Public Quality, Safety & Experience Committee

Tue 11 April 2023, 14:00 - 16:00

Agenda

14:00 - 14:10
10 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee Meeting held on 07.03.23

Ceri Phillips

1.4 Public QSE Mins 07.03.23.pdf (12 pages)

1.5. Action Log – Following the meeting held on 07.03.23

Ceri Phillips

1.5 Action Log.pdf (3 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

14:10 - 15:30
80 min

2. Items for Review & Assurance

2.1. Children & Women's Clinical Board Assurance Report

30 minutes *Jason Roberts / Meriel Jenney*

2.1 CW Assurance Report.pdf (21 pages)
2.1a Appendix 1 Obs & Gynae Newsletter.pdf (8 pages)

2.2. Quality Indicators including: Peri-Natal Mortality

15 minutes *Jason Roberts*

2.2 Peri-Natal Mortality Slides.pdf (9 pages)

2.3. Pressure Damage Collaborative Work Plan

15 minutes *Jason Roberts*

2.3 Pressure Damage Collaborative Work Plan.pdf (4 pages)
2.3a Appendix 1 - Mattress Selection Pathway.pdf (1 pages)

2.4. Quality of Care Assurance in Commissioned Services in response to the Operation Jasmine & the Flynn Report

10 minutes *Jason Roberts*

- 2.4 Operation Jasmin & Flynn Report.pdf (6 pages)
- 2.4a Appendix 1 PCIC Care Home.pdf (12 pages)

2.5. Board Assurance Report – Patient Safety

5 minutes *James Quance*

- 2.5 Board Assurance Framework Covering report.pdf (2 pages)
- 2.5a Board Assurance Framework - Patient Safety.pdf (18 pages)

2.6. BREAK – 5 Minutes

15:30 - 15:30
0 min

3. Items for Approval / Ratification

3.1. Policies for ratification including:

No policies for this period

15:30 - 15:45
15 min

4. Items for Noting & Information

4.1. National Collaborative Commissioning Unit Quality Assurance & Improvement Service Annual Position Statement 2021-2022

5 minutes *Jason Roberts / Meriel Jenney / Paul Bostock*

Due to the large file size of the documents, the English and Welsh version of the Service Annual Position Statement 2021-2022 can be located under the **Supporting Documents Folder** in AdminControl and the Cardiff and Vale UHB website.

- 4.1 Covering Report.pdf (3 pages)
- 4.1 National Collaborative Commissioning Unit Annual.pdf (10 pages)

4.2. Minutes from Clinical Board QSE Sub Committees:

5 minutes *Jason Roberts / Meriel Jenney*

4.2.1. Children & Women's 24.01.2023 & 28.02.2023

- 4.2.1 CW QS Minutes 24.01.2023.pdf (13 pages)
- 4.2.1a CW QS Minutes 28.02.2023.pdf (10 pages)

4.3. Committee Self-Effectiveness Survey

5 minutes *James Quance*

- 4.3 Self Effectiveness Survey 2022-23.pdf (3 pages)
- 4.3a Annual Board Effectiveness Survey - QSE (1).pdf (6 pages)

15:45 - 15:45
0 min

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

15:45 - 15:45
0 min

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

i) Private Minutes

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

iii) Relocation of Pentyrch Surgery (Confidential Discussion)

15:45 - 15:45
0 min

7. Any Other Business

15:45 - 15:45
0 min

8. Review of the Meeting

15:45 - 15:45
0 min

9. Date & Time of Next Meeting:

Tuesday 9th May 2023 at 2pm via MS Teams

15:45 - 15:45
0 min

10. Declaration

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

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 07.03.2023 at 09.00am
Via MS Teams

