients, and its inspectors witnessed staff being respectful and friendly towards patients. The refurbished environment also promoted dignity and enabled staff to provide treatment privately and addressed issues of IP&C raised at its previous visit.



Timely Care

Emergency and Acute Medicine

Emergency attendances have seen an upward trend of 10% since November 2023. The Emergency Medicine footprint discharges 73% of patients without a referral. 12-hour breaches continue to increase month on month with an average of 31 referred patients in the department which is 50% of the available capacity. The Emergency Unit's 'front door model' has been revamped since January 2024 to support senior decision makers to provide RATZ/Streaming and Redirection from 08:00 –

00:00 daily. It seeks to provide a front-loaded model with a senior decision maker to facilitate rapid triage, assessment, early decision making and treatment initialisation of ambulatory and minor injury patients who should be in the unit for no more than 4 hours. It is recognised the ambulatory areas can remain over-crowded with up to 34 patients, with a nursing ratio 1:10 for a maximum of 20 patients.

Significant transformational work continues across the Emergency and Acute Medicine footprint. This includes the relocation of Acute Medicine which has provided the Emergency Unit with the opportunity to reassess its footprint and associated clinical model. In November 2023 the Adult Clinical Decisions Unit was opened, and since this time has seen 86% of patients discharged directly supporting timely care. This has reduced admission to respective assessment areas by 2%

improving patient experience as patients are no longer waiting within the ambulatory areas for protracted times. The Paediatric Clinical Decisions Unit opened in February 2024 has exceeded usage by 21%.

Digital transformational work has produced a digital task list allowing for a more efficient management of nursing tasks. This is working effectively to enable the timely delivery of nursing care and diagnostics. The E-triage system has been introduced with ongoing embedding of this process. Early data notes positive results from the process with patients presenting with life-threatening conditions such as Stroke and Myocardial Infarction, resulting in being reviewed by a clinician in RATZ prior to a triage by a nurse.

The Electronic-Whiteboard is well embedded and utilised by Acute Medicine providing accurate data of performance and seamless tracking of patients through the medical pathway. It is widely acknowledged further engagement from other specialties is required to support those patients within the Emergency Unit footprint.

Stroke

CaV Stroke service has implemented measures to support adoption of the 2023 updates to the National Clinical Guidelines for Stroke for the UK and Ireland. Specifically, the extended treatment windows for thrombolysis and thrombectomy for appropriate patients are being implemented, supported by advanced imaging techniques including CT brain perfusion scans and the Brainomix e-stroke interpretation software. Progressive improvement has been achieved in thrombolysis and thrombectomy treatment rates at UHW, with thrombectomy rates in June 2024 reaching 8.6% (target 10%).

Supporting the pre-hospital stroke pathway, CAVUHB introduced Pre-Hospital Video Triage (PVT) for stroke in a first in Wales project with WAST colleagues. PVT has been extensively tested in stroke services across NHS England, with results demonstrating that connecting the ambulance clinicians to the Stroke team in a secure video consultation reduces the number of stroke mimic cases requiring stroke team assessment at hospital, and accelerates the stroke pathway for those patients requiring urgent imaging and assessment by the stroke team on arrival to hospital. The results so far align with those seen in NHS England and CAVUHB stroke team are keen to further develop PVT as a permanent element of the patient pathway.

Stroke unit beds at UHW and UHL are reserved for patients admitted on the stroke pathway, supporting timely admission to the stroke unit in line with the National Clinical Guidelines. This ringfencing is only breached in exceptional circumstances and times of highest escalation, and the stroke team work closely with Emergency Department and Patient Flow and Site Services colleagues to ensure that the optimal emergency stroke pathway is implemented without delay.
CAVUHB has a Stroke Improvement Action Plan, reviewed regularly with updates provided to the NHS Executive Performance and Assurance team. The action plan includes patient pathway improvement initiatives and an agreed path for investment into an improved, more sustainable emergency stroke and TIA clinical model. A business case to the value of £1.4m has been approved which will support

implementation of this with a focus on increased presence of the senior clinical decision makers for stroke, and 24/7 support of Clinical Nurse Specialists.

Endoscopy and Gastroenterology

The Endoscopy and Gastroenterology service has significant pressures to schedule patients for a variety of endoscopic and colonoscopy procedures which is reflected in the number of Nationally Reportable Incidents. The main themes centre around demand and capacity misalignment, safety netting, the validation process, governance and escalation, internal processes to drive the correct pathways and disjointed engagement with Primary Care colleagues. An overarching improvement plan is being progressed by the directorate and includes rolling validation of endoscopy waiting lists, in week and weekend insourcing to target surveillance endoscopic backlogs and waiting list initiatives funding for complex overdue surveillance procedures. In addition, accelerated training academy has been approved to train Endoscopists for JAG accreditation.

Transnasal Endoscopy (TNE) has been embedded as a primarily Clinical Endoscopist led service within Endoscopy after its pilot within the UHB in 2023. TNE is an upper Gastrointestinal endoscopy method performed via the nose rather than the mouth, using a thinner endoscope. The benefits of TNE include the procedure being less invasive and therefore more comfortable for the person and improved efficiency as TNE can take less time and fewer resources. Patient feedback illustrates the positive impact this is having;

> *"I had a transnasal endoscopy this morning at Llandough following an unsuccessful attempt at a "normal" one via the mouth 3 months ago due to severe narrowing of my oesophagus.*
>
> *I understand that this is a new service so I thought it was important to feedback from my experience today.*
>
> *The CNS endoscopist has been amazing throughout the process, from her initial phone call last week the moment that I left the hospital today. She explained the reason for the procedure being recommended and the procedure itself in a calm way that instilled confidence. Today she went through the consent process very comprehensively without making me anxious.*
>
> *During the procedure she communicated with me throughout and was kind, considerate and totally professional. Her explanation after the procedure was clear and reassuring*
>
> *The nurses who did the pre-bronze procedure checks and who were present during the procedure were professional, very friendly and reassuring putting my welfare first and foremost."*

As part of the health board's aim to centralise services and improve the experiences and outcomes of patients requiring specialist care, Gastroenterology services are now centralised at UHW following implementation of the Acute Gastroenterology Model. This has stopped Gastroenterology admissions to UHL with a shift to it providing planned diagnostic, therapeutic and specialist Endoscopic and Gastroenterology care.

Dermatology

Work is ongoing on right sizing a business case within Dermatology, including a bid for transformation which includes a GP education programme. The extension of skin surgery in Primary Care for low risk BCC will enable the Dermatology Consultants to treat more complex BCC and skin cancers and reduce time to treatment.

Welsh Nursing Care Record

The roll out of the Welsh Nursing Care Record continues across the Clinical Board. This has been fully implemented across our community hospitals and University Hospital Llandough improving efficiency and bolstering patient safety and quality of care. The implementation of Welsh Nursing Care Record allows the streamlining of administrative processes for our healthcare staff allowing more time to focus on patient care.

Efficient Care

Hepatology and Endoscopy

Within Hepatology the commencement of a Liver Project (MDT lead initiative) aims to look at the early commencement of NG feeding to reduce patient mortality and admission to hospital in patients with chronic liver disease.

Within Endoscopy a trial of Cytosponge (a string test which helps diagnose conditions such as Barrett's oesophagus which can lead to oesophageal cancer) will commence in Quarter 4 with increased throughput to support reducing the risk of procedural complications and a better patient experience.

Integrated Medicine

The Acute Oncology Service has been given funding from Moondance for an observership in Toronto in 2025 to support with geriatric oncology and expectations to implement improvements in our service.

To support patients presenting with cellulitis investment into a CNS post to deliver prevention and intervention clinics has been introduced. Since this investment 803 patients have completed treatment. In addition, the number of cellulitis episodes, admissions, total bed days and average length of stay have reduced. The realised reduction is equivalent to £625,968.

Stroke are beginning a pilot project for the introduction of CYP2C19 genotype testing prior to prior to prescribing Clopidogrel into routine care in the Hyperacute Stroke Unit University Hospital of Wales. The main aim of the project is to establish a safe and effective approach to embedding the test into routine clinical practice with minimal disruption for patients, whilst exploring and highlighting implementation challenges. The findings of the pilot will support a phased coordinated spread and scale approach to CYP2C19 testing across Wales aligned to NICE Diagnostic Assessment Programme recommendations published in July 2024.

The first two wards in the Clinical Board have achieved Bronze Ward Accreditation under Cardiff and Vale University Health Board's Ward Accreditation and Improvement Programme;

- Sam Davies at BCH
- C4 Stroke

The accreditation recognises the dedication of the teams to delivering high standards of care and successfully using data-driven insights to implement meaningful improvements.

The ambition is to achieve Bronze Ward Accreditation in all Ward/Dept areas, Ward East 6 is currently progressing on the Bronze Pathway and a further ten wards are on the Bronze waiting list: A7, B7, C7, East 2, West 2, Elizabeth Ward, Lakeside Wing Wards 1 and 2, IACU Wards A and B.

Sam Davies Ward

C4 Stroke Ward

Equitable Care

The Emergency and Acute Medicine Directorate have implemented Hospital Health Pathways targeting common complaints as a means of ensuring patients who present to the clinical areas receive equitable care, standardizing care and reducing variance to improve patient experience improving quality and safety. Examples of the Health Pathways being used include Orthopaedics, Infectious Diseases and Cardiology which supports staff to access concise information and the required investigations supporting staff how to refer to specialties. The use of the Cardiology palpitation's pathway has shown a reduction in the number of patients referred to palpitation clinic. The pathways are currently being evaluated and with the help of the Value team working is ongoing as to how quantitate data can be captured.

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

Clinical Board Highest Risks

Risk Category	Area	Controls / Actions
Workforce	Stroke – Compliance with NICE and SSNAP (15 ↔)	Stroke Business Case approved, revision of triage and assessment process and imaging pathways.
	Gastroenterology – (25 ↔)	Acute Gastro model launched, risk score under review.
	Speciality components of Gastroenterology – Service with single handed operator (severe intestinal failure) (20 ↔)	Collaborative working with CD&T Clinical Board. Business case and SBAR to JCC for additional service support including Consultant post.
	Violence and Aggression against staff and patients in EU & AU (16 ↔)	Security cameras / alarms in situ, V&A training, estate works following HSE inspection. Ongoing work looking at body cams.
	Lung Cancer Service – Single point of failure, possible breaches / patient harm / staff impact (16)	Consultant and SAS grade doctor recruited, risk score under review.

	Diabetes – Insufficient CNS staffing, inability to deliver inpatient reviews, impact on LoS and flow (20)	Priority system of triage, consultant support, recruitment yet shortfall remains.
	Memory Team – Insufficient staffing to meet demand, increased waits (20)	Monitoring of waiting list, SBAR for additional resource.
	SRC – Understaffing of medical workforce, possible patient harm, delayed discharges, staff impact (15)	Senior doctor daily to provide support, rota review and movement of staff / locum hire to provide cover, look to redesign workforce.
Patient Safety	Endoscopy – Cancer surveillance and planned recall waiting times, diagnosis, staging and treatment of benign and malignant conditions (20 ↔)	Risk level reported to JCC in recent risk exercise. Clinicians prioritise patients based on clinical urgency, formal temporary arrangement in place with ABHB for EMR, additional sessions offered to clinicians to increase capacity for complex endoscopy.
	Emergency / Acute overcrowding / WTBS (20 ↔)	Positive impact of RATZ and streaming but Acute model not robust.
	EU Flow following specialty referral (16 ↔)	Variable compliance with the Acute Referral Policy and utilisation of Whiteboard.
	Falls in EU, patient presenting conditions, limited access to low rise trolleys/beds (15 ↔)	Purchase of low-rise trolleys.
	Stroke – Timely in-patient Thrombolysis (16 ↔)	As above and implementation of Brainomix.
	Stroke – Access to Thrombectomy at UHW (15 ↔)	Business case approved by WHSSC, revised imaging protocol, Brainomix, CNS bleep holder protected when on duty.
	Stroke – No centralised cardiac monitoring equipment on C4, AF patients at risk of further stroke (15 ↔)	Installation progressing.
	Adult Asthma Service – Increased waiting list, failure to meet national guidelines due to prescribing guidelines / biologics (16 ↔)	SBAR for investment developed, MCB review.
	IP&C – Risk of cross infection of patients in ED and AU, increased LoS, ability to effectively isolate (16 ↔)	Environmental actions to: ensure bed spaces are adequately set up to reduce contact; access to handwashing facilities and alcohol gels, PPE. Escalation to support flow when isolation prevented.

Recommendation:

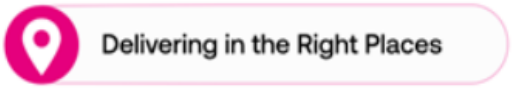
The Committee is requested to:

a) **NOTE** the assurance provided by the Medicine Clinical Board in this report and the steps being taken to improve quality, safety and patient experience across Medicine.

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

1. Putting People First	X	2. Providing Outstanding Quality	X

Click the objective above to view more detail.		**Click the objective above to view more detail.**	
 3. **Click the objective above to view more detail.**	X	4.  **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)***		*n/a*

Impact Assessment: *Please state **yes** or **no** for each category.* ***If yes please provide further details.***
Risk: Yes
As outlined within the report
Safety: Yes
As outlined within the report
Financial: Yes
As outlined within the report
Workforce: Yes
As outlined within the report
Legal: Yes
As outlined within the report
Reputational: Yes
There is a reputational risk for the Clinical Board and the organisation when quality, safety and patient experience is not satisfactorily delivered.
Socio Economic: No
Equality and Health: Yes
As outlined within the report
Decarbonisation: No
Welsh Language: No

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

Report Title:	Quality Indicators Report			Agenda Item no.	2.2
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	7th January 2025
		Private			
Status:	Assurance	X	Approval	Information	
Lead Executive:	Executive Medical Director and Executive Nurse Director				
Report Author (Title):	Assistant Director of Quality and Patient Safety				

Main Report
Background and current situation:

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

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

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

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

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

- NRI reporting remains in line with national rates with Intrauterine deaths occurring from 22 weeks gestation onwards and neonatal deaths up to 28 days meeting the criteria for completion of the National Perinatal Mortality Review Tool accounting for 28% of all cases at the time of reporting.
- Pressure damage and falls account for the highest category of incidents reported in the UHB
- Cases of Clostridium difficile and Methicillin-susceptible Staphylococcus aureus (MSSA) remain elevated. Approximately 34% of MSSA cases are acquired in hospital and are frequently associated with venous access devices. Adherence of the Aseptic Touch technique is being promoted with ongoing training delivered.
- 453 medication incidents were reported between July and September 2024 with the majority resulting in no or low harm. The implementation of the electronic prescribing and medicine Administration (ePMA) system will support recording and recognition of allergies and will alert staff to the prescribing of critical time medications.
- HIW published the Cedar and Alder ward Hafan y Coed inspection report in October 2023, the report made a number of recommendations. Significant environmental Improvements have been implemented in response and multidisciplinary team input has been strengthened.
- The development of a UHB mortality dashboard has been completed and will support scrutiny of mortality including triangulation with information from the Medical Examiner.
- Between June and November 2024 thousands of staff were observed by both the ward staff and by the Infection Prevention and Control teams to capture hand hygiene and bare below the elbow compliance. While the majority of staff demonstrated good practice there was variation between the findings of ward staff and IP&C staff, with poorer compliance noted by the IP&C team. Likewise, the IP&C team identified poorer compliance with peripheral venous cannula maintenance. Further work is required to improve compliance in amongst clinical staff.
- A mealtime audit was undertaken across all clinical and the results were presented to the Nutrition and Hydration group and has informed a programme of improvement including

reinstating protected mealtimes and the development of a liver dashboard of patient allergies and dietary requirements.

- During October and November 2024, the UHB received 504 concerns with 67% closed within 30 days and 29% closed under early resolution.
- The UHB responded to a regulation 28 report to prevent Future Deaths and in response has strengthened telemetry arrangements in Cardiology, with monitors programmed to reactivate after 2 minutes in the event that the alarm condition has not been resolved.
- The UHB patient experience rating between December 2023 and November 2024 was 7.46 (rating 1-10) compared to a national rating of 7.47. between October and November 2024, 3413 patients completed (either in part or fully) a survey. 86% of patients stated that they felt safe and 85% stated they were always treated with kindness. In the Emergency department 62% of patients felt well cared for as did 64% of patients in mental health.
- 86.9% of acute inpatient medical and surgical wards were compliant with safecare in February 2024.

Recommendation:

The Board / Committee are requested to: **NOTE** the assurance provided by the report

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

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment:
Risk: Yes/No
Safety: Yes/No
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No
Socio Economic: Yes/No
Equality and Health: Yes/No
Decarbonisation: Yes/No

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

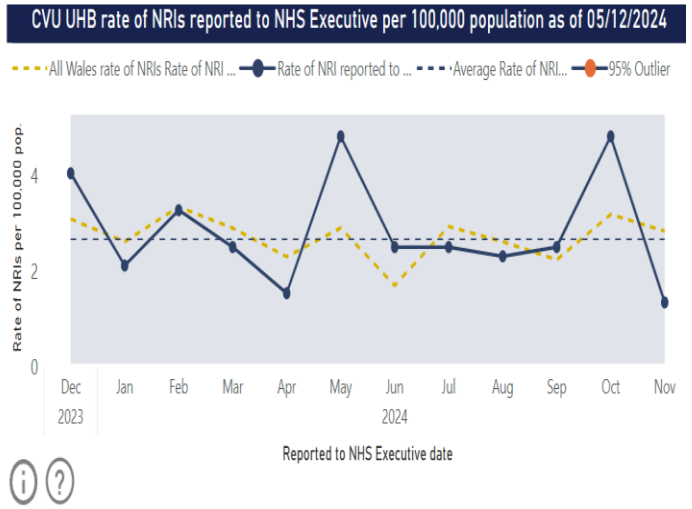
Quality Indicators Report

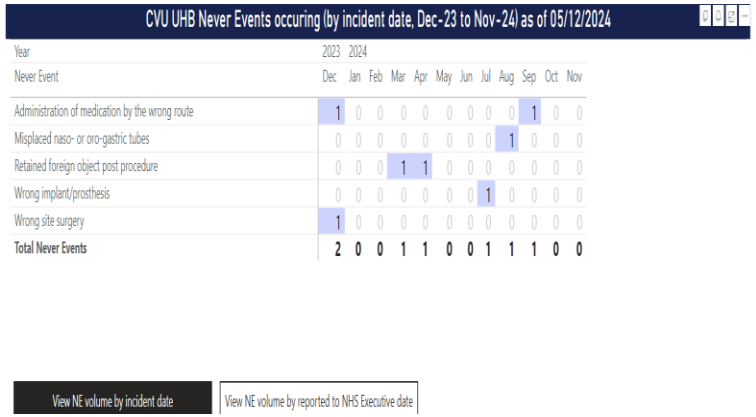
Quality Safety and Experience Committee

December 2024

Patient Safety Incidents

Safe Care



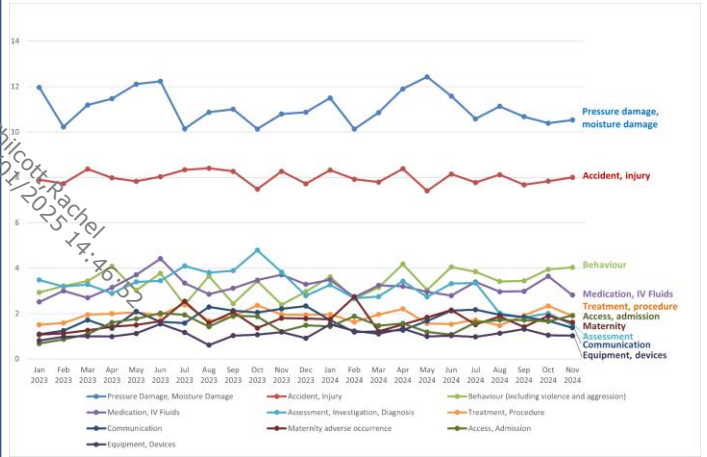


Cardiff and Vale reported 7 NRIs in November 2024, compared to 25 reported the previous month.

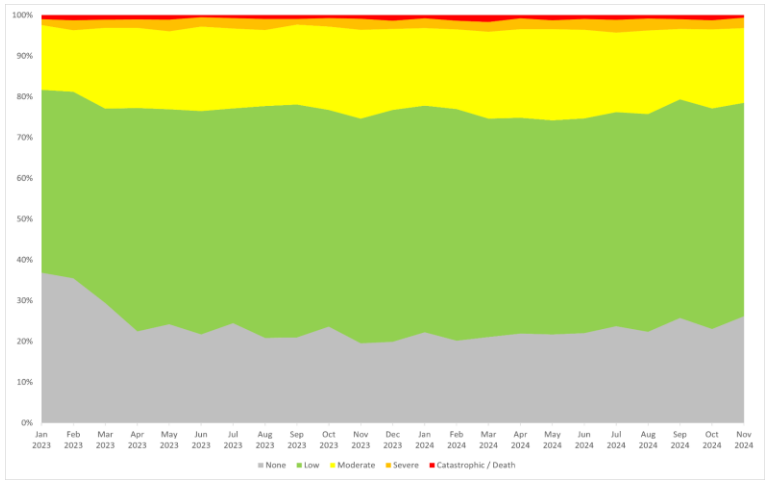
There are 101 open NRIs across all clinical areas, and 48 of these are overdue for closure. Twelve closure forms were submitted in November to NHS Executive. There are five open Never Events.

There are 7327 open patient safety incidents, 1712 new patient safety incidents were reported in November 2024 of these 79% were reported as having caused no or low harm. Pressure damage followed by falls are the highest reported patient safety incident category.

Patient incidents per 1000 daily occupied beds by top 10 classifications



Initial harm by incident date



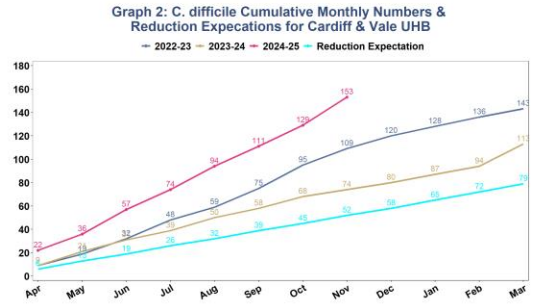
Action

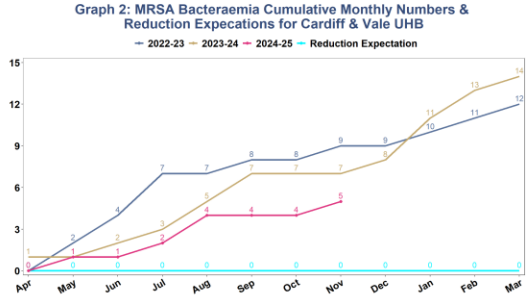
Targeted sessions are being provided to help support incident managers to manage their open incidents to closure, this is to ensure incidents are managed in a timely and safe manner as well as to reduce the number of open incidents open more than 30 days.

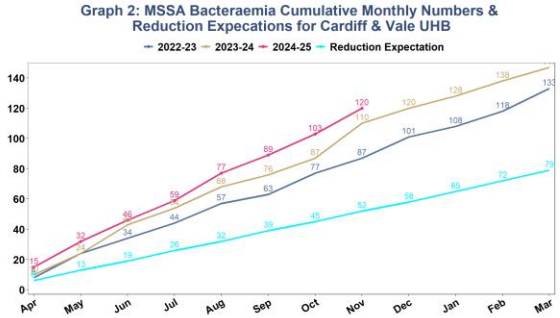
Falls prevention training is now included in the preceptorship training for nursing staff; the plan is to provide this for existing staff and to explore delivering this to other staff groups.

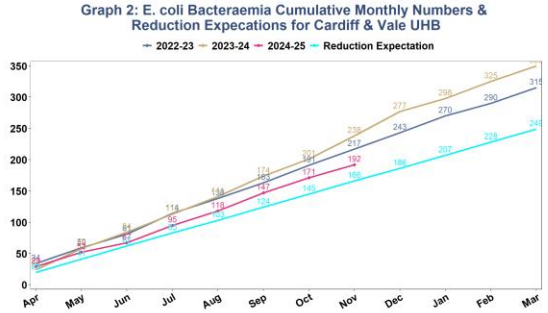
Infection Prevention and Control

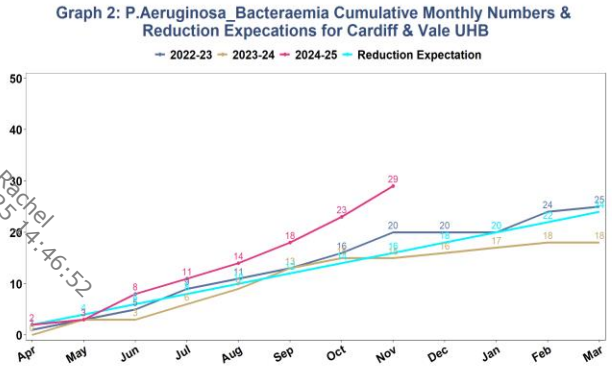
Safe Care

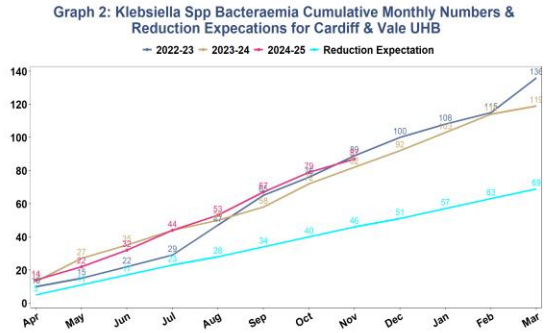












C'diff **-** numbers have been higher than in recent years and the reason for this is unknown. Whole Genome sequencing data demonstrates that most cases are not linked. Most areas in the UHK are also experiencing a rise in numbers of cases. We continue to review the RCA data to identify trends

MRSA – the number of MRSA cases is lower than in previous areas and at present CAVUHB have the lowest rate per 100,000 population. Adherance to ANTT continues to be promoted particularly to medical teams as compliance is poor in that staff group

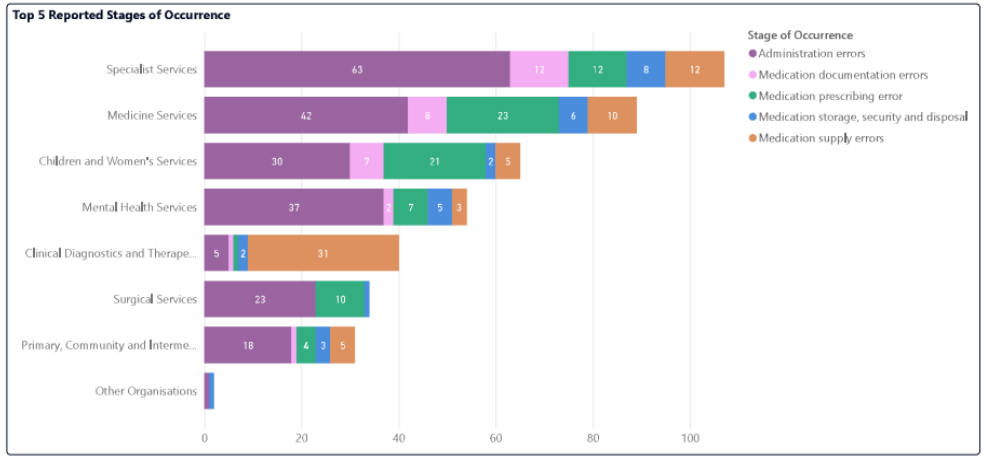
MSSA – Number of cases remains elevated, CAV has the highest rate at 35.80 cases per 100,000 population. Executive review of hospital acquired cases is taking place along with promotion of ANTT compliance. RCA reviews are undertaken on all cases to identify if there is any learning. Approximately 34% of cases have been acquired in hospital

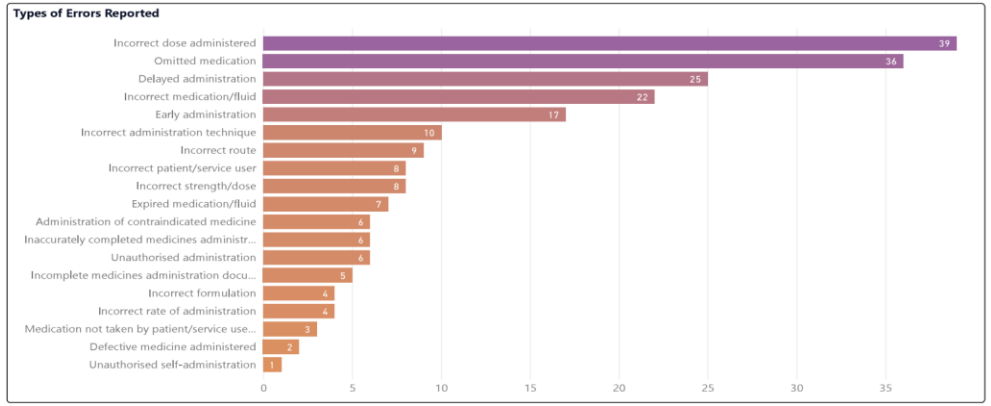
E.coli - CAVUHB continues to have the lowest rate per 100,000 population across all acute Health Boards in Wales

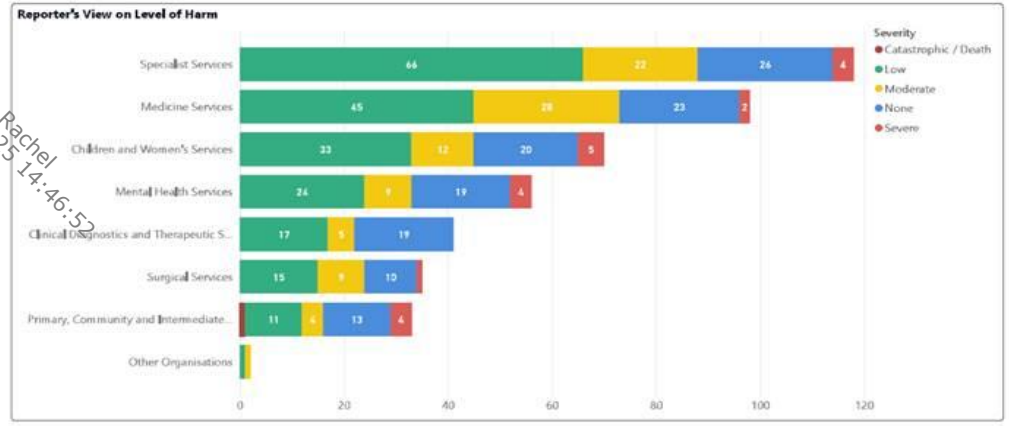
Klebsiella sp. - monthly number of cases remain variable and there are slightly more cases to the equivelant period last year

Paer – The numbers of cases continues to rise compared to the same period lst year and CAVUHB currently has the highet rate per 100,000 acrodd all acute Health Boards.. All cases are fully investigated but no link between cases has been identified

Medication Incidents







Between 1st July 2024 - 30 September 2024 453 medication incidents were reported via the Datix Cymru system.

Specialist Services Clinical Board were the highest reporting Clinical Board and Administration errors accounted for the highest category of incident accounting for 48%. The most common reasons for administration errors are :

- 18% wrong dose administered
- 17% Medication doses omitted
- 11% medication dose delayed
- 7% medication dose administered early

76% of incidents were reported as resulting in no or low harm. All incidents will be reviewed and sever and catestrophic incidents are discussed at the medication Safety Executive forum.

In November 2024 three incidents reported in the month prior as causing severe harm were discussed and all three were downgraded to either low or no harm. Themes from these incidents included:

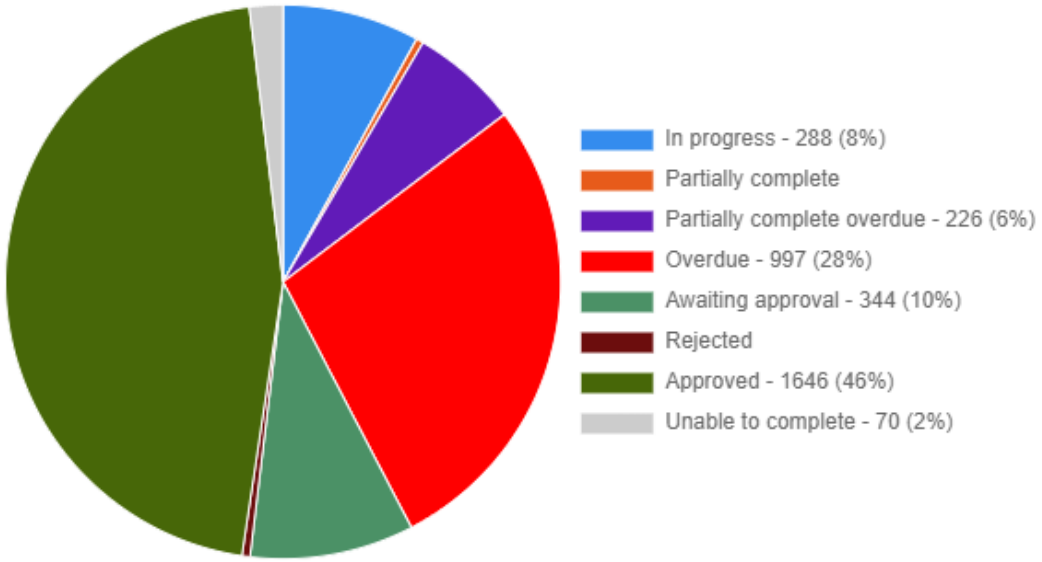
- Administration of antibiotics in patients documented as having an allergy. The implementation of electronic medicines prescribing and administration system (ePMA) will strengthen the recording of allergies and safeguard against inappropriate prescribing.
- Dispensing of chemotherapy at the weekend, in response to the incident revised delivery arrangements have been implemented.
- Omission in administration of steroid doses – the UHB has an ongoing workstream to strengthen the governance around timely administration of critical time medications.

HIW

Safe Care

Organisation wide

Download



An Unannounced inspection was undertaken on Cedar and Alder ward in Hafan y Coed unit in University Hospital Llandough on 1, 2 and 3 July 2024 and the report was published on 23 October 2024 . The full report can be accessed at 20241023HafanYCoedUniversityHospitalLlandoughEN_0.pdf.

Review recommendations included:
The health board should install seating in the garden of Cedar Ward to provide a more pleasant, therapeutic environment for patients
• The health board should ensure there are designated, gender-specific areas on both wards which can be used as required
• The health board must ensure patient bedrooms are fitted with suitable fixtures and fittings which support their privacy and dignity and allow them to rest and sleep in comfort
• The health board must ensure the patient bedroom ROS monitor cabinets are appropriately secured at all times to support their privacy, dignity and safety 7
• The health board must ensure patients are provided with relevant, up-todate and accessible information to support their care • The health board must implement a policy which provides clear guidance to staff on the procedures and protocols for locking doors to prevent unauthorised access or egress.

In response to the findings Cedar ward has been relocated for a period of time to allow for capital work on the underfloor heating.

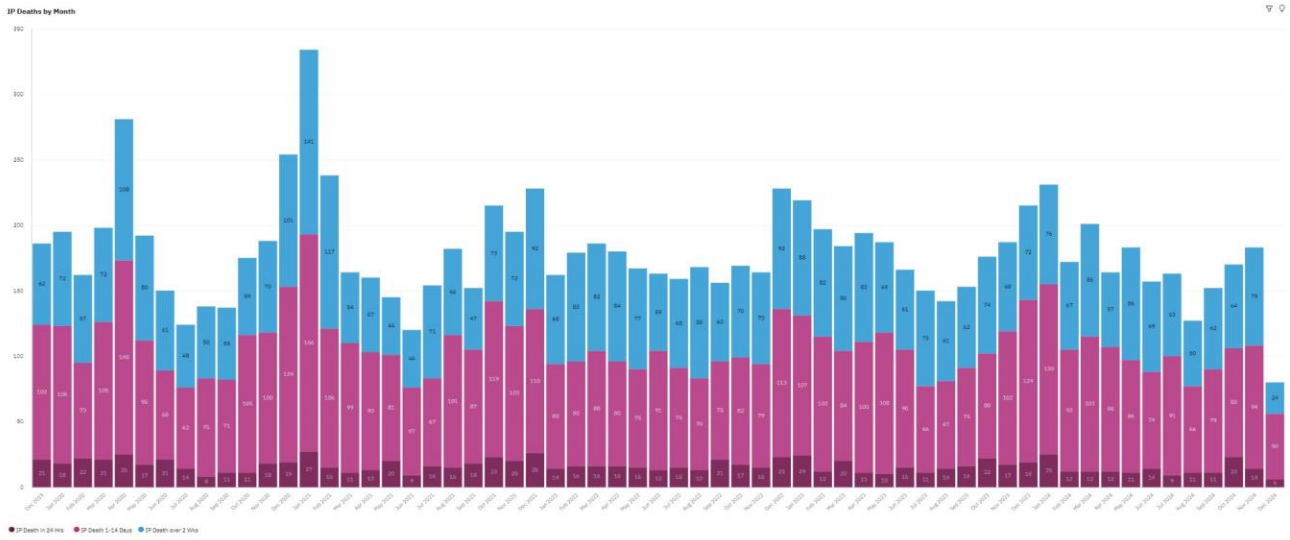
Oversight of incidents of restraint is being reviewed with all Wales work underway to strengthen reporting of restrictive practice in Datix Cymru

A review of the multi-disciplinary team (MDT) working on the two wards has been undertaken to ensure input from the wider MDT including Occupational Therapy.

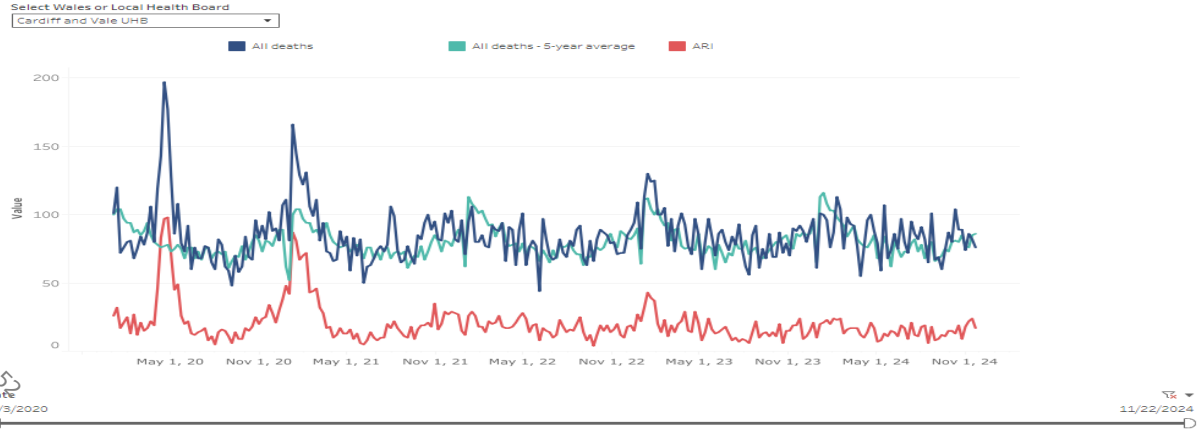
Environmental improvements have been made to improve privacy for patients on both wards and gender specific days rooms can now be designated and the Lived Experience Team will support the development of guidance around this.

