Quality Committee 01.04.2025

Tue 01 April 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 18.02.2025

1.4 - Draft Quality Public Minutes 18.02.2025.pdf (8 pages)

1.5. Action Log – Following the meeting held on 18.02.2025

1.5 - Quality Committee Public Actions following 18.02.2025.pdf (2 pages)

1.6. Chair’s Action taken since last meeting

14:05 - 15:25
80 min

2. Items for Review & Assurance

2.1. Surgical Clinical Board – Assurance Report

30 mins *Clare Wade / Abraham Theron / Rachel Thomas*

2.1 - UHB QSE April 2025 Surgical CB.pdf (34 pages)

2.2. Deep Dive – The Deteriorating Patient

20 mins *Alexandra Scott*

2.2 - Care of the Deteriorating Patient 202503.pdf (7 pages)

2.3. Children Looked After Assessment Backlogs - Six Month Update

10 mins *Andy Jones*

2.3 - QSE LAC Report Board Mar 25 final 2.pdf (5 pages)

2.4. Research and Development Six Month Update

10 mins *Sarah Martin / Matthew Wise*

2.4 - 2024-25 Research update.pdf (7 pages)

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2.5. Baby Friendly Breastfeeding Accreditation

10 mins *Jason Roberts / Lisa Parry*

2.5 - UNICEF BFI update.pdf (4 pages)

15:25 - 15:25
0 min

3. Items for Approval / Ratification

Ceri Phillips

No items.

15:25 - 15:35
10 min

4. Items for Noting & Information

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

Jason Roberts

4.1.1 - MCB QSE Minutes 20 Nov 24.pdf (4 pages)

4.2. Medical Records Tracking Update

Paul Bostock

4.2a - Medical Records Tracking.pdf (2 pages)
4.2b - Medical Records Tracking Audit - Nov 24 update.pdf (6 pages)

4.3. Cancer Services – Audit Wales

5 mins *Paul Bostock / Matt Phillips*

4.3 - Cancer Services in Wales - English_0 (1).pdf (72 pages)

4.4. Smoking Cessation Internal Audit Report

Matt Phillips

4.4 - Smoking Cessation Final Internal Audit Report (1).pdf (11 pages)

4.5. Joint Commissioning Committee Quality Safety and Outcomes Highlight Report

Ceri Phillips

4.5 - QSO Highlight Report Feb 25.pdf (6 pages)

4.6. Quality Committee Annual Report 2024/25

Ceri Phillips

4.6 - Quality Committee Chairs Report 2024-25.pdf (4 pages)

15:35 - 15:35
0 min

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

Ceri Phillips

No items.

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15:35 - 15:35
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)*

15:35 - 15:35
0 min

7. Any Other Business

Ceri Phillips

15:35 - 15:35
0 min

8. Review of the Meeting

Ceri Phillips

15:35 - 15:35
0 min

9. Date & Time of Next Meeting

Ceri Phillips

13th May 2025 at 2pm via MS Teams

15:35 - 15:35
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]"

Minutes of the Public Quality **Committee**

Held on 18th February 2025 via MS Teams

To view the meeting: CAVUHB Public Quality Committee Meeting 18.02.2025

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
Akmal Hanuk	AH	Independent Member – Local Community
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
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
David Fluck	DF	Executive Medical Director
Angela Hughes	AH	Assistant Director of Patient Experience
Sian Rowlands	SR	Head of Quality and Clinical Governance
Suzanne Wood	SW	Consultant in Public Health Medicine (SW)
Claire Main	CM	Director of Operations for Medicine and Unplanned Care
Katja Empson	KE	Clinical Board Director - Medicine
Linda Hughes-Jones	LHJ	Head of Safeguarding
Chisom Uwaezuoke	CU	Senior Nurse for Infection Prevention and Control
Barbara Davies	BD	Deputy Director for Nursing – Medicine Clinical Board
Paul Rogers	PR	Directorate Manager - ALAS
Sian Griffiths	SG	Consultant in Public Health Medicine (SG)
Observers		
Lauranne Cullen	LC	Regional Director for Llais
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Claire Beynon	CB	Executive Director of Public Health

		ACTION
QC 25/02/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	
QC 25/02/002	**Apologies for Absence** Apologies for absence were noted.	

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QC 25/02/003	**Declarations of Interest** No declarations of interest were raised.	
QC 25/02/004	**Minutes of the Committee meeting held on 26.11.2024** The minutes of the Committee meeting held on 26.11.2024 were received. **The Committee resolved that:** a) The minutes of the meeting held on 26.11.2024 were approved as a true and accurate record of the meeting.	
QC 25/02/005	**Action Log following the Meeting held on 26.11.2024** The Action Log following the Meeting held on 26.11.2024 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 26.11.2024 was noted.	
QC 25/02/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 25/02/007	**Medicine Clinical Board – Assurance Report** A Patient Story was presented to the Committee about a gentleman who experienced a haemorrhagic stroke due to undiagnosed high blood pressure. He shared his journey from the initial stroke event through his treatment and rehabilitation process. The CC thanked the patient for sharing his story. The Clinical Board Director - Medicine (CBD-M), the Deputy Director for Nursing – Medicine (DDN-M), and the Head of Quality and Clinical Governance (HQCG) presented the Assurance Report which detailed the clinical governance arrangements within the Clinical Board in relation to Quality, Safety and Patient Experience (QSPE). It set out achievements, progress and planned actions to maintain the priority of QSPE. The Executive Medical Director (EMD) asked how they demonstrated improvement in certain areas, specifically regarding the eTriage. The CBD-M responded that they were collecting patient feedback on eTriage which should be available within a few weeks. Since its introduction, eTriage had demonstrably reduced the time to triage, although only about 40% of EU attendees used it. There was still an option to register in EU with the reception team, and efforts were being made to improve accessibility. The Independent Member – Trade Union (IM-TU) asked what they hoped to capture in the Stay Questionnaire's for staff, and how well they were working. The DDN-M responded that the Stay Questionnaire was a pilot which aimed to understand what factors made staff stay in the organisation rather than exit questionnaires. The pilot was pending data collection. The IM-TU asked for feedback on the questionnaires to be shared with the Committee.	

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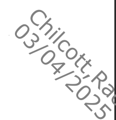
	The Chief Operating Officer (COO) commended the team for their ambitious work programme and acknowledged the improvements made despite the challenges and risks. The Independent Member – Local Community (IM-LC) asked for further information on their AI-based system and what they aimed to capture in terms of patient safety. The DDN-M responded that the Safe Care system focused on nurse rostering and recording patient acuity on the wards. It used a scoring system to assess acuity levels and respond accordingly, such as redeploying staff or providing additional support for high-risk patients. Additionally, the Welsh Nursing Care Records digitised nursing risk assessments. The Executive Nurse Director (END) highlighted the increase in the number of open and overdue Nationally Reportable Incidents (NRIs) and provided assurance that there was monthly oversight with Clinical Boards to address this. The END suggested that the Stay Questionnaire feedback be discussed in the People & Culture Committee. **The Committee resolved that:** 1) 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 was noted.	
QC 25/02/008	**Quality Indicators Report** The Assistant Director of Quality and Patient Safety (ADQPS) and the Assistant Director of Patient Experience (ADPE) presented the Quality Indicators Report and slides which provided assurance in relation to several quality, safety and patient experience priorities. It provided data through the end of January 2025 where available and detailed ongoing actions to drive necessary improvements. Additionally, it included exception reporting to highlight emerging trends and issues related to quality and patient safety. Regarding medication incidents, the IM-LC asked what the 18% of wrong doses administered represented in real numbers, and after such incidents were reported, what was the procedure to prevent reoccurrence. The ADQPS responded that the Datix system had limitations in classifying patients' incidents, often categorising them as dispensing, administration or prescribing issues. Most incidents occurred at the administration stage. She noted that there was some discrepancy across the UHB in how they manage patient safety incidents. The UHB supported staff using a just culture approach, focusing on system improvements rather than individual blame. Nurses underwent competency training when they joined the organisation and if involved in any patient safety incidents. The EMD agreed with the IM-LC's comments and noted that whilst they were good at recording issues, they needed to work out the improvement plan to stop reoccurrence. The CC suggested that the Senior Service Improvement Programme Manager (SSIPM) support the EMD's team. Chilcott, Rachel 03/04/2025 11:24:48 Regarding the NRIs, the CC asked whether an analysis had been conducted on the relationship between pressure damage and the prevalence of falls with the length of stay. If there was a relationship, it highlighted the need to reduce length of stay to mitigate these risks.	

	The ADQPS responded that research from another organisation showed that pressure damage and falls increased the length of stay, as patients required additional care. Interestingly, patients were more likely to fall either at the beginning of their stay when acutely unwell or near discharge when more mobile. This highlighted the importance of timely discharge to prevent deconditioning and ensure safety, as patients were often safer at home. **The Committee resolved that:** 1) The assurance provided by the quality indicators was noted.	
QC 25/02/009	**JICPA Update - Improvement Plan** The END reminded the Committee that the UHB underwent a Joint Inspection of Child Protection Arrangements (JICPA) review in December 2023. The findings and recommendations from this review were presented to the Quality Committee approximately six months ago. The Committee had requested a progress update on the Improvement Plan in six months' time. The Head of Safeguarding (HOS) presented the JICPA Action Plan and highlighted the progress made in addressing the issues identified by Health Inspectorate Wales (HIW) and the ongoing work to improve safeguarding practices. The Director of Corporate Governance (DCG) asked whether progress was tracked on a local spreadsheet which contained recommendations and actions from HIW after inspections, or whether they used an AMAT-type system to track. The HOS responded that a multi-agency spreadsheet was used to track actions with partners in Cardiff MASH, including children's services and education. The spreadsheet was a working document that changed regularly. **The QSE Committee resolved that:** a) The JICPA Update – Improvement Plan was noted.	
QC 25/02/010	**Healthcare Associated Infection (HCAI) Measures** The Senior Nurse for Infection Prevention and Control (SNIPC) presented the HCAI 2024/25 Update to the Committee which highlighted the improvement goals and current status within the UHB for C. difficile infection, Staphylococcus aureus infection, and other infections. The importance of Infection Prevention and Control (IP&C) measures was emphasised, including training, audits, and reviews of cases. The END highlighted the following: • IP&C was a major concern for the UHB, particularly focusing on MSSA and C.diff. • The IP&C team were actively addressing these issues, with national and internal efforts in place. • Monthly updates were presented in Executive Performance Reviews with Clinical Boards, and the IP&C Project Group had been established to drive improvements. The END suggested allocating more time to IP&C on future Quality Committee agendas to keep IP&C issues prominent. The SSIPM noted that the Hospital Acquired Infection (HAI) Project was part of the Future Quality Excellence Programme, whose goal was to improve the visibility of HAI rates across the organisation to better inform clinical decision-making.	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	The CC suggested giving the item more consideration in a future meeting. **The QSE Committee resolved that:** 1) The Healthcare Associated Infection (HCAI) Measures update was noted.	
QC 25/02/011	**Hepatitis B/C Recovery Plan Update** The Consultant in Public Health Medicine (SW) (CPHM-SW) summarised the following: • There was a global, national and local goal to eliminate Hepatitis B/C by 2030. • Hep B can be prevented with vaccination, and Hep C has a 90% cure rate with treatment. • The 2024/25 Elimination Plan for CAV was overseen by a bi-monthly meeting group. • Key achievements included resumed testing at HMP Cardiff, a mobile outreach van for testing and treatment, and opt-out bloodborne virus testing for substance misuse services. The CC suggested that this item comes back in six months for a progress update. **The QSE Committee resolved that:** 1) The progress to date was noted; 2) The content and ambition of the Hepatitis B and C Elimination Plan 2024/25 was noted.	
QC 25/02/012	**Gastro Surveillance Verbal Update** The COO summarised the following: • The Gastroenterology Department had addressed the issue of overdue surveillance, reducing the number of overdue patients beyond their surveillance interval from 2000 (April 2023) to 500, with plans to eliminate the backlog by April 2025. • Overdue surveillance had led to significant harm for some patients (around 10 patients). • There had been two false starts due to issues around the triaging of patients and consultant job planning and capacity. • This work had been at the expense of the diagnostic waiting times, which were in excess of eight weeks. **The QSE Committee resolved that:** 1) The Gastro Surveillance Update was noted.	
	Items for Approval / Ratification	
QC 25/02/013	**Policies** The following policies were presented and discussed: 1) UHB 322 – Ultrasound Clinical Governance Policy & Procedure 2) UHB 282 – CAVUHB Reusable Medical Device Decontamination Policy & Procedure **The QSE Committee resolved that:** a) The two policies were approved.	
QC 25/02/014	**Healthy Eating Standards for Hospital Restaurant & Retail Outlets** The CPHM-SW summarised the following:	

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	• CAV had adopted the Restaurant and Retail Standards since December 2015. • Initially, a 75% healthy to 25% unhealthy food ratio on hospital and retail sites was set, later adjusted to 60% healthy due to financial challenges. The plan was to review the ratio in 12 months' time. • Regular audits on hospital and retail sites had been undertaken, and in October 2024 an audit indicated that many areas were achieving the 60% target, although snacks and confectionaries were still quite low. • An options appraisal proposed three options, with the agreed approach being a gradual shift to 65% healthy ratio, aiming for 75% by November 2025. The IM-TU asked what control they had (if any) over what products were sold in the stores in the UHW Concourse. The CPHM-SW responded that discussions were ongoing with outlets regarding the healthy/unhealthy food split with specific allowances detailed in the standards provided. The goal was to ensure a smooth transition, with future audits planned. The Committee Vice Chair (CVC) asked whether the uniform approach to the healthy/unhealthy food split across all catering facilities had considered the specific needs of different settings, such as the Children's Hospital for Wales (CHfW). The CPHM-SW responded that the CVC's suggestion to potentially make the food offer stricter/more nuanced on the CHfW site would need stakeholder feedback. The Executive Director of AHPs, Health Scientists and Community Services Development (EDAHC) added that the Nutrition and Catering Group (NCG) was addressing the food provision at the CHfW, aiming to meet standards and reduce the high salt and sugar content in the adult foods currently offered. Discussions included increasing healthy choices and incorporating health promotion. The COO mentioned that the UHB had been highlighted in the news for offering unhealthy food to patients and inquired about any initiatives to enhance the food options for inpatients. The EDAHC responded that the NCG had received significant patient feedback on the food offer. Recent efforts involved collaboration between catering, public health and dietetics to improve and broaden the food options. She noted that this work was separate to the retail offer. The IM-LC noted the timing of the inpatient food delivery was sometimes problematic which led to wastage. He emphasised the need for significant improvements to provide a balanced menu and meet diverse patient's needs. The EDAHC agreed and noted that whilst various food options were available, they were not always accessible when needed. The focus for the year would be on improving the basics of food and catering services. The CC suggested an amendment to the recommendation which asked for the review of the healthy/unhealthy food ratio split to be undertaken in January 2026. The EDAHC suggested a future item come to the Committee around the catering offer for patients. **The QSE Committee resolved that:** a) The Option 2 (65:35 split) for the next 12 months was approved;	

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	b) The amendments to the Healthy Eating Standards for Hospital Restaurants and Retail Outlets, which reflects Option 2 (Appendix A) were approved; c) The reversion to the 75:25 split in January 2026 was approved.	
QC 25/02/015	**Good Food and Movement** The CPHM-SW summarised the following: • The "Move More Eat Well" Plan introduced in 2020 was a three-year plan which aligned with Cardiff Public Service Board (PSB), the Vale of Glamorgan PSB and the Regional Partnership Board (RPB). • Despite efforts, only 77.5% of reception-aged children had a healthy weight, with significant health inequalities between deprived and affluent areas. • A systems approach, considering settings, policies, and cultural factors, was needed. • Stakeholder engagement involved 160 participants from 35 organisations across CAV led to the creation of the "Good Food and Movement Framework", a six-year plan with three two-year implementation phases. • The team sought approval for the Framework and current implementation plan. The SSIPM suggested the team create a project plan to outline the progression of the improvement actions within the implementation plan. **The QSE Committee resolved that:** a) The Good Food and Movement Framework and Implementation Plan was approved.	
QC 25/02/016	**Smoke Free Legislation Update** The Consultant in Public Health Medicine (CPHM-SG) summarised the following: • The team sought approval for a new no smoking enforcement approach on hospital sites. • The Health Board's No Smoking Policy, updated in 2021, aligned with the 2020 Wales regulations making it illegal to smoke on hospital grounds. • The proposal involved partnering with the Vale of Glamorgan Council's litter enforcement officers, authorising them to issue fixed penalty notices for smoking. • The plan included an initial educational phase until March 2025, followed by a full implementation with fines of up to £100. • They recognised that some areas within their sites were particularly sensitive (e.g. Hafan Y Coed), and a sub-group had been specifically set up for UHL. • The approach aimed to raise awareness and support smoking cessation. The IM-TU noted his full support for the new enforcement approach. The CC suggested an update come back to the Committee in six months on the progress of the education phase and the initial implementation of the fixed penalty notices. **The QSE Committee resolved that:** a) The phased development and implementation of the new enforcement approach was approved.	
	Items for Noting & Information	
QC 25/02/017	**Minutes from Clinical Board QSE Sub-Committees and the Safeguarding Steering Group (SSG)** **The QSE Committee resolved that:**	

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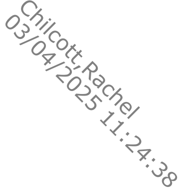
	1) The minutes were noted.	
QC 25/02/018	**Safeguarding Children and Adults at Risk Annual Report 2023/24** **The QSE Committee resolved that:** a) The Safeguarding Children and Adults at Risk Annual Report 2023/24 was noted.	
	Items to bring to the attention of the Committee	
QC 25/02/019	The END expressed concern around the UHB's IP&C position, specifically regarding MSSA and C.diff. He highlighted the need for a strong focus on these issues moving forward and suggested providing a more comprehensive update on the IP&C status in two months' time.	
	Agenda for Private QSE Meeting	
QC 25/02/020	*i) Minutes and Action Logs from the Private QSE Committee on 08.10.2024* *ii) Any Urgent / Emerging Themes – Verbal Update* *iii) Discharge Advice Letters (DALs) Verbal Update* *iv) Eye Health Needs Assessment*	
	Any Other Business	
QC 25/02/021	*No items.*	
	Date & Time of Next Meeting:	
QC 25/02/022	1st April 2025 at 2pm via MS Teams	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Action Log

Public Quality Committee

Update for meeting 1st April 2025
(Following the meeting held on 18th February 2025)

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.	**01.04.2025**	Claire Beynon / David Thomas	*Update to be provided in April 2025's QSE meeting in the Action Log section.*
QSE 24/11/012	**Sexual Safety**	For the statistics on sexual harassment cases within the UHB to be shared with the Committee.	**18.02.2025**	Katrina Griffiths	*This action will be marked as complete once the statistics have been circulated.*
QSE 24/11/007	**Royal College of Psychiatrists (RCP) Review**	For a progress update on the improvement plan to come to a future Committee.	**13.05.2025**	Neil Jones / Jason Roberts	**COMPLETED** *Added to the Forward Plan for May 2025's meeting.*
QC 25/02/010	**Healthcare Associated Infection (HCAI) Measures**	For an update on the UHB's IP&C position to come to a future Committee.	**13.05.2025**	Jason Roberts / Yvonne Hyde / Chisom Uwaezuoke	**COMPLETED** *Added to the Forward Plan for May 2025's meeting.*
QC 25/02/011	**Hepatitis B/C Recovery Plan Update**	For an update to come back to the Committee in six months.	**16.09.2025**	Claire Beynon / Annie Ashman	**COMPLETED** *Added to the Forward Plan for September 2025's meeting.*
QC 25/02/014	**Healthy Eating Standards for Hospital Restaurant & Retail Outlets**	For an update on the catering offer for inpatients to be brought to a future Committee.	**24.06.2025**	Emma Cooke	**COMPLETED** *Added to the Forward Plan for June 2025's meeting.*
QC 25/02/016	**Smoke Free Legislation Update**	For an update on the No Smoking Enforcement to be brought to the Committee in six months.	**16.09.2025**	Claire Beynon / Sian Griffiths	**COMPLETED** *Added to the Forward Plan for September 2025's meeting.*

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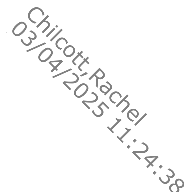
MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions referred to Board / Committees					
QC 25/02/030	**Discharge Advice Letters (DALs)**	For an update to be brought into the Public Quality Committee.	13.05.2025	Aled Roberts	**COMPLETED** *Added to the Forward Plan for May 2025's meeting (Public)*
QC 25/02/031	**Primary Care Eye Health Needs Assessment**	For the Cardiff and Vale UHB Eye Health Needs Assessment, published by the end of March 2025, to be shared with the Committee for review.	13.05.2025	Emma Cooke / Jane Brown	**COMPLETED** *Added to the Forward Plan for May 2025's meeting (Public)*
QC 25/02/007	**Medicine Clinical Board – Assurance Report**	For feedback on the Medicine CB's 'Stay Questionnaires' to be shared with the P&C Committee.	23.09.2025	Barbara Davies / Medicine CB	**COMPLETED** *Added to the Forward Plan for September 2025's P&C meeting.*
Actions referred FROM Board / Committees					



Report Title:	QSE Surgical Clinical Board Assurance Report				Agenda Item no.	2.1
Meeting:	Quality Committee		Public	X	Meeting Date:	1st April 2025
			Private			
Status:	Assurance	x	Approval		Information	
Lead Executive	Jason Roberts Executive Nurse					
Report Author:	Clare Wade Director of Nursing – Surgery Clinical Board					

Main Report
Background and current situation:

This report provides details of the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety and Patient Experience agenda during 2024/ 2025.

We believe that in focusing on 8 key priorities, we can aspire to provide safe, effective services that deliver excellent user experience. These eight key areas are:

- Safety Culture
- Leadership and the prioritisation of QSE
- Experience and Involvement
- Patient Safety Learning and Communication
- Staff engagement and involvement
- Data and insight
- Professionalism of QSE
- Quality Governance Arrangements

Between January 2024 – December 2025, the Surgery Clinical Board (SCB) provided a significant number of emergency and elective services to service users of Cardiff and Vale University Health Board. The specialties within the Clinical Board that provide these services include Trauma and Orthopaedics (T&O), Breast, General Surgery, Spines, Urology, Head and Neck, Dental, Vascular and Peri-Operative Care. The Clinical Board employs 2194 whole-time equivalent staff and has a budget of 185, million for 2025/ 2026

The Surgery Clinical Board provides services not only to Cardiff and Vale residents, but also beyond the local population at both the University Hospital of Wales and University Hospital of Llandough such as regional Spinal Surgery, Hepatobiliary Surgery and Vascular Surgery.

The Surgery Clinical Board also supports the activities of all other Clinical Boards within the Health Board through the provision of services provided by the Perioperative care Directorate, which includes Anaesthesia, Pain Management, Operating Theatres and Hospital Sterilisation and Disinfection Unit (HSDU).

Whilst many services provided by the Surgery Clinical Board are core activities, due to the high volume of activity and the diversity of its services, risk in the Clinical Board is high. Therefore, robust risk management arrangements are in place to reduce and manage these in order that our service users and staff are kept safe.

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The Surgery Clinical Board has a well-established formal Quality, Safety and Patient Experience (QSPE) that meets bi-monthly which is chaired by the Director of Nursing for Surgery Clinical Board. This structure is formally replicated in each of the Clinical Directorates.

The QSPE group has two key sub-groups that report to it; our Health and Safety group and Infection Prevention and Control group. The Surgery Clinical Board also has a part time Clinical Leader for QSE who assists the Director of Nursing for Surgery Clinical Board to ensure that all aspects of quality, safety and patient experience within the Clinical Board are monitored and reviewed, acting to mitigate risks on an ongoing basis

Each Speciality holds monthly Q&S meetings further work is required to strengthen this structure and the role of the local clinical lead for Q&S

SAFE CARE

Patient Safety Alerts/Internal Safety Notices

The Surgical Clinical Board has a robust process for cascading all Patient Safety Alerts. The designated Quality and Safety Clinical Leader is responsible for maintaining and updating the local surgical Safety Alerts database containing the details of all safety alerts which have been released over the past 12 months together with the evidence to support actions which have been taken. All notices are shared at the SCB QSE meetings and at the local Directorate Q&S meetings within the SCB

NRI Management

From January 2024 to December 2024 to date there were 4 reported Never Events.

- March 2024 – Retained paper ruler in patient's abdomen
- July 2024 – Wrong sized hip implant
- October 2024 – Wrong side FIB
- December 2024 – Wrong patient FIB

Actions put in place

The Clinical board recognizes that each of the above incidents should not have occurred if the available preventative measures have been implemented.
The most common causes of Never Events are substandard team function, safety culture and adherence to national standards.

The Clinical Board recognises that the 3 "wrong "Never Events was due to the failure to follow the checklists that are in place to protect both the patient and member of staff. Out of the 4 Never events, 2 occurred in theatre and 2 occurred in the Emergency Unit. Unfortunately, the Surgery Clinical board have continued to have a further Never Event of a wrong side surgery in 2025.

Several actions have been put in place

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- Finalisation of the Fascia Iliac block (FIB) Local Safety Standards for Invasive Procedures (LocSSips) and discussion as to whether to restrict this procedure to more senior staff
- Revised protocol around hip prothesis checking and working to implement scan 4 safety
- Use of suture material to measure intra- abdominally.

Harm and Never Events

Despite being nationally reportable incidents, it is generally found that Never Events are associated with lower levels of harm, the reasoning for reporting relates to the breach of the safeguards already in place to prevent occurrence. Never Events are also reported to Welsh Risk Pool if harm is felt to be significant, as a breach of duty will already be assumed.

A culture where staff feel reluctant to speak up, can contribute to unsafe practices. If safety isn't openly discussed, it becomes harder to address systemic issues that might lead to never event

Recognising that Surgery Clinical Board, and in particular, the Perioperative Directorate, are the predominant reporters of Never Events, the Clinical Board recognises that Perioperative Care Directorate need the leadership and support of the Surgical clinical aboard team and a wider collaborate approach with corporate tam support to change the culture and this will link in with the further culture and leadership review that is taking place in theatres. A culture that doesn't prioritize safety, or where staff feel reluctant to speak up, can contribute to unsafe practices. If safety isn't openly discussed, it becomes harder to address systemic issues that might lead to never event

A collaboration has been set up by the Director of Nursing for Surgery Clinical board with engaged stakeholders to re look at the use of the WHO checklist and local policies and how they are interpreted by the Perioperative Directorate. The collaborative will be focusing on:

- Education for all Heath Board staff what work or visit theatres
- Culture and the ability to speak up safely to raise a patient safety issue
- The role of the WHO check list and responsibilities

There were 19 National Reportable Incidents in 2024 of which one was investigated and subsequently downgraded, and there were 19 closures (which includes some NRI's reported in 2023). Others remain under investigation and will be prioritised so that they can closed as soon as possible.

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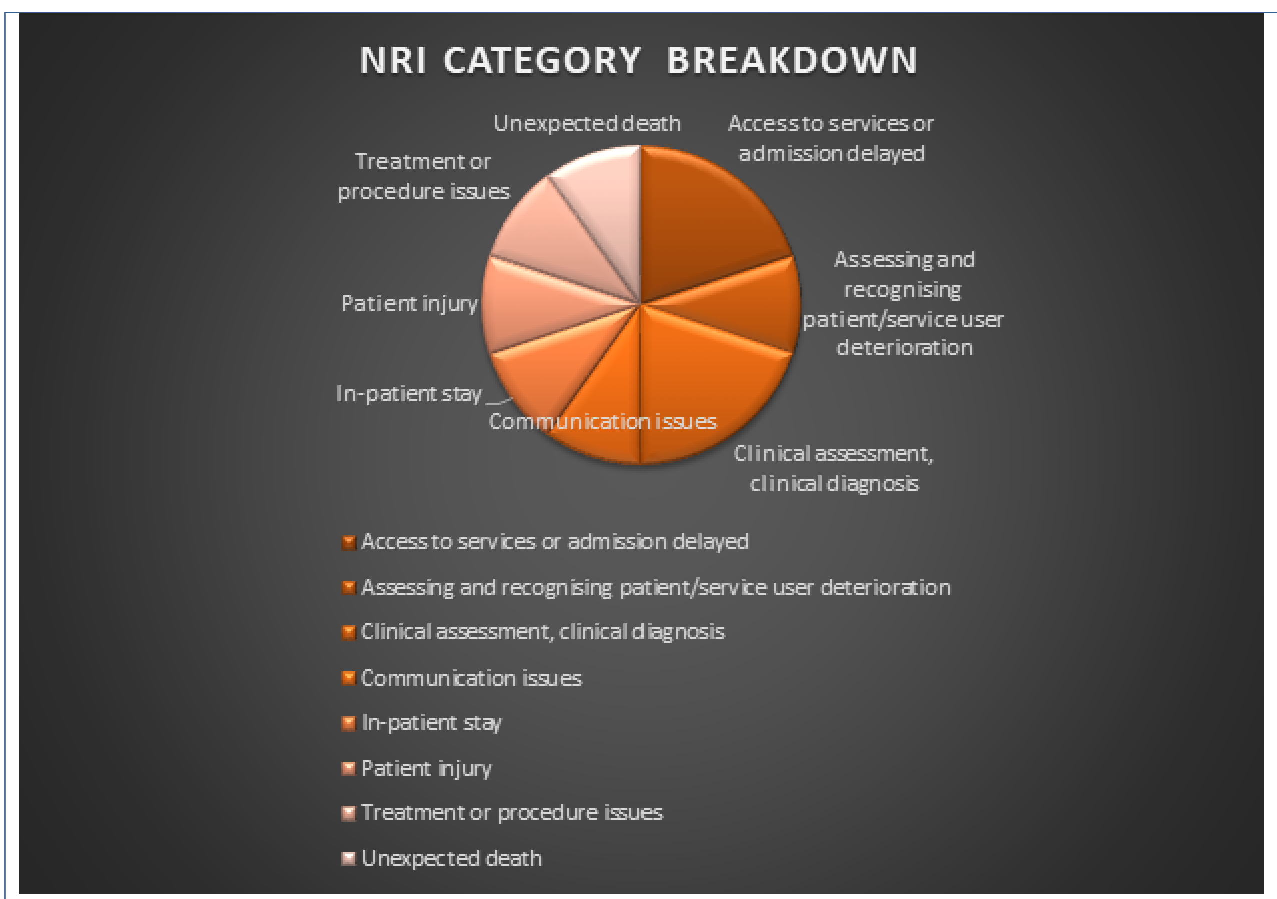
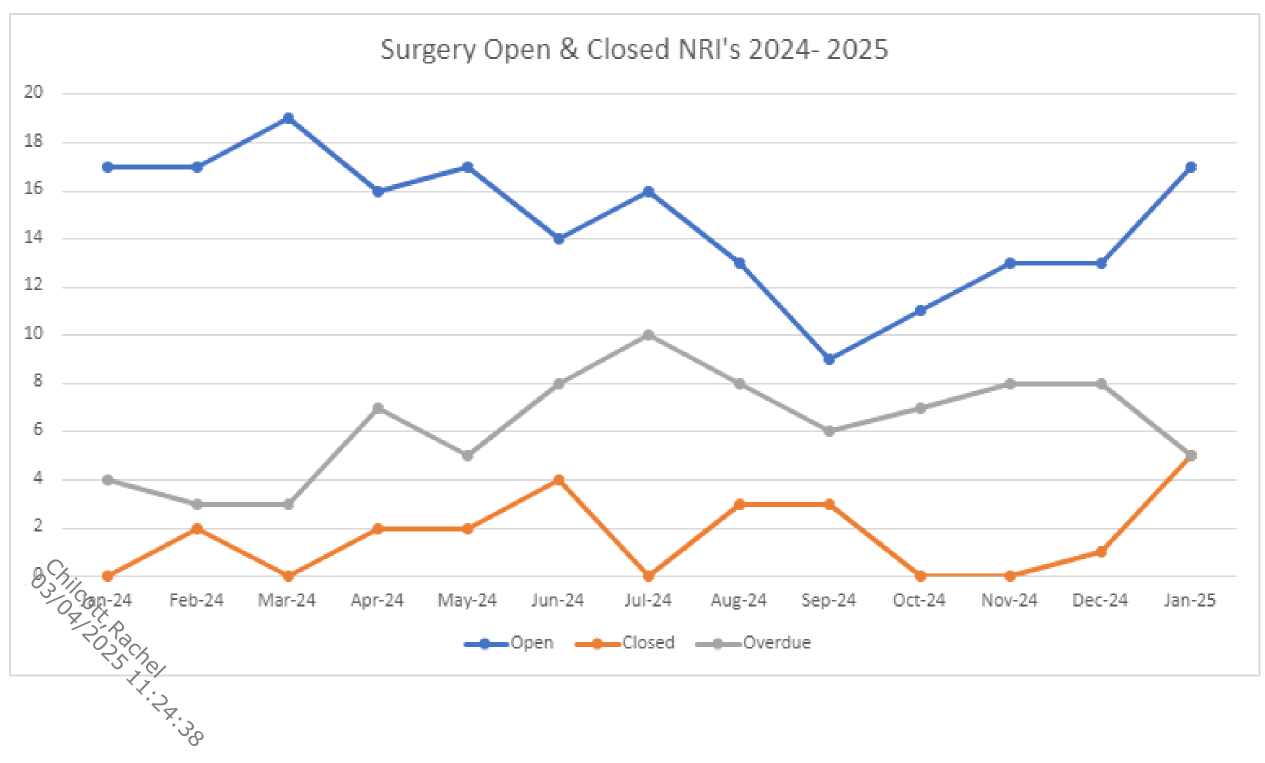


Currently open NRI's

There are 17 current open NRI's. 5 investigations are overdue and there are 2 expected closures in March 2025.



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Current Investigations

- Delay in escalation of deterioration x 2

- Untreated elevated calcium
- Delay of review in ophthalmology
- Lost to follow up x 3
- Wrong hip implant (never event)
- Non-escalation of carcinoma
- Paediatric adverse outcome
- Wrong side FIB (never event)
- Delay in CT scans x 2
- Loss of ETT in theatre
- Wrong patient FIB (never event)
- Wrong side Surgery (never event)
- Delay in surgery

Early Warning Notices

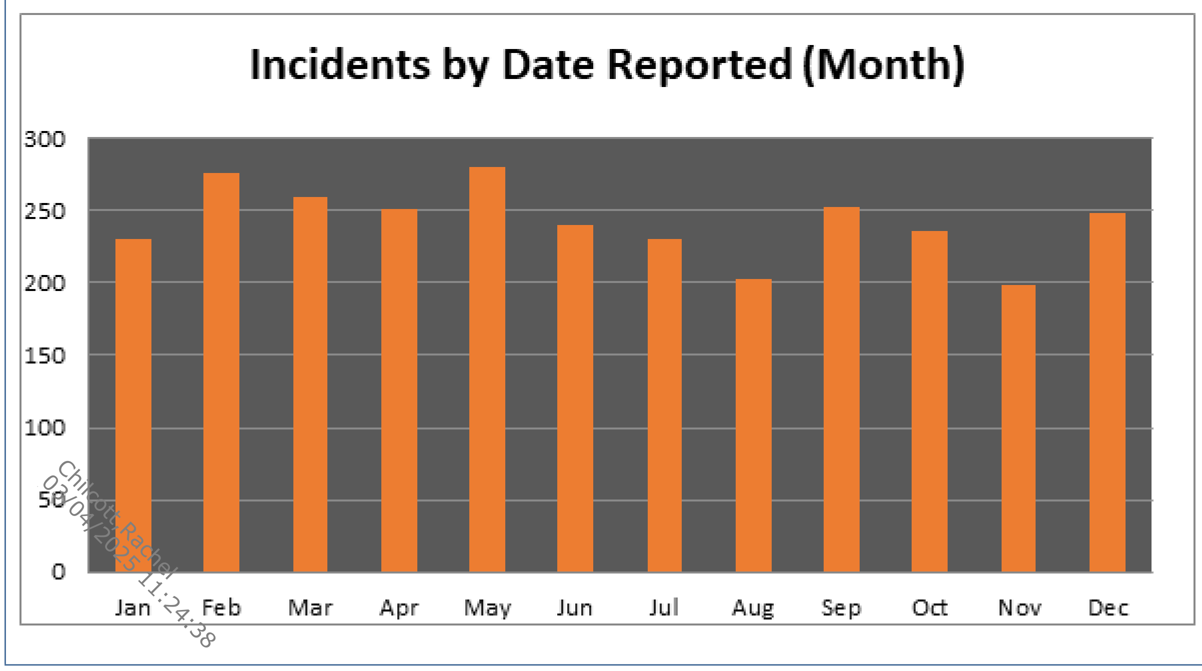
There was 1 early warning notifications sent to NHS executive in 2024:

- A dental patient protest re her treatment

Patient Safety Incident Management

The Datix Cymru incident reporting system is thoroughly embedded within the Surgical Clinical Board. The Clinical Board demonstrates an open reporting culture with a high number of incidents reported, with the vast majority of incidents leading to no or minor harm. The current number of incident managers is 195, with 12 superusers included in this number. Surgery representation has continued at the Patient Safety Datix Cymru Group, and updates and changes are disseminated to incident managers.

At the end of Dec 2024 there were a total of 830 open incidents excluding COVID incidents, which is a 12.5% increase from this point in December 2023 when there were 738 open incidents. Datix queues are being actively managed, however due to operational pressures queue reduction is challenging. Monthly queue data is shared with all senior nurses and managers to help identify hot spots and enable the provision of targeted support for incident managers or specific areas which need additional support.



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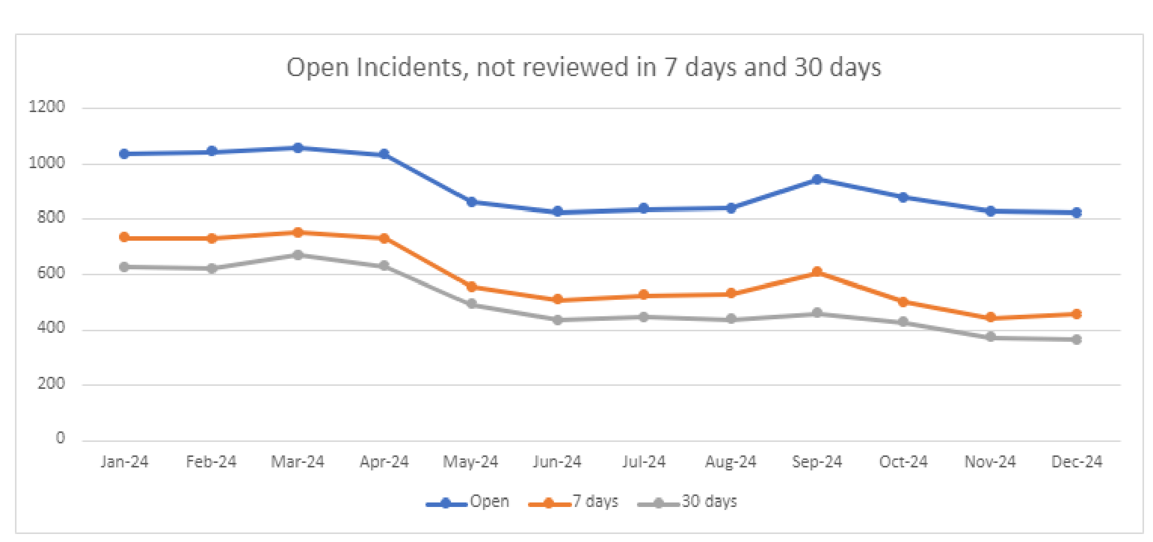
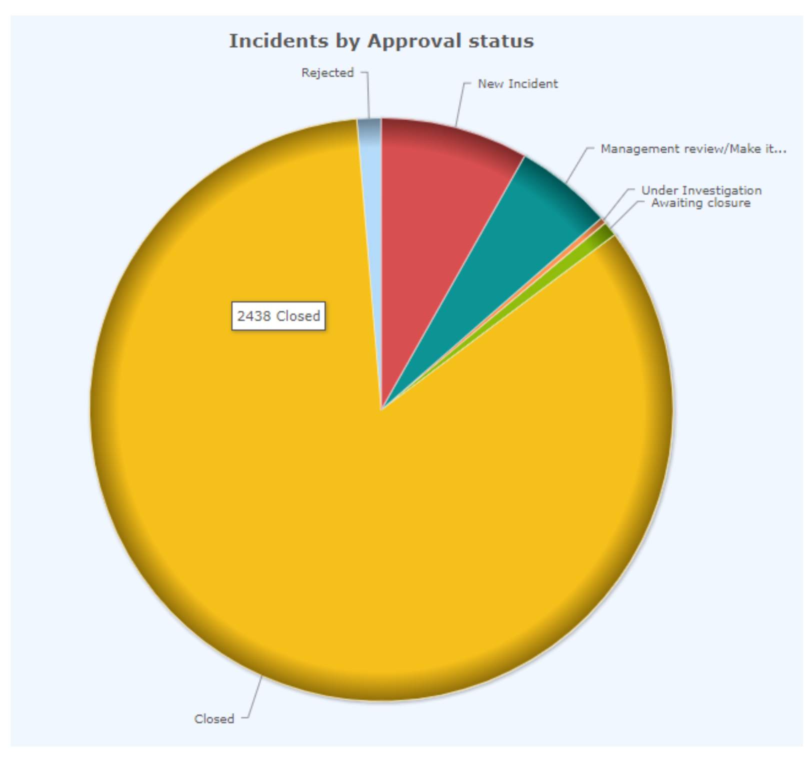


The incidents awaiting review in 7/30 days graph above demonstrates our future challenge, and the need to work with and educate all incident managers to actively manage their assigned incidents and move them along efficiently to reduce these numbers

This graph identifies the status of the Incidents reported from Jan – Dec 2024



Top 10 incidents reported

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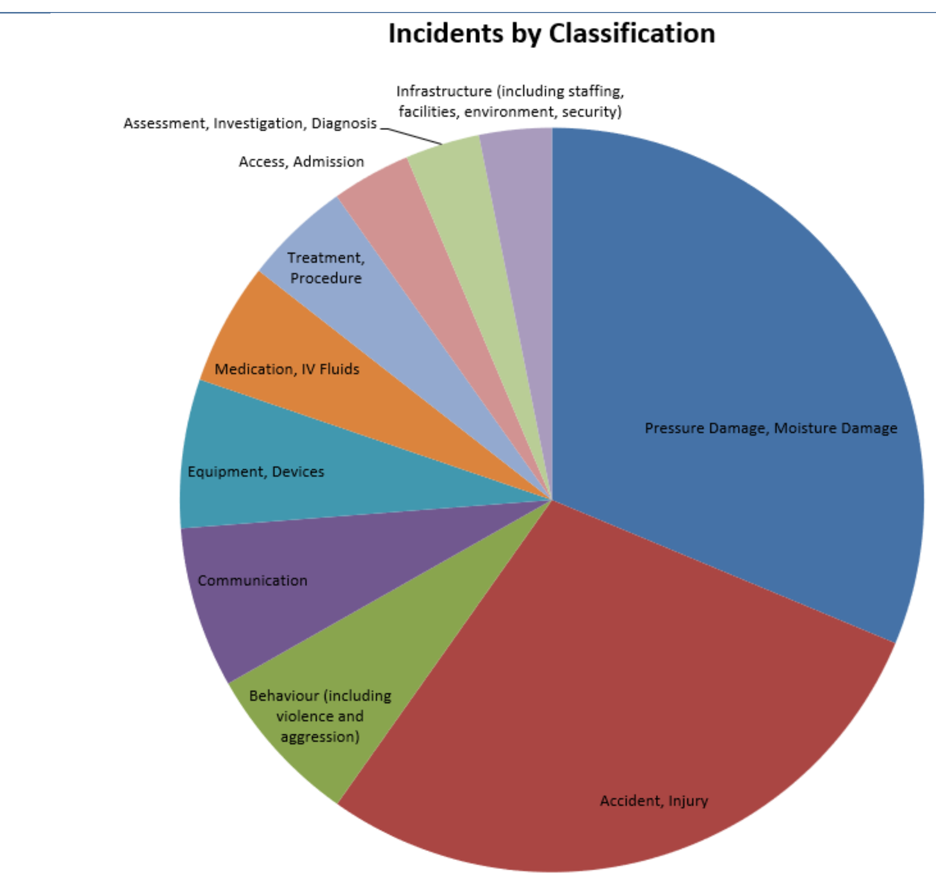

Pressure Damage

The SCB Pressure Area Scrutiny and Learning Panel have been in place for 2 years , the meetings have been held every 4-6 weeks. Staff have benefited from presenting and discussing their patients as part of the group.