Chair:		
Ceri Phillips	CP	Vice Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Keith Harding	IM	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Mike Bond	MB	Managing Director – Acute Services
Paul Bostock	PB	Chief Operating Officer
Guy Blackshaw	GB	Clinical Board Director – Specialist
Marcia Donovan	MD	Head of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Fiona Kinghorn	FK	Executive Director of Public Health
Sarah Lloyd	SL	Interim Director of Operations – Specialist
Bryony Roberts	BR	Senior Nurse – Major Trauma
Jason Roberts	JR	Executive Nurse Director
Melissa Rossiter	MR	Clinical Director (Major Trauma)
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Richard Skone	RS	Deputy Medical Director (joined at 11.15am)
James Quance	JQ	Interim Director of Corporate Governance
Catherine Wood	CW	Director of Operations - Children & Women
Observing		
Rebecca Aylward	RA	Deputy Executive Nurse Director
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Paul Bostock	PB	Chief Operating Officer
Susan Elsmore	SE	Independent Member – Local Authorities / Chair of the Committee
Meriel Jenney	MJ	Executive Medical Director

QSE 23/03/001	**Welcome & Introductions** The Committee Vice Chair (CVC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 23/03/002	**Apologies for Absence** Apologies for absence were noted. The Executive Medical Director (EMD) advised the Committee that she would need to leave the meeting early to attend another meeting. The Chief Operating Officer (COO) advised the Committee that he would need to leave at 10am to attend the Trauma Network Group.	
QSE 23/03/003	**Declarations of Interest** No declarations were noted.	
QSE 23/03/004	**Minutes of the Committee meeting held on 10 January 2023** The minutes of the Committee meeting held on 10 January 2023 were received. The Executive Director of Public Health (EDPH) advised the Committee that minute QSE 23/01/005 should have stated that the data was collated by the substance misuse APB commissioning team.	

	The Committee resolved that: a) The minutes of the meeting held on 10 January 2023 were approved as a true and accurate record of the meeting pending the one amendment noted.	
QSE 23/03/005	**Action Log following the Meeting held on 10 January 2023** The Action Log following the Meeting held on 10 January 2023 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 10 January 2023 was noted.	
QSE 23/03/006	**Chair's Actions** No Chairs Actions were raised.	
QSE 23/03/007	**Specialist Clinical Board Assurance Report (including a Patient Story).** The Specialist Clinical Board Assurance Report was received. The Clinical Board Director – Specialist (CBDS) highlighted the following areas in the report:- • The Patient at Risk Team (PaRT) team. The CBDS advised the Committee that it was the first anniversary of the PaRT team being set up. He added that during that first year of the service impressive results had been seen and that the team would get called those who had a national early warning score of greater than three. The CBDS advised the Committee that it had been agreed last week to extend the PaRT team in order to provide a more robust service. He concluded that the case for expanding the PaRT service to 24/7 cover was being progressed. The Executive Director of Public Health (EDPH) advised the Committee that it was clear that the PaRT team had provided an extensive amount of support right across the three sites (i.e. University Hospital Wales (UHW), University Hospital Llandough (UHL) and Hafan Y Coed (HYC)) and asked if outcomes could be observed, even if direct correlation with The Risk-Adjusted Mortality Index (RAMI) could not be shown. The EDPH also asked if there was any training element. The CBDS responded that the team had dedicated time within their schedule for education and to try and educate other staff on the wards. He added that even though the PaRT service had been up and running for a year, the team was still trying to get the message out as to what exactly the PaRT team did. The Committee was advised that in relation to outcome data, there were figures which related to the proportion of patients who went to Critical Care and the proportion of those who improved and stayed on the wards. The CBDS concluded that the data could be looked at in more depth to provide better outcome data. • National Organ Retrieval Service (NORS) The Committee was advised that the Health Board did not transplant livers, but that it did transplant kidneys and pancreas. The CBDS noted that the Health Board was the only standalone NORS team in the UK and that it had started to use a pioneering technique, normothermic Regional Perfusion (NRP), to allow the retrieval of organs from donors after circulatory death, increasing the pool of accepted organs.	