HIW also undertook an inspection of the Nuclear medicine and Medical Physics departments in UHW on 16 and 17 October 2024 with publication of the report scheduled for 17 January 2025

Mortality

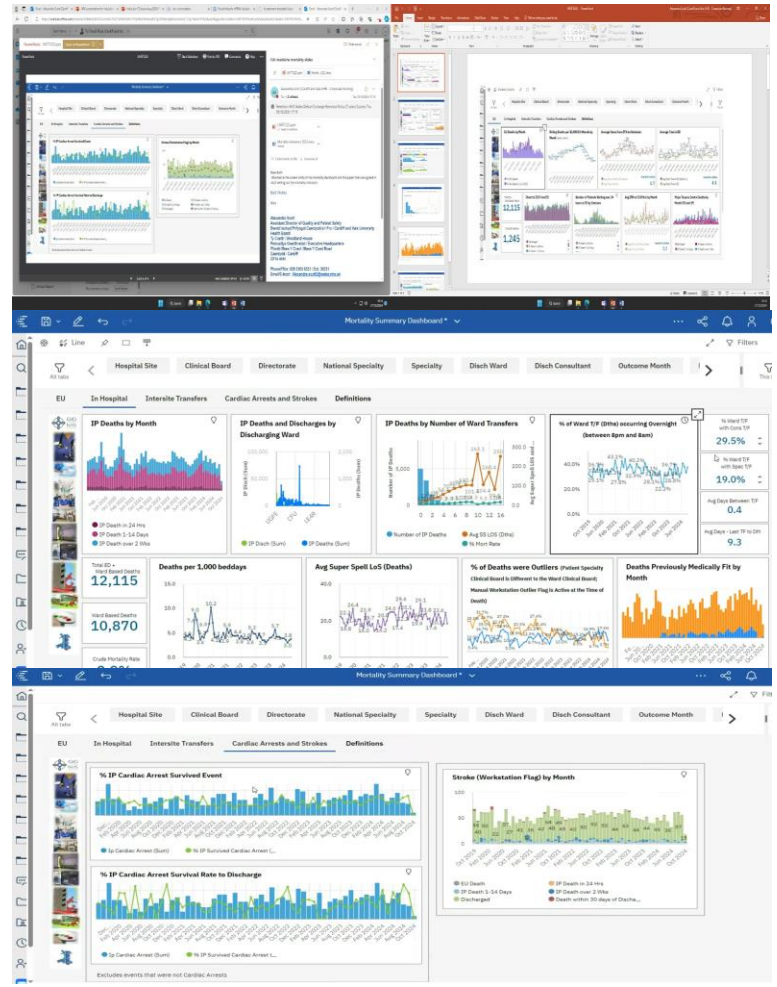


Weekly number of deaths registered, all deaths, ARI deaths (any mention) and 5-year average*, week ending 3 January 2020 (Week 1) to week ending 22 Nov 2024 (Week 47), Cardiff and Vale UHB



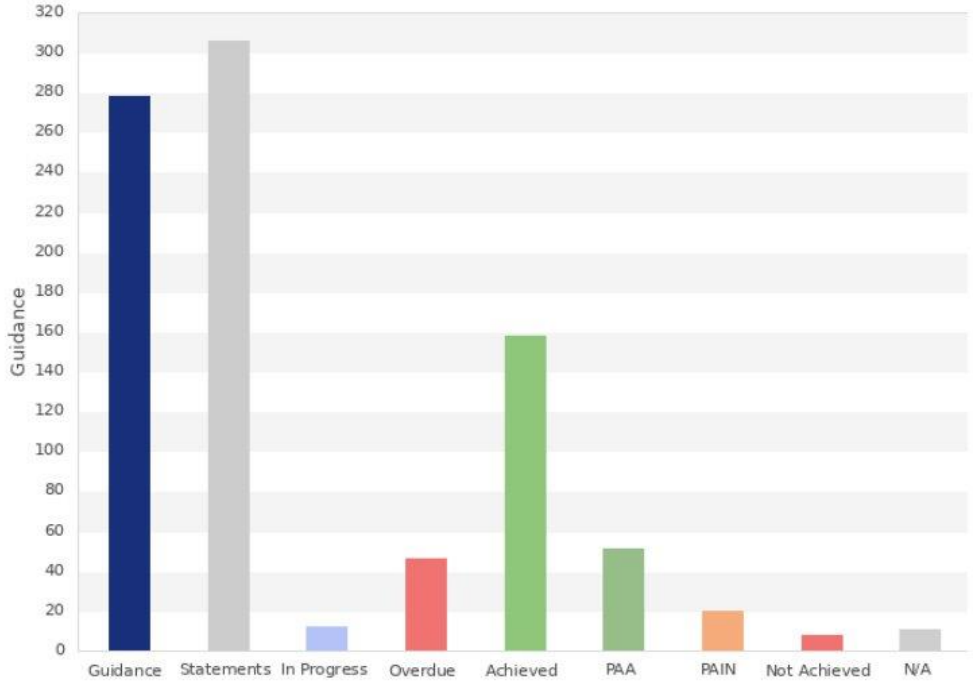
Provisional figures to Week 47 2022 for Welsh residents have been produced using data provided by ONS to Public Health Wales. This analysis is based on date the death was registered, not when it occurred. There is usually a delay of at least five days between occurrence and registration. The analysis requires the joining of weekly and daily data using NHS numbers. Figures may differ slightly between those published by ONS due to the use of different extracts of the data at different time periods. Data is therefore subject to change as more information is received. ARI was identified using ICD-10 codes J04, J09-J22, J80, U07.1, U07.2, U09.9 and U10.9 (any mention), and J04, J09-J22, J80, U07.1, U07.2 and U10.9 (underlying cause only). ARI (any mention) refers to deaths that had ARI mentioned anywhere on the death certificate, whether as underlying cause or not.

A Cardiff and Vale UHB mortality dashboard has been developed and is available to support scrutiny and oversight of mortality rates across the UHB



Clinical Effectiveness

Corporate overview of all NICE and health Technology Wales (HTW) guidance is being undertaken on a bi monthly basis to support dissemination.



- **Guidance (278)** - total number of guidance (that may contain one or more statements)
- **Statements (306)** - total of 'In Progress', 'Achieved', 'Partially Achieved', and 'Not Achieved' bars
- **In Progress (12)** - number of the trust's Guidance Statement entries that do not currently have a status
- **Overdue (46)** - number of the trust's Guidance Statement entries that are overdue
- **Achieved (158)** - number of the trust's Guidance Statement entries that have this status value
- **PAA (51)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Acceptable' status value
- **PAIN (20)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Improvement Needed' status value
- **Not Achieved (8)** - number of the trust's Guidance Statement entries that have 'Not Achieved' status value
- **Not Applicable (11)** - number of the trust's Guidance Statement entries that have 'Not Applicable' value

▲ Guidance overview 2023/24

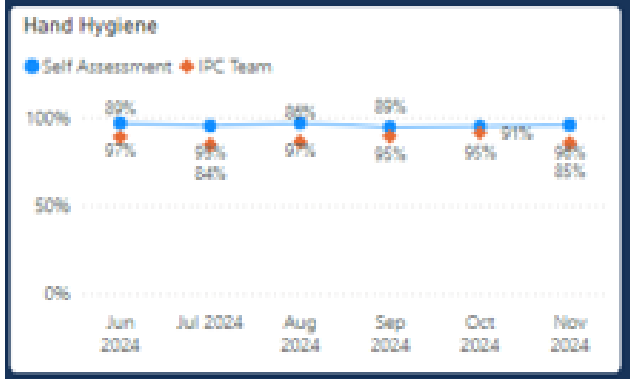
Effeithiol
Effective

Tendable Audit Programme

Infection Prevention and Control audit information: June – November 2024

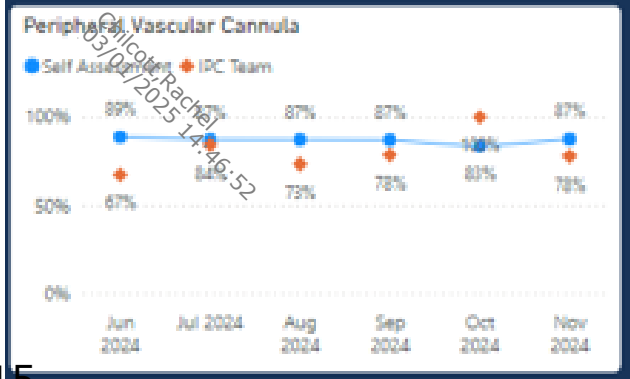
Ward - BBE average score	Ward - BBE professionals observed	Ward - BBE number of audits
96%	4505	641

IPC Team - BBE average score	IPC Team - BBE professionals observed	IPC Team - BBE number of audits
86%	1379	150



Ward - HH average score	Ward - HH professionals observed	Ward - HH number of audits
96%	3995	641

IPC Team - HH average score	IPC Team - HH professionals observed	IPC Team - HH number of audits
87%	682	72



Carnicom, Rachel 03/02/2025 14:46:52

Ward - PVC average score	Ward - PVC number of audits
87%	409

IPC Team - PVC average score	IPC Team - PVC number of audits
78%	42

The charts show bare below the elbow, hand hygiene and peripheral cannula audits completed across the UHB by the ward/department teams and the IPC team, who provide validation audits.

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

CAV Nursing Team Dashboard - Power BI

Effeithiol Effective

Tendable Audit Programme

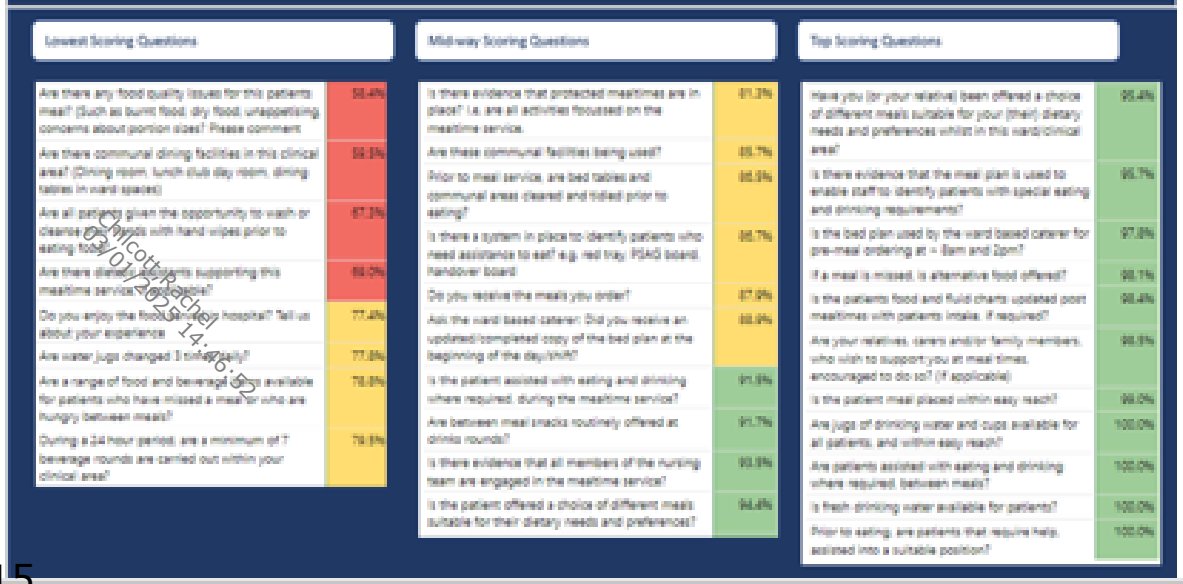
Nursing

Cardiff and Vale University Health Board

Number of Audits	Number of Areas	Average Score UHB wide
55	52	88%

Mealtime audit

Audit Type	Category	Aug 2024
Care Specifics	MEALTIME - Ward provisions	92.0%
	MEALTIME - Support	88.5%
	MEALTIME - Pre-mealtime preparation	79.7%
	MEALTIME - Patient Experience	89.4%
	MEALTIME - Mealtime Service	88.4%
	MEALTIME - Beverages	90.1%



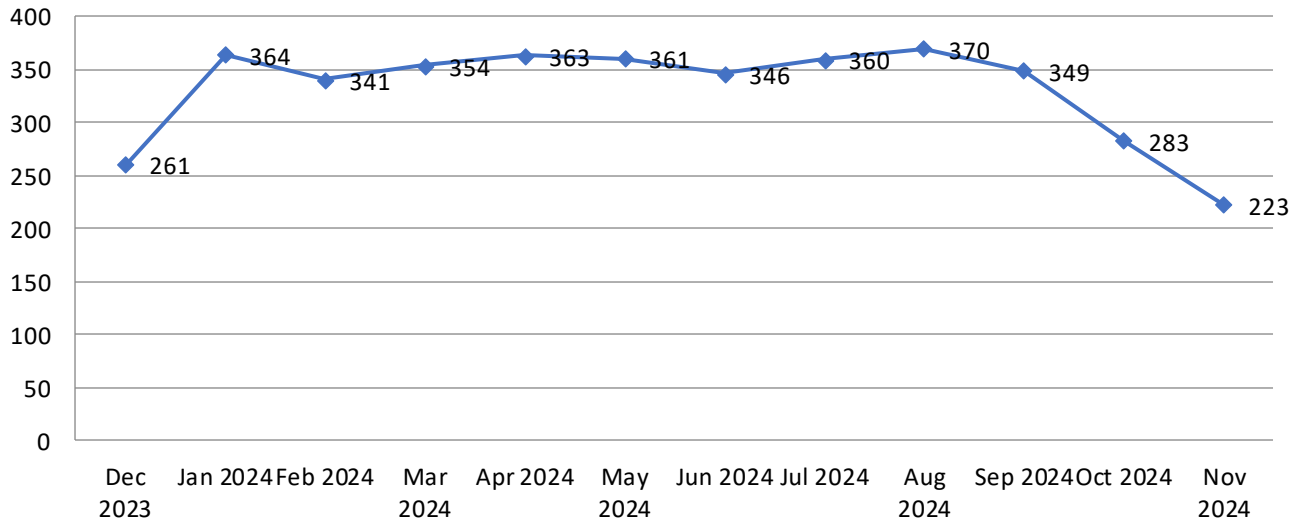
A mealtime audit was conducted across all inpatient areas in August 2024. The results were presented to the UHB Nutrition and Catering Steering group on 15th October 2024. The following actions were agreed to drive improvements:

1. Clinical boards to re-establish the principles of protected mealtimes (whilst being supportive of the principles of John's campaign).
2. Review of the Nutrition and Hydration bed plan on Clinical Workstation to consider best practice when recording patient food allergies and preferences.
3. Evaluation of the Symbiotix meal ordering system for patients and consideration of its impact on clinical safety.
4. Development of a live dashboard of patient allergens/preferences to support clinical staff.
5. Use of the Ward Accreditation and Improvement programme to support teams in driving change in clinical areas.
6. Formulation of an internal and external communication plan to promote the availability of special diets within the health board.

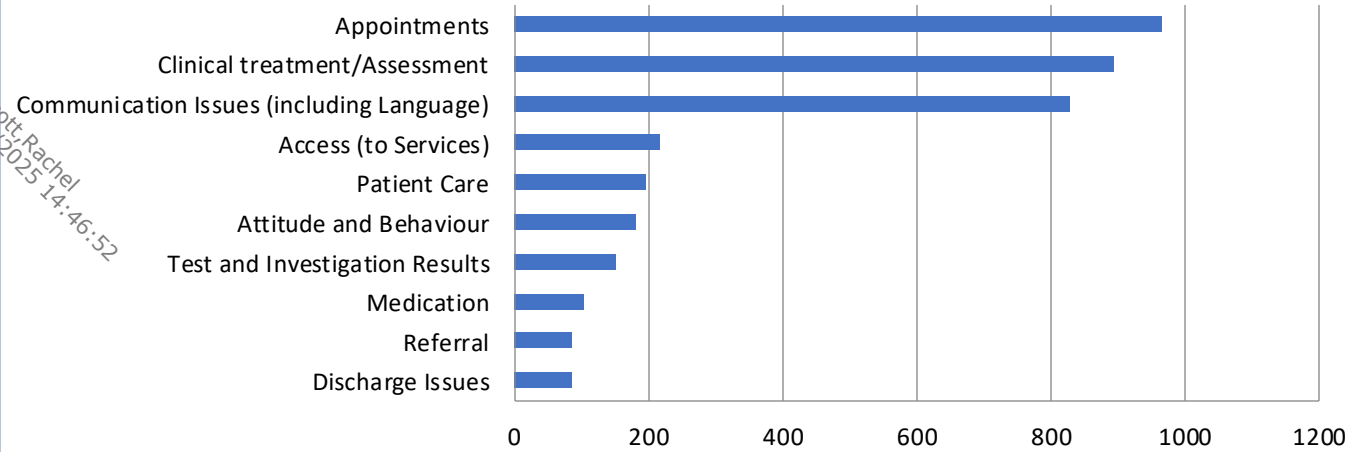
Person Centred Care

Patient Experience

Concerns received by month - last 12 complete months



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



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During October and Nov 24, the Health Board :

- **Received 504 Concerns**
- **Closed 480 concerns**
- **67 % closed within 30 working days (including Early Resolution)**
- **29 % closed under Early Resolution (within 2 days including day of receipt)**
- **Received 479 Enquiries**
- **Received 59 Compliments**
- **We currently have 289 active concerns**

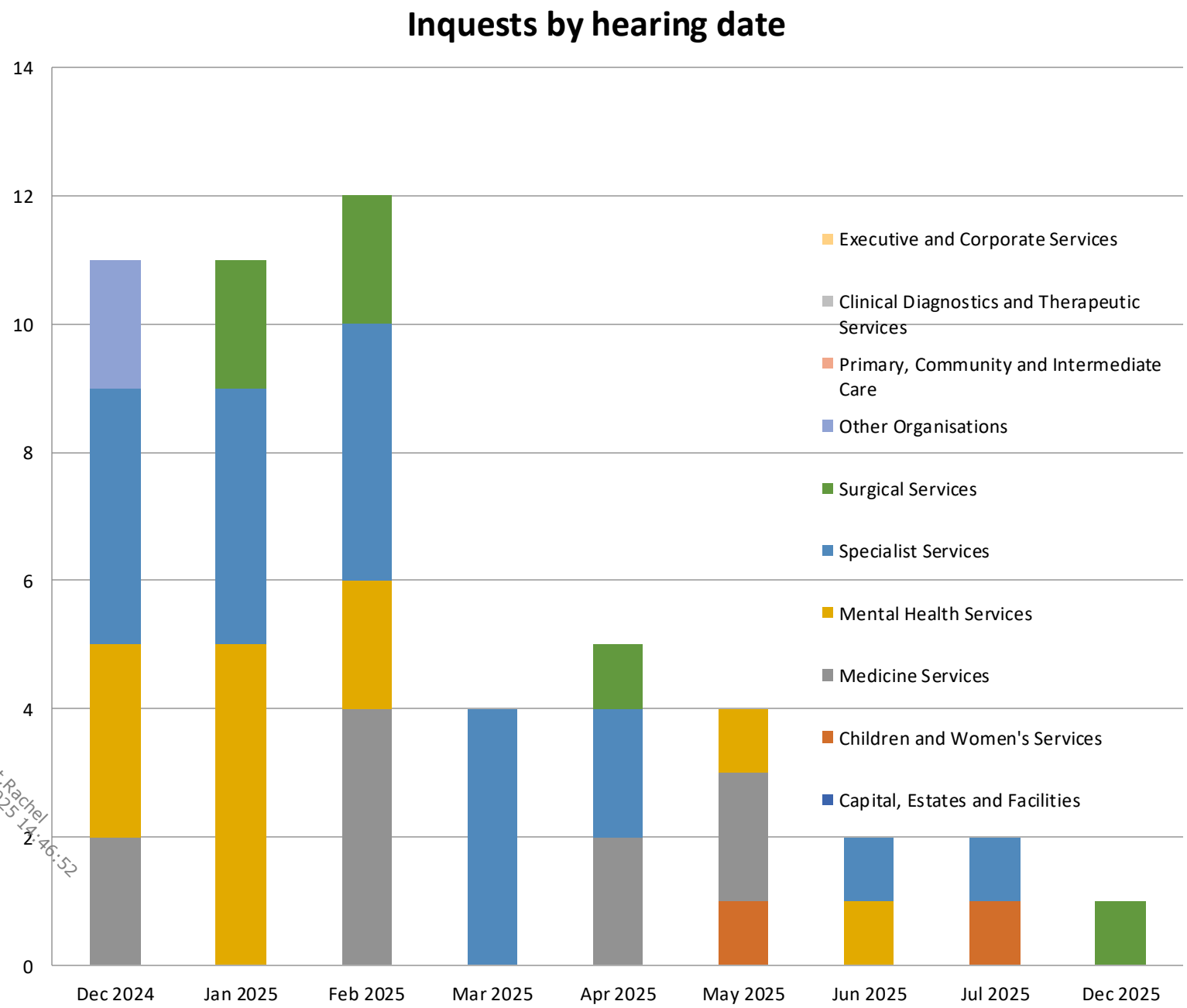
Top 3 themes and trends

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

Duty Of Candour

- Since April 1st, 2023, 42,161 incidents have been reported across the Health Board.
- We continue to support DOC awareness sessions across Primary and Secondary care.
- Since April 1st, 2023, we have triggered the DOC on 225 occasions.
- We have conducted internal audits of the process and compliance.

Person Centred Care



There are 320 inquest cases currently managed through patient experience.

A regulation 28, Report to Prevent Future Deaths was issued to the Health Board in October 2024 in relation to the monitoring and telemetry arrangements for patients. Changes to the cardiac alarm system have been implemented to include the inclusion of a yellow banner at the top of the telemetry screen that remains in place until the alarm has been reactivated.
All silenced alarms are now programmed to reactivate after two minutes if the alarm condition has not been resolved. This work will be replicated in other clinical wards in the Cardiology Directorate. An evaluation of all patient monitoring systems in the Health board will be undertaken to understand if the configurations are relevant in other clinical areas.

Person Centred Care

Patient Experience - CIVICA

AW2, TT(A) Survey

SMS sent: 19786

Survey responses: 3413

Response rate: 17%

Bedside responses: 257

88% were satisfied with their overall experience.

AW2 Survey results

Based on **3,413** partial/full survey completions (1st October – 30th November 2024 discharges).

- Whilst in our care did you feel safe? **86%** of respondents answered 'Always'.
- Were staff kind and caring? **85%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **77%** of respondents answered 'Always'.
- **89%** were satisfied with their overall experience.

Person Centred Care

Patient Experience - CIVICA

Emergency Unit Survey

SMS sent: 8782

Survey responses: 1155

Response rate: 13%

70% were satisfied with their overall experience.

Emergency Unit Survey results

Based on **1,155** partial/full survey completions (1st October – 30th November 2024 discharges).

- Did you feel that you were listened to? **66%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **41%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **54%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **62%** of respondents answered 'Always'.
- Were things explained to you in a way that you could understand? **70%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **65%** of respondents answered 'Always'.
- **70%** were satisfied with their overall experience.

Person Centred Care

Patient Experience - CIVICA

Mental Health Survey

SMS sent: 3435

Survey responses: 217

Response rate: 6%

76% were satisfied with their overall experience.

Mental Health Survey results

Based on **217** partial/full survey completions (1st October – 30th November 2024 discharges).

- Did you feel that you were listened to? **65%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **21%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **56%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **64%** of respondents answered 'Always'.
- Were things explained to you in a way that you could understand? **65%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **61%** of respondents answered 'Always'.
- **76%** were satisfied with their overall experience.

Effeithlon
Efficient

Safe Care

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

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

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

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

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

Efficient Care

WHC (2024)038

WELSH HEALTH CIRCULAR

Status: Action/Information

Category: Public Health Quality & Care

Title: AMR & HCAI IMPROVEMENT GOALS FOR 2024-2025

Date of Expiry / Review: This WHC will remain applicable until replaced by the next iteration in 2025.

For Action by: **Required by:** Immediate

Chief Executives, Health Boards/Trusts
Directors of Public Health, Health Boards/Trusts
Medical Directors, Health Boards/Trusts
Directors of Primary Care, Health Boards/Trusts
Nurse Executive Directors, Health Boards/Trusts
Directors of Therapies and Health Sciences, Health Boards/Trusts
Chief Pharmacists, Health Boards/Trusts
Executive Director of Public Health, Public Health Wales
General Practitioners, dental practices and community pharmacies
PHW HARP team, Public Health Wales

For information:
DG/Chief Executive, Health, Social Services and Early Years Group (HSCEY)
NHS Wales Deputy Chief Executive (HSCEY)
Welsh NHS Partnership Forum
General Practitioner Council, Wales
Royal College of GPs
Royal College of Nursing
Royal College of Midwives
Royal College of Paediatrics and Child Health
British Dental Association
Royal Pharmaceutical Society
Community Pharmacy Wales
Care Inspectorate Wales
Healthcare Inspectorate Wales

Senders:
Pushpinder Mangat, Deputy Chief Medical Officer – Health Services
Sue Tranka, Chief Nursing Officer
Andrew Evans, Chief Pharmaceutical Officer
Prof Andrew Dickenson, Chief Dental Officer

Welsh Government Contacts:

Health Protection, Welsh Government, Cathays Park, Cardiff CF10 3NQ
HealthProtection@gov.wales; and

Quality & Nursing, Welsh Government, Cathays Park, Cardiff CF10 3NQ
QualityAndNursing@gov.wales>

Enclosures: AMR and HCAI Improvement Goals for 2024-25 (Annex 1)

Pushpinder Mangat
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer – Health Services

Sue Tranka
Prif Swyddog Nyrsio
Chief Nursing Officer
Cyfarwyddwr Nyrsio GIG Cymru
Nurse Director NHS Wales

Dear Colleagues

Antimicrobial Resistance (AMR) & Healthcare Associated Infections (HCAI) Improvement Goals 2024/25

As part of the UK 20-year vision to confront and address antimicrobial resistance (AMR), Wales alongside the other three UK nations, is committed to developing a series of five-year national action plans to prioritise actions and direct resources in areas of highest risk. The UK's second five-year national action plan setting out ambitions and actions for the next five years (2024-2029) was published on 8 May 2024.

This Welsh Health Circular sets out the improvement goals for 2024/25 reflecting on the data from the previous year and the new targets set out in the new AMR national action plan.

Healthcare associated infections (HCAIs) remain a key patient safety issue that result in a significant burden of disease and financial cost to the NHS in Wales and across the care sector.

Whilst some progress was made in 2023-24 in reducing the incidence of a number of HCAIs in some areas, we remain a significant way off achieving the majority of the improvement goals and achieving the UK AMR vision.

Working with colleagues in the NHS Executive, Welsh Government will monitor and support progress through the new AMR and HCAI governance structures.

We are grateful for your support in achieving these goals to reduce the impact of AMR and improve patient safety across Wales.

Yours sincerely

Pushpinder Mangat
Deputy Chief Medical Officer
– Health Services

Sue Tranka
Chief Nursing Officer

Prescott Rachel
05/01/2024 15:46:52

Andrew Evans
Chief Pharmaceutical Officer

Andrew Dickenson
Chief Dental Officer

Annex 1

AMR and HCAI Improvement Goals for 2024-25

The UK 20-year vision to confront and address antimicrobial resistance (AMR) sets the ambitious goal of ensuring AMR will be controlled and contained by 2040. Wales alongside the other three UK nations, is committed to developing a series of five-year national action plans to prioritise actions and direct resources in areas of highest risk and provide sustained and ongoing progress towards achieving the vision's ambitions for change.

The UK's second five-year national action plan, 'Confronting antimicrobial resistance 2024 to 2029', builds on the achievements and lessons of the first. It contains outcomes and commitments that will make progress towards the 20-year vision for AMR to be contained, controlled and mitigated. The action plan has 9 strategic outcomes organised under 4 themes. Action will be taken across all sectors (human health, animal health, agriculture and the environment).

Setting the improvement goals for the NHS for 2024/25 takes into consideration the position against previous improvement goals set out in the 2023/2024 Welsh Health Circular. They also consider the human health targets included in the new national action plan informed by reviewing the evidence-base and learning from the measurable ambitions that were set out in the first national action plan.

The improvement goals set out for the NHS for 2024/25 has been set out under the relevant theme, outcomes and human health targets set out in the five-year national action plan for 2024-2029.

Theme 1 – Reducing the need for, and unintended exposure to, antimicrobials

Outcome - Infection prevention and control and infection management

Tackling AMR requires a focus on preventing and reducing the burden of infection in the human population by optimising IPC measures. This also improves patient safety. This outcome under the UK AMR action plan sets out 2 human health targets:

- target 1a: by 2029, we aim to prevent any increase in a specified set of drug-resistant infections in humans from the 2019 to 2020 financial year baseline
- target 1b: by 2029, we aim to prevent any increase in Gram-negative bloodstream infections in humans from the 2019 to 2020 financial year baseline

To deliver on this outcome and make progress in delivering theses targets in 2024/25 the improvement goals for community and hospital onset cases are set under each bacteraemia/infection.

The surveillance data for Wales shows annual increases of Gram-negative bacteraemia in Wales since pandemic related decreases observed in 2019/20. The position for 2023/24 showed 4% fewer infections than in 2019/20 although two of the three Gram-negative organisms included in the target showed increases. Data is now collected from hospital onset cases vs community onset cases and the improvement goals separate overall and hospital onset cases.

E. coli bacteraemia:

Improvement Goal 1 – health boards to have fewer overall cases of *E-coli* Bacteraemia compared to 2023/24

Improvement Goal 2 – health boards to have 10% fewer hospital onset cases of *E-coli* bacteraemia compared to 2023/24

P. aeruginosa bacteraemia:

Improvement Goal 3 – health boards to have fewer overall cases of *P. aeruginosa* bacteraemia compared to 2023/24

Improvement Goal 4 - health boards to have 10% fewer hospital onset cases of *P. aeruginosa* bacteraemia compared to 2023/24

Klebsiella spp. bacteraemia:

There has been a substantial increase in *Klebsiella spp.* compared to 2019/20 figures, and there is concern about rising resistance rates in this particular Gram-negative organism.

Improvement Goal 5 – health boards to have fewer overall cases of *Klebsiella spp.* bacteraemia compared to 2023/24

Improvement Goal 6 - health boards to have 20% fewer hospital onset cases compared to 2023/24.

Clostridioides difficile:

Rates were higher in Wales in 2023/24 compared to 2022/23 (+4%), and there remain large differences between different health boards and a need to prioritise reduction and explore interventions to implement in the community to reduce the burden of community onset *C. difficile*.

Improvement Goal 7 - All health boards to have fewer hospital onset *C. difficile* cases than they had in the 2023/24 FY.

- **For HBs who achieved the 23/24 Improvement Goal – fewer cases than 23/24**
- **For HBs who achieved a rate between 25 and 30 cases / 100,000 population in 23/24 – a 10% reduction in hospital onset cases.**
- **For HBs who had a rate of >30 cases / 100,000 population in 23/24 – a 20% reduction in hospital onset cases.**

Improvement Goal 8 - All health boards should have no more community onset cases than in 23/24, aiming to reduce the overall burden towards 25 cases / 100,000 population.

Staphylococcus aureus bacteraemia:

MSSA bacteraemia rates have increased from 22/100,000 population in 2010/11 to 26/100,000 population in 2023/24. There was a small decrease in the *S. aureus* bacteraemia rate between 2023/24 and 2022/23 (1%), with five of the health boards having lower rates, and a substantial decrease in rates of hospital onset *S. aureus* bacteraemia (21%).

Improvement Goal 9 - All health boards to have fewer hospital onset MRSA and MSSA bacteraemia than they had in the 2023/24 FY.

Improvement Goal 10 - All health boards to develop plans to target reductions in community onset *Staph. aureus* bacteraemias, aiming for an overall rate of no more than 25/100,000 population.

Theme 2 – Optimising the use of antimicrobials

This theme focuses on improving the use of antimicrobials to preserve future effectiveness and raising awareness with the workforce to optimise the use of antimicrobials.

Outcome – Antimicrobial stewardship and disposal

UK AMR National Action Plan Targets for 2024 to 2029

The UK AMR National Action Plan sets out the two human health targets under this outcome. These are shown below.

Target 4a: by 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline.
Target 4b: by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system.

Situation at the end of the last National Action Plan period

At the end of the previous ten-year target to achieve a minimum 25% reduction in antimicrobial usage in the community from the 2013/14 baseline an overall 19.8% reduction was achieved in Wales. This showed good progress especially in the context of the increase in managing the Group A Streptococcus (also known as GAS, group A strep, strep A, and Streptococcus pyogenes) outbreak in 2022. The previous improvement goal to increase to or maintain the proportion of antibiotic usage within the WHO access category to >55% of total antibiotic consumption was achieved by all health boards.

Welsh antimicrobial usage improvement goals

The high-level antimicrobial usage improvement goals for 2024-2025 are set out below.

Total Antimicrobial Usage

Separate goals are defined for primary and secondary care with the aim of making the improvement goals for total antimicrobial usage more relevant and meaningful.

Improvement Goal 11a: a reduction in total antimicrobial use in primary care consistent with a trajectory required to achieve a minimum 10% reduction against the 2019/20 baseline by 2029/30. The measure is Defined Daily Doses and will be reported as DDDs/1000 STAR PU.

Improvement Goal 11b: a reduction in total antimicrobial use in secondary care consistent with a trajectory required to achieve a minimum 5% reduction against the 2019/20 baseline by 2029/30. Reported as DDDs/1000 occupied bed days.

Proportion of total usage from with WHO 'Access' category

Improvement Goal 12: a reduction in the total use of antibiotics from the Access category in both primary and secondary care consistent with a trajectory required to achieve at least 70% by 2029/30. The measure is Defined Daily Doses %.

Analytical Support for Delivery of Improvement Goals

For 2024/25 Public Health Wales will analyse and report data, including trajectory reports, to inform and support delivery partners on the journey to achieve the improvements to meet the AMR National Action Pla targets by 2029/30.

Such analysis and support is highly dependent on the quality of the data on which it is based. It is essential health boards and primary care contractors continue to document the appropriate indication and clinical diagnosis (READ/SNOMED code) for all antimicrobial prescriptions.

Report Title:	Update on the Hepatitis B/C Recovery Plan				Agenda Item no.	*2.6*
Meeting:	Quality, Safety and Experience		Public	X	Meeting Date:	7 January 2025
			Private			
Status:	Assurance	X	Approval		Information	
Lead Executive Title:	Executive Director of Public Health					
Report Author (Title):	Deputy Director of Public Health					

Main Report
Background and current situation:

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

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

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

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

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

Current situation

Quality, Safety and Experience (QSE) Committee received the Hepatitis B and C Recovery Plan 2023 to 2025 on 18 July 2023. Following its ratification by QSE, it was sent to Welsh Government, with a request from QSE for an annual update. An update was last received in July 2024, reporting positive progress including the establishment of a programme management structure to support delivery of the plan, 100% of actions assigned to an owner, Phase 1 of the re-engagement list complete and a communications plan in place. The committee requested a further report in six months' time.

The work programme for elimination of Hepatitis B and C elimination is overseen by the Cardiff and Vale of Glamorgan Hepatitis B and C Elimination Oversight Implementation Group. This is a multi-

agency forum chaired by the Deputy Director of Public Health, which feeds into the Health Protection Forum and meets bi-monthly.

Much has been achieved since the previous update. In feedback to Welsh Government in September 2024, the oversight group reported the following:

- Multi-agency discussions have been held about recommencing Hepatitis C point of care testing in HMP Cardiff, which had halted due to staffing issues, with a view to achieving micro-elimination in our prison. Resource has been identified and testing is now recommencing
- The Cardiff and Vale Drug and Alcohol Service's mobile outreach van is now operational and offering testing and treatment in targeted areas
- Opt-out blood-borne virus testing protocols are in place for all substance misuse services
- Plans are underway to target high-risk populations outside of the usual settings, including people using performance enhancing drugs and people from areas of the world with high prevalence
- Task and finish group established to explore hepatitis B vaccination pathways for high-risk groups
- As part of our communications plan, a video case study has been shared on social media of a patient from Cardiff talking about his experiences of being tested and treated; this has received significant engagement and has been well-received
- Work is underway with community pharmacies to raise awareness of hepatitis C testing

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

1. Elimination of hepatitis B and C is health promoting and cost-saving.
2. The funding for the elimination of hepatitis B and C is core funded, with some additional funding from the Health Protection budget towards elimination. This needs to be maintained if we are to achieve elimination of hepatitis B and C in our region.

3. The work programme is monitored and evaluated by a Programme Manager, from the Health Protection Team, and this is critical to the functioning of the work, and therein the elimination of hepatitis B and C.

Recommendation:

The Committee is requested to:

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

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

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

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

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

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

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

Cardiff and Vale University Health Board

Hepatitis (B and C) Joint Recovery Plan

2023-2025

Part of the Cardiff and Vale of Glamorgan Health Protection Plan

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

Cardiff & Vale APB
Achieving better substance misuse outcomes

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Contents

Foreword

Our Joint Recovery Plan for Cardiff and Vale University Health Board sets out the actions we will take to achieve prevention and elimination of hepatitis (B and C) by 2030, in line with the aims of Welsh Government and the World Health Organisation (WHO).

Hepatitis B and C are discrete forms of viral hepatitis. Both cause acute and chronic liver disease and have significant associated mortality and morbidity. The global burden of disease because of these infections is at endemic levels.

It is a public health tragedy that in 2023 we are still seeing new hepatitis B infections. The modern hepatitis B vaccine, available since 1986, renders >98% of people immune and has been part of the UK childhood immunisation schedule since 2017, yet we are still seeing new disease.

Unfortunately, there is no similarly efficacious vaccine for hepatitis C. Natural infection with hepatitis C does not confer long-lasting immunity so reinfection in certain populations is a significant clinical burden. The advent of highly efficacious, tolerable, orally administered, directly-acting antiviral drugs around 2014 has changed the therapeutic landscape for those living with hepatitis C. Over 95% of people will be cured of their hepatitis C infection following appropriate therapy.

Stigma, particularly surrounding hepatitis C infection, lies in the misperception that it only affects people who inject drugs. Many of us have non-modifiable risk factors for both hepatitis B and C, including, but not exclusively; having received blood transfusions pre-1991, being born in a world region where these infections are more prevalent, or being born into a family where these infections exist but there may not have been awareness of infection. As a Health Board we are here to support everyone living with these infections, irrespective of aetiology.

Over the past 8 or 9 years the Infectious Diseases service, which heads up the Blood Borne Virus (BBV) team, have made significant in-roads in testing, case-finding and administration of therapy. However, these are infections with long clinical latencies, which eventually present with end organ disease when therapy is less effective and affect large numbers of our population. To achieve the vision of elimination and prevention we need efficient, effective, joined-up partnership working across organisations, both regionally and nationally.

Our Joint Recovery Plan has been developed by an oversight group made up of those who know our systems and processes best, enabling us to accurately identify our key challenge areas. This has led to a focus on the 5 action areas of infection prevention (in terms of hepatitis B vaccinations and Needle Syringe Programmes), case-finding and testing, treatment, re-engagement, and data improvements to monitor and evaluate this. We now look forward to implementing our wide-ranging actions in Cardiff and Vale and striving towards prevention and elimination of hepatitis (B and C).

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Clinical Migrant Health lead for Public Health Wales

Glossary of Key Abbreviations

APB – Area Planning Board

BBV – Blood Bourne Virus

CAVDAS – Cardiff and Vale Drug and Alcohol Service

CAVHIS – Cardiff and Vale Health Inclusion Service

DoSH – Department of Sexual Health

MDT – Multidisciplinary Team

NICE – National Institute of Clinical Excellence

NSP – Needle Syringe Programme

PHW – Public Health Wales

SMTF – Substance Misuse Treatment Framework

SVR – Sustained Virological Response

UHB – University Health Board

WCP – Welsh Clinical Portal

WDS – Welsh Demographic Service

WHDM – Welsh Health Data Mart

WHO – World Health Organisation

1 Background and context

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

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

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

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

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

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

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

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

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

2 Where we are now

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

The Cardiff and Vale Eliminating Hepatitis (B and C) Joint Recovery Plan Oversight Group was established in March 2023 to facilitate the development of this Hepatitis (B and C) Joint Recovery Plan for Cardiff and Vale University Health Board.

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

2.1 Structures and processes (inputs)

2.1.1 Infection prevention

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

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

Hepatitis B vaccinations are recorded on the Harm Reduction Database, and on System One in HMP Cardiff.

NSPs are the first line service to prevent infections by enabling the provision of single-use sterile injecting equipment (and sharps' disposal bins) for every injecting event. Attendance is anonymised, open access, and non-conditional in line with National Institute of Clinical Excellence (NICE) guidelines[9]. NSP paraphernalia and sharps bins are drawn from the All Wales Paraphernalia contract managed by NHS Wales Shared Services Partnership, specified in line with NICE/Welsh Government Substance Misuse Treatment Framework[10]. BBV testing is provided at Specialist NSP sites, with no testing in Pharmacy NSP sites; from these, individuals are signposted to substance misuse services, specialist NSPs or DoSH.