There have been specific challenges and risks highlighted with patients on B2, many of whom have existing peripheral vascular disease (PVD). They are therefore at much higher risk of developing pressure ulcers and then those pressure ulcers deteriorating or failing to heal. Consideration is being given to the detail of investigation these types of incidents require if PVD can be identified as a primary cause.

Within T&O Hip fracture patients have also been singled out as a focus as many are spending extended times prior to admission to hospital lying or without food/ hydration.

Falls

In total there were 419 reported falls from 01/01/2024 - 31/12/2024 within Surgical Services. Of this number, 5 were ultimately categorised as being of moderate harm following investigation, however on further review it appears that two of those were deemed as unavoidable so could be downgraded. A total of 2 falls within ENT Head & Neck, and 3 within General Surgery, none of which met the criteria for NRI reporting. All falls focused reviews are scrutinised and discussed at the Falls Panel with representation from the Patient Safety Team.

There was no common theme amongst the falls, which included mechanical falls, slips from seating and unwitnessed falls variously.

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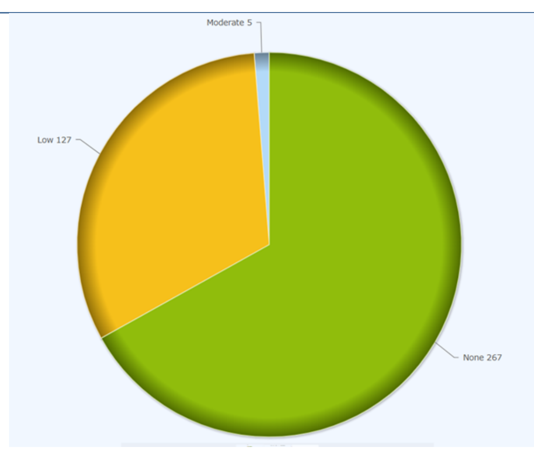

Risk management

- Training session for band 7's and above has happened in 2024
- All Risk Registers have been transferred to Teams for easier access
- Top 3 risks for each speciality to be discussed at directorate performance meetings
- Support for governance team and I&I to map Risk registers to **AMaT** – surgery will be the 2nd clinical board to migrate post medicine - 2 meetings already held with I&I and governance team to progress this

Risk	Rating	Post mitigation Risk
Potential Failure of AHU HSDU	25	12
Ophthalmology IT systems	20	12
LTFU ophthalmology	25	16
Asbestos Dental Hospital	20	12
Cast iron waste pipe Dental	20	12
Urology Surveillance Cystoscopy back log	20	16
FUNB cohort for all specialties	20	16
General poor estate across many areas	20	16
Inability for out of area spinal injured patients to access spinal beds in a timely manner	16	16
A backlog in typing results in delayed communication of critical clinical information	20	16

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Safeguarding

All safeguarding referrals relating to community concerns or raised against staff working within the Surgery 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, with appropriate actions taken and shared more widely if required. The Clinical Board has key links with the Safeguarding Team to ensure openness and transparency and remains a standing agenda item on the QSPE and Nursing Board agenda. The Clinical Boards DON is the safeguarding lead who attends the UHB Safeguarding Committee on behalf of the Director of Nursing.

Infection, Prevention and Control

C Difficile

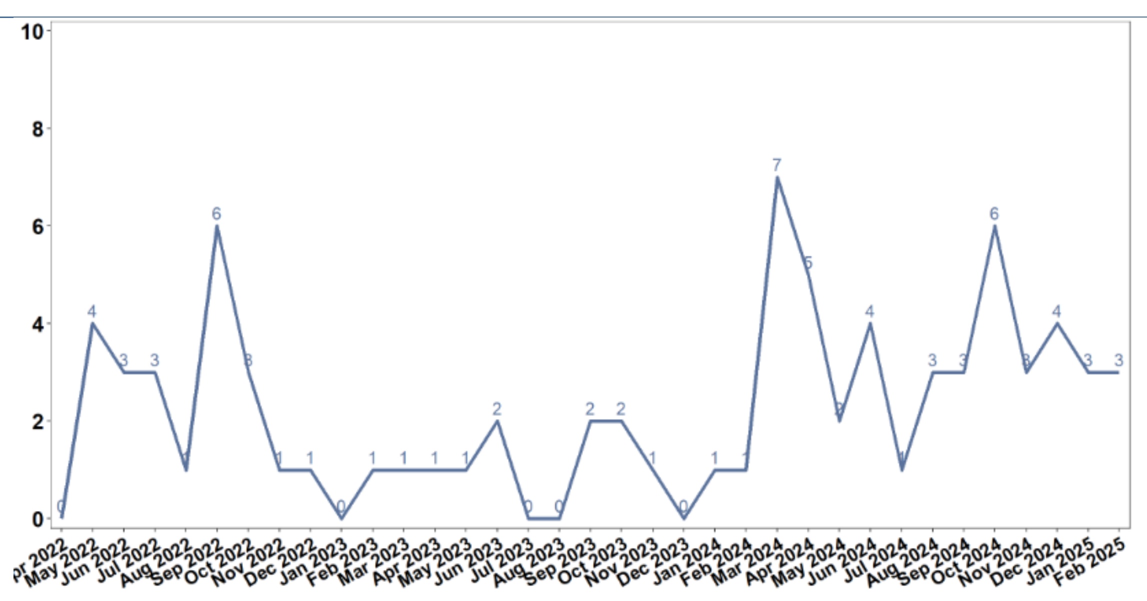
Monthly Numbers and Cumulative of C Difficile for Surgery Clinical Board

	Monthly Numbers for 2022/23	Cumulative Monthly Numbers for 2022/23	Monthly Numbers for 2023/24	Cumulative Monthly Numbers for 2023/24	Monthly Numbers for 2024/25	Cumulative Monthly Numbers for 2024/25
Apr	0	0	1	1	5	5
May	4	4	1	2	2	7
Jun	3	7	2	4	4	11
Jul	3	10	0	4	1	12
Aug	1	11	0	4	3	15
Sep	6	17	2	6	3	18
Oct	3	20	2	8	6	24
Nov	1	21	1	9	3	27
Dec	1	22	0	9	4	31
Jan	0	22	1	10	3	34
Feb	1	23	1	11	3	37
Mar	1	24	7	18	-	-

37 incidents for C Difficile were attributed to the Clinical Board from 1st April 2024 to 28th February 2025 which is a 236% increase more than the equivalent period in 2023/ 2024
A focused piece of work has been carried out on the worrying position which is replicated all over the Health board and across Wales and the following themes have been found

- patients over the age of 65 (5 of which were over > 90 years)
- multiple admissions over 6 months.
- patients developed symptoms at home
- patients readmitted with symptoms and diagnosed
- patients having GI surgery
- patients had excessive alcohol intake
- Patients treated with Tazocin

Monthly Numbers of C Difficile for Surgery Clinical Board (April 2022 Feb 2025)



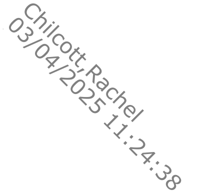
MRSA

There have been no reported cases of MRSA for 2024

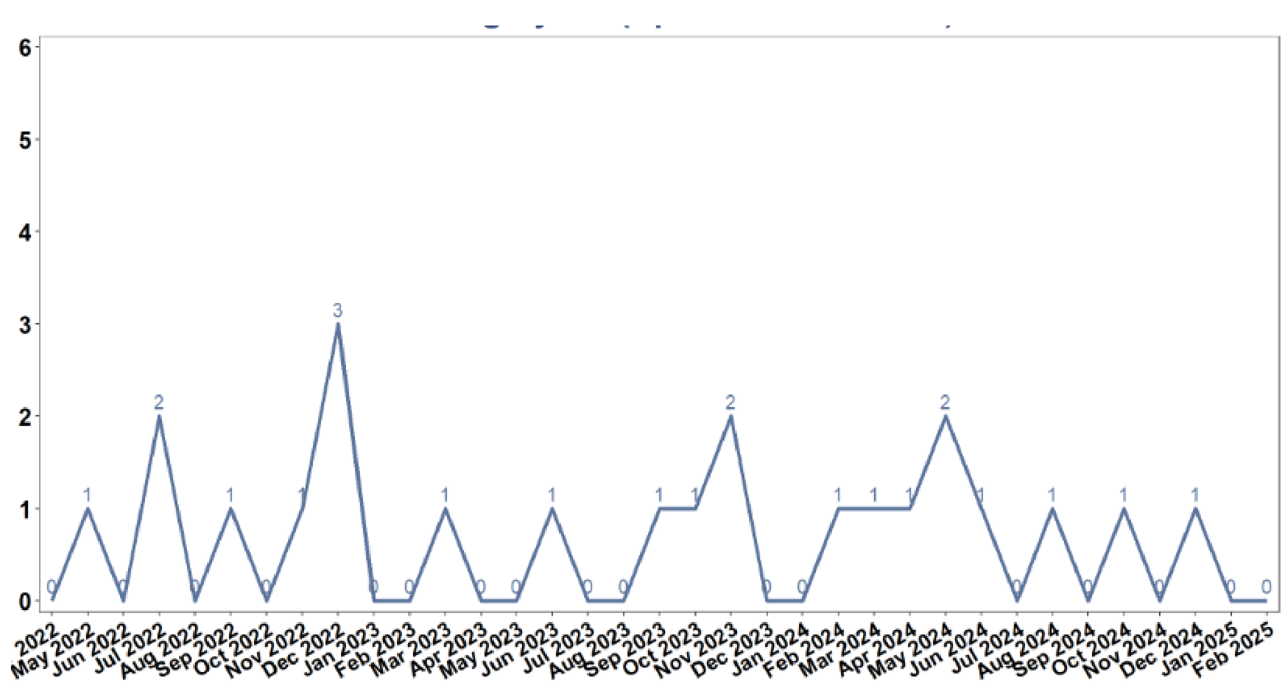
	Monthly Numbers for 2022/23	Cumulative Monthly Numbers for 2022/23	Monthly Numbers for 2023/24	Cumulative Monthly Numbers for 2023/24	Monthly Numbers for 2024/25	Cumulative Monthly Numbers for 2024/25
Apr	0	0	0	0	0	0
May	0	0	0	0	0	0
Jun	0	0	0	0	0	0
Jul	0	0	0	0	0	0
Aug	0	0	0	0	0	0
Sep	0	0	0	0	0	0
Oct	0	0	0	0	0	0
Nov	0	0	0	0	0	0
Dec	0	0	0	0	0	0
Jan	0	0	0	0	0	0
Feb	0	0	0	0	0	0
Mar	1	1	1	1	-	-

MSSA

There have been 7 cases, which is 17% more than the equivalent period in 2023/24

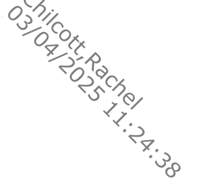


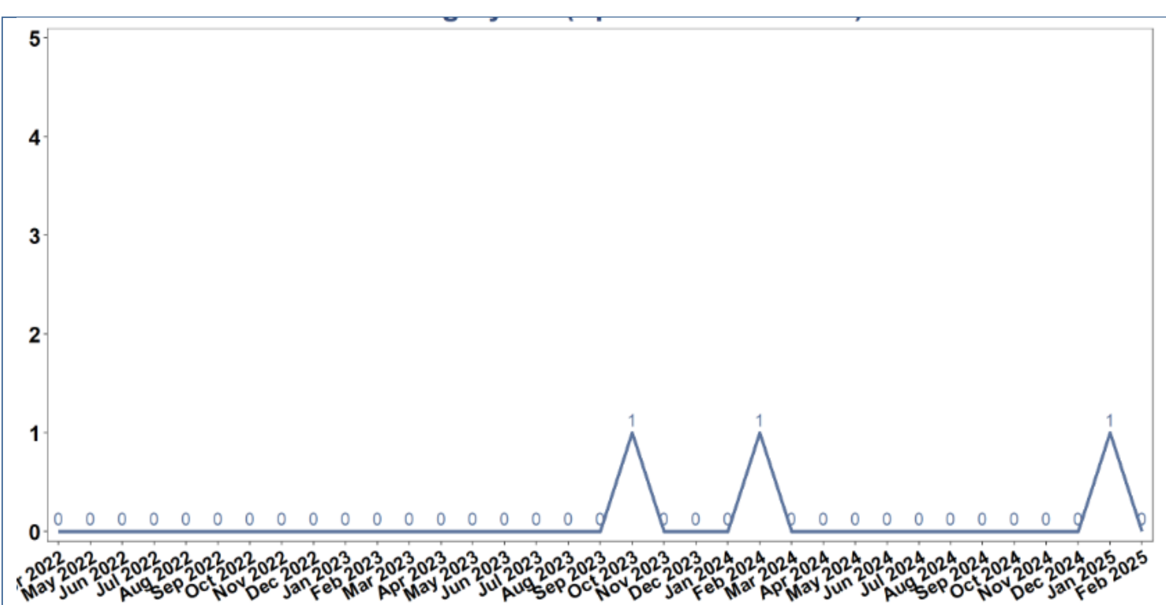
	Monthly Numbers for 2022/23	Cumulative Monthly Numbers for 2022/23	Monthly Numbers for 2023/24	Cumulative Monthly Numbers for 2023/24	Monthly Numbers for 2024/25	Cumulative Monthly Numbers for 2024/25
Apr	0	0	0	0	1	1
May	1	1	0	0	2	3
Jun	0	1	1	1	1	4
Jul	2	3	0	1	0	4
Aug	0	3	0	1	1	5
Sep	1	4	1	2	0	5
Oct	0	4	1	3	1	6
Nov	1	5	2	5	0	6
Dec	3	8	0	5	1	7
Jan	0	8	0	5	0	7
Feb	0	8	1	6	0	7
Mar	1	9	1	7	-	-



Pseudomonas

There has been 1 case of Pseudomonas reported

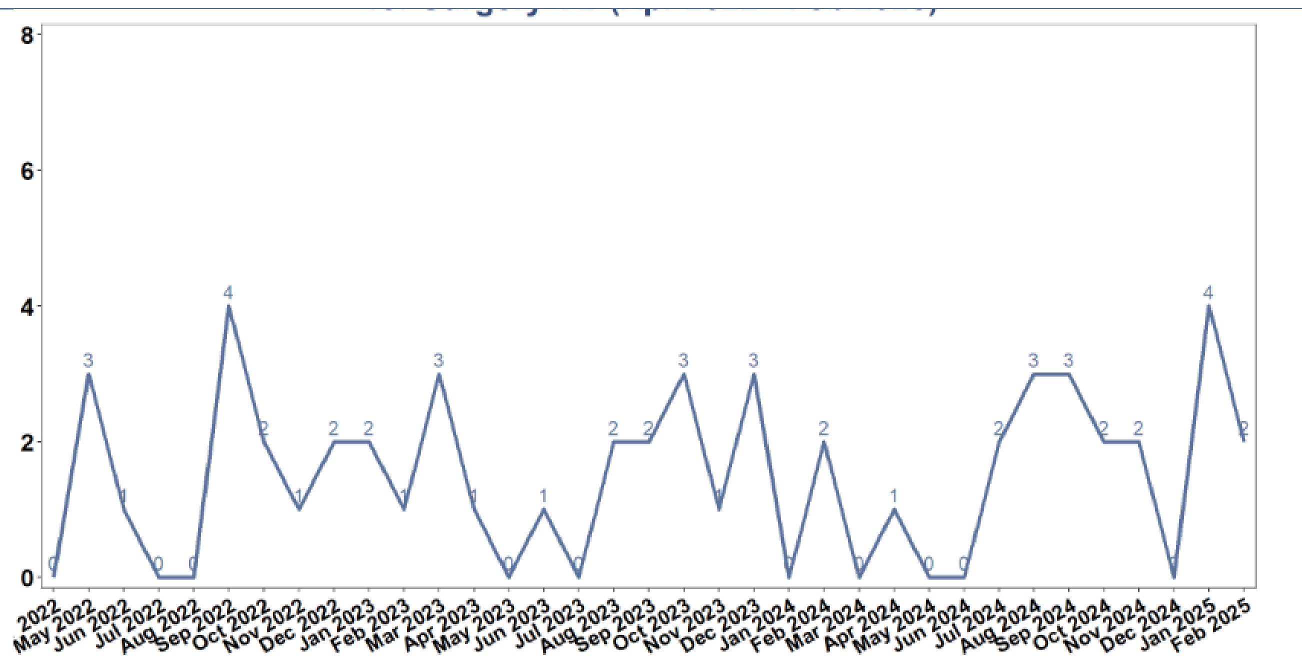




Klebsiella

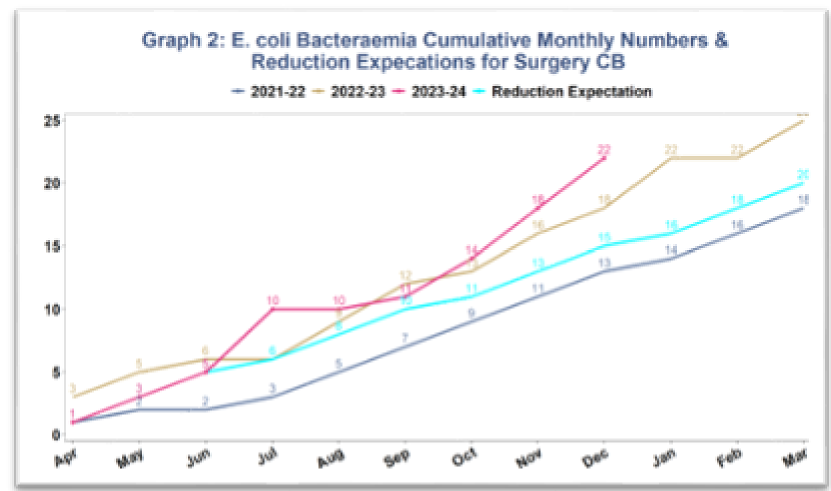
There were 19 cases of Klebsiella reported between April 2024 and February 2025

	Monthly Numbers for 2022/23	Cumulative Monthly Numbers for 2022/23	Monthly Numbers for 2023/24	Cumulative Monthly Numbers for 2023/24	Monthly Numbers for 2024/25	Cumulative Monthly Numbers for 2024/25
Apr	0	0	1	1	1	1
May	3	3	0	1	0	1
Jun	1	4	1	2	0	1
Jul	0	4	0	2	2	3
Aug	0	4	2	4	3	6
Sep	4	8	2	6	3	9
Oct	2	10	3	9	2	11
Nov	1	11	1	10	2	13
Dec	2	13	3	13	0	13
Jan	2	15	0	13	4	17
Feb	1	16	2	15	2	19
Mar	3	19	0	15	-	-



E Coli

There has been a cumulative of 19 cases for 2024 this is a 21% reduction period last year which is in line with other areas of the Heath Board E-Coli was associated with several urinary tract infections particularly within T&O, as a result with help of the ICP team additional teaching has been undertaken with the use of Catheter Bundles.



Workforce Well-being:

Workforce data – January 2025

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	Feb-24	March-24	Apr-24	May-24	June-24	July-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Long Term	3.02%	4.18%	3.74%	3.60%	3.94%	3.72%	4.06%	3.68%	3.92%	4.30%	5.02%	3.92%
Short Term	2.47%	2.03%	1.84%	1.90%	1.71%	1.85%	1.30%	1.19%	2.32%	1.63%	1.61%	2.18%
VBAs	69.49%	79.04%	83.08%	83.04%	82.71%	81.14%	80.72%	80.98%	78.59%	77.54%	77.56%	75.84%
Medical Appraisal	85.33%	83.02%	84.62%	85.02%	86.14%	84.27%	86.09%	84.81%	82.37%	80.50%	81.34%	88.24%
Vacancies	4.77%	5.31%	5.64%	6.92%	8.32%	8.07%	8.46%	6.83%	7.26%	7.65%	7.38%	3.48%
Statutory Mandatory Training	77.20%	78.12%	78.19%	77.90%	77.40%	77.21%	77.02%	75.89%	74.16%	74.07%	74.10%	73.87%
Fire Training					67.88%	66.72%	65.48%	64.07%	63.01%	63.09%	63.09%	62.74%
Turnover	10.56%	11.29%	11.27%	11.25%	11.45%	11.24%	9.61%	9.48%	9.83%	9.61%	9.41%	9.11%
Medical Job Plans	61%	64.22%	64.40%	68.81%	69.35%	70.23%	70.87%	68.79%	66.77%	66.25%	70.57%	71.39%

There is a recognition that high levels of sickness absence not only impact on the well-being of the individual by also on our ability to ensure we provide the best patient care. Managing sickness absence has become a priority focus for the Health Board over recent months, thereby the clinical board have increased their focus and support to managers, through the following set of actions:

Robust Clinical Board Sickness action plan which identifies areas where managers require support to reduce absence and highlights 4 key deliverables. Sickness panels, focus on those over 6 months on LTS, top frequent individuals, high frequent sickness by ward.

Sickness panels are now held monthly with a key focus on hotspot areas, frequent cases and long-term sickness, during each panel a plan for each case discussed is agreed, the line manager will take responsibility for leading on the actions with the support of People Services.

People Services and ECOD team are developing new absence training for line managers, training will be delivered on a module basis so line managers can attend the most relevant module and have access to go back and review the training as and when required to support their continued development.

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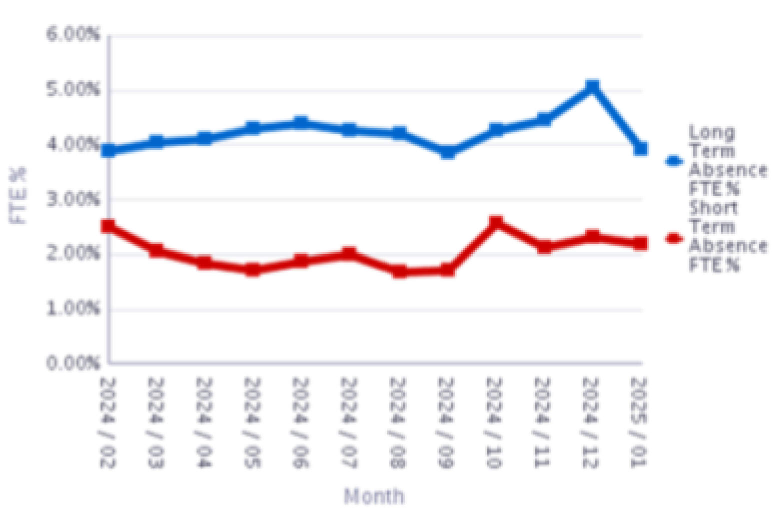
A set of agreed regular data files to be shared with the clinical board and lines managers.

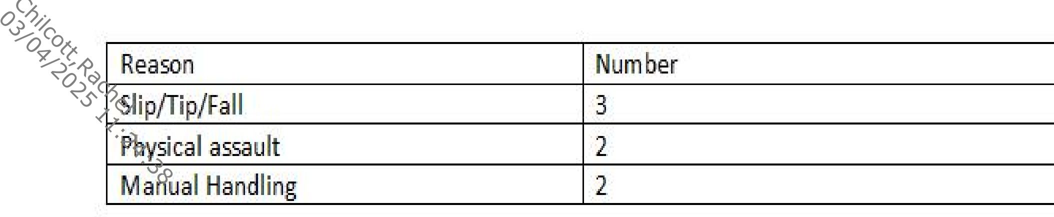
A review of sickness absence and RIDDOR reportable sickness to be undertaken to identify any key themes.

The sickness trajectory for the Clinical Board suggests a reduction of absence rates but we know from April 2025 there will be an ask for a 2% reduction in absence rates for the clinical board. This would signify a need for a large reduction to a figure not reported post COVID. To achieve this, a focus will also be needed on how we support our workforce in 'keeping well'.



RIDDOR reports.

Year to date there have been 7 staff absences that have been RIDDOR reported, the incidents case be classified as below:



Reason	Number
Slip/Tip/Fall	3
Physical assault	2
Manual Handling	2

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Workforce Engagement:

Staff Survey 2023

The clinical board developed a set of key actions to address some of the themes presented in the 2023 staff survey results, these are currently being actioned and will be linked into the results of the 2024 survey

Actions Agreed/Planned	Timelines
1) **Review of Staff Survey Results** • SMT to complete deep dive into results of 2023/4 Survey	November 2024
2) **Employee Engagement/ Promote Opportunities for Feedback:-** • Introduction of Local Partnership Forums at Departmental level • Plan for regular departmental visits of TU Lead with Member of SMT to increase level of visibility/provide direct opportunity for staff engagement/feedback • Sustain annual Staff Awards celebratory event	End of March 2025
3) **To increase awareness of EQI to ensure appropriate levels of support being provided to staff** • Arrangements for UHB Strategic Lead to undertake update training sessions for all Managers and Lead Clinicians in April 2025 • Baseline Assessment of adherence to EQI standards to be completed • More visible promotion of EQI related activities across Surgical Board • Establishment of EQI Engagement Group within Clinical Board	End of April 2025
4) **To ensure Staff are supported in Raising Concerns/Appropriate Management of Staff Concerns** • Promotion of Key Policies- Freedom to Speak Up Policy, Sexual Safety Charter etc.. • Update Training for Managers and Nursing Leads on Management of Conduct/Capability Issues • Explore opportunities to use digital means by which to provide staff with easier access to key information • Offer Sexual Harassment/Sexual Safety training	End of May 2025
5) **To Maximise opportunities for gauging staff feedback on an ongoing basis** • Explore opportunities to improve robustness of feedback loop in respect of positive and negative staff feedback (exit questions, reported staff concerns, compliments) • Use of QR codes to encourage staff engagement and feedback on key priorities within the Clinical Board adding the digital solutions we already have in place eg SUS	End of March 2025

Staff Survey 2024

The most recent staff survey has just been made available and high levels results suggest an overall decline in employee engagement (not just within Surgery CB), despite this there are small improvements in some areas for the clinical board which indicate more positive leadership and improvements to culture where staff are more confident to raise concerns.

Leadership and Culture:

Currently there are 13 open formal disciplinary cases, 3 of which are directly related to patient care.

In the last year we have run an internal Culture Survey in both UHL and UHW Upper Mains theatres. The results of the comprehensive service review in UHW Upper Mains results has led to an Executive Sponsored Culture Review looking at:

- Values and behaviours

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- Leadership and management capability
- UHW theatres leadership structure and roles and responsibilities
- Team Dynamics
- Communication and engagement
- Fairness and equity
- Staff turnover

The final report and recommendation are planned to be share with the executive team prior to Easter holidays and from the back of this there will be a suite of actions that will be undertaken

For additional support in the shorter term the Director of Operations, Clinical Director, Director of Nursing and the Deputy Director of Nursing are providing and enhanced level of support for the perioperative team

Method to improve staff enouncement

Local Partnership Forums/Trade Union Engagement- The Surgical Clinical Boards is taking steps to introduce Local Partnership Forums at departmental level so as to provide more local opportunities for staff engagement and feedback to the Board. We also have a new lead TU representative for the Clinical Board, who has had facilitated visits to our departments again to demonstrate positive and visible partnership working.

Two Way Communication: We have used QR codes to enable two-way communication with our staff on key Clinical Board matters e.g. No Idea is a Silly Idea; ways to engage staff in how we could work more prudently to save resources, how we can improve on some of our staff related events e.g. Surgery Star Awards.

Sharing Good News Stories/Best Practice Ideas - We are currently in the process of developing our own CAV Community by which we can communicate more directly with staff on items which hopefully make them feel more connected to the activity going on across the Clinical Board. We also are fervent users of 'private site' social media, again to re-enable staff to directly engage on matters of interest relevant to the Clinical Board

Staff Survey Feedback: We have used the feedback received from the Staff Survey 2023 to develop an action plan, which focuses on increasing the visibility of Senior Management Team at clinical departmental level, ensuring staff are aware of all of the various forms of support available to them should they wish to raise any concerns, additional training opportunities on policies that will help them feel confident and safe in delivery of their roles.

Surgery Star Awards: The 2024 Surgery Star Awards, held in Lecture Theatre 3, was well attended by all staff group with over 80 attendees. It was a fantastic event celebrating the positive work and efforts over the previous year from all SCB staff. Feedback received from staff has been positive with many highlighting the range of award winners and that names were shared of all staff who had received a nomination.

Colleagues recognised at Surgery Star Awards Ceremony

Category	Winner	Runner-up
Outstanding Performance in Work	Dr William Havelock	Karen Rice
Dominga David Unsung Hero	Sarah Portlock	Claire Williams
Inspirational Leader	Clare Jacobs	Guiseppe Pecora
Embodying our Values and Behaviours and Promoting Equality and Diversity	Mr. Cellan Thomas and the Maxillo-Facial Team	Alix Spiteri
Exemplary Team	The General Surgery Secretarial Team	The Stoma Team
Wellbeing of Staff and Colleagues	Claire Andrews	Karen Burke
Green Champion	The Scope Room Team, UHW	Steve Hill

Resources

Financial Position as of 28th February 2025

The Board has reported an overspend of £6.800m for the eleven months of the year. This reflected a deterioration of £0.643m in month.

The position is summarised in the table below: -

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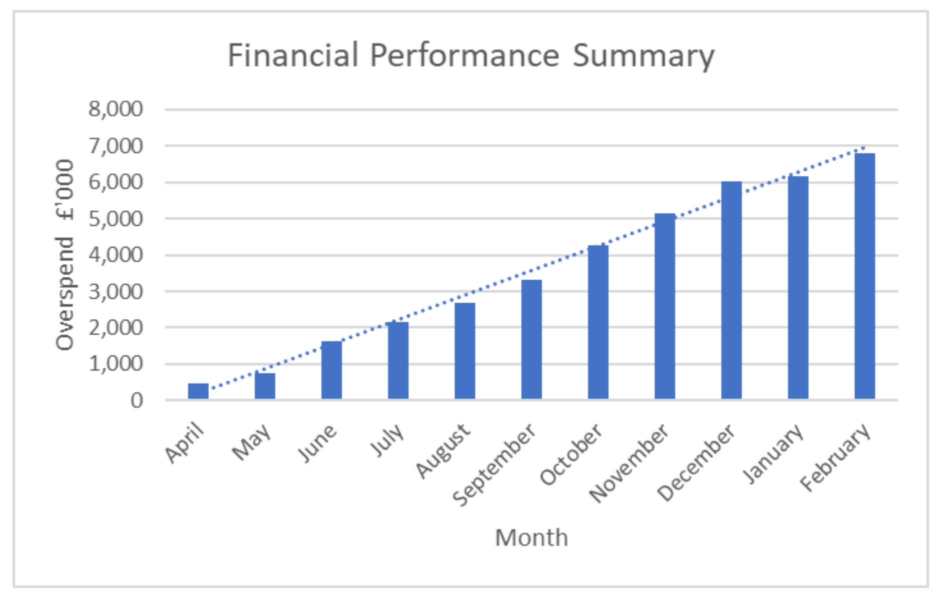
	In-Month			To Date		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Pay	13,706	13,902	**196**	151,548	153,067	**1,519**
Non-Pay	3,842	4,228	**386**	37,907	43,458	**5,550**
Income	-531	-469	**62**	-6,977	-7,246	**-269**
Totals	**17,017**	**17,661**	**643**	**182,478**	**189,278**	**6,800**

Performance by operational and savings positions is summarised below: -

	Month 11 £'000	Month 10 £'000	Variance £'000
Operational	2,918	2,628	**289**
CRP	3,882	3,529	**354**
Totals	**6,800**	**6,157**	**643**

The month 11 position reflected a largely unchanged position, as can be seen within the graph below: -



Whilst the bottom line is tracking in line with the likely forecast, an improvement of £200k per month on temporary pay has been largely absorbed by further non-pay pressures on theatre budgets.

The graph below shows the registered nursing/ODP and HCSW agency, bank and overtime expenditure since April 2024. There is a £134k reduction in spending in month 11 compared to the month 1 to 9 average.

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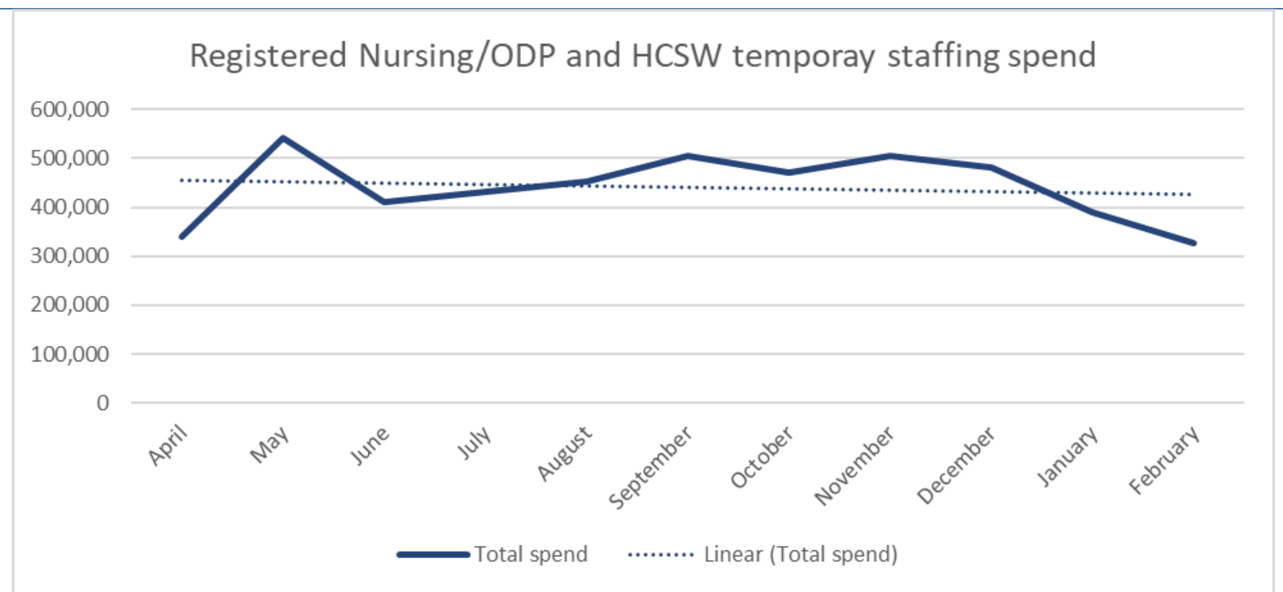

A key priority of the Clinical Board over the last 3 months has been to reduce the nursing spend on temporary staffing and the Clinical Board nursing team via an enhanced scrutiny process have reduced their temporary staffing nursing spend The SCB nursing teams have started using Safecare as a tool to monitor their nurse staffing levels and patient acuity over the last year and it has been rolled out in both UHW and UHL. The tool allows the Director of Nursing and Senior Nursing Team to have clear visibility across all areas about staffing risks.

The month 11 position compared to forecast is summarised below: -

	Forecast Month 11 £'000	Actual Month 11 £'000	Variance Month 10 £'000
Operational	2,957	2,918	-39
CRP	3,898	3,882	-16
Totals	**6,855**	**6,800**	**-55**

Without further actions the board was forecasting a best case overspend of £6.909m as at month 06. Performance in the last five months has created further risk such that without intervention the clinical board overspend is forecast to increase to £7.546m.

The board remains in financial escalation with regular meetings with the Director of Finance and Chief Operating Officer as the financial overspend represents a significant risk to the Health Board being able to deliver its year-end target as agreed with Welsh Government.

Key Actions

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- **Weekly progress required against delegated savings targets**
- **Plans required to address material cost pressures brought forward from 23/24**
- **Mitigation actions required to improve the financial forecast.**
- **Clarification as to the significant non-pay overspend in Theatres**

EFFECTIVE CARE

Mortality Reviews

The Clinical Board is represented at both the UHB Mortality Screening Panel and Learning from Mortality Group. The clinical board is looking to roll out the use of the Business Intelligence System (BIS) Mortality Dashboard which is now live, and work continues to standardize mortality reviews within the Clinical Board. 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.

Clinical Audit

Each Directorate has a Clinical Audit Lead. Clinical Audit forms part of the Clinical Board Director's responsibilities. The Clinical Board has an audit/research plan for 2023/ 2024.
The Clinical Board has welcomed the introduction of AMaT (Audit Monitoring and Tracking) to support accurate and timely audit programmes and compliance and so far, 78 Clinical Board Audits have been logged on the AMaT system

Tendable Audits

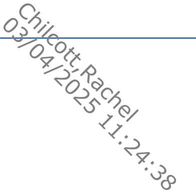
Tendable has been successfully rolled out to all Surgical inpatient settings and theatres in 2023
The quality improvement and auditing app is used across the Surgical Clinical Board to monitor standards of care and the clinical environment as well as patient and staff experience. It is used by over 70 members of staff across 17 inpatient areas, 3 outpatient areas and 50 theatre areas. The audit data is reported and communicated directly through the Tendable application and is reported locally via Cardiff and Vale UHB, Power Bi Nursing dashboards.

The Surgical Clinical Board use the data from their audits to drive improvements in practice and to shape their improvement agenda.

The Clinical Board monitor compliance with the ward audit programme monthly. Teams are expected to complete a:

- Core Standards audit
- Infection Prevention and Control audit,
- Care Specifics – monthly topic audit
- Lead and Senior Nurse review.

Theatre suites also follow this structure along with undertaking ad hoc QUAD Theatre audits and Theatre Environment audits.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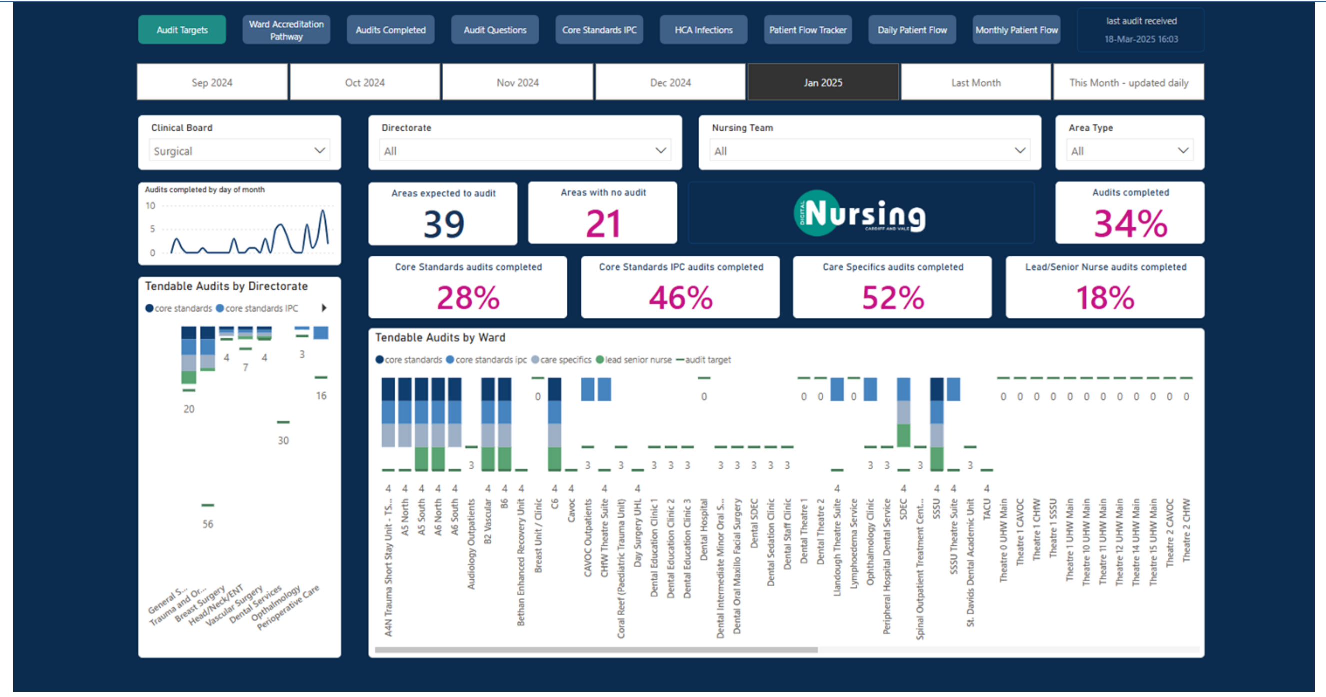

Surgery Clinical board has had its first bronze ward accreditation in 2024 – ward C6

The Surgical Clinical Board currently has two areas eligible to join the Ward Accreditation and Improvement programme -A6N and B6 South

Theatre transformation

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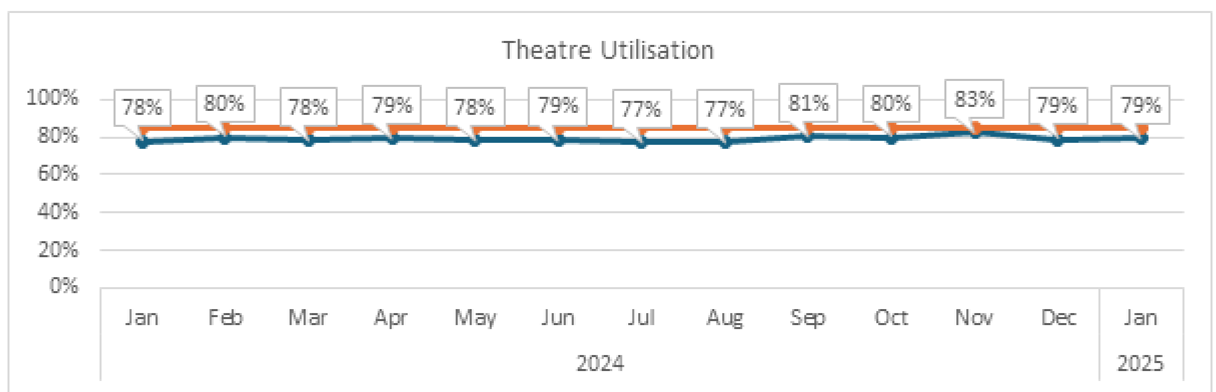
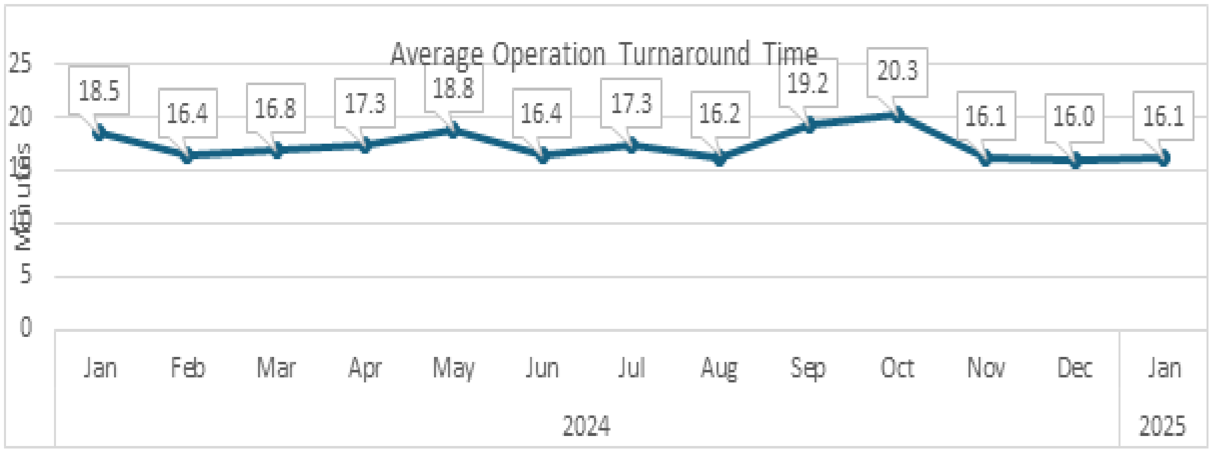
In July 2024 GIRFT (Getting It Right First Time) published recommendations for improving 'Theatre Productivity', as part of this programme 'Module 3' addresses 'Theatre Scheduling'. SCB agreed to strengthen existing practices to work in line with GIRFT recommendations. The change was initially implemented at UHL September 2024 to test the process, before being rolled out across the UHB in January 2025.