	He added that Cardiff was one of only 3 centres in the UK able to deliver that option and the only non-liver centre in the UK able to retrieve livers. The CBDS concluded that it allowed people on the waiting list an opportunity (that had not previously been available to them) to receive an organ. • Major Trauma Centre (MTC) The Committee was advised that the (MTC) was still in its infancy stages and that it went live in September 2020. It was noted that the Major Trauma Directorate management team (DMT) was led by the Clinical Director for Major Trauma and sat within, and was accountable to, the Specialist Services Clinical Board. The CBDS added that Major Trauma care did not sit in one single Directorate, but was delivered in a coordinated way which involved multiple different specialities and organisations across the network. He added that, as anticipated, the MTC treated a significant proportion of silver trauma (43% of all cases in Q3) and that the majority of patients were transferred straight home from the MTC rather than repatriated to their home Health Board. It was noted that that the intensive rehabilitation model had been a success. The CBDS advised the Committee that in March 2022 the South Wales Trauma Network had its first peer review. He added that the review identified 6 serious concerns and that an action plan had been developed to address the issues raised. It was noted that a number of the issues were within the control of the organisation and had been addressed and closed, whilst others required investment from commissioners to resolve. The CBDS concluded that the Clinical Board was working with WHSSC to seek additional investment and to mitigate the risks. The CVC asked where the Clinical Board was in relation to working with WHSSC to get additional investment. The Interim Director of Operations – Specialist (IDOS) responded that in April 2022, the Clinical Board submitted a bid to WHSSC to address a number of concerns that had been highlighted as part of the action plan. She added that they had not been successful in securing any funding from WHSSC during the prioritisation process and that WHSSC did not have sufficient revenue to be able to allocate any funding to the Clinical Board for this year. She noted that it presented a problem to the Clinical Board and the organisation as a whole because it meant that there would be a whole year without any allocation from WHSSC to support the service. The IDOS advised the Committee that what had been agreed at the most recent delivery assurance group was that Welsh Government (WG) was going to do a Gateway 5 review on the service in quarter two of the year. She added that all of the outcomes would hopefully be seen from that review and that it meant there would be some weight to some of the areas needed to develop the service and that the bidding process would start again with WHSSC. The CVC noted that it would be useful for the Committee to be kept up to date with ongoing conversations with WHSSC. • Infection Prevention and Control	**JR/SL**

	The CBDS advised the Committee that during 2021/2022 the Clinical Board had seen an increase in MSSA cases, particularly within the renal population. He added that the Directorate reviewed both incidences of infections between centres within South East Wales and the Renal Registry data across the UK which had showed that whilst the Clinical Board's data was very similar to other populations, it highlighted some variances in practice. It was noted that the review resulted in a standardisation of practice for dialysis line care both prior to insertion and also through each dialysis session, and an enhanced training package for staff. • National Reported Incidents (NRIs) The CBDS advised the Committee that overall, the Clinical Board had seen a decrease in the number of National Reported Incidents that it had occurred between the twelve-month periods, despite seeing an increase in the number of incidents reported overall. That was a positive indicator within the safety agenda. The CVC thanked the CBDS, the IDOS and their teams for all of the hard work being undertaken in the Specialist Services Clinical Board. The Senior Nurse – Major Trauma presented the Committee with a Patient Story. The Patient Story outlined a Polytrauma Patient. It was noted that the patient had come off his quad bike at force and that the quad bike had landed on him. The patient's journey was presented which included: • The Incident – Quad Bike incident in a rural location. • Pre-Hospital – The Emergency Medical Retrieval and Transfer Service Cymru (EMRTS) arrived at the scene • Emergency Department – Pre-alert by EMRTS. The trauma team awaited arrived. • Theatre – Surgery to fix significant injury • Critical Care – a 2 day stay in ITU • Polytrauma Unit • Major Trauma Centre • Specialist Rehabilitation • Repatriation to patient's local Health Board. • Follow on care The Executive Nurse Director advised the Committee that the patient story provided was an example of where a system came together in the NHS. The IDOS advised the Committee that as part of the South Wales Trauma Network, the story would be shared wider across Wales which was important about how to garner support from WHSSC longer term. She added that the story demonstrated the acute phase, but also touched across the wide range of services provided across the Organisation. **The QSE Committee resolved that:** a) The progress made by the Clinical Board to date was noted. b) The content of the report and the assurance given by the Specialist Clinical Board was noted.	
QSE 23/03/008	**Looked After Children – Assessment Backlogs** The Looked After Children – Assessment Backlogs were received. The Committee received an updated position regarding assessments for Looked after Children (LAC).	