NSP activity is recorded live via the Harm Reduction Database Wales using service-user generated reference numbers. Further intervention (e.g. screening) is recorded using full patient details. Declinations cannot be recorded due to the anonymised nature of NSP intervention. Injection-risk data is recorded on the Harm reduction Database.

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

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

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

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

2.1.2 Case-finding and testing

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

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

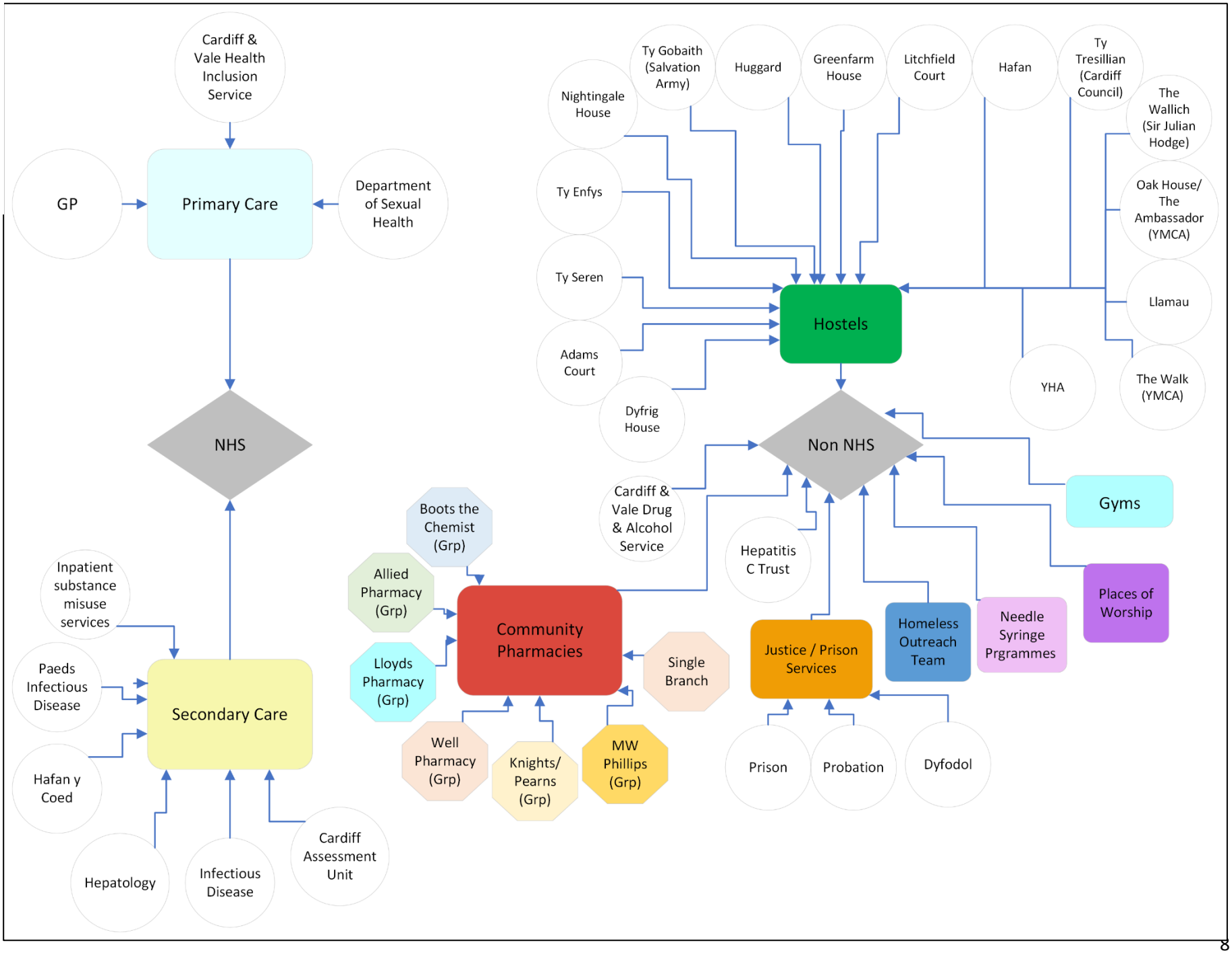
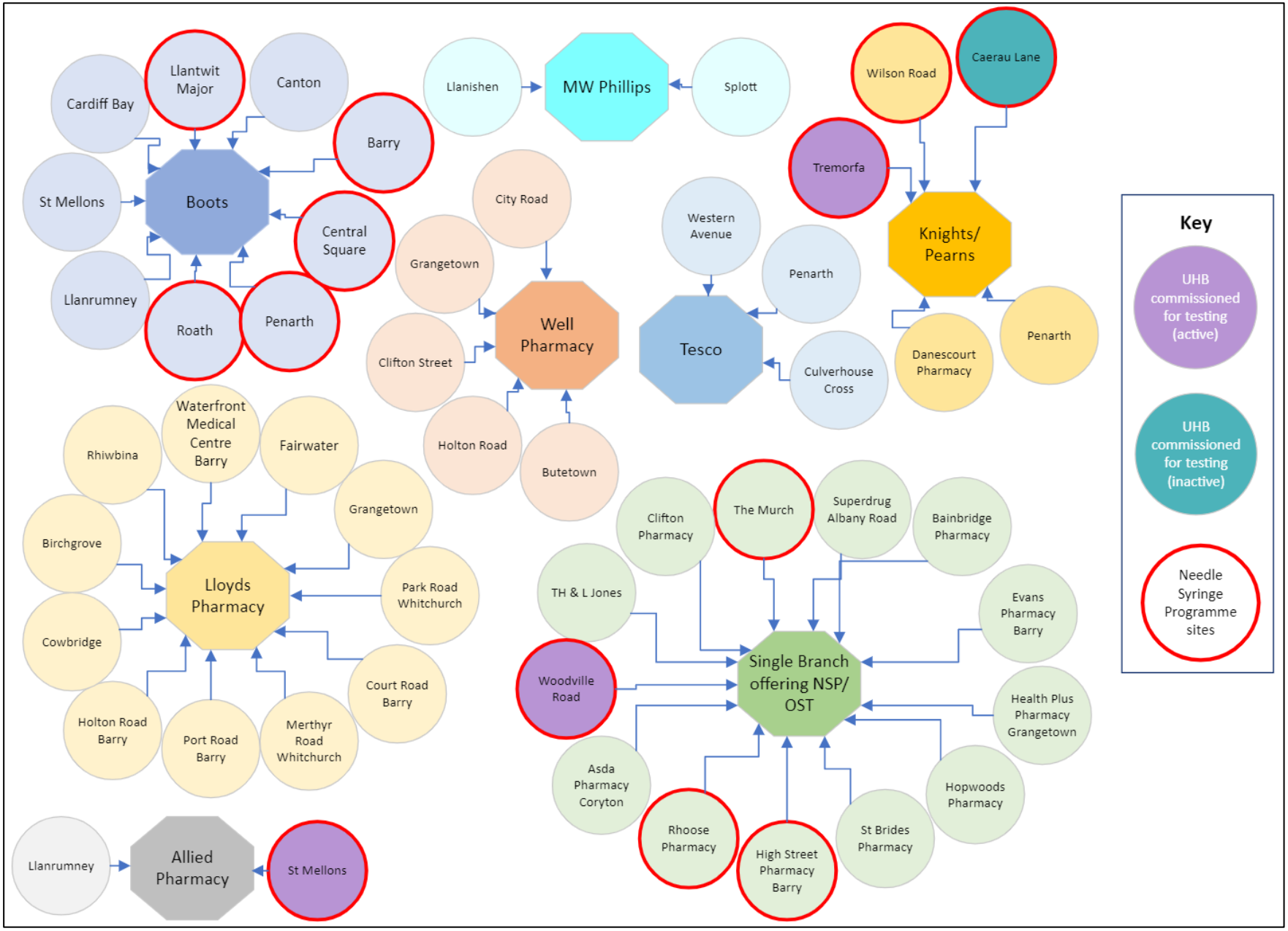


Figure 2:
Community pharmacy sites with links to hepatitis work in Cardiff and Vale UHB, including those currently commissioned for BBV testing and Needle Syringe Programme sites.



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

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

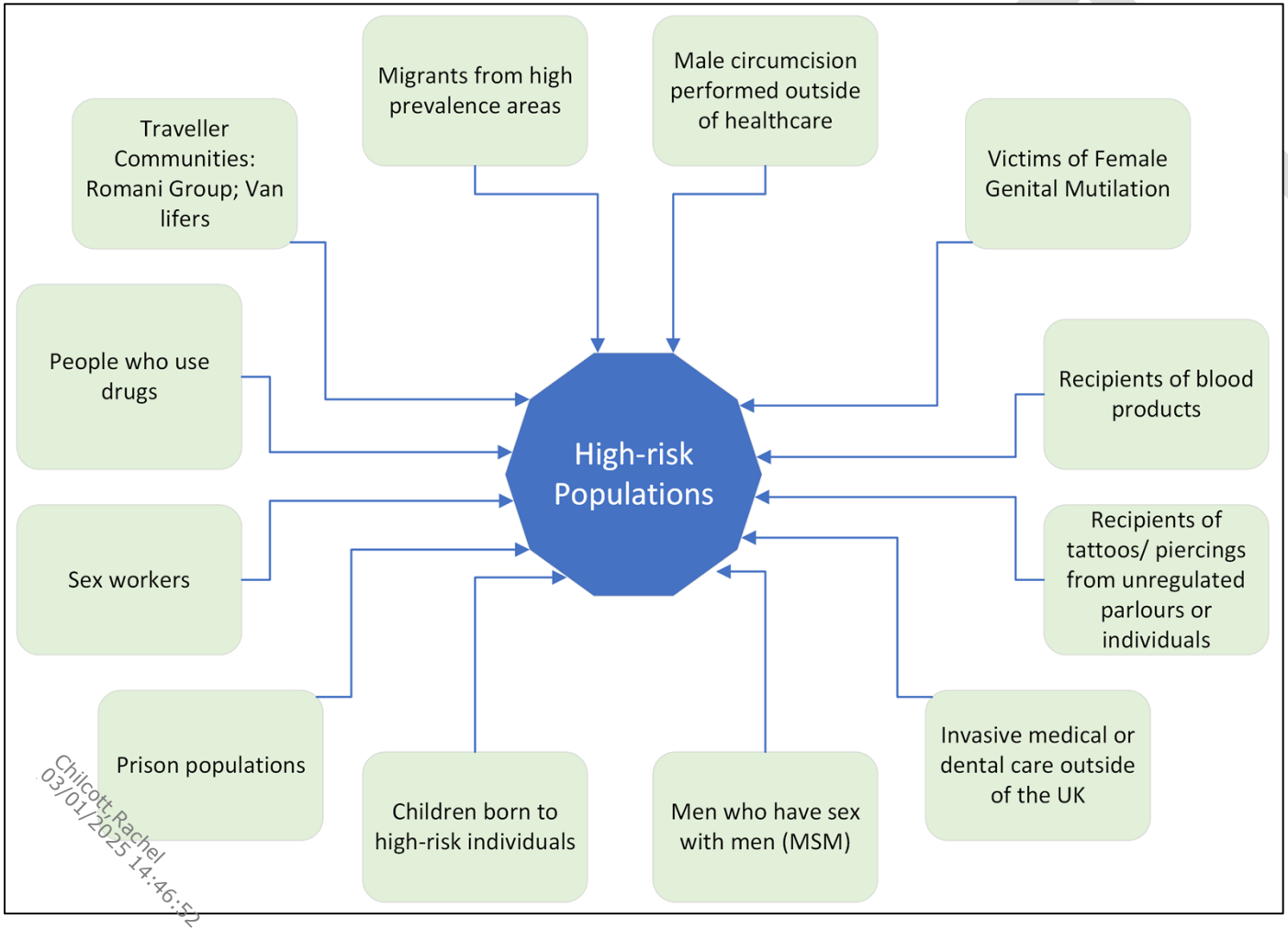


Figure 3: *Hepatitis (B and C) high-risk populations*[11 12 13 14 15]*.*

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

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

- Venepuncture (4week wait)
- Point of Care Testing (POCT) mouth swab for antibodies (20min wait)
- Polymerase Chain reaction (PCR) bloodspot (6week wait)
- POCT Cepheid machine (40min wait)

Testing is accessed and completed via the following routes:

- HMP Cardiff: opt-out. Not operating since October 2022 in HMP Cardiff due to resource capacity limitations.
- Substance Misuse Treatment and Support Services: opt-out (including Criminal Justice Intervention Teams, and NSPs).
- Hepatitis C Trust Peer-to-Peer Follow-Me scheme.
- Health Board BBV community clinic/outreach service.
- Public Health Wales Laboratory: high intensity testing events.
- Community pharmacy sites: 4 commissioned sites, with 3 active (see *Figure 2*). National service review underway, updated specification due later this year.
- Screening of blood, organ and tissue donations.
- Frisky Wales test and post scheme: Public Health Wales, in collaboration with Welsh Government and Health Board sexual health services, established a postal testing service for BBVs and sexually transmitted infections. Tests are requested online via questionnaire completion and guidance. Turnaround times are approximately 7 days, but often less. Negative results are notified via text message. People screened positive are referred to appropriate specialist services for confirmatory testing and treatment (if indicated).
- Sexual health clinics: BBV testing may be offered if an individual is symptomatic or at risk.

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

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

2.1.3 Treatment

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

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

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

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

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

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

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

2.1.4 Re-engagement

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

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

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

1. Attempt to locate via the Welsh Demographic Service (WDS) or other engaged services.

2. Make contact.

3. Deploy Outreach team, peers and wider multidisciplinary team to help engage.

4. Consultation: repeat full BBV screen and assessment.

5. Review and treat as per pathway. If cirrhotic refer to the Hepatology team for ongoing surveillance.

2.2 Outcomes

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

2.2.1 Infection prevention

Childhood vaccination uptake data is available from the Public Health Wales quarterly cover report. For the latest quarter (Oct-Dec 2022), hepatitis B vaccination uptake via the 6in1 childhood vaccine was 93.3% in Cardiff and Vale (92.5% in Cardiff Local Authority; 95.9% in Vale of Glamorgan Local Authority).

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

Outcome	Cardiff and Vale UHB	Wales
Uptake of 3 doses of hepatitis B immunisation in children born to hepatitis B positive mothers reaching their 1st birthday 01/04/2021 to 31/03/2022 and resident in Wales on 31/03/2022	100%	100%
Immunisation of service users engaged with substance misuse services: Number of individuals given a hepatitis B vaccination or referred for one, 2022	0	243
Hepatitis B vaccination coverage in prisons, 2017		*1st dose:* 55.1% (95% CI 53.5 – 56.8) *Full course:* 39.6% (95% CI 38.0 – 41.2)

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

NSP data is presented in a quarterly Harm Reduction Interventions Activity report, produced by the APB Support Team. *Table 2* presents the latest annual data available on NSP activity[6].

Outcome	Cardiff and Vale UHB	Wales
Needle Syringe Programme clients	3,287	20,382
Needle Syringe Programme interactions	26,296	97,337
Needle Syringe Programme syringes dispensed	357,949	1,751,650

Table 2: *NSP activity in Cardiff and Vale UHB and Wales, 2021-22[6].*

2.2.2 Case-finding and testing

Data on hepatitis B and C testing activity for 2022 in the general population in Cardiff and Vale UHB and Wales is shown in *Table 3*[6]. Both the proportion of individuals testing positive for hepatitis B, and the rate per 100,000 population reactive for hepatitis C antibodies, were higher in Cardiff and Vale than for Wales. Annual testing rates for hepatitis C (per 100,000 population) increased each year from 2015 to 2019, before dropping in 2020 and 2021 due to the COVID-19 pandemic, but in 2022 they returned to higher levels than 2019 (*Figure 4*)[6].

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

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

Table 3: *Hepatitis B and C testing activity and outcomes for Cardiff and Vale UHB and Wales, 2022[6]. Grey indicates data not provided.*

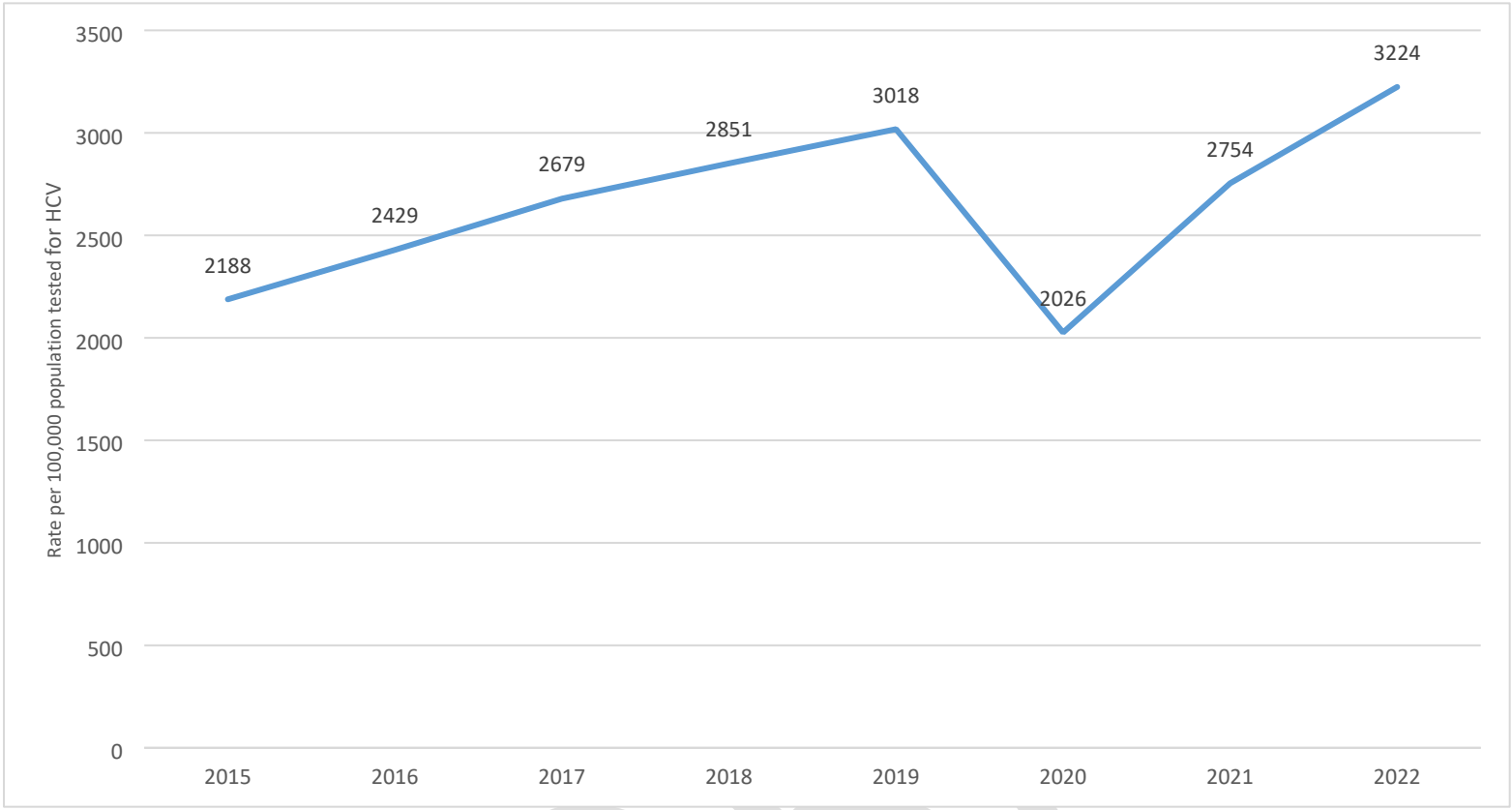


Figure 4: *Rate per 100,000 population tested for HCV (anti-HCV or HCV-RNA) resident in Cardiff and Vale UHB by year, 2015-2022*[6]*.*

Data on Substance misuse service (SMS) testing is shown in *Table 4*[6]. Testing coverage for the offer of a hepatitis C test in 2021-22 was 26.1% in Cardiff and Vale, with 21.5% being tested. This coverage was higher than that of Wales as a whole. Of all those screened for hepatitis C via SMS in 2018-22, 13.1% had a reactive result. This rose to 40.5% amongst those who currently or previously (in the last 12 months) injected drugs, indicating a higher prevalence amongst this subgroup and highlighting the need for targeted actions with this population.

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

Table 4: *Testing activity and outcomes for Substance Misuse Services in Cardiff and Vale UHB and Wales*[6].

Data on HM Prison testing and outcomes is shown in *Table 5*[6]. Testing coverage was lower in Cardiff and Vale than in Wales in 2021, but the proportion testing reactive and positive for hepatitis C in 2022 was higher. During the period of May-October 2022 at HMP Cardiff there were 1100 Point of Contact Tests (POCT) completed, leading to 18 individuals being treated for hepatitis C (data from BBV Team). Routine opt-out testing stopped in HMP Cardiff in October 2022, so coverage is likely to be low so far in 2023.

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

Table 5: Testing activity and outcomes in prison settings in Cardiff and Vale and Wales[6].

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

Testing in community pharmacies has received low engagement and uptake to date, with only two tests completed in 2022-23 at a single pharmacy site (Source: Harm Reduction Database via Community Pharmacy service).

2.2.3 Treatment

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

The number of individuals commencing hepatitis C treatment in Cardiff and Vale and Wales from 2015 to 2022 is shown in *Figure 5*[6]. This data may not be accurate however, and it is not known what proportion of those commencing treatment went on to complete treatment under current data reporting formats.

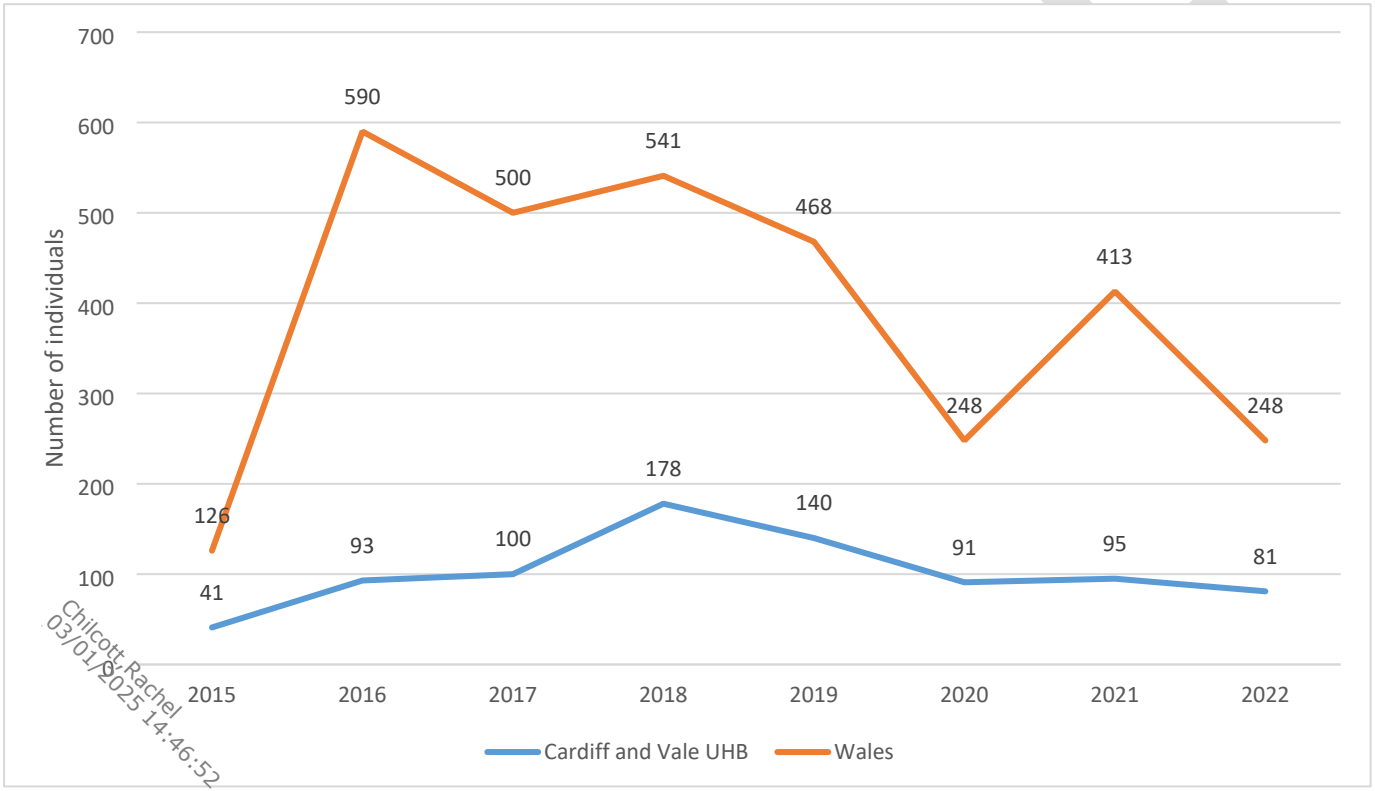


Figure 5: *Number of individuals commencing HCV treatment in Cardiff and Vale UHB and Wales, by year, 2015-2022*[6].

2.2.4 Re-engagement

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

2.3 Current Challenge Areas

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

Challenge Area 1: Infection prevention

- The hepatitis B childhood vaccine (6in1) uptake is currently <95% in Cardiff and Vale UHB. The reasons behind this are not understood.
- For babies born to parents at high-risk of hepatitis B, mothers with hepatitis B are successfully and efficiently identified and managed, however, if the father has hepatitis B, this is not identified at an early stage.
- Improvements are required regarding accessibility, coverage and attendance at Needle Syringe Programme sites, with the reasons behind a decrease in attendance being observed since the COVID-19 pandemic requiring further investigation.

Challenge Area 2: Case-finding and testing

- Identification of individuals at high-risk is challenging due to gaps in data and awareness of different sub-populations in the area and the prevalence of hepatitis amongst these groups.
- There is a lack of awareness of all those at high-risk for case finding, amongst both healthcare staff and the public.
- Testing:
  - There are issues regarding the supply chain of resources for staff to undertake testing.
  - There is a lack of easy access to tests for individuals seeking to self-test via online resources.
  - Not all those at high-risk who are offered testing will accept it.
  - There is a lack of accessible testing pathways outside of those that are perceived to be high-risk.
  - There is a reluctance to perform testing in generically accessed healthcare settings such as out-of-hours services, GP services and Emergency Departments.
  - There is low engagement with testing at community pharmacy sites, both from pharmacy staff and from service users. The reasons behind this are not fully clear, although some have been explored for incorporating into a new service specification.
  - There is a gap between the number of individuals with reactive anti-HCV tests and the proportion of these that receive a confirmatory HCV-RNA test.

Challenge Area 3: Treatment

- Tracking individuals to provide test results, treatment, and engagement can be difficult due to the chaotic lifestyles of some individuals.
- Time from test to treatment: there are delays due to lab turnaround times, with currently up to six weeks' wait for a PCR result. Some substance misuse services are unable to access timely results, and hard copies of results are at risk of going missing. Third sector services don't have access to Welsh Clinical Portal, and as such are reliant on paper results via post or other services to provide them with results.
- Treatment compliance, in terms of commencement, adherence, and completion, is not always achieved, leading to disengagement from the treatment pathways.

Challenge Area 4: Re-engagement

- There can be challenges with engagement/re-engagement with services and support by individuals at high-risk.

Challenge Area 5: Data

- Recording of data on the Harm Reduction Database and E-form database is not always complete.
- The identification of individuals at each stage of the test/treatment pathway (for monitoring and re-engagement purposes) is not routinely possible or complete.
- There is no single accessible source of outcome data for hepatitis (B and C) evaluation either locally or nationally.

3 Where we want to be

Where we want to be, in terms of our aim and objectives, is outlined below in *Figure 6*.

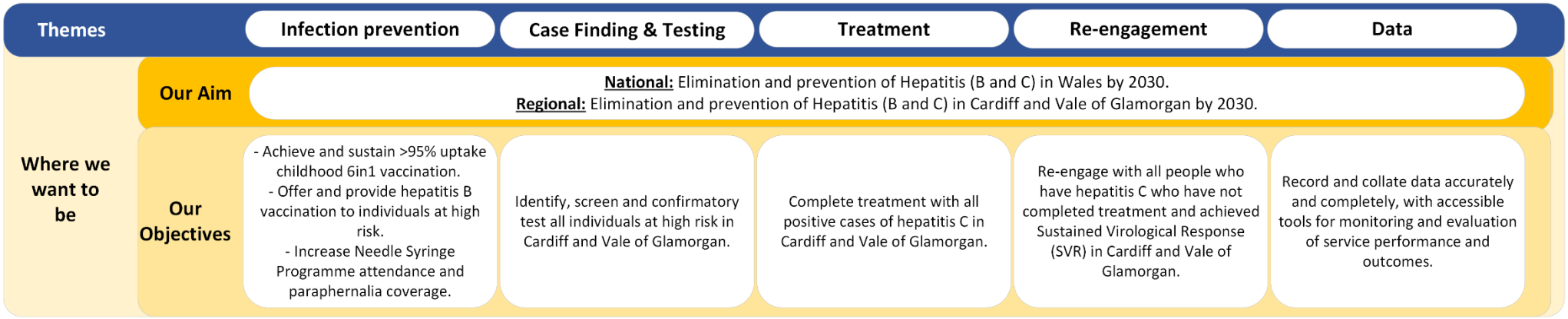


Figure 6: *Where we want to be: our aim and objectives for the prevention and elimination of hepatitis (B and C).*

4 How we will get there

4.1 Action Areas

Following a review of 'where we are now', and the challenges areas for getting to 'where we want to be', we have identified 37 actions across five action areas to facilitate the achievement of our aims and vision:

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

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

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

The timescale for the identified actions is the first two years following publication of this Joint Recovery Plan.

4.2 Action Plan

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

Action area	Action	Lead	Timescale	Measure of success
1. Infection Prevention	**1.1** Launch of a mobile outreach van to support NSP services.	Substance Misuse Service	Year 1	Operational mobile outreach van.
	1.2 Progress implementation of NSP peer-to-peer delivery.	Substance Misuse Service	Year 1	Increased peer-to-peer delivery of NSP services achieved.
	1.3 Widen provision of NSP within hostel settings.	Substance Misuse Service	Year 1	Increased NSP provision in hostels achieved.
	1.4 Explore the reasons for decreased NSP attendance and opportunities to increase provision to targeted subgroups of people who inject drugs (PWID).	Substance Misuse Service	Year 1	Report on NSP attendance explanations with actions.
	1.5 Accurately record activity on the Harm Reduction Database and ensure quality assurance.	Substance Misuse Service	Year 1	Data recording standards agreed with audit tools.
	1.6 Improve and widen promotion of NSP locations, hours and services offered.	Substance Misuse Service	Year 1	Increased NSP sites and hours of operation achieved.
	1.7 Gain an understanding of the barriers to hepatitis B childhood vaccination uptake being <95% for Cardiff and Vale UHB.	tbc	Year 2	Report on the barriers to vaccination completed.
	1.8 Identify a source of vaccination history information that can be accessed by BBV staff in outreach services. This may be in the form of access to Welsh Clinical Portal data, or exploring the use of Health Passports.	tbc	Year 1	BBV staff having access to vaccination history data.
	1.9 Explore options for referral pathways for hepatitis B vaccination for identified high-risk individuals, including close contacts of cases and those providing care to high-risk individuals, such as through the Mass Immunisations Team.	tbc	Year 2	Agreed referral pathway for vaccination produced.
2. Case-finding and testing	**2.1** Improve understanding of high-risk populations in Cardiff and Vale, in terms of numbers, demographic details and point prevalence surveys, building on the high-risk populations mapping work undertaken to date and linking with the inclusion health, substance misuse, DoSH and other relevant teams. This action area will include exploration of methods for identifying pregnant women where the father has hepatitis B, prior to birth.	tbc	Year 2	Report on the make-up of populations at high risk in Cardiff and Vale, including mapping illustrations.
	2.2 Advocate for an awareness campaign in conjunction with the Hepatitis C Trust, nationally, to raise awareness amongst both healthcare staff and the public of who is at risk of Hepatitis (B and C) and how they can access support; with a focus on countering the misperception that it is only those who inject drugs who are at risk.	tbc	Year 2	Active awareness campaign launched in Cardiff and Vale and Wales.

	2.3 Ensure website improvements for signposting information for testing.	tbc	Year 1	Clear testing signposts online are operational and monitored.
	2.4 Conduct investigations to identify the barriers to engagement of testing services at community pharmacy sites, both in terms of staff engagement and service-user engagement.	tbc	Year 2	Completed report on the barriers with recommendations.
	2.5 Explore the potential of increasing the number of community pharmacy test sites; provided either by pharmacy staff or via in-reach peer-to-peer provision within pharmacy settings. Identification of additional sites will require investigation of the most effective locations to facilitate.	Pharmacy	Year 1	An increased number of active community pharmacy test sites.
	2.6 Explore website self-referral functions and processes based on the Frisky Wales test and post scheme.	Pharmacy	Year 1	Completed report on feasibility with recommendations.
	2.7 Explore options for BBV team having access to community Cepheid machines for outreach testing.	tbc	Year 2	Completed report on feasibility with recommendations.
	2.8 BBV screening to be implemented as part of substance misuse service harm reduction initiatives.	Substance Misuse Service	Year 1	Successfully implemented BBV screening in substance misuse service initiatives.
	2.9 Recommence testing in HMP Cardiff following discussions with Primary Care and Public Health Wales Prison Health Protection team.	tbc	Year 1	Active BBV testing in HMP Cardiff with data.
	2.10 Consider potential for the introduction of home test kits, following evaluation of the scheme in England.	tbc	Year 2	Completed report on feasibility with recommendations.
	2.11 Seek to identify opportunities to source funding for expansion of the Hepatitis C Trust Peer support services, with a remit across wider populations.	tbc	Year 2	Completed report on options for expansion with recommendations.
	2.12 Ensure opt-out testing protocols are implemented across all substance misuse treatment and support services through replication of BBV testing/treatment pathway mapping work undertaken by CAVDAS, BBV Clinical Nurses, Hepatitis C Trust, APB Support Team, Gilead, and Public Health Wales.	tbc	Year 1	Achievement of implementation of opt-out testing protocols.
	2.13 Implement opt-out induction testing across hostels and homeless services, as per current process in the Salvation Army hostel with the Hepatitis C Trust.	tbc	Year 2	Achievement of opt-out testing processes in hostels and homeless services.
	2.14 Explore new settings for POCT that are not currently used, based off the findings of action 2.1.	tbc	Year 2	Completed report on potential sites for POCT with recommendations.
	2.15 Explore the potential for Emergency Department opt-out testing by performing a pilot at the University Hospital of Wales Emergency Department.	Infectious Diseases team	Year 1	Completed pilot of emergency department testing with write-up and recommendations.

3. Treatment	**3.1** Develop a 'screening to treatment pathway' across all services, which includes integrated care planning with allied services to ensure individuals complete treatment. If clinically appropriate, patients will potentially be able to commence treatment the same day via Rapid Treatment Pathways (such as in HM Prison). Our aim will be for all positive cases to commence treatment within two weeks of testing, where appropriate.	tbc	Year 1	An active screening to treatment pathway in place.
	3.2 Develop robust processes for ensuring that non-UHB providers are able to access results in a timely and sustainable manner.	tbc	Year 2	Processes in place for non-UHB providers to access results.
	3.3 Raise awareness of the effectiveness, side-effects and requirements of treatment, and dispel myths around these. (linked with action 2.2)	tbc	Year 2	Active awareness campaign launched in Cardiff and Vale and Wales.
	3.4 Increase use of Video-based therapy (VOT): This is live now as an All-Wales approach. It is for patients that fail first line therapy for hepatitis C through poor compliance. As a result VOT will aim to improve adherence to therapy and achievement of SVR.	Pharmacy	Year 1	Completed evaluation of impact of VOT, with recommendations for further use.
	3.5 Incentivise test completion via £10 'Love to Shop' vouchers, with subsequent incentive vouchers for completing treatment and attending an SVR test.	tbc	Year 1	Active incentive scheme in place.
	3.6 Use of Hepatitis C Trust Peer Support services to support treatment adherence.	tbc	Year 2	Completed review of Hepatitis C Trust peer support service activity.
4. Re-engagement	**4.1** Obtain an updated re-engagement list from Public Health Wales for acting on by the BBV team.	tbc	Year 1	Receipt of phase 2 re-engagement list by BBV team.
	4.2 Produce a clear process for cross-referencing and cleaning of the re-engagement list by the BBV team.	tbc	Year 1	Agreed process produced and in use.
	4.3 Produce a clear step-process for making contact with individuals on the re-engagement list; to include identification of support needed (staff, identification pathway, communication and promotion and any joint sharing of information protocols).	tbc	Year 1	Agreed process produced and in use.
	4.4 Use of Hepatitis C Trust Peer Support services to improve re-engagement.	tbc	Year 2	Hepatitis C Trust peer support services in place with re-engagement work.
	4.5 Regular monitoring and evaluation of the re-engagement list.	tbc	Year 1	Completed report on re-engagement activity.
5. Data	**5.1** Ensure improved recording of data at point of testing and treatment on the E-form database and Harm Reduction Database Wales, including quality assurance measures for completeness of data inputs.	tbc	Year 1	Agreed quality standard in place with processes for audit.
	5.2 Improve data availability and accessibility, working collaboratively with the other health boards in Wales and Public Heath Wales Communicable Disease Surveillance	tbc	Year 1	Active data tool available to Health Boards in Wales.

	Centre (CDSC) to develop indicators (based on the WHO 'progress to elimination targets'[16]), and scope out an information tool to monitor this going forwards.			

4.3 Resources required

The facilitation and implementation of the actions outlined in the 5 action areas will require resources for delivery. This will require a combination of using current services and staff within the system to incorporate the additional pieces of work, as well as likely requiring additional new staff and other resources on top of these. The work on these action areas will form part of the Cardiff and Vale Integrated Health Protection Partnership's new system model for an integrated and sustainable health protection approach in Cardiff and Vale.