The recommendations include a three phased approach;

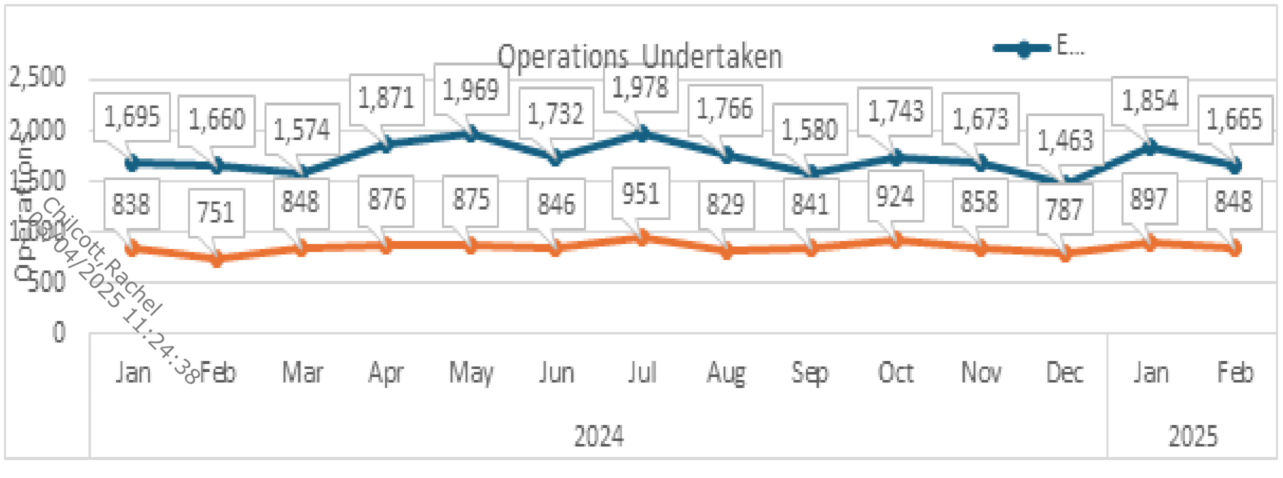
1 – Introducing a speciality planning meeting
2 – Theatre scheduling meeting (known as 642)
3 – Formal lookback at Directorate/speciality performance to improve theatre utilisation, as part of this process the 'Theatre Delivery Group' was relaunched as the forum to review data and address performance concerns and to identify any additional support required to improve utilisation of available theatre time.



Efficiency gains have been made since the introduction of the GIRFT recommendations, with November 2024 being the most productive month we have had in recent years. Sustaining the gains has however been challenging. Poor theatre infrastructure particularly at UHW is a significant contributing factor in our inability to maintain performance gains.



A small gain has also been made in relation to turnaround time, which relates to the inactive period of time in between patients in theatre. This is the start of the potential to treat more patients during surgical lists in the forthcoming year.



Chilcott, Rachel

In August 2024 cardiothoracic operating returned to UHW. Activity has been maintained during the transition; this is despite the challenges faced around ongoing poor infrastructure (ventilation, temperature and water ingress) leading to a recurrent intermittent reduction in total number of available theatres in which to deliver surgery.

Plans for the next financial year

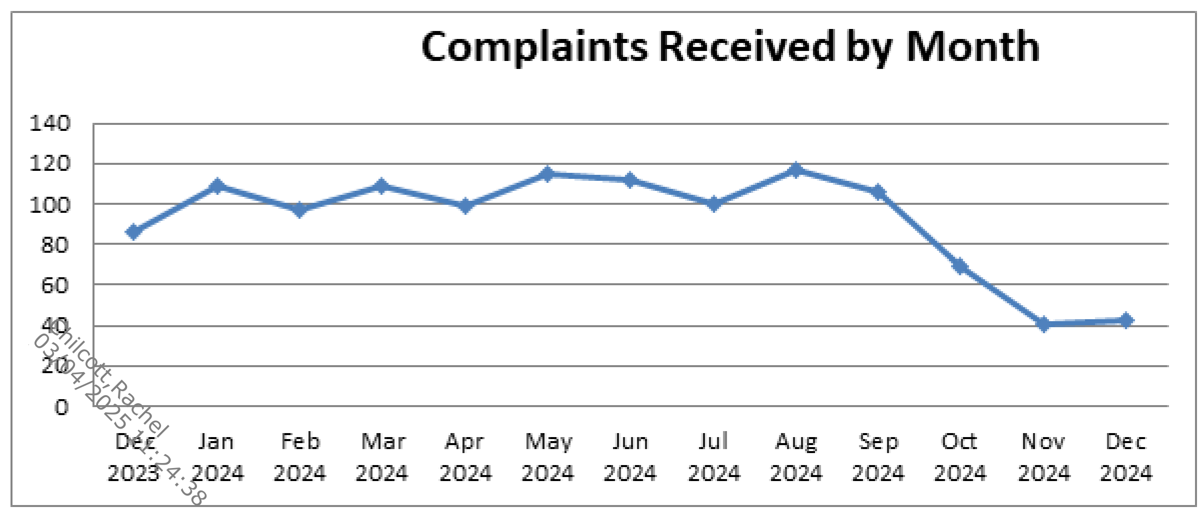
- The Theatre Delivery Group formal lookback has identified challenges which will be addressed, these include: - reducing on the day cancellations and supporting all specialities to increase their planned theatre utilisation. This will result in improved theatre utilisation, more procedures completed and reduced RTT.
- There are challenges with the availability of timely data as we work a month in arrears. Discussions have started with the BIS team to relaunch the 'Theatres' dashboard, this will enable more timely information to inform discussions and decision making. Access to timely information will support more productive conversations with surgical teams to address challenges earlier.
- A Theatre Staffing Review is currently ongoing but will conclude in early 2025. This review is in response to a number of serious concerns raised by different staff relating to values and behaviours and leadership and management capability. It is hoped that this report will provide a set of recommendations that will include recommendations to change the current management structure.

Challenges

- Our Theatre estate is ageing and the impact this has on day-to-day productivity cannot the underestimated. There are plans for 25/26 in hand which will bring about an update for some air handling units and building management systems. However, while this work is welcomed these updates will not fully address all the estates issues which are a weekly occcurence.

PERSON CENTRED CARE

Concerns



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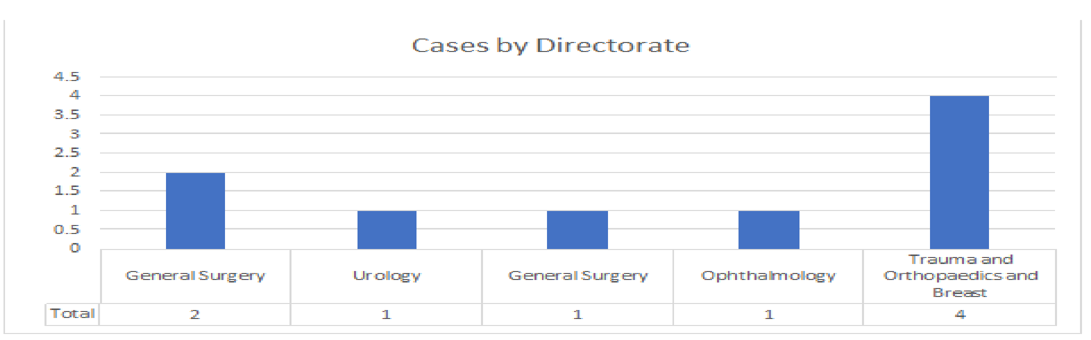
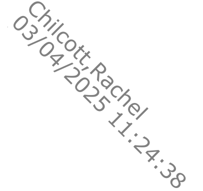
You will note a significant decrease in the complaints received in Q3 as the triage system changed in Concerns and more patient contacts were being processed as enquiries, particularly queries around waiting times.

	General Surgery	Dental	Peri-Operative Directorate	Trauma and Orthopaedics and Breast	Urology	Ophthalmology	ENT and Head and Neck	Total
Dec 2023	22	6	3	32	1	19	8	91
Jan 2024	17	11	1	26	8	21	12	96
Feb 2024	21	6	0	35	4	10	12	88
Mar 2024	26	9	1	32	7	14	16	105
Apr 2024	31	6	3	30	8	22	7	107
May 2024	20	7	1	48	6	15	15	112
Jun 2024	15	5	2	31	5	21	17	96
Jul 2024	31	8	2	31	6	13	15	106
Aug 2024	24	8	2	34	3	18	22	111
Sep 2024	31	6	3	28	8	20	10	106
Oct 2024	17	6	0	12	5	17	9	66
Nov 2024	9	1	0	10	3	11	2	36
Dec 2024	6	4	1	8	4	9	3	35
Total	904	259	59	1162	247	657	436	3724

Active Redress Cases

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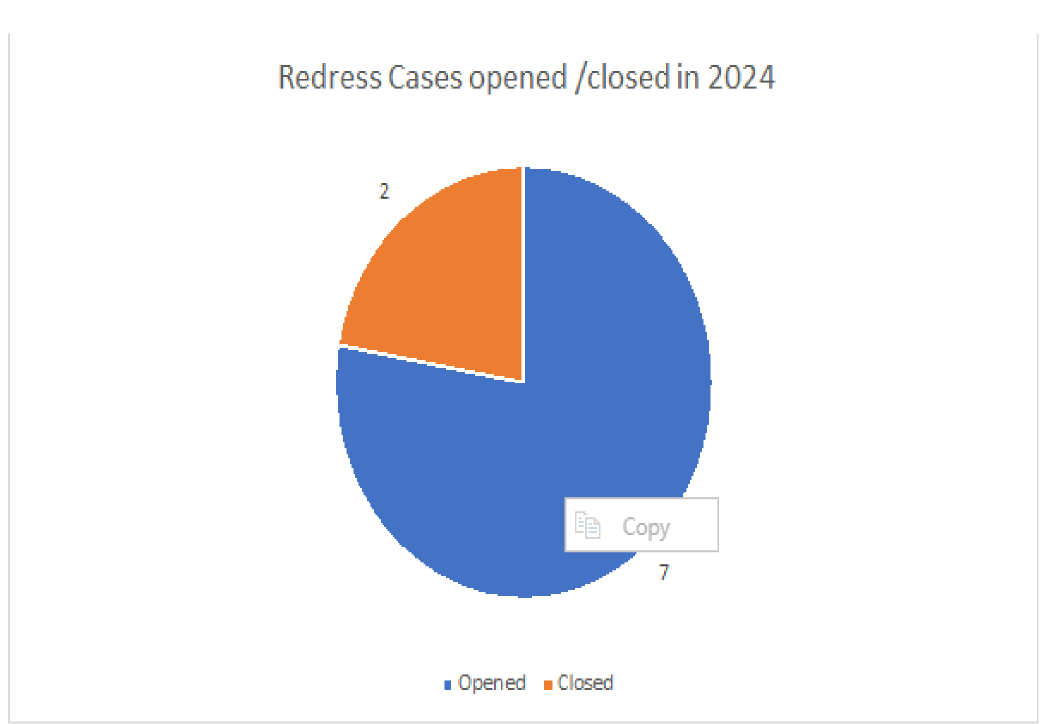

Redress Examples of cases

(T&O): This case involved an elderly gentleman who had sustained a wrist fracture. A breach of duty was identified in that there was no dictation from clinic, and therefore he was not brought back to clinic when he should have been which resulted in a malunion. A financial offer of redress has been made to the patient (£12,500).

(Ophthalmology): This case involved a gentleman who had undergone cataract surgery. He was discharged with a Mydriasert pellet in his eye and returned with pain and discomfort. He required antibiotics. A financial offer of redress has been made to the patient (£500).

Personal Injury Claims

As of 3rd January 2025, Surgery Clinical Board has 2 active PI Claims

- 1 Manual Handling
- 1 IPC/Covid Exposure

4 PI claims have been closed in the last year (2 defended and 2 settled)

As a theme, two of these cases related to slipping claims, one defended and one settled. This area of litigation is in line with other Health Boards in Wales, being reported as the highest category of PI Claim received during the last 12 months. The Health Board is active in improving compliance to mandatory training which covers Health and Safety, ensuring that all staff are aware of their responsibilities regarding responding to spillage.

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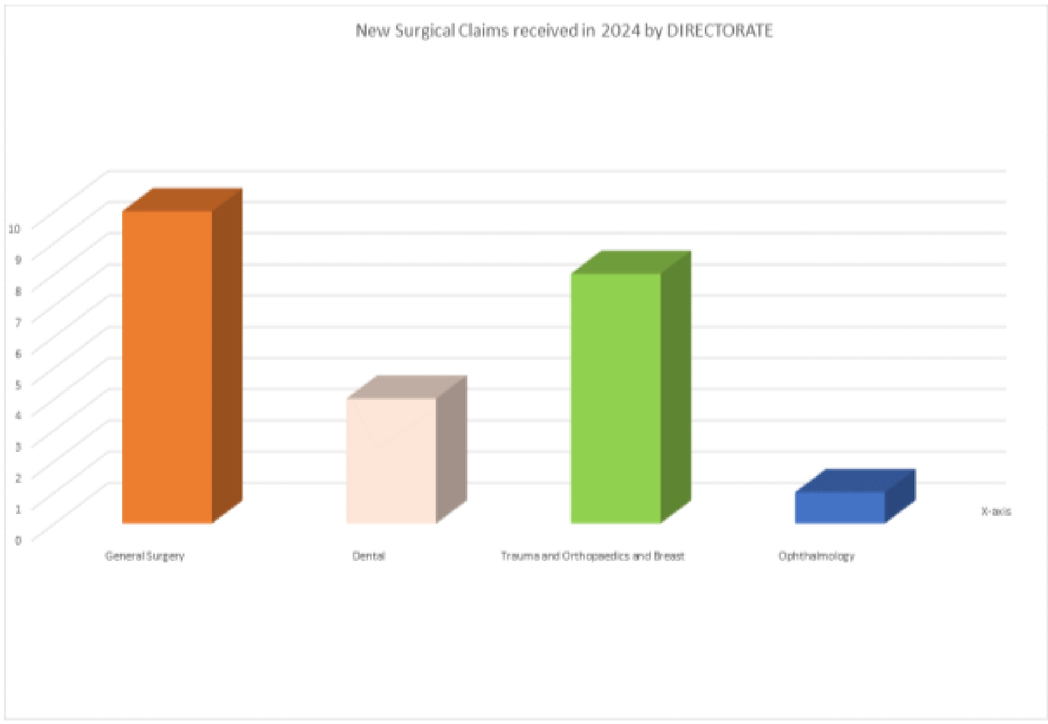
Patient Claims



From analysis of the data available, in 2024, the UHB received 23 new clinical negligence claims for surgery as allocated in the above graph. The main theme of the allegations remains failure and/or delay to diagnosis.

Case Summary 1

Total Reimbursement: £116,580.00

Claimant: Female
Incident: Fall from bike on 26 May 2021, resulting in a left knee injury
Initial Diagnosis: Soft tissue injury, discharged after X-ray
Radiographer's Report: Noted 'small lipohaemarthrosis' and 'suggestive of an un-displaced fracture', recommended repeat X-ray which was not acted upon
Investigation:

Letter of Concern: Received and responded to by Health Board on 28 January 2022
Letter of Claim: Issued on 20 September 2022

Admissions:
Failure to diagnose proximal tibial plateau fracture on 26 May 2021
Negligence in not acting on the recommendation for a repeat X-ray on 3 June 2021
If diagnosed correctly, the claimant would have been referred to the Orthopaedic Department and received appropriate treatment
Proper treatment would have included a range of movement brace, non-weight bearing advice, and physiotherapy
Correct diagnosis and treatment would have led to full or near-full recovery within 3-6 months, avoiding complications like valgus deformity, osteoarthritis, or knee replacement surgery
Harm:

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Incorrect diagnosis led to malunion, causing pain, limp, and increased risk of secondary osteoarthritis

Case Summary 2

Total Reimbursement: £321,800.08

Claimaint: Male, born
Incident: Surgical treatment for femoral arterial disease starting February 2017
Medical History: Long history of spinal problems with multiple surgeries

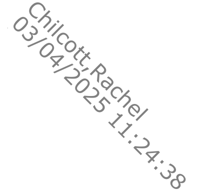
Timeline: January 2016: Severe pain in right calf, Doppler ultrasound showed femoral artery occlusion
18 October 2016: Right femoral endarterectomy, successful outcome
2 February 2017: Left common femoral endarterectomy and profundaplasty agreed upon
21 February 2017: Surgery performed; claimant discharged next day
22 March 2017: Reported worse pain, claudication, and night pain
25 April 2017: Left leg femoral popliteal bypass with PTFE
17 May 2017: Feet went white and numb, referred to vascular clinic
23 May 2017: CT angiogram confirmed calcified bifurcation disease; Doppler scan showed occlusion

Outcome:
Revascularisation of both legs, good recovery

Counsel Advice:
Low prospects of successfully defending allegations at trial due to lack of documentary evidence supporting the surgeon's performance

Compliments and patient feedback

The Clinical Board uses Civica Once for Wales Patient Experience platform as a means of sharing patient feedback. An examples of a response shared on social media is noted below: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Value in Health Impacts

Name	Stage	Latest Position
Trans Nasal Oesophagoscope	Evaluation Stage	Value Impact • Reduce Carbon Footprint • Reduce Hospital Visits • Released Theatre Capacity • Realised value opportunity is equivalent to £429,000 pa
Peri-Operative Diabetes	Evaluation Stage	Value Impact • Realised value opportunity is equivalent to £143, 585 p.a. • Reduced day of surgery cancellations • Reduced unnecessary testing and unwarranted variation of care • Focused training and development of staff supporting these patients to sustain and spread impact opportunities
Sentinel Lymph Node Biopsy	Evaluation Stage	Value Impact • Realised value opportunity is equivalent to £4,541.27 per case • Improved Qol • Improved clinical outcomes – shoulder function etc • Reduced LOS and operating time •
Per-op Anaemia Management Nurse-Led IV Iron Programme	Running at UHW supported by WG funding	Value Impact • Reduced consultant appointments releasing capacity • Improved iron therapy ahead of surgery = reduced complications and LOS
Dental Conscious Sedation Bevan Exemplar	Evaluation Stage	Value Impact • Realised value opportunity is equivalent to £43,598 pa • Released capacity • Reduce waiting list for dental treatment

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The SCB recognises the need for Leadership in Value and has in this last financial year dedicated a team to working on projects with a Value lens.

The first project (TNO) is currently undergoing interim analysis and is forecasted to be delivering on its financial, environmental, social and health inequalities outcomes. Projects have been growing organically over the last year and are supported by the Value team.

There are over 10 projects within different directorates such as Sentinel node Biopsy (Max Fax), Anaemia (Peri-operative Care), Micro shunt (Ophthalmology), Metro mapping the colorectal pathway (General surgery), UGI pathway analysis (General Surgery), PROMS (patient reported outcome measures) in Anesthesia (Peri-operative Care) and Green Theatre (Grey theatre UHL). The Value projects involve work across the hospital departments and provide partnership working arrangements from Finance, Costings, Shaping change, IT, Procurement, Clinical staff, Welsh Value in Health centre, Patient Experience and the SCB team.

SUSTAINABILITY

The 'Green Theatres' project began in NHS Scotland and aims to reduce the environmental impact of the operating theatres, which contribute to a substantial amount of clinical waste and traditionally use chemicals/drugs during surgery which have an environmental impact during surgery. The project is split into four distinct areas; 'Anesthesia', 'Prepping for surgery', 'Intraoperative equipment' and 'after the operation'.

Anesthesia

1. This has been the most successful aspect of the work and had been supported by Consultant anaesthetists. This work is now complete.

Prepping for surgery

1. Re-usable textiles have been trialled and switching from disposable drapes is being considered, careful consideration will be given to balancing the financial impact against the environmental benefits.
2. Reducing water consumption. A 'gloves off' campaign will be launched in April 2025. Discussions have been had with Infection Control & Prevention about the 'Rub, don't scrub' initiative which encourages the use of alcohol gel to 'scrub' in between patients. This will be encouraged in the new financial year.
3. Avoiding unnecessary interventions. This relates to evaluating established practice in relation to antibiotic use, catheter insertion and histology investigations. This needs to be taken forward by the relevant clinical teams to confirm if there is an indication to change existing practice.

Intraoperative equipment

1. We are working closely with our colleagues in procurement to switch to reusable products when possible.
2. We are also in the process of selling components of single use diathermy devices to be repurposed generating a small amount of income as a consequence.

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After the operation

1. We are working with the UHB recycling team to dispose of clinical equipment/waste in an environmentally friendly way. This work will begin in April 2025.
2. We are unable to progress with the 'Power off' element of this workstream which recommends switching off the ventilation at the end of the day as there are challenges associated with theatre

ventilation. However, this is something we would like to explore when the theatre ventilation has been updated.

National sustainability award – Nomination

1. We were shortlisted for a national sustainability award for our work on reviewing and rationalising our single use items, making a switch in favour of re-usable items. Although there was initial spend to purchase the re-usable items, future spend was avoided and resulted in savings of an estimated £10-£15K P/A.

TIMELY CARE

Waiting List Performance (OPWL 52, 104, 156, and 208 Weeks)

- Significant improvement across all waiting time categories compared to last year.
- The number of patients waiting over 2 years has reduced by 1,000.
- The number of 3-year breaches has been cut by more than half.
- No 4-year breaches remain.
- Despite not fully clearing 3-year breaches, all remaining patients are now scheduled for treatment, with none classified as clinically urgent.
- Hot spot areas remain in urology, ophthalmology, and spinal surgery but plans are either in place or have commenced to right size these areas to continue to drive improvements.
- While we have made improvements against the Ministerial Priorities this year, we know that the cohort of patients to treat next year is larger. We remain focused on our revised detailed approach to demand and capacity management and are supporting directorates on delivering continued improvements.

Hip Fracture Pathway Performance

- This service is ranked among the top 5 in the UK.
- Performance has remained strong for over a year, improving quality, safety, and patient outcomes.
- Length of stay (LOS) has improved, contributing to cost savings and enhanced service delivery.

CHKS SCB Indicators (Elective & Non-Elective Care)

- **Elective Care:**
  - Some specialties perform better than national peers, particularly in Urology (higher day case rate, lower DNA rate).
  - Areas needing improvement include General Surgery (longer LOS, lower day case rate).
- **Non-Elective Care:**
  - ENT, General Surgery, and Ophthalmology have longer LOS than peers.
  - Urology and Orthopaedics are closer to peer performance.
  - A data-driven approach is being used to improve efficiency in key areas, focusing on LOS, DNA rates, and day case rates.

Cancer Pathway Delivery

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- Demand on Cancer care within the surgical specialties has increased 7.7% in 24/25 compared to 23/24
- This is particularly evident in Urology where 20% more referrals were received in this financial year
- Performance throughout the year has been variable. Breast and Upper GI and Head and Neck all achieved the 75% standard at points in the year, however Urology and Colorectal failed to meet the standard.

- In total the average performance compliance for surgical specialties was 54.4% in 24/25
- Across the year, an average of 60% of patients were seen within 14 days of their point of suspicion. H&N performed well with an average of 86%. Urology have struggled with 44%
- Both the total cancer waiting list and over 62-day backlog across all surgical specialties has grown 48%, however Breast and Head and Neck have reduced their backlog in the year.
- We have undertaken rigorous analysis in this last year and believe we have a full understanding of our position and the actions we need to undertake across all pathways to achieve and sustain the standard in 25/26.

Harm review process for follow up not booked (FUNB) in AMD

The Age-related macular degeneration (AMD) harm review process had continued to take place through 2024/ 2025. On the collation of this review, several themes have emerged. However, the principal theme is that there was inconsistency in practice for documenting outcomes of clinical reviews by both the nursing staff administering the injections and the clinicians reviewing the scans and assessing the patients due to the use of 3 (paper, Medisoft and Open Eyes). There was also an inconsistency in administration procedures and lack of an agreed electronic pathway that fits the current need for the service This has made collating the data very difficult and is considered to be a significant factor in why the patients have been lost to follow up.

Actions taken

- The Standard Operating Procedure (SOP) for AMD patients has been updated and agreed upon by key clinical and management staff. It will be audited for compliance

- Two new locum AMD consultants are being recruited for long-term service stability.

- A new treatment plan, prescription chart, and SOP for nurse injectors have been developed and implemented on the Open Eyes system.

- Work is ongoing to develop an electronic consent form with the Royal College of Ophthalmology, although delays are due to Welsh language requirements.

- The AMD service was relocated to a new facility in August 2024, improving patient and staff experience.

- Requests have been made for accommodation for an Ophthalmology Hub, and engagement sessions have been held.

- The medical records team is scanning and uploading any remaining AMD paper documents to the Clinical portal.

- An audit process is in place to track patient outcomes and ensure safety by monitoring clinic processes.

- The General Manager and Senior Nurse for Ophthalmology have benchmarked practices with other services in Swansea Bay and Aneurin Bevan.

- New roles, including a Senior Nurse for Quality, Safety, and Service Improvement, a patient safety facilitator. They are working on managing lost-to-follow patients in AMD and when complete will move onto the glaucoma cohort

- Opthamology now use Open Eyes as the one documentation source for all opthalmo9logy procedures

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- Royal College of Surgeon external review – report due imminently

Further actions

Validation is required for those patients who are lost to follow up outside this AMD cohort is progressing. The cohort of patients who are FUNB for Glaucoma are currently being reviewed. The directorate are currently at the data cleansing stage and duplications are being removed.

Currently:

- 3873 Glaucoma patients have a FUNB (follow up not booked date) over 3 months
- 213 validated for "data cleanse" - approximately 50% removed due to duplicates.
- MDT meeting to be arranged to arrange complete process map to formalise and standardise process and to set the "terms for reference"

Patients identified as not having any follow up appointments booked, currently 211 identified are being sent out appointments with those who have waited the longest being given priority. There are 80 glaucoma patients who require a clinical review by a senior Clinician and WLI's are in the process of being set up for these reviews.

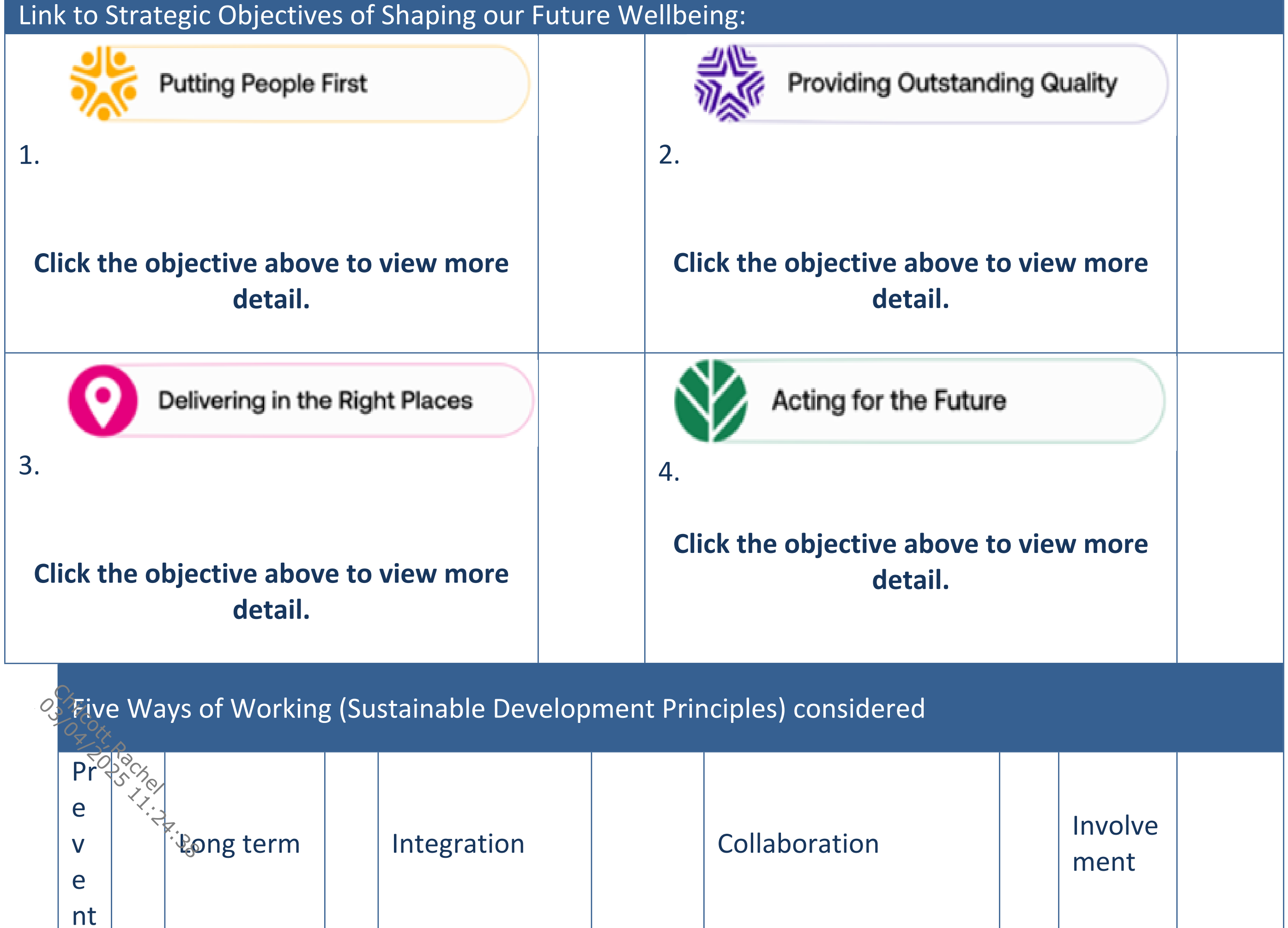
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Recommendation:

The Committee are requested to:

1. **NOTE** assurance provided by the Surgery Clinical Board QSE assurance report and
2. **AGREE** the mitigation being taken to improve quality, safety and experience and reduce harm by the Clinical Board

Link to Strategic Objectives of Shaping our Future Wellbeing:



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

Prevent		Long term		Integration		Collaboration		Involvement	

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Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*n/a*

Impact Assessment:
Risk: n/a
Safety: n/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

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

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Report Title:	Care of the Deteriorating Patient			Agenda Item no.	2.2	
Meeting:	Quality Committee	Public	x	Meeting Date:	1st April 2025	
		Private				
Status *(please tick one only)*:	Assurance	X	Approval		Information	x
Lead Executive:	Executive Medical Director and Executive Nurse Director					
Report Author:	Senior Nurse P@RT and Senior Nurse Resuscitation Service					

Main Report
Background and current situation:

The National Institute for Health and Care Excellence published clinical guidance CG50 Acutely ill adults in hospital: recognising and responding to deterioration in 2007 to provide guidance on how patients in hospital should be monitored to identify deterioration and to prevent avoidable harm. Recommendations include:

- a minimum set of physiological recordings at the time of the patient's admission, a clear written monitoring plan that considers the patient's diagnosis, presence of comorbidities and an agreed treatment plan.
- The guidance recommends the use of a physiological track and trigger system that includes multiple parameter or aggregated weighting scores
- Graded response strategy dependant on an aggregated score that prompts increased monitoring, medical escalation and emergency escalation.
- A critical care outreach service for patients whose clinical condition is deteriorating supported by trigger systems for referral and review.

National Early Warning Score (NEWS)

The National Early Warning Score (NEWS) was introduced into health organisations in Wales thirteen years ago. It provides a structured assessment of physiological observations, defines specific observation parameters and provides an aggregated score that then prompts a specific and standardised response. It aims to identify deterioration at an earlier stage to improve sepsis detection and thereby reduce avoidable harm and cardiac arrests.

In March 2024 Welsh Government published a Welsh Health Circular (WHC) requiring health organisations in Wales to implement:
NEWS2: Implementation in all areas where NEWS or NEWS Cymru is currently used by 30 September 2025.
PEWS: Full implementation in all acute paediatric services by 30 September 2025.
NEWTT2: The Maternity and Neonatal Network have set out the expectation that NEWTT2 will have commenced by 31st March 2025 and will be fully implemented in acute settings by 30th September 2025.
MEWS: The Maternity and Neonatal Network have set out the expectation that MEWS will have commenced by 31st March 2025 and will be fully implemented in acute settings by 30th September 2025

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Work is underway to implement the recommendations of the WHC across the UHB with NEWTT2 fully implemented to support perinatal monitoring and PEWS currently in use in most paediatric areas. MEWS will be adopted across acute maternity services and a risk-based approach will be taken to implementing in community maternity services.

NEWS 2 will result in small changes to the aggregate scores attributed to patients including the recognition of type 2 respiratory failure, however significant changes to scoring parameters, the frequency of monitoring that is required and the clinical response will result.

The UHB Patient at Risk Team (P@RT) currently respond to all patients scoring NEWS 3 and above and the Resuscitation Team and medical decision makers including airway support respond to all patient scoring NEWS 9 and above or those who have experienced a cardiac arrest. The Royal College of Physicians, recommends that patients scoring NEWS 5 should be reviewed by a clinical team with core competencies in the care of acutely ill patients while patients scoring NEWS 7 and above should receive an emergency assessment by a team with critical care competencies including practitioners with advanced airway management skills. 3941 patients with NEWS score of 6-8 were reviewed by the P@RT team between May 2024 and March 2025, many of these patients will require a critical care response including airway management from September 2025. A local clinical response model is currently being developed and will be supported with revised care bundles and protocols. NEWS 2 will be implemented in conjunction with a programme of training and education.

NEWS 2

Observation chart for the National Early Warning Score (NEWS2)

NEWS key: 0 1 2 3

FULL NAME / DATE OF BIRTH / DATE OF ADMISSION / DATE / TIME

Parameter	Range	Score
A+B Respirations Breaths/min	≥25	3
	21–24	2
	18–20	
	15–17	
	12–14	
	9–11	1
	≤8	3
A+B SpO₂ Scale 1 Oxygen saturation (%)	≥96	
	94–95	1
	92–93	2
	≤91	3
SpO₂ Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure. †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O₂	3
	95–96 on O₂	2
	93–94 on O₂	1
	≥93 on air	
	88–92	
	86–87	1
	84–85	2
	≤83%	3
Air or oxygen?	A=Air	
	O₂ L/min	2
	Device	
C Blood pressure mmHg Score uses systolic BP only	≥220	3
	201–219	
	181–200	
	161–180	
	141–160	
	121–140	
	111–120	
	101–110	1
	91–100	2
	81–90	3
	71–80	3
	61–70	3
	51–60	3
	≤50	3
C Pulse Beats/min	≥131	3
	121–130	2
	111–120	2
	101–110	1
	91–100	1
	81–90	
	71–80	
	61–70	
	51–60	
	41–50	1
	31–40	3
	≤30	3
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert	
	Confusion	3
	V	3
	P	3
	U	3
E Temperature °C	≥39.1°	2
	38.1–39.0°	1
	37.1–38.0°	
	36.1–37.0°	
	35.1–36.0°	1
	≤35.0°	3
NEWS TOTAL		
Monitoring frequency		
Escalation of care Y/N		
Initials		

National Early Warning Score 2 (NEWS2) © Royal College of Physicians 2017

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Clinical response to the NEWS2 trigger thresholds

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

The Shaping our Future Quality Excellence Deteriorating Patient Programme will oversee the UHB delivery of the actions set out in the Welsh Health Circular by September 2025.

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Treatment Escalation Plan (TEP)

At the outset of the Covid-19 pandemic health originations across Wales implemented the widespread use of treatment escalation plans. NICE Covid -19 rapid guideline: critical care in adults NG159 recommended the use of a process of shared decision making with patients and families that

includes a decision about appropriate and agreed treatment options and acknowledgement of those interventions which may be inappropriate. The use of TEPs supported shared decision making and the documentation of discussion with patients.

Since the pandemic the use of TEPs has reduced across the Health Board, increasing the potential for inappropriate escalation of care that does not align to the patient’s wishes or best interests. The UHB is participating in All Wales work that has resulted in the a standardised TEP document that will be used in all health organisations. There is associated virtual training package that will be used to support the use of TEP.

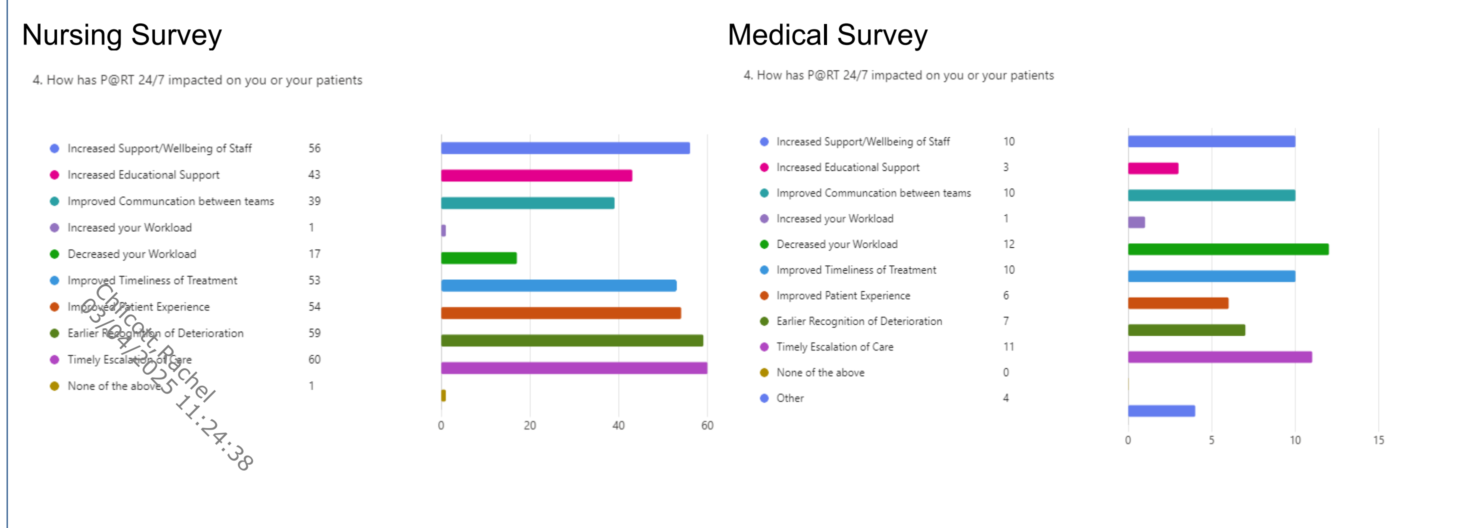
A TEP task and finish group led by P@RT but with health board wide multi professional membership is leading on the delivery of the All-Wales TEP form.

Patient at Risk team (P@RT)

The Royal College of Anaesthetists (RCoA) undertook an external review of intensive care services in the UHB (published April 2019). Under ‘immediate actions’ it was recommended that the UHB adopt a single critical care outreach model across all acute clinical settings. The implementation of a Patient at Risk Team (P@RT) was implemented to fulfil this recommendation and the recommendations of Welsh Government All Wales task and finish group for critical care.

P@RT was set up in 2021 in response to the review and now has an embedded 24/7 service across UHL and UHW with the exception of Maternity, Paediatrics, Theatres and the Emergency Unit. The demand on P@RT has grown significantly over the last 12 months and the team are now reviewing between 1000-1500 patients a month. 40% of P@RT responses are out of hours (19:00-07:30 and weekends/bank holidays). A further, 38.8% of all P@RT referrals are for patients with a NEWS score of over 6. The mandated Welsh standard for responding to this more acute cohort of patients is 30 minutes. Regardless of the time of day, P@RT are achieving a response time of 14 minutes. The majority of NEWS calculation used to inform a referral to P@RT are correct however 28% of patients assessed as scoring 3-5, 38% of patients scoring 6-8 and 43% of patients scoring 9 were incorrectly calculated with the majority of cases over estimating the NEWS calculation. This audit finding aligns with the outcome of patient safety incidents relating to the care of the deteriorating patient.

P@RT offers support to ward teams by delivering hands on care to deteriorating patients when needed, providing bedside education, and in conjunction with the local clinical team will develop a robust, clinical management plan. This coproduction approach builds the skills and confidence of ward staff to deal with complexity; and has been particularly impactful in mitigating the risks associated with reduced ICU capacity. A staff survey undertaken to evaluate the service has demonstrated the value beyond the immediate clinical outcomes of the patient cohort.



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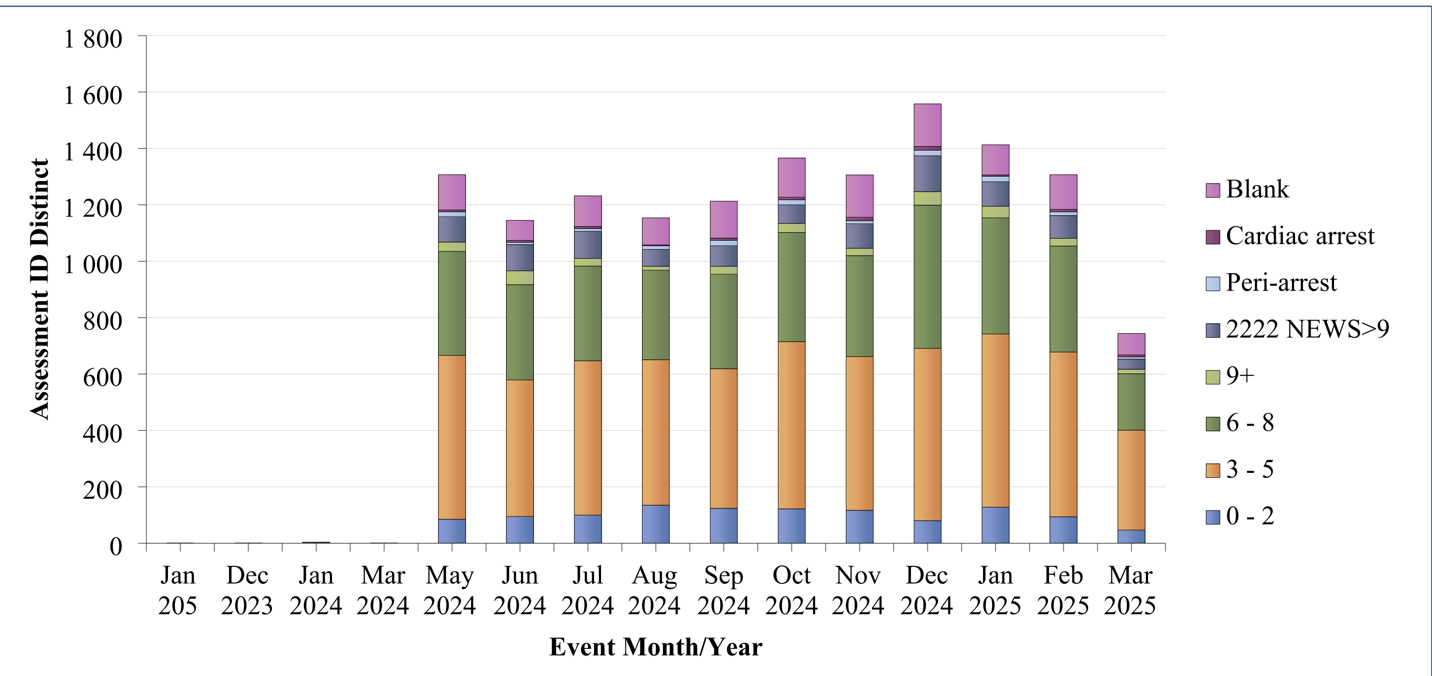


Call for concern
Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted following a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to and in 2023 the Coroner ruled that Martha, aged 13 would probably have survived had she been moved to intensive care earlier. In response the Secretary of State for Health and Social Care and NHS England committed to implement Martha's Rule to ensure that the concerns of the patient and those that know them best are listened to and acted upon.