	The Director of Operations - Children & Women's Clinical Board (DOCW) noted that performance against Statutory Regulations stipulated that a child being accommodated by the Local Authority should have a holistic health assessment within 28 days. She added that meeting the Regulations was difficult, due to insufficient capacity for both medical and nursing assessments, which had further deteriorated due to the retirement of a Consultant within the team. It was noted that there had been a consistent increase in children in care in Cardiff and the Vale of Glamorgan, with 1,638 children currently on the LAC database in February 2023. The increase in LAC numbers had impacted significantly on the number of Initial & review Health Assessments required each year. The Committee was advised of the actions that had been undertaken or started. That included: • Alternative staffing models were being explored to consider options to address the backlog, meet current demand and also to manage caseload in line with recommendations. • Additional nurses had been appointed and would commence employment in March 2023. It was anticipated that would deliver a total of 1,130 assessments, and reduce the backlog assessments for children over the age of 10. • There was a medium-term plan to recruit an additional 2.4 wte Band 6 nurses to assess all children over 5, and a longer-term plan to deal with expected growth and safe caseload numbers. • Other modernisation and change of delivery models would continue to be explored with the service to ensure efficiency and best use of resources, with a further expansion in nursing resource to support assessments for children over 5. The DOCW asked the Committee for permission to return in a few months with another paper that demonstrated the actions being taken. The EDPH noted that discussions had been held in the Children & Women's Clinical Board performance review to note the proactive approach to dealing with the challenges raised and welcomed the paper being received to outline actions. The END noted that the increased number of LAC and that the Clinical Board had identified the risks and was working through those in order to mitigate the same. The Independent Member – Community (IMC) asked if there was a collaboration with other areas such as Social Services, other community settings and Third Sector services. The DOCW responded that the growth in LAC identified related to children who were in the adoption or foster process or residential care and that from that specific side, it was difficult to work in partnership because it was a clinical need set out in statute. She added that in terms of the wraparound care offered to the children that was where the partnership working could be beneficial. The Independent Member – University (IMU) asked if there was anything that could done to get more finance from WG. The EDPH responded that it was complex because LAC and vulnerable children were just one example of a disadvantage in the population and noted that when allocation of funding was received by WG, there was a method used by them right across Wales and that all Local Authorities (LA) were seeing an increase in LAC. The CVC asked what would happen now that the actions had been initiated to respond to the trajectory of growth in LAC because it appeared that the trajectory would continue upwards. The DOCW responded that at the current point in time, the actions initiated had helped the Clinical Board to maintain a position but not to manage the demand at the increasing rate. She added it would take time to test the actions being undertaken, and then further information could be provided to the Committee at a later date.	**JR/CW**