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

- Cardiff and Vale Area Planning Board (and Support Team)
- The Integrated Cardiff and Vale Health Protection service
- The BBV Team
- Substance Misuse Services (Third Sector, Health Board and Criminal Justice)
- The Department of Sexual Health
- Primary Care services
- Her Majesty's Prison Services
- Public Health Wales
- The Mass Immunisation and Testing team
- Community Pharmacies
- Hepatitis C Trust Peer Support Services
- Potential (tbc): Shared Regulatory Services Health Protection Officers

In addition to these current resources, the implementation work will require the following additional posts and roles:

- Health Protection Manager (as part of the Integrated Heath Protection Team development)
- Prison site staffing for test and treat services: in the form of a Specialist Nurse
- Peer Support Workers: for outreach services and POCT
- Potential: additional community pharmacy support

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

4.4 Implementation, monitoring and reporting mechanisms

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

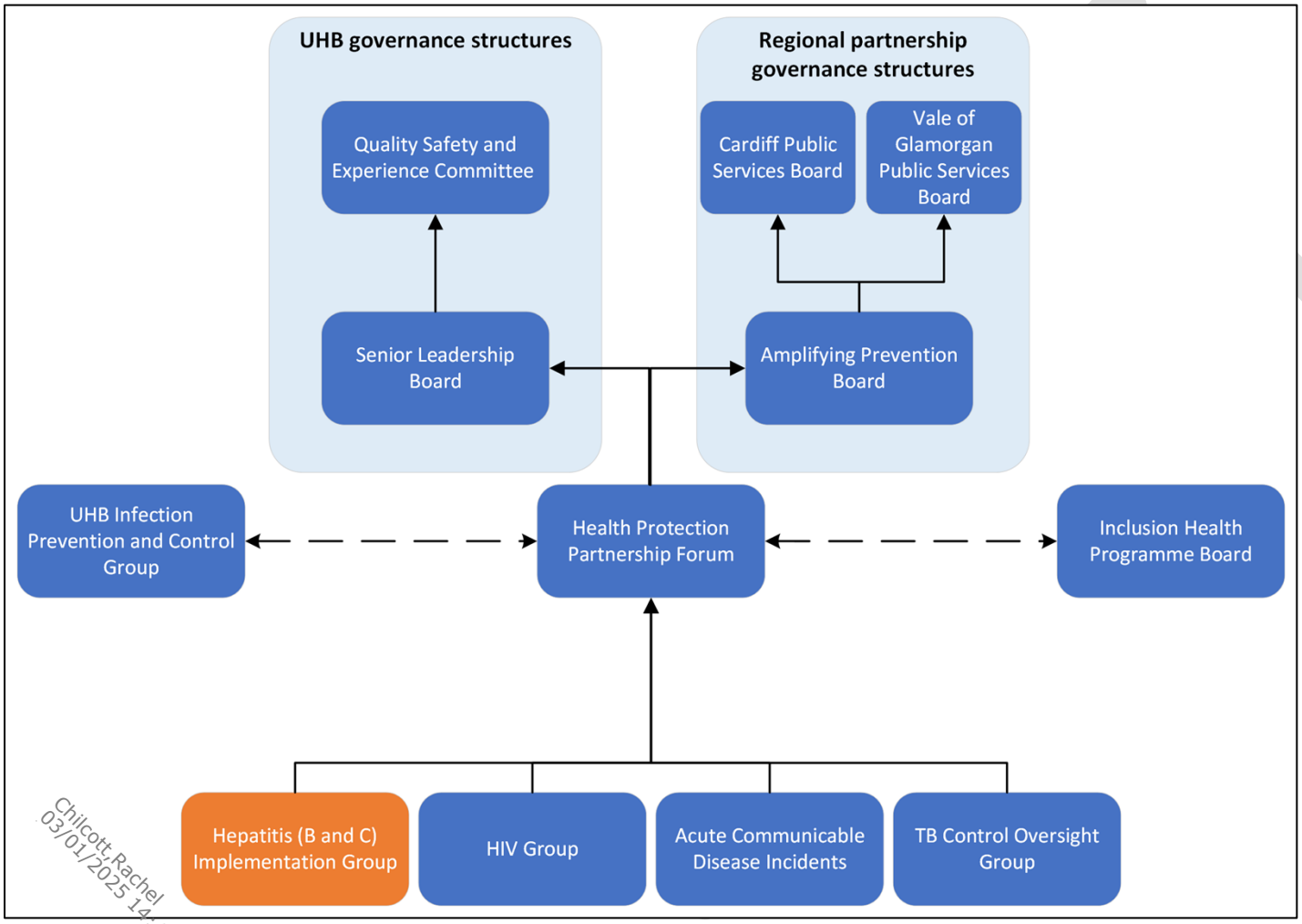


Figure 7: *The reporting mechanisms for the hepatitis (B and C) implementation group.*

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

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

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

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

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

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
	likely make a positive impact on their health.		
6.3 People of different genders: *Consider men, women, people undergoing gender reassignment* ***NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender* *Stonewall* *Gender Identity Research & Education Society – Improving the Lives of Trans People (gires.org.uk)* Chilcott Rachel 03/01/2025 14:46:52	The incidence of hepatitis C is greater in males than in females. For example, in 2023, for Cardiff and Vale UHB area, the incidence of hepatitis C in men was 16.62/100,000 population; whereas in women it was 4.25/100,000. This was according to the BBV-PET tool. Trans-women in one cross-sectional analysis had the highest prevalence of hepatitis C (0.7%) and hepatitis B (0.4%), as compared to their cis-gender counterparts (6). This Elimination Plan includes all people, including male, female and trans. It therefore, will have a positive impact on their health outcomes.	The Plan is inclusive of males, females and trans people. No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	Anyone who is co-habiting and in a sexual relationship is at an increased risk of contracting either hepatitis B or C (2). People who are married or who are in a civil partnership would be as likely to contract hepatitis B or C or if they contract hepatitis C, to obtain the necessary treatment. Therefore, this Plan would have a neutral impact on those married or in a civil partnership.	No further action needed.	No further action needed.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. *They are protected for 26 weeks after having a baby whether they are on maternity leave.* Chilcott Rachel 03/01/2025 14:46:58	Pregnant women should routinely receive antenatal screening for hepatitis B at around 10 weeks gestation. If they test positive they will have specialist care and their baby will need to have 6 hepatitis B vaccinations (7). This Plan will include all pregnant women, and antenatal screening is universal, so the Plan overall will have a neutral impact.	No further action needed.	No further action needed.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-	An opt-out testing programme in 33 England Emergency Units showed that the highest	No further action needed.	No further action needed.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
English speakers, gypsies/travellers, migrant workers The Runnymede Trust	proportion of new diagnoses of hepatitis B were among people of black African ethnicity, and for hepatitis C, it was among people of white ethnicities other than white British (8). Within the action plan, we hope to do anonymous blood testing for hepatitis B and C in Emergency Unit, which may in the future become opt-out testing if viable in Cardiff. Therefore, it will be a positive impact within the Plan.		
6.7 People with a religion or belief or with no religion or belief. *The term 'religion' includes a religious or philosophical belief* Chilcott Rachel 03/01/2025 14:46:52	The literature search did not reveal any conclusive evidence of an effect of religion on hepatitis B or C prevalence/incidence. However, one article mentioned it can either bring on a duty to care for oneself; or a fatalistic approach to hepatitis (9). The Plan aims to work with centres of religion to increase Hepatitis C screening. Therefore,	No further action needed.	No further action needed.

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

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

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

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts and any groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Refer to where the mitigation is included in the document, as appropriate
neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces	in community pharmacies, and outreach services taking mobile units direct to communities, all ensuring services required (screening/vaccination etc.) are available in locations which are already safe and familiar and utilised by the relevant cohorts. The Plan is therefore likely to have a neutral impact on the physical environment.		
7.5 People in terms of social and community influences on their health: *Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos* Chilcott Rachel 03/01/2025 14:46:52	The Plan highlights the importance of the use of peers in the delivery of NSP services, in pharmacy settings to support testing, and in the Hepatitis C Trust peer support services for treatment adherence/re-engagement. These trusted voices are hoped to positively impact these areas, and are trained to provide information that certain cohorts would not be receptive to coming from medical professionals. The Plan is likely to have a positive impact on community influences on health.	No further action needed.	No further action needed.

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

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

8.1 Please summaries the potential positive and/or negative impacts of the strategy, policy, plan, or service Chilcott Rachel 03/01/2025 14:46:52	The following positive impacts of the Plan are noted: • People of all ages • People with a disability • Male, female and trans people • People of a different race • People with different religions • People regardless of sexuality • People according to where they live • People being able to access the service offered • People being able to improve healthy lifestyles • People in terms of social/community influences on their health There were no negative impacts.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	No further actions were identified.			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? *This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?*	No, a more comprehensive Impact Assessment is not required.			
8.4 What are the next steps? *Some suggestions: -* • *Decide whether the strategy, policy, plan, procedure and/or service proposal:* ○ *continues unchanged as there are no significant negative impacts* ○ *adjusts to account for the negative impacts* ○ *continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)* ○ *stops.* • *Have your strategy, policy, plan, procedure and/or service proposal approved* • *Publish your report of this impact assessment* • *Monitor and review*	The current Plan will remain unchanged. However, as it will be renewed next year, it may be advisable to do a more in-depth EHIA at that time.			

Appendix A: Search strategy

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

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

References

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2. **NHS.** Hepatitis. *NHS UK.* [Online] [Cited: June 17, 2024.] https://www.nhs.uk/conditions/hepatitis/.
3. **UK Health Security Agency.** Hepatitis B vaccination. *Green Book.* [Online] April 24, 2024. [Cited: June 17, 2024.] https://assets.publishing.service.gov.uk/media/6655e46cd470e3279dd332cc/Hepatitis_B_Green_Book_Chapter_18_20240517.pdf.
4. **UKHSA.** Green Book on Immunisations: Chapter 18 Hepatitis B. *Green Book.* [Online] May 2024. [Cited: June 24, 2024.] file:///Y:/Health%20Protection/Communicable%20Disease/Infectious%20Diseases/Blood%20Borne%20Viruses/Hepatitis%20B%20and%20C%20Elimination/Hepatitis%20Recovery%20Plan/Recovery%20Plan%202024_25/EHIA/Hepatitis_B_Green_Book_Chapter_18_20240517.pdf.
5. **Enescu, A. et al.** Psychosocial Issues in Patients with Chronic Hepatitis B and C. *Current Health Sciences Journal.* 2014, Vol. 40, 2.
6. **Brown, J. et al.** Prevalence of cancer risk factors among transgender and gender diverse individuals: a cross-sectional analysis using UK primary care data. *British Journal of General Practice.* 2023, Vol. 73, 732.
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8. **UKHSA.** Thousands diagnosed with HIV, hepatitis B and C following programme. *UKHSA.* [Online] November 9, 2023. [Cited: June 24, 2024.] https://www.gov.uk/government/news/thousands-diagnosed-with-hiv-hepatitis-b-and-c-following-programme#:~:text=For%20HIV%20and%20hepatitis%20B%2C%20the%20highest%20proportion%20of%20new,ethnicities%20other%20than%20white%20British..
9. **Moonen, C. et al.** A systematic review of barriers and facilitators for hepatitis B and C screening among migrants in EU/EEA region. *Frontiers in Public Health.* 2023, 11:1118227.
10. **UKHSA.** Don't forget to check for hep - testing and treatment for hepatitis. *UKHSA.* [Online] May 18, 2023. [Cited: June 24, 2024.] https://ukhsa.blog.gov.uk/2023/05/18/dont-forget-to-check-for-hep-testing-and-treatment-for-hepatitis/.
11. **Welsh Government.** More than just words. *Welsh Government.* [Online] [Cited: June 24, 2024.] https://www.gov.wales/sites/default/files/publications/2019-04/delivering-the-active-offer-information-pack-health_0.pdf.
12. **Harris, M., Ward, E. and Gore, C.** Finding the undiagnosed: a qualitative exploration of hepatitis C diagnosis delay in the United Kingdom. *Journal of Viral Hepatitis.* 2016, Vol. 23, 6.

Report Title:	**Ultrasound Clinical Governance Policy and Procedure UHB 322 approval**			Agenda Item no.	*3.1*
Meeting:	QSE Committee	Public	X	Meeting Date:	07/01/2025
		Private			
Status *(please tick one only):*	Assurance		Approval X	Information	
Lead Executive (**Title**):	Emma Cooke, Exec director of Therapies and Health Science				
Report Author (**Title**):	Paul Rogers, Directorate Manager of the Aritifical Limb and Appliance Service				

Main Report
Background and current situation:

The Ultrasound Clinical Governance Policy and Procedure (UHB 322) provides a set of minimum service standards to which all healthcare staff employed or contracted by the UHB to undertake diagnostic imaging and therapeutic ultrasound on patients should comply.

Complying with the Ultrasound Governance Policy and Procedure will ensure that Ultrasound, if carried out correctly, and in the appropriate clinical situation, is one of the most effective diagnostic tools in healthcare. Ultrasound examinations and procedures are undertaken by people a wide range of professional backgrounds, in many different clinical settings.

SITUATION

The Ultrasound Clinical Governance Policy and Procedure, UHB 322, have been reviewed and updated by the Ultrasound Clinical Governance Group (USCGG).

ASSESSMENT

The Ultrasound Governance Policy and Procedure has been thoroughly reviewed and updated by members of the USCGG. Updates include better language describing the scope of the policy and procedure, clarification of training recommendations and updated links to associated internal and external documents.

- Change to policy Statement to better reflect those that the policy relates to (this also aligns with the Point of Care Testing inclusion list).
- Updated supporting documents list and references with hyperlinks.
- Update to author list.
- Corrected key Ultrasound roles and responsibilities.
- Minor changes to aligning updates in governance to those described in the procedure.
- Clarity of equipment modification, Procedure section 6.4.
- Clarification of training recommendations
- Reference in the procedure to the new US safety module.
- Various grammatical, formatting and definition updates.

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

Development of the Ultrasound safety module has been a positive step and we are keen that this promoted widely across all Ultrasound users within the UHB.

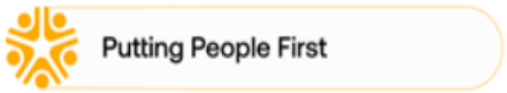
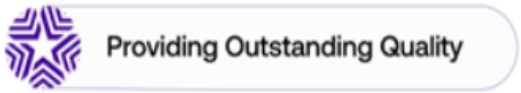
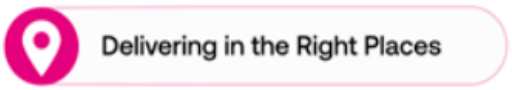
Please note the requirement for "Robust and accurate archive systems for the reporting, documentation and storage of clinical scans, scan requests, equipment decontamination, and associated clinical images. ", under section 7 'Resources' in the Ultrasound Clinical Governance

Procedure. This is currently an area of considerable concern as there are many areas who are unable to appropriately store and retrieve images.

Recommendation:

The Committee is requested to:

a) Exec QSE to approve the reviewed US Governance Policy (UHB 322)
b) Exec QSE to approve the reviewed US Governance Procedure (UHB 322)

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*			
1.  **Click the objective above to view more detail.**		2. ✖  **Click the objective above to view more detail.**	
3.  **Click the objective above to view more detail.**		4.  **Click the objective above to view more detail.**	

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

Quality Impact Assessment Completed? *Please place an "**X**" in the below boxes as relevant. 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)***	✖	*Policy and procedure review for sign-off so QIA no required.*

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

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

Chilcott Rachel 03/01/2025 14:46:52

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board	**Reference Number: UHB 322** **Version Number: 2** **Date of Next Review: 20 Jul 2023** **Previous Trust/LHB Reference Number: N/A**

ULTRASOUND CLINICAL GOVERNANCE POLICY

Policy Statement

Cardiff and Vale UHB is committed to providing high quality diagnostic and therapeutic ultrasound services which consistently meet as a minimum all national evidence-based standards.

The Ultrasound Clinical Governance policy provides a set of minimum service standards to which all healthcare staff employed or contracted by the UHB to undertake diagnostic imaging and therapeutic ultrasound on patients should comply. This includes, but is not limited to those on honorary contracts, students working within the UHB, persons employed by Cardiff University, persons undertaking R&D, Public Health Wales, and independent contractors commissioned by the UHB to undertake testing. The Policy also applies to primary care services such as - Urgent Treatment Centres, Community Diagnostic Centres, Wellbeing Hubs, community dental services, community Pharmacy services, community nursing services, family planning clinics, care homes, mobile Point of Care Testing (POCT) services and GP out of hours services. GP contractors are not mandated to follow this policy as they are ultimately responsible for developing their own governance processes, policies and procedures for the quality and safety of Ultrasound usage. However, it provides a framework for good practice with particular relevance to quality assurance and training, complementing existing guidance, as listed under 'other supporting documents' below.

Complying with this policy will ensure that ultrasound procedures, if carried out correctly, in appropriate clinical situations, is one of the most effective diagnostic tools in healthcare. Ultrasound examinations and procedures are undertaken by people from a wide range of professional backgrounds, in many different clinical settings.

Ultrasound is highly operator dependent and should only be undertaken by trained and competent professionals, or less trained staff under appropriate supervision. Ultrasound examinations, and their interpretation, must be of a high quality, as they have a direct impact in patient management.

Ultrasound can present significant clinical and/or safety risks if:

- examinations are undertaken or interpreted by untrained or poorly trained individuals
- equipment is poorly specified, maintained, or out of date
- it is undertaken in the absence of audit of clinical performance and outcome
- there is no effective clinical governance framework
- effective decontamination processes are not available or not used

This Cardiff and Vale UHB Ultrasound Clinical Governance Policy aims to ensure that we manage the use of Diagnostic and Therapeutic ultrasound, to ensure these ultrasound examinations and procedures are of the highest possible standard, adequately documented, and performed by appropriately trained and competent individuals, using fit for purpose, well maintained ultrasound equipment.

The supporting procedure translates the policy aims into practical implementation measures including the identification of organisational and individual responsibilities.

Policy Commitment

All those involved in Ultrasound, as described in paragraph 2 of this policy, agree to:

- Provide a robust framework for the management of diagnostic ultrasound services, to ensure that services are safe, of the highest possible standard, and compliant with current legislation, standards and guidelines.
- Ensure that all diagnostic and therapeutic ultrasound services have adopted, and are adhering to, the general requirements for good ultrasound governance.
- Ensure that managers and staff recognise their responsibility in the provision of diagnostic ultrasound services.
- Ensure all diagnostic and therapeutic ultrasound users are suitably trained or supervised, and maintain the appropriate levels of competence, performance and patient safety.
- Provide a robust framework for the documentation of ultrasound referrals, examinations and procedures, and the secure storage of images and associated reports, to ensure data is recorded accurately and consistently, and stored safely across the UHB.
- Manage the procurement of ultrasound equipment, and ensure all ultrasound equipment is fit for purpose, safe and regularly calibrated and maintained.
- Demonstrate compliance through record keeping and audit.

Supporting Procedures and Written Control Documents

This Policy and the supporting Ultrasound Clinical Governance Procedure describes the following with regard to the use of diagnostic ultrasound:

- Responsibilities in the management of diagnostic and therapeutic ultrasound services.
- Training and competence requirements for the use of diagnostic and therapeutic ultrasound.
- Management of ultrasound equipment and the scan / therapeutic environment
- Procurement and use of diagnostic and therapeutic ultrasound equipment.
- Maintenance, repair and quality assurance of diagnostic and therapeutic ultrasound equipment.
- General requirements for the provision of diagnostic and therapeutic ultrasound examinations and procedures.
- Requirements for documentation, results reporting and image storage.
- Demonstration of compliance with regulatory requirements.
- Review processes.

Other supporting documents are:
Cardiff and Vale UHB Policies and Procedures

- **UHB 322** - Ultrasound Clinical Governance Procedure
- **UHB 082 - Medical Equipment Management Policy**

- **UHB 021 - Health and Safety Policy**
- **UHB 002 - Data Protection Policy**.
- **UHB 142 - Records Management Policy**
- **UHB 101 - Patient Identification Policy**
- **UHB 023 - Risk Management Policy**
- **UHB 092 - Chaperone Policy**
- **UHB 149 - Infection Control Procedure for Infectious Incidents and Outbreaks in University Health Board Hospitals**
- **UHB 004 - Infection Control Procedure for Meticillin Resistant *Staphylococcus Aureus* (MRSA) in Acute Hospitals**
- **UHB 055 - Clostridioides Difficile Procedure**
- **UHB 062 - Point of Care Testing (POCT) Policy**
- **UHB 366 - Point of Care Testing (POCT) Procedure**
- **UHB 282 - Decontamination of Reusable Medical Devices Policy**
- **UHB 282 - Decontamination of Reusable Medical Devices Procedure**
- **Decontamination of flexible endoscopes Part F: Decontamination of Semi-Critical Ultrasound Probes; Semi-invasive and Non-invasive Ultrasound Probes**

Scope

This policy applies to all of Cardiff and Vale UHB staff in all work locations including those with honorary contracts. It covers all ultrasound devices used by Cardiff and Vale UHB services irrespective of whether the ultrasound device is owned, loaned, leased or used by external service providers commissioned by the UHB.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed for this policy.
Health Impact Assessment	A Health Impact Assessment is not required for this policy.
Policy Approved by	Quality, Safety and Experience Committee

Group with authority to approve procedures written to explain how this policy will be implemented	Ultrasound Clinical Governance Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science.
Author	Kate Bryant, Consultant Medical Physicist, Head of Non-ionising Radiation Sally Lynch, Senior Sonographer Ceri Phillips, Midwife Sonographer Nerys Thomas, Consultant Sonographer Paul Williams, Principal Clinical Scientist, Non-ionising Safety Lead Paul Rogers, Chair of Ultrasound Clinical Governance Group

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	28/06/2016	16 Aug 2016	New policy
2	20/07/2020	17 Feb 2021	Updated content
3	Awaiting approval	Awaiting approval	Change to policy Statement to better reflect those that the policy relates to (this also aligns with the Point of Care Testing inclusion list).

			Updated supporting documents list and references with hyperlinks. Update to author list. Corrected key Ultrasound roles and responsibilities. Minor changes to aligning updates in governance to those described in the procedure. Clarity of equipment modification, Procedure section 6.4. Reference in the procedure to the new US safety module. Various grammatical, formatting and definition updates.

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

CARDIFF AND VALE UHB REUSABLE MEDICAL DEVICE DECONTAMINATION POLICY AND PROCEDURES

Policy Statement

Every patient has the right to expect that medical devices used in their care will be clean and safe.

Reliable, consistent and fit for purpose decontamination processes and procedures based on contemporary evidence for multi-use medical devices are a fundamental tenet for the provision of good health care. Decontamination of non-sterile reusable medical devices is pivotal to maintaining a high standard of infection prevention and protection for patients, staff and visitors within Cardiff and Vale UHB's diverse healthcare settings.

Therefore, effective decontamination of reusable medical devices needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable Healthcare Associated Infections (HCAIs). Improving, adapting and sustaining reusable medical device decontamination services forms an important part of the UHB's overarching HCAI prevention framework.

Decontamination covers all aspects of cleaning, disinfection and sterilisation of reusable medical devices. Therefore, there is a critical clinical safety need to comply with decontamination procedures by all staff who are required to use, maintain or store reusable medical devices and equipment. Medical devices should be decontaminated and stored in accordance with available legislation, evidence based best practice guidance and in line with manufacturers' reprocessing instructions.

Cardiff and Vale UHB is required to provide safe decontamination systems which generate a clean, disinfected or sterile product as appropriate for its intended clinical use. This must be embedded as part of the UHB's culture in support of successful clinical outcomes and the associated safety, health and well-being of patients and staff. This policy describes the requirements for the UHB's overarching decontamination framework to ensure that all reusable medical devices are properly decontaminated prior to use or maintenance, and that the risks associated with decontamination facilities and processes are well managed.

The UHB has historically tended to focus major decontamination improvement policies on acute (secondary and tertiary) services as this is where the perceived major risks of infection transmission by reusable medical devices and in particular surgical instruments exist. However, the risk of encountering HCAI exists in primary care as well as the secondary and tertiary care sectors. The UHB owes the same duty of care to patients and staff across all sectors where is provides healthcare including primary and community

services.

Therefore, UHB healthcare services delivered in community settings (General Practitioner surgeries, dental practices and community clinics, pharmacies etc.) must have in place fit for purpose processes and facilities to ensure decontamination is in accordance with current national policy including Welsh Health Technical Memoranda (WHTM), EU Directives and Welsh Government's "Health and Care Standards).

Policy Commitment

- Cardiff and Vale UHB's Board acknowledge that decontamination procedures for reusable medical devices play an essential part in the prevention and control of Healthcare Associated Infections (HCAI). As such decontamination will be prioritised accordingly by the Executive team, recognising that is critical to safety and therefore a core business for the UHB.
- Wherever reasonably practicable Cardiff and Vale UHB healthcare services will use single use medical devices to reduce the risks of avoidable HCAI. Where this is not reasonably practicable Cardiff and Vale UHB will adopt the best available evidence-based decontamination practices. Patient safety must take primary in the decision-making process.
- The UHB will ensure decontamination procedures and facilities across the UHB's healthcare services are fit-for-purpose and meet the WHTM 01-01 (Parts A to E), WHTM 01-05, WHTM 01-06 (Parts A to F) and HBN 13 (2004) (for refurbished decontamination facilities and new builds). This will ensure statutory regulatory compliance, ISO standard compliance and a move to achieving fully Joint Advisory Group (JAG) on Gastro-intestinal Endoscopy Accreditation of relevant services.
- All reusable medical devices used in acute healthcare settings requiring sterilisation will be reprocessed in an ISO compliant accredited facility.
- Local reprocessing will only be carried out in community dental settings which meet the requirements of WHTM 01-05 where it is not reasonably practicable to send the medical devices to an ISO Accredited facility.
- All reusable medical devices will be covered by suitable tracking and traceability systems to ensure full tracking and traceability records are available covering all episodes of use. This requirement extends to reusable medical devices which are loaned ("on demo" or as part of business continuity plans) or "ex demo" purchased items.
- The choice of decontamination methodology must be proportionate to the level of risk of infection.
- All re-usable medical devices must be reprocessed using a validated automated process.
- Only chemicals approved by the UHB's Infection Prevention and Control (IP&C) team will be used in UHB decontamination procedures.
- Disinfectants must be used at the correct concentrations as recommended by

relevant IP&C Standard Operating Procedures (SOPs) following manufacturers guidelines.

- There must be sufficient stock of medical devices including surgical instrument sets and endoscopes to allow for effective decontamination cycle times. The efficacy of decontamination processes, and therefore patient safety, must never be compromised to achieve desired levels of operational performance.
- All sterile good must be stored in clean dry conditions.
- Items returned to sterile service units must not expose staff to an avoidable infection risk / sharps injury.
- All staff that are required to decontaminate reusable medical devices must be trained and competence assessment.
- Personal protective equipment must be work to undertake decontamination practices where indicated by risk assessment.
- All novel an emergent decontamination technology (equipment, processes, chemistries etc.) must comply with the essential requirements of the MDR and must be CE marked. They must be authorised by the Director of Infection, Prevention and Control, NHS Wales Shared Services Partnership / Facilities Services (NWSSP-FS) Authorising Engineer (Decontamination) (AE(D)) and be formally signed off by the UHB's IP&C committee and Decontamination Group. This may be done in conjunction with the UHB's Medical Equipment Group for decontamination equipment.
- All decontamination facilities and processes used in clinical practice will be routinely audited with findings reported to the UHB's Decontamination group.
- Local self-audit tools will be available to clinical areas where decontamination of reusable medical devices is required.
- All decontamination processes must be subject to continuous quality improvement programmes to ensure that they meet or exceed evolving standards for decontamination and provide the greatest level of protection to patients, visitors and staff.
- All equipment used in decontamination processes must be validated for its intending use and regularly checked and inspected locally to ensure its continued fitness-for-purpose and be on an approved planned preventative maintenance contract.
- A permit to work must be completed every time decontamination equipment is taken out of service for routine testing, repair and maintenance.
- An accurate declaration of contamination status form must be completed prior to inspection, service, repair or transport of medical, dental or laboratory equipment, either on hospital premises or elsewhere.
- Decontamination services must develop robust local business continuity plans to cover scheduled and unplanned disruption to service.
- The UHB is committed to deploy and utilise all available decontamination resources to maximum effect to optimise outcomes for patients and to protect staff and visitors regardless of which Department, Directorate or Clinical Board they are held within. It will manage the life cycle risks of all decontamination equipment in accordance with

the Cardiff and Vale UHB's "Management of Medical Equipment Policy". It will ensure that all Health and Safety risks associated with the use of equipment and chemicals are managed in accordance with Cardiff and Vale UHB's "Health and Safety Policy".

- The UHB is committed to the overarching principles of standardisation and centralisation where patient focused benefits are evident. This will ensure that prudent healthcare principles of reducing waste, variation and harm are adhered to through the adoption of evidence-based decision making, rather than user preference. This will be done in partnership with NHS Wales Shared Services Partnership – Facilities Services (NWSSP-FS).
- The UHB is committed to building organisational resilience, capacity and capability to effectively decontaminate reusable medical devices to ensure the safety of service users and staff and to safeguard its reputation and stakeholder confidence.
- The UHB will establish and maintain the necessary functional requirements and infrastructure to ensure that it meets its statutory obligation to, as far as reasonably practicable, ensure that all reusable medical devices are properly decontaminated prior to use. This will ensure that the risks associated with decontamination facilities and processes are adequately managed.
- The Decontamination Lead is organisationally responsible for the effective and technically compliant provision of decontamination services. The Decontamination Lead is responsible for the implementation of an operational policy for decontamination. The Decontamination Lead is also responsible for monitoring the implementation of the policy.
- The Decontamination Lead delegates specific responsibilities to key personnel and the UHB's Decontamination Group. The Decontamination Group's primary role is to provide assurance to Cardiff and Vale UHB that decontamination procedures and facilities across the UHB's healthcare services are fit-for-purpose and meet the requirements of WHTM 01-01 (Parts A to E), WHTM 01-05 and HBN 13, (2004) (for refurbished decontamination facilities and new builds).
- Ultimately it is the clinician's responsibility to satisfy themselves that any medical device they are about to use is safe and this includes being satisfied that the device is appropriately decontaminated before use.

Supporting Procedures and Written Control Documents

This Policy and the Decontamination of Reusable Medical Devices Procedure describe the UHB will discharge its duties in respect of statutory legislation and its obligations to meet external quality standards set out by health service accreditation bodies.

Other supporting documents

- *Cardiff and Vale UHB Policies and Procedures:*

- *UHB Decontamination Procedure*
- *Medical Equipment Management Policy and Procedure*
- *Infection Control Standard Precaution Procedure for Cardiff and Vale University Health Board*
  Waste Disposal Policy
- *Decontamination of Ultrasound Transducers – Standard Operating Procedure*
- *COSSH Policy*
- *Health and Safety Policy*
- *Management of CJD / VCJ Protocols*

- *National Guidance Documents*

- *WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part A: Management and Environment*
- *WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part B: Common Elements*
- *WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part C: Steam Sterilisation and Steam for Sterilisation*
- *WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part D: Washer Disinfectors*
- *WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part E: Alternatives to Steam for the Sterilisation of Reusable Medical Devices*
- *WHTM 01-05 Decontamination in Primary Care Dental Practices and Community Dental Services*
- *WHTM 01-06 Parts A-F Decontamination of Flexible Endoscopes*
- *British Society of Gastroenterology (BSG) Guidelines for Decontamination of Equipment for Gastrointestinal Endoscopy*
- *Health Building Note 13: Sterile Services Department, NHS Estates, Department of Health (2004).*
- *Medical Device Regulations (MDR)*
- *ISO 13485*

Scope

This policy applies to all of Cardiff and Vale UHB staff in all locations including those with honorary contracts. It applies to the decontamination of all reusable Medical Devices or Equipment used by Cardiff and Vale UHB services irrespective of whether the Medical Device or Equipment is owned, loaned, leased or used by commissioned external service providers.

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

Health Impact Assessment	A Health Impact Assessment (HIA) is not required for this policy.
Policy Approved by	Quality, Safety and experience Committee.
Group with authority to approve procedures written to explain how this policy will be implemented	Decontamination Group.
Accountable Executive or Clinical Board Director	Chief Operating Officer UHB.

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	*2nd July 2024*	20th Sept 2024	Full re write of old policy
2			

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
DECONTAMINATION OF REUSABLE MEDICAL DEVICES PROCEDURE

CONTENTS

1. Summary

1.1 Decontamination procedures for reusable medical devices play an essential part in the prevention and control of Health Care Associated Infections (HCAI).

1.2 Single use devices should be considered if reasonably practicable, cost effective and support the sustainability targets of Cardiff and Vale UHB.

1.3 CVUHB will work towards reprocessing reusable medical devices used in acute healthcare settings, in a Medical Device Regulations (MDR amended part II) accredited facility.

1.4 The choice of decontamination methodology must be proportionate to the level of risk of infection.

1.5 Only chemicals approved by the Infection Prevention and Control Committee (IPC) and Decontamination Group are to be used for disinfection in the UHB.

1.6 Disinfectants and detergents must be used at the correct concentrations as recommended by the Infection Prevention and Control Committee and in line with manufacturers instructions for use (IFU).

1.7 There must be sufficient stock of medical devices including surgical instrument sets and endoscopes to allow for effective decontamination cycle times. The efficacy of decontamination processes, and therefore patient safety, must never be compromised to achieve desired levels of operational performance.

1.8 All sterile goods must be stored in designated clean areas, in accordance with NHS Estates Health Building Note 13, controlled environments (humidity / temp monitoring) and designated racking to ensure goods are protected.

1.9 Items returned to sterile service units must not expose staff to an avoidable infection risk / sharps injury.

1.10 All staff that are required to decontaminate reusable medical devices must be trained and competent to do so. Training must be completed by appropriate persons suitable qualified to train and the training must be

undertaken at routine periods, to include refresher packages. They must have supporting evidence of a competence assessment.

1.10 Personal protective equipment must be worn to undertake decontamination practices where indicated by risk / COSHH assessments. Management must ensure where PPE is provided, staff wear the appropriate protection at all times.

1.12 All novel decontamination technologies (equipment, processes, chemistries etc.) must comply with the essential requirements of the MDD, have CE marking in place and have to be authorised by the UHB's IPC Committee, Decontamination Group, Authorising Engineer for Decontamination (AED).

1.13 All decontamination facilities and processes, must operate in accordance with relevant WHTM/WHBN and minimise potential for environmental recontamination. All departments will be routinely audited with findings reported to the UHB's Decontamination Group.

1.14 All decontamination processes must be subject to continuous quality improvement programmes to ensure that they meet or exceed evolving standards for decontamination and provide the greatest level of protection to patients, visitors and staff.

1.15 All equipment used in decontamination processes must be regularly inspected locally to ensure its continued fitness-for-purpose, be on an approved maintenance contract and validation reports authorised by the AED.

1.16 Local self-assessment audit tools will be available to clinical areas where decontamination of reusable medical equipment is required.

1.17 The UHB has established the functional requirements and infrastructure to ensure that it meets its statutory obligation to, as far as reasonably practicable, ensure that all reusable medical devices are decontaminated effectively prior to use. This will ensure that the risks associated with decontamination facilities and processes are adequately managed. This function is delegated by the Head of Decontamination through the UHB's Decontamination Lead to the UHB's Decontamination Group. The Decontamination Groups primary role is to provide assurance to Cardiff and Vale UHB that decontamination and sterilisation procedures and facilities across the UHB's healthcare services are fit-for-purpose and meet the requirements of WHTM 01-01 (Parts A to E), WHTM 01-05 and HBN 13.

2. *Introduction*

Reliable, consistent and fit for purposed decontamination processes and procedures based on contemporary evidence for multi-use medical equipment and devices are a fundamental tenant of good health care. Decontamination of non-sterile reusable equipment is pivotal to maintaining a high standard of infection prevention and protection for patients, staff and visitors within Cardiff and Vale UHB's diverse healthcare settings.

Cardiff and Vale UHB are required to provide a safe decontamination service that generates a clean and sterile product and is embedded as part of the service culture in support of successful clinical outcomes and the associated well-being of patient and staff.

Decontamination covers all aspects of cleaning, disinfection and sterilisation of reusable medical equipment. There-fore there is a critical clinical safety need to comply with decontamination procedures by all staff who are required to use, maintain or store reusable medical devices and equipment.

Medical devices should be decontaminated and stored in accordance with legislation, guidance and in line with the manufacturers reprocessing instructions.

This document describes the UHB's systems which ensure that all reusable medical devices are properly decontaminated prior to use or maintenance, and that the risks associated with decontamination facilities and processes are well managed.

The UHB has historically tended to focus major decontamination improvement policies on acute (secondary and tertiary) services as this is where the perceived major risks of infection transmission by reusable medical devices and surgical instruments exist. However, all sectors of healthcare delivered by the UHB including primary and community services owe the same duty of care to patients and staff.

The risk of encountering HCAI exists in primary care as well as the secondary and tertiary care sectors. UHB healthcare services delivered in community settings (General Practitioners surgeries, dental practices, pharmacies etc), must have in place fit for purpose processes and facilities to ensure decontamination is achieved in accordance with current, national

policy including Welsh Government "Health and Care Standards", Welsh Health Technical Memoranda (WHTM) and EU Directives.

3. *STATEMENT OF INTENT*

3.1 Where reasonably practicable Cardiff and Vale UHB healthcare services will use single use medical devices to reduce the risks of avoidable HCAI.

3.2 Where his is not reasonably practicable Cardiff and Vale UHB will adopt the best available evidence-based decontamination practices. The UHB will ensure decontamination procedures and facilities across the UHB's healthcare services are fit-for-purpose and meet the WHTM 01-01 (Parts A to E), WHTM 01-05, WHTM 01-06 (Parts A to F) and HBN 13 (for refurbished decontamination facilities and new builds). This will ensure statutory regulatory compliance, ISO standard compliance and a move to achieving Joint Advisory Group (JAG) accreditation of relevant services.

3.3 Cardiff and Vale UHB is committed to deploy and utilise all available decontamination resources to maximum effect to optimise outcomes for patients and to protect staff and visitors regardless of which Department, Directorate or Clinical Board they are held within. It will manage the life cycle risks of all decontamination equipment in accordance with the Cardiff and Vale UHB's "Medical Equipment Policy". It will ensure that all Health and Safety risks associated with the use of equipment and chemicals are managed in accordance with Cardiff and Vale UHB's "Health and Safety Policy".

3.4 The UHB is committed to the overarching principle of standardisation and centralisation where patient focused benefits are evident. This will ensure that prudent healthcare principles of reducing waste, variation and harm are adhered to through the adoption of evidenced based decision making, rather than user preference. This will be done in partnership with NHS Wales Shared Services Partnership – Specialist estates Services (NWSSP-SESS).

4. Aims of Policy

4.1 To deliver a system-wide, consistent and robust decontamination infrastructure to provide appropriate advice to staff so that effective decontamination is achieved at all UHB locations which complies with national standards.

4.2 To provide advice on the approved materials and equipment for their use for effective decontamination.

4.3 To provide advice on the approved methods for standard and effective decontamination.

5. *OBJECTIVES*

5.1 To prevent and control transmission of infection through medical devices – with specific reference to surgical instruments and the risk of human prion disease or Transmissible Spongiform Encephalopathies (TSEs) transmission.

5.2 To adopt a comprehensive and consistent approach to infection risk control and reduction across instrument management and decontamination.

5.3 To provide assurance to the UHB's Executive Board regarding the management and decontamination of medical devices including surgical instruments, in terms of availability, quality and suitability.

5.4 To ensure the continuous improvement of high-quality engineering through the adoption of European Norms (ENs), quality systems and standards.

5.5 To universally adopt best practice guidance for optimisation of the environment, equipment and facilities used in decontamination.

5.6 To develop an effective quality management system to cover all aspects of the decontamination life cycle.

5.7 To ensure that documented robust and comprehensive policies and procedures are available to clinical services to ensure that decontamination processes are undertaken in a controlled manner to protect the health and safety of patients, service users, visitors and staff.

5.8 To ensure UHB procurement practices are organisationally "joined up" and have oversight by Cardiff and Vale UHB's Decontamination Group and Medical Equipment Group so that all purchased instruments are compatible with decontamination processes available within the UHB and all stakeholders are consulted prior to device procurement.

5.9 To ensure that manual cleaning of devices is restricted to those items or those components of an overall decontamination process deemed

incompatible with automated / validated processes by the device's manufacturer.

5.10 To ensure that reprocessing of reusable medical devices will be undertaken in dedicated facilities and outside the clinical / patient environment, in facilities accredited to the Medical Device Regulations amended Part 2 (MDR).

5.11 To ensure that any local reprocessing will only be undertaken in community settings where is not reasonably practicable to send the equipment to an MDR accredited facility. This decision must be supported by a comprehensive and robust risk assessment signed by the Primary, Community and Intermediate Care (PCIC) Clinical Board Director, Director of Infection Prevention and Control, the UHB Decontamination Lead and User's. However, CVUHB strives to centralise all decontamination into accredited units where practically possible.

5.12 To ensure that equipment used to decontaminate medical devices and associated equipment (for example, washer-disinfector's) must be fit for purpose, validated, tested and maintained in accordance with national guidelines and manufacturers recommendations.

5.13 To develop comprehensive service wide systems to track instruments trays and endoscopes through decontamination processes, from clinical area, to the reprocessing centre to the patient.