In July 2024, in response to Martha's Rule P@RT expanded their remit to include Call 4 Concern, a referral mechanism that enables patients and their family members, visitors or advocates to call for immediate help and advice if they are concerned. This initiative offers a P@RT review to patients that have expressed concern either themselves or through relatives, that their clinical condition is deteriorating despite engagement from the ward team.

After the initial pilot in Nov 2023, C4C phase one was rolled out on July 1st 2024.
Phase one – Adult & Paediatric inpatient wards UHW & UHL
Phase Two – MHSOP & HYC UHL – Date to be decided
Phase Three – Emergency & Assessment areas UHW & UHL Date to be decided
Phase Three – Maternity UHW Date to be decided

The team have received 43 calls from July '24 to Jan '25, of which 6 were potential deterioration, 2 of these calls resulted in escalation of care to the medical registrar and resulted in a change of management plan and improvement in the patient's acute deterioration.

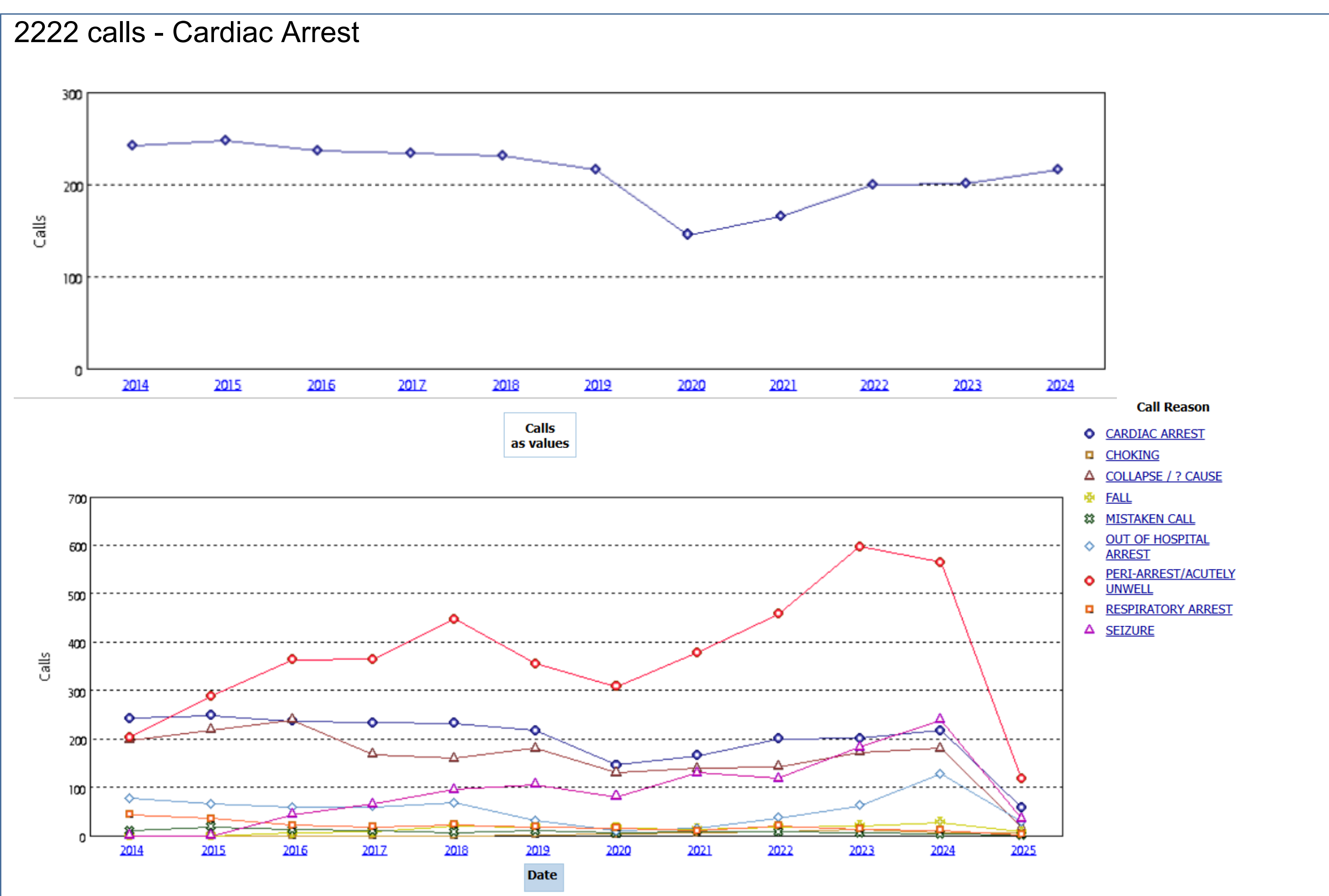
The Call 4 Concern has also been implemented in the Children's Hospital for Wales with calls received by a paediatric nurse who triages the call and escalated to the paediatric registrar.

Resuscitation

The resuscitation service responds to patients with a NEWS score of 9 and above and those that have experienced a peri arrest or cardiac arrest.

Between May 2024 and March 2025 there were 896 resuscitation calls for patients with a NEWS score of over 9, of these 68% were correctly calculated and the remaining subsequently assessed as scoring NEWS 0-8. A reduction in cardiac arrests was noted over the pandemic period, with anecdotal evidence indicating improved decision making as a result of the use of the treatment escalation plans. Cardiac arrest numbers have not returned to their pre-pandemic rates.

2222 calls - Cardiac Arrest



One of the fundamental aspects of the Resuscitation Service is the collection of data related to cardiac arrests. The Resuscitation Service consolidates data from all resuscitation calls within the UHB. The information gathered by the service exceeds the universally accepted Utstein data requirements for resuscitation audits. The data provided by the Resuscitation Service has been recognised as best practice and the UHB is collaborating with the NHS Executive to establish an All Wales comparable data set to support national learning.

Data from 2222 calls is inputted in to a "CUBE". Since its inception in April 2015, the Cube (Resuscitation Data modules) has significantly enhanced the efficiency of data analysis. This improvement has been made possible through streamlined processes for data extraction, including the automatic compilation of survival to discharge metrics following cardiac arrests, which were previously gathered through labor-intensive manual analysis of multiple resuscitation databases.

P@RT facilitated a Burden of Acute Care Audit in November 2024, comprising audits of NEWS charts of every inpatient in acute wards in UHW and UHL sites to review the care of all patient with a NEWS score of 5 and over. The results demonstrated very good compliance with the implementation and escalation of the UHB deteriorating patient policy.

Results Audit of Burden of Acute Illness (Nov 24)

Question	Average Score
(NEWS 6 - 8) Was the patient escalated in line with local policy?	92.9%
(NEWS 9-11) Was the patient escalated in line with local policy?	100.0%
Did the patient have a management plan?	100.0%
If yes, what action was taken?	100.0%
Was a cardiac arrest call made?	0.0%
Was a PART (Patient At Risk Team) call made?	100.0%
Was sepsis considered?	90.9%
What category does the patient's highest NEWS score (in the past 24 hours) fall into?	100.0%

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Patient safety incidents relating to a failure to recongise and escalate deterioration are infrequent as a proportion of all patients whose care is monitored using NEWS, however resuscitation related incidents were reported on Datix of which 43% related to monitoring and completion of observations and a further 15% categorized as assessment and diagnosis and 12% treatment or procedure issues. The implementation of NEWS 2 will be accompanied by guidance to standardise deteriorating patient incident reporting to ensure collation of learning.

Executive Summary

- The Patient at risk team has been in place since 2021 and now provides a 24/7 services on both UHW and UHL sites reviewing up to 1500 patients a month
- The National Early Warning Score is used to assess patients and to provide an aggregated score that prompts a standardised clinical response to deterioration in patients. Following the receipt of a WHC in 2024 the UHB has progressed work to implement NEWS 2 which requires revised clinical responses
- The implementation of NEWS 2 will require significantly more patients to have an emergency assessment from a team with critical care competencies and airway management, a UHB model is being developed with oversight from the UHB RADAR group
- NEWS 2 will be implemented with an associated education programme on ongoing monitoring and assurance.
- A TEP task and finish group led by P@RT but with health board wide multi professional membership is leading on the delivery of the All-Wales TEP form with associated education.
- Since July 2024 the UHB has delivered a call 4 concern response allowing patients and their families to call a number to request a clinical review. This service is now also available in the Childrens Hospital for Wales
- The resuscitation service noted a reduction in the number of cardiac arrests over the pandemic and the overall number of arrests has not increased to pre-pandemic levels.

Recommendation:

The Committee is requested to:

a) NOTE the assurance provided by the Implementation of P@RT and the Resuscitation service
b) NOTE the implementation of the Call 4 Concern service to meet the requirements of Marth's Rule
c) NOTE the improvement work to deliver NEWS2 and TEP with health board wide education programmes.

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

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

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*n/a*

Impact Assessment:
Risk: n/a
Safety: n/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

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

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Report Title:	Children looked after– Assessment Backlogs			Agenda Item no.	2.3
Meeting:	Quality Committee	Public	X	Meeting Date:	01.04.2025
		Private			
Status *(please tick one only)*:	Assurance X	Approval		Information	X
Lead Executive:	Executive Nurse Director				
Report Author:	General Manager, Children, Young People and Family Health Services				

Main Report
Background and current situation:

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

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

The Children Looked After (CLA) team are an integral part of the Children, Young People and Family Health Directorate and deliver an area of work where there are statutory health requirements. It is well known that children in care have adverse health outcomes so the assessments are aimed at improving health outcomes and reducing health inequalities, as well as ensuring identified health needs are actioned and monitored.

The service is provided by a small staffing team of Medical session, Specialist Nurses and more recently Health Visitors. The nursing team was increased in March 2023 in response to the number of children waiting for a statutory health assessment. This additional staffing was achieved through diverting vacancies from elsewhere within the CYPFHS directorate, and so is not recurrently funded. The integration of heath visiting staff enables changes to be made around the service model in respect of age categories by clinical team.

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

Performance against Statutory Regulations

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

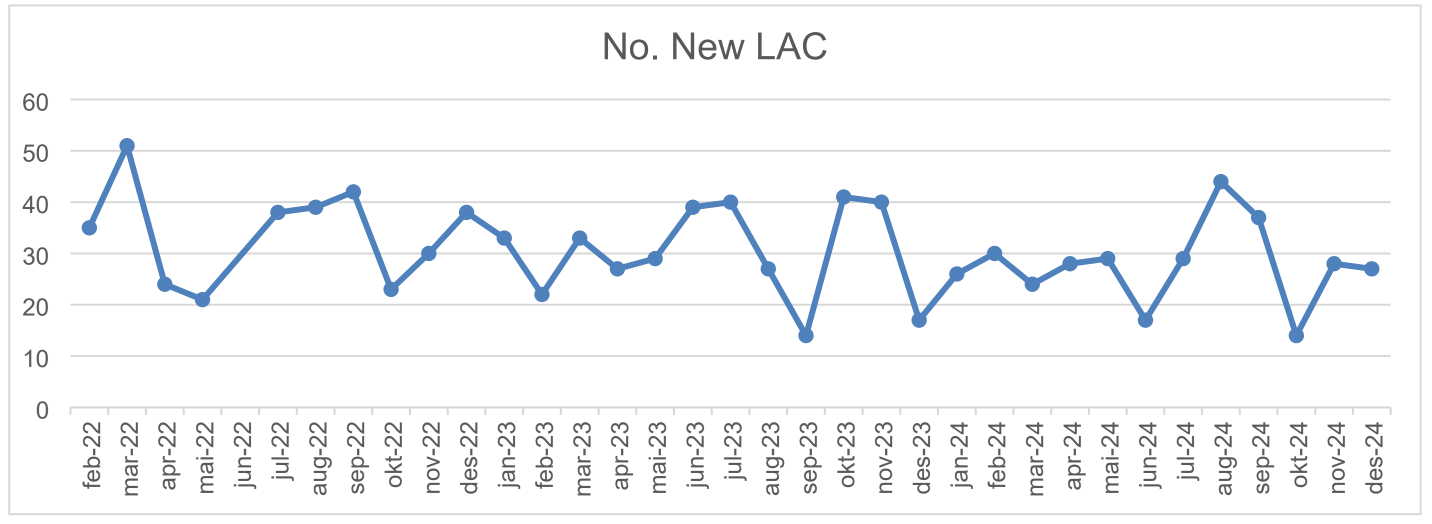
Growth

As previously reported there had been a consistent increase in children in care in Cardiff and the Vale of Glamorgan. There has been a consistent increase in children in care in Cardiff and the Vale of Glamorgan rising from 840 in 2017, to 1070 in 2019, and 1275 in March 2022, with no associated recurrent funded increase in the staff team.

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

The graph below shows the number of new CLA cases per month. In 2023 there were 362 new cases referred into the service, an average of 30 per month. In 2024 there were 333 new referrals, an average of 28 per month.

Graph 1 - Number of new LAC referrals



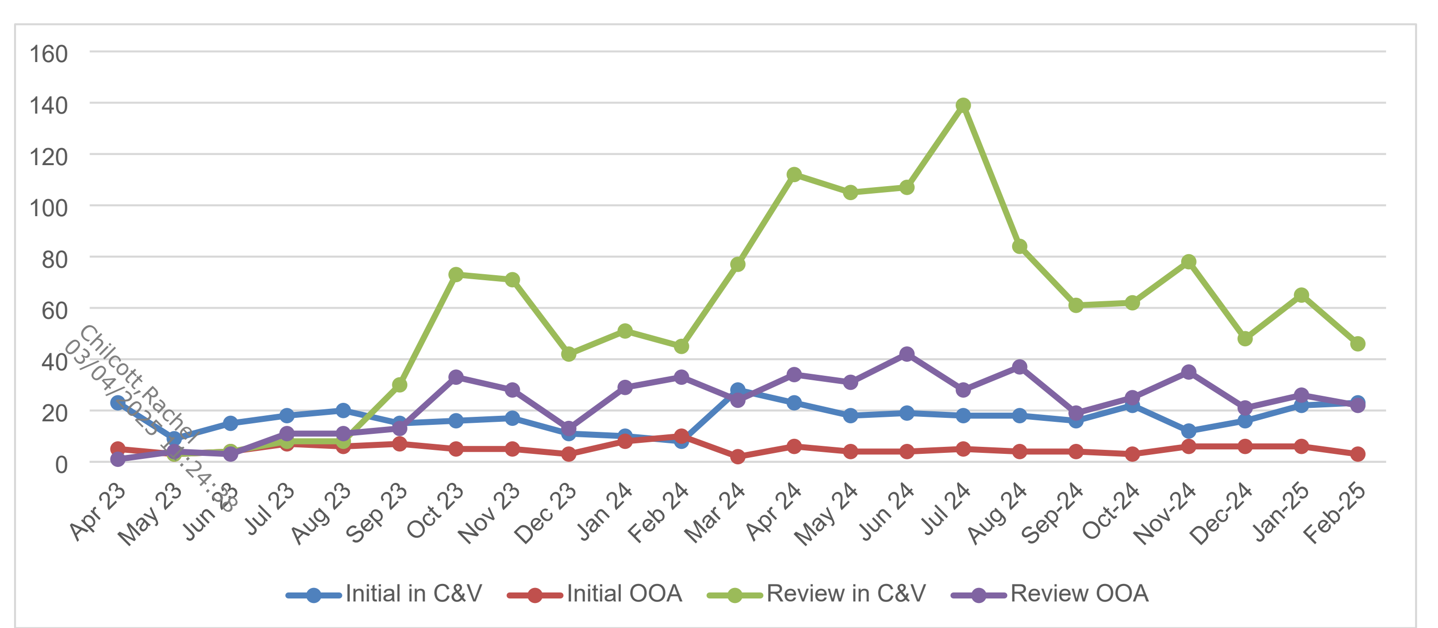
Impact of actions taken

During the last 2 years we have increased the workforce.

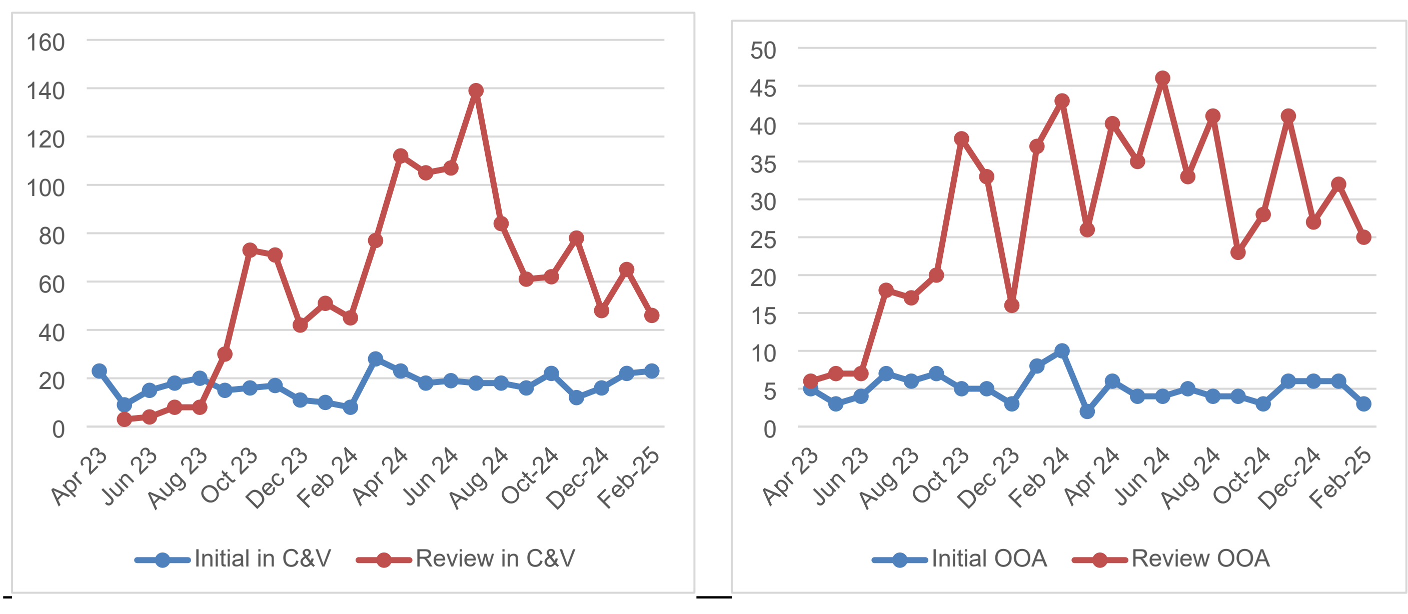
- Nurse are now undertaking all initial and review health assessments for children over 5 (excluding adoptions).
- Health Visiting roles now contribute to review Health assessments for the under 5s (excluding adoptions).
- One additional GPwSI session delivering initial Health Assessments for under 5's since April 2024.

The graphs below demonstrate the increase in Heath Assessments undertaken.

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



Graph 3 - Assessments undertaken in C&V   Graph 4 – Assessments undertaken out of area



This graph demonstrates the significant increase in the number of assessments to August 2024 in Cardiff and Vale, as a result of the increase in specialist nurses, the introduction of heath visitors and additional medical session.

This activity has reduced due a number of reasons;

- Health visitors appointment focused on clearing review backlog for under 5s
- Vacant post - now recruited but a period of time with reduced capacity
- Cessation of bank and overtime in line with increased financial scrutiny across the Health Board
- Increase in complexities with young people which has been taking time away from health assessments; increase in disclosures, increase involvement with police, increase in meetings due to risk taking behaviours.
- Size of caseloads - CNS and HV caseloads are over the by 30% on average (range 12% to 63%)

The role of the CNS and HV is not limited to Health Assessments. This is a very small part of their role. Other duties include; attend CLA review meetings, strategy meetings. case conference and placement panels, taking children to health appointments, safeguarding supervisions and training.

Due to the reasons described above the backlog of assessments has increased.

Initial HA - there are currently 134 children awaiting their initial assessment, 99 within Cardiff and Vale, and 35 placed out of area. This has increased from 47 in August, 43 within Cardiff and Vale and 4 placed out of area. The increase across Cardiff and Vale is across all age groups.

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Review HA - there are currently 316 children awaiting their review assessment, 103 within Cardiff and Vale, and 213 placed out of area. This has increased from 152 in August, 108 within Cardiff and Vale and 213 placed out of area.

The increase in backlog of reviews is predominantly those children placed out of area. This is disappointing this backlog had significantly reduced due to the efforts of the team leader engaging with health boards where children are placed, to ensure a statutory Heath Assessments is undertaken.

Whilst the children are placed out of area we maintain responsibility for ensuring the completion of Health Assessments by their host Health Board / Trust.

Actions to address;

- Additional capacity to be requested using bank and overtime
- Consideration of skill mix of band 4s to support the nurses with follow ups and non-Health Assessment work
- The current evaluation of the Health Visitors is indicating caseloads are high and unmanageable. Skill mix of Band 4s is also being considered to support Health Visitors in line with specialist nursing.
- Team leader to continue to engage with Health Boards where children are placed out of area. The team leader has already undertaken review assessments for children placed in CTM due to the backlog.
- Assessment forms currently being reviewed on a National level. Lead Consultant for fostering adoption sits on the national group as part of the Public Health Role. These new forms are likely to improve information sharing at point of referral. The forms will also include a section on consent which will also speed up the process and remove some time delays in undertaking assessments. This National work was due for completion in January 2024, but has encountered delays. It is expected these will be available early 2025.
- Currently reviewing role of medical advisor to increase capacity to undertake assessments for children on the adoption pathway.
- A new module for CLA in PARIS is nearing completion and will streamline clinicians reporting time, releasing capacity to increase face to face support and assessments.

Recommendation:

The Committee is requested to:

- **Note** the content of the paper and the actions taken to mitigate the risks associated child health assessments.

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	√	Long term	√	Integration		Collaboration		Involvement	

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

Risk: Yes
This has been risk assessed and entered onto the Risk Register

Safety: Yes
In the main body of the report

Financial: Yes

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Immediate financial risk has been mitigated by redirecting resource to CLA service due to risk being held.	
Workforce: Yes	
Detailed in body of the report	
Legal: No	
Reputational: No	
Socio Economic: No	
Equality and Health: No	
Decarbonisation:No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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Report Title:	Research and Development Six Month Update .			Agenda Item no.	2.4
Meeting:	Quality Committee	Public	X	Meeting Date:	01.04.2025
		Private			
Status (please tick one only):	Assurance X	Approval		Information	X
Lead Executive:	David Fluck - Medical Director				
Report Author:	Sarah Martin - R&D manager				

Main Report
Background and current situation:

This report provides details of the arrangements, progress and outcomes within Research in the last financial year.

Cardiff and Vale is the largest NHS research organization in Wales with a broad range of research activity being conducted in nearly all clinical boards. At any one time we have over 700 studies running and approve approximately 170 new studies each year. The types of studies we run is expansive extending from early phase trials of advanced therapies to qualitative observational studies.

Our research activity is predominately conducted on behalf of other sponsor organizations, as a host site, however we do also act as sponsor to run our own investigator led research. Clinical research shapes all current clinical practice. Clinical trials either test the safety, efficacy or cost benefit of novel therapies which would otherwise be unavailable to patients, or they robustly examine commonly used therapies which subsequently prove to be ineffective, neutral or beneficial. In the latter case therapies should be adopted and implemented broadly within the NHS. If they are ineffective or neutral they can be disregarded and resources repurposed into other areas.

The department receive a budget of £6,389,389 from Health and Care Research Wales to support 175.32 WTE. An additional 32.4 WTE are funded by research infrastructure funding or reinvestment of commercial funds.

This report provides assurance on the process being made with regards to;

- Research Activity
- Research Performance to national performance metrics – delivering to time and target
- Governance and accountability
- Patient Experience

<u>Research Development</u>
Since 2021, the Health Board, in common with other large academic health trusts, has created a Joint Research Office (JRO) with Cardiff University to share expertise around research governance, costing and contracting processes and identify opportunities for collaborative working.

<u>Research Approvals</u>
Research will undergo a combination of national and local approvals before it is able to commence within the Health board. The UK Policy Framework for Health and Social Care Research set out the principals of good practice in the management and conduct of health and social care research. These principles protect and promote the interests of patients, service users and the public in health and social care research. Nationally, all research is required to be reviewed and approval issued by a Research Ethics Committee (REC) and the Health Research authority (HRA). The REC will conduct an independent review to ensure that the research proposal is ethical, taking into the requirement and impact on the participant. The HRA assesses the governance and legal compliance of a study. If the research is a clinical trial of a medicinal product (CTIMP) or a study of an unlicensed device the study requires review and authorization from the Medicines and Healthcare Product Regulatory Agency

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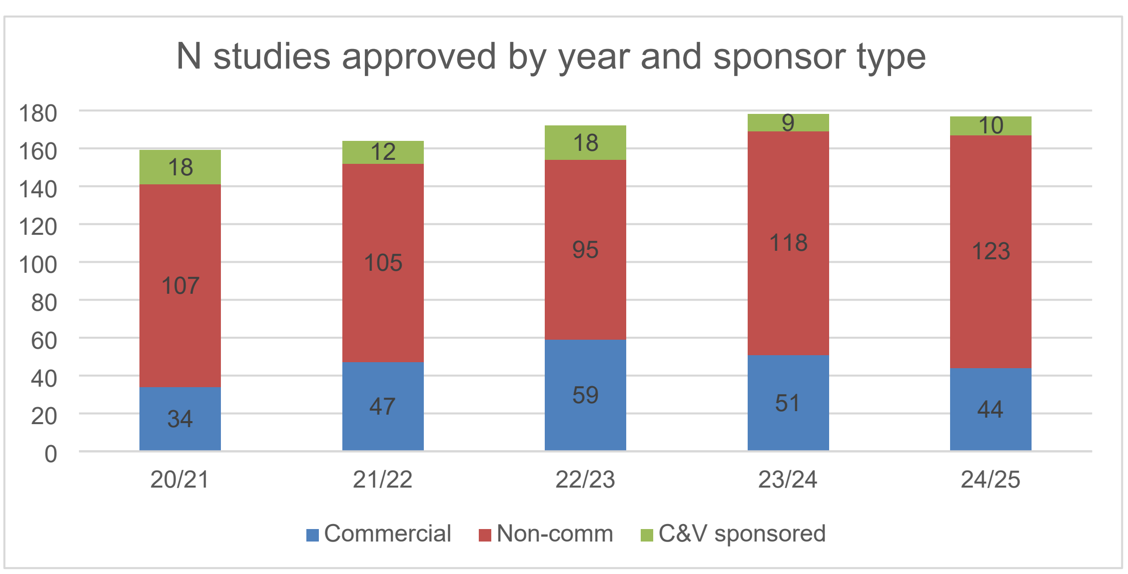
(MHRA). Additional national approvals are required if a study involved Genetic Modified Organisms, ionizing radiation or to obtain information without consent.

Locally, the studies undergo a review of Capacity and Capability, conducted by the R&D department to ensure that the organization has appropriately trained the staff resources and adequate facilities to ensure that the study protocol can be delivered. To make this assessment the R&D office engage with the researchers, departments and support services to ensure it is feasible to delivery and then obtain sign off by the directorate research lead, directorate manager before final sign off by the JRO director. It is only once these reviews are completed that the study can commence within the health board.

Approvals

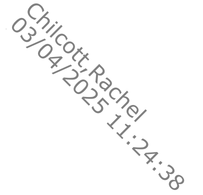


Our portfolio remains around 25%-30% of our activity being commercially funded. We have seen an increase in our non- commercial portfolio, this is in part to an increase in the number of CU studies opening within health board, from approximately 10% of our activity to 16%. This increase has been supported by the joint processes developed within the JRO supporting collaborations across organisations.

Prompted by the Lord O'Shaughnessy review 'Commercial clinical trials in the UK' there has been a shift in emphasis at both NIHR and HCRW to address this. Investment via the **Voluntary Scheme for Branded Medicines Pricing and Access (VPAG)** scheme will see an additional £21m be invested into research infrastructure in Wales between 2025-2028 some of which will be allocated to Cardiff and Vale to boost commercial activity. Cardiff and Vale has been successful in a number of bids for this funding total value yet to be confirmed but we anticipate we will see an increase in commercial activity as a result.

Recruitment to trials

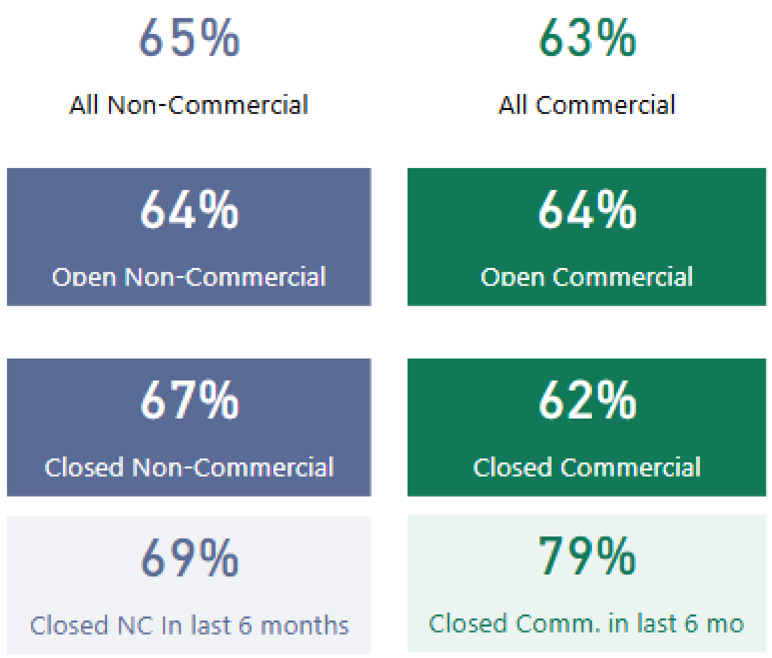
Year to date (up to end of February) we have recruited 4212 patients into research studies.



Clinical Board	No. studies with Recruitment	Current FY Recruits	Total No. Studies
All Wales Medical Genomics Service	4	81	25
Children & Women's	42	298	61
Clinical Diagnostics & Therapeutics	8	71	14
Dental Services	0	0	1
Medicine	45	723	77
Mental Health	13	228	16
Other	2	316	3
Primary, Community & Intermediate Care	4	130	20
Specialist Services	87	1359	154
Surgical Services	43	1006	66
Unknown	0	0	3
Total	**248**	**4212**	**440**

Health and Care Research Wales set a performance metric that 80% of all studies should recruit to time and target, meaning there is a requirement to recruit the agreed number of patients within the agreed study time frame.

This is an important metric as it demonstrates our ability to deliver research and therefore will be seen as a favored site for sponsors. Currently we are performing at 65% for non commercial and 63% for commercial. We are working with teams to ensure that the targets we set are realistic and deliverable. We also hold quarterly activity performance meetings so that issues discussed and barriers removed.



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Monitoring of Clinical Trials Activity

The research regulations outline requirements for monitoring trial activity. All clinical trials must be registered on public international trials registration websites (such as https://clinicaltrials.gov). Each protocol will outline the safety reporting requirements including reporting to the regulators.

Each trial is required to have a trial steering group and independent Data Safety Monitoring Board (DSMB). The latter is comprised of independent trialists and a senior trials statistician. The DSMB will meet at defined time points according to the statistical analysis plan, but at any time deemed necessary if there is a safety concern or new information which effects the ongoing conduct of the trial. The DSMB reports to the chief investigator and steering group and will recommend that the trial continues, or stops on the basis of futility or harm.

Regulatory Compliance and Quality Assurance
All CTIMP or device trials are subject to inspection by the regulatory bodies to ensure GCP (Good Clinical Practice) compliance. Within the UK inspections are led by MHRA. As we are no longer within the EU any studies lead within the EU we could be inspected by the European Medicine Agency (EMA) and for studies led by the USA inspections could be conducted by the FDA.

The regulatory bodies can call an inspection as part of routine practice, for cause (if a series of noncompliance has been identified) or if the product being investigated is going for license. There are 2 ways in which we as an organization can be inspected by the regulatory bodies, either as a sponsor organization or as a host organization.

As a sponsor organization the Health board would be acting as the organization legally responsible for the management, oversight and delivery of the study. MHRA Inspectors would be coming in to inspect our processes, procedures and oversight of the study as well as our research conduct to ensure compliance with the regulatory requirements. Please note where CAV take on the role of sponsor for CTIMP studies a clinical trials unit is appointed to oversee trial management.

As a host organization the Health board would be inspected on our how we have delivered a study to ensure compliance with the protocol, sponsor processes and the regulatory requirements.

CAV were last inspected by MHRA as a sponsor organization in 2012. CAV are acting as sponsor for 1 CTIMP study which would be subject to MHRA inspection with a second currently in set up.

CAV have been inspected as a host organization twice in the last 2 years, once by MHRA and once by the EMA.

Health board Research Governance, Leadership and Accountability
The UHB Joint Research Governance Group (JRGG) has been formed as part of the joint governance structures with the University to support the Joint Research Office (JRO). The aim of the group is ensure robust Research Governance arrangements are in place for research which falls under the remit of the Joint Research Office (JRO) and the UK Policy Framework for Health and Social Care Research.

JRGG is chaired by Professor Colin Dayan JRO Director and is attended by JRO Senior Management team, the R&D leads from each directorate, research delivery managers. There is also representation from Pharmacy, Biobank, Genetically modified Safety Committee (GMSC) and Information Governance (IG).
The Cardiff Joint Research Office (JRO) reports into to the QSE (via the Medical Director).
Since the September 2022 the JRGG has focused on

- Inspection readiness
- Oversight of Incidents and Breaches
- Revised Audit Processes and scope of Audit cycle
- Development of a joint risk register

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The risk register has been jointly developed with the team at Cardiff university and is broken down into;

- MHRA regulatory requirements

- Study Specific level risk which takes in to account the phase an complexity of the study, the experience of the lead clinician and team supporting them and how this compares to standard patient pathways.

Currently 11 studies deemed to be high risk, mainly as they are phase 1 or phase 2 studies and included advanced therapies. The high risk studies are required to report into JRGG quarterly via Clinical board leads to give an update on activity and performance.

The JRGG committee has reviewed and approved an annual audit plan with a renewed focus on audits of research processes. The audits have been conducted using the AMAT system and are now mandatory across all research delivery teams.

The first audit looked at the consenting process showing a high level of compliance for documentation of the consent process by an appropriate member of the team using the correct study specific documentations. Areas of learning identified documenting the time of the consent in the medical record and documenting that the patient received a copy for their records.

A second audit has been completed on the delegation logs which document the delegation of research tasks within the study team. Results of this audit are still being reviewed.

NHS R&D Framework

Health and Care Research Wales (HCRW) has published a new R&D Framework in a drive to embed and integrated research into all aspects of health and care services in Wales. The framework outlines what 'research excellence looks like' within NHS organisations in Wales where research is embraced, integrated into services and is a core part of the organisations culture, broken down into 10 key pillars. A copy of the framework has been included in appendix 1.

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The R&D senior management team have re-established the Research Management Board to develop and deliver on the strategic plan for research. Workstreams are to be agreed but it is anticipated that the following will be an area of focus;

- Embedding in standard care
- Increasing commercial opportunities

- Development of advanced therapies portfolio
- Recognising Research Impact

CAV Leading Research

This year Cardiff and Vale researchers have continued to achieve success in securing large National Institute of Health Research (NIHR) Grants, the 4th in as many years. Dr Rachel Abbott in collaboration with Cardiff University Centre for Trials Research was awarded a £1.2 million NIHR Health Technology Assessment Grant to conduct the The EXCISE Study -Examining antibiotics for ulcerated skIn cancer surgery Excision: a pragmatic, multi-arm 'durations' design randomized controlled trial. The study with will open across multiple UK sites in 2025.

Our researchers have also demonstrated the ability to create their own investment opportunities. The QuicDNA project led by Sian Morgan and Magda Meissner is looking to evaluate the use of liquid biopsies as a quicker less invasive option within the Lung cancer diagnostic pathways to gain quicker access to treatment for patients. The project started as a feasibility project funded by Health and Care Research Wales (HCRW) and through engagement and investment from various collaborators within industry partners, government, charities and patient groups raised funds to expand to a national study open at all health boards in Wales. It is hoped this work will form the foundation in which to explore possibilities for liquid biopsies to be used as a diagnostic tool in other tumors groups.

There have been 9 investigator led research projects developed and set up this year by Cardiff and Vale staff. It is hoped the success of our own investigators will continue to grow with the support of the Joint Research Office and collaboration with our academic partners.

Patient Impact

The Research Delivery Team whilst being an expert workforce consistently delivering high-quality participant care and prioritizing participant safety, the service provided has not been evaluated from the participants perspective nor had formal feedback been sought. To address this the team developed a research participant feedback questionnaire and conducted a 3 months pilot.

The results were overwhelmingly positive, indicating that participants would be willing to engage in future studies, felt the study visits were well organized and understood participation was voluntary with the option to withdraw at any time.

"Everyone has been absolutely amazing. Caring, considerate and empathetic. Always available for support and have helped me beyond my expectations. Thank you!"

However, feedback also provided insight to areas for improvement such as need for better directions/ signage to the CRF facility and lack of information about future research opportunities.

Action has been taken to address the findings of the survey including additional signage and additional support from the communications team to make research activity more visible to our patients and service users. The survey will be repeated annually to ensure that we are hearing and acting on the views of our patients.

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

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Recommendation:

The Committee is requested to:

- **NOTE** the progress made by Research to date
- **NOTE** the content of this report and the assurance given by R&D

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*			
1. Putting People First. **Click the objective above to view more detail.**		2. Providing Outstanding Quality. **Click the objective above to view more detail.**	X
3. Delivering in the Right Places. **Click the objective above to view more detail.**		4. Acting for the Future. **Click the objective above to view more detail.**	X

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

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

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

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

Chilcott,Rachel
03/04/2025 11:24:38

Report Title:	Baby Friendly Initiative – UNICEF UK Re-assessment of Health Visiting Service 2025			Agenda Item no.	2.5	
Meeting:	Quality Committee	Public	X	Meeting Date:	01.04.2025	
		Private				
Status:	Assurance X	Approval		Information	X	
Lead Executive:	Executive Nurse Director					
Report Author:	Director of Nursing & Children, Young People and Family Health Services					

Background and current situation:

The purpose of this report is to provide Committee Members will an updated position regarding the UNICEF UK Baby Friendly Initiative re-assessment of Health Visiting Service.

Background:

The UNICEF UK BFI Accreditation Programme was introduced to the UK in 1994 and supports maternity, neonatal and children' community NHS services to transform their care interlinking evidence-based standards. Services which implement the BFI standards receive the prestigious Baby Friendly award, a nationally recognised mark of quality care.

The programme supports services by:

- **Setting Standards -** the health visiting service have four standards that need to be maintained in practice.
- **Training –** Infant feeding coordinator has completed the training to ensure the health visiting service implements the standards.
- **Assessing progress –** by measuring the skills and knowledge of health professionals and interviewing mothers about their individual experiences of care

The BFI standards are designed to provide parents with the best possible care to build close and loving relationships with their baby and feed their baby in ways which will support optimum health and development.

Timeline of BFI assessment & accreditation within HV in CVUHB: -

- **Aug 2010** Declared intent of working towards BF accreditation.
- **Oct 2011** Certificate of commitment issued.
- **Jul 2012** Awarded STAGE 1: Building a firm foundation.
- **Oct 2014** Awarded STAGE 2: An educated workforce.
- **Dec 2015** Full accreditation awarded STAGE 3: Parent's experiences.
- **Oct 2018** Reaccredited
- **Dec 2021** Reaccredited
- **Feb 2025** Reaccredited

Community / Health Visiting Standards: -

1. **Antenatal** – Support those who are pregnant to understand the evidence for breastfeeding and early relationships and their influence on the health & wellbeing of them and their baby.
2. **Continued breastfeeding** – Protect and support breastfeeding in all aspects of the service and enable mothers to continue breastfeeding for as long as they wish.
3. **Maximising breastmilk** – Support parents to make informed decisions regarding the introduction of other foods or fluids other than breastmilk.

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4. **Close and loving relationships** – Support parents to have a close and loving relationship for their baby.

Current Situation:

The Baby Friendly Initiative (BFI) assessment team visited Cardiff & Vale UHB on the 12th & 13th February 2025 to undertake a Stage 3 reassessment of the Health Visiting Service. This was the 1st on site visit since 2015, as a virtual assessment was undertaken in 2021.

The assessors interviewed 58 mothers who were either breastfeeding or formula feeding their babies, 37 staff members including the Baby Friendly Guardian, Infant Feeding Coordinator, Health Visiting Management Team and a several of the health visiting team members selected by the assessment team.

The assessors visited 4 facilities across Cardiff and Vale to ensure they were code compliant.

A formal report of the reassessment was completed and presented to the BFI Designation Committee. The report was accepted with the outcome that the CVUHB Health Visiting Service should be 'reaccredited' as Baby Friendly. There are, however, some actions required, and the service will need to submit further evidence in 6 months to support this being completed. This accreditation does provide assurance that all the standards have been embedded in health visiting to support excellent practice for babies, mothers, parents and families and is reflective of the significant work undertaken across the HV service over the last couple of years.

BFI have asked for further audit data to evidence an increase in mothers who confirm:

1. *They understood responsive breastfeeding*
2. *They had been supported with making up formula feeds safely.*
3. *That they had received information about the importance of close and loving relationships.*

Following the resubmission of the audit forms in August 2025, the HV service aim to achieve the 'Gold Standard' and 'Achieve Sustainability'. No other Health Board in Wales has achieved this to date.

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

The standards for achieving sustainability include Leadership, Culture, Monitoring and Progression. To enable this a Baby Friendly Guardian was appointed on the Executive Board, and this is our EDON. With a Baby Friendly Guardian in post, we are to ensure that the 'Baby Friendly' agenda is strategically supported across the organisation.

Following the report, Baby Friendly require an action plan from the HV service outlining how the recommendations in the report will be met. A key action is to support the roll out of increased antenatal groups across the whole HV service and to align this with midwifery services wherever possible.

The infant feeding team and health visiting service currently deliver: -

- Face-to-face antenatal workshops
- Three drop-in breastfeeding support groups – Vale & Cardiff
- Infant feeding specialist clinic which offers face to face appointments for more complex issues
- Home visits for infant feeding support via a referral process

We are undertaking some public engagement sessions around location of our breastfeeding support in the Cardiff Bay area.

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Following an incredibly positive reassessment and being reaccredited for the third time we know that the Baby Friendly standards are embedded well in the health visiting service, but we need to continue development and achieve sustainability. The report commended our HV service for the challenging work in continuing to support mothers and confirmed that the pregnant women and mothers received a high standard of care.

The BFI report also asks us to ensure that BFI is widely discussed and actioned across appropriate UHB agendas. We will therefore ensure it is a standard agenda item on our QSPE meetings, and that data is more meaningfully utilised and reported through our performance and QSPE processes. Regular position reports and updates will also be shared with the UHB BF Guardian.

There is a financial commitment to continuing with the assessment process however achieving Gold accreditation would reduce long term costs. The cost varies depending on what is included in the assessment from £1400 +VAT to £2350 +VAT, it also depends on whether any additional manager/mother interviews are required. Once Achieving Sustainability is achieved the annual licence fee is currently £990+VAT.