	The QSE Committee resolved that: a) The content of the paper and the actions taken to mitigate the risks associated child health assessments were noted.	
QSE 23/03/009	**Quality Indicators Report to include: C-Diff Update.** The Quality Indicators Report was received. The END advised the Committee that the report was presented during a climate that had experienced some of the most difficult challenges with regards to capacity and the workforce in Health Care. He added that the report initially talked about the implementation of the Quality Framework. He added that the Duties of Quality and Candour had a start date of 1st April 2023 and noted that the teams were well trained to implement both of those new Duties. The END provided the Committee with updates on a number of areas which included: • Incident reporting – It was noted that reporting remained consistently high within the Organisation, with pressure damage providing the largest number of incidents reported. The END advised the Committee that pressure damage was being monitored and measured carefully and that he was pleased to say that the number of incidents, specifically related to staffing issues, had reduced. • Nationally Reportable Incidents (NRIs) – It was noted that the position was improving and that had reflected the focus and hard work of the Clinical Boards and Patient Safety Teams. It was noted that there had been a reduction of overdue NRIs by 41% since September 2022. • Infection Control - Hospital Infections – The END advised the Committee that the grouped total C'diff, Ecoli, MRSA and MSSA infections, was showing no in-year improvement against the baseline but noted that Ecoli, MRSA and MSSA were demonstrating an in-year improvement, whereas C'diff in-year had increased, compared to baseline of December 18th. The END added that C'diff rates were observed to be high across the UK after the first and subsequent waves of Covid and that all community cases were now subject to investigation to understand the cause of the infection. He concluded that there had been significant investment in the IP&C team in the past 2 years, which had enabled increased audit and review of infections and had supported a bespoke approach to supporting wards and Primary Care reviews. • Performance – The END advised the Committee that it had been a very challenging period and noted that the Chief Operating Officer (COO) had continued to outline the significant amount of work going on operationally to improve the position of the Health Board. • Patient Concerns – The END advised the Committee that during December 2022 and January 2023, it had been pleasing to note that, despite the current demand on the service, the Health Board had achieved a slight improvement in an overall 30 working day response time for all concerns. He added that the Patient Experience team had closed 80% of concerns in December within 30 working days and 77% in January. • Civica 'Once for Wales' Platform – The END advised the Committee that the Civica platform went live on Friday 28th October 2022 and that the Patient Experience team was currently surveying up to 600 patients daily via SMS. He added that at the time of reporting the Patient Experience team had contacted circa 36,227 people for feedback via text messaging with a return rate of 18%.	

- Stroke – The Managing Director – Acute Services (MDAS) advised the Committee that the Stroke pathway was time critical with key decisions that improved both mortality and outcome in relation to Quality of Life.

He added that there has been significant public awareness raising of the symptoms of a stroke and it's time critical nature. Ongoing work to improve the service had included:

- Increased out of hours CNS support for "Code Stroke".
- Dedicated specialist middle grade to support Emergency Unit for Stroke.
- Focused training for acute medics on Stroke assessment, thrombolysis and thrombectomy.
- Ring-fencing additional Stroke beds and deploying pull model "Think thrombolysis, Think Thrombectomy".
- Thrombectomy next steps – work to strengthen neuroradiologist workforce.

- Ambulance Handovers – The Committee was advised that there has been a sustained improvement in Ambulance patient handovers, although it was noted that, unfortunately, due to a number of events 2 ambulances had waited overnight the previous Saturday.

The IMU asked, in relation to the operating hours of the Patient Experience team, if a 3-hour period of manning phones from 10am until 1pm was sufficient to get a real picture of complaints, and asked if the 3-hour limit was due to financial constraints.

The Assistant Director of Patient Experience (ADPE) responded that the 3-hour phone manning operation was just the Patient Experience inquiry line and noted that the team their early resolution phone lines which were manned from 7am until 6pm.

She added that the Patient Experience line was for those matters that could be resolved on the Ward and that the reason for it being 3 hours was due to no additional resource.

The IMU asked if there was any potential for other agencies to help the Health Board to get more enriched data.

The Assistant Director of Quality and Patient Safety (ADQPS) advised the Committee on mortality data.

She noted that the November 2022 Quality Safety and Experience Committee had agreed a three-tier model for reporting and monitoring mortality data across the Health Board. Data was received by the Committee which included:

- Age-standardised mortality rates in 2022 were significantly lower than most other years since 2001 in Wales and England, although it remained above the rate observed in 2019.

- Alzheimer's and dementia remained the leading cause of death in Wales in December 2022, with a rate higher than the five-year average.

- Cancer mortality rates per 100,000 population had demonstrated a reducing trend in population rates in Wales and in Cardiff and Vale UHB area.

- Still birth rates in the UK fell to 3.9 per 1000 births in 2019 and 2020 with increased rates associated with ethnicity in several populations, in particular, Bangladeshi, Pakistani, Black African and Black Caribbean. Provisional figures from the Office of National Statistics suggested that still birth rates increased in 2021 to 4.2 per 1000 births, with a particular increase noted in the second half of 2021. National rates for 2022 were not yet reported.