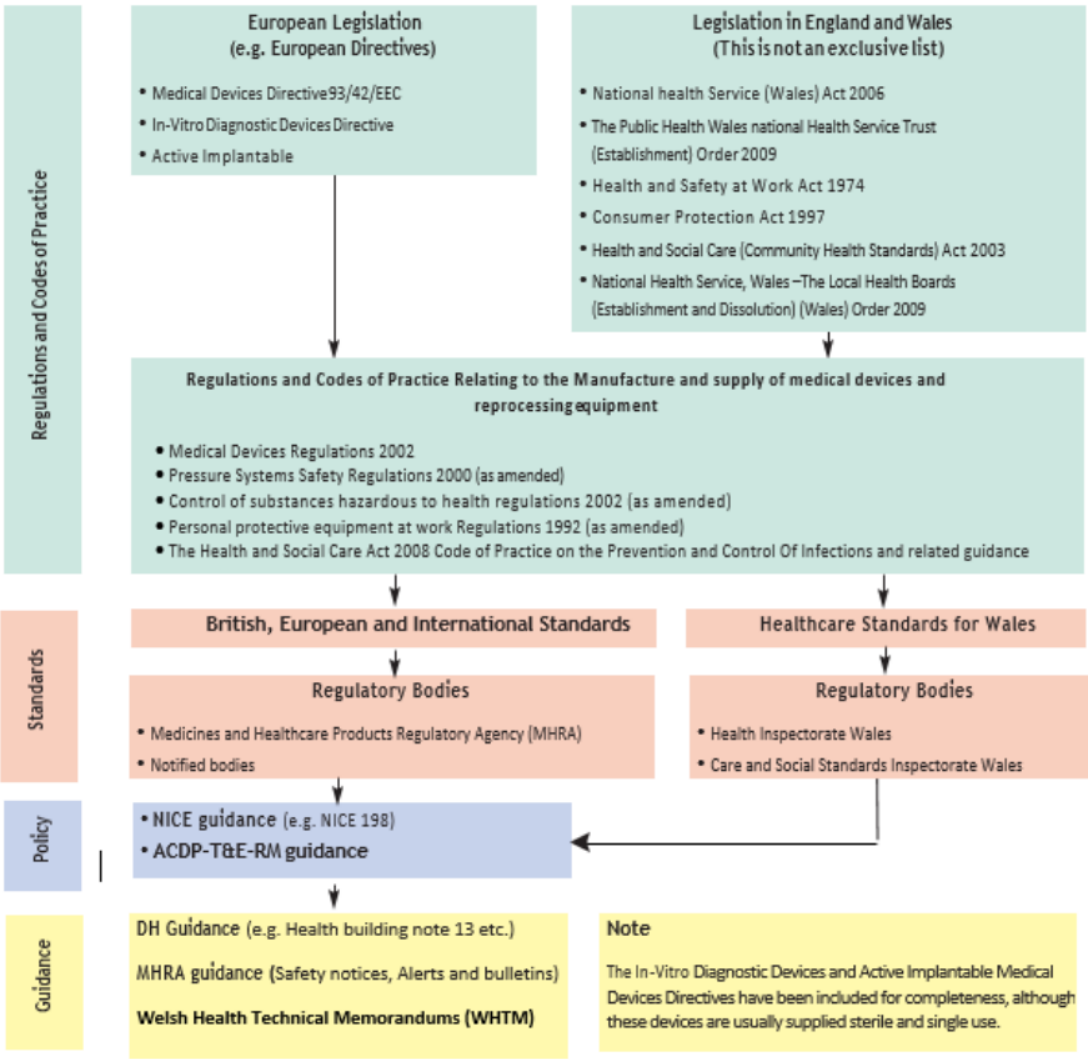
5.14 To ensure that robust documented training schemes are available for all staff who are required to decontaminate medical devices.

5.15 Electronic tracking systems should be in place in the acute reprocessing facilities where possible. The tracking system must be capable of identifying what equipment has been used on what patient, track the following patients who the equipment was used on, identify location of equipment within the Hospital, track limited use devices and facilitate individual instrument marking systems if in use.

6.0 Legislation and Standards

This section sets out the duty of care for Decontamination across Wales and the Local Health Boards.

6.1 The following regulatory framework applies to all sites that operate a decontamination service



NHS Wales Shared Service Partnership (2017) "WHTM 01-01: Decontamination of surgical instruments (medical devices) used in acute care, Part A: Management and Provision".

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European Legislation

6.2 There are three EU Directives relating to the manufacture and supply of medical devices:

- Medical Device Regulations (MDR) 2002 as amended part 2
- In-vitro Diagnostic Devices Directive 98/79/EEC as amended by Directive 2007/47/EC

- Active implantable Medical Devices Directive 90/385/EEC as amended by Directive 2007/47/EC

Regulations

6.3 There are a number of regulations relating to the manufacture and supply of medical devices and reprocessing equipment. The primary regulations are:

- The Medical Device Regulations 2002 (as amended)
- The Pressure Systems Safety Regulations 2000 (as amended)
- The Control of Substances Hazardous to Health Regulations 2002 (as amended)
- The Personal Protective Equipment at Work Regulations 1992 (as amended)
- The Electromagnetic Compatibility Regulations (the EMC Regulations)
- UK Government (2000) “Pressure Systems Safety Regulations 2000”.

Standards Relevant to Decontamination Equipment

6.4 Standards relevant to decontamination equipment:

- BS EN ISO 17665-1: Sterilisation of health care products. Moist heat. Requirements for the development, validation and routine control of a sterilisation process for medical devices (this includes porous loan and fluid sterilisers (except where used for medicinal products), and sterilisers for unwrapped instruments and utensils).
- BS EN 285: Sterilisation. Steam sterilisers. Large sterilisers.
- BS EN 13060: Small sterilisers, Large sterilisers.
- BS EN ISO 15883-1: Washer disinfectors. General requirements, terms and definitions and tests.
- BS EN ISO 15883-2: Washer disinfectors. Requirements and tests for washer-disinfectors employing thermal disinfection for surgical instruments, anaesthetic equipment, bowls, dishes, receivers, utensils, glassware, etc.
- BS EN ISO 15883-3: Washer disinfectors. Requirements and tests for washer-disinfectors employing thermal disinfection for human waste containers.

- BS EN ISO 15883-4: Washer disinfectors. Requirements and tests for washer-disinfectors employing chemical disinfection for thermo-labile endoscope.

Standards for Health

6.5 The Welsh Government document "Doing Well, Doing Better: Standards for Health Services in Wales (2010) sets out the core and developmental standards that all healthcare organisations in Wales which treat NHS patients.

6.6 Users should comply with the Welsh Government guidance document "Decontamination of Medical Devices (WHC/2015/050).

6.7 All Healthcare organisations in Wales will be expected to assure themselves and the communities they serve that they are achieving or working towards these standards of care. Healthcare Inspectorate Wales will carry out external, independent assessments of organisations to ensure compliance with, or progress towards meeting Standards.

6.8 Decontamination standards in Doing Well, Doing Better: Standards for Health Services in Wales and in the National Minimum Standards require decontamination to be properly carried out in facilities that comply with guidance issues by the MHRA and are subject to external audit by a designated body approved by the MHRA.

Guidance

6.9 For guidance refer to the following:

- Department of Health Building Note 13 – Sterile Services Department.
- WHTM 01-01 Part A-E: Management and Decontamination of Surgical Instruments (medical devices) used in Acute Care.
- WHTM 01-06 Part A–F: Decontamination of Flexible Endoscopes
- WHTM 01-05: Decontamination in Primary Care Dental Practices and Community Dental Services
- WHTM 07-01: Safe Management of Healthcare Waste

- WHTM 03-01: Specialised Ventilation for Healthcare Premises
- WHTM 04-01: Safe Water in Healthcare Premises.

7.0 Definitions

- **Contamination –** the soiling or pollution of inanimate objects or living material with potentially infection substances. In the clinical situation this is most likely to be organic matter (e.g. blood, faeces, proteins etc.) but may also include inorganic substances such as dust. Such contamination may be transferred to susceptible host (person).

- **Decontamination –** a process, which removes or nullifies contamination by biomass reduction and thereby prevents microorganisms reaching a susceptible (body) site in sufficient quantities to cause infection. Differing levels of decontamination are available. They are:

  Cleaning followed by high level of disinfection; or cleaning followed by sterilization, depending on the procedure and chemicals used

  Or

  Decontamination, the combination of processes (including cleaning, disinfection and sterilisation) used to render a reusable item safe for further use on patients and handling by staff. – "*A guide to the decontamination of reusable surgical instruments – NHS Estates 2003".*

- **Cleaning –** a process that physically removes contamination but does not necessarily destroy microorganisms. Cleaning is a necessary prerequisite to ensure effective disinfection or sterilization.

- **Disinfection –** is a process following cleaning that reduces the number of viable micro-organisms but may not inactivate some microbes such as certain viruses and bacterial spores. There are 2 main methods of disinfection; thermal and chemical. Thermal disinfection is governed by the A0 scale of above 600 to effectively disinfect or A0 3000. In a washer disinfector this is normally achieved by holding a temperature (normally using RO water) for a min of 1 min.

In decontamination, chemical disinfection is predominately used to disinfect thermally restricted devices (i.e. flexible endoscopes) and is achieved by the appropriate dosing process and contact times.

- **Sterilisation –** a process used to render the object completely free from viable microorganisms, including viruses. This process is required for high-risk equipment. Within UHB, sterilisation is predominately achieved using steam sterilisation, which subjects the devices to temperatures of 134-137°C for 3-3.5 mins / 121°C for 15mins. For heat sensitive equipment the UHB has the capability to use hydrogen peroxide for low temperature sterilisation.

- **Detergent –** An agent whose action in combination with cleaning removes visible contamination and the majority of micro-organisms.

- **Disinfectant –** An agent that destroys micro-organisms including bacteria, viruses and parasites but not necessarily bacterial spores.

- **Single Patient-Use:** A device that can be used more than once on a single patient, and can be decontaminated between users on that patient only.

- **Single-use** A device that is used once, on a single patient, and then disposed of. Devices that are labelled by the manufacturer for “single-use only” must not be re-used. The reuse of single-use devices can affect their safety, performance and effectiveness, exposing patients and staff to unnecessary risk. Such devices are required to be identified by the single-use symbol on either the instrument or its packaging as shown in Fig 1:

Figure 1 – Symbol for single-use devices

These devices must be disposed of safely after use and it is important that the single-use instruments are not allowed to enter reusable instrument sets. This statement also applies to single use implantable devices.

- **Medical Device or Medial Equipment.** In the context of this policy this includes any instrument, apparatus, appliance, or other article, whether used alone or in combination, together with any accessories, to be used specifically for diagnostic and / or therapeutic purposes. This will include:

- Diagnosis, prevention, monitoring, treatment or alleviation of disease,

- Diagnosis, monitoring, treatment, alleviation of a compensation for an injury or handicap,

- Investigation, replacement or modification of the anatomy or of a physiological process,

8.0 General Principles of Decontamination

8.1 Spaulding Classification: The level of decontamination required depends on the risk of the item transmitting micro-organisms, and the process the device will tolerate. Therefore, devices can be categorised into one of three levels of risk. Fig 2 Spaulding Classification:

Spaulding Classification- adapted.

Classification	Indication	Level of decontamination	Method
High Risk ***(Critical)***	Items that come into contact with normally sterile body tissues.	Single use Sterilise	Autoclave Low temperature steriliser
Medium Risk ***(Semi- Critical)***	Items that come into contact with mucous membranes or non-intact skin.	Single use Sterilise Disinfection	Autoclave Low temperature steriliser Automated high level disinfection
Low Risk ***(Non- Critical)***	Items that come into contact with intact skin	Clean +/- disinfect	Detergent wipes/ solution Combined detergent & disinfection wipes

Spaulding, E.H. (1957) "Chemical disinfection and antisepsis in the hospital". *JHospRes*. 9: pp 5–31.

Only low-risk devices should be decontaminated in the ward environment. Manufacturers' instructions must be followed unless otherwise authorised by the Infection Prevention & Control (IP&C) team and a risk assessment completed. All medium and high-risk items must be decontaminated in designated areas by fully trained and competent staff who are trained on the products and equipment in use.

8.2 Decontamination Cycle for reusable medical devices.

Regardless of the location of decontamination (for example, primary, community or acute sectors), the same standards apply, Figure 3 highlights each stage of the decontamination process through which medical devices pass before every use:

Figure 3: The reusable surgical instrument cycle

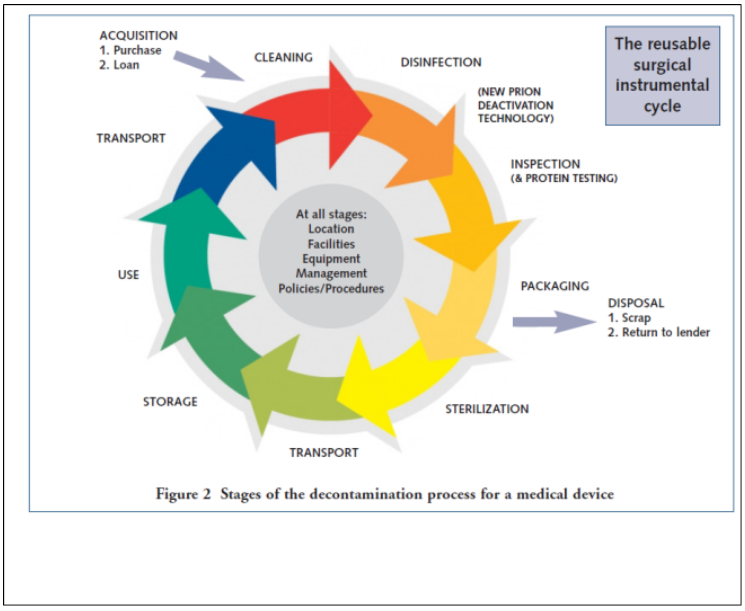


Figure 2 Stages of the decontamination process for a medical device

At all stages of reprocessing reusable medical devices, the following issues need to be considered:

1. The existence of effective management arrangements;

2. The existence of policies, procedures and effective competence-based training programmes for all aspects of decontamination work;

3. The location and activities where decontamination takes place;

4. Fit for purpose facilities and equipment available to each clinical service which utilises reusable medical devices to ensure effective and verifiable decontamination;

5. Ensuring the equipment used is validated, maintained and tested in accordance with manufacturer's guidelines and legislation.

6. The equipment is fully tacked through all aspects of the decontamination life cycle.

8.3 Reducing the Time from Close of Procedure to Reprocessing

Prions are easier to remove if they have not dried on the surface of an instrument. To enable efficient prion removal, theatre and HSDU staff should ensure that instruments are transported to the HSDU immediately after the close of the procedure, for cleaning and reprocessing as soon as practically possible.

- This will make the cleaning process more effective, hence reducing the risks to the patients and staff handling the devices. If devices cannot be returned in a timely manner, it is important that the instruments are kept moist using appropriate methods approved by the HSDU. In Cardiff and Vale this can be a moist bag or a pre-spray of an enzymatic solution.

  For further guidance on keeping instruments moist, Users can refer to WHTM 01-01 Part A: Management and Decontamination of Surgical Instruments (medical devices) used in Acute Care.

8.4 Tracking and Traceability of Medical Devices

It is important to be able to trace products through the decontamination processes to which they have been subjected and to the patient on whom they have been used. Whether individual or part of an instrument set, such items must be fully traceable. All processing information must be documented in accordance with the manufacturer's guidance. This should include the number of times an item has been processed as there will be a finite reprocessing life of the product.

Traceability information should be kept as stated within the Quality Management System (QMS) of the processing unit (in Cardiff and Vale UHB this is predominantly 15 years). Any of the related information, which may include the number processed, graphical information or any other processing records, should be accessible if required in circumstances such as product recall or investigations due to unexpected failure of an item. These records need to link directly to patients where they were used. The risk management option to move to the use of pre-sterile single use implantable items (where possible) offers a simple solution to these challenges.

The ability to track and trace medical devices and equipment enables corrective action to be taken when necessary.

Records should be maintained for all trays cleaned, identifying:

a. The cleaning and sterilisation method used;
b. The name of the person undertaking the decontamination;
c. Details of the actual tray processed;
d. Which patients have been treated with the tray;
e. The equipment cycles details and numbers;

This information is required so that instrument trays can be traced, if required. In the event of a failure in the decontamination cycle or for infection control reasons.

The use of untracked supplementary instruments should be avoided, where possible, and instruments grouped together into traceable trays.

In Cardiff and Vale UHB, an electronic tracking system is predominantly used in the sterile service departments and endoscopy, however there are still areas with manual systems in place across the Health Board. Where manual decontamination tracking systems are in place, regular audits need to be performed to ensure accuracy of systems.

8.5 Loan Sets

Reusable medical devices acquired on loan are subject to the same decontamination requirements as set out in this policy. All surgical instruments and associated equipment entering the organisation, regardless of the source, should be cleaned and sterilised before and after use in accordance with the manufacturers' instructions.

Only reusable medical devices that are compatible with the Health Board's decontamination methods and policy should be acquired on loan. Records must be kept for traceability purposes and in line with the requirements of the Health Board's policy.

Departments should develop their own procedure in relation to loan of specialist equipment that covers initial inspection, check of inventory is complete, documentation, and traceability records.

The master indemnity register must be checked prior to accepting the loan agree to ensure the company have appropriate indemnity cover for the loan of surgical devices.

Prior to return of the equipment to the supplier, the equipment must be reprocessed and sterilised unwrapped prior to return. For traceability purposes and proof of process performed prior to return a decontamination certificate must be provided with the equipment.

8.6 Human Prion Disease (including variant Creutzfeldt-Jakob disease ((CJD)) and other forms of CJD).

The human prion diseases are a group of rare fatal neurological disorders that occur in sporadic, genetic and acquired forms, the latter occurring by transmission from one individual (species) to another. These conditions are all associated with the conversion of a normal protein in the body, the prion protein, to an abnormal disease-associated form that accumulates in the brain and results in neuronal degeneration and death. The abnormal prion protein is thought to be the major component of transmissible prion agents.

The most common human prion disease is the sporadic form of Creutzfeldt-Jakob disease (sCJD), with an annual incidence worldwide of one-to-two cases per million of the population. In the UK, there are between 50 and 90 cases annually, with a peak incidence in the 60-70-year age group. This disease presents with rapidly progressive dementia and a range of other neurological sins and symptoms, with death occurring in around three-to-six months of disease onset. The genetic forms of human prion disease account for around 10% of total cases, while acquired cases account for around 1%, including iatrogenic CJD (iCJD) in human growth hormone and dura mater graft recipients, and variant CJD (vCJD). Incubation periods in acquired human prion diseases can vary from two to over 40 years, depending on the route of exposure. vCJD was first reported as a novel human prion

disease in 1996, acquired from infection by the bovine spongiform encephalopathy (BSE) agent, most likely via the oral route.

Patient with sCJD and vCJD have differences in the distribution of prion infectivity around the body. In sCJD (and also in some cases of genetic prion diseases and iCJD), abnormal prion protein appears to be restricted to the central nervous system (CNS), whereas in vCJD it has also been detected in lymphoid tissues, including tonsils, spleen and gastrointestinal lymphoid tissue. Abnormal prion protein has been detected in the lymphoid tissues of a few individuals infected with vCJD before the onset of clinical signs and symptoms of the illness, indicating asymptomatic vCJD infection.

vCJD is distinguishable from non-vCJD in a number of ways:

- It tends to affect younger people with an average (median) age of onset of around 26 years (median age at death 28 years).
- The predominant initial clinical symptom is of psychiatric or sensory problems, with coordination problems, dementia and muscle-twitching occurring later.
- The illness usually lasts about 14 months (range 6-84 months) before death.

A definitive diagnosis of vCJD can only be confirmed by examining brain tissue, usually at post-mortem, and requires the exclusion of other forms of human prion disease, particularly sCJD. In the UK. As of 2016, there have been 177 deaths from definitive or probable cases of vCJD, three of which appear to have been acquired by packed red blood cell transfusion from infected donors. The peak year of deaths was 2000, since when numbers of cases have fallen progressively with no new cases reported since 2012. However, given the long incubation periods previously seen for acquired CJD, and with evidence from tissue-based prevalence studies in the general population, the potential for further cases to emerge or for potential asymptomatic abnormal prion carriage within the general population has yet to be ruled out.

While three vCJD cases may have been transmitted by blood transfusion, there are no known cases of vCJD being transmitted by surgical instruments or endoscopes. However, it may be possible because:

- sCJD has been transmitted by neurosurgical instruments used on the brain;
- abnormal prion protein binds avidly to steel surfaces and can be very difficult to remove from surgical instruments;
- prion infectivity has been found in a range of tissues (brain, spleen, tonsils etc) of patients developing symptomatic vCJD

8.7 Improvements to processes to reduce risk of vCJD

Because of the risks of prion transmission, there is a need to optimise the whole of the decontamination pathway of surgical instruments. Further guidance of this can be found in the: *Guidance from the Advisory Committee on Dangerous Pathogens Transmissible Spongiform Encephalopathy (ACDP-TSE) Subgroup, formerly the TSE Working Group.*

Reducing the time from close of procedure to reprocessing

Prions are easier to remove if they have not dried on the surface of an instrument, prion adhesion can occur as little as 20 mins from onset to a surgical instrument. To enable efficient prion removal, theatre and HSDU staff should ensure that instruments are transported to the HSDU immediately after the close of the procedure, for cleaning and reprocessing as soon as practically possible and keeping them in a moist environment when possible (moist bags / enzymatic spray).

This will make the cleaning process more effective, hence reducing the risks to the patients and staff handling the devices. If devices cannot be returned in a timely manner, it is important that the instruments are kept moist using appropriate methods, which within the Health Board are moist bags or neutral enzymatic preparation spray immediately post op.

Cleaning validation and continuous monitoring

Traditionally, cleaning validation has been about removing visible soiling. Now the emphasis is on removing proteins to very low levels. To be able to have a greater chance of removing these proteins, there needs to be an efficient a cleaning process as possible – the HSDU work with NWSSP Shared Services at time of validations, to ensure the cleaning efficacy process is as effective as possible. This could mean considering alternative chemistries and additional wash phases to improve the cleaning efficacy process.

With any change in chemistry Users must ensure compatibility with the medical devices, reprocessing equipment and water quality within the locality.

Results should be recorded and monitored in accordance with WHTM 01/01-part D. Appropriate actions should be taken based on these results. HSDU's should undertake:

- Daily testing using process challenge devices (PCD's)
- A schedule of weekly residual protein testing (quantifiable protein measurement / residual swab method).

- Priority for cleaning validation and continuous monitoring should be given to instruments that have been in contact with high – prion – risk tissues as defined by ACDP – TSE's:

Table A1 – Distribution of TSE infectivity in human tissues and body fluids

Key: **+ve** = tested positive **-ve** = tested negative
NT = not tested **P** = infectivity proven in experimental transmission studies

Tissue	Presence of abnormal prion protein and level of infectivity			
	CJD other than vCJD		vCJD	
	PrP^{TSE} detected	Assumed level of infectivity	PrP^{TSE} detected	Assumed level of infectivity
Brain	+ve	High P	+ve	High P
Spinal cord	+ve	High P	+ve	High P

2 Published: 2 June 2003
Updated: December 2010

Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection: Annex A1

Cranial nerves, specifically the entire optic nerve and only the intracranial components of the other cranial nerves	+ve	High	+ve	High
Cranial ganglia	+ve	High	+ve	High P
Posterior eye, specifically the posterior hyaloid face, retina, retinal pigment epithelium, choroid, subretinal fluid, optic nerve	+ve	High P	+ve	High
Pituitary gland	+ve	High (?)	+ve	High (?)
Spinal ganglia[1]	+ve	Medium	+ve	Medium P
Olfactory epithelium	+ve	Medium	NT	Medium
Dura mater[2]	-ve	Low	+ve[4]	Low
Tonsil	-ve	Low	+ve	Medium P
Lymph nodes and other organised lymphoid tissues containing follicular structures	-ve	Low P	+ve	Medium P
Gut-associated lymphoid tissue	-ve	Low	+ve	Medium
Appendix	-ve	Low	+ve	Medium
Spleen	+ve	Low P	+ve	Medium P
Thymus	-ve	Low	+ve	Medium
Anterior eye and cornea	-ve	Low	-ve	Low
Peripheral nerve	+ve	Low	+ve	Low
Skeletal muscle	+ve	Low	+ve	Low
Dental Pulp	-ve	Low	-ve	Low
Gingival Tissue	NT	Low	-ve	Low
Blood and bone marrow	NT	Low	-ve	Low
CSF[3]	-ve	Low P	-ve	Low
Placenta	-ve	Low	-ve	Low
Urine	-ve	Low	-ve	Low
Other tissues	-ve	Low P	+ve[4]	Low

[1]Spinal ganglia have a high assumed level of infectivity in the WHO Guidelines. However, unpublished results on the infectivity of spinal ganglia indicate that this tissue is of medium infectivity.

3 Published: 2 June 2003
Updated: December 2010

Methods for detecting residual protein

Any method used to detect residual protein, should be validated as being able to detect protein equivalent to <5 µg of BSA in situ on the surface of an instrument. Methods that do not have protein as their target, such as ATP assays (Ninhydrin), cannot be used as a substitute for residual protein detection.

Within the Health Board we have adopted the "in-situ" protein detection technology and perform daily tests on high risk and low risk instrumentation.

Continuous improvement plans

Sterile service departments should have in place a plan of continuous process improvement. This plan is part of the risk assessment plan (BS EN ISO 14971) and is reviewed as part of the department's management review meetings.

9.0 Roles and Responsibilities

This chapter describes the roles and responsibilities of key personnel involved in the operation, maintenance and use of decontamination processes. Fig 4 is the Decontamination Management Structure for Wales:

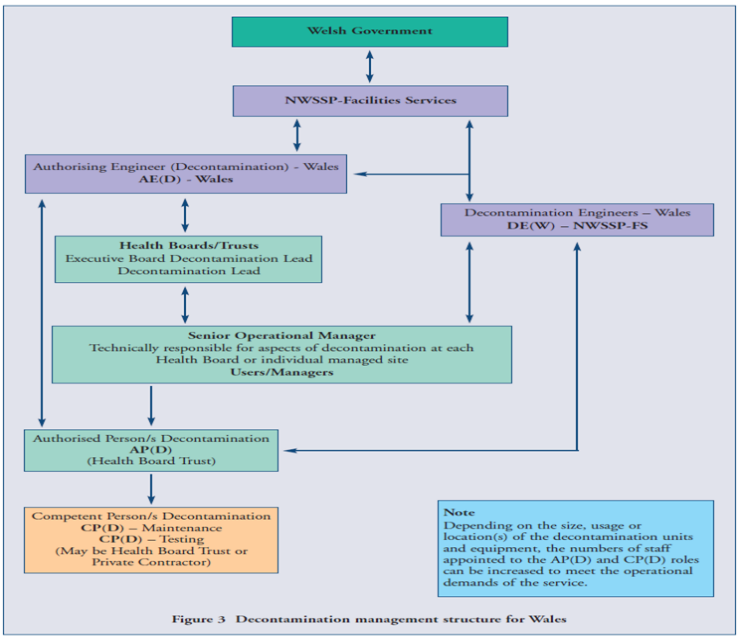


Figure 3 Decontamination management structure for Wales

The following persons are considered key personnel who have a specific responsibility within decontamination:

a. Executive Board Lead (for example, Chief Executive)

b. Decontamination Lead

c. Senior Operational Manager (for example, Estates Manager)

d. User (for example, Sterile Service Manager)

e. Authorising Engineer (Decontamination)

f. Decontamination Engineers (Wales) at NWSSP-SES

g. Authorised Person (Decontamination)

h. Competent Person (Decontamination)

i. Lead for Infection, Prevention and Control

j. Microbiologist (Decontamination)

k. Operator

l. Manufacturer

m. Contractor

n. Purchaser

o. Competent Person (Pressure Systems)

9.1 Executive Board Lead

Has ultimate responsibility, including allocation of resources and the appointment of personnel for the organisation. Within the Health Board this post is nominated to the Chief Operating Officer for the Organisation.

9.2 Decontamination Lead

The Health Board has a nominated Decontamination Lead with responsibility for decontamination. The Decontamination Lead reports directly to the Executive Board Lead via the Decontamination Group.

The Decontamination Lead is organisationally responsible for the effective and technically compliant provision of decontamination services.

The Decontamination Lead is responsible for the implementation of the operational policy for decontamination. They must ensure the operational policy clearly defines the roles and responsibilities of all personnel who may be involved in the use, installation and maintenance of decontamination equipment across the Health Board. The Decontamination Lead is also responsible for monitoring the implementation of the policy.

The Decontamination Lead should have received formal training, specific for management of medical device decontamination on undertaking the role.

9.3 Senior Operational Manager

The Senior Operational Manager is technically, professionally and managerially responsible for the engineering aspects of decontamination (for example, decontamination equipment and environment). Within the Health Board this role is designated to the Head of Estates for the UHB.

9.4 User

Within the Health Board the user is the designated sterile service manager for the organisation.

The principal responsibilities of the user are as follows:

a. to certify that the decontamination equipment is fit for use;

b. to hold all documentation relating to the decontamination equipment

c. to ensure that decontamination equipment is subject to periodic testing and maintenance;

d. to appoint operators where required and ensure that they are adequately trained;

e. to maintain production records;

f. to establish procedures for product release in line with the quality management system;

g. to ensure that procedures for production, quality control and safe working are documented and adhered to in the light of statutory requirements and accepted best practice. The user may seek the advice of infection prevention and control team;

h. to ensure the surgical instrument management is carried out.

Specifically, the responsibility of the user will cover the following,

a. make judgements on the suitability of reusable instruments in consultation with surgical teams and those responsible for decontamination. This work is assisted in the Health Board via the Sterile Service User Group and the Endoscopy User Group.

b. Determine appropriate instrument-set structures designed to assist in the prevention of leakage on of instruments between sets (including preventing the movement of supplementary instruments between sets) in consultation with clinical specialists and decontamination teams; ensure that guidance on tracking and traceability is appropriately applied to all instruments (this includes loan sets and implantable items including screws and plates) and collaborate with those responsible for patient records to ensure any patient with whom they are used can be identified and linked to the sets or individual instruments used;

c. Ensure that missing or damaged surgical instruments are replaced preserving the appropriate set structure;

d. oversee the monitoring of condition and suitability for surgical instruments;

e. oversee the audit process for instrument sets from procurement through to use, decontamination and final disposal;

f. ensure instrument sets never used are reviewed and / or disposed of;

g. oversee actions to provide a mechanism for routinely revalidating instrument – set content (for example, annual sign off of the tray checklist by surgical teams);

h. mange the loaning of instrument sets to and from external suppliers

i. purchase new instrument and sets (including, as a minimum, the documented approval of the theatre team, decontamination specialists and Control of Infection Lead);

j. ensure repaired instruments are returned to the original instrument set;

k. oversee a standardised approach to instrument recognition throughout the organisation.

l. ensure all instrument sets have an accurate version-controlled checklist validated by the surgical team

m. determine that all instrument stores are audited on a regular basis, and all redundant items removed from circulation;

n. ensure a mechanism is in place for addressing instrument set usage non-conformities such as wet pack, wrong inventory, holes in tray wrap etc.

o. provide and oversee mechanisms to ensure all instruments in the health board's inventory are fit for purpose;

p. ensure the health board hold an accurate database of its instrument-set inventory including tray type, location of use and stock level;

q. ensure all instrument sets which are critical in stock levels are risk assessed, to maximise patient safety and inform instrument set investment;

r. ensure compliance with all manufacturers' reprocessing instructions of any implantable items;

9.5 Authoring Engineer (Decontamination (AE(D)

The AE(D) is defined as a person designated by management to provide independent auditing and advice on washer-disinfectors, sterilisers and sterilisation and to review and witness documentation on validation.

The AE(D) is required to liaise closely with other professionals in various disciplines and consequently, the appointment should be known in writing to all interested parties.

Role of AE (D)

This role should be fully independent of the Health Boards 'and healthcare facilities' structure for maintenance, testing and management of the decontamination equipment.

The AE (D) at NWSSP-SES has a reporting route to the Decontamination Lead via the Health Boards Decontamination Group and reports directly to Welsh Government via the All Wales Welsh Assembly Government Decontamination Committee.

The AE(D) provides technical advice to AP(D)s, CP(D)s and users involved in the control of decontamination processes in healthcare facilities.

Responsibilities of the AE(D)

The principal responsibilities of the AE (D) are as follows:

a. to provide Management and others, general and impartial advice on all matters concerned with decontamination;

b. to provide Management and others, on programmes of validation;

c. to audit reports on validation, revalidation and yearly tests submitted by the AP(D);

d. to advise Management and others on programmes of periodic tests and periodic maintenance;

e. to advise Management and others on operational procedures for routine production;

f. to advise Management on the appointment of the AP(D);

g. to provide technical advice on the relevant guidance for wales on decontamination equipment for the users;

h. to provide technical advice on the relevant guidance for Wales on decontamination equipment and procedures;

i. NWSSP-SES undertakes the role of Authorising Engineer for the NHS in Wales.

j. The Institute of Healthcare Engineering and Estate Management (IHEEM) supports and operates the DTP (Decontamination technology Platform) which is made up of IHEEM-registered AE(D)s.

9.6 Decontamination Engineers (Wales) at NWSSP-SES

The Decontamination Engineers (DE(W)) in Wales support the AE (D) and undertake the testing programme of decontamination equipment on behalf of the Welsh Government.

The DE(W) will also be responsible for:

a. the engineering technical advice of decontamination equipment to all users;

b. the safe and effective systems of work for all installed decontamination equipment within his / her area of responsibility;

c. participate and undertake technical audits of decontamination facilities and equipment on behalf of welsh Government and NWSSP-SES;

d. close liaison with the AE(D), AP(D), Decontamination Led, users and other interested professionals to enable

them to discharge their responsibilities for management of decontamination effectively;

e. ensuring the continued support of a liaison with site CP(D)s, as appropriate.

9.7 Authorised Person (Decontamination (AP(D))

The AP(D) will be an individual representing a health care organisation possessing adequate technical knowledge and having received appropriate training, appointed in writing by the health care organisation (in conjunction with the advice provided by the AE(D)), who is responsible for the practical implementation and operation of Management's safety policy and procedures relating to the engineering aspects of decontamination equipment.

The AP(D) should be able to undertake the safe and effective management of the engineering aspects of the service.

The role of AP(D) is intended to provide the organisation with an individual who, as part of the management infrastructure, will provide day-to-day operational management responsibility for the safety of the system. This should be an internal appointment within the organisation. It is however, recognised that in some organisations there are so few items of decontamination equipment in use that a service provided by a third party may be adequate. In most organisations the role of AP(D) would only be one of a number of areas of similar responsibility for the individual(s) concerned. However, any additional responsibilities should not reduce the importance of the role nor impair the ability of the AP(D) to carry out his/her duties effectively.
When the scope and range of services dictates, healthcare organisations may wish to consider the appointment of more than one AP(D) to ensure that appropriate cover is provided. In these circumstances the organisation should appoint a senior AP(D). In any event, organisations will need to ensure that cover is available during the absence of the AP(D). Larger organisations may be able to warrant the appointment of an AP(D) dedicated full-time to the role.

If the estates roles are contracted out, it is recommended that the AP(D) function remains the responsibility of the healthcare organisation.

The healthcare organisation has a responsibility to ensure that the AP(D) reporting structure has a line of professional accountability.

The AP(D) will also be responsible for:

a. the engineering management of decontamination equipment – site specific only;

b. the management and / or appointment of the CP(D)s on each site for the organisation;

c. safe and effective systems of work for all installed decontamination equipment within his/her area of responsibility;

d. the acceptance criteria for operational and performance testing as decided with the relevant users and AE(D) of all installed decontamination equipment;

e. liaison with the AE(D) and/or DE(W) at NWSSP-SES, Decontamination Lead and other interested professionals;

f. authorising the use of decontamination equipment after repair or refurbishment and after quarterly tests;

g. operation of the permit system in line with guidance specified in this document;

h. ensuring the continued local registration of the CP(D)s, as appropriate;

i. liaising with the user, and other technical support personnel, to enable them to discharge their responsibilities for management of decontamination effectively.

The AP(D) must have a knowledge of the specific equipment installed on-site and not simply a generic overview of decontamination equipment.

The AP(D) must have received appropriate training and be conversant with periodic testing. He/she should have completed an accredited course for CP(D)s and successfully passed the examination.

9.8 Competent Person (Decontamination) (CP(D))

The CP(D) is defined as a person designated by Management to carry out maintenance, validation and periodic testing of washer-disinfectors and sterilisers.

The CP(D) may be either directly employed labour or provided as a service to the healthcare organisation from third parties. Healthcare organisations may wish to maintain the sperate functional roles of provision of testing and/or maintenance. The content of this role can be developed at a local level dependant on training and work-based experience. Consultation with the AE(D or DE(W) is recommended.

The CP(D) should report directly to an appropriate member of the estates department prior to commencement of work activity, for example, AP(D) and liaise with the DE(W) / AE(D).

The principal responsibilities of the CP9D) are:

a. to carry out the maintenance tasks outlined in Welsh Health Technical Memorandum 01-01 Parts C and D;

b. to carry out additional maintenance and repair work at the request of the user;

c. to conduct the periodic tests specified in Welsh Health Technical Memorandum 01-01 Parts C and D and to prepare reports as required by the user;

d. to conduct any additional tests at the request of the user, AE(D) or De(W).

The CP(D) should:

a. be able to clearly demonstrate adequate technical competence working with decontamination equipment they work with (e.g. activities such as maintenance):

b. have completed an accredited course for CP(D)s and successfully passed the examination;

c. have a certificate demonstrating satisfactory completion of an accredited course in the validation and periodic testing of at least two decontamination processes/machine types;

d. have at least three year's experience in the validation and periodic testing of porous-load sterilisers and at least one other decontamination process/machine type.

e. Received appropriate training from equipment manufacturers on how to carry out maintenance/service tasks.

f. If the CP(D) does not undertake duties for a prolonged period, the need for refresher training may need to be implemented.

g. External CP(D)'s must work in accordance with the CVUHB Control of Contractors policy, for engineers working on premises

9.9 Infection Prevention and Control Lead

The Lead for Infection Prevention and Control is defined as a person designated by Management to be responsible for advising the user on all infection control aspects.

9.10 Microbiologist

The Microbiologist (Decontamination) is defined as a person designated by Management to be responsible for advising the user on microbiological aspects of disinfecting and sterilising non-medicinal products. He/she should also be defined as the person responsible for advising the user on

the microbiological aspects of handling. washing, disinfecting and sterilising used medical devices.

The Microbiologist (Decontamination) should be suitably qualified and nominated by the healthcare organisation.

The principal responsibilities of the Microbiologist (Decontamination) are:

a. To advise the user on the microbiological aspects of decontamination procedures for non-medicinal products;

b. to audit the documentation from all decontamination equipment that has been tested by microbiological methods.

9.11 Operator

The operator is defined as any person with the authority to operate decontamination equipment, including the noting of instrument readings and simple housekeeping duties.

Operators should have their tasks defined in their job description. Operators should also have documented training records to demonstrate that they are competent to undertake their assigned tasks and receive refresher training as and when required.

9.12 Manufacturer

The manufacturer is defined as a person or organisation responsible for the manufacture of a washer-disinfector or steriliser. The manufacturer should ensure that the decontamination equipment if designed, manufactured and tested with a quality system. The manufacturer should also carry out pre-delivery works testing. The extent of testing will depend on whether the product is in serial production or a one-off and, for machines in serial production, whether the manufacturer has obtained a certificate of compliance with the relevant British or European Standards by means of a type test for the particular type and size of decontamination equipment. (See BS EN 15883 Parts 1 and 2 for type-test details for washer disinfectors and BS EN 285 for type-test details for sterilisers).

9.13 Contractor

The contractor (or supplier) is defined as a person or organisation designated by management to be responsible for the supply and installation of the washer-disinfector or steriliser, and for the conduct of the installation checks and tests. The contractor (or supplier) may also be the manufacturer of the machine.

9.14 Purchaser

The purchaser is defined as the person or organisation that orders the washer disinfector or steriliser and is responsible for paying for it.

9.15 Competent Person (Pressure Systems)

The competent person as defined in the Pressure-System Regulations (latest -edition) is not the same person as the Competent Person (Decontamination) defined in the WHTM 01-01. The former is an engineer responsible for drawing up a written scheme of examination for the system. The latter is the person who carries out maintenance, validation and periodic testing of washer-disinfectors and sterilisers.