The community/health visiting standards have recently been updated by Baby Friendly and therefore the infant feeding coordinator is required to ensure the training curriculum is updated in line with the changes and ensure the health visiting service is meeting the standards by June 2026.

The infant feeding coordinator is responsible for ensuring the standards are met and embedded in practice by providing training to the health visiting service.

- All new staff members are expected to attend 2-day breastfeeding management training within 6 months of commencing their post.
- Provide annual updates to all staff and managers – during 2024, 93% of the health visiting service received training.
- Complete staff and mother audits regularly and provide an annual report to BFI in February 2026

The infant feeding coordinator is expected by Baby Friendly to commit to ongoing professional development relevant to their role, attending national conferences and training etc.

To provide an adequate specialist service for complex feeding issues requires the breastfeeding champions to be upskilled and trained appropriately. We have approximately 20 BF champions across the HV service.

To increase breastfeeding rates in the health board requires venues, venues that are currently used are provided to health visiting are free of cost. Ideall breastfeeding support groups should be across the health board to be more accessible for mothers to attend.

Recommendation:

The Committee is requested to:

- Add Baby Friendly as standard agenda item to QSPE agenda and ensure data is reported through this and performance processes.
- Consideration of additional staff resource to support the Infant feeding Specialist Team. This will enable the IF Co-ordinator to have ringfenced time to strategically manage the Baby Friendly project and work towards achieving Gold sustainability.
- In principle UHB commitment to support the cost of maintaining Baby Friendly Accreditation (costs as above)

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- Staff to be provided with appropriate equipment when supporting a mother to breastfeed (small cost to service)
- Training to upskill breastfeeding champions covering the infant feeding specialist clinic – Tongue Tie assessment course (non-accredited training £145.00, Level 3 accredited £185.00) Approx 10 staff.
- Leadership course recommended for Infant Feeding Lead.

Link to Strategic Objectives of Shaping our Future Wellbeing: https://shapingourfuturewellbeing.com/			
Putting People First 1. **Click the objective above to view more detail.**	X	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	X
Delivering in the Right Places 3. **Click the objective above to view more detail.**	X	Acting for the Future 4. **Click the objective above to view more detail.**	

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

Quality Impact Assessment Completed?				
Yes – ***(please provide completed QIA document)***		No – ***(Please provide reasoning, e.g. not required)***		n/a

Impact Assessment:
Risk: n/a
Safety: n/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

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

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Minutes of the Medicine Clinical Board Quality, Safety & Experience Committee Meeting Held on 20 November 2024 14:30 – 16:00, Via MS Teams

Present:	
Katja Empson	Consultant/ interim Clinical Board Director (Chair)
Claire Main	Director of Operations for MCB and Unplanned Care
Ceri Richards-Taylor	Interim Deputy Director of Nursing
Sian Rowlands	Head of Quality and Clinical Governance
Aneurin Buttress	Consultant Respiratory Physician/ Clinical Director
Derek King	Clinical Nurse Specialist, Infection, Prevention and Control
Sam Hughes	Professional & Practice Development Nurse
Liz Vaughan	Professional & Practice Development Nurse
Jason Roome	General Manager, Integrated Medicine
David Pitchforth	Lead Nurse, Specialised Medicine
Lisa Green	Interim Lead Nurse, Emergency and Acute Medicine
Dave Mcrae	Lead Pharmacist, Medicine
Sarah Wright	Clinical Nurse Specialist, Infection Prevention and Control
Cath Evans	Patient Safety Facilitator, Patient Safety Team
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Rachael Maiden	Senior Nurse, Integrated Medicine
Sue Eshel	Senior Nurse, Integrated Medicine
Lowri Warren	Senior Nurse, A&E
Cath Morris	Senior Nurse, A&E
Beth Jones	Senior Nurse, Specialised Medicine
Andrew Brown	Senior Nurse, Specialised Medicine
Nicholas Denny	Organisational Learning Facilitator, Mortality Lead
Jeff Turner	Consultant Gastroenterologist, Specialised Medicine
Hibaq Musa	Clinical Nurse Specialist, Infection Prevention & Control, Corporate Nursing
Vicci Page	Deputy General Manager, Specialised Medicine
Secretariat	
Sheryl Gascoigne	MCB Secretary/ Project Support Officer
Apologies:	
Barbara Davies	Interim Director of Nursing
Lyndsey MacDonald	Consultant Emergency Medicine/Clinical Director
Katherine Prosser	Quality and Governance Lead
Brijesh Srivastava	Consultant Hepatologist, Gastroenterology/ Deputy Clinical Director
Dharmaraj Durai	Consultant Gastroenterologist
Sharon Jones	Consultant, Rheumatology/ Clinical Director
Sian Brookes	Senior Nurse, Integrated Medicine
Natasha Whysall	Interim Lead Nurse Integrated Medicine
Wayne Parsons	Lead Nurse Integrated Medicine
Angela Jones	Senior Nurse, Resuscitation Service
Chisom Uwaezuoke	Clinical Nurse Specialist, Infection Prevention and Control

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Item No	1. Standing Items	Action
MCBQSE/ 2024/0175	**Welcome and Introductions** – KE thanked staff for the work being done to keep patients safe during this high escalation level. CR-T advised that due to the current high escalation level, the meeting will be scaled down today to cover the two items listed below which require ratification and for any urgent business. - MCB Inpatient Influenza Vaccination Process 2024 to 2025 - Capsule Sponge Test Procedure in Gastroenterology	

<table>
<tr><td>MCBQSE/ 2024/0176</td><td>To receive the minutes of the previous meeting held on 16/10/24 – the group were requested to notify CR-T/SG if any amendments were required by 22/11/24. The group resolved: if no amendments are required, the minutes will be accepted.</td><td></td></tr>
<tr><td>MCBQSE/ 2024/0177</td><td>Action Log – will be updated outside of the meeting.</td><td></td></tr>
<tr><td>MCBQSE/ 2024/0178</td><td>Declarations of Interest – none.</td><td></td></tr>
<tr><td colspan="3">2. ITEMS FOR REVIEW AND ASSURANCE</td></tr>
<tr><td>MCBQSE/ 2024/0179</td><td>Patient Story – Acute & Emergency Medicine – carried over to next meeting.</td><td></td></tr>
<tr><td>MCBQSE/ 2024/0180</td><td>Concerns, Claims, Compliments – carried over to next meeting.</td><td></td></tr>
<tr><td>MCBQSE/ 2024/0181</td><td>Infection Prevention and Control (IP&C) update from report sent following the meeting
95 days since last MRSA bacteraemia (UHL E2)
40 days since last MSSA bacteraemia (UHW C7)
7 days since last C difficile (UHL E2)
19 days since last E. Coli bacteraemia (IACU A)
93 days since last Pseudomonas bacteraemia (UHL E8)
6 days since last Klebsiella bacteraemia (UHW C4S)
There are 2 outbreaks within the MCB, affecting 11 patients, 8 staff members, resulting in 14 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 and pseudomonas in October.
MCB position based on same period 2023-2024:
250% increase with Pseudomonas.
42% increase with C. difficile.
17% increase with SAUR Bacteraemias
42% reduction with E. coli.
8% reduction has been seen with Klebsiella
There are 11 outstanding RCA's.
Audit results for October varied widely with two wards exhibiting unsatisfactory results and Endoscopy UHW having and excellent audit.
C7 MSSA - three cases since September. MCB to arrange IP&C meeting to discuss.
C. difficile cluster LSGF1 and 2, with genomics at 0 SNP. Will require IP&C meeting / PII.
Duty of Candour issues being raised in unscheduled care constantly. Patients are still being transferred into bays following samples (respiratory and stool) prior to results being obtained
ARI guidance changes 2024 are now in operation.
Respiratory virus scenarios (see graphs) indicate that admissions this winter due to respiratory viruses mirror the 2023-2024 activity (admissions based on most likely scenarios).
The group resolved: to note the above.
Actions from discussion:
Action: All to ensure the Safe to Move document is used.

Action: RM, CR-T and DK to meet to prepare a plan going forward regarding MSSA and C. difficile.</td><td>ALL

Rachael Maiden
Derek King
Ceri Richards-Taylor</td></tr>
<tr><td>MCBQSE/ 2024/0182</td><td>MCB Resus Summary – carry over to next meeting</td><td></td></tr>
<tr><td>MCBQSE/ 2024/0183</td><td>Health Board overview of controlled drug and medication related incidents (July – September 2024) – carry over to next meeting.</td><td></td></tr>
<tr><td colspan="3">3 ITEMS FOR APPROVAL/ RATIFICATION</td></tr>
<tr><td>MCBQSE/ 2024/0184</td><td>National Reportable Incidents (NRIs) – carry over to next meeting.</td><td></td></tr>
</table>

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MCBQSE/ 2024/0185	**Learning from Events, Claims/ Concerns/ Redress Overview** – all to note the slides that accompany this agenda item. To be discussed further at the next meeting.	
MCBQSE/ 2024/0186	**MCB Inpatient Influenza Vaccination Process 2024 to 2025** – presented by Ceri Richards-Taylor This process has been brought here for discussion/ratification. The process applies to adult inpatients at UHW, UHL, LSW and community hospitals. This is for eligible patients who are medically fit for discharge, medically fit for vaccine, consent is obtained. Vaccines must be ordered via the ward Pharmacy Team, should be administered by the ward Doctor and cannot be administered by the Nursing Team. The group resolved: the group agreed this process. Action: This relates to Influenza only. CR-T will check what happens with Covid vaccinations. CR-T will ask if trained nurse vaccinators can administer the vaccines. Action: CR-T will link in with Jonathan Underwood who does the Monday lunchtime teaching to share this information for awareness.	Ceri Richards-Taylor Ceri Richards-Taylor
MCBQSE/ 2024/0187	**Capsule Sponge Test Procedure in Gastroenterology** – presented by Dr Jeff Turner SPRI funding is in place to undertake an implementation evaluation of capsule sponge between January to March 2025. This is an alternative diagnostic test to endoscopy. The process uses a little sponge wrapped in a vegan capsule attached to a string that the patient swallows. The capsule dissolves in the stomach, the sponge is then retracted and collects cells from the Oesophagus on the way backup. This is routinely used in Scotland and England and a similar evaluation has been undertaken at Betsi Cadwaladr Health Board (HB) and Powys HB. Funding is in place; corporate support has been given and Paul Bostock has signed this off. This has been through IG and data protection assessments have been signed off. There are plans to roll this out nationally throughout Wales. Evidence shows that this is more cost effective than an endoscopy and also frees up endoscopy capacity. For reflux patients, a clerical pre-assessment takes place to ensure the patient is suitable. If suitable they can have the capsule sponge. Consent forms have been reviewed by specialist colleagues. The forms have been populated with core risks. Quality control of consent forms will stay with Endoscopy. If approved, send the form to Chloe who will get them prepared via Medical Illustration. The forms are not currently part of EIDO, but this will be explored. The forms are available locally and in Welsh. If the sponge detaches, an endoscopy would need to take place to retrieve the sponge, however, the risk is very low. The group resolved: agreed for this to progress and the procedure was ratified.	
4 ITEMS FOR NOTING AND INFORMATION		
MCBQSE/ 2024/0188	**Patient Safety Alerts/MDAs/ISNs:** • UK Health Security Agency Briefing note 2024/045: Multi-region cluster of *Burkholderia stabilis* ST1565 suspected to be associated with non-sterile ultrasound gel • PSN065/March2023 the safe use of ultrasound gel to reduce infection risk • Urgent Field Safety Notice: Braun Pro 6000 ear thermometers outdated version of Instructions for Use **The group resolved**: for noting. **Action from discussion**: shared for information.	
MCBQSE/ 2024/0189	Minutes from Directorate QSE Groups and Chairs Reports/Exceptions: - Acute & Emergency Medicine 8th October 2024 - Integrated Medicine o UHW 19th September 2024 (next meeting 19th November 2024).	

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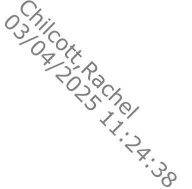
	- Integrated Medicine UHL o 19th November 2024 cancelled (next meeting Jan 2025). - EUG meeting 24th October 2024 (await minutes) **The group resolved**: to note the above. **Action from discussion:** none	
MCBQSE/ 2024/0190	**Minutes from QSE Sub Groups:** - IP&C last meeting 4th October 2024 (await approved minutes). - H&S last meeting 2nd October 2024 (await approved minutes). - Medicines Governance and Access Group last meeting 18th October (await approved minutes). - Professional Nursing Board 14th October 2024 **The group resolved**: to note the above. **Action from discussion:** none.	
MCBQSE/ 2024/0191	**Feedback from UHB QSE Committee** – carry over to next meeting.	
MCBQSE/ 2024/0192	**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/ 2024/0193	**Any Other Business** 5.1a Self Neglect and the MCA Lunch and Learn Sessions – attend if available. 5.1b Eradicating Avoidable Harm Summit Thurs 21 Nov 13:30-16:30	
6. DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2024/0194	18th December 2024 14:30-16:00 2024 MS Teams	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Report Title:	Medical Records Tracking			Agenda Item no.	4.2	
Meeting:	Quality Committee	Public	X	Meeting Date:	1st April 2025	
		Private				
Status:	Assurance	Approval		Information	ü	
Lead Executive	Chief Operating Officer					
Report Author:	CD&T Director of Operations					

Background and current situation:

At the November Audit & Assurance Committee, an update was provided on the Medical Records Tracking Audit. The slides were presented and have been shared for the Quality Committee to note, along with this supplementary covering report.

Key points of note:

Whilst 'Limited Assurance' for the tracking of acute medical records was found when the report was first issued in January 2023, a follow-up report in June 2023 concluded progress had been made, resulting in the assurance level increasing to 'Reasonable'.

Of the four open actions, three were noted as partially complete, one recognised as ongoing due to the magnitude of the operational tasks required, with the remaining action related to the establishment of a related management group.

Subsequently, a Record Management Internal Audit commenced during December 2024, many aspects of which relate to those addressed within the Medical Records Tracking Audit. This audit has now concluded, with the report due to be considered at May's Audit & Assurance Committee.

The Head of Internal Audit has recommended the Medical Records Tracking report be superseded by the recent Record Management Internal Audit report, and actions for both audits progressed via this.

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

Recommendation:

The Committee is requested to:

a) **Note** the contents of this report

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

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

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Click the objective above to view more detail.		Click the objective above to view more detail.							
Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration		Involvement	ü

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	ü	N/A

Impact Assessment:
Risk: No
Safety: No
Financial: No
Workforce: n/a
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

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

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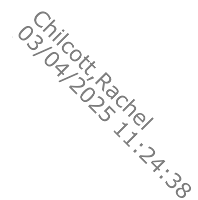
Follow-up: Medical Records Tracking Audit

Audit & Assurance Committee Update
05.11.2024



Context & Further Actions Required

- Original Medical Records Tracking audit report issued 24/01/2023. The report indicated 'limited assurance' for the tracking of acute (secondary care) medical records.
- Follow-up report issued on 06/06/2024 found 'reasonable assurance' recognising the progress made
- 7 recommendations made, 4 still open
- Two recommendations indicated as partially complete; with one of the high priority recommendations moving to medium, and one of the medium recommendations moved to a low priority, as actions have been undertaken within these areas.
- Two recommendations not implemented and requiring further action, one high priority, one medium.

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Progress & Next Steps

- New recommendation 2.1: Medium Priority: Establish Clinical Information Management Group
  - *New forum titled the Clinical Information Management Group and medical records matters will be taken forward in this group rather than through the monthly Information Governance Sub-group as initially stated in the initial management action.*
  - *Management should ensure that the terms of reference for the new group is produced, and the group is established as soon as possible to provide effective oversight of medical records matters.*
  - *Terms of reference for the Clinical Information Management Group will be agreed by the Interim Medical Director prior to being formally taken to the Group's inaugural meeting. A schedule of future meetings will be arranged, within which the terms of reference will be approved.*

Progress

- Discussion with Interim Medical Director regarding the purpose, scope and terms of reference have taken place
- TOR yet to be confirmed or the Clinical Information Group set-up
- Meeting with Head of IG and Cyber Security 9th November to finalise draft TOR to go to Deputy Medical Director

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Not complete

Progress & Next Steps

- New Recommendation 4.1 Medium Priority: System for Tracking of Medical Record Learning and Improvement Proposal
- *Management should ensure that on establishment of the new Clinical Information Programme Board, a system is put in place to oversee the 'Tracking of Medical Record Learning and Improvement Proposal' when the proposal is developed.*
- *Management should ensure that on establishment of the new Clinical Information Programme Board, a system is put in place to oversee the 'Tracking of Medical Record Learning and Improvement Proposal' when the proposal is developed*

  "1. Further digitisation of elements of the medical record (e.g.COM2) which will lead to recording and storage of the record electronically.

  2. Implementation of an app which links to the tracking database.

  3. Undertake a review and enhance the governance arrangements for management of the health record in order to ensure that the governance arrangements are suitable and robust.

  4. Develop a communications strategy to inform the organisation of their responsibilities with regards to safe storage of the medical record which will include a review of tracked notes and a records 'amnesty'

  5. Undertake a review of the record scanning solution as part of the digital mix"

Progress

- Clinical Information Programme established – focus on transformation
- Clinical Information Management Group – to focus on governance

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Partially complete

Progress & Next Steps

- New Recommendation 5.1 High Priority: Communications Strategy to ensure the appropriate handling and transfer of clinical records
- Management, in relation to their previous management response, should ensure that the new Clinical Information Management Group develop a Communications Strategy to remind staff of their responsibilities to return and record health records, in line with the points within the letter from the Ombudsman
- As part of the Clinical Information Programme Board's communication campaign, responsibility for the appropriate handling and transfer of clinical records will be emphasised widely across the UHB. These obligations will also be reinforced through the Medical Director's new Clinical Information Management Group

Progress

- Clinical Information Management Group to have oversight of strategy
- PMS team train new users on tracking
- Occasional email communication to remind all staff the importance of appropriate handling of records
- Clinical note tracking training package being developed to support the ongoing training and Communication Strategy

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Partially complete

Progress & Next Steps

- New Recommendation 6.1 Low Priority: Complete Location Based Tracking & Monitor Progress
- Management should ensure the scheduled periodic checks are undertaken on a regular basis. Acknowledging the progress highlighted, management should ensure a 'specific plan' detailing the progress of the universal filing system is developed.
- A plan for achieving full LBF in rooms 4 and 5 will be updated, including presenting options to improve timelines. Progress against this will be outlined at the monthly Directorate Performance reviews with the CD&T Clinical Board, as will quality control metrics; principally results of spot check audits. It will link into the Clinical Information Programme as part of its 'Consistency of Approach' workstream where assessment of practice occurs and where recognised good exemplars are shared

Progress

- Location Based Filing in place in 5 out of 7 libraries. Final 2 in progress – includes largest room.
- A proportion of non-current notes being stored off-site to support this
- Metrics being finalised as part of the Clinical Information Programme as part of its 'Consistency of Approach' and the wider paper 'asset' assessment

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Partially complete

Cancer Services in Wales:

A review of the strategic approach to improving the timeliness of diagnosis and treatment

January 2025

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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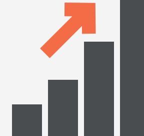
Key facts

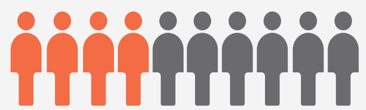
Exhibit 1: key facts

Cancer is the **leading cause of death** in Wales

Wales has the **second highest** cancer mortality in the UK. The UK has one of the highest cancer mortality rates of all OECD countries



Five-year cancer survival has improved. **62%** of people diagnosed with cancer between 2016-2022 survived at five years compared to **54%** of people diagnosed between 2002-2006



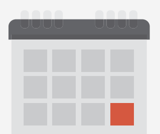
4 in 10 annual cancer cases in Wales could be prevented

At £719 million in 2022-23, spending on cancer services was the **third highest area of NHS spending** after mental health and trauma and orthopaedics

Real terms spending on cancer services has **increased by 54%** from 2009-10 to 2022-23

Since August 2020, no health board has met the overall target that **75%** of patients should start their first definitive treatment within **62 days** of first suspicion of cancer

From August 2023 to August 2024, between **53%** and **61%** of patients started treatment within **62 days**



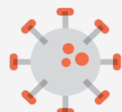
In 2021, **24%** of cancer patients were diagnosed at stage 4 and **18%** at stage 3

Survival decreases as stage advances for all cancer types

Bowel screening eligibility has expanded in stages since October 2021. It now includes people aged **50 to 74** and uses a more sensitive test.

From July 2023 to July 2024, just **21%** of bowel screening participants referred to their health board for a colonoscopy were offered the procedure within 4 weeks against a standard of **90%**

Breast and cervical screening uptake were **below standard**



Non-melanoma skin cancer, bowel, female breast, lung and prostate cancers are the most **common cancers** in Wales

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Source: Audit Wales

Notes: *Welsh Government data: NHS Expenditure by programme budget category and year, ‘cancer and tumours’, on StatsWales

Key messages

Context

1 One in two people in the UK born after 1960 will be diagnosed with some form of cancer during their lifetime[1]. Many people go on to survive cancer and lead healthy lives. Early diagnosis and timely treatment are key to survival for most cancers.

2 Services to detect, diagnose and treat cancers and to support cancer patients are provided by many public and third sector organisations. Some services, notably Systemic Anti-Cancer Therapy[2] and radiotherapy, mostly serve cancer patients. However, much of the outpatient, diagnostic and surgical capacity needed for cancer patients is part of the wider planned care system.

3 The Welsh Government is responsible for setting the vision and targets for health care and for the allocation of funding. It sets out a range of expectations for the NHS Executive, including supporting improvement in cancer services, through an annual remit letter. The National Strategic Clinical Network for Cancer[3] is part of the NHS Executive and brings together clinicians and health professionals to support improvement. Health boards are responsible for providing high quality care to patients and meeting performance targets. **Appendix 1** explains roles and responsibilities for cancer services and key elements of the strategic approach.

4 Our work has examined the coherence of the national arrangements to drive improvements in cancer services in Wales. The report includes an overview of NHS Wales' performance in providing cancer diagnosis and treatment and offers views on the prospects for improvement, including through prevention. The report does not comment on the performance of individual NHS bodies as this will be examined as part of the Auditor General's 2025 programme of local audit work at those bodies. **Appendix 3** provides more detail about our work.

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1 Cancer Research UK.

2 Systemic Anti-Cancer Therapy includes chemotherapy, immunotherapy and hormonal therapy.

3 Called the Wales Cancer Network at the time. We refer to the Network as the 'Cancer Network' throughout the report for ease of reference.

Overall conclusions

5 Overall, we found that despite increased investment, there is a continuing failure to meet the national performance targets for cancer with a minority of patients facing unacceptably long waits for diagnosis and/ or treatment. Cancer outcomes in Wales have improved over recent years but are still poor compared to other countries. Stronger and clearer national leadership is urgently needed to help drive the necessary improvements in the timeliness and sustainability of cancer diagnosis and treatment.

Key findings

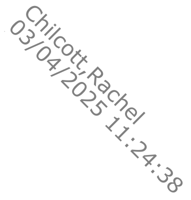
Performance and resources

6 Demand from suspected cancer patients is increasing ahead of the NHS' ability to meet it. As a result, the waiting list for diagnosis and treatment is growing. Our indicative modelling shows that without a significant increase in activity to diagnose and treat patients, the waiting list will not return to pre-pandemic levels.

7 The national target that 75% of cancer patients should start their first definitive treatment within 62 days of first suspicion has not been met by any of Wales' health boards since August 2020. Performance deteriorated following the pandemic and has been stable since early 2022 with between 52% and 61% of patients starting their treatment within the target time. Waiting times for some cancer types are particularly long with some patients waiting over 100 days for treatment[4]. There are also growing waits between diagnosis and the start of treatment.

8 A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival. In 2021, patients diagnosed with cancers of the gall bladder, pancreas and lung were more likely than patients with other types of cancers to be diagnosed at stage four (74%, 52% and 48% of patients).

9 Screening plays a vital role in early detection. While the standard for uptake of bowel screening is being achieved, this is not the case for breast and cervical screening programmes.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4 See **Exhibit 8.**

10 Patient outcomes have improved over time. But Wales has the second highest cancer mortality rate in the UK after Scotland. The UK itself has a worse rate than many OECD countries. Mortality rates in Wales are significantly worse for people living in deprived areas and the gap between the most and least deprived is growing.

11 Real terms spending on cancer care over the last 13 years has grown considerably more than the overall increase in real terms NHS spending. However, this increase does not necessarily translate into extra activity as there are a range of inflationary cost pressures, including costs of drugs and new treatments. There are also challenges around capacity – including gaps in the workforce and concerns about a shortage of modern scanning equipment.

Strategic direction

12 The Welsh Government has set out its high-level strategic vision for cancer services in its 2021 Quality Statement for Cancer. In February 2023, at the request of the then Minister for Health and Social Care, the Cancer Network published a three-year Cancer Improvement Plan as a collated NHS response to the Quality Statement. The NHS Executive is developing a National Cancer Recovery Programme as part of the wider national approach to transforming planned care. The Welsh Government has also launched a 'Cancer: Improving Outcomes' initiative through its Life Sciences Hub aimed fostering innovation and collaboration between the NHS and industry.

13 Whilst these various developments demonstrate a clear national commitment to improve cancer services, their collective efficacy is undermined by a lack of clarity over the status of the three-year Cancer Improvement Plan. Welsh Government officials were clear that the Plan was not their document but rather the collated response of the NHS to the Quality Statement.

14 However, NHS and third sector bodies are confused about the Cancer Improvement Plan's status and what, if anything, they should be doing to implement it. Many were also confused about the links between the Improvement Plan, the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative.

15 There is similar confusion about the split of leadership and accountability between the Welsh Government and the NHS Executive and about roles within the NHS Executive. Overall, we identified a consensus, including within the Welsh Government and the NHS Executive, that the arrangements were not yet providing the strong leadership needed to drive system-wide improvement in cancer services.

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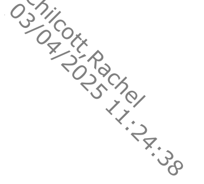
16 We identified examples of important Welsh Government investment to improve cancer services and broader planned care including rapid diagnostic centres and a new cancer centre for Velindre NHS Trust. However, the pace at which some new developments are taken forward can be slow, in areas such as digital cellular pathology and lung cancer screening.

17 There is also a risk that the Welsh Government may not get a good return on its £3.4 million investment in a National Imaging Academy. The Academy is training more radiologists to address workforce shortages, but some NHS bodies have not been able to create jobs for newly qualified people.

18 The Welsh Government relies heavily on its performance management arrangements to oversee and drive improvement. However, these arrangements are focussed predominantly on the 62-day timeliness target, which only covers part of the patient pathway. The Welsh Government told us it also focuses on delivery of National Optimised Pathways, although at the time of drafting the NHS Executive was still developing plans for monitoring compliance with those pathways.

19 The Welsh Government's Quality Statement does not set out any specific expectations in respect of cancer prevention despite around 38% of cancers being preventable. Whilst there are other Welsh Government strategies and frameworks aimed at encouraging healthier lifestyles these do not constitute a coherent policy framework for population health and disease prevention.

20 Data and digital are two other key areas for improvement. We identified inaccuracies in national data and a need for more consistent national data that helps track delivery across the patient pathway. Work is underway to replace the previous outdated cancer information system. However, progress has been slow, and services continue to rely on fragmented digital systems that consume time and carry risks to patient safety.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The Welsh Government's Quality Statement, the identification of nationally optimised pathways and the publication of a Cancer Improvement Plan are all examples of a clear commitment to secure high quality cancer care for the people of Wales.

However, despite this and increased investment over recent years, too many people are experiencing unacceptably long waits for cancer diagnosis and treatment. Variations in performance and outcomes persist within and between health bodies in Wales, and insufficient attention is being placed on prevention of the lifestyle factors that can cause cancer and other major health conditions.

The arrangements for the national leadership and oversight of cancer services in Wales need to be clarified and strengthened as a matter of urgency. This must include a clear statement on the status of the NHS Wales Cancer Improvement Plan and how the Welsh Government and NHS Executive expect it to be used, alongside other programmes and initiatives, to shape the improvements which are needed in cancer services in Wales.

Adrian Crompton
Auditor General for Wales

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Recommendations

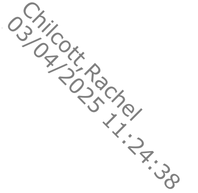
Exhibit 2: recommendations

Setting out a coherent, long-term strategic approach for cancer in Wales, supported by clear system leadership and informed oversight

R1 The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan.

R2 The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of cancer service performance, quality and opportunities for improvement.

R3 The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer.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Developing the strategic approach to population health improvement and disease prevention

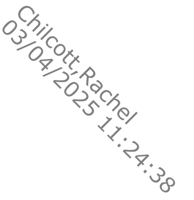
R4 The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions.

Exploiting specific opportunities for improvement

R5 The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme.

R6 As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for cancer diagnosis and treatment, where it is appropriate to do so.

R7 The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy.



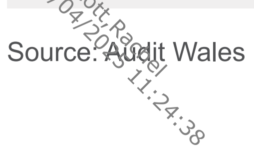
Improving Data and Digital

R8 The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance.

R9 The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include:

- the number of people currently waiting for cancer diagnosis or treatment (open pathway data).
- performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area.
- performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible.
- timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes.
- accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people).

R10 The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England.



Source: Audit Wales

Performance and resources

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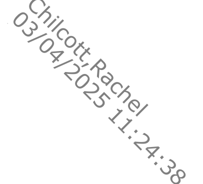
1.1 This part of the report looks at how well services to diagnose and treat cancer are performing, including against national targets. It considers performance in the wider context of demand, financial and capacity pressures.

What we looked for

We looked for evidence that the NHS is sustainably meeting demand to diagnose and treat cancer; whether it is meeting the national performance targets for timeliness of cancer diagnosis and treatment; and for evidence that outcomes for cancer patients are improving and compare well internationally.



Demand is increasing ahead of the NHS's ability to meet it and the waiting list for diagnosis and/ or treatment is growing

The number of people referred for suspected cancer has continued to rise following a sharp drop during the pandemic

1.2 Suspected cancer referrals create demand for NHS services even though the vast majority of those referrals (over 84%[5]) go on to find out that they do not have cancer. Around 80% of patients with suspected cancer are referred by GPs. However, because they are far less likely than those coming from other routes[6] to actually have cancer, those referred by GPs only make up around 54% of patients who go on to start treatment.

1.3 The number of suspected cancer referrals increased by 14% from June 2019 to August 2024 (**Exhibit 3**); equivalent to around 3% growth each year. Referrals have increased after a drop at the start of the pandemic. The highest numbers of referrals in August 2024 were for skin (excluding basal cell carcinoma[7]) and lower gastrointestinal cancers (17% and 15% of referrals respectively).

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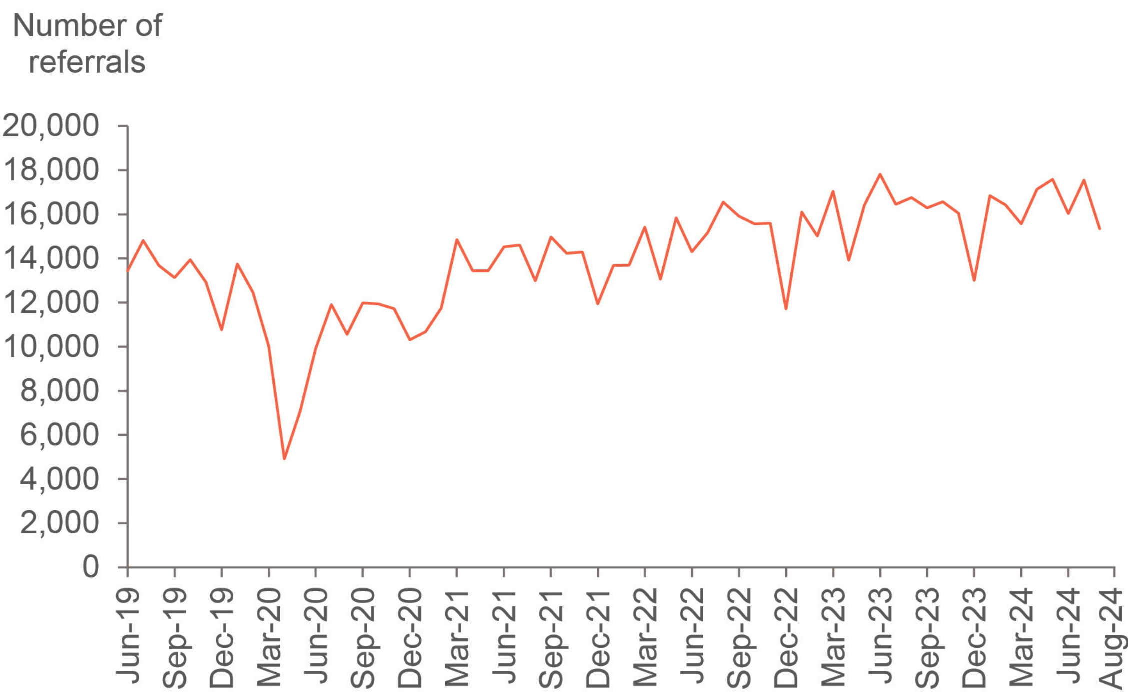
5 Since November 2020.

6 Other routes include screening services, emergency departments, and other secondary care professionals.

7 Basal cell carcinoma is the most common type of skin cancer and less likely than other skin cancers to spread to other parts of the body. NHS Wales does not refer suspected basal cell carcinomas via the suspected cancer pathway unless there is a concern that delayed investigation may cause significant impact to the patient in line with NICE Guidance NG12, last updated October 2023.

Exhibit 3: urgent suspected cancer referrals, June 2019 – August 2024



Source: DHCW, Suspected Cancer Pathway – Open Pathways Dataset, on StatsWales.

Note: data from June 2019 to November 2021 is based on experimental analysis on StatsWales and may not be directly comparable to the validated data from December 2021 onwards.

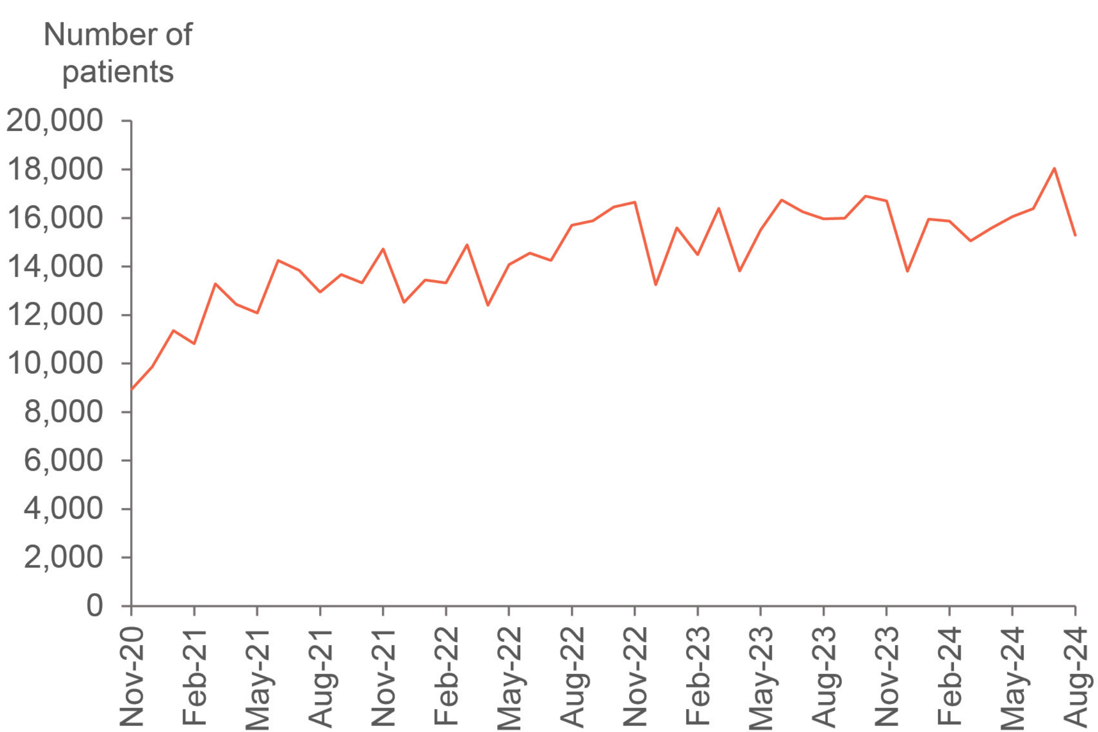
1.4 The number of newly diagnosed cancer patients has also increased over time (by 22% from 2002 to 2021) (see **Appendix 2, Exhibit 26**). Numbers fell in 2020, probably because fewer people accessed healthcare during the pandemic. Numbers of newly diagnosed cancers increased in 2021 but have not yet returned to pre-pandemic levels. The Welsh Cancer Intelligence and Surveillance Unit (WCISU)[8] has not yet published clinical cancer registry data beyond 2021.

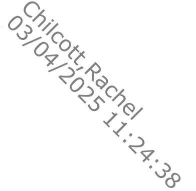
8 WCISU is part of the Public Health Wales NHS Trust.

The sharp increase in activity after the pandemic seems to have levelled off

1.5 Activity to diagnose and treat suspected cancer patients[9] has increased since the pandemic but seems to be levelling off. The overall number of pathways closed – including those who were told they do not have cancer and those who started treatment – has increased since November 2020 (**Exhibit 4a**). There is no comparable historic data to show how overall activity levels compare with pre-pandemic levels. However, the number of patients starting treatment for cancer increased quickly after a drop at the start of the pandemic and exceeded pre-pandemic figures by March 2021 (**Exhibit 4b**). The number of patients starting treatment appears to have to broadly levelled out from November 2022.

Exhibit 4a: all closed pathways November 2020 – August 2024

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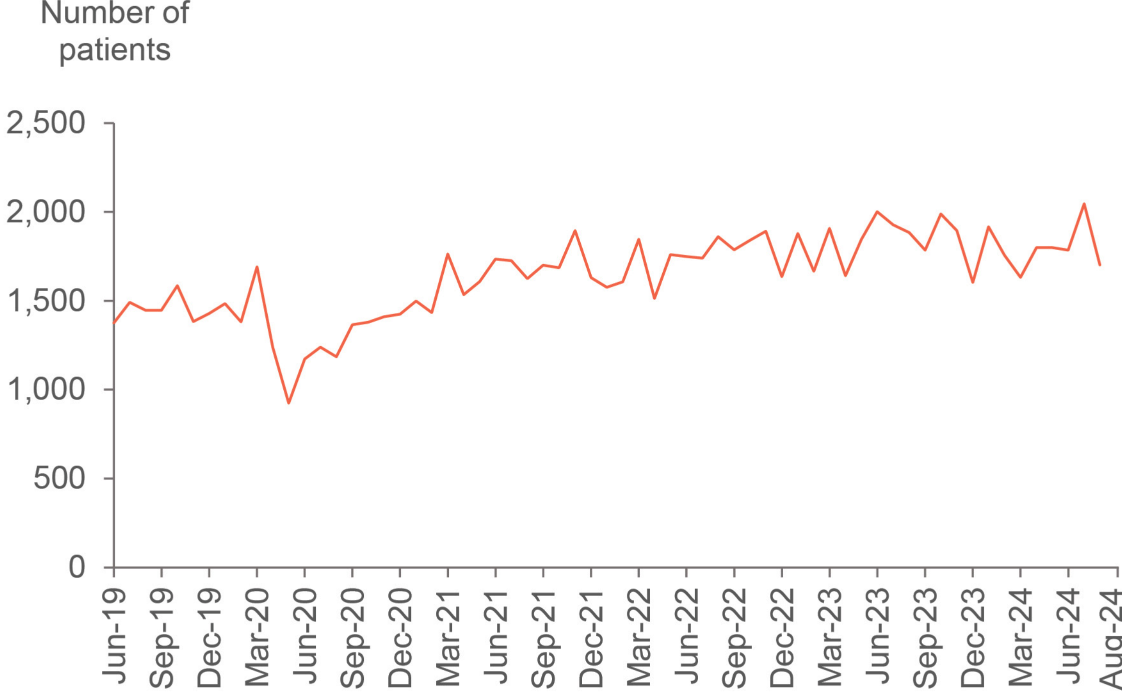
9 As measured by pathways closed.

Exhibit 4b: pathways closed due to patient starting first treatment, June 2019 – August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.

1.6 The available data understates the amount of activity because it only includes activity to the point of first treatment. Many people will need multiple episodes of care after they start their first treatment. It is likely that the amount of activity after first starting treatment is growing with the increasing complexity of new treatments, particularly in immunotherapy. The three cancer centres in Wales[10] hold information on the timeliness of access to radiotherapy and Systemic Anti-Cancer Therapy. However, inconsistencies in the way some of the data is collected means it cannot currently provide any insight on national trends or comparative timeliness of ongoing treatment across Wales.

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10 In north Wales, southwest Wales, and south Wales. The centres are managed individually by Betsi Cadwaladr University Health Board, Swansea Bay University Health Board and Velindre NHS Trust.

The numbers of patients awaiting diagnosis or treatment is growing and our analysis suggests the NHS needs to further increase activity if it is to reduce the backlog and sustainably meet demand

1.7 As part of its vision for quality cancer care, the Welsh Government wants to see the waiting list volume return to pre-pandemic levels. It has also set a target that 80% of cancer patients start treatment within 62-days by March 2026. However, the waiting list for diagnosis and/ or treatment has continued to increase, and it is difficult to see how that target will be achieved (**Exhibit 5**). Our indicative modelling shows that the list will continue to grow based on recent trends of demand and activity. It is clear that without a significant increase in activity to diagnose and treat more patients the waiting list is unlikely to return to previous levels.

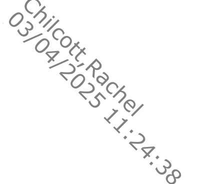
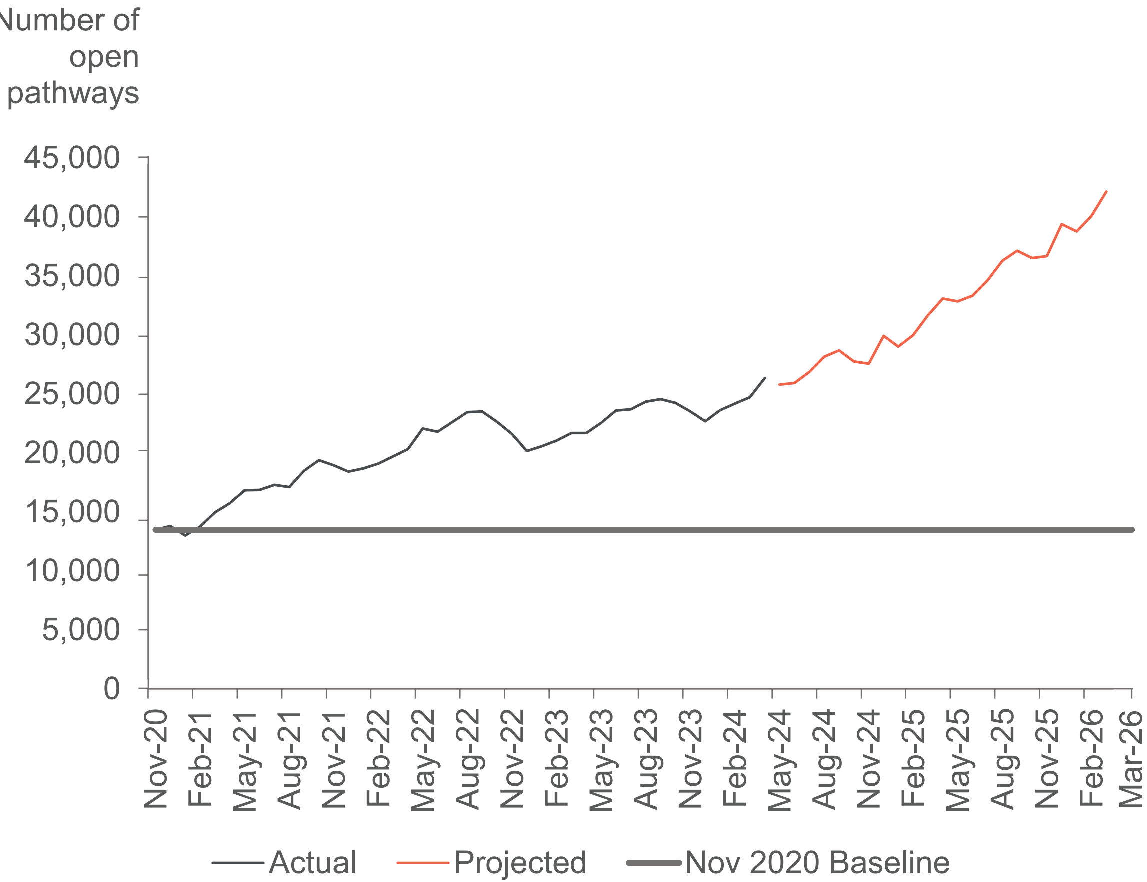


Exhibit 5: actual and modelled numbers of open suspected cancer pathways to March 2026



Source: Audit Wales analysis of DHCW data, open suspected cancer pathways at month end

Note: Patients may have more than one pathway if they are waiting for diagnosis or treatment for more than one cancer.