- Still birth rates in Cardiff and Vale UHB increased from 4.39 in 2021 to 5.74 in 2022. The presence of a Foetal Medicine Unit, meant that the Health Board could provide specialist diagnosis and treatment of complications which could arise in unborn babies.

The END advised the Committee that it was important to note the explanation on still birth rates because the Health Board had received some criticism that the still birth rate had been higher than the national average.

He added that assurance could be provided that every still birth was robustly investigated by the formal NRI process.

	The QSE Committee resolved that: a) The content and the developing process to monitor Quality Indicators was noted.	
QSE 23/03/010	**HIW Activity Overview** The HIW Activity Overview was received. The END advised the Committee that Heath Inspectorate Wales (HIW) had undertaken three unannounced visits, namely: - • Maternity Services • Hafan Y Coed - HIW undertook an unannounced inspection in Hafan Y Coed from the 9th to the 11th of January 2023. An immediate action plan was submitted in response to the recommendations and an update would be provided following the publication of the report. • IRMER Inspection - An Ionising Radiation Medical Exposure Regulations (IRMER) compliance inspection was undertaken in the Nuclear Medicine Department at UHL on the 11th and 12th of October 2022. Overall, the feedback was positive, and no immediate concerns were identified. An action plan was submitted and accepted in response to the recommendations and the final report was published on 12th January 2023. He added that the Committee would receive full reports with regards to each visit once the formal HIW reports had been published. **The QSE Committee resolved that:** a) The assurance provided by the response to HIW inspections and progress against existing improvement plans were noted.	**JR**
QSE 23/03/011	**Community Health Council Reports** The Community Health Council Reports were received. The END advised the Committee that a number of Community Health Council (CHC) Announced Scrutiny Visits had occurred. The Committee received a list of CHC Q2, Q3 &Q4 final reports in the following areas: • Alcohol Treatment Centre • Spinal Rehabilitation Unit UHL • Ward West 1 UHL • Transport to Health Services The main issues highlighted in those reports included: • Infrastructure • Estates • Patient Experience. The CVC thanked the CHC for the reports and noted that it was a good initiative for the Committee to receive them. **The QSE Committee resolved that:** a) The contents of the report and the CHC feedback and recommendations were noted.	
QSE 23/03/012	**Maternity Services – Verbal Update** The verbal Maternity Services Update was received. The END advised the Committee that Health Inspectorate Wales (HIW) had undertaken an unannounced visit in November 2022 and that the Health Board had submitted its improvement plan, which would be received by the Committee as soon as the HIW report had been published.	

	He added that following the Ockenden review, a resource gap analysis had been undertaken and the same was due to be submitted to the Health Board's Investment Group for consideration. It was noted that a Maternity Neo-Natal group had been established in order to share best practice across Wales. The Independent Member – Trade Union (IMTU) asked about staff morale in the Maternity Service. The END responded that work there had been continuous and that he had heard that staff were feeling much better about outcomes. He added that the Committee should not forget that HIW had visited after a prolonged staff sickness period as well as a gap in staff vacancy. It was noted that in September 2022, the Maternity Service had overfilled its vacancies which had closed the gap. The END concluded that the teams continued to review and monitor staff evaluations and staff wellbeing. **The QSE Committee resolved that:** a) The Maternity Services Update was noted.	
QSE 23/03/013	**Quality, Safety and Experience Framework - Effectiveness review – Verbal** The Quality, Safety and Experience Framework - Effectiveness review was received. The ADQPS presented to the Committee. She advised the Committee that in September 2021, the Quality, Safety and Experience Framework was published which set out a 5-year ambition to improve quality and safety across the organisation. It was noted that traditionally, the focus of quality and safety had been on what had gone wrong and what patients were telling the Health Board about why they were unhappy. The ADQPS advised the Committee that where there was no doubt that the learning from those incidents or information sources was vitally important. There was a significant body of evidence that demonstrated that the health system was moving to a more contemporary approach to include more psychological safety and staff engagement, as well as focusing on human factors and development of a whole systems approach to quality and safety. She added that it would support the Health Board in meeting its statutory requirements in relation to the Duty of Quality and the Duty of Candour. It was noted that one of the areas the team had wanted to focus on was around leadership and prioritisation and noted that the Health Board would be looking to support the organisational and compassionate leadership programme and to embed quality and safety as part of that. The Committee was advised that the Health Board was also looking at developing multidisciplinary roles and role profiles across the organisation, which focused on those people who were involved in quality and patient safety, whether a medical role, allied health care professional or nursing role. The ADQPS noted that in relation to patient safety learning improvement, the Health Board would be developing an organisational learning committee and the role of that committee would be to have Health Board wide engagement. The ADPE advised the Committee that World Patient Safety Day 2023 would be observed on September 17th 2023 under the theme of "Engaging Patients for Patient Safety". She added that the really important part was that patients and families had an important role in elevating the voice of patients. **The QSE Committee resolved that:**	