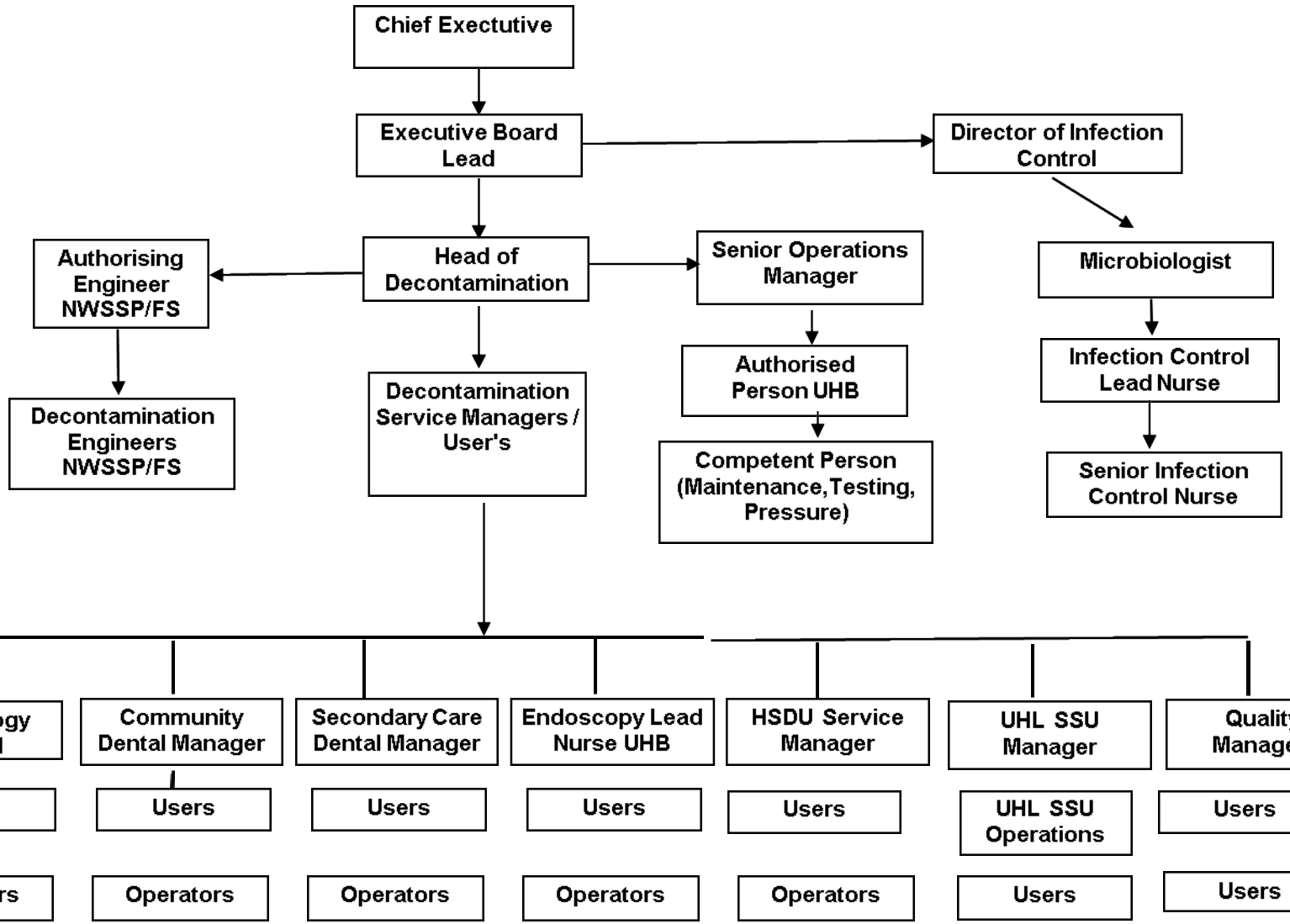
Most insurance companies maintain a technical division able to advise on appointing a CP(PS). The AE(D) should also be able to provide advice.

9.16 Management Structure for the Management of Decontamination at Cardiff and Vale UHB.

Fig 5 confirms the Decontamination Management Structure for Cardiff and Vale. Details of named individuals in the positions identified can be sought from the Head of Decontamination. This structure identifies all positions in line of the requirements of WHTM 01-01 Part A and WHTM 01-05:

Fig 5

Cardiff and Vale UHB Decontamination Management Structure



10.0 Decontamination Training

Decontamination is a science in its own right. Staff undertaking decontamination must be competent and properly trained. Individual training records, detailing the individual's core competencies and any other training, should be maintained and updated regularly. Line managers are responsible for maintaining these records. In the primary care setting, whoever owns or manages the practice is responsible for ensuring that systems are in place for ongoing staff training.

Within the UHB each department has robust training systems in place to ensure all Operators are appropriately trained to perform the act in hand and use decontamination correctly and safely.

Accredited courses are sourced dependant on the departments through appropriate providers such as Eastwood Park or the Institute of Decontamination Sciences. In addition, other providers include internal training courses, mandatory training and specialist training courses through the approved body.

11.0 Permit-to-Work System

To manage decontamination equipment that is required to be taken out of action for service, validation or repair. WHTM 01-01 Part A recommend the use of a robust permit to work system.

The permit to work system reduces the possibility of process failure as a result of the following issues:

- Failure to undertake work activities in a safe manner during validation and maintenance;
- Accidental reconfiguration of the validated process;
- Failure to comply with the work permit system;
- Accidents associated with engineers working within the facility;
- Communication failure associated with engineering activities;

The following process should be completed when managing the permit to work system in line with WHTM 01-01 Part a:

The user should sign the permit to allow the equipment to be taken out of use for routine testing, repair and maintenance by the relevant CP(D).

The CP(D) should sign the permit to allow the equipment back into use after routine maintenance and weekly testing. The user should sign the permit to allow the equipment back into use.

As part of the accountability, three copies of the permit should be produced. The user, the CP(D) and the AP(D) should all retain copies for their records.

Permit to work's should be implemented for any activity which can compromise the safety and configuration of the decontamination equipment, to include maintenance, breakdown, repair, validation and/or software upgrades.

After repairs following a breakdown and after quarterly testing, both AP(D) and the CP(D) should sign the permit to allow the equipment back into use. The DE(W) from NWSSP-SES and the user should sign the permit following the annual testing. The CP(D) carrying out the work should also sign the permit. In the event of work spanning a number of shifts or days, the signatures of all the CP(D)s involved should show continuity.

The AE(D) or the DE(W) under authorised delegation, should sign the initial permit to use the equipment after installation and validation testing (or revalidation testing for existing equipment that has been reinstalled). The user should sign the permit to accept the equipment into use.

The AE(D) should formally audit the permit system records with the AP(D) at periodic intervals.

Fig 6 is the Permit to work template used within the UHB:

DECONTAMINATION EQUIPMENT – PERMIT TO WORK – in accordance with WHTM01-01 Part A

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

Hospital / Trust - _____ Permit No 01/ 4051

The purpose of this permit is to ensure that other than weekly testing no maintenance or other testing is carried out on decontamination equipment without the approval of the Authorised Person – Decontamination.

Part 1 AP (D): Description of work and authorisation / permission to proceed:

Location / Department of decontamination equipment _____

Manufacturer _____ Asset No _____

Serial No _____ Model No _____

The Following work is to be carried out:

_____

_____

_____

The work will take place between _____ hours on ___/___/___ and _____ hours on ___/___/____

NO OTHER WORK WILL BE CARRIED OUT UNDER THIS PERMIT

User Permission (to be completed by Authorised User / Department Manager / Person in charge)
I hereby give permission for the above equipment to be taken out of use and the above described work can be carried out.
It has not been possible to guarantee that the decontamination equipment is free of contaminants.

Name _____ Signature _____

Date _____ Time _____

Position _____

Authorised Person

I hereby give permission for the work as described to proceed

AP (D) – Name (Print) _____ Sign _____ Date _____ Time _____

Part 2 CP (D): Acceptance of work and conditions

I accept responsibility for the work as described
No other work will be carried out by me or persons working under my control
I am **fully conversant** with the work described and relevant health and safety requirements

CP (D) – Name (Print) _____ Sign _____ Date _____ Time _____

Part 3 CP (D): Detail of work carried out

Work Performed	*(Tick appropriate box)*
Breakdown maintenance / Repair	
Routine Servicing / maintenance	
Quarterly Periodic Testing	
Yearly Periodic Testing	
Installation / PQ/PRQ	

Explanation of work carried out _____

_____

_____

_____

The work on the above decontamination equipment has been *completed / suspended**
The decontamination equipment *may / may not* be returned to service*

**Delete as applicable*

Appropriate tests have been carried out to verify the performance of the equipment in accordance with WHTM. (See Equipment logbook for further details)

CP (D) – Name (Print) _____ Sign _____ Date _____ Time _____

Part 4 AP (D): Authorisation to use Decontamination Equipment

The Decontamination Equipment may be taken into use*
The Decontamination Equipment may not be taken into use, as further work under new permit is now necessary*

**Delete as applicable*

AP (D) – Name (Print) _____ Sign _____ Date _____ Time _____

Part 5 – Acceptance of Decontamination Equipment Status by Authorised User / Department Manager / Person in charge

I declare that all aspect of the work has been explained to me. I hereby accept the decontamination Equipment back into service*

I understand that further work is required and will ensure that the Decontamination Equipment will remain out of use*
**Delete as applicable*

Name _____ Signature _____

Date _____ Time _____

Position _____

Original (White) copy to be retained in book by Authorised Person (D) – Pink copy to Department Manager – Yellow copy to Competent Person (D)

Fig 6

23.0 Reporting of Incidents

All incidents involving decontamination equipment or decontamination processes must be reported following the UHB's incident reporting procedures contained in the UHB's "Risk Management Policy". All incidents must be reported using the RLDatix system within the UHB by the relevant operators and discussed at the UHB Decontamination Group.

Where necessary these incidents may also be subject to the reporting requirements established by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR) and be escalated to the local office of the Health & Safety Executive (HSE). Serious incident requires a full investigation and discussion at a Serious Untoward Incident meeting arranged through the UHB Health and safety Team.

The user / Responsible Person within the Organisation should notify the HSE immediately, normally by telephone, if any of the following occur:

a. Any fatal injuries to employees or other people in an accident connected with the operation of an item of decontamination equipment;

b. Any major injuries to employees or other people in an accident connected with the operation of the steriliser;

c. Any of the dangerous occur

Management responsible within the healthcare organisation should send a written report to the HSE in Wales within seven days of an incident including:

a. Any of the notifiable incidents listed above;

b. Any other injury to an employee which results in their absence from work or being unable to do their normal work for more than three days;

c. Any of the cases of ill-health listed in the Regulations.

A record should be kept of any injury, occurrence or case of disease requiring a report. This should include the date, time and place, personal details of those involved and a brief description of the nature of the event.

Examples of dangerous occurrences applicable to sterilisers include:

a. The explosion, collapse or bursting of any closed vessel;
b. Electrical short-circuit or overload causing fire or explosion;

c. Any explosion or fire resulting in the suspension of normal work for more than 24 hours;

d. An uncontrolled or accidental release or escape of any pathogens or substance from any apparatus or equipment;

e. Any incident where breathing apparatus malfunctions in such a way as to deprive the wearer of oxygen.

Examples of reportable diseases applicable t sterilisers include:

a. Poisoning by steriliant;

b. Any illness caused by a pathogen;

Full details can be found in the HSE guidance: A guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.

Incidents and dangerous occurrences that are reported to the HSE should also be reported either to the MHRA or to the Welsh Government, as appropriate, by telephone as soon as possible and by the latest during the first working day after the incident and then followed by a written report.

13.0 Risk Management

The UHB have an over arching decontamination risk register. This identifies any risks currently being held in the UHB with a risk rating of 15 or above.

In addition to the risk register each directorate captures any decontamination risks of 10 -15 within the Directorate Risk Register.

Any department that is active in performing decontamination processes or managing equipment, is required to risk assess the

activities and if scoring 0-10 captured on the departments risk register.

Any member of staff or management completing risk assessments, must have completed the UHB Risk Management Training and Risk Assessments must be generated using the risk assessment templates found in the UHB Risk Management Policy.

The HSDU, DSDU and SSU Departments that are accredited to ISO 13485, in addition must carry out risk analysis in line with ISO 14971:2019 to identify hazards and estimate risk.

FIG 7 shows the scoring system and management tool used in the UHB:

5.0 Risk Analysis Evaluation

Key:

- C= Consequence
  1 – Negligible
  2 – Minor
  3 – Moderate
  4 – Major
  5 – Catastrophic
- L = Likelihood
  1 – Rare
  2 – Unlikely
  3 – Possible
  4 – Likely
  5 – Almost Certain
- Risk =Consequence x Likelihood

Risk Scoring = Consequence x Likelihood (C x L)

Consequence Score	Likelihood Score				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 - Catastrophic	5	10	15	20	25
4 - Major	4	8	12	16	20
3 - Moderate	3	6	9	12	15
2 - Minor	2	4	6	8	10
1 - Negligible	1	2	3	4	5

1 - 3 = Low Risk	**Quick, easy measures implemented immediately and further action planned for when resources permit**
4 -10 = Moderate Risk	**Actions implemented as soon as possible but no later than a year**
12 -16 = High Risk	**Actions implemented as soon as possible but no later than six months**
20 - 25 = Extreme Risk	**Requires urgent action. The UHB Board is made aware and it implements immediate corrective action**

Red = Extreme Risk
Unacceptable if it is within the scope of responsibility of HSDU. If the risk is outside the scope of responsibility of the HSDU then the users are notified of the risks. A copy is also sent to the Corporate Risk Department.

Orange = High risk
Unacceptable if it is within the scope of responsibility of HSDU. If the risk is outside the scope of responsibility of the HSDU then the users are notified of the risks. A copy is also sent to the Corporate Risk Department.

Yellow = Moderate Risk
Acceptable but risk reduction methods need to be addressed

Green = Low Risk
Risk reduction methods need to be addressed where possible

14.0 Control of Substances Hazardous to Health

Hazardous substances include:

-substances used directly in work activities (e.g. cleaning agents)
-substances generated during work activities (e.g. fumes from welding)
- biological agents such as bacteria and other micro-organisms.

There are many cleaning agents used across departments actively performing decontamination or managing decontamination equipment. In order to comply with the COSHH Regulations the following eight steps are required:

- Assess the risks
- Decide what precautions are needed
- Prevent or adequately control exposure
- Ensure that control measures are used and maintained
- Monitor exposure
- Carry out appropriate health surveillance
- Prepare plans and procedures to deal with accidents, incidents, evacuation and emergencies
- Ensure that employees are properly informed, trained and supervised

Each decontamination department should designate a COSHH Co-ordinator who shall:

-Identify the substances present in their assigned area
- Ensure the facility has appropriate ventilation in accordance with the Material Safety Data Sheet for each product used within the designated area.
-Obtain a manufacturer's safety data sheet for chemicals purchased by the UHB
-Determine if an appropriate generic assessment is available for the substance (check the activity on the assessment is the same as how it is used in practice)
-If an appropriate generic assessment is not available, complete and submit to the Health and Safety Department a COSHH assessment request form (CARQ) for each identified substance which will consider –

a. How much of the substance is in use or produced?

b. Work practises i.e. how the substance is used

c. Existing control measures e.g. engineering controls such as fume cupboards, personal protective equipment (PPE), environmental monitoring within the room and notification of room status outside of the room.

Each departments COSHH Co-ordinator should develop a COSHH file, which is subject to annual review and includes all Safety Data Sheets for the chemistries in use and the relevant safety data sheets.

15.0 Audit / Quality Assurance

Decontamination audits are vital to ensure practices are in line with standard operating procedures set by the User / Department Leads.

Each department that is active in decontamination should have a robust internal audit schedule, developed in line with the standard operating procedures for decontamination practices. The internal auditors must be appropriately trained to perform the audits, with training courses available through the UHB or Approved Bodies.

In addition to internal audits, the departments that are accredited to ISO 13485 / Med Dev Regulations, must be subject to surveillance, re-certification and unannounced audits by the approved body assigned by the MHRA. These audits are required to ensure certification and compliance to ISO 13485 / Med Dev Regulations.

The UHB Infection Control Department can provide environment, uniform and hand hygiene audits on request from the User / Department Manager.

The AED(Decontamination) carries out regular decontamination, process and equipment audits on behalf of Welsh Government, as outlined in the WHTM 01-01 guidance.

The designated storage areas of sterile packs and trays, must be subject to audits completed by the theatre teams on a six-monthly basis. The provider i.e. sterile service departments should also perform random assurance checks using the same audit tool.

16.0 Procurement

Procurement is an essential function when related to decontamination. Advice must be sought from the User / Managers before any of the following take place:

- Purchase of new equipment
- Loan of equipment
- Changes in decontamination processes for existing equipment
- Methods of decontamination, i.e. decontamination products / wipes / consumables.

The UHB has a medical equipment management group which over-see the capital bids of new equipment being brought into the organisation. Included in the Capital Medical Devices Bidding Form is a section on decontamination which must be completed by the designated manager completing the bid. Each capital bid must be reviewed by the Head of Decontamination, to ensure the organisation has the relevant processes and infra-structure to decontaminate the devices in line with the manufacturer's instructions.

As well as the cost of the equipment, the cost of the decontamination process / equipment should also be assessed and, in some instances, it may be cost effective to opt for single use. However, these should be suitably manufactured and fit for use. When considering the option of single use equipment, the costs associated with its disposal e.g. increased clinical waste, disposal costs, should also be considered.

17.0 Maintenance / Validation

All automated decontamination equipment and ancillary plant servicing, must be used, maintained and validated according to the manufacturers' instructions, regulatory requirements and Welsh Health Technical Memorandum Guidance.

17.1 Validation

Steam steriliser maintenance and validation is governed by WHTM Part C: Steam sterilization and steam for sterilisation and WHTM 01-05 WHTM 01-05 Decontamination in Primary Care Dental Practices and Community Dental Services for bench top autoclaves. The sterilizers require daily test and in addition weekly, quarterly and annual

validation. Fig 8, shows the required periodic tests required for porous-load steam sterilisers:

Fig 8

Table 4 Periodic tests for porous-load sterilizers

Daily test – User
Bowie-Dick test for steam penetration
Weekly tests – CP(D)
1. Weekly safety checks 2. Air leakage test 3. Air detector function test 4. Automatic control test 5. Bowie-Dick test for steam penetration*
Quarterly tests – CP(D)
1. Weekly safety checks 2. Air leakage test 3. Air leakage test (temperature and pressure sensors connected) 4. Automatic control test 5. Verification of calibration of sterilizer instruments* 6. Thermometric test for a small load* 7. Air leakage test (sensors removed) 8. Air detector function test 9. Bowie-Dick test for steam penetration
Yearly and revalidation tests – CP(D)
1. Yearly safety checks 2. Non-condensable gas test 3. Steam superheat test 4. Steam dryness test 5. Steam chemical purity tests 6. Air leakage test 7. Air leakage test (temperature and pressure sensors connected) 8. Automatic control test 9. Verification of calibration of sterilizer instruments* 10. Air detector performance test for a small load 11. Air detector performance test for a full load 12. Thermometric test for a small load 13. Thermometric test for a full load 13a. Load dryness test for a metal load (see BS EN 285) 14. Test for PRQ as required by the user 15. Air leakage test (sensors removed) 16. Air detector function test 17. Bowie-Dick test for steam penetration 18. Hollow load test
At a frequency defined by the manufacturer
1. Dynamic pressure test

* May be carried out simultaneously with the preceding test

Alternative systems to steam for sterilisation are governed by WHTM 01-01 Part E. There currently is no standard for the test methods used on these technologies including hydrogen peroxide, gas plasma and Ethelyn oxide systems. Part E contains recommendations however of tests to be considered, including IQ, OQ, PQ, process challenge devices and reference microorganism challenges to present to the system. Currently the tests are developed by the manufacturer of these systems to ensure

performance monitoring of the systems are in place and working effectively.

Washer disinfectors used within the sterile service department require daily, weekly, quarterly and annual validation. These tests are governed by WHTM 01-01 Part D: Washer-disinfectors. Fig 9 shows the required periodic tests for sterile service washer disinfectors:

Fig 9

Daily tests – User
1. Check spray arm rotation for free movement
2. Check spray nozzles for blockage (paying particular attention to those fitted to carriages for cannulated instruments)
3. Remove and clean strainers and filters, etc.
4. Ensure sufficient additives available and that dosing system is functioning
Weekly tests – User or CP(D)
1. Weekly safety checks
2. Carry out daily tests
3. Water hardness (all process stages)
4. Water conductivity (final rinse stage)
5. Automatic control test
6. Cleaning efficacy test by residual soil detection
Quarterly tests – CP(D)
1. Weekly safety checks
2. Automatic control test
3. Verification of calibration
4. Thermal disinfection test

5. Cleaning efficacy test: – reference load[1] general instruments endoscopic/MAT instruments – test soil
Yearly and revalidation tests – CP(D)
1. Yearly safety checks
2. Automatic control test
3. Verification of calibration of washer-disinfector instruments
4. Water system: – chemical purity – bacterial endotoxins
5. Drainage: – free draining – efficacy of discharge
6. Doors and door interlocks: – Cycle start interlock – In-cycle interlock – Failed cycle interlock
7. Fault indication on sensor failure
8. Water vapour discharge test
9. Chemical additive dosing tests: – reproducibility of volume admitted – low level detection
10. Load carriers
11. Air quality
12. Cleaning efficacy test: – test soil – reference load[1] general instruments endoscopic/MAT instruments
13. Over temperature cut-out test
14. Thermometric test for thermal disinfection – reference load[1]
15. Load dryness test – reference load[1]
16. Process residue test
Notes 1 Additional test loads and alternative test soils may be required for washer-disinfectors that are also intended for use with hollowware and/or anaesthetic accessories. The additional testing should also include tests on the load carriers that will be used with these additional loads. Calibration, limits and function, including fault/alarm, of independent monitoring system should be checked during quarterly and yearly tests.

Table 3 Schedule of periodic tests

Ultrasonic cleaners used within sterile services and dental practices require weekly, quarterly and annual tests, which are governed by WHTM 01-01: Part D Washer Disinfectors. Fig 10 shows the required periodic test required:

Fig 10:

Test	IQ	OQ	PQ	Periodic
Automatic control test	X	X	X	W Q Y
Chamber wall temperature		X	X	Y
Chemical additive(s): low level detection		X	X	
Chemical additive(s): process residue			X	
Chemical: reproducibility		X	X	Y
Cleaning efficacy by residual soil		X	X	W
Cleaning efficacy with test soil		X	X	Q Y
Doors: in-cycle interlock		X	X	Y
Doors: cycle start interlock		X	X	Y
Doors: door-opening force		X	X	Y
Drainage: free drainage		X	X	Y
Fault interlock		X	X	Y
Load carrier temperature test	X	X		
Load carriers				Y
Load dryness test		X	X	Y
Over-temperature cut out test		X	X	Y
Remove and clean strainers or filters				D W
Weekly safety checks		X	X	W Q
Sound pressure test		X	X	Y
Test for ultrasonic activity		X	X	Y
Thermometric test for disinfection		X	X	Y
Verification of calibration	X	X	X	W Q Y
Water: hardness	X			Y
Water: overflow test		X	X	Y
Water supply temperature	X			Y
Volume of water used per stage		X	X	Y
IQ = installation qualification OQ = operational qualification PQ = performance qualification W = weekly Q = quarterly Y = yearly				

Table 4 Schedule of testing for ultrasonic cleaners

Automated endoscope disinfectors used within endoscopy reprocessing departments again require daily, weekly, quarterly and annual validation. These tests are governed by WHTM 01-06 Part D: Decontamination of Flexible Endoscopes Testing Methods. Fig 11 shows the required periodic test for automated endoscope disinfectors:

Fig 11

Table 5 Schedule of periodic tests

Daily tests – User or operator
1. Automatic control test (see paragraph 3.1 in HTM 01-06 Part E)
2. Remove and clean strainers and filters
Weekly tests – User or operator, CP(D) or contractor
1. Weekly safety checks
2. Carry out daily tests
3. Process challenge device cleaning efficacy test*
4. Water hardness (all process stages)
5. Water conductivity (final rinse stage if appropriate)
6. Final rinse-water supply – total viable count

Quarterly tests – CP(D) or contractor
1. Weekly safety checks
2. Weekly tests including automatic control test
3. Verification of calibration
4. Final rinse-water tests:
• appearance
• TOC
• total viable count
• environmental mycobacteria
• electrical conductivity
• water hardness
5. Leak and patency testing:
• leak test
• lumen patency detection test
• lumen disconnection detection test
6. Thermometric tests:
• chamber wall temperature for the self-disinfection cycle (if used)
• temperature during routine cycle
7. Cleaning efficacy test
8. Residual protein detection test
Yearly and revalidation tests – CP(D) or contractor
1. Weekly safety checks
2. All quarterly tests including automatic control test
3. Verification of instruments
4. Final rinse-water system:
• TOC
• total viable count
• environmental mycobacteria
• volume of water used per stage
5. Drainage:
• blocked drain protection
• free draining
• efficacy of discharge through the trap
• estimation of dead volume of pipework
6. Venting system:
• load contamination from ductwork
• droplet emissions
• chemical vapour emission
7. Doors and door interlocks:
• cycle start interlock
• in-cycle interlock
• double-ended EWDs

• on sensor failure
• door opening force
• failed cycle interlock
• fault indication on sensor failure
8. Chemical dosing:
• reproducibility of volume admitted
• indication of insufficient chemical additives
9. Load carriers
10. Chamber wall temperature for the self-disinfection cycle
11. Load carrier temperature during self-decontamination
12. Over-temperature cut-out test
13. Temperature during routine cycle
14. Verification of calibration
15. Air quality
16. Sound pressure
Note * The use of a process challenge device, as listed in the weekly tests, is recommended to balance the overall testing of routine performance of both the cleaning procedures/washing machines and the consistent washing performance against the verification of the process. Process challenge devices are available to prove that the wash process is operating at the optimum performance as set up and reported by validation testing. Some devices can be used both for the cleaning efficacy test with the relevant test pieces and with a restricted device to impede the water flows under the tests.

Validation of High-Level Disinfectors is governed by WHTM 01-06 Part F. Weekly, quarterly and annual validations as prescribed by the manufacturer must be performed on a periodic basis.

17.2 Servicing

The servicing requirements of decontamination equipment is set out by the manufacturer of the device. The frequency can vary dependant on the type of equipment, from quarterly, six monthly or annual. When the decontamination equipment is being serviced, it is paramount that all routine replacement parts are replaced and authorised service kits are used for the service.

17.3 Test Schedule

All departments that manage the validation, servicing and breakdown call outs of decontamination, must develop a test schedule to track the frequency and completion of the works performed. The test schedule must be reviewed on a regular basis to ensure works are carried out at the appropriate times. If department carry out a management review meeting, the test schedule should be on the agenda of those meetings for review.

17.4 Water Testing

Sterile Services

A continuous supply of water of the specified chemical and microbial quality is essential to the correct functioning of all washer disinfectors, including endoscope disinfectors.

Water that is too hard or has too high a concentration of dissolved solids can impair the activity of detergents, or require the use of increased quantities of chemical additives, and cause deposits, scaling or corrosion of the washer / disinfector.

Water containing high numbers of micro-organisms may re-contaminate disinfected items.

The water quality requirements for sterile service washers, is set out by WHTM 01-01 Part D: Washer-disinfectors. Fig 12 shows the requirements for water quality, final rinse and process water:

Fig 12:

Parameter	Guidance on recommended values	Note
pH	5.5 to 8	Same
Conductivity uS/cm	300	Conductivity is a simple test that can be carried out regularly and can be helpful in identifying unusual trends. Unexpected results indicate that other parameters should be investigated.
Hardness CaCO3(mg/L)	<210	To be assessed locally both through test results and visual assessment of washer-disinfector chamber/devices reprocessed.
Chloride mg/L	50	
TVC cfu/100 ml	5000	Level determined as a result of terminal sterilization process undergone by these instruments reprocessed within the washer-disinfector's.
Endotoxin Units EU/device	<20 EU	Limit based upon risk to patient safety of endotoxins on device rather than in rinse water.

Table 5 Requirements for water quality: final rinse and process water
(See Appendix 1 for additional tests that may be necessary in certain circumstances)

Endoscopy

The final rinse water quality in endoscopy is more critical than sterile services as there is no terminal kill process during a standard endoscopy decontamination processes (not scopes for sterilisation). The final rinse water quality requirements for endoscopy are governed by WHTM 01-06 Part D. Fig 13 sets out the periodic final rinse water tests required:

Fig 13:

4 Water system:
- appearance
- pH
- final rinse-water conductivity (if pure water used)
- total viable count
- volume of water used per stage
- TOC (Nc)
- environmental mycobacteria

Table 2 Total viable count results guide

Aerobic colony count in 100 mL	Interpretation/action	Colour grade
Less than 1	Satisfactory	Green
1–9 on a regular basis	Acceptable – indicates that bacterial numbers are under a reasonable level of control	Yellow
10–100	Risk assessment required to investigate potential problems and super-chlorinate or repeat EWD self-disinfect	Orange
Over 100	Risk assessment required to consider taking EWD out of service until water quality improved	Red

Notes:

Microbiological results from weekly tests should be plotted on a graph to give a trend. This will allow the "normal" and "unusual" results to be distinguished for a particular situation. Investigation of unusual or unsatisfactory results can then be undertaken if results demand (for example, if routine results are below 10 cfu/100 mL, occasionally some of the results may be above 10 cfu/100 mL).

If a bacterial count above 10 cfu/100 mL is obtained from test water, identification of the species is advised. If a significant proportion of the microbes appear the same species from their colonial morphology, carry out an oxidase test to presumptively identify *Pseudomonas* spp. Then if the test is positive, further investigations are required to determine whether *Pseudomonas aeruginosa* is present.

Adapted from: Willis, C. (2006). "Bacteria-free endoscopy rinse water – a realistic aim?" *Epidemiology and Infection*. Vol. 134 No. 2, pp. 279–284.

18.0 The Built Environment

The design and requirements for sterile service departments is set out and governed by *HBN 13 Sterile Services Department – NHS Estates.*

HBN 13 provides guidance to help health planners, estates and facilities managers, sterile services managers and capital planning and design teams to plan and design a sterile services department. In particular the *HBN* focuses on:

- Raising standards in decontamination services by optimising the built environment.
- Service Requirements strategy.
- Calculating the optimum capacity of an SSD to eradicate bottlenecks.
- Determining the most appropriate location of and SSD.

For guidance on design and requirement's for endoscopy decontamination facilities, *WHTM 01-06 Decontamination of Flexible Endoscopes Part A: Policy and Management.*

19.0 Storage

The sterile storage areas are traditionally managed by the theatre users; however, governance and responsibility of the areas remains under the remit of the decontamination service provider. The provider should perform regular surveillance audits of the areas, ensuring storage conditions are optimised for the sterile products.

The sterile storage areas should be controlled with restricted access and environmentally controlled with temperature and humidity control the optimum storage conditions for sterile products, are between 18°C – 25°C and between 40%-60% humidity, the temperature and humidity should be monitored continuously and a daily recording chart should be completed.

The shelving and capacity of the storage area is critical to maintain the integrity of the sterile product. The shelving should be able to accommodate all sterile trays / consumables, with a maximum stacking of 2 high on tray sets dependant on weights of the trays. Sterile and non-sterile products should be segregated in the area and clean and dirty segregation is paramount.

There should be no direct sunlight into the storage area, as this can affect the integrity of the product.

The storage area must have a daily / weekly cleaning schedule and periodically the shelving should be emptied of its contents and wipe down with multi-purpose wipes.

20.0 Transportation

All used medical devices represent a risk of cross-contamination, which may lead to infection. To minimise this risk, any device that needs to be transported for decontamination to take place, must be placed in closed, secure containers (identified as clean and dirty) and transported to the decontamination area as soon as possible following use. All relevant documentation should be fully completed and be transported with the device. These should be kept in the relevant departments and be easily accessible.

To protect the device and handler, transport containers must be:

- Leak proof
- Easy to clean
- Rigid
- Capable of being securely closed
- Labelled to identify the user and contents

- Robust enough to protect the device in transit

Transport containers must be easily identifiable as carrying clean or dirty items I.e. green or red liners for Endoscopes and clean and dirty signs on surgical instrument trolleys / containers
-Subject to a regular cleaning schedule.

Transport containers must be decontaminated with an approved product following use and before subsequent reuse. The cleaning procedure performed must be documented on an appropriate cleaning schedule document.

Staff handling contaminated equipment must wear appropriate PPE in accordance with relevant IPC Policy and be up to date with any vaccinations required for their role e.g. Hepatitis B.

Transportation of medical devices must be in accordance with *"The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009".* Members of staff are not permitted to transport medical devices in their own vehicles.

All medical devices that are decontaminated locally must be decontaminated prior to transportation between wards and departments. This is the case also when requesting maintenance from the estates / clinical engineering departments or third-party contractor / provider.

A decontamination certificate must be completed and accompany each piece of equipment if transferred between wards/departments or when requesting maintenance.

21.0 Business Continuity Plans (BCP)

Service delivery of the sterile service departments in the UHB is essential to ensure surgical activity is sustained and operations are unaffected by the unavailability of surgical instruments and medical devices. The aim of the BCP is to ensure service delivery is maintained and patient cancellations are minimised.

The BCP will come into operation should there be nay equipment failures, major works / installations in the department and in extreme circumstances the whole department being taken out of commission.

The plan aims to:

- Assist Sterile Services to continue services and assist recovery in the event of a disruption.
- Maintain service delivery to the customers of the sterile service departments.
- Categorise the level of escalation required dependant on the type of failure
- Identify department contacts should escalation be required
- Confirm required actions to manage the type of failure

The level of failures is dependent on the percentage lose of services requirements. Fig 14 identifies this:

Priority		Definition
Red	Level 3 Failure losing 100% of service requirements	Critical service needing to be restored within 0-1 hour (Cepod, Major Trauma, Maternity Services). Full capacity to be restored within 5 days.
Yellow	Level 2 Failure – Facility losing 50% of service requirements	Essential service needing to be restored within 1-12 hours.
Amber	Level 1 Failure – Facility losing 50% of service requirements	Essential service needing to be restored within12-24 hours
Green	No failures – Normal service provided	No Action

21.1 Plan Activation

The level of escalation will be based on the impact of the failure:

Level One

- Machine failure 1-3 Units
- Supplier stock failure
- Staff sickness

Action:

- Manage In house if possible, contact competent person and APD
- Source alternative suppliers or stock from other health boards
- Source overtime or bank usage in house
- Inform directorate manager of potential service disruption

Level Two

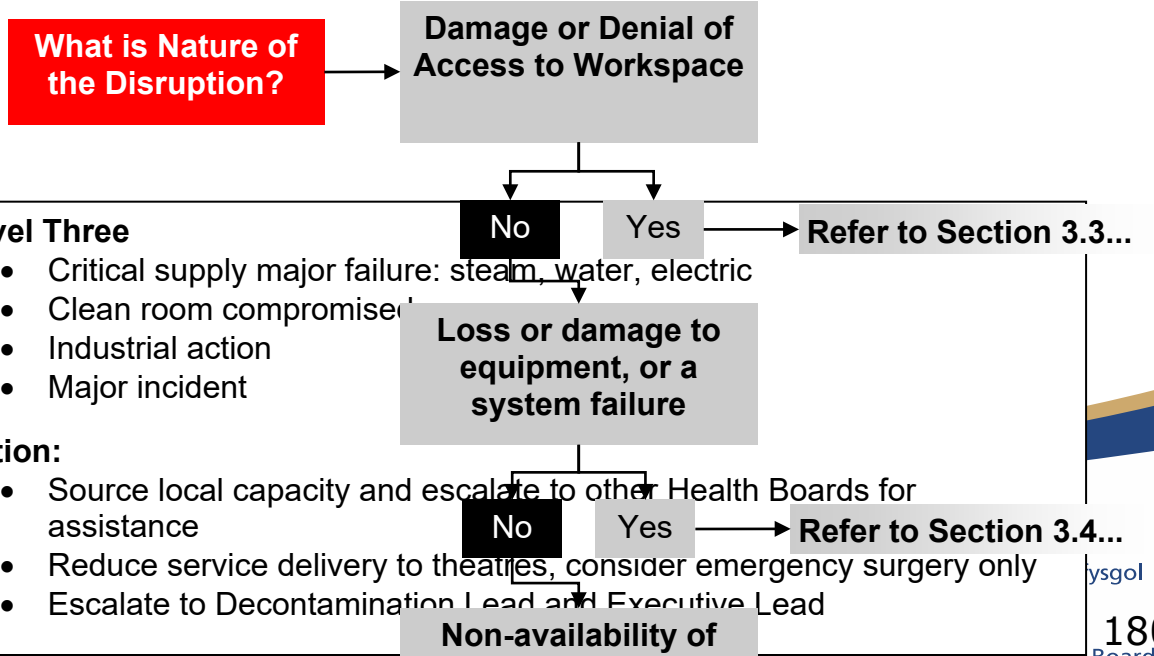
- Machine failure i.e. all washers / sterilisers
- Critical Supplier Stock Failure
- Major staff sickness

Action:

- Source washer / steriliser capacity in UHB Departments, inform competent person
- Consider temporary implementation of alternative supplier i.e. wrap / chemistry
- Source agency staff, request staff support from other UHB Departments
- Escalate to Directorate Manager and Decontamination Lead, reduce service

21.2

Process



Level Three

- Critical supply major failure: steam, water, electric
- Clean room compromised
- Industrial action
- Major incident

Action:

- Source local capacity and escalate to other Health Boards for assistance
- Reduce service delivery to theatres, consider emergency surgery only
- Escalate to Decontamination Lead and Executive Lead

22.0 Decontamination of Semi-Critical Ultrasound Probes; Semi-invasive and Non-invasive Ultrasound Probes

The decontamination of semi-critical ultrasound probes, both semi-invasive (SIUPs) and non-invasive, is governed by *WHTM 01-06 Part F.*

SIUPs cover:

- Transoesophageal Echocardiography (TOE).
- Transvaginal (TV)
- Transrectal (TR) Ultrasound Probes

Non-invasive probes used on broken skin include:

- For vascular access
- Cannulation
- Wound assessment

Vascular access includes:

- Venepuncture/cannulation
- Fine needle aspirations/guided biopsy
- Drainage procedures
- Wound cavity assessments

Ultrasound probes are increasingly becoming a cornerstone in the diagnosis and treatment of patients in healthcare settings. Despite the beneficial impact on patient care, infection control concerns exist over the use of probes and their role as a vector for pathogen transmission. Under the Spaulding Classification Ultrasound Probes that come into contact with broken skin or intact mucous membrane are considered semi-critical devices and should undergo manual cleaning followed by High Level Disinfection (HLD) between each patient use. This decontamination process significantly reduces microbial contamination (i.e. mycobacteria, fungi, viruses and bacteria) and renders if safe for reuse, although small numbers of bacteria spores may still be present.

Cleaning and Disinfection

Cleaning is essential and the most important step in the reprocessing life cycle. UK guidelines mandate the manual cleaning of visible soil from the device, to include probe and cable.

The preferred method of cleaning is using an immersion method within dedicated wash/rinse sinks, using cleaning agents designed for purpose and concentrated to validated

levels. However, it is acknowledged that immersion methods are not always possible with Ultrasound probes, so secondary systems must be confirmed.

The removal of visible soil from probe and cable as per the Instructions for Use (IFU) is an essential pre-requisite prior to further decontamination stage and the activity must be, followed by a robust visual inspection of cleanliness prior to disinfection or sterilisation.

Removal of chemical residues form the probes is essential after the cleaning phase, prior to HLD, remaining chemical residues may interact with the probe material causing damage and also may interact with any subsequent high-level disinfection process. Rinsing maybe necessary where pre-clean wipe compatibility is not confirmed with device or HLD process.