Our projection assumed demand, as measured by referrals, increases by 3% a year in line with recent trends and that activity increases by 1% a year.

1.8 Much of the capacity the NHS uses to diagnose and treat cancer patients is also used for other non-cancer patient pathways. Achieving the political and policy ambitions to improve access to both cancer and wider planned care within the system's existing capacity will therefore be challenging. Priorities on cancer care will need to be balanced with other planned care priorities. A consideration of how existing capacity can be better used or expanded will also be needed.

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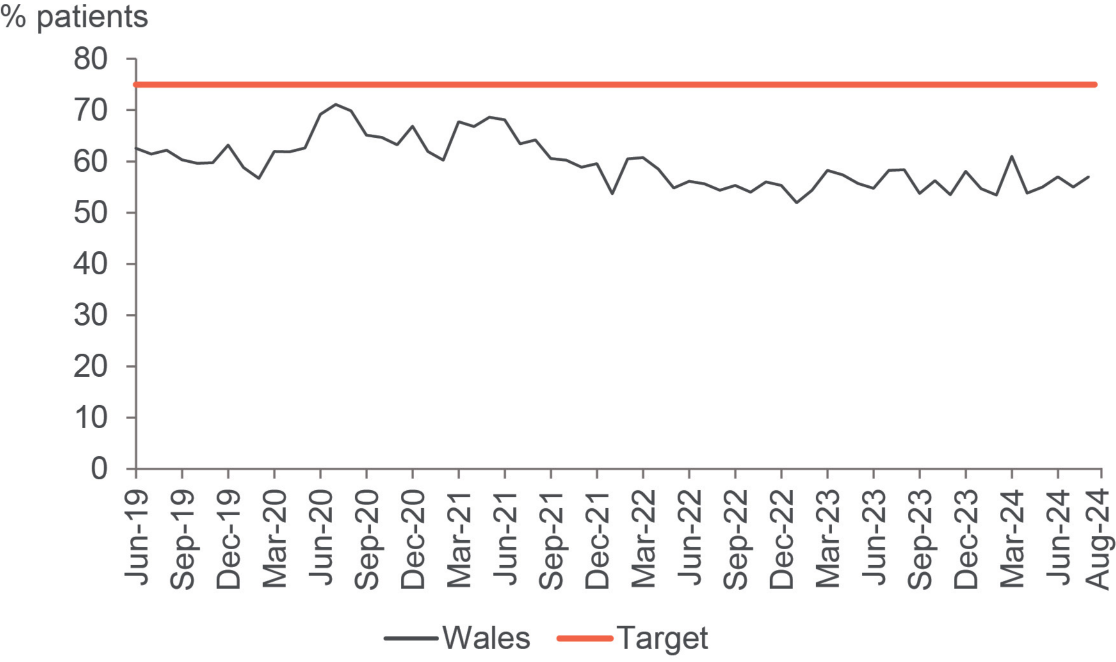
The NHS in Wales is continuing to miss the national performance target for cancer treatment

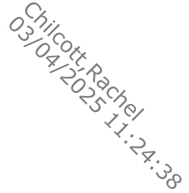
While the majority of patients start their treatment within 62 days, performance is well short of the national target of 75%

1.9 The Welsh Government started implementing its Suspected Cancer Pathway in June 2019, with a target that 75% of cancer patients should start their first definitive treatment within 62 days of the first suspicion of cancer[11]. No health board has met the overall 75% target since August 2020 although performance has been better for some individual tumour sites (**paragraphs 1.10 and 1.11**). During the summer of 2020, referrals were lower and health boards were prioritising urgent and cancer care over other patients due to the pandemic. Since then, despite some month on month variations, performance has stayed between 52 and 61% (**Exhibit 6**).

Exhibit 6: performance against the 62-day Suspected Cancer Pathway Target, June 2019 – August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.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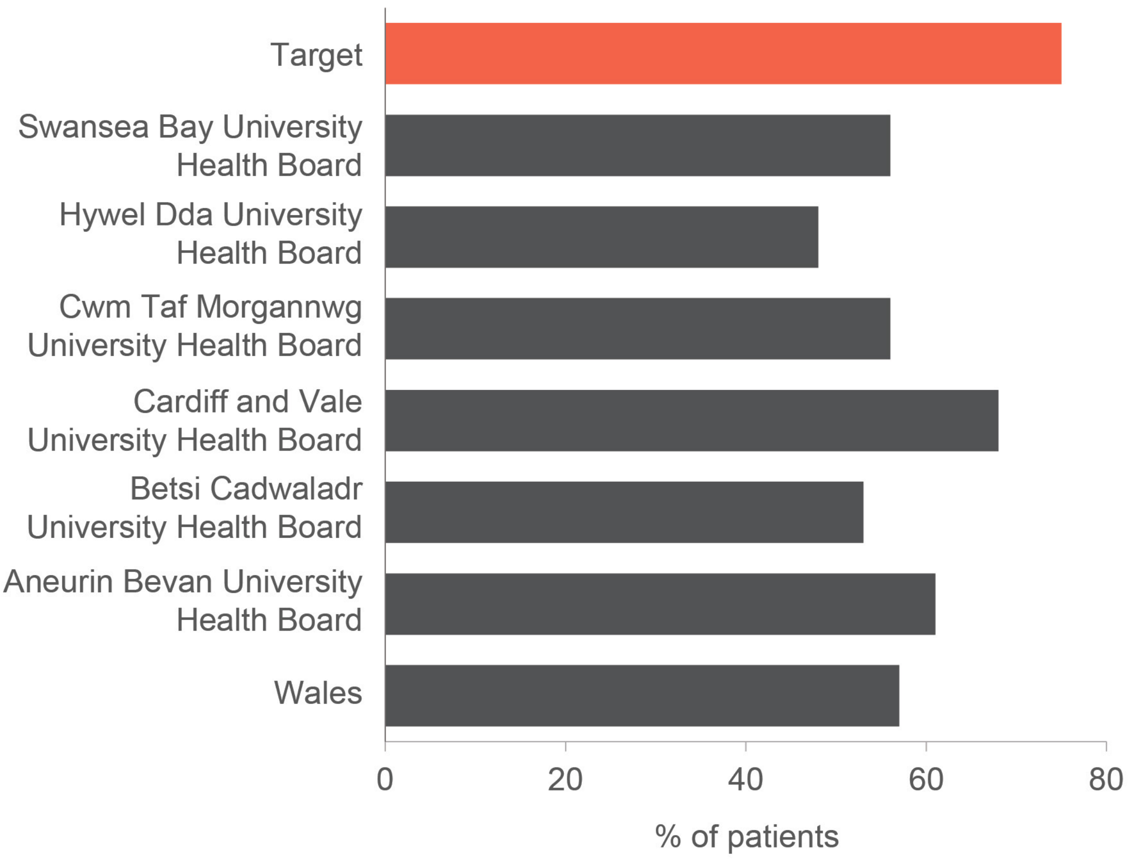
11 Some data on performance against the target is available from June 2019 and the Welsh Government officially required health boards to report against the target from February 2021.

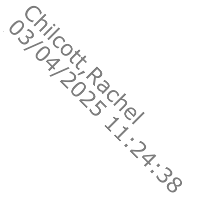
1.10 There is considerable variation and fluctuation in performance against the target by health board area. In August 2024, Cardiff and Vale University Health Board was closest to meeting the target at 68%, and Hywel Dda University Health Board was the worst performer at 48% (**Exhibit 7**). Health board performance has fluctuated considerably since 2019 (see **Appendix 2, Exhibits 27a to f**).

Exhibit 7: health board performance against the 62-day Suspected Cancer Pathway Target, August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Note: StatsWales publishes data for residents of each health board unless they are treated by NHS England. Residents of Powys Teaching Health Board treated by other Welsh health boards are included in that health boards' figures. StatsWales does not distinguish between residents of Powys and residents of the health board they are treated by.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Time to start treatment varies by type of cancer and some patients can face unacceptably long waits

1.11 Waiting times vary depending on the site of the cancer. Waiting times for skin cancer, excluding basal cell carcinoma (BCC) have been consistently above the 75% target, aside from a brief dip in November 2023. However, waiting times for other tumour sites have rarely been at or above the target at an all-Wales level[12]. Waiting times for gynaecological, lower gastrointestinal and urological cancers, and sarcoma are particularly poor with less than half of patients starting their first treatment within 62 days of first suspicion in August 2024 (**Exhibit 8**). Performance may vary within the sub-tumour sites[13] for these cancers but there is no nationally available information to understand performance by sub-tumour site (**recommendation 9**).

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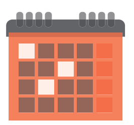
12 Performance for breast and lung cancers briefly met the target in June 2021 but has deteriorated since. Brain and central nervous system and haematological cancers, acute leukaemia and sarcoma have all met the target at various points from November 2020 to June 2024 but represent low numbers of patients.

13 For instance, cervical and ovarian cancers are both gynaecological sub tumour sites.

Exhibit 8: performance against the Suspected Cancer Pathway target, median and 75th percentile waits for gynaecological, lower gastrointestinal, skin, and urological cancers, and sarcoma, and August 2024



	Performance against the 75% target	Median waiting times	75th percentile waiting times
Skin (excluding BCC)	80%	35 days	61 days
Sarcoma	20%	No data	No data
Urological	40%	86 days	132 days
Gynaecological	35%	83 days	115 days
Lower gastrointestinal	45%	70 days	106 days

Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset on StatsWales (data on performance against the 75% target) and DHCW data on the Suspected Cancer Dashboard (data on median and 75th percentile waits).

Note: Median waiting time is point where half the people have had their treatment and the other half are still waiting. The 75th percentile represents the time when 75% of people have had their treatment but 25% are still waiting.

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While diagnostic waits are getting shorter, waits between diagnosis and starting treatment are getting longer

1.12 Health board, NHS Executive and Welsh Government officials told us that delays at diagnostic stage are one of the main reasons for poor performance against the 62-day cancer target. Median waits from first suspicion of cancer to first diagnostic test have fallen from 20 days in February 2021 to 16 in August 2024. Depending on the type of cancer, patients usually face another wait between having a diagnostic test and finding out whether they have cancer (diagnosis). Median waits from first suspicion to actual diagnosis increased from 26 days in February 2021 to 36 in January 2022 but fell to 27 in August 2024[14].

1.13 Our analysis[15] points to problems between diagnosis and starting treatment. Between February 2021 and August 2024, median waits from diagnosis to treatment increased by 38% from 21 days to 29. Waits between diagnosis and treatment vary between tumour sites, with patients with lower gastrointestinal and breast cancers waiting longer than those with other cancer types in August 2024[16] (**Exhibit 9**).

1.14 There are also considerable variations in waits at other stages of the pathway across tumour sites. For instance, in August 2024, the median wait for urological cancers was 16 days from first suspicion to diagnostic test, 49 days from first suspicion to diagnosis, and 86 days from first suspicion to the start of treatment. By comparison, the median wait for skin cancers was 41 days from first suspicion to diagnostic test and 34 days from first suspicion to diagnosis, and 35 days from first suspicion to the start of treatment (**Exhibit 9**).

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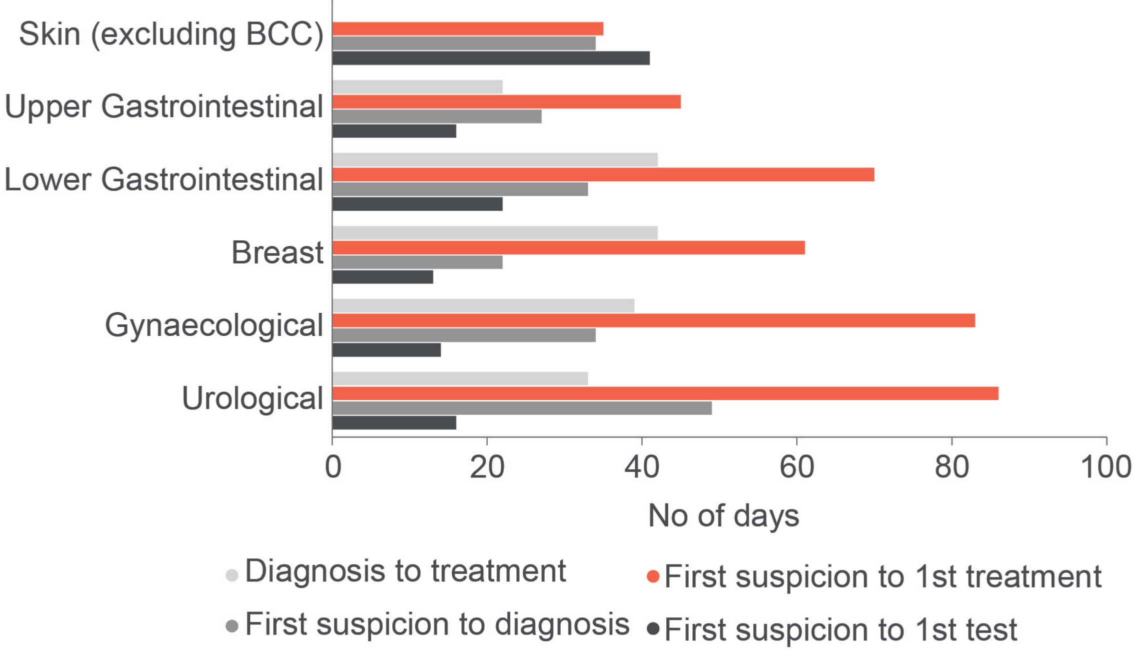
14 **Appendix 2, Exhibit 28** gives median waits from first suspicion to diagnosis over time.

15 Of DHCW data from the Suspected Cancer Pathway Dashboard. DHCW only publishes median waits for the tumour sites included in **Exhibit 9.**

16 The Welsh Government does not publish median waits for all tumour sites.

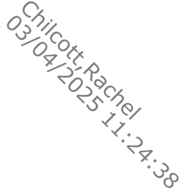
Exhibit 9: median wait from first suspicion of cancer to first test, diagnosis and starting first treatment, August 2024



Source: DHCW data from the Suspected Cancer Pathway Dashboard

A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival

1.15 Survival decreases as stage at diagnosis advances for all cancer types[17]. In 2021, 24% of cancer patients were diagnosed at stage four and 18% at stage 3 (**Exhibit 10**). The increase in the proportion of cancer patients diagnosed at stage 1 between 2011 and 2021 corresponds with a fall in patients diagnosed at stage 2 and patients whose stage is unknown at diagnosis. With the exception of an increase in 2020, the proportion of cancer patients diagnosed at stage 4 has ranged between 19% and 24% during the same period. Positively, the overall proportion of cancer patients whose stage at diagnosis was 'unknown' has significantly decreased since 2011.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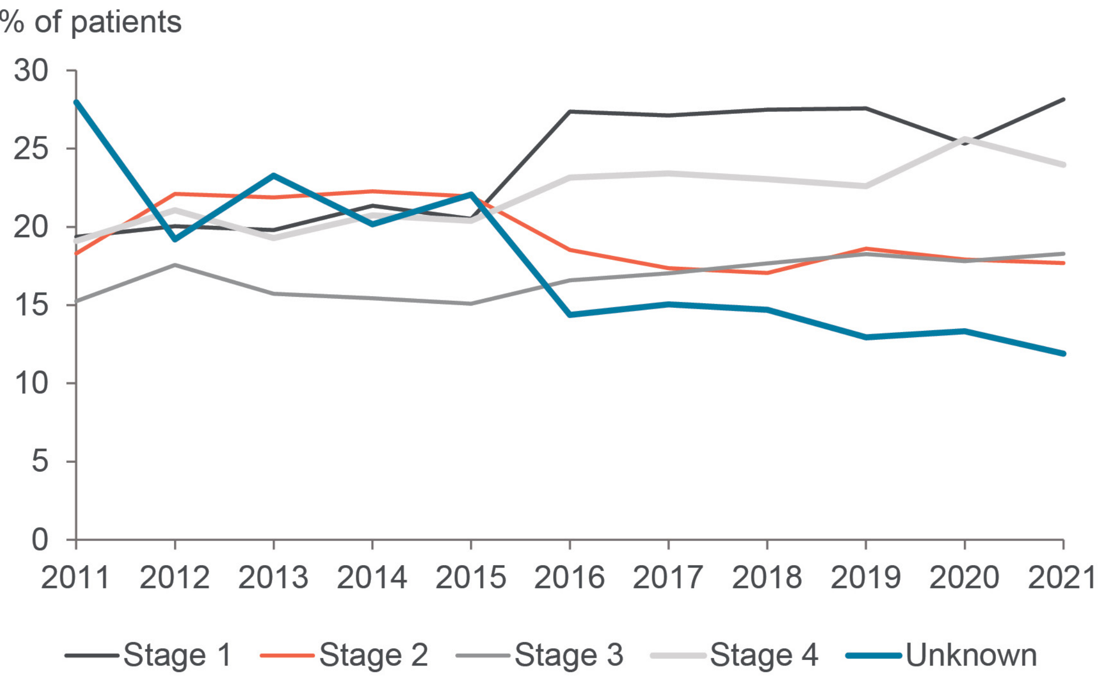
17 WCISU, Cancer Survival in Welsh Residents Diagnosed Between 2002 and 2020, November 2023.

Exhibit 10: proportion of cancer patients by stage at diagnosis, 2011 to 2021



Source: WCISU cancer incidence data

Note: Our analysis is based on WCISU cancer incidence data which does not include 'non-stageable' cancer, non-melanoma skin cancer, and some rare cancer types.

1.16 Some cancers are more likely than others to be diagnosed at a late stage, particularly asymptomatic cancers. In 2021, patients with gall bladder, pancreatic, and lung cancer were more likely than other cancer patients to be diagnosed at stage four[18]. 48% of lung cancer patients were diagnosed at stage four in 2021 (1,175 people). To illustrate the importance of early diagnosis, five-year survival for lung cancer diagnosed during 2016-2020 is 55% at stage one, 30% at stage two, 13% at stage three, and just 3% at stage four[19].

1.17 Although the numbers are relatively small, the number of people whose suspected cancer was identified via emergency departments has increased by over 40% from October 2021 to April 2024 (**Exhibit 11**).

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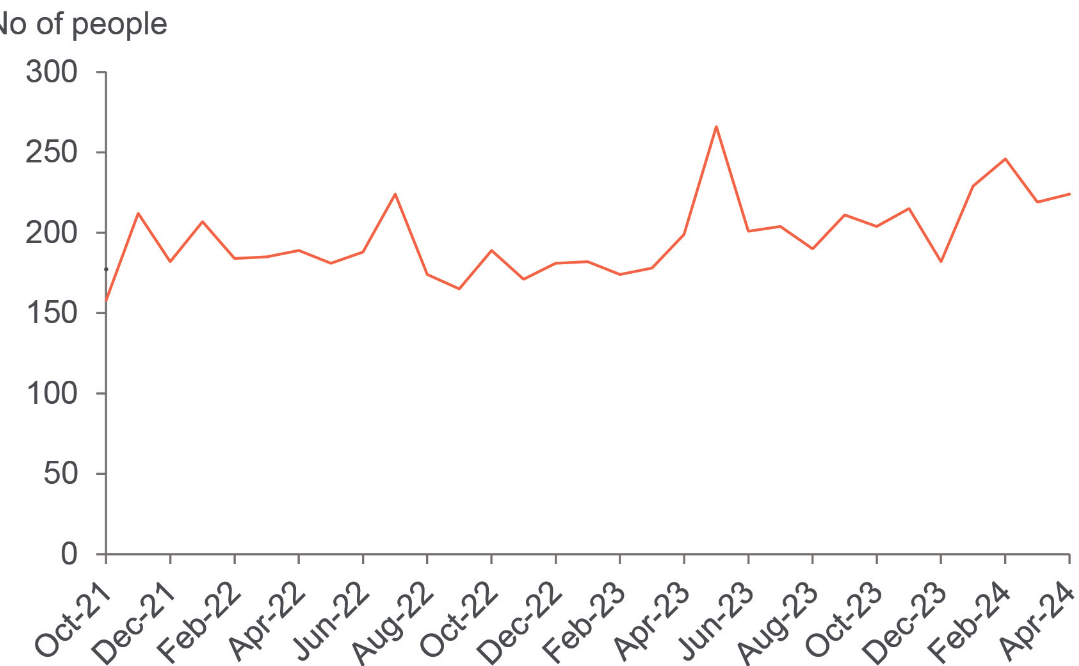
18 74% of patients with gall bladder cancer and 52% of patients with pancreatic cancer were diagnosed at stage 4 in 2021.

19 WCISU, Cancer Survival in Welsh Residents Diagnosed between 2002 and 2020, November 2023.

Exhibit 11: number of urgent suspected cancer referrals via emergency departments from October 2021 to April 2024.



Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

1.18 Research by the International Cancer Benchmarking Partnership[20] found that countries with higher rates of cancer diagnosis after emergency presentation had poorer survival rates[21]. It explained that Wales and Scotland have some of the highest rates amongst comparable countries. Our own analysis found that suspected cancer patients referred from emergency departments were more likely than those referred via other routes to die before being diagnosed or starting treatment[22]. While some caution is needed due to the small numbers, there is an upwards trend in patients referred from emergency departments dying before treatment or diagnosis.

20 The Partnership brings together international clinicians, policymakers and researchers to identify best practice and support improved cancer outcomes for patients.

21 Abd Elkader, Alv, R; Barclay, M; Johnson, S; McPhail, S; Swann, R, Risk Factors and Prognostic Implications of Diagnosis of Cancer Within 30 Days After and Emergency Admission (Emergency Presentation): An International Cancer Benchmarking Partnership Population-Based Study, 2022.

22 Based on our analysis of on our analysis of DHCW Suspected Cancer Pathway Data. In April 2024, 4% of suspected cancer patients referred from an emergency department died before starting treatment or finding out they did not have cancer compared to 1% of all suspected cancer referrals.

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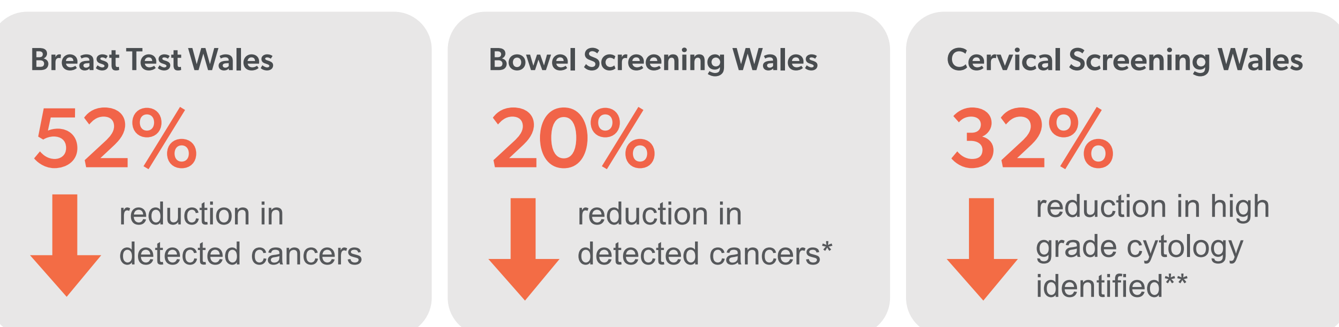
There is scope to increase uptake of screening to detect cancers earlier

1.19 Screening plays a vital role in early detection. Public Health Wales NHS Trust (PHW) runs Wales's three cancer screening programmes: Breast Test Wales, Bowel Screening Wales and Cervical Screening Wales. The Trust estimates that brief pauses to its screening programmes[23] at the start of the pandemic reduced the number of detected cancers in 2021 compared to previous years (**Exhibit 12**).

Exhibit 12: reduction in cancers detected via screening, from April 2020 to March 2021 compared to the previous year



Source: PHW, Update on Population Based Screening Programmes in Wales to the Quality, Safety and Improvement Committee, June 2021

Note: * from April 2020 to February 2021.

**abnormal cells with the potential to develop into cervical cancer.

1.20 Whilst bowel screening is achieving its uptake standards, there are opportunities to increase screening uptake for the breast and cervical screening programmes which were both below the standard in August and April 2024 respectively (**Exhibit 13**). In 2022, the Trust reported differences in screening uptake for all three programmes depending on age, the health board area people live in, and whether the area is deprived or not[24]. It is working to address inequity in screening uptake via its Screening Equity Strategy but has not published a progress report on screening equity since June 2022.

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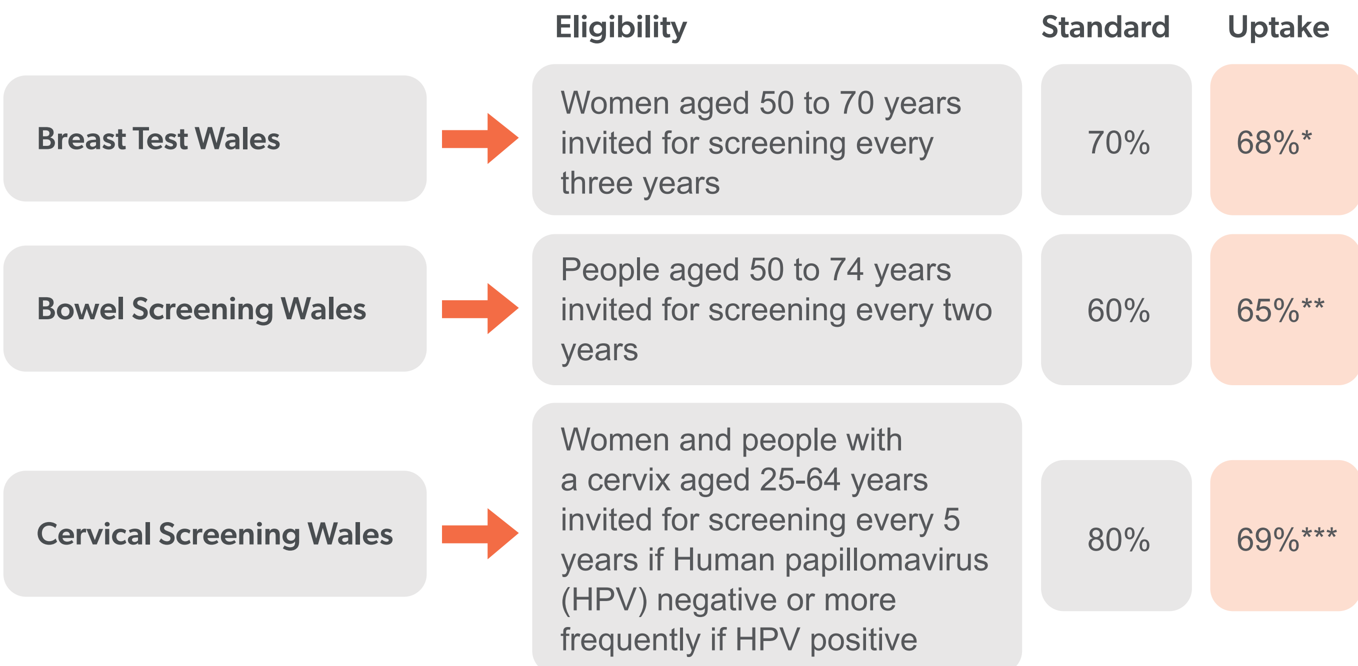
23 Audit Wales, A Review of Arrangements to Recover Screening Services at Public Health Wales NHS Trust, August 2023, provides more information the pause and recovery screening services including performance measures, eligibility and coverage standards for each programme.

24 Public Health Wales NHS Trust, Screening Division Inequities Report 2020-21, June 2022.

Exhibit 13: screening coverage against target, April and August 2024



	Eligibility	Standard	Uptake
Breast Test Wales	Women aged 50 to 70 years invited for screening every three years	70%	68%*
Bowel Screening Wales	People aged 50 to 74 years invited for screening every two years	60%	65%**
Cervical Screening Wales	Women and people with a cervix aged 25-64 years invited for screening every 5 years if Human papillomavirus (HPV) negative or more frequently if HPV positive	80%	69%***

Source: Audit Wales, based on information and wording from PHW, October 2024.

Note:

*Rolling annual rate at August 2024
**Average over the previous year at August 2024
***Age appropriate coverage at April 2024

1.21 Referrals from breast and bowel screening programmes were amongst the most likely to go on to start cancer treatment (92% and 28% respectively in 2023-24 compared to 12% overall)[25]. However, there is no national data on the timeliness of subsequent cancer diagnosis and treatment for people referred from breast or cervical screening. From July 2023 to July 2024, just 21% of eligible people referred from bowel screening were offered a colonoscopy by the relevant health board within four weeks of phoning to book[26]. The target is 90%. Waiting times for colonoscopies varied between health boards from four to 14 weeks.

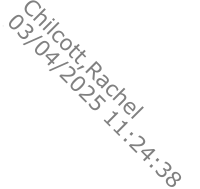
25 Based on our analysis of DHCW Suspected Cancer Pathway Data. We have excluded cervical screening referrals from our analysis due to low numbers. Less than 5 people are referred with suspected cancer following cervical screening each month.

26 Public Health Wales NHS Trust, October 2024.

Survey data suggests that patients are generally satisfied with their cancer care, though the latest survey pre-dates the recent decline in performance

1.22 Data on patient experience is collected via the annual Wales Cancer Patient Experience Survey commissioned by the Cancer Network and Macmillan Cancer Support. The most recent data is from 2021 and pre-dates the downturn in performance against the 62-day target.

1.23 The vast majority of cancer patients who responded to the survey rate their overall care highly. The average rating for overall care was 9 out of 10 across Wales, based on 5,859 responses. The positive results reflect the hard work and compassionate care of the many staff working across the NHS to care for and support cancer patients. 87% of respondents said that the different professionals treating and caring for them worked well together to give them the best possible care either 'always' or 'most of the time'. The survey does not ask patients how they felt about the overall length of time they waited from first suspicion to starting treatment.



Outcomes for cancer patients are generally improving but lag behind comparable countries and are worse for people living in deprived areas

1.24 Cancer is the leading cause of death[27] in Wales, accounting for 25% of all deaths in 2022. Lung, bowel, and prostate cancer account for the largest proportions of cancer deaths[28]. The number of cancer deaths has increased from 8,295 in 2002 to 9,154 in 2022 and is projected to increase by 27% by 2040 (based on 2021 levels)[29]. The rise in cancer deaths is primarily explained by the changing age structure of the population. The age standardised rate[30] of cancer deaths has generally decreased since 2011 although there was a slight increase in 2022 (**Exhibit 14**).

1.25 The cancer death rate in Wales compares poorly to other UK nations and internationally[31]. Wales has had the second highest age standardised cancer death rate in the UK almost consistently since 2010 (**Exhibit 14**). The OECD compared age standardised cancer death rates in 2023, based on 2021 data. It placed the UK 35th out of 45 countries[32].

27 In 2022, 24% of deaths were caused by diseases of the circulatory system, 12% by diseases of the respiratory system, 10% by dementia and Alzheimer's, and 29% by other causes.

28 WCISU cancer mortality data.

29 National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

30 Deaths per 100,000 of the population taking account of differences in the age structure of different parts of Wales.

31 Many factors affect cancer incomes including the relative wealth and spending on healthcare in each country, underlying population health, and deprivation.

32 OECD, Health At A Glance 2023: OECD Indicators, OECD, 2023.

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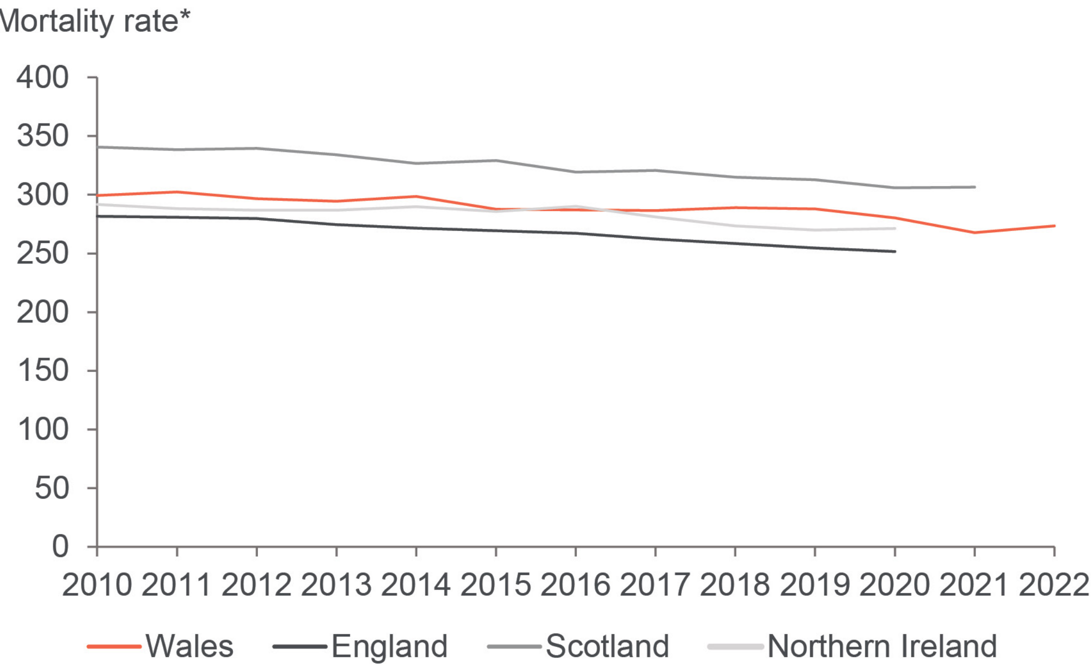
Exhibit 14: age standardised cancer mortality rates in UK countries (excluding non-melanoma skin cancer), 2010 to 2022



Source: WCISU cancer mortality data

Note: *per 100,000, adjusted to reflect the age of the population

1.26 Cancer survival[33] improved between 2002 and 2020. 54% of patients diagnosed with cancer from 2002-2006 survived their cancer at five years compared to 62% of patients diagnosed between 2016 and 2020. There is not yet data available to track the impact of the pandemic on survival rates. Differences in data collection methods makes it difficult to compare overall survival figures across UK countries.

1.27 There is a significant deprivation gap in survival rates. While 69% of cancer patients living in the most affluent parts of Wales survive cancer at five years, that falls to 51% for those in the most deprived areas (**Exhibit 15**). Worryingly, the deprivation gap has widened from a difference of 16 percentage points for people diagnosed between 2002-06 to 18 percentage points for people diagnosed between 2016-20.

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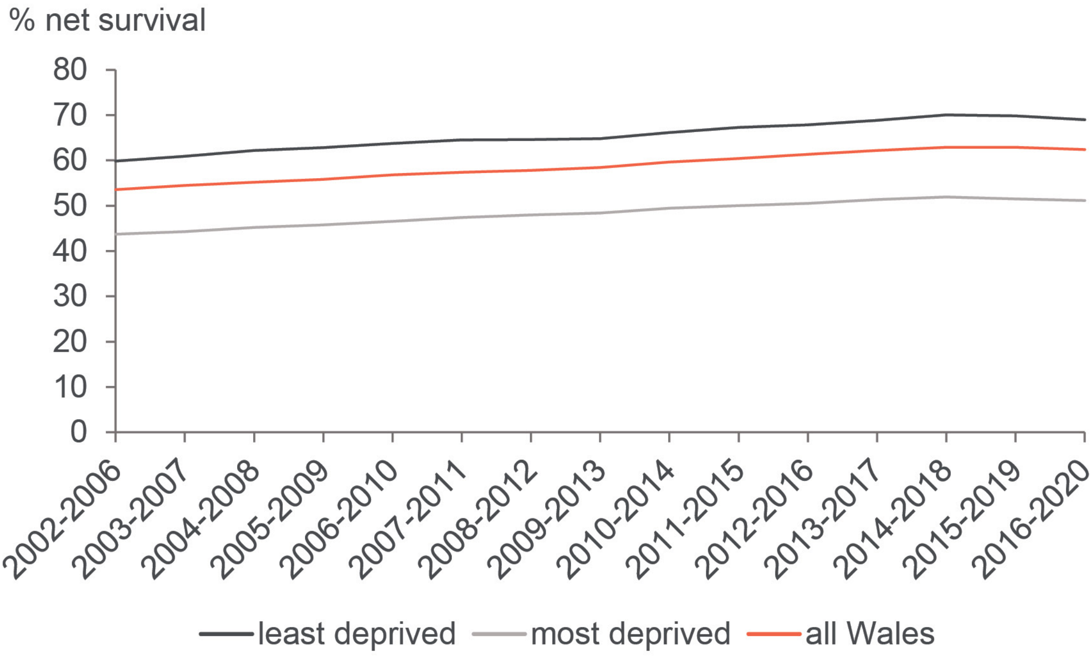
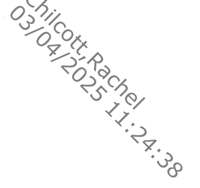
33 Cancer mortality figures show the number of deaths where cancer was the underlying cause whilst survival figures show how many people who have had cancer are still alive after a certain period of time so it takes several years for accurate data to be published.

Exhibit 15: percentage unstandardised rolling net survival at five years comparing most and least deprived areas with the all Wales figure for patients diagnosed in the periods 2002-2006 to 2016-20 (excluding non-melanoma skin cancer).



Source: WCISU cancer survival data



Spending on services to diagnose, treat and support cancer patients has risen faster than overall NHS spending but there are gaps in staffing capacity

Real terms spending on services to diagnose, treat and support cancer patients has grown more than overall growth in NHS Wales spending but there are significant cost pressures on those services

1.28 Real terms spending on services to diagnose, treat and support cancer patients increased by 54% from just over £450 million in 2009-10 to almost £720 million in 2022-23 (**Exhibit 16**). This increase is considerably greater than the overall 33% real terms growth in NHS Wales spending[34]. As a proportion of overall NHS spending, spending on services to diagnose, treat and support cancer patients has increased slightly from 7% in 2009-10 to 8% in 2022-23. Increased spending does not necessarily translate to additional capacity or activity. There are lots of cost pressures on services including rising workforce costs associated with pay growth and the use of agency staff; rising costs of existing drugs; new drugs and new technologies to improve treatment.

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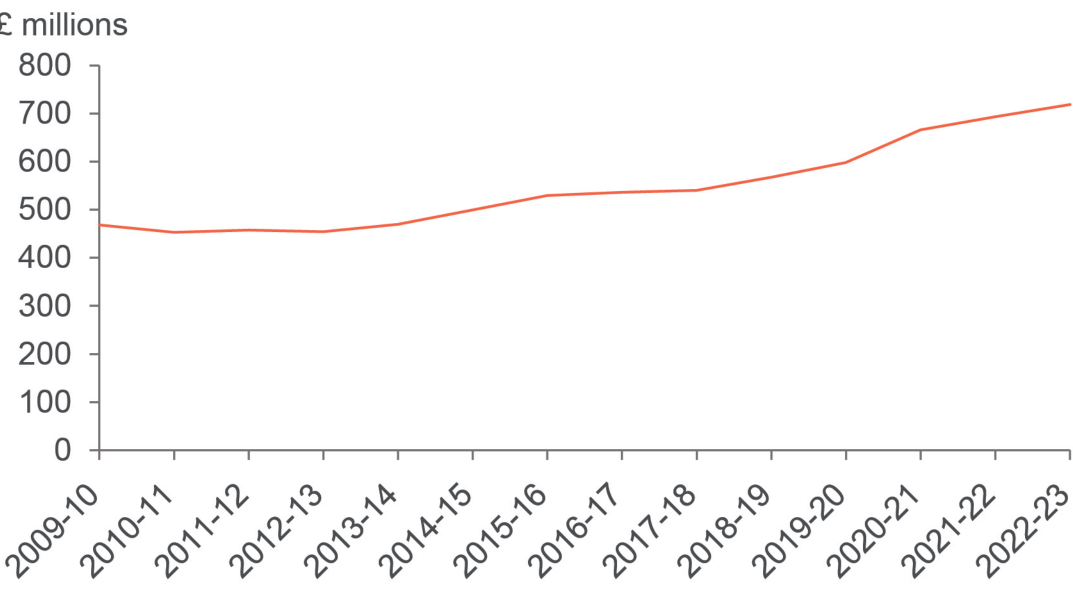
34 Based on revenue spending in the Welsh Government's NHS expenditure by programme budget category data on StatsWales for consistency with cancer spending figures. The NHS Finances Data Tool on our website is based on published Welsh Government budgets and gives a slightly different figure.

Exhibit 16: real terms NHS spending on cancer, 2009-10 to 2022-23



Source: Welsh Government, NHS Expenditure by programme budget category and year, 'cancer and tumours', on StatsWales.

Note: Real terms figures are adjusted to take account of inflation. We used HM Treasury GDP deflators at market prices and money for 2022-23, March 2024.

The Welsh Government confirmed that this data is based on NHS Wales patient activity costs including staff, consumables, medicines and overhead costs such as estates, catering, HR and finance costs.

1.29 In 2022-23 NHS Wales spent £230 per head of the population on services to diagnose, treat and support cancer patients[35]. Spend per head ranged from £206 in Cardiff and Vale to £270 in Swansea Bay University Health Board. An examination of the reasons behind differing spending figures across health board areas was outside the scope of this review but it is likely to reflect different local models of care and population factors including demography and deprivation.

1.30 Despite improvements in cancer waiting times being one of the key priorities for NHS Wales, the prospects for spending on services to diagnose, treat and support cancer patients are uncertain. UK public finances are under pressure. NHS bodies in Wales are already under financial strain, with six out of seven health boards overspending in 2023-24 and most projecting deficits for 2024-25. It is unclear whether they will be able to prioritise services for urgent suspected cancer patients to increase activity sufficiently to meet demand and reduce waiting times. Health boards are also under pressure to prioritise other parts of the system where performance is poor, including long waits for unscheduled care and for planned care.

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35 There is no comparable data from other UK or comparable countries.

Workforce capacity is a significant challenge and there is an absence of information on the availability and condition of equipment

1.31 Despite spending increases, workforce capacity remains a significant challenge and workforce shortages are reducing service capacity[36]. HEIW's Education and Training Plan 2025-26[37] describes 'significant national shortages and longstanding gaps' in specialist professional roles impacting diagnostics, cancer, emergency care and mental health. It highlights particular shortages in dermatologists, clinical oncologists, consultant urology surgeons, and histopathologists. It cites pressure from increasingly complex cancer reporting and the evolving field of geonomics on histopathology, and demand from cancer patients on urology.