	a) The Quality, Safety and Experience Framework - Effectiveness review was noted.	
QSE 23/03/014	**Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response** The Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response was received. The Interim Director of Corporate Governance (IDCG) reminded the Committee that it had asked for regular updates regarding progress made with the implementation of the recommendations of the report, as recorded in the Committee Action Log. He added that the implementation of recommendations continued to be monitored by the Risk and Regulation Team and a number of the recommendations were recognised as longer-term and formed part of the Health Board's preparations for the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act. The Committee was advised that six recommendations had been made by Audit Wales, which formed part of the wider quality improvement programme in place within the Health Board, with specific actions shown against each recommendation. It was noted that all recommendations were in progress and formed part of the Health Board's preparations for the implementation of the Quality and Engagement Act. **The QSE Committee resolved that:** a) the progress made with the implementation of the recommendations of the Audit Wales report was noted.	
QSE 23/03/015	**Board Assurance Report – Patient Safety** The Board Assurance Report – Patient Safety was received. The IDCG advised the Committee that a number of risks linked to Patient Safety were included on the Board Assurance Framework (BAF) which included: • Maternity (score of 20) • Critical Care (score of 20) • Cancer (score of 15) • Stroke (score of 15) • Planned Care (score of 12). He added that those were in addition to the risks already logged on the BAF: • Patient Safety (score of 20) • Urgent and Emergency Care (score of 15) The CVC noted that the format in which the report was received was very helpful and gave the Committee an indication of where it was and where it was going. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety, Quality and Experience were reviewed and the Committee was able to provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
QSE 23/03/016	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The IDCG advised the Committee that a robust process continued whereby the Risk and Regulation Team continued to work with Clinical and Corporate colleagues to refine risk descriptors, controls and actions within Risk Registers.	

	He added that the risks linked to the Quality, Safety and Experience Committee were received by the Committee for further scrutiny and to provide assurance to the Committee that relevant risks were being appropriately recorded, managed and escalated. **The QSE Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work which was progressing with Clinical Boards and Corporate Directorates, were noted.	
QSE 23/03/017	**Committee Work Plan 2023/24** The Committee Work Plan was received. The IDCG advised the Committee that the Committee Work Plan had been prepared by his predecessor and that no further changes had been made from it. He added that the work plan identified key areas of work, but noted that it did not prevent other items from being added as and when required. The CVC added that the QSE Committee was moving to monthly meetings from April 2023 and so flexibility on the work plan would need to be observed. **The QSE Committee resolved that:** a) The Quality, Safety and Experience Committee Work Plan 2023/24 was reviewed. b) The Committee Work Plan for 2023/24 was ratified c) The Work plan was recommended to the Board on 30th March 2023 for approval.	
QSE 23/03/018	**Policies for ratification including:** The Deteriorating Patient Policy was received. The END assured the Committee that the policy had been through the resuscitation forums and that good governance had been observed. **The QSE Committee resolved that:** a) The Deteriorating Patient Policy was approved.	
QSE 23/03/019	**Minutes from Clinical Board QSE Sub Committees:** **Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/03/020	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/03/021	**Agenda for Private QSE Meeting** *i) Private Minutes -* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *iii) Royal College of Physicians Summary Report: Inpatient Suicides – Verbal (Confidential Discussion)*	
QSE 23/03/022	**Any Other Business** The CVC asked for thanks to be placed on record to Susan Elsmore as Chair of the QSE Committee who would be stepping down in April 2023.	
QSE	**Review of the meeting.**	