HLD using the manual multi-wipe system is the least preferred option for disinfecting Semi-critical Ultrasound Probes. Internationally it is recognised that the use of an automated validated process for decontaminating SIUPs will provide enhanced risk reduction of infection transmission.

Where manual cleaning systems are used in isolation and are not followed by an automated/validated procedure., it is essential that all activities are documented, can be traced and operators who complete tasks are trained and competency assessed routinely by appropriate personnel. Systems should also be audited routinely by the organisations Decontamination Lead or IPC representative.

Medical devices must always be compatible with all detergents and decontamination methods that are used. Compatibility statements from suppliers of probe manufacturer and wipe manufacturer must be confirmed in writing prior to use for decontamination activities.

When choosing a wipe for pre-cleaning/disinfection of a probe following removal of the probe cover, User's must consider the following:

- Choose an appropriate wipe or a pH neutral detergent wipe for pre-cleaning the probe

- The chosen wipe should be recommended & approved by the probe manufacturer s being compatible with the ultrasound probe; review Instructions for Use (IFU).

The IFU of the chosen wipe should be consulted to determine:

- Chosen wipe should be classified under UKCA as a medical device (with a CE mark & accompanying number).
- Chosen wipe should not contain any type of alcohol
- Do not use wipes where the IFU states “do not mix with other chemicals”, this indicates the chemistry may not be compatible with other HLD chemistries

The recommended steps for probe reprocessing are:

- Patient Use
- Bedside Clean (If delays are presented prior to return transport)
- Transport
- Cleaning
- Rinsing (Where compatibility uncertainties remain)
- Drying (Essential where moisture would interact with subsequent processes)
- High Level Disinfection
- Transport / Storage
- Preparation for Use (Gel selection / cover)
- Patient Use

Fig 15 – Decontamination Life Cycle Diagram – Semi Critical Probes (No Sterilization)

The information in each of these steps need to be linked through formal traceability systems and responsibilities at each stage must be confirmed.

Device inspection should be taken when cleaning probes, paying extra attention to indentations or complex surfaces. The probe IFU should always be consulted for cleaning instructions and lists of compatible products. Typical cleaning solutions indicated for use with ultrasound probes include detergent – based cleaning wipes, combined cleaning and disinfection wipes or appropriate liquid detergents diluted as per instructions.

Types of HLD methods available:

Compatible Ultraviolet Light Systems

Semi-critical Ultrasound Probe (Semi-invasive and Non-invasive) High Level Decontamination Procedure

Confirmation of compatibility from ultrasound device manufacturers must always be sought prior to utilization of such UV light HLD systems. Where such systems are used there must be a robust validation procedure to determine optimal values of equipment performance and performance qualification tests to determine whether the efficacy of the installed equipment achieves HLD, with no shadowing present.

In Cardiff and Vale UHB, this technology is adopted for high level disinfection of TOE Probes within the cardiology department.

Using Hydrogen Peroxide Systems:

Semi-critical Ultrasound Probe (Semi-invasive and Non-invasive) High Level Decontamination Procedure

Confirmation of compatibility from ultrasound device manufacturers must always be sought prior to utilization of such HLD systems.

Hydrogen Peroxide Systems are used for the majority of semi-invasive systems across the UHB in areas performing ultrasound procedures.

Using Manual Multi-wipes:

Semi-critical Ultrasound Probe (Semi-invasive and Non-invasive) High Level Decontamination Procedure. This is the least preferred option for decontaminating SIUP's as the process cannot be validated and is subject to operator variation and process drift over time, not least when there are clinical pressures within a department.

Confirmation of compatibility from ultrasound device manufacturers must always be sought prior to utilization of individual manual multistage wiping systems.

Additionally, there must be consideration for alternative systems that have advanced with technology. Evidence of process effectiveness must be determined and agreed prior to acceptance.

Facilities for Ultrasound Decontamination Activities

Best practice identifies that decontamination activities should be performed in a suitable location external to the clinical treatment area. This area should facilitate the separation of clean and dirty activities.

Where decontamination is undertaken in the clinical area, consideration must be given to distance the activity from the patient area.

Fig 16: Example of Single Room Decontamination Area

Example of Single Room Decontamination Area

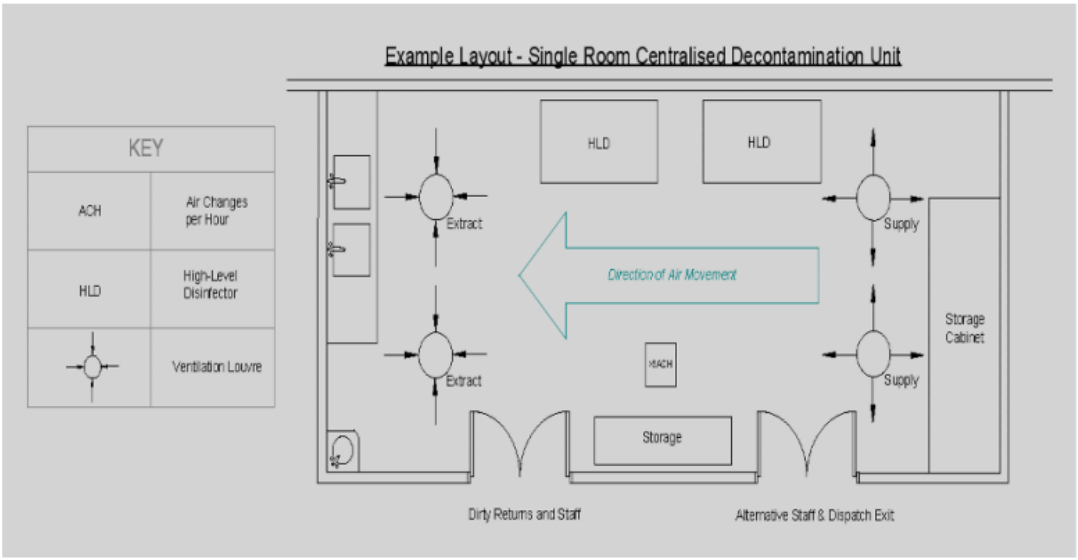
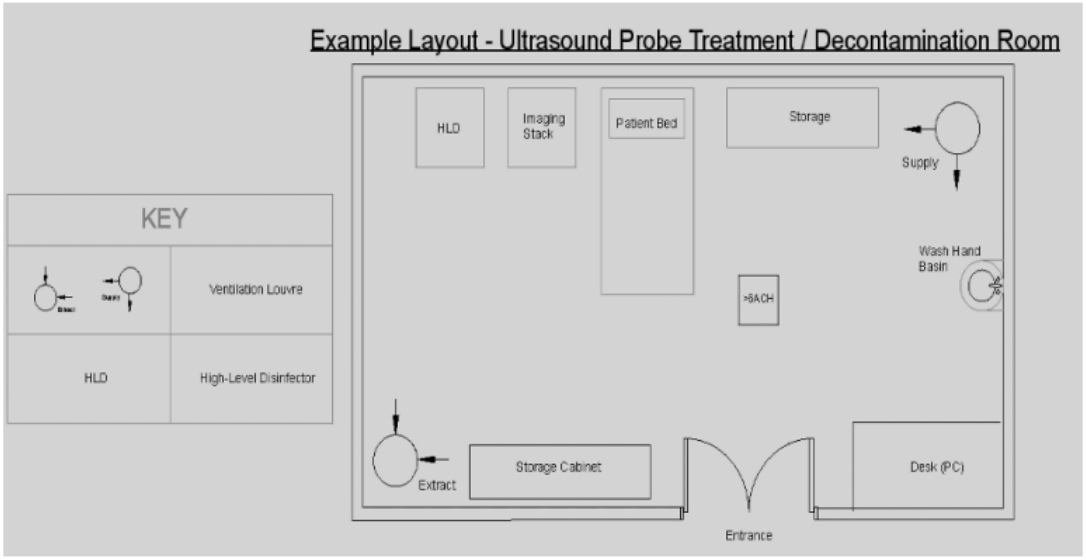


Fig 17: Example of Clinical Room with decontamination activities taking place within.

Example of Clinical Room with decontamination activities taking place within.



Use of a Probe Barrier

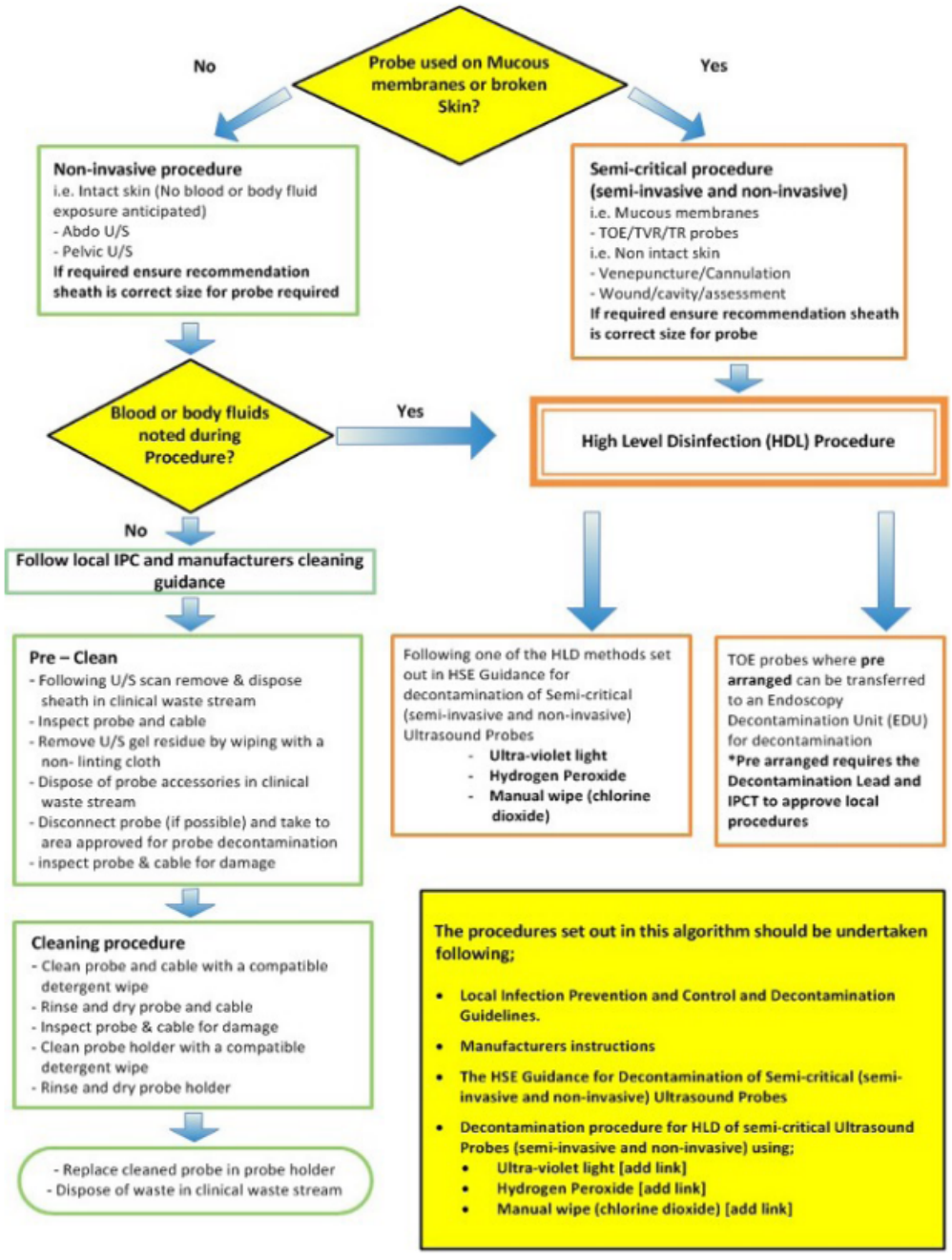
The purpose of probe barriers (sheaths) is to provide an additional layer of protection to prevent gross soiling of the reusable device. Where used, there should be consideration given to periodic bioburden testing as part of quality control, they are usually supplied as unsterile.

Literature evidence and studies are available to demonstrate the high frequency of probe sheath perforation. Use of such barriers does not negate the need for Probes to undergo full decontamination, to include manual cleaning prior and HLD between each patient use.

A sheath, designated for purpose an appropriately certificated in accordance with national standards (UKCA/CE marked) should be used for diagnostic purposes in accordance with manufacturers instructions and should be the correct size for the Probe to be used. The sheath should be visually inspected for damage after use. Where damage is identified it should be recorded in the decontamination records / patients.

Semi-critical Ultrasound Probe (semi-invasive and Non-invasive) Decontamination Algorithm

Decontamination Algorithm (Adopted from NHS Scotland Guidance Document, 2016)



23.0 References and Further reading

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Report Title:	Update of Healthy Eating Standards for Hospital Restaurant and Retail Outlets			Agenda Item no.	3.2
Meeting:	Quality, Safety & Experience Committee	Public	x	Meeting Date:	26/11/2024
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Director of Public Health				
Report Author (Title):	Senior Public Health Practitioner Consultant in Public Health Medicine				
Main Report Background and current situation:					

Background

Being overweight or obese is the leading risk factor for long-term illness and second greatest cause of preventable cancer[1]. The cost to the UK NHS of obesity was £6.1 billion per year in 2020 and continues to rise[2]. People who are overweight or obese are more likely to develop complications when in hospital, requiring additional treatment and bed days at a cost to the Health Board[3]. Obesity is associated with deprivation, with an increasing trend towards obesity in our most deprived communities, as compared to our least deprived communities[4].

In Cardiff and Vale, preventing and reducing obesity is one of the top 3 priorities for preventing ill health and reducing the strain on our NHS services. The *Good Food and Movement Framework*, our local framework to encourage and engage regional partners, including the public sector, aims to improve the availability of good food across public sector sites. Cardiff and Vale UHB are leading the way locally by taking a systems approach to ensuring that our hospital sites present a healthier food environment to staff, patients and visitors through implementing the *Healthy Eating Standards for Hospital Restaurant and Retail outlets (Standards)*, see Appendix A.

Cardiff and Vale University Health Board (UHB) formally adopted the Standards in December 2015. Nationally this work has been used as an exemplar for The *Healthy Weight; Healthy Wales* strategy, where hospitals are viewed as a key setting to alter the way our population is exposed to unhealthy food and drink.

In November 2023, in recognition of the financial challenges in providing a healthy and sustainable restaurant and retail model, the Quality, Safety and Experience Committee approved temporary arrangements for the Standards. The overall compliance requirements were revised downwards to a target of 60% healthier food as opposed to 75%, with the intention to revert back to 75% after 12 months. This applied to all UHB-run restaurant and retail food outlets. Vending provision was required to continue to meet 75% compliance, allowing us the opportunity to find a supplier that could provide a healthier and sustainable offer. It was also agreed that any expression of interest documents informing new tenancies, would contain an expectation on external retail providers to adhere to a 60:40 % split, in favour of healthy choices.

In parallel to this, healthy food environments are also receiving more focus as a national priority. In 2022, the Welsh Government led a consultation on draft regulations to make the healthy choice the easiest choice for Welsh consumers by:

1.Restricting volume price promotions of high fat, salt and sugar (HFSS) products, which can encourage over consumption.

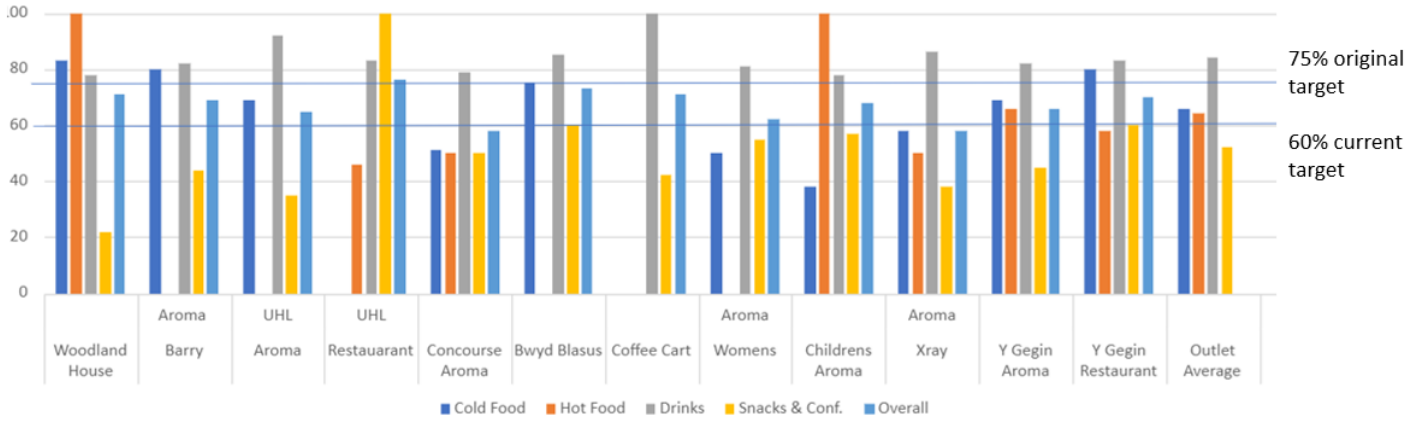
2. Restricting the placement of HFSS food and drink products at key selling locations, which can lead to pester power and impulse purchases of HFSS products.

This was followed by a second consultation in 2024, to gain views on the draft restrictions and plans for enforcement. The restrictions are expected to be finalised in 2025, with implementation planned for 2026. We will prepare for any changes from these consultations and report any relevant feedback via the Nutrition & Catering Steering Group.

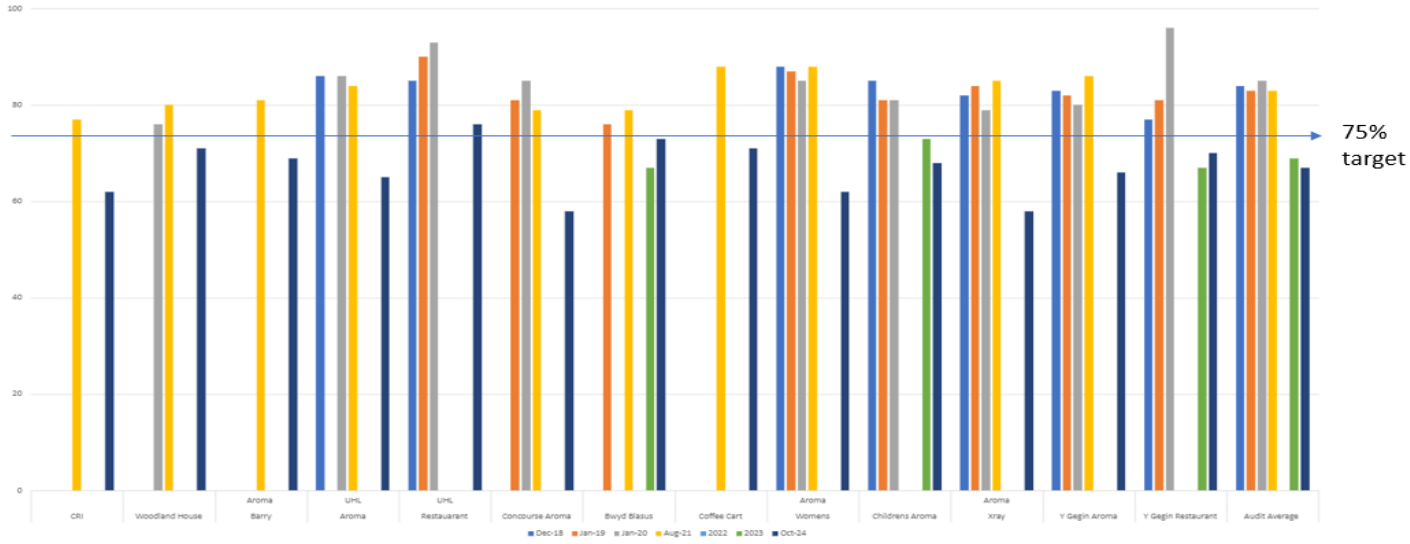
Current Situation

All UHB-run restaurant and retail outlets and external vending provision were audited in October 2024. The average overall compliance for the UHB-run outlets 67%, with a breakdown of compliance for each category: Hot Food 64%, Cold Food 66%, Drinks 84% and Snacks & Confectionaries 52%, shown in graph 1. A Comparison of the data collected from 2018 – 2024 is shown in graph 2.

Graph 1: Average compliance from October 2024 audits, showing all 4 category breakdowns.

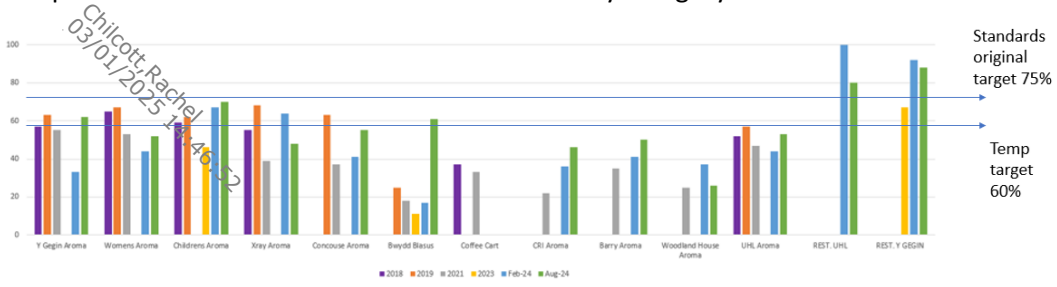


Graph 2: Comparison of overall data from 2018 – 2024



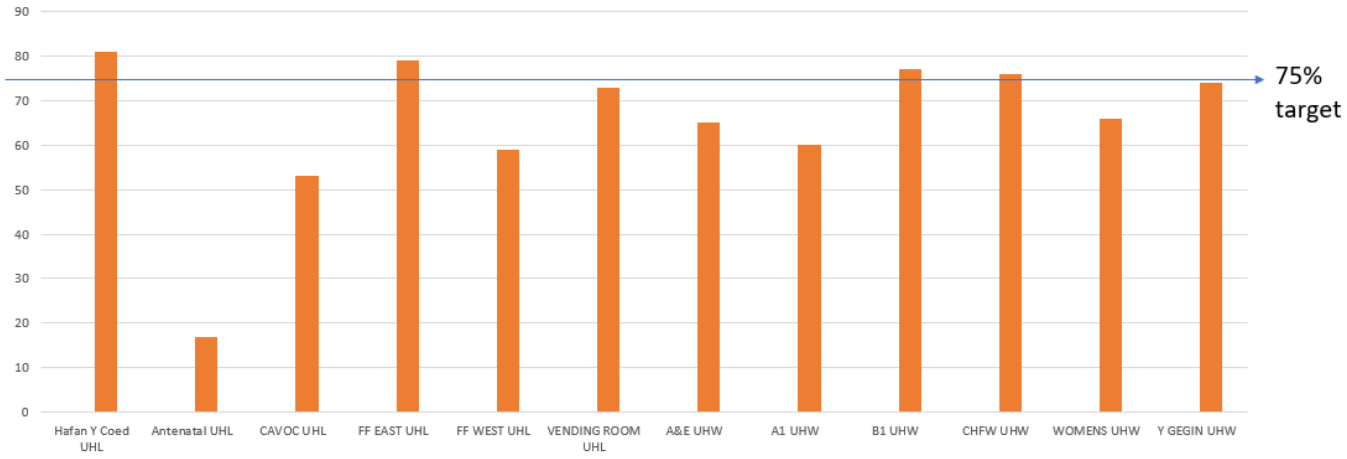
The Standards require that all categories meet the compliance target and snacks and confectionaries have been the most challenging area to achieve this. Graph 3 shows a noticeable improvement in compliance within this category for the majority of outlets, those that scored lower had limited stock available (supply issues etc.) but as they have now streamlined the product range across the outlets, there is a more consistent offer that should be reflected in future audits. The overall offer has improved significantly and this has been closely aligned to interrogation of the sales figures to limit unhealthy options, whilst modelling a financially sustainable outlet. Healthier food and drink options are continually being trialed e.g. introducing a salad bar, fruit pots and yoghurts, whilst reducing the range of cakes and fizzy drinks to best sellers.

Graph 3: Audit results for snacks and confectionary category 2018 - 2024



The breakdown of the vending machine compliance is shown in graph 4. Average compliance was 58%, however half of the machines achieved the 75% target, those with low stock levels scored lower but follow the same product planogram, therefore all offer the range of healthy options we would expect to see. The current provider has worked alongside us to source healthier options and ensure the machines are well stocked.

Graph 4: Vending audits October 2024



Following a sharp drop in sales in 2020/21 due to outlet closures and a change in the products being sold (more 'grab and go' cold food and snacks), the sale of chocolate and fizzy drinks was reintroduced. In 2024, the chocolates were removed from sale and the range of fizzy drinks has been reduced and now offering mostly sugar free options. Sales data from 02/10/23 to 01/10/24 show that soft drinks, cakes, desserts and impulse buys comprise 14.4% of total food and drink sales across UHB sites.

In recognition of the context presented above the Committee is asked to consider 3 options:

Option 1. Maintain the revised 60:40 offer for a further year.
Option 2. Make incremental progress beyond the current position. **This is the preferred option.**
Option 3. Revert back to the original 75:25 Standards immediately.

A full description of the options can be found in Table 1 below.

Table 1: Options appraisal

Option	Rationale	Additional requirements
1.Continue with 60:40% split in favour of healthy options until Nov 2025.	Whilst overall compliance has exceeded 75:25, this has never been fully achieved across the entire range of categories (hot food, cold food, snacks and drinks). This flexibility will allow for a phased approach to reach 75:25 in future but in the meantime emphasis on the area for most concern – snacks and confectionary. The 60:40 target removes disadvantage with expectation on external retail shop providers, as opposed to competing for sales.	All categories must comply Monthly specials to be restricted to festive offers (Christmas/Easter) Quarterly sales reports provided in order to make incremental improvements. Permanent installation of salad/fruit bars at Y Gegin Reduction in range of fizzy drinks to top 3 sellers Outlets/categories already achieving the 75:25 split must continue to work towards this. 60:40 will be applied to the outlets where progress is evident but improvement is required.
2.Work towards 65:35% split in favour of healthy options until Nov 2025.	This will support incremental progress towards increased compliance across the UHB but require commitment from all stakeholders to reduce the sale of unhealthy options	All categories must comply Quarterly sales reports provided in order to make improvements that limit financial impact under current pressures. Outlets/categories already achieve the 75:25 split must continue to work towards this. The 65:35 will be applied to the outlets where progress is evident but improvement is required.
3.Revert back to 75:25% split immediately in favour of healthy options.	Obesity is one of the main public health priority areas for the UHB, with focus on moving resource upstream to invest in prevention to avoid preventable illness and death in the future. A strong commitment to the original agreed Standards supports the intention to provide healthier food for our staff, patients and visitors.	Compliance with original Standards Criteria All outlets and categories to meet 75:25 split and remainder of Standards criteria.

We will continue to monitor and review this arrangement on a quarterly basis and report progress through the Nutrition and Catering Steering Group. A full annual audit will be carried out prior to November 2025 for this Committee.

A digital audit tool has been developed and is now being used to carry out audits and host a database of all products sold at the outlets, allowing more efficient management of the audit process and increased capacity to scrutinise the nutritional content of products and work more closely with suppliers. The Public Health Team are supporting initial discussions with national and local procurement teams to source cost-effective, healthier options, by having wider discussions around any potential new supply contracts.

NB: These standards do not apply to inpatient food provision, which must currently comply with the Welsh Government All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011).

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

1. The Committee can be assured that the Nutrition and Catering Steering Group and stakeholders have a strong commitment to implementing the Standards back to a 75:25 split as soon as practicable.

2. The Nutrition and Catering Steering Group have been advised that the financial position of the organisation and differential in profit from healthy and unhealthy foods mean that the reinstatement of a 75:25 split will need to be staggered over time.

3. A draft version of this paper was circulated and comments received were in favour of option 2 as an intermediate step of a 65:35 split over the next year, with a view to returning to a 75:25 split from November 2025.

Recommendation:

The Committee are requested to:

- APPROVE option 2 (65:35 split) for the next 12 months
- APPROVE the amendments to the Healthy Eating Standards for Hospital Restaurants and Retail Outlets, which reflects Option 2 (Appendix A)
- APPROVE reversion to the 75:25 split in November 2025

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	

Impact Assessment:

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

Risk: Yes

- Depending on the chosen option, there is a potential risk in not returning to our original compliance and the number of unhealthy products on sale will increase.

Safety: No

Financial: Yes	
• There is potential for a financial impact to retail catering from any reduction in sales that occurs with the removal of unhealthy products.	
Workforce: No	
Legal: No	
Reputational: Yes	
• There is a reputational risk if we do not return to a 75:25 split, as we are currently the only Health Board in Wales with these measures in place.	
Socio Economic: Yes	
• If prices continue to increase, it becomes more challenging for staff on lower incomes to be able to purchase a healthy and nutritious meal during their shift.	
Equality and Health: Yes	
If we do not return to a 75:25 split, we will be limiting access to healthy and affordable food for staff during their working day.	
Decarbonisation: Yes	
• Offering healthier choices increases the consumption of fruit and vegetables on site. We will continue to source a wider range of plant-based options and sustainable food and drink containers.	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Nutrition and Catering Steering Group	Circulated for approval November 2024
Quality, Safety & Experience Committee	26th November 2024

References:

[1]Public Health Wales. 2018. *The case for action on obesity in Wales.* Available at: https://phw.nhs.wales/topics/overweight-and-obesity/the-case-for-action-on-obesity-in-wales/. [Accessed: 3 November 2024].

[2] UK Health Security Agency (2017) Health Matters: Obesity and the food environment. Available at: Health Matters: Obesity and the food environment – UK Health Security Agency [Accessed: 3 November 2024]

[3] Public Health Wales. 2018. *The case for action on obesity in Wales.* Available at: https://phw.nhs.wales/topics/overweight-and-obesity/the-case-for-action-on-obesity-in-wales/. [Accessed: 3 November 2024].

[4] StatsWales (2023), Adult lifestyles by area deprivation, Adult lifestyles by area deprivation, 2020-21 onwards (gov.wales), [accessed: 4 November 2024].

[4] Masters, R. et al. (2017) *Return on investment of public health interventions: a systematic review*. *Journal of Epidemiology Community Health*, 71, pp.827-834

Healthy Eating Standards for Hospital Restaurant and Retail Outlets

Date of issue: December 2014
Updated: November 2019, October 2021, September 2023, and November 2024

UHB Steering Group members:

Andrew Poole, Head of Estates & Facilities, Capital, Estates & Facilities

Andrew Pritchard, Deputy Head of Catering, Capital, Estates & Facilities

Vacant post, Environmental Sustainability Improvement Manager, Strategy and Planning

Carl Sealy, Retail Team Manager, Y Gegin, UHW

Chloe Barrell, Public Health Practitioner, Public Health Team

Heidy Arnot, Staff Health Dietitian, Dietetics Services

Helen Griffith, Senior Public Health Practitioner, Public Health Team

Illiass Dadda, Procurement Business Officer, Procurement Services

Jacqueline Prosser, Senior Catering Team Manager

Joanne Jefford, Dietetic Catering Lead & Nutrition & Dietetic Manager, UHL

Lily Prance, Procurement Business Officer

Marie Price, Clinical Lead for Public Health Dietetics, Dietetics Services

Rachel Sanderson, Public Health Practitioner, Public Health Team

Rhian Harvey, Catering Supervisor

Rhianon Urquhart, Principal Public Health Practitioner, Public Health Team

Shona Mulroy, Assistant Retail Manager

CONTENTS

FOREWORD

Cardiff & Vale University Health Board is committed to improving the health and wellbeing of our staff as well as our local population. Cardiff & Vale UHB formally adopted Healthy Eating Standards for Restaurant & Retail Outlets in December 2015 to improve the food offer for staff, visitors and patients attending our hospital sites. The Standards apply to all UHB-run restaurant and retail food outlets, and we audit each outlet to monitor and ensure compliance with the Standards. We are the first Health Board in Wales to adopt this approach, making the healthy choice the easy choice for customers.

We are continuously improving the availability, range and affordability of healthy options offered at our UHB-provided hospital restaurants and cafes in order to make the healthy choice the easy choice. We hope that you will help us make Cardiff and Vale UHB a healthier place to work and take the opportunity to make positive changes to improve your health.

Claire Beynon

Executive Director of Public Heath

BACKGROUND

Being a healthy weight has become one of the most effective ways to reduce the risk of long-term health conditions such as diabetes, heart disease and cancers. However, in our current environment it is difficult to achieve this as our food provision has developed in a way that prioritises convenience over health.

Despite widespread knowledge regarding the benefits of maintaining a healthy balanced diet, increasing urbanisation, a more fast-paced way of life and increased production of processed foods has led to a gradual shift in the dietary habits of the UK population. As a result, individuals are eating less fruit and vegetables, oily fish and dietary fibre, but instead are consuming a greater proportion of energy-rich foods high in fat, salt and sugar [1].

In Cardiff and Vale, only 39% of adults report eating the recommended 5 portions of fruit and vegetables a day, and over half (57%) are overweight or obese[2].

VISION

We are committed to caring for people, taking preventative measures to keep people well and influencing healthier food provision. We have a public duty to act now and ensure the Wellbeing of Future Generations[3] and work hard to be an exemplar in empowering people to make healthier choices.

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[1] World Health Organisation (2020) Healthy Diet. Available at: Healthy diet (who.int)

[2] StatsWales. Adult lifestyle by health board [updated July 2023] Available at: Adult lifestyles by local authority and health board, 2020-21 onwards (gov.wales)

[3] Future Generations Commissioner for Wales. Well-being of Future Generations (Wales) Act 2015. Available at: Well-being of Future Generations (Wales) Act 2015 – The Future Generations Commissioner for Wales

As outlined in the Cardiff and Vale UHB Shaping our Future Wellbeing Strategy[4], our lifestyle behaviours are influenced by the environment in which we live and work and how able we feel to make changes. Cardiff and Vale University Health Board (UHB) is one of the largest NHS organisations in the UK, providing healthcare services for over 490,000 people living in Cardiff and the Vale of Glamorgan. To improve the future health and wellbeing of our population we will create an environment in which individuals have a sense of personal responsibility for their health and are supported to adopt behaviours, which reduce their risk of poor health. Cardiff and Vale UHB has a responsibility to ensure provision of opportunities to access healthy food and drink within the workplace, to positively contribute towards the health and wellbeing of the 16,000 staff it employs, supporting them to be fit and healthy to offer the best service to patients and reduce staff sickness. As well as our staff, we welcome approximately 200,000 patients and visitors per year onto our sites. Supporting staff, patients and visitors to make healthier food and drink choices requires strategic co-ordination and the collaboration of Retail Catering Services, Dietetic Services, Procurement and the Local Public Health Team. A Steering Group was established in 2015 to implement the 'Hospital Restaurants and Retail Catering Outlets Food Standards' and following a review in 2022, renamed the 'Healthy Eating Standards for Hospital Restaurant and Retail Outlets'.

LARGE SCALE CHANGE

Supporting people to change their dietary habits is a gradual process that requires long-term thinking and a shift in the way we procure, sell and prepare food. We recognise this and continue to work collaboratively with our health board colleagues and food industry partners to identify and address changes in the wider system that enable us to make healthier choices more accessible and sustainable. In order to do this, we present a set of Standards that require executive commitment to ensure implementation.

[4] Cardiff and Vale UHB. Shaping Our Future Wellbeing: Cardiff And Vale University Health Board Strategy to 2035. Living Well, Caring Well, Working Together. Available at: SHAPING-OUR-FUTURE-WELLBEING-STRATEGY_FINAL.pdf (shapingourfuturewellbeing.com)

The Standards drive our ambition to normalise a healthy food environment, changing peoples' expectation of restaurant and retail food provision on hospital sites to one that represents and promotes wellbeing. As part of our commitment to the national obesity strategy, Healthy Weight: Healthy Wales[5], we will continue to implement strict criteria that supports people to achieve and maintain a healthy weight.

REQUIREMENTS:

The Standards ensure that staff, visitors and patients are encouraged and supported to eat well, with healthy* options widely available, and a significant reduction in the quantity of energy-dense, high fat, high sugar and high salt food and drink products.

All UHB Restaurant & Café Outlets

Due to the current financial challenges faced by the UHB, it is recommended that the overall compliance be gradually increased requiring a 65:35% split in favour of healthy options. This is for a period of 12 months and will be monitored on a quarterly basis, with a view to returning to the overall compliance of 75% across all UHB-run restaurants and retail outlets, after 12 months.

	A minimum of **65%** of the quantity and range of items available for customers to purchase within each product category must be classed as healthier.
	**Only healthier food and drink items can be promoted**, e.g. at till point, in special offers/meal deals, in window displays and via other promotional activities. Products that are not classed as 'healthier' cannot be promoted.
	A **healthier hot meal must be available for purchase as the cheapest** hot meal option available and promoted as such, for example, the 'deal of the day'.

[5] Welsh Government. Healthy weight strategy: Healthy Weight Healthy Wales. Available at: https://gov.wales/healthy-weight-strategy-healthy-weight-healthy-wales

*Food and drink products are classified 'healthy' in accordance with the Food Standards Agency Traffic light system. See page 10.

	**Whole fresh fruit must be available** for purchase at all meal times, that it is cheaper for the customer to purchase than the majority of confectionary items, and that it is included as an option in all meal deals.
	The **nutritional information of all** products to be **displayed to the customer**, as per the FSA traffic light system[6].
	**Free drinking water is readily available** to all restaurant users and location of drinking water highlighted to customers at till point.
	**Salt must not be provided at tables** – sachets must be available at service counter only.
	**Ensure compliance with the** EU Food Information for Consumers Regulation 1169/2011[7]

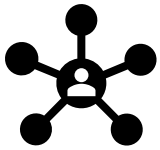
External Retail Provision

In recognition of the current challenges to provide a healthy and sustainable retail model and to attract high quality suppliers, from October 2024 we will be implementing the following criteria for all retail shops:

	A minimum of 55**%** of the quantity and range of items available for customers to purchase, must be available, with a view to increase compliance to 60% within an agreed timescale.

[6] Food Standards Agency. Check the Label Guidance. FSA:2020. Available at:https://www.food.gov.uk/safety-hygiene/check-the-label

[7] European Commission. Food information to consumers – legislation. EC: 2016. Available at: https://ec.europa.eu/food/safety/labelling-and-nutrition/food-information-consumers-legislation_en

	All non-UHB outlets will be required to participate in a network/nominate a 'Champion' to discuss progress and opportunities to improve the healthy retail food environment.
	All vending machines must comply with the 75/25% split in favour of healthy options. Branding must support health promoting messages. All existing and new vending contracts must agree to the above as outlined in contractual agreements.

These standards do not apply to inpatient food provision, which must currently comply with the Welsh Government All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011)[8].

[8] Welsh Government. All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients. WG:2011 [cited 2021 October 07]; Available at: All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011)

COMPLIANCE WITH THE STANDARDS

In order for food and drinks to be classified as healthier and included within the 65% range they must not have high levels of fat, saturated fat and/or sugar as defined by FSA. The audit process will measure compliance within the following categories, see Table 1 below.

Table 1: Criteria for 'healthier' food and drink products by category

Restaurant & Café Outlets	Product Category	Examples	Criteria
	Hot food	Hot meals, cooked puddings, microwavable ready meals, etc.	Must **NOT** be high in fat, saturated fat or sugar as defined in table 2
	Cold food	Sandwiches, salads, cold pasties/sausage rolls, cereals, etc.	
	Snacks and confectionary	Crisps, sweets, nuts/seeds, cereal bars, fresh fruit, fruit pots, cakes, biscuits, ice cream, etc.	Must **NOT** be high in fat, saturated fat or sugar as defined in table 2, unless fat or sugar is naturally occurring in the product.
	Drinks	Hot chocolate, coffee drinks (e.g. lattes, cappuccinos), flavoured water, carbonated drinks, fruit juice/juice drinks, milk-based drinks, etc.	1. Must **NOT** be high in fat, saturated fat **or sugar** 2. Must **NOT** contain **any** 'added sugars', except for the following products provided there is no more than 5% 'added sugars' and the dairy based drinks are based on skimmed, 1% or semi-skimmed milk: - Flavoured milk - Milk based drinks, e.g. iced coffee drinks - Yoghurt drinks - Dairy smoothies 3. **No carbonated drinks are permitted** except: - Carbonated water - Carbonated pure fruit and vegetable juices - Pure fruit and vegetable juices diluted with carbonated water.