1.32 The Royal College of Radiologists describes shortfalls of 34% and 12% in the radiology and clinical oncology workforces, likely to deteriorate to 38% and 28% respectively by 2028[38]. We also heard that there are shortages of medical physicists, specialist and district nurses, and in the geonomics, Systemic Anti-Cancer Therapy and radiotherapy workforce.

1.33 HEIW set out its plans to address workforce shortages in its Education and Training Plan and Integrated Medium-Term Plan 2024-27. In line with its commitment in the Cancer Improvement Plan, HEIW has published its workforce plans for pharmacy and for geonomics, and intends to publish its plan for nursing in early 2025. The Ten-Year Workforce Strategy for Health and Social Care 2020 sets out the broader strategic approach.

1.34 As well as sufficient staff, NHS Wales needs sufficient equipment to deliver timely and effective diagnosis and treatment. The NHS Executive is building up a picture of capacity associated with the age and availability diagnostic imaging equipment including the age and availability of equipment. We heard anecdotal evidence that Wales has fewer imaging machines than comparable countries, and that some machines are old and prone to breaking down. Whilst it was beyond the scope of this review examine those claims, we did hear that limitations in access to diagnostic equipment are putting pressure on staff, affecting recruitment and retention, and restricting HEIW's ability to offer training places for diagnostic students[39].

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36 Audit Wales, Workforce Data Briefing, 2023, sets out broad workforce issues, with many affecting services for cancer patients where services are not specific to cancer patients (such as diagnostics and surgery).

37 The Plan sets out commissioning and training recommendations for the health professional workforce in Wales.

38 Royal College of Radiologists, Radiology Workforce Census 2023, June 2024.

39 It is exploring using simulated training environment as an alternative.

Strategic direction

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2.1 This part of the report looks at national strategic direction and leadership to improve cancer care in Wales. **Appendix 1** explains key elements of the strategic approach and broad roles and responsibilities for cancer services.

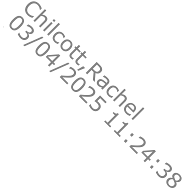
What we looked for

We looked for evidence of a clear strategic direction for improving cancer outcomes and services, and for reducing demand for cancer services by preventing cancer occurring in the first place. We also looked for evidence of appropriate and clear leadership structures to direct, oversee and support improvement and tackle barriers at a national level.

There is a lack of clarity on the status of the Cancer Improvement Plan and how it aligns with other cancer improvement initiatives

The Cancer Improvement Plan has not been sufficiently integrated into the wider strategic approach for improving cancer services

2.2 The Welsh Government set out its vision of what 'good' cancer services should look like in the Quality Statement for Cancer (2021). The Statement is generally high-level but is underpinned by tumour specific national optimal pathways. The pathways set out what should happen at different stages of the patient journey according to professional guidance. The Welsh Government instructed health boards to start embedding the pathways by September 2022[40]. When it published the Statement, the Welsh Government said that the Cancer Network would develop a rolling, three-year plan to achieve the national vision.



40 Via Welsh Health Circular (2022) (021).

Exhibit 17: vision set out in the Quality Statement for Cancer

The Cancer Quality Statement sets out that its ultimate aim is to improve population survival and reduce cancer mortality rates. It identifies key areas for action:

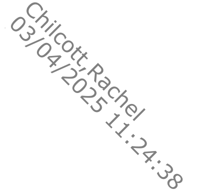
- that cancer is effectively prevented where possible,
- that cases of cancer are detected at earlier more treatable stages,
- that complex treatment pathways are optimised, while throughout people are properly supported and co-produce their care.

The statement sets out a series of attributes, indicating what good quality care looks like, under six headings:

- Equitable
- Safe
- Effective
- Efficient
- Person centred
- Timely

Source: Welsh Government Quality Statement for Cancer, 2021.

2.3 In 2023, the Network published A Cancer Improvement Plan for Wales 2023-26 (the Plan) at the request of then Minister for Health and Social Services. The Plan encompasses a broad range of cross-sector actions to improve cancer patient outcomes and reduce health inequalities. It's three year horizon was deliberately aligned to local health board planning cycles. However, this means the Plan lacks focus on longer-term actions to build sustainable cancer services. It also lacks detail on prevention, palliative and end-of-life care, and on services for children and young people and does not cover the full range of ambitions in the Quality Statement.



2.4 The then Minister used the Plan to set the new expectation that by March 2026, 80% of patients would start their first treatment within 62 days. The Minister announced publication of the Plan in an oral statement, describing it as a collective NHS Wales approach to delivering the policy intentions in the Quality Statement for Cancer. The Welsh Government told us that it is not a Welsh Government Plan. It considers that it does not require a national plan to implement the Quality Statement because health boards and trusts are responsible for implementing the vision through their own local plans.

2.5 Nonetheless, the Plan exists at the request of the Minister and many of its actions require national direction and leadership to support successful implementation. This would include consideration of the funding needed to support the Plan's actions and using national planning and performance management frameworks to clarify requirements around the Plan's delivery (**recommendation 1**).

2.6 The Cancer Improvement Plan commits the Welsh Government to monitoring delivery of the Plan through its existing performance arrangements. However, during our fieldwork, Welsh Government officials told us that such monitoring was not taking place. Since then, at the then Minister's request, the Cancer Network has collated a retrospective progress 'update' on delivery of the Plan. However, the Welsh Government is not routinely monitoring implementation in line with its commitment in the Cancer Improvement Plan.

New national initiatives to improve cancer services have merit but stakeholders are confused about how they link to the Cancer Improvement Plan

2.7 Since publication of the Plan in 2023, the Welsh Government and NHS Executive have set up new programmes aiming to improve cancer services (**Exhibit 18**). While there are merits in each programme, stakeholders are unclear about how they align with the Cancer Improvement Plan.

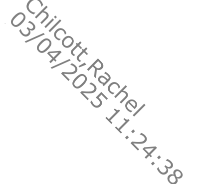


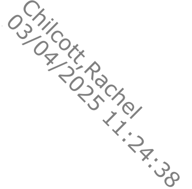
Exhibit 18: new programmes to improve cancer services

Programme	Description
Cancer: Improving Outcomes initiative	The Welsh Government commissioned Life Science Hub Wales to develop the initiative, which is aimed at focusing innovation on key problem areas and removing the barriers to delivering innovation at pace.
National Cancer Recovery Programme	The NHS Executive set up the programme, which is aimed at reducing long waits to achieve a target that 80% of suspected cancer patients start treatment within 62 days by 31st March 2026.

Source: Audit Wales.

2.8 The NHS Executive is currently finalising arrangements for its National Cancer Recovery Programme. The Programme focuses on five specific tumour sites[41] with some cross-cutting actions to improve more general services to diagnose and treat cancer patients. Rather than large-scale, whole-system transformation, the Programme aims to improve performance and improve compliance with the National Optimal Pathways within existing budgets.

2.9 The Welsh Government has repurposed Cancer Network funding to provide £2 million per annum for 2024-25 to 2026-27 for the NHS Executive to implement the Programme. Around half of this funding will pay for staff costs in line with the Programme aims around encouraging improvement within existing budgets. NHS Executive officials told us that the Programme may identify improvement opportunities which would then be costed and developed into business cases for additional Welsh Government funding.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41 Breast, gynaecological, lower gastrointestinal, skin, and urological cancers.

Many NHS bodies and third sector partners are confused about the strategic direction

2.10 NHS and third sector organisations told us they are confused about the strategic direction for cancer services in Wales. Some all-Wales NHS bodies have embraced the commitments in the Plan (for example **paragraph 1.33**). Others have rejected actions attributed to their organisation and saw some actions in the Plan as irrelevant (for example **paragraph 2.37**).

2.11 Health boards have developed local initiatives to improve diagnosis, treatment and support for cancer patients but it is not clear how they link to the Cancer Improvement Plan. During our fieldwork it was apparent that NHS bodies were not clear about the status of the Plan and how it should be shaping their activities. NHS and third sector bodies told us that the development of the new initiatives and programmes so soon after the publication of the Cancer Improvement Plan has increased their confusion about the strategic direction.

National leadership, decision-making and oversight arrangements are not effective and there is an over-reliance on narrow performance management

There is a lack of clarity as to who is responsible and accountable for driving system wide improvement to cancer services

2.12 The Welsh Government established the NHS Executive to drive improvements in the quality and safety of care. It brings together existing improvement organisations to better coordinate and drive improvements to the quality and safety of care[42]. However, officials in NHS bodies and third sector representatives we interviewed, were confused about the differing roles of the Welsh Government and NHS Executive. We also heard that there was confusion about the different roles and functions within the NHS Executive. At the time of our review, three NHS Executive functions had responsibility for driving cancer improvement:

- the Strategic Planned Care Programme had responsibility for supporting improvement in the timeliness of cancer diagnosis and treatment;
- the Performance Assurance Directorate provided direct support to NHS bodies to improve cancer performance; and
- the Cancer Network worked with clinicians, health professionals, and third sector and patient representative organisations to improve outcomes and care for cancer patients.

2.13 We found a general consensus, including within the Welsh Government and NHS Executive, that the Executive is not yet providing the intended strong leadership to drive improvement. Many NHS and third sector bodies described arrangements after the establishment of the Executive as a 'step backwards' or 'worse than ever.'

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42 The NHS Wales Delivery Unit, the NHS Wales Finance Delivery Unit, the NHS Wales Health Collaborative; and Improvement Cymru.

2.14 Stakeholders raised various concerns about the national leadership and accountability arrangements for cancer services including:

- the Cancer Network lacking the authority to make decisions and commit the level of resources needed to secure change;
- lack of integration of the Cancer Network within the NHS Executive's leadership and with the wider NHS, and gaps in arrangements to share frontline insight from clinicians;
- third sector bodies are struggling to know who to engage with and how to share important intelligence and more generally feeling under-appreciated for the extensive support they provide to the system[43] and individuals and their families (**recommendation 2**);
- overlap and duplication between the cancer recovery work carried out by the Strategic Planned Care Programme and the intervention work led by the Performance Assurance Directorate; and
- lack of communication between the Welsh Government and NHS Executive to assess whether funding for additional capacity is being allocated to areas of greatest need.

2.15 Since our fieldwork the NHS Executive has established a Network Clinical Leadership Group to support closer working between clinicians and wider NHS Executive senior leadership. Whilst this is a positive development, wider action is needed to strengthen national leadership arrangements. The gaps, lack of clarity and duplication described above have led to a situation where many stakeholders from inside and outside of the NHS told us: 'we don't know who is in charge' (**recommendation 2**). The Senedd Health and Social Care Committee's report on gynaecological cancers[44] raised similar concerns and called on the Welsh Government to be 'more accountable' for driving improved cancer services.

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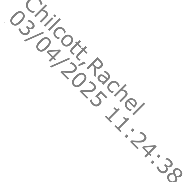
43 The third sector has a wealth of knowledge and insight and provides funding for some services in Wales (such as the Teenage Cancer Trust cancer ward in Cardiff). We also found examples of third sector organisations attracting private sector funding to drive innovation, and developing data resources which are now used by NHS Wales.

44 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

National decision-making and leadership arrangements are not sufficiently robust to systematically identify and prioritise opportunities to improve cancer services

2.16 Cancer treatment is an area of significant innovation, with opportunities to improve outcomes and efficiency. We identified examples of Welsh Government investment and decision making to improve cancer and planned care. For instance, it has worked with health boards and the NHS Executive to introduce rapid diagnostic centres; supported improvements to the bowel screening programme and is funding a new cancer centre for Velindre NHS Trust[45].

2.17 However, the Welsh Government recognises that it lacks a robust approach to identifying, assessing and prioritising such opportunities. Current arrangements need strengthening to ensure there is sufficient capacity to assess and prioritise initiatives for funding. Arrangements should address gaps in decision making structures to prioritise investment in areas such as digital, workforce and diagnostics (**recommendation 2**). **Exhibit 19** sets out two areas of opportunity to improve efficiency and outcomes, where decision making has been slow.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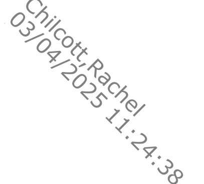
45 We are conducting a separate examination of decision-making relating to the development of the new Velindre Cancer Centre. We aim to publish that report in 2025.

Exhibit 19: potential innovations where decision making has been slow

Programme	Description
Digital cellular pathology	During our review, NHS bodies and third sector organisations cited frustration with the speed of national decision making on the use of digital cellular pathology. Betsi Cadwaladr University Health Board was a pioneer of the approach and transformed its pathology service in 2014. Laboratories could scan and upload images onto digital systems to be analysed remotely rather than transporting samples between locations. Alongside a broader transformation programme*, the approach dramatically improved the timeliness of pathology results and helped the health board recruit and retain staff because it facilitated flexible working arrangements. The National Pathology Programme has been working with the Welsh Government and health boards to develop a consistent all-Wales approach to digital cellular pathology since 2019. Despite general consensus on the benefits of the approach, progress has been restricted by uncertainty about who would fund modern scanning equipment and digital storage. Health boards have been reluctant to commit funds without clarity on the Welsh Government's financial contribution. Despite investing in other aspects of digital cellular pathology, at the time of our review, the Welsh Government was not clear about whether it would fund the equipment and storage to establish an all-Wales approach. The National Pathology Programme was still working with health boards to agree a business case share ongoing annual costs of around £3 million for the scanning equipment and storage. Wales now lags behind the rest of the UK for digital cellular pathology capacity, making it a less attractive employment option for newly qualitied pathologists in an already competitive market.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Programme	Description
Lung Screening	In 2019, the Cancer Network started exploring evidence on the effectiveness lung screening. It concluded that screening could increase the percentage of cancers identified at an early stage and had the potential to reduce lung cancer mortality by 20%. The work informed a pilot lung health check programme in Cwm Taf Morgannwg University Health Board, which started in 2022 and was funded by third sector organisations and private industry. The UK National Screening Committee recommended that UK nations develop targeted lung screening for people aged 55-74 years with a history of smoking in June 2022. Despite an endorsement from the Wales Screening Committee in November 2022, the Welsh Government did not task PHW with developing options for a national programme until July 2023. The Welsh Government has asked PHW to provide interim proposals on a national lung screening programme by May 2025. If PHW meets the 2025 deadline, it will have taken three years from the UK National Screening Committee's recommendation just to develop interim proposals. Finalising proposals and implementing a national programme would take more time after this point (**recommendation 5**).

Source: Audit Wales.

Note: *The digital cellular pathology approach was part of a wider transformation programme including combining regional services into a single Betsi Cadwaladr University Health Board Cellular Pathology Service.

2.18 We also heard concerns about the Welsh Government's ability to secure the benefits from its investment in capacity and new ways of working. In particular, stakeholders frequently cited an incoherent approach that has seen the Welsh Government invest in the training and recruitment of radiologists only for many to be unable to find work in NHS Wales (**Exhibit 20**).

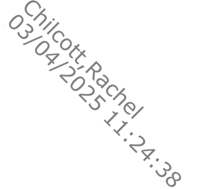


Exhibit 20: investment in training and radiologists

A National Imaging Academy opened in 2019, as a result of the Welsh Government providing £3.4 million to HEIW to establish the facility to help meet identified workforce gaps in respect of radiologists and imaging professionals.

However, many of the newly qualified radiologists are leaving Wales because, despite workforce gaps there are no jobs for them. Some health boards told us that financial pressures have led to recruitment freezes which limited their ability to recruit diagnostic staff. We also heard that weaknesses in health board workforce planning including projections of future need and slow recruitment processes were part of the problem*.

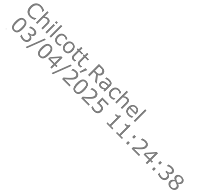
The NHS Executive's National Diagnostics Implementation Plan** contains a weak commitment to work with HEIW to 'advocate' for commitment to employment from health boards when requesting training numbers. It is unclear what role the Welsh Government intends to play in ensuring the benefits of its investment in training the future workforce are not lost to Wales (**recommendation 7**).

Source: Audit Wales

Notes:

* Our review of workforce planning made specific recommendations to health boards to improve workforce planning. Individual reports for each NHS body are available on our website www.Audit.Wales.

** NHS Executive, National Diagnostic Implementation Plan 2023-25.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2.19 Regional working across health board areas can help to share capacity and bolster fragile services. Health boards are developing regional approaches in some areas that can increase capacity in the system[46]. The NHS Executive is also developing plans for two regional diagnostic hubs in South Wales to provide additional shared diagnostic capacity for the region. However, the overall pace of regional collaboration is slow. Whilst there is a clear onus on health boards to take forward regional working, there is also a need for national leadership and co-ordination from the Welsh Government and the NHS Executive. In that regard the recent creation of a dedicated senior role within the NHS Executive to support regional working is a welcome development. However, success will also depend on action to tackle barriers to regional working such as a lack of integration between digital systems making it difficult to share waiting lists across health boards[47] (**recommendation 6**).

Welsh Government oversight is narrowly focussed on the 62-day target

2.20 The Welsh Government's NHS Performance Framework (2024-25) sets out the measures (but not the targets) against which NHS bodies are accountable. The 62-day measure is the main cancer specific measure. There is a measure on the timeliness of colonoscopy for bowel screening referrals (**paragraph 1.21**) but no measures for breast or cervical screening referrals. Previous performance frameworks[48] included coverage measures for all three cancer screening programmes. There is also a measure for uptake of the human papillomavirus (HPV) vaccine (**paragraph 2.24**).

2.21 The Performance Framework does not include any measures on cancer incidence, mortality and survival rates. It does not clearly link to the six quality attributes set out in the Quality Statement for Cancer and the Framework makes no reference to compliance with the National Optimal Pathways that underpin the Quality Statement. While the Welsh Government has made the NHS Executive responsible for monitoring compliance with the pathways it is still developing methods for doing so.

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46 Including developing regional approaches to diagnostics and treatment in North, Southeast and Southwest Wales using Welsh Government planned care recovery funding.

47 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

48 NHS Wales Performance Framework 2022-23.

2.22 There is a well-established framework for oversight of NHS bodies' planning and performance through activities such as scrutiny of NHS bodies' annual or medium-term plans, monthly Integrated Quality, Planning and Delivery meetings and twice yearly Joint Executive Team meetings between Welsh Government, the NHS Executive and individual NHS bodies. In addition, monthly cancer performance meetings provide a specific focus on the diagnosis and treatment of cancer patients. Collectively this represents a significant volume of performance management activity and includes positive developments around collaboration and information sharing between the Welsh Government and NHS Executive. However, the focus is largely on short-term delivery of the 62-day cancer performance target, rather than broader system change and wider delivery of the vision in the Quality Statement (**recommendation 3**).

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The strategic approach lacks a coherent focus on cancer prevention, and is undermined by gaps in data and fragmented digital services

There is no coherent strategic approach to prevention, even though many cancers are preventable and doing so could save lives and reduce demand for NHS services

2.23 The Cancer Improvement Plan states that 38% of cancers each year in Wales are preventable. There are considerable opportunities to tackle lifestyle factors which increase the risks of some cancers. Many of the lifestyle risk factors for cancer are similar across major conditions accounting for the majority of planned and emergency care in the UK. Data from PHW's Public Health Outcomes Framework[49] showed that in 2022-23, 13% of adults in Wales smoked; 17% drank more alcohol than recommended guidelines[50]; and only 36% of working age adults were a healthy weight[51].

2.24 There are also opportunities associated with increasing the uptake of the human papillomavirus (HPV) vaccine. Since its introduction in 2008, the vaccine has reduced cancer rates by almost 90% in women in their 20s and is expected to save hundreds of lives a year in the UK[52]. PHW reported that 74% of children in school year 9 during 2023-24 had the vaccine. There was considerable variation in uptake ranging from 60% in Cardiff and Vale University Health Board to 88% in Swansea Bay. Changes in eligibility for the vaccine make it difficult to compare changes in uptake over time[53].

49 Public Health Wales NHS Trust Observatory, Public Health Outcomes Framework.

50 Based on adults who reported drinking over 14 units of alcohol per week.

51 Smoking and alcohol consumption data uses age standardised rates to account for differences in age structures of different parts of Wales. Data on healthy weight is age specific.

52 Public Health Wales NHS Trust: immunisation and vaccines.

53 Public Health Wales, Vaccine Uptake in Children in Wales, Quarterly Report January to March 2024, May 2024.

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2.25 The World Health Organisation states that prevention offers the most cost-effective long-term strategy for managing cancer[54]. The Welsh Government's Science Evidence Advice[55] agrees that there are considerable opportunities to reduce the burden of disease on the NHS by preventing cancer and other major conditions. It identifies scope for long-term financial savings and calls for 'drastic action' to address increases in lifestyle risk factors, making many suggestions to reshape services around prevention.

2.26 The Welsh Government's NHS Planning Framework 2024-27 refers health boards to the Science Evidence Advice, explaining that it expects to see evidence of prevention in health boards plans. However, the Welsh Government does not go further in encouraging and leading health boards to develop local preventative initiatives.

2.27 Preventing cancer would also reduce demand on NHS capacity. **Exhibit 21** sets in crude terms what impact a 10%, 20% and 38% reduction in cancer cases could have, based on 2022-23 activity levels. The potential annual financial savings from the reduction in bed days would be in the order of £8.2 million to £31.4 million[56]. There could also be significant savings from reducing outpatient appointments and drugs costs. However, there would also be costs associated with activity to prevent cancer.

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54 World Health Organisation, Health Topics – Cancer Prevention.

55 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

56 Savings calculation based on £500 per day cost of an NHS bed in Wales.

Exhibit 21: potential capacity gains associated with preventing cancer occurring in the first place based on 2022-23 activity

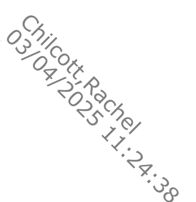
	Finished consultant episodes	Admission episodes	Bed days	Regular attenders
2022-23	**90,532** finished consultant episodes	**84,583** admission episodes	**164,971** bed days	**10,864** regular attenders*
-10%	**81,479** finished consultant episodes (9,053 reduction)	**76,125** admission episodes (8,458 reduction)	**148,474** bed days (16,497 reduction)	**9,778** regular attenders (1,086 reduction)
-20%	**72,426** finished consultant episodes (18,106 reduction)	**67,666** admission episodes (16,917 reduction)	**131,977** bed days (32,994 reduction)	**8,691** regular attenders (2,173 reduction)
-38%	**56,130** finished consultant episodes (34,402 reduction)	**52,441** admission episodes (32,142 reduction)	**102,282** bed days (62,689 reduction)	**6,736** regular attenders (4,128 reduction)

Source: Audit Wales analysis of DHCW data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets, Welsh Providers

Note:

*Our analysis is indicative of potential capacity gains based on averages. We calculated potential gains associated with a 38% reduction in activity based on the assertion in the Cancer Improvement Plan that 38% of cancers each year are preventable.

*Regular attenders are patients who are admitted to hospital on a regular basis to receive treatment.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2.28 Despite compelling evidence and it being a long-standing ambition, the Welsh Government has yet to translate broader aims on prevention into more concrete and cohesive policy approaches aimed at shifting the balance of care towards prevention (**recommendation 4**). In particular:

- it has never set out a clear, over-arching strategic approach to achieving this shift across the many public sector bodies whose priorities, choices and behaviours would need to change;
- it has a piecemeal approach with individual strategies on healthy weight and tobacco control[57] but no plan related to the health impacts of alcohol use; and
- the Future Generations Commissioner, amongst others, criticised the Welsh Government for cutting its preventative health improvement budgets in 2024-25[58].

There are gaps in the availability and quality of data to understand how well cancer care is being provided

2.29 Good quality data is essential for the planning, delivery and improvement of cancer care. The NHS Executive has improved the timeliness and accessibility of performance data in an unpublished interactive dashboard used by health boards, the Executive, and the Welsh Government. DHCW publishes a different Suspected Cancer Pathway Dashboard with less detailed information[59].

2.30 However, there are gaps in published data right across the patient pathway (**Exhibit 22**). The Welsh Government publishes data on 'closed' pathways showing how many patients were treated within 62 days but does not publish 'open' pathway waits to show how many patients are currently waiting for treatment.

2.31 Much of the available data focusses narrowly on the period between referral and diagnosis or first treatment. There is no national data on the activity and timeliness leading up to a referral. There is also no available data on activity after the first treatment starts (see **paragraph 1.6**), including follow-up tests, ongoing treatment and access to palliative and end-of-life care (**recommendation 9**).

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57 Welsh Government, Healthy Weight Healthy Wales, 2019 and Welsh Government, A Smoke Free Wales – Our Long-term Tobacco Control Strategy, 2022.

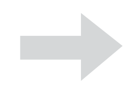
58 The budget for health improvement and healthy living reduced by £3.8 million bringing the total budget to £10.8 million; the substance misuse action plan fund by £2.5 million bringing the total budget to £47.5 million); and the health promotion budget fell by £710,000 to £12.2 million.

59 DHCW's dashboard uses data which has been validated to identify errors but the internal NHS Executive dashboard is unvalidated performance data.

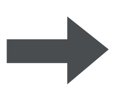
Exhibit 22: gaps in data at different stages of the cancer pathway

First suspicion to first definitive treatment

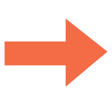
First suspicion of cancer

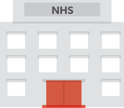


First appointment



First diagnostic test





First definitive treatment

Information to understand how many times patients had to visit a GP before being referred

Waiting times for urgent suspected cancer referrals made via screening programmes

More timely information on stage / severity at diagnosis and waiting times by stage

Better information to understand potential delays between diagnosis and treatment such as:

Waiting times between the test and a decision to treat the patient

Waiting times for the patient to receive their test results

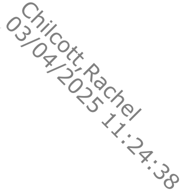
Waiting times for subsequent diagnostic tests

Waiting times for subsequent treatment and follow up appointments

Waiting times for radiotherapy and Systemic Anti-Cancer Treatment

Information on demand for and access to palliative and end of life care

Source: Audit Wales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2.32 There is very limited data to track progress against the ambitions in the Quality Statement. Against the overarching ambition of prevention and early detection, we found limited information on the causes of growing demand that can be used to prevent or detect cancer early amongst those most at risk. For instance, little is known about why some people are presenting at a more advanced stage, or as an emergency. There is also limited information about the demographic profile and location of people with unhealthy lifestyles. A new project led by WCISU has the potential to improve national intelligence on cancer risk factors. It will link Cancer Registry data to Census 2021 information via the SAIL databank to explore the influence of factors like ethnicity, income and educational status on cancer outcomes[60].

2.33 There is also very limited information to understand how equitable cancer support services are. For example:

- the Welsh Government requires heath boards to record the ethnicity of cancer patients[61] but compliance is extremely low. We were unable to analyse waiting list and timeliness trends by ethnicity because over two thirds of the pathways had no information on patient ethnicity.
- DHCW reports performance against the 62-day target by sex but there is little information to understand patient experience and outcomes by sex. The Senedd inquiry into gynaecological cancers found that women can experience many barriers to accessing cancer treatment but there is little information to understand how many women are affected[62].
- there is insufficient public data to understand potential differences in the timeliness of cancer diagnosis and treatment across Wales, particularly for people living in Powys. Timeliness data for Powys residents treated by other Welsh health boards is included in data for those health boards. The data is not disaggregated to show timeliness for Powys residents or the residents of the health board providing treatment[63]. There is also a lack of data on Welsh patients from any health board who are treated by NHS England (**recommendation 10**).
- there is also little information to understand equity of provision for children and young people. DHCW groups all data for under 30-year-olds together in the Suspected Cancer Dashboard data whereas other patients are grouped ten-year age bands. Under 16-year-olds are excluded from the Macmillan cancer patient experience survey.

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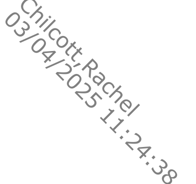
60 The project aims to report its findings in late 2024.

61 Under Data Standards Change Notices from 2020 onwards (DCSN 2020/21 and DSCN 23/45). The Notices mandate compliance with data standards.

62 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

63 Other published NHS Wales data does include distinct health board 'residence' and 'provider' performance data. For instance the Referral for Treatment data on StatsWales.

2.34 There are problems with the quality of some of the available data. WCISU officials told us Wales is a year behind England in publishing Cancer Registry data because a high volume of errors in the source data is creating extra work for its staff. NHS bodies told us that poor compliance with data standards by NHS staff inputting patient information is creating data errors. We found that there is confusion around who is responsible for improving compliance (**recommendation 8**). We have not specifically reviewed data quality as part of this review but have uncovered several inaccuracies in published data and bespoke analysis provided by DHCW.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Digital systems are fragmented and progress implementing the new cancer information system has been slow

2.35 Progress in updating the core digital system for cancer patients has been extremely slow. The previous system (Canisc) was constructed using a programming language in 1997 which Microsoft stopped supporting in 2014. Following our 2018 report on NHS Wales informatics systems[64], the Senedd Public Accounts Committee inquiry raised serious concerns about slow progress replacing Canisc[65]. It took a further five years to implement the first phase of the new cancer information system. DHCW told us that the pandemic has added to delays. The Welsh Government has recently confirmed funding for the second phase of the programme, aimed at improving integration and digital processes and dealing with requests for specific changes from individual NHS bodies.

2.36 More broadly, NHS bodies told us that lack of integrated digital systems is consuming valuable staff time because they are using manual 'workarounds' to transfer patients across the different patient administration systems. The process is frustrating staff and diverting their time from seeing patients. It also carries risks to patient safety because details could be transferred incorrectly or not at all. DHCW is responsible for delivering national digital systems for NHS Wales but not their local configuration. DHCW described considerable barriers to getting those systems to join up. In particular, there are numerous examples of NHS bodies either procuring their own digital systems rather than using the national products, or adapting the national products which limits interoperability.

2.37 The Cancer Improvement Plan committed PHW, the Cancer Network and DHCW to developing a cancer version of the national Digital and Data Strategy for Wales by the end of June 2023. No such plan had been created at the time of our review and we found confusion about the commitment to create one in the first place. DHCW told us there is no need to create a separate digital cancer plan because the overarching Digital and Data Strategy sets out the system wide approach to improve digital provision.

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64 Wales Audit Office, Informatics Systems in NHS Wales, 2018.

65 National Assembly for Wales Public Accounts Committee, Informatics Systems in NHS Wales, 2018.

Appendices

1 Strategic context

2 Additional data analysis

3 About our work

1 Strategic context

Exhibit 23: broad roles and responsibilities for cancer services in Wales

Welsh Government

Sets priorities for the NHS Executive and health bodies

NHS Executive

National Strategic Clinical Network for Cancer (formerly the Wales Cancer Network)

Leading and supporting improvement of cancer services

NHS bodies responsible for delivering cancer services

Health Boards	Velindre NHS Trust	Public Health Wales NHS Trust
Responsible for the health of their resident population including health improvement, providing cancer services* and end-of-life and palliative care	Responsible for providing cancer services** in South East Wales and specialised blood services across Wales	Responsible for improving health and wellbeing, reducing health inequalities, providing cancer screening services, and the cancer registry (WCISU)

NHS bodies supporting NHS Wales***

Digital Health and Care Wales	NHS Wales Shared Services Partnership	Health Education and Improvement Wales
Responsible for providing digital solutions to support cancer services	Provides support functions and services to NHS Wales	Responsible for supporting the development of the health and care workforce

Bodies supporting cancer patients and their families including:
The social care sector; third sector; local authorities; and patient groups

Source: Audit Wales

Note:

*Including diagnostic tests; treatment; and support and advice for patients. The level and type of services provided differs between health boards because some services are provided by other healthcare providers. For instance, Powys Teaching Health Board provides some diagnostic services but commissions other cancer services from other NHS providers in England and Wales.

**Including chemotherapy; radiotherapy; and support and advice for patients.

***There are also organisations and groups responsible for research, development and innovation including: Geonomics Partnership Wales; Health and Care Research Wales; Life Sciences Hub Wales; and the Wales Cancer Research Centre.

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Exhibit 24: key elements of the strategic approach to cancer services in Wales

Programme for Government

Ministerial priorities

Health and Social Care (Quality and Engagement) (Wales) Act 2020

A Healthier Wales: Plan for Health and Social Care

Set the Welsh Government's vision for health and social care:

NHS Planning Framework
Planning guidance and principles for NHS bodies

NHS Performance Framework
Sets performance measures for NHS bodies

National Clinical Framework
Principles for planning and delivery of clinical services

Quality Statement for Cancer 2022
The national vision for cancer services

National Optimum Pathways
Guidelines for each stage of patient pathways depending on tumour site

Integrated Medium Term Plans

Wales Cancer Network: Cancer Improvement Plan 2023
A collective plan for NHS Wales to improve services for cancer patients

NHS Executive: National Cancer Recovery Programme 2024
National programme to improve cancer services

Life Sciences Hub Wales: Cancer: Improving Outcomes Initiative
A Welsh Government commissioned programme, aimed at delivering innovation at pace.

Broader Welsh Government Strategy including:

Diagnostics, Recovery and Transformation Strategy for Wales 2023-25

Digital and Data Strategy for Health and Social Care in Wales 2023

National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges 2023 and A Healthier Wales: Our Workforce Strategy for the Health and Social Care Workforce, 2020 (commissioned by the Welsh Government from Health Education and Improvement Wales)

Healthy Weight, Healthy Wales, 2019 including a 2022 to 2024 delivery plan

A smoke-free Wales: Long-term tobacco control strategy, 2022 including a 2022 to 2024 delivery plan

Chilcott, Rachel 03/04/2025 15:24:48

Source: Audit Wales

2 Additional data analysis

Data on demand for cancer services

Exhibit 25: Patients who were treated by source of suspicion, monthly average across 2023-24

Source of suspicion / referral	% overall suspected cancer referrals	% of patients starting treatment as a proportion of referrals by source of suspicion
GP	**80%** (12,635 people)	**8% of GP referrals** (975 people)
Internal secondary care	**10%** (1,570 people)	**17% of internal secondary care referrals** (266 people)
Following a diagnostic test	**6%** (911 people)	**37% of referrals following a diagnostic test** (341 people)
Bowel screening	**1%** (120 people)	**28% of bowel screening referrals** (33 people)
Breast screening	**1%** (106 people)	**92% of breast screening referrals** (98 people)
Cervical screening	**<1%***	**50% of cervical screening referrals***
Emergency department	**1%** (214 people)	**38% of emergency department referrals** (81 people)
Other primary care professional	**1%** (120 people)	**5% of referrals from other primary care professionals***
Other health professional	**<1%** (66 people)	**15% of referrals from other health professionals***
Consultant from another health board	**<1%** (38 people)	**21% of referrals from external consultants***

Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

Note: A small number of patient pathways did not have data on the source of suspicion / referral.

*Where there are 10 people or less.

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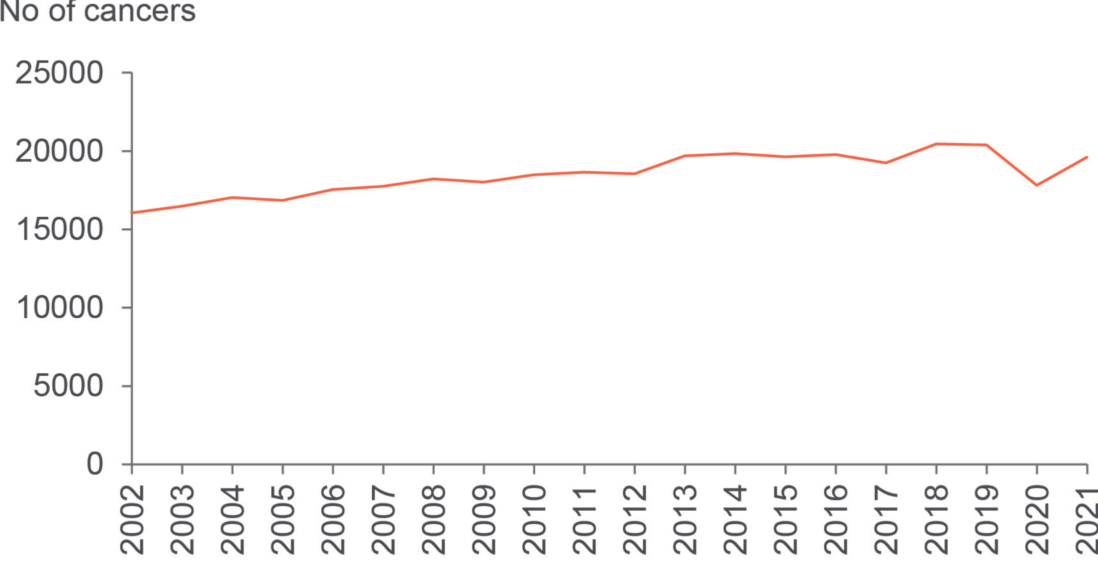
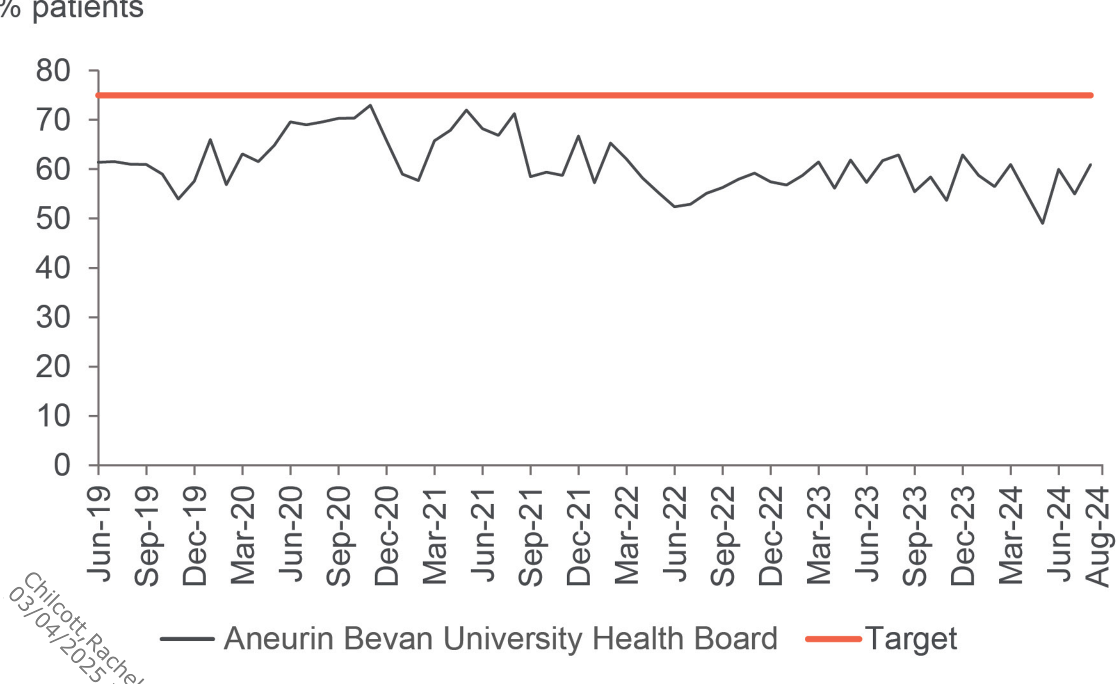
Exhibit 26: number of newly diagnosed cancers in Wales (excluding non-melanoma skin cancer), 2002-2021



Source: WCISU cancer incidence data

Exhibit 27a: performance against the 62-day target by Aneurin Bevan University Health Board, June 2019 to August 2024



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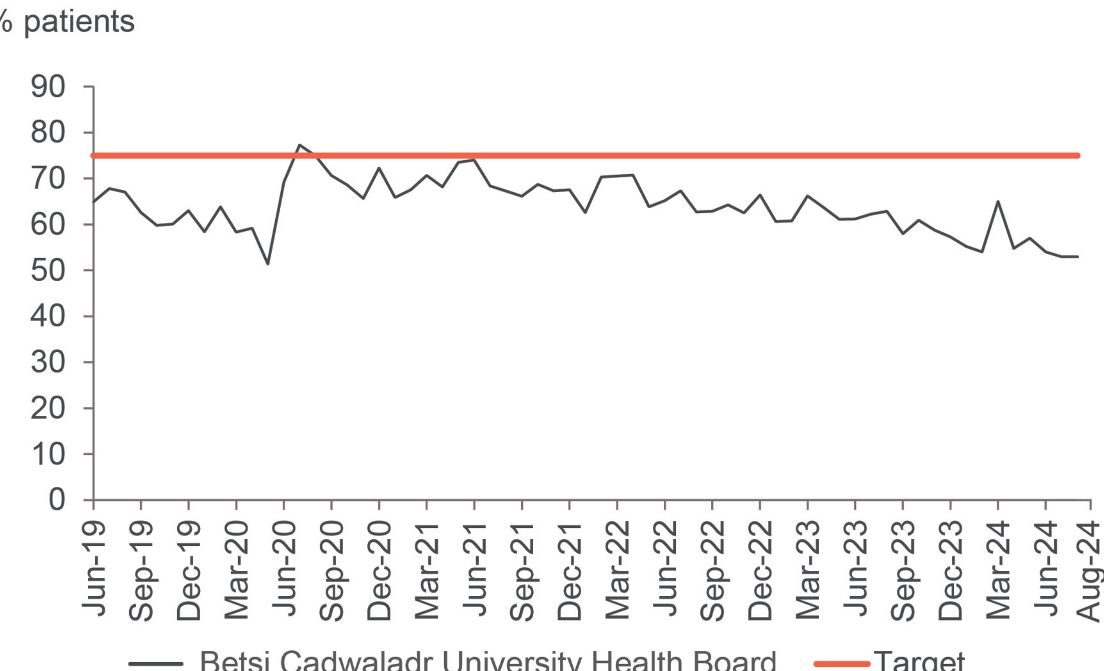
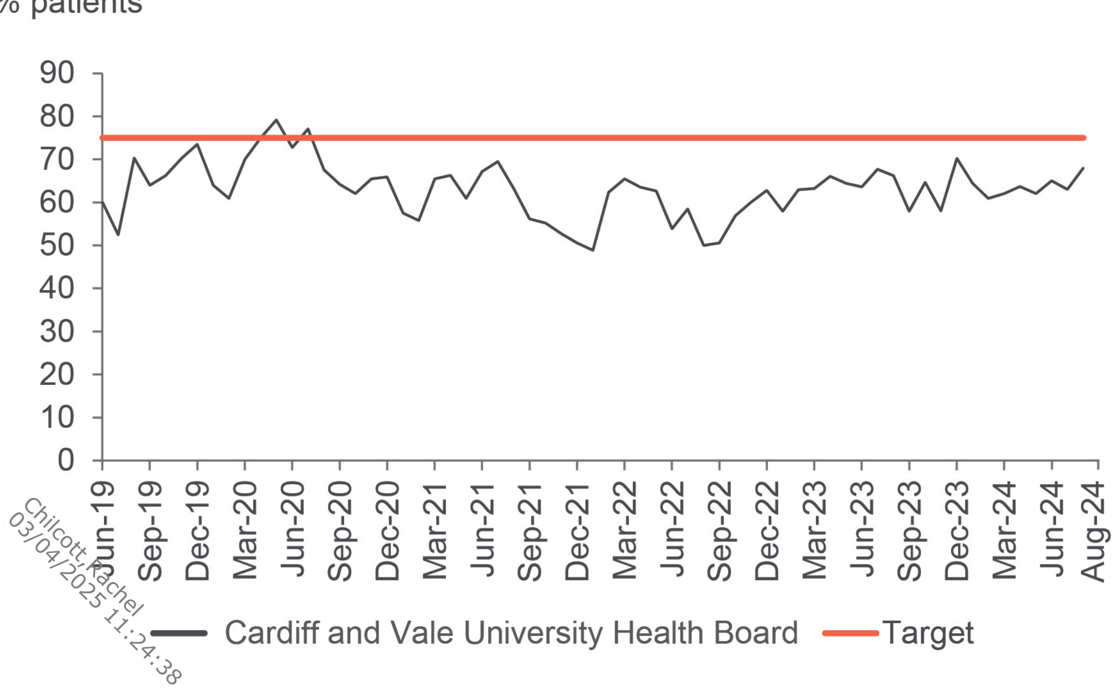
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27b: performance against the 62-day target by Betsi Cadwalladr University Health Board, June 2019 to August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways, on StatsWales.

Exhibit 27c: performance against the 62-day target by Cardiff and Vale University Health Board, June 2019 to August 2024



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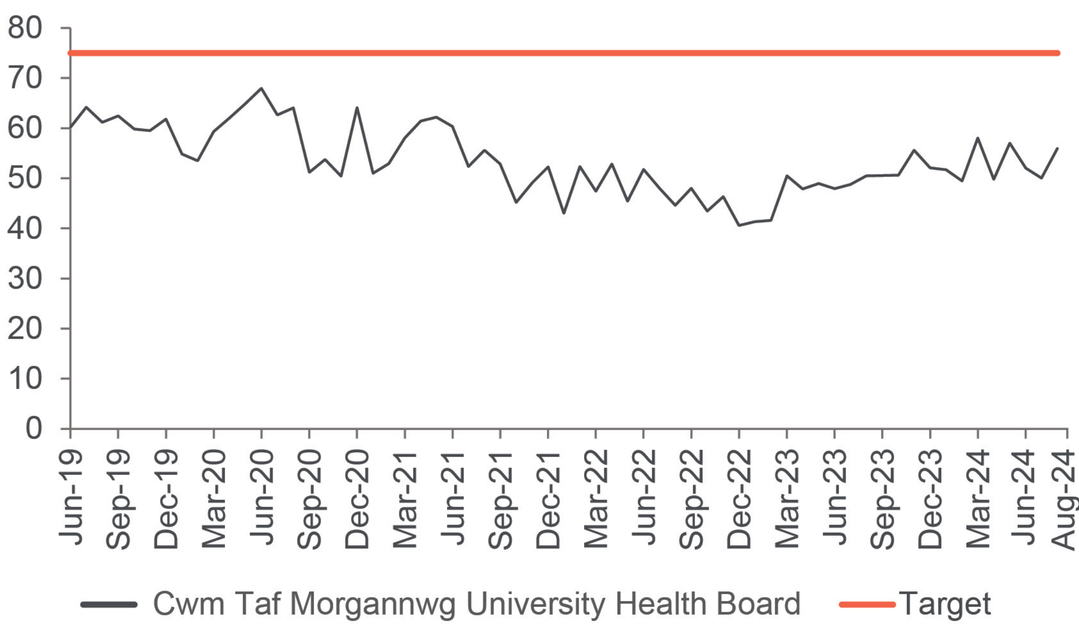
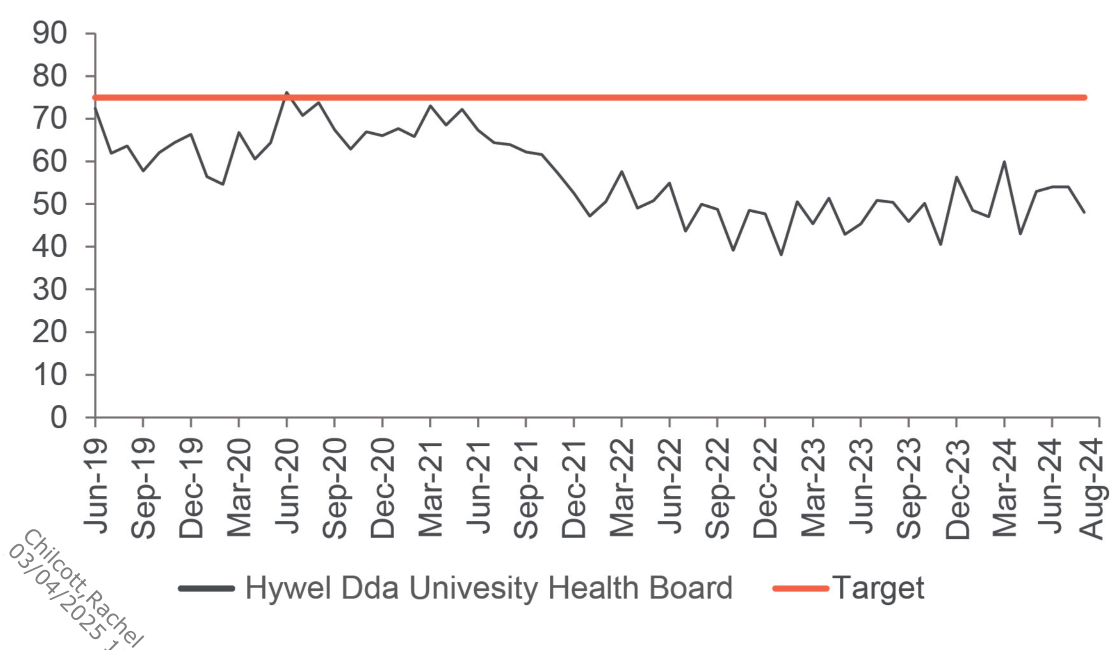
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, On StatsWales.

Exhibit 27d: performance against the 62-day target by Cwm Taf Bro Morgannwg University Health Board, June 2019 to August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27e: performance against the 62-day target by Hywel Dda University Health Board, June 2019 to August 2024



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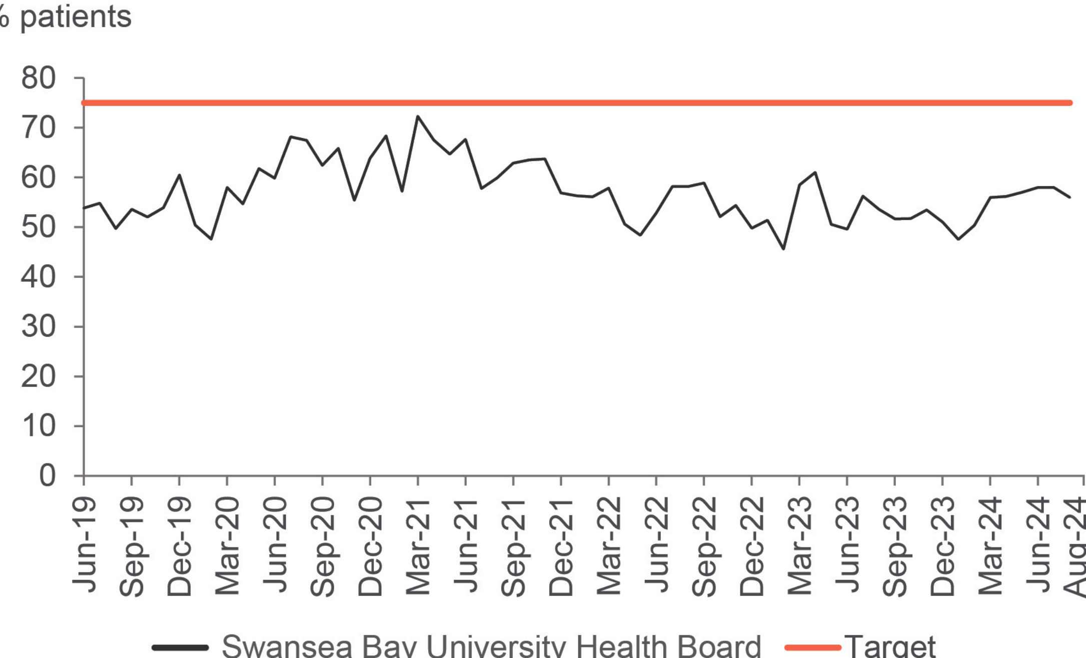
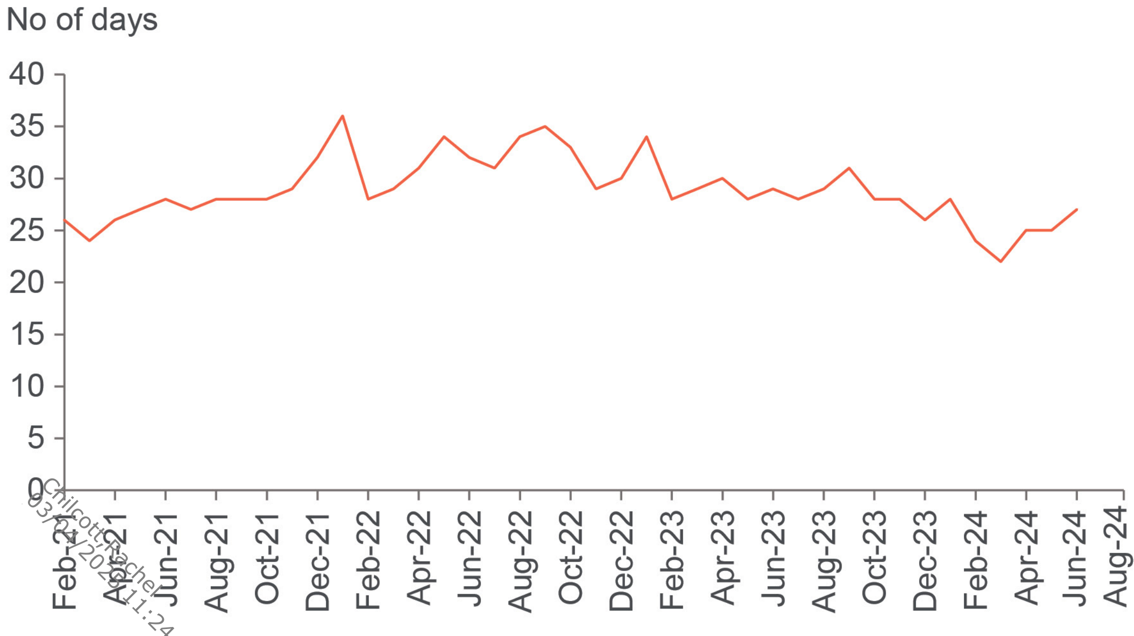
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27f: performance against the 62-day target by Swansea Bay University Health Board, June 2019 to August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 28: median waits from first suspicion to diagnosis, February 2021 to August 2024



Source: DHCW data from the Suspected Cancer Pathway Dashboard

3 About our work

Audit question, scope and criteria

We chose to focus on the national strategic approach to improving the timeliness of cancer diagnosis and treatment because we identified significant systemic challenges facing cancer services during our scoping. This review focuses on the Welsh Government and NHS Executive (and its National Strategic Clinical Network for Cancer) as system leaders, recognising that health boards and trusts have responsibility for the operational delivery of different aspects of cancer services. We will consider the merits of further work focusing on NHS bodies' approach to delivering cancer services in our 2025-26 work programme.

We developed our audit criteria based on learning from our previous audits of planned care[66] and local health audit work, analysis of key strategic documents[67], and research from relevant organisations on the challenges associated with cancer services in Wales.

66 Audit Wales, NHS Wales Waiting Times for Elective Care in Wales, 2015; Audit Wales, 10 Opportunities for Resetting and Restarting the NHS Planned Care System, 2020; and Audit Wales, Tackling the Planned Care Backlog in Wales, 2022.

67 Including Welsh Government, A Healthier Wales – a Long Term Plan for Health and Social Care, 2021; Welsh Government, Our Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales, 2022, Welsh Government, The Quality Statement for Cancer, 2022, Welsh Government, Diagnostics Recovery and Transformation Strategy for Wales 2023 to 2025; and the National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

Audit methods

Document review

We reviewed relevant documentation including:

- documents setting out the national strategic approach. Key documents include the Quality Statement for Cancer, Cancer Improvement Plan, the Diagnostic Recovery and Transformation Strategy, National Clinical Framework, National Optimal Pathways and NHS planning and performance frameworks
- documents relating to the NHS Executive's national cancer recovery programme
- individual NHS body plans setting out their approach to delivering cancer services, and relevant board and committee papers on cancer performance
- papers from the Welsh Government's performance management meetings
- Public Health Wales NHS Trust information on the delivery of population screening servicesinformation on cancer data and population health including reports from the Welsh Cancer Surveillance and Intelligence Unit and the Welsh Government's Science Evidence Advice[68]
- the Senedd Health and Social Care Committee's report on its inquiry on gynaecological cancers[69] and supporting evidence

Semi-structured interviews

We interviewed officials from the following organisations:

- the Welsh Government;
- the NHS Executive including its National Strategic Clinical Network for Cancer;
- a sample of health boards including officials from Betsi Cadwaladr, Hywel Dda and Swansea Bay University Health Boards, and Powys Teach Health Board;
- officials from other NHS bodies including Digital Health and Care Wales, Health Education and Improvement Wales, Public Health Wales and Velindre NHS Trusts; and
- we also met with officials from the NHS Executive, Cardiff and Vale, Hywel Dda and Swansea Bay University Health Boards to inform our scoping.

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68 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

69 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

Workshop with third sector representatives

We held a workshop with representatives from the third sector on 1st May 2024 organised by the Wales Cancer Alliance[70]. We asked participants for their views of the strengths and weaknesses of the national strategic approach and invited further written responses with more detail on the same topic. We conducted follow-up interviews with some organisations for clarification where necessary. Representatives from the organisations below took part in the workshop:

- ALK Positive UK
- Association of the British Pharmaceutical Industry
- Blood Cancer UK
- Bowel Cancer UK
- Breast Cancer Now
- Cancer Research UK
- Fair Treatment for the Women of Wales
- Leukaemia Care
- MacMillan Cancer Support
- Marie Curie
- Prostate Cancer UK
- Royal College of Pathologists
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Tenovus Cancer Care
- Young Lives vs Cancer
- We established an expert panel to inform our understanding of the systemic barriers to the timeliness of cancer diagnosis and treatment and provide critical challenge on our findings. The panel included representatives from Marie Curie, the Association of the British Pharmaceutical Industry, the Royal College of Physicians, and the Wales Cancer Alliance.

70 A coalition of charities working to prevent cancer, improve care, fund research and influence policy in Wales.

Data analysis

We reviewed data from different sources including:

- DHCW published data on open and closed cancer pathways, on StatsWales;
- DHCW published data on hospital admissions. We also requested data on discharge destinations of cancer patients admitted to hospital;
- we requested data from the Suspected Cancer Pathway dataset managed by DHCW that is not published elsewhere. We analysed data on performance against the Suspected Cancer Pathway target by ethnicity; source of suspicion ; and closed pathways by whether patients started treatment for cancer, were downgraded for not having cancer, or died before being downgraded or starting treatment; and
- Welsh Cancer Surveillance and Intelligence Unit data on cancer incidence, mortality and survival.

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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Chilcott,Rachel
03/03/2023 11:24:38

Smoking Cessation

Final Internal Audit Report

2024/25

Cardiff and Vale University Health Board

Reasonable Assurance

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Executive Summary 1
Findings & Agreed Action Plan 3
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Review Reference	**CVU-2425-18**
Fieldwork	**28th August to 7th November 2024**
Executive Sign Off	**6th December 2024**
Audit Committee	**4th February 2025**
Executive Lead	**Claire Beynon, Executive Director of Public Health**
Head of Internal Audit	**Ian Virgill**
Deputy Head of Internal Audit	**Lucy Jugessur**

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Executive Summary

Purpose

To undertake a review of hospital based Smoking Cessation services, and the processes and actions being taken to achieve public health targets in relation to smoking cessation within Cardiff and Vale University Health Board (the 'Health Board').

Overview

The Health Board provides a hospital Smoking Cessation Service that can be accessed by staff, patients and family members who want support in giving up smoking. It offers a number of strategies and approaches which are undertaken in partnership with the NHS Wales' 'Help Me Quit' programme and services. The Welsh Government produced 'A smoke-free Wales: Our long-term tobacco control strategy' in July 2022 with its long-term plan towards a smoke-free Wales by 2030, and NHS Wales has a Performance Measure of "percentage of adult smokers who make a quit attempt via smoking cessation services – Target = 5% annually". This is reported as part of the Health Board's Integrated Performance Report (IPR), and the hospital Smoking Cessation Service plays a key role in helping to achieve this strategy.
There is also a NICE guidance in place, which was last updated in 2023: 'Tobacco: preventing uptake, promoting quitting and treating dependence (NG209)' and this covers support to stop smoking for everyone aged 12 and over, and help to reduce people's harm from smoking if they are ready to stop in one go.

We have concluded reasonable assurance on this area. The significant matters requiring management attention include:

- A review of the Hospital Smoking Cessation Service needs to be undertaken to establish if it is appropriately resourced to fully deliver its mandate.
- There is currently an absence of effective promotion of the Hospital Smoking Cessation Service within the Health Board.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Structures and processes are in place to facilitate and deliver smoking cessation services within the Health Board and to the Cardiff and Vale population.	1	**Limited**
2	Documentation informing patients about smoking cessation education, advice and access to support services is available within hospital wards and other relevant clinical areas.	2	**Limited**
3	Patients current smoking status is recorded/updated within their clinical records upon accessing clinical services, and relevant support/referral offered.	-	**Reasonable**
4	Plans are in place, and are being progressed, to ensure that public health targets in relation to smoking cessation can be met.	-	**Substantial**
5	The Health Board is able to show that it complies with NICE guidance on smoking cessation and supports the Welsh Government's 'A smoke-free Wales: Our long-term tobacco control strategy'.	-	**Substantial**
6	Smoking cessation progress activity can be evidenced and is subject to regular reporting to the Health Board and other stakeholders.	-	**Substantial**

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Summary of Management Actions

The table below summarises the findings made, their priority rating, theme and details on whether the finding relates to a control design issue or control operation issue. We group our findings into themes, which allows us to identify common themes and trends across NHS Wales organisations.

2	
High Priority	
Quality, Safety & Patient Experience	[Control Operation]
Communication & Engagement	[Control Design]

Control **Design** Issues: Inadequate or poorly designed controls that do not address risks	**1**
Control **Operation** Issues: Controls that are not executed correctly or consistently	**1**

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Findings & Agreed Action Plan

Objective 1: Structures and processes are in place to facilitate and deliver smoking cessation services within the Health Board and to the Cardiff and Vale population.	**Limited**

The delivery of smoking cessation services forms part of the Health Board's 2023 10 year 'Shaping our Future Well-being Strategy'. A suite of strategic priority change programmes were established relating to local public health provision titled 'Shaping our Future - Population Health Plan 2022-2025'. One of the programmes was the "development of our hospital patient Smoking Cessation Service to increase the number of smokers routinely engaging with smoking cessation services."

The Health Board also has a 'No Smoking and Smoke Free Environment' procedure in place for staff and patients which states the provision of both a public health team led, and hospital based smoking cessation service to support and facilitate those wishing to stop smoking.

Our review of the content and delivery objectives of both the 'Shaping our Future - Population Health Plan 2022-2025', and the UHB 'No Smoking and Smoke Free Environment' Procedure confirms that both are in alignment with, and also make reference to, the requirements of the Welsh Government Smoke Free Wales 2030 Strategy.

The Hospital Smoking Cessation Service is supported by a formal structure, standing operating procedure and a delivery mandate that outlines its aims and objectives. However, the service's ability to fully deliver it's aims and objectives is potentially limited due to the current establishment and funding arrangements.

	Key Findings	Risk & Impact	Agreed Management Action
1	<u>Appropriate Resourcing of Hospital Smoking Cessation Service</u> The Hospital Smoking Cessation Service sits and reports managerially within the Medicine Clinical Board, and its staffing establishment sits within the Integrated Medicine Directorate budget. The Hospital Smoking Cessation Service is currently budgeted to provide a 7am-3pm Monday to Friday service at UHW, a five hour a week service at UHL, and a fifteen-hour a week service at Barry Hospital for patients from across the Vale of Glamorgan. As such, there is a limited service provided at UHL in comparison to that of UHW, and also to that of the 15 hours service provision at Barry Hospital. Currently the focus of the Hospital Smoking Cessation Service is only that of counselling work, and there is no resource to undertake proactive promotional awareness exercises across the	Health Board patients are not aware of smoking cessation advice and services.	Final Agreed Action: Ahead of the decision on future funding via the business case, the Hospital Smoking Cessation Service and Public Health Team will review collaborative working arrangements to ensure referral and treatment pathways are efficient, appropriate, meet the needs of patients/clients and ensure smooth transition from inpatients to outpatient/community services. Once future funding is established, the two teams will work collaboratively to assess what action is required to optimise resourcing to the Hospital Smoking Cessation Service to enable it to effectively deliver its formally documented mandate and role in full.

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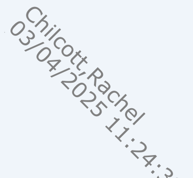
	UHB hospital sites, nor Ward liaison work in respect of nursing NRT (Nicotine Replacement Therapy) advice provision. This Service currently holds no budget of its own and there is no evidence of it having been subject to any review of its ability to effectively and efficiently undertake its full role and prescribed mandate. The key issue is that of historical establishment funding for these posts, which were in place prior to the launch of the Welsh Government Smoke Free Strategy. Also, there is no additional funding available from the Medicine Clinical Board, given its own budgetary pressures and constraints relating to other clinical needs. As such there is a clear risk that the stated organisational strategic and patient focussed operational objectives pertaining to smoking cessation cannot be delivered effectively and in accordance with the Welsh Government Smoke Free Wales 2030 Strategy.		Expected Evidence of Implementation: Review of pathways complete by end February 2025 Future service plan developed – by June 2025
		High Priority	Officer: Siân Griffiths, Consultant in Public Health Medicine Emma Keen, Deputy General Manager, Integrated Medicine Date: June 2025
	Theme: Quality, Safety & Patient Experience	Control Operation	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Objective 2: Documentation informing patients about smoking cessation education, advice and access to support services is available within hospital wards and other relevant clinical areas.	**Limited**

There is a Hospital Smoking Cessation Service site on the Health Board's Sharepoint site. However, from our review of the site, there is only a home page which provides a brief overview of the Health Board's smoke-free status and relevant legislation, smoking cessation support information, and contact numbers for the Hospital Smoking Cessation Service team members.

The Health Board Local Public Health Team internet site has a 'Stopping Smoking' webpage which includes information and contact information relating to the NHS Wales smoking cessation service 'Help Me Quit', as well as that of the Health Board Smoking Cessation Service.

However, there is a lack of specific smoking cessation promotional information on the Sharepoint site and also within the Health Board’s hospital sites and ward areas.

	Key Findings	Risk & Impact	Agreed Management Action
2	<u>Absence of effective promotion of the Hospital Smoking Cessation Service within the Health Board</u> It was evident from our review that no smoking cessation promotional information, or advice documentation has been posted to the Hospital Smoking Cessation Sharepoint site. Although the site has pages set up in readiness for the provision of ‘Get help’, Clinical Factsheets, Help Me Quit, Top tips to quit and Reasons to quit, none of this information was held within these tabs. We note that the Smoking Cessation Manager and Local Public Health Team Tobacco Lead, have requested the upload of this documentation by the IT Webmasters, but it remains on a 'waiting list' to be undertaken. We visited the UHW and UHL sites to verify whether there were any smoking cessation promotional information in the form of posters/leaflets on display within publicly accessible areas e.g. Concourse Receptions, and patient/staff Lift areas, and there were none available. Furthermore, there were none available within the clinical areas that we sampled for our testing; namely, the	Health Board patients are not aware of smoking cessation advice and services.	Final Agreed Action: Work will be undertaken collaboratively between the Hospital Smoking Cessation Service and Public Health Team to increase and improve the level of awareness of smoking cessation support available via electronic media across the UHB for patients, staff and visitors. In addition, more Smoking Cessation promotional resources will be placed on display within public, clinical and Ward based settings. Expected Evidence of Implementation: Communications plan developed by February 2025 Evidence of increased communications across all media within the hospital setting by Summer 2025

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	CAVOC, UHL Outpatients waiting area and Inpatient nursing stations, and the waiting areas and nursing stations at Wards B2 Link and B7, UHW. Additionally, no awareness or outreach exercises have been undertaken at Wards or clinical departments by the three Hospital Smoking Cessation team members at UHW, UHL and Barry Hospital respectively, this is due to the staffing establishment constraints as discussed previously in this report. There is a risk of lessened awareness relating to the Service due to the lack of promotional information and guidance documentation posted to the Health Board Smoking Cessation Service Sharepoint site and absence of of information for patients and staff, and specifically those staff working in hospital Wards and Outpatient areas. This is further exacerbated by the lack of time available for Smoking Cessation Advisors to undertake in-person awareness exercises within Ward and clinical areas across the Health Board. Our testing identified there are no metrics in respect of feedback provided by service users of the Hospital Smoking Cessation Service, or of the uptake of promotional information provided by the Service.		Increase in number of appropriate referrals to Hospital Smoking Cessation service by Autumn 2025 Increasing trend in number of staff completing e-learning module – monitor quarterly
		High Priority	Officer: Helen Poole, Smoking Cessation Counsellor Catherine Perry, Principal Public Health Practitioner Date: Autumn 2025

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Objective 3: Patients current smoking status is recorded/updated within their clinical records upon accessing clinical services, and relevant support/referral offered.	**Reasonable**

We planned to visit four Wards (Inpatients CAVOC, UHL; Ward C7, Ward B2 Link and Ward B7, UHW) in order to ascertain whether a patient's smoking status was recorded upon admission via a standard clerking pro-forma, and also whether this information is recorded anywhere else within the Ward. However, due to ongoing staffing shortages and sickness on Ward C7, Ward B2 Link, and Ward B7, UHW, we were unable to undertake testing in these areas, but did so within the Inpatients Ward at CAVOC, UHL.

Additionally, we sought to identify if Ward staff were aware of the Hospital Smoking Cessation Team, and how to contact them if required to provide support, and/ or undertake a formal referral into their service.

As such, we identified that there is an awareness of the Hospital Smoking Cessation Team within CAVOC, and Ward Management were satisfied that nursing staff knew how to contact them when required.

Our testing also confirmed that recording of patient smoking status on Clinical Workstation nursing portal has recently been implemented on the Ward, and smoking status is also incorporated into Ward admission pre-surgery assessment documentation and surgical anaesthetic charts. We note at the time of our testing none of the patients were smokers, and this status was recorded accordingly within the aforementioned documentation.

We also sought to ascertain whether any patients that were smokers had been offered Nicotine Replacement Therapy (NRT) during their stay, and also the existence of a Ward stock in the event that the Pharmacy Department could not efficiently provide e.g. outside of Pharmacy working hours.

Whilst testing was not able to validate whether any smokers had been prescribed NRT due to there being no smokers present at the time of our audit; we could confirm that an adequate supply was held in the CAVOC Inpatient Ward drug storage cabinet.

Whilst we have not identified any findings under this objective, we are only able to provide reasonable assurance due to the restriction on the level of testing we were able to undertake.

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Objective 4: Plans are in place, and are being progressed, to ensure that public health targets in relation to smoking cessation can be met.	**Substantial**

Smoking Cessation delivery progress action plans are in place within both the Local Public Health Team and the Hospital Smoking Cessation Service, and both show evidence of progress during 2023/24 and year to date 2024/25 to ensure that potentially preventable smoking related harm is reduced/removed across Cardiff and the Vale of Glamorgan.

The achievement of these are supported by a draft Business Case which is currently scheduled for review by the Business Case Panel in November 2024. The Business Case seeks to obtain additional funding to support the UHB's achievement of the Welsh Government target for the country to be smoke free by 2030. However, if the additional funding fails to be secured there is a risk that the current plans in place may not be fully actualised and the strain on the current Hospital Smoking Cessation Service will continue and targets may not be achieved.

Objective 5: The Health Board is able to show that it complies with NICE guidance on smoking cessation and supports the Welsh Government's 'A smoke-free Wales: Our long-term tobacco control strategy'.	**Substantial**

Our review of the content and delivery objectives of both the 'Shaping our Future - Population Health Plan 2022-2025', and the UHB No Smoking and Smoke Free Environment Procedure confirms that they are in alignment with, and refers to, the requirements of the Welsh Government Smoke Free Wales 2030 Strategy and NICE Guidance on smoking cessation.

Operationally, this is further confirmed via the public facing information stated on the Cardiff and Vale Local Public Health Team internet page relating to tobacco control and cessation, as well as its work and action plans which underpin the smoking cessation strategy and procedure.

Furthermore, the work undertaken by, and the work and action plan of the Hospital Smoking Cessation Service also confirms the incorporation of NICE Guidance on an operational basis.

Objective 6: Smoking cessation progress activity can be evidenced and is subject to regular reporting to the Health Board and other stakeholders.	**Substantial**

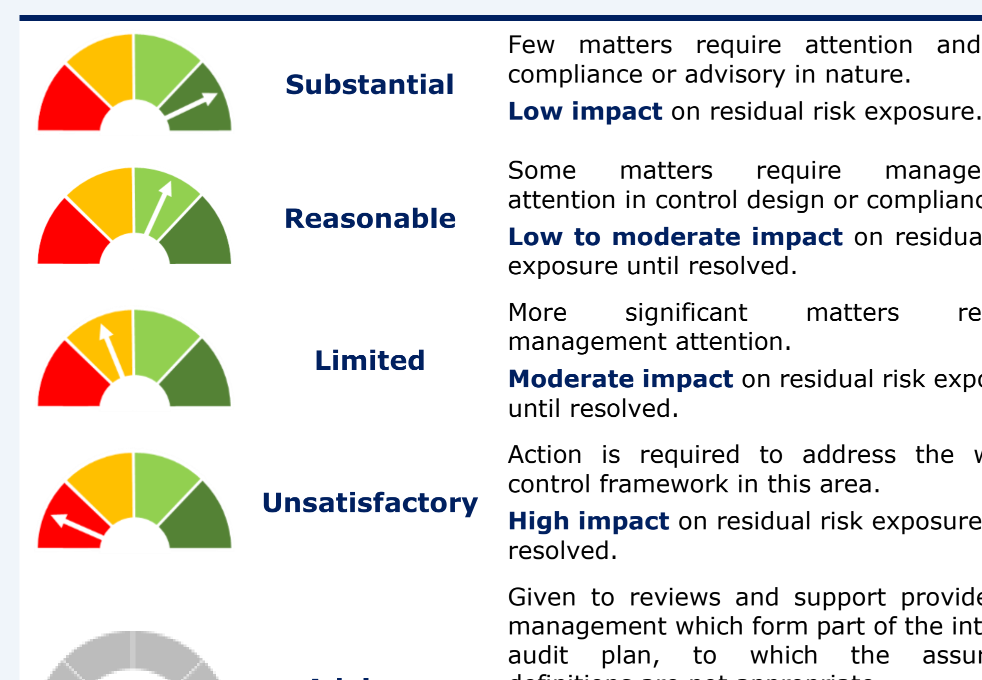
Smoking cessation is reported as part of Aim 1 "People in Wales have improved health and well-being with better prevention and self-management" within the Integrated Performance Report (IPR) which is reported to the Board and also the Finance and Performance Committee.

The NHS Wales Performance Measures are:

- Percentage of adult smokers who make a quit attempt via smoking cessation services - 5% per year – The IPR which was taken to the September Board meeting had the in month performance at 0.6%; and
- Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks - The IPR which was taken to the September Board meeting had the in month performance as 70%.

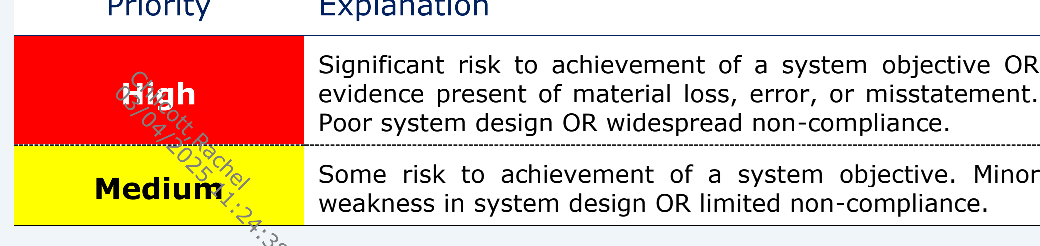
Appendix A

Assurance Opinion



	Opinion	Description
	Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings



Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Ellicott, Rachel
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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Cardiff and Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Agenda Item
5.2.2

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	18/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Corporate Governance
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 3 February 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

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The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

The Quality and Safety Outcomes Committee Terms of Reference can be found here.

3. HIGHLIGHT REPORT

(Links to reports highlighted February 2025 – NHS Wales JCC QSO)

RAG Rating	Highlight
Alert / Escalate	• The Chair and Members expressed concern in relation to the risks and pace of resolution for Neonatal and Paediatric Services. Before escalating this formally to the JCC a specific update on the strategic approach and progress from the escalation process will be brought to the March 2025 QSO meeting for further discussion. Members discussed potential inequity of access and how this would be reported. It was agreed that where such inequities were identified these could be highlighted and addressed within the Director reports. This will form part of the Commissioning Approach for the JCC which will be developed over the coming months as part of the next phase of the formation work and organisational development.
Advise	• The Chair welcomed members and attendees to the first JCC QSO meeting. The Terms of Reference and Forward Work Plan were presented. Members noted the inclusion of a HB CEO as a member rather than an attendee. Further work on the forward work plan will be undertaken to ensure a comprehensive approach to reporting. The reporting of patient experience was queried and members were assured that outcomes reporting would be included within the directors' commissioning reports and the overarching incident and concerns reports. A suggestion was made to broaden the scope of the concerns report to include patient experience to meet the reporting requirements for the duty of Candor and duty of Quality. • Members discussed the reporting mechanisms into Health Boards (HBs), with the Director of Nursing suggesting the reinstatement of the Quality Newsletter to share information with HBs, as this highlighted good practice and service improvements. This would be in addition to a highlight report for inclusion on HBs' Quality and Safety Agendas and the Joint Commissioning Committee (JCC) public meeting Agenda.

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RAG Rating	Highlight
	• The Director of Commissioning for Specialised Services provided updates on various specialist services, including improvements in workforce for paediatric and neonatal services, progress in plastic surgery wait times, and the status of the major trauma network data system. Members raised concerns in relation to neonatal and paediatric services as highlighted above. • The Director of Nursing presented the Director of Commissioning for Ambulance Services and 111 report and provided updates in relation to ongoing emergency ambulance pressures, including a critical incident declared by the Welsh Ambulance Service. The commissioning team has been working closely with health board colleagues to address these pressures and develop improvement plans. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. An update on ambulance measures review was provided which aims to align quality patient outcomes with ambulance performance targets. Members raised concerns over bundle compliance and it was noted that compliance for ST-elevation myocardial infarction (STEMI) was under 70%. A request was made for adding immediate release red and amber data to this report for future meetings. • The Director for Mental Health and Vulnerable Groups report was presented and members noted in relation to framework services quality ratings, that some units, including St. Andrews in Northampton, faced staffing and medication challenges, which may lead to safety concerns. Action plans have been implemented to address these issues. Staffing issues at Rampton High Secure Hospital and one patient waiting for many months for admission was highlighted as an issue within High Secure Services. The JCC Director for Mental Health will write to the Director of Specialised Commissioning in England highlighting concerns with Broadmoor Hospital not being accessible to Welsh patients. Capacity issues at Caswell were also noted. Members received an update on the review of gender assessment clinics in England and plans to open satellite clinics in Wales. An update on children and young people's gender services and the commissioning of beds in a new perinatal unit in North Wales was also provided.

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RAG Rating	Highlight
Assure	• Members were informed about the Risk approach and noted that by March 2025, risks related to quality and safety will be reported to this sub-committee for review and assurance. Members requested additional information for the March 2025 meeting on the following items: • Specific update on the qualitative information regarding the review of long waiters for plastic surgery (south Wales). • An update on the resolution of the radioactive isotope production issue at Cardiff University and its impact on South Wales patients. • There were gaps in the Ambulance and 111 reporting data around percentages of patients kept at home rather than transferred to hospitals and further information was requested; and • Mental Health –a detailed update on the commissioning framework for secure services including staff training and experience to be provided. A discussion around concerns and incident reporting led to the Director of Nursing and Lay Member agreeing to meet and progress some work on this outside of the meeting.
Inform	• A presentation was shared which focused on the Microprocessor Knee (MPK) Service at Cardiff Artificial Limb and Appliance Service (ALAS). The presentation highlighted the benefits of MPKs, such as improved mobility, less pain, and increased confidence among users. The presentation included quotes from patient impact statements, emphasising the positive changes in their lives due to the MPK. • A patient story was also received, and the patient highlighted the benefits in improved mobility, reduced falls and overall quality of life along with the improved emotional and mental wellbeing. • Members received an update on incidents and concerns across the range of JCC commissioned services. A summary of the open incidents and complaints was provided and members noted that work was underway to improve reporting on complaints and concerns. • Members received an update on regulatory activity, including recent changes in representation and ongoing work with the NHS executive and Welsh Government.
Appendices	None

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4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Improve Equity and Population Health Ensure Quality
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals** *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A More Equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred If more than one applies please list below: Equitable
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

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Impact Assessment

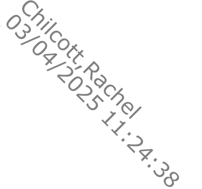
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Annual Report of the Quality Committee 2024/25



1.0 INTRODUCTION

In accordance with best practice and good governance, the Quality Committee (“the Committee”) produces an Annual Report to the Board setting out how it has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

Each Committee will comprise a minimum 3 Independent Members and an identified Executive Lead. Each Committee will have an Independent Member Chair and Vice Chair. The CAVUHB website will maintain and up to date record of the Independent Members and Officer members required at each Committee. The Board will determine the above attendees. The Executive Leads for the Quality Committee are: Executive Nurse Director, Executive Medical Director, Executive Director of Public Health, and the Executive Director of AHPs, Health Scientists and Community Services Development.

3.0 MEETINGS & ATTENDANCE

The Committee met five times during the period 1 April 2024 to 31 March 2025. This is in line with its Terms of Reference.

Attendance	21.05.2023	Role	16.07.2023	Role	08.10.2023	Role	26.11.2023	Role	18.02.2024	Role	Graph	Percentage
Ceri Phillips	☑	Chair	☑	Chair	☑	Chair	☑	Chair	☑	Chair	1.0	100.00%
Rhian Thomas	☑	V.Chair	☑	V.Chair	☑	V.Chair	☑	V.Chair	☑	IM	1.0	100.00%
Akmal Hanuk	☑	IM	☑	IM	☑	IM	☐		☑	IM		80.00%
Mike Jones	☑	IM	☑	IM	☑	IM	☑	IM	☑	IM	1.0	100.00%
Jason Roberts	☑	Exec	☑	Exec	☑	Exec	☑	Exec	☑	Exec	1.0	100.00%
Paul Bostock	☑	Exec	☑	Exec	☑	Exec	☑	Exec	☑	Exec	1.0	100.00%
Richard Skone	☑	Exec	☑	Exec	☑	Exec	n/a		n/a		1.0	100.00%
Emma Cooke	☑	Exec	☐	Exec	☑	Exec	☑	Exec	☑	Exec		80.00%
Claire Beynon	☑	Exec	☑	Exec	☑	Exec	☑	Exec	☐			80.00%
Matt Phillips	☐	Exec	☐	Exec	☑	Exec	☑	Exec	☑	Exec		60.00%
David Fluck	n/a		n/a		n/a		☑	Exec	☑	Exec	1.0	100.00%

The Committee achieved an attendance rate of 90% (80% is considered to be an acceptable attendance rate) during the period 1st April 2024 to 31st March 2025.

Two meetings scheduled to take place on the 27th of August 2024 and the 7th of January 2025 were cancelled due to operational pressures.

4.0 TERMS OF REFERENCE

Previously, there had been standalone terms of reference for each committee, available to access through the website. This allowed a degree of variation between some of the standard powers and responsibilities of the committees. A shared General Terms of Reference which applied to every Committee was reviewed and approved by the Board on the 28th November 2024.

5.0 WORK UNDERTAKEN

The purpose of the Committee is to provide advice and assurance to the Board with regards to the discharge of its functions and responsibilities around the quality, safety and experience (QSE) of health services within the Health Board. During the financial year 2024/25, the Committee considered the following:

- **Clinical Board Assurance Reports**

  The Committee received and discussed Clinical Board Assurance reports and Patient Stories from each of the Clinical Boards. These reports provided details of the clinical governance arrangements within the Clinical Board. The reports identified the achievements, issues, progress and planned actions to maintain the priority of QSE which had arisen during the previous 12 months.

  - Children & Women’s Clinical Board – 21.05.2024
  - Clinical Diagnostics and Therapeutics Clinical Board – 16.07.2024
  - Primary, Community and Intermediate Care (PCIC) Clinical Board – 08.10.2024
  - Mental Health Clinical Board – 26.11.2024
  - Medicine Clinical Board – 18.02.2025

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- **Quality Indicators Report**

  At every other meeting, the Committee received an overview of the Health Board’s current performance against a range of agreed quality indicators which included National Reportable Incidents and Never Events, Infection Prevention and Control, Medication Incidents, Patient Safety Solutions, Patient Safety incidents, Health Inspectorate Wales (HIW) Activity Reports, Mortality, Clinical Effectiveness, Patient Experience, and Safe Care.

In the alternate meeting, the Committee were presented with a Deep Dive on the following topics:

- Nationally Reportable Incidents (NRIs)
- Never Events
- Perinatal Mortality Review Tool (PMRT)

- **Policies and Procedures**

A number of policies and procedures were discussed & approved at the Committee as follows:

1. UHB 068 – Blood Component Transfusion Policy
2. UHB 528 – Development and Approval of UHB Local Procedure Specific Patient Information Leaflets Principles and Framework
3. UHB 519 – Request for approval of the 'Development and Approval of UHB Procedure Specific Consent Forms Principles and Framework'
4. UHB 322 – Ultrasound Clinical Governance Policy & Procedure
5. UHB 282 – CAVUHB Reusable Medical Device Decontamination Policy & Procedure

- **Minutes from Clinical Board QSE Sub-Committee Minutes**

A number of minutes from Clinical Board QSE Sub-Committee minutes were noted at the Committee meetings, which included:

- Children & Women's Clinical Board
- Medicine Clinical Board
- Primary, Community and Intermediate Care (PCIC) Clinical Board
- Clinical, Diagnostic & Therapies Clinical Board

Additional minutes noted by the Committee included:
- WHSSC Patient Safety Minutes
- Safeguarding Steering Group (SSG) Minutes

- **Other matters of business discussed during the year, included**: -

- Prison Inquest Update
- Clinical Effectiveness Committee
- Equity, Equality, Experience and Patient Safety Action Plan
- COVID-19 Investigation Programme
- Update on the Hepatitis B/C Recovery Plan
- Joint Inspection of Child Protection Arrangements (JICPA) Update and Improvement Plan
- Patient Safety Notice 066 (Safer Identification of Unknown Patients)
- Research and Development Update
- Improving Patient Experience within the Emergency Unit Department following HIW Inspection
- Emergency Unit, Acute Medicine and Frailty Showcase
- Looked After Children – Assessment Backlogs
- Ombudsman Annual Letter
- Regulation 28 PFD Improvement Plan
- Sexual Safety
- Medical Examiners (Wales) Regulations 2024 and Care After Death
- Controlled Drugs Accountable Officer Annual Update April 2023 – March 2024
- Director of Public Health Annual Report
- Joint Commissioning Committee Quality and Patient Safety Committee (QPSC) Chairs Report – 12.11.2024
- Healthcare Associated Infection (HCAI) Measures
- Gastro Surveillance Verbal Update
- Healthy Eating Standards for Hospital Restaurant & Retail Outlets
- Good Food and Movement Framework
- Smoke Free Legislation Update
- Safeguarding Children and Adults at Risk Annual Report 2023/24

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All of the items discussed were reported to the Board via the formally agreed minutes and Chairs Reports.

6.0 REPORTING RESPONSIBILITIES

The Committee reported to the Board following each of its meetings by presenting a summary report of the key discussion items at the Committee. The report is presented by the Chair of the Committee.

7.0 OPINION

The Committee is of the opinion that the Quality Committee Report 2024/25 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Ceri Phillips

Committee Chair