Restaurant & Café Outlets	Product Category	Examples	Criteria
Retail outlets / Convenience Store	Groceries	**Chilled/fresh foods:** cheese, spreads, fresh milk, deserts, etc. **Ready meals:** fresh/frozen pre-packaged lasagnes, pizzas, burgers etc. **Perishable foods:** bread, eggs, flour, etc. **Non-perishable foods:** pasta, rice, tinned vegetables, tinned/packet soups, jam, pasta/curry sauce, etc.	Must **NOT** be high in fat, saturated fat or sugar as defined in table 2

MONITORING THE STANDARDS

Products will be audited based on the Food Standards Agency guidance for determining whether products are low (green), medium (amber) or high (red) (table 2)[9].

The information needed is the amount of fat, saturated fat and total sugar per 100g.

If the portion/serving size of the product is more than 100g or 150 ml, you will also need:

- Amounts of fat, saturates, (total) sugars and salt **per portion** (can be calculated using per 100g/ml information and portion size).
- Criteria for red (HIGH), amber (MEDIUM) and green (LOW) as set out below.

Table 2: Criteria for 100g of food

Colour Code	*Low*	*Medium*	*High per 100g*	*High per portion*
Fat	≤ 3.0g/100g	> 3.0g to ≤ 17.5g/100g	> 17.5g/100g	> 21g/portion
Saturates	≤ 1.5g/100g	> 1.5g to ≤5.0g/100g	>5.0g/100g	> 6.0g/portion
Total Sugars	≤ 5.0g/100g	> 5.0g to ≤ 22.5g /100g	> 22.5g/100g	> 27g/portion
Salt	≤ 0.3g/100g	> 0.3g to ≤ 1.5g/100g	>1.5g/100g	>1.8g/portion

[9] Food Standards Agency. Guide to creating a front of pack (FoP) nutrition label for pre-packed products sold through retail outlets. FSA: 2016 [cited 2021 October 07] Available at: https://www.food.gov.uk/sites/default/files/media/document/fop-guidance_0.pdf

Table 3: Criteria for drinks (per 100ml)

Note: Portion size criteria apply to portions/serving sizes greater than 150ml

Colour Code	*Low*	*Medium*	*High per 100g*	*High per portion*
Fat	≤ 1.5g/100ml	> 1.5g to ≤ 8.75g/100ml	> 8.75g/100ml	>10.5
Saturates	≤ 0.75g/100ml	> 0.75g to ≤ 2.5g/100ml	> 2.5g/100ml	> 3g/portion
Total Sugars	≤ 2.5g/100ml	> 2.5g to ≤ 11.25g/100ml	> 11.25g/100ml	> 13.5g/portion
Salt	≤ 0.3g/100ml	>0.3g to ≤0.75g/100ml	> 0.75g/100ml	> 0.9g/portion

Exceptions

Processed products containing natural fats or sugars, directly pertaining from foods known to have health benefits, including fruit, vegetables, nuts and seeds are exempt unless they have added sugar or fat.

Added sugars: sugars from fruit will not be taken in to account when assessing sugar levels, unless the product has added sugar (or a sugar derivative including honey, glucose syrup, etc.) as an ingredient. For example, a product containing dried fruit may exceed the bought-in product specification for sugar, however if they have no added sugar then the product is acceptable. Acceptability will be determined by the ingredients list, which will reference any “added sugar”.

Added sugars: fats from nuts and seeds are not taken in to account when assessing fat content, unless the product has added fat from an additional ingredient. For instance, if a cereal bar contains nuts and seeds and no additional vegetable oil or other fat source it will be acceptable.

EVALUATION AND GOVERNANCE

- The Steering Group oversees the implementation of the Standards and monitors compliance. The Steering Group reports into the UHB Nutrition and Catering Steering Group, 3 times per year.
- In addition to audit data, we collect feedback from customers using customer surveys.
- Sales data is reviewed by the Steering Group and used to inform healthier product selection, and monitor sales
- Nutrition training and regular updates on the standards are provided for catering staff to increase knowledge of the importance of healthier food provision and support implementation of the policy.
    - All outlets (restaurants, cafes, retail outlets and vending machines) across the UHB will be audited on an annual basis by representatives from Catering, Public Health and Public Health Dietetics. Regular spot checks will also be carried out throughout the year to support the audit process and maintain the requirements of the standards
- Audit results will be calculated and fed back to:
    - Healthy Eating Standards for Hospital Restaurant & Retail Outlets Steering Group
    - Nutrition and Catering Steering Group
    - Cardiff & Vale Public Health Team monthly performance management meetings
    - Capital & Estates performance meetings and Operational Service Board

SUSTAINABILITY

The Steering Group is committed to supporting the Health Board's aim to reduce its carbon footprint by identifying measures to promote plant-based products, reduce food waste, avoid unnecessary use of plastics and offer more sustainable food choices.

References:

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2. StatsWales. Adult lifestyle by health board [updated July 2023] Available at: Adult lifestyles by local authority and health board, 2020-21 onwards (gov.wales) [accessed 24 October 2024].

3. Future Generations Commissioner for Wales. Well-being of Future Generations (Wales) Act 2015. Available at: Well-being of Future Generations (Wales) Act 2015 – The Future Generations Commissioner for Wales [accessed 25 October 2024].

4. Cardiff and Vale UHB. Shaping Our Future Wellbeing: Cardiff And Vale University Health Board Strategy to 2035. Living Well, Caring Well, Working Together. Available at: SHAPING-OUR-FUTURE-WELLBEING-STRATEGY_FINAL.pdf (shapingourfuturewellbeing.com) [accessed 24 October 2024].

5. Welsh Government. Healthy weight strategy: Healthy Weight Healthy Wales. Available at: https://gov.wales/healthy-weight-strategy-healthy-weight-healthy-wales [accessed 24 October 2024].

6. Food Standards Agency. Check the Label Guidance. FSA:2020. Available at:https://www.food.gov.uk/safety-hygiene/check-the-label [accessed 24 October 2024].

7. European Commission. Food information to consumers – legislation. EC: 2016. Available at: https://ec.europa.eu/food/safety/labelling-and-nutrition/food-information-consumers-legislation_en [accessed 24 October 2024].

8. Welsh Government. All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients. WG:2011. Available at: All Wales Catering and Nutrition Standards for Food and Fluid Provision for Hospital Inpatients: (nhs.wales) [accessed 24 October 2024].

9. Food Standards Agency. Guide to creating a front of pack (FoP) nutrition label for pre-packed products sold through retail outlets. FSA: 2016. Available at: https://www.food.gov.uk/sites/default/files/media/document/fop-guidance_0.pdf [accessed 24 October 2024].

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

Present:	
Barbara Davies	Interim Director of Nursing (Chair)
Katja Empson	Consultant/ interim Clinical Board Director
Ceri Richards-Taylor	Interim Deputy Director of Nursing
Sian Rowlands	Head of Quality and Clinical Governance
Katherine Prosser	Quality and Governance Lead
Aneurin Buttress	Consultant Respiratory Physician/ Clinical Director
Derek King	Clinical Nurse Specialist, Infection, Prevention and Control
Hibaq Musa	Clinical Nurse Specialist, Infection Prevention & Control, Corporate Nursing
Sam Hughes	Professional & Practice Development Nurse
Liz Vaughan	Professional & Practice Development Nurse
Jason Roome	General Manager, Integrated Medicine
Wayne Parsons	Lead Nurse Integrated Medicine
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Harriet Foley	Senior Nurse, Integrated Medicine
Lowri Warren	Senior Nurse, A&E
Jane Andrew	Interim Senior Nurse, Integrated Medicine
Nicholas Denny	Organisational Learning Facilitator, Mortality Lead
Dave Mcrae	Lead Pharmacist, Medicine
Donna Davies	Head of People and Culture
Rebecca Corbin	Head of OD and Culture
Sarah Cornes-Payne	Senior Nurse, Diabetes
Diane Walker	Head of Integrated Discharge Service
Tara Rees	Specialist Nurse, Hepatology
Secretariat	
Sheryl Gascoigne	MCB Secretary/ Project Support Officer
Apologies:	
Claire Main	Interim Director of Operations for MCB/ Acute and out of hospital care
Marianne Jenkins	Consultant Nurse Emergency Medicine
Brijesh Srivastava	Consultant Hepatologist, Gastroenterology/ Deputy Clinical Director
Dharmaraj Durai	Consultant Gastroenterologist
Mark Davies	Acute Physician
Angela Jones	Senior Nurse, Resuscitation Service
Sharon Jones	Consultant, Rheumatology/ Clinical Director
Sian Brookes	Senior Nurse, Integrated Medicine
Cath Evans	Patient Safety Facilitator, Patient Safety Team
Natasha Whysall	Interim Lead Nurse Integrated Medicine
David Pitchforth	Lead Nurse, Specialised Medicine
Lisa Green	Interim Lead Nurse, Emergency and Acute Medicine
Chisom Uwaezuoke	Clinical Nurse Specialist, Infection Prevention and Control
Sarah Wright	Clinical Nurse Specialist, Infection Prevention and Control
Beth Jones	Senior Nurse, Specialised Medicine
Andrew Brown	Senior Nurse, Specialised Medicine
Lyndsey MacDonald	Consultant Emergency Medicine/Clinical Director

Item No	1. Standing Items	Action
MCBQSE/ 2024/0154	**Welcome and Introductions** – were undertaken.	

MCBQSE/ 2024/0155	**To receive the minutes of the previous meeting held on 18/9/24** – the group were asked to advise if any amendments are required by 21/10/24. The group resolved: if no amendments are required, the minutes will be accepted.	
MCBQSE/ 2024/0156	**Action Log** – was updated.	
MCBQSE/ 2024/0157	**Declarations of Interest** – none.	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2024/0158	**Patient Story – Integrated Medicine** – delivered by Tara Rees A patient in his 40's presented to A&E in 2018 with a fall and intoxication. A year later the patient presented to A&E following another fall. As part of this admission the patient had an ultrasound scan, and was referred to Hepatology following a diagnosis of alcohol liver sclerosis and CKD. The patient was followed up in Hepatology clinic by CNS nurses every 6 months noting the patient found abstinence for alcohol difficult and did not find CAU helpful. In the autumn of 2022 the patient required 2 weekly paracentesis, the patient was unable to take diuretics secondary to the CKD and was not considered a transplant candidate. TIPs challenging doe to CKD and nutrition. In May 2023 following attendance for paracentesis the patient was actively withdrawing from alcohol and agreed for admission to commence CIWA with dietary support. 18 months on the patient continues to abstain from alcohol, CKD improved with a TIPS inserted with ongoing paracentesis and has undergone a transplant assessment for both liver and kidney. **Learning** • This is a good example of the speciality and early intervention. • Good example of getting dietitians involved. • The HCSW engaged with the patient and encouraged him to attend hospital AA meetings. • The whole team saved his life with their intervention and teamwork. The group resolved: to note the above. **Actions from discussion**: none.	
MCBQSE/ 2024/0159	**Concerns, Claims, Compliments** **Concerns** – no issues raised. **Claims** – no issues raised. **Compliments** – were received regarding A7, C4 Stroke and Respiratory. **Family Feedback Medical Examiner Reports** – was shared at the meeting. The group resolved: to note the above. **Actions from discussion**: to keep sharing feedback.	
MCBQSE/ 2024/0160	**Care After Death Phase 1 Presentation** (for information) All death certifications are completed via a QR code which in turn triggers other processes which are required following a patient's death. The group resolved: this will significantly improve relative's experience. **Actions from discussion:** there are concerns regarding UHL and SDH accessing the QR codes. ND will follow up on these concerns.	Nick Denny
MCBQSE/ 2024/0161	**Infection Prevention and Control (IP&C) update:** 60 days since last MRSA bacteraemia (UHL E2) 6 days since last MSSA bacteraemia (UHW C7) 17 days since last *C difficile (UHL E6)* 17 days since last *E. Coli* bacteraemia (UHL E2) 43 days since last *Pseudomonas* bacteraemia (UHL E8) 13 days since last *Klebsiella* bacteraemia (UHL MEAU) • There have been two outbreaks affecting 10 patients, no staff and resulted in three bed days lost. • DMT scores – all MCB wards remain compliant for the last 4-week period. • HCAI reduction goals – there were <u>new</u> cases of all reduction goal organisms except MRSA in September 2024.	

	• MCB position based on same period 2023-2024:
	  ○ 250% increase with *Pseudomonas.*
	  ○ 45% increase with *C. difficile.*
	  ○ 19% increase with SAUR Bacteraemia's
	  ○ 44% reduction with *E. coli.*
	  ○ 10% reduction has been seen *with Klebsiella*
	There are 10 outstanding RCA's.
	The MSSA report 2023-24 was discussed at the recent MCB IP&C meeting.
	Audit results – Hand hygiene and BBE continue to improve on both sites.
	Bed & mattresses audits – need urgent attention. Still seeing poor results. The themes regarding mattresses is strike through. The theme regarding beds is dusty panels and spillage on the panels.
	East 2 MRSA Exec Review – has been rescheduled to a later date.
	Environmental Cleaning Programme - has commenced at UHL. As part of this, wards are being temporarily relocated to East 4 for thorough cleaning and decluttering. East 2, is currently undergoing the process, with plans to move back by the end of the week. The next ward scheduled for cleaning is West 2.
	Antimicrobial audit – West 2 was carried out.
	RCA's – Action DK has received a well written RCA and is awaiting approval from the author before sharing as an exemplar with the group.
	Bed cleaning concerns - a common concern raised by nursing teams is the lack of time allocated for bed cleaning between discharges and admissions. Guidance re-affirmed at IP&C cell. COMMS will be sent to remind staff 45 minutes of protected cleaning time should be provided.
	IP&C link day - will take place on 5/11/24, small lecture theatre, Dental Hospital. Please encourage attendance.
	Winter planning teaching 12/11/24 at 14.00 VTBC. HCID training at 14.00 on 21/11/24 and 14/11/24 VTBC.
	International IP&C week this week. The IP&C Team are attending each site with a stand for information (not UHL where ward visits will occur).
	Influenza - community Influenza detection has increased recently, however, activity remains low. RSV incidence is increasing and is at medium intensity levels (RSV vaccinations are available in Primary Care). Covid-19 rates in the community have decreased slightly (9.5 per 100,000).
	UHB Staff Vaccinations - are available for Covid-19 and Influenza.
	WNCR – cannulation and VIPs are going onto WNCR in March 2025.
	
	The group resolved: to note the above.
	Actions from discussion: all to encourage staff to take up the vaccinations for protection of self, colleagues, patients to ensure operational continuity.
		Derek King
		
		All

MCBQSE/ 2024/062	**Hypo Box Audits** – the aim is to improve hypoglycaemia in the Health Board (HB). Audits were carried out across the HB. 6 out of 10 boxes were completely empty. 3 were partially stocked. 1 box was fully stocked. **Location of hypo boxes** – more nurses than doctors knew the location. **Awareness of hypo management** – doctors were more aware of the management for a patient with a hypo compared to nurses. **Guidance** will be added to the hypo boxes, regarding Hypo symptoms and stock ordering. Anyone with diabetes could have a care plan to manage a hypo. **Hypo Awareness Week 2024** – 7 to13 October 2024. **Diabetes Education Board** – scan QR code for diabetes education resources. This is available in primary care and secondary care. **CDEP_HAW24 Cambridge Diabetes Education Programme (CDEP)** – this is the recommended programme. Certificates are available on completion of this programme which would be good for re-validation. The group resolved: to continue to raise awareness. **Actions from discussion**: none.	
MCBQSE/ 2024/0163	**Recommendations following Llais Visit to the Stroke Rehabilitation Centre (SRC)** **An Improvement Plan** - has been developed by SRC and submitted for sign off and has been accepted. Training compliance was over 80%. All to be aware of the recommendations. SRC have carried out extensive work.	

	The group resolved to note the above. **Actions from discussion**: none.	
3	**ITEMS FOR APPROVAL/ RATIFICATION**	
MCBQSE/ 2024/0164	**National Reportable Incidents (NRIs)** **MCB NRI Position** – there are currently 17 open NRIs across the Clinical Board. Integrated Medicine have 2 open (0 have breached the closure date). Specialised Medicine have 12 open (7 have breached the closure date). Acute & Emergency Medicine have 3 open (all have breached the closure date). **NRIs for closure**: **Acute & Emergency Medicine, ID37911 Intrauterine death** A patient who was heavily pregnant had a seizure at home. Her English was OK but the husband's English poor. He contacted 111, however they did not pick up on the severity of the lady being pregnant and having a seizure, therefore the lady was mis-triaged and was not allocated as a red call. When the patient presented to A&E her high blood pressure was escalated to the nurse in charge and a doctor, but not a senior doctor. The Emergency Department (ED) was at full capacity secondary to both Emergency Department and UHB pressures. After the patient had been in ED for 40 minutes a Registrar noted the seriousness of the situation and referred her to Obstetrics. Whilst on maternity a USS scan sadly confirmed a intrauterine death. **Issues identified:** The patient was mis-triaged by 111. 1.5 hours later the patient came to the ED brought by the husband rather than waiting for WAST. There was a delay between the patient being triaged and being seen by a Registrar. **Learning:** Joint learning between ED, WAST, 111. There has been education regarding how dangerous it is to have high blood pressure in pregnancy. Maternity EWS (MEWS) charts have been brought in. Education is ongoing. Pathway work is on-going. Full capacity protocol was not implemented at the time. The patient safety learning review could not establish if the baby died within the 40-minute delay from triage on arrival to ED and transfer to maternity, or whilst in the community. **ID34468 (pressure damage)** The patient presented to the Emergency Department (ED) on 15/6/23. The patient was transferred to the Assessment Unit where 4 days later unstageable pressure damage was reported. **Issues identified:** Whilst in the ED the patient spent 8 hours on a trolley which would have potentially impacted on changes to the patient's skin integrity. There was no documentation in terms of the patient's skin condition until the unstageable pressure damage was reported to support safe/timely and clinically effective care. The patient was not nursed on the correct mattress in line with guidance. **Learning:** Tendable audits show variable compliance. Education regarding pressure damage needs to continue. **IRMER ID50831 (CD&T)** Unjustified duplicate CT chest, abdomen and pelvis. **Issues identified/ Learning:** There was a failure to adequately identify the status of previously requested examination.	

	There was a failure to adequately consider prior imaging at vetting and imaging. There was an error in allocation of the scan completed 29th December 2023. Recommendations: Review of the process for identifying the status of radiology requests prior to submitting further imaging requests for patients. Reiterate the importance of checking prior imaging at all stages of the imaging process to both Radiologists and Radiographers. Review Radiographer process of checking prior imaging for vetted examinations. Ensure the correct allocation has been accurately recorded on RIS at the end of each day. **The group resolved**: to note the above. **Actions from discussion:** none.	
MCBQSE/ 2024/0165	**Learning from Events, Claims/ Concerns/ Redress Overview** **CNUHWDCIQ1681 EH** This is a clinical negligence claim regarding the incorrect interpretation of lung function tests resulting in unnecessary commencement of Pirfenidone. The patient was a 68-year-old- gentleman with a history of asbestosis. **Learning** The incorrect lung function tests had been uploaded to the patient's records and were therefore incorrectly interpreted. This resulted in the patient suffering side effects of the Pirfenidone, including red rashes, blisters to the face and scalp, low mood, anxiety, loss of appetite, sleep deprivation. The claim is ongoing, however, an early sum of £7,500 has been offered. The Lung Function Team now upload test results with the patient present, not at the end of clinic. **CNUHW3743 PM** This relates to a failure to identify an intracranial hypertension for a clinical negligence claim. A 29-year-old lady attended the Assessment Unit in 2016 with a headache, neck and shoulder pain. The patient had a significant history of spinal surgery. The patient had a CT head scan which confirmed no signs of intracranial bleeding, therefore, the patient was discharged back to Rookwood Hospital. The patient self-presented to an Optician on 16/5/16 who referred her for urgent treatment. A fundus examination should have been performed which would have indicated the presence of papilledema and led to a neurology referral. This would have resulted in a lumbar puncture being undertaken within 24 hour and the claimant's loss of vision avoided. **Conclusion** The case has been settled for £4,600. Expert medical opinion concluded the patient's presentation 13th May 2016 was the very early phases of IH, confirming it was an exceptionally rare presentation of an unusual condition. There was a complex lack of any red flag symptoms or signs associated with the headache at first presentation. Agreed there was a through and complete history and examination but did note whilst it is not absolutely mandated, or widely practice they would do and encourage staff to check the fundus. The patient's long term visual field loss was an inevitable result of the disease and even if a lumbar puncture had been undertaken on 13th May 2016 with a diagnosis of IH, the damage to the optic nerve head would have occurred in any event. An Ophthalmology opinion noted if the patient had the appropriate treatment they would have had better visual field function, good acuity, good central vision in the right eye, visual field defects when first measured, but would have stayed at that. **Learning** All doctors in training have a named Educational Supervisor who is responsible for their overall training with a named Clinical Supervisor for each attachment who takes responsibility for clinical supervision within the rotation. On call supervision is provided by a Consultant on call and supervised in their clinical area. The junior doctor involved previously provided comments and reflected on this incident. **CNUHW4333 CM** This relates to a failure to consider the risk of a DVT following a fractured right ankle.	

	The 45-year-old male patient had a history of DVTs and PEs. The gentleman presented to the ED in July 2020 following a fall and fractured his ankle. The patient was placed in an air step boot. Safety netting advice was given and the patient was discharged. On 10/7/20, the gentleman presented to ED, was thoroughly examined and discharged home. On 11/7/20 the patient presented to the ED with shortness of breath and right sided chest pain. The patient was diagnosed with DVT, bilateral PEs and remained an inpatient until 29/7/20. **Conclusion** Advice was sought on this. Three vulnerabilities were noted. 1. The Health Board expert advised that a test should have been performed earlier on in the patient's presentations. 2. Records regarding the alleged attendance on 8/7/20 could not be found. 3. The patient should have received anticoagulants in light of his medical history. Based on this evidence the case was settled for £57,500. **Learning** All ENP's trained on VTE risk assessments Venous thromboembolism risk in lower limb immobilisation with a walking air cast boot is audited and included in a regular audit programme. A sticker for staff to use in the notes to ensure relevant risk assessments are completed with guidelines updated to reflect this. Staff reminded of the VTE pathways and documentation. **The group resolved**: to note the above. **Actions from discussion:** none.	
MCBQSE/ 2024/0166	**Inpatient Falls Training: Spread and Scale –** no update. **The group resolved**: no update. **Actions from discussion:** none.	
MCBQSE/ 2024/0167	**NHS Wales Staff Survey Feedback/Results 2023** The response rate was 21.4% which was 3662 responses. The response rate for MCB was 17.01% which was 333 responses. There were 4 Key themes: 1. Staff engagement 2. Diversity and equality. 3. Negative experiences: bullying and harassment and behaviours of a sexual nature. 4. Burnout. It is important to reflect and share this information. Look at what is the key factor of concern and look at what can be worked through now and going forward. The expectation is to present at the People and Culture Committee any actions that have been taken. It is of great concern staff are experiencing bullying. The sample of respondents was quite small; however, their voices need to be heard. Remind staff of the availability of the employee wellbeing service. Pockets of work are underway in nursing. The Emergency Unit are looking at a 'Stay Survey' with the aim to keep staff rather than them leaving. **The group resolved**: to note the above. **Actions from discussion:** all to encourage their teams to complete the Staff Survey for 2024, which is now available until 29/11/24. It would be good to have a larger sample of respondents this year.	
4	**ITEMS FOR NOTING AND INFORMATION**	
MCBQSE/ 2024/0168	**Patient Safety Alerts/MDAs/ISNs:** - Safety Memo: Blunt fill needles with filter - Safety Memo: Date and time of phlebotomy - Safety Memo: Oxygen Cylinders (PSN 042 reminder) - Safety Memo: Revised guideline – symptom triggered alcohol detoxification - Phenytoin – signs and symptoms of toxicity and recommendations for monitoring	

	The group resolved: for noting. **Action from discussion**: shared for information.	
MCBQSE/ 2024/0169	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions** - Acute & Emergency Medicine last meeting 8/9/24 (await confirmed minutes). - Integrated Medicine. - UHW (awaiting minutes). - Integrated Medicine UHL September 2024. - EUG minutes 11th September 2024. - Gastroenterology 17th July 2024 **The group resolved**: to note the above. **Action from discussion:** none	
MCBQSE/ 2024/0170	**Minutes from QSE Sub Groups:** - IP&C minutes 2/8/24. Previous meeting 4/10/24. - H&S minutes previous meeting 7/8/24. - Medicines Access and Governance Group last meeting 6/9/24 (meeting November20/9/24 cancelled). - Professional Nursing Board 12/8/24 **The group resolved**: to note the above. **Action from discussion:** none.	
MCBQSE/ 2024/0171	**Feedback from UHB QSE Committee** – 8/10/24 **The group resolved**: to note the above. **Action from discussion:** SR will share a summary of the meeting post this meeting with this group.	Sian Rowlands
MCBQSE/ 2024/0172	**Datix Newsletter** – CR-T will take the lead for safeguarding for MCB. **The group resolved**: for information. **Action from discussion:** to note the above.	
5. ANY OTHER BUSINESS		
MCBQSE/ 2024/0173	**Any Other Business** **Acute Gastro Model/ Changes in Service** – launched this week. SOP's have been circulated. Any further comment, please pass information to Katie Innes. A QIA was completed regarding the service change.	
6. DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2024/0174	20 November 2024 at 14:30 – 16:00 via MS Teams	

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

Held on 25th November 2024

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

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 24/347	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 24/348	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 24/349	**Minutes of the previous meeting** The minutes of the previous meeting were received. **The Group resolved that:** a) The minutes of the previous meeting held on 25th October 2024 were accepted as an accurate record.	
CDTQSE 24/350	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 24/114 Chaperoning SOP* The final version was circulated prior to the meeting and has been signed off. *CDTQSE 24/180 Information Asset Owners* Directorates to send HJ the names of their Information Asset Owners if not already done so. *CDTQSE 24/250 Changes to the Process of Issuing of Death Certificates* The Bereavement Team to present to the meeting in February. *CDTQSE 24/277 Heel Pressure Incident* SR to arrange for the heel pressure incident to be presented in January. *CDTQSE 24/277 Learning from Incidents Relating to Pathology Delays* To be presented at the February meeting.	**All** **SO** **SR** **SG**

	CDTQSE 24/279 Learning from Operation POET BJ to present the learning from the Operation POET exercises to the January meeting. *CDTQSE 24/343 CD&T Staff Recognition Awards* The Group to provide any thoughts on how the Clinical Board can recognise staff differently or any improvements to the current scheme. **The Group resolved that:** a) The update on the actions outstanding from the previous meeting were noted.	**BJ** **All**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 24/351	**Concerns and Compliments Report** In October 2024, the Clinical Board received 26 concerns, 7 formal and 19 early resolution. There were no breaches in response times. The main themes of concerns received related to difficulties cancelling and arranging appointments and waiting times. The group resolved that: a) The concern report was received with a breakdown of the data by department.	
CDTQSE 24/352	**National Reportable Incidents** A complex incident is being investigated involving multiple Clinical Boards relating to a digital glitch. The incident relating to an x-ray miss has now been closed. The LRI investigation is underway. Other open NRIs relate to delays within the Cellpath laboratory. These investigations are ongoing and a summary of the themes will be brought to a future meeting Fact finding has been undertaking relating to the NRI involving a very rare complication of a CT guided biopsy which resulted in the death of a patient. The exercise identified that there was no issue with the patient care and has been downgraded from an NRI. The NRI involving the delay in identifying an issue on a scan may be downgraded as the outcome for the patient may not have been affected. However, this has been reported and is being investigated.	**SR/SG**

	The Group resolved that: a) JF to provide a summary of the learning from incidents involving Radiology misses to the meeting in March.	**JF**
CDTQSE 24/353	**Duty of Candour Cases** **The Group resolved that:** a) There are no new cases outside of the NRI process.	
CDTQSE 24/354	**Risk Register Updates** MM reported that Estates have closed the maintenance request relating to the ceiling in the print room but the issue is not resolved. MM to send HL the latest update and she will follow this up. JF noted that risks have been added to the Radiology risk register relating to funding for IT equipment required prior to the implementation of the RISP system. The reliability of the analogue portable x-ray machines in St David's hospital is also an issue given its an aging piece of equipment. She also noted that a risk assessment relating to delays in diagnoses due to reporting backlogs is being finalised. MM noted that she has not received an update from Occupational Health in relation to health surveillance. Medical Physics are also awaiting a response from Occupational Health in terms of radiation doses. **The Group resolved that:** a) HL will email Occupational Health for an update on the ongoing issues and copy in Health and Safety who have been providing support.	**MM/HL** **HL**
CDTQSE 24/355	**Patient Safety Alerts** **The Group resolved that:** a) There were no relevant patient safety alerts received.	
CDTQSE 24/356	**Medical Device/Equipment Risks** **The Group resolved that:** a) There were no medical device or equipment risks raised.	

CDTQSE 24/357	**Point of Care Testing** **The Group resolved that:** a) There were no issues to report.	
CDTQSE 24/358	**IP&C/ Decontamination Issues** SR reported that the UHB Decontamination Group was held on 12th November. Concerns were raised that equipment is being returned to Clinical Engineering without being sufficiently cleaned. A reminder will be sent out to all areas with the correct process. A review of the decontamination procedures of tracheostomies will be undertaken following an incident in a clinical area where a bleach like substance was identified in part of a tube. An audit will be undertaken in areas that have infrequent use of Ultrasound machines and may not be as familiar with the decontamination processes as area where ultrasound machines are in regular use. It was noted that vaccination drop in clinics are still being held on different sites. **The Group resolved that:** a) The updates on decontamination and IPC issues were noted.	
CDTQSE 24/359	**Safeguarding Update** All directorates were requested to feedback on their safeguarding training compliance at the next meeting. **The Group resolved that:** a) Directorates to provide a breakdown or level of detail that is available to them.	**All**
CDTQSE 24/360	**Consent Issues** SR reported that the UHB compliance is 22%. Therapy staff are reporting 28.8% compliance, the highest compliance rate of all the staff groups and medical and dental staff are reporting 8.2% compliance. A reminder was issued that all staff that take consent are required to complete the module on ESR. Departments to check that any staff where this is not applicable have this module removed from their ESR records. SC commented that it is helpful for staff who do not consent but are working in area where consent is given to undertake the training, so they have an understanding that appropriate consent is being obtained for their patients.	

	Going forward all directorates will need to complete a proforma to be submitted to SR to collate into a Clinical Board response to feedback into the Consent Group. Information is requested for any consent issues within areas, details of ongoing work or innovation around consent or any queries. **The Group resolved that:** a) The Clinical Board Lead for EIDO will be presenting at the January meeting.	
CDTQSE 24/361	**Health and Safety** JD reported that the training facilities at Denbigh House will no longer be available in the New Year as training will be moved to Woodlands House in March. UHL will retain their training facility. HL issued a reminder that all staff that require fit testing are up to date within their 3-year period. **The Group resolved that:** a) The update on health and safety issues were noted.	
CDTQSE 24/362	**Regulatory Compliance** SMPU were subject to a DGM audit and positive feedback was received. Issues were raised relating to the estate. The team are working on a response to the audit. The laboratories quality staff are preparing for their forthcoming inspections. The HIW inspection report for Nuclear Medicine has not yet been received. **The Group resolved that:** a) The minutes from the Regulatory Compliance Group was noted.	
TIMELY		
CDTQSE 24/363	**Initiatives to Improve Access to Services** A concern has been received around patients or relatives that are neuro diverse and the difficulties they experience when telephoning to make appointments. **The Group resolved that:** a) Departments to give thought as to how people can access their services to meet their needs.	

CDTQSE 24/364	**Waiting Times Performance** BJ reported that in October, Radiology patients waiting 8 weeks or over reduced by 600. There re over 10,000 patients waiting over 8 weeks but the department are making significant efforts to address turnaround times. For patients waiting 14 weeks or over for Therapies, Dietetics are reporting 72 patients waiting over 14 weeks. Pelvic Health have reduced their waits by 173 patients over 14 weeks. Speech and Language Therapy are reducing their longest waits. The Cellular Pathology team are maintaining good consistent turnaround times and reducing their reporting times. **The Group resolved that:** a) The waiting times performance update was noted.	
EFFECTIVE		
CDTQSE 24/365	**Feedback from UHB QSE Committee** **The group resolved that:** a) The Minutes of the meeting held on 8th October 2024 are not yet available.	
CDTQSE 24/366	**NICE Guidance** **The Group resolved that:** a) There was no new guidance to share.	
CDTQSE 24/367	**Research and Development** RM reported that RB, the longstanding R&D Lead for AWTTC is retiring. A new R&D Lead for the directorate has been identified. The R&D Forum has been postponed to 3rd December due to the availability of a key speaker. RM shared the R&D recruitment dashboard for trials that are specifically based in this Clinical Board. There are 3 trials relating to Physiotherapy, Podiatry and Radiology that are off track in terms of recruitment However the reasons for this are known and are not an issue. RM requested to be advised if there are any trials involving external organisations where engagement with the NHS is poor. **The Group resolved that:**	

	a) The update from the R&D Lead was noted.	
CDTQSE 24/368	**Service Improvement Initiatives** MJ and VG presented on the impact of non-medical prescribing in Podiatry practice. In recent years, the landscape of professional practice in the health service has changed. With a growing complexity of people assessing services and the increased numbers of people requiring care, adaptations to clinical practice were essential. Podiatry Services identified that this was an opportunity to drive forward change. Historically, Podiatry relied on Primary Care for antimicrobial prescriptions for the Podiatry caseload. There were limitations to this method in terms of delays in prescription requests, GPs prescribing without assessing the patient etc. Medicines legislation was amended to allow Podiatrists and Physiotherapists to independently prescribe during clinical practice and it was determined to provide Podiatry clinicians with the ownership to prescribe independently as non-medical prescribers. Podiatrists had already been accustomed to exercising legal rights to access, supply, administer and sell a restricted range of medicines and in 2021 non-medical prescribing was introduced in Podiatry. The Podiatrist Independent Prescribers were able to prescribe any medicine for any medical condition within their scope of practice and legislation. This allowed the potential to streamline patient care pathways, improve quality of care and enhance patient safety through greater prescriber accountability. The Podiatry Service leads and manages the diabetes foot service for the UHB. Understanding that 2.5% of the people living with diabetes will have a diabetic foot ulcer at any given time and the increase in susceptibility they have to bacterial infection, created further necessity to timely access to antimicrobial therapy. Diabetic foot ulcers remain the most frequent diabetes related complications requiring hospitalisation and the most common precipitating events leading to lower extremity amputation. Timely access to prevent and manage these ulcers not only presented an opportunity for best outcomes for the patient, but also had a significant impact on costs and capacity management. The Podiatry Team were best placed to ensure prompt access to antibiotics for foot infections. Timely access in a time of crisis is imperative to improving ulcer healing rates and reducing lower limb amputations. A One Stop clinical appointment service was implemented which not only improved the patient experience but it also supported prudent healthcare and value-based health by reducing unnecessary wastage of supplies and incorrect antibiotic prescriptions and patients could be seen closer to home.	

	Prescribing data was collated for the project. 89% of the prescriptions were written for people living with diabetes. 60% of Podiatry's patients with active foot ulcerations are living with diabetes. Since the introduction of the first independent prescriber in 2021, there is now a current team of 5. The service has seen improved patient experience with patients receiving a full assessment, investigations, wound treatment and prescriptions all within a single appointment. In terms of outcomes data for 2023-24 showed that 55.7% of patients living with diabetes were alive and ulcer free at 12 weeks. This is significantly higher than the Wales average of 32.6% and the England average of 42.2%. This directly correlates with DIVA data which shows that the Podiatry service has the lowest rate of leg and foot amputations in Wales. There are cost savings associated with Independent Prescribing. 193 GP appointments were saved equating to £32.6k. With 193 prescriptions written by Independent Prescribers rather than GPs, this realised over £6k of savings. The Diabetic Foot Emergency Early Triage clinics (DFEET) realises savings of around £90k compared to patients visiting their GP over the course of 12 months. An additional outcome was that the Independent Prescribers were directly involved in the review of the CAV UHB Antimicrobial Prescribing Guide. This recognised the importance of the role of the Independent Prescriber in the management of this complex cohort of patients. This work supports the UHB Strategic objectives. Independent prescribing allows Podiatry clinicians to work to the top of their licence and supports their autonomy to provide a patient centred approach. This has a positive effect on the service and also supports workforce reshaping. In terms of moving forward, the team will support training of other Independent Prescribers from across other professional groups and explore opportunities for an All Wales approach within Podiatry. The long-term ambition is to extend the scope of practice of the Independent Prescribers into the management of long-term conditions and pain. Explore opportunities with Cardiff Metropolitan University to include independent prescribing within the undergraduate podiatry programme. Regular audits will continue and a project related to this is to review the medical management of patients with diabetes related Osteomyelitis. HL enquired on the frequency of the national Diabetes Foot Care Audits. It was noted that this is a continuous process that demonstrates how Cardiff and Vale is performing in relation to the other services across Wales. An annual summary is	

	provided and this provides assurance around the standard and quality of the service being provided by the team. HL also asked if there is a mechanism for peer support that links with Independent Prescribers outside of Podiatry. It was noted that there is a peer group across Podiatry in Wales and Therapies wide peer support group is in the process of being established. MK is a member of the Non-Medical Prescribers Governance Group and this ensure that the service can align to the new Welsh Government standards. **The Group resolved that:** a) Podiatry will attend a future meeting to feedback on the Osteomyelitis review.	
CDTQSE 24/369	**Information Governance/Data Quality** **The Group resolved that:** a) There was no update to report.	
CDTQSE 24/370	**HIW/LLAIS Reports and Improvement Plans** **The Group resolved that:** a) There have been no reports received relating to this Clinical Board.	
CDTQSE 24/371	**Policies and Procedures** **The Group resolved that:** a) There were no new policies and procedures to receive.	
EFFICIENT		
CDTQSE 24/372	**Exception Reports from Directorates** Feedback and learning from the Operation POET exercises will be brought to the next meeting. **The Group resolved that:** a) There were no other issues raised from directorates.	
CDTQSE 24/373	**Clinical/Internal Audits** A review of audits on AMAT relating to this Clinical Board will be undertaken at the next meeting. **The Group resolved that:** a) Going forward directorates will present a summary from any audits in their areas with the key learning or findings.	**All**

CDTQSE 24/374	**Waste and Sustainability** **The Group resolved that:** a) There were no updates to report.	
EQUITABLE		
CDTQSE 24/375	**Feedback from Clinical Board Inclusion Ambassadors Group** **The Group resolved that:** a) There was no update from the Inclusion Ambassadors Group.	
CDTQSE 24/376	**Equality and Diversity Issues** HL had circulated slides from the UHB Equality Adviser of the work being undertaken across the Health Board. **The Group resolved that:** a) There were no further issues to report.	
PERSON CENTRED		
CDTQSE 24/377	**Patient Story – Health Records** **The Group resolved that:** a) The team were unavailable to present their patient story.	
24/378	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/379	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/380	**National User Experience Framework/Feedback from Patient and Service User Surveys** Civica feedback was shared with the group. . **The Group resolved that:** a) Positive comments were noted from service users within the report.	

CDTQSE 24/381	**Staff Awards and Recognition** It was pleasing to note that Danni Marez from the Lymphoedema Team was the runner up in the RCN Specialist Nurse Award last week. It was noted that Steve Hendrickson from the Back in Action Team also reached the interview stage. **The Group resolved that:** a) There were also a number of winners at the Awards from across the UHB.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 24/382	There were no items to report.	
ANY OTHER BUSINESS		
CDTQSE 24/383	Nothing further to report.	
CDTQSE 24/384	**Date & time of next Meeting** The next meeting will be held on 20th December at 9am via Teams.	