23/03/023		
	Date & Time of Next Meeting: Tuesday, 11 April 2023 via Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 11 April 2023
(Following the meeting held on* 07 March 2023*)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 22/11/005	**Action Log – Mortality Indicators**	Revisit the way in which mortality data was presented and to consider that offline and bring back to the March meeting.	**07.03.2023**	Meriel Jenney	**COMPLETED** **Updated on 7 March 2023** *To be discussed via the Action Log (agenda item 1.5)*
QSE 23/01/014	**Maternity Services Update**	It was anticipated that the report would have been shared by March 2023 and so then a full paper will be received by the QSE Committee	**07.03.2023**	Jason Roberts	**COMPLETED** **Updated on 7 March 2023** *Agenda item 2.6*
QSE 22/11/007	**Quality Indicators Report – Cdiff**	The Executive Nurse Director and the Deputy Medical Director to undertake a Cdiff root cause analysis and share their learnings with the relevant areas	**07.03.2023**	Jason Roberts/Richard Skone	**COMPELTED** **Updated on 7 March 2023** **(agenda item 2.3)**
QSE 22/08/013	**Review of Quality Governance Arrangements - Audit Wales Report and Health Board**	Progress had been made and would be presented to the Committee.	**07.03.2023**	James Quance	**COMPLETED** **Updated on 7 March 2023** *Agenda item: 2.9*

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
	Management Response				
Actions in Progress					
QSE 23/01/013	**Pressure Damage**	Committee to be provided with a copy of the Pressure Damage Collaboration's annual paper.	**11.04.23**	Jason Roberts	**Update on 11 April 2023**
QSE 23/01/010	**HIW Activity Overview**	Once published, the Committee would receive a copy of the report relating to the Mental Health Services at Hafan y Coed visit.	**11.04.2023**	Jason Roberts	**Update on 11 April 2023**
QSE 23/03/007	**Specialist Clinical Board Assurance Report – re** South Wales Trauma Network	To update the Committee with regards to the WHSSC funding for South Wales Trauma Network review and associated actions	**29.08.2023**	Jason Roberts/Sarah Lloyd	**Update in August 2023**
QSE 23/03/008	**Looked After Children – Assessment Backlogs**	An update report to be brought back to the Committee in 3-4 months.	**29.08.2023**	Jason Roberts/Catherine Wood	**Update in August 2023**
QSE 23/03/010	**HIW Activity**	Once published, the Committee would receive copies of the reports relating to (i) Maternity Services and (ii) IRMER Inspection	**09.05.2023**	Jason Roberts	**Update on 9 May 2023**
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					
UHB 22/09/011	**Integrated Performance Report**	Pressure damage – the management approach to mitigating pressure damage issues to be	**09.05.2023**	Jason Roberts	**Update on 09 May 2023**

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
		explored further at the Quality, Safety and Experience Committee			Due to be considered at the QSE Committee meeting on 9 May 2023

Report Title:	Children & Women's Clinical Board Assurance Report			Agenda Item no.	2.1
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	11th April 2023
		Private			
Status *(please tick one only)*:	Assurance X	Approval		Information	
Lead Executive:	Jason Roberts, Executive Nurse Director				
Report Author (Title):	Andy Jones, Director of Nursing & Midwifery for C&W Clinical Board Catherine Wood, Director of Operations for C&W Clinical Board				

Main Report
Background and current situation:

Background:

This report provides details of the arrangements, progress and outcomes within the Children and Women Services Clinical Board in relation to the Quality, Safety and Patient Experience agenda over the last 12 months. It highlights the achievements, innovation and transformational work undertaken to date, and describes key residual risks and their mitigating actions that carry forward into 2023/24.

Quality and Safety and patient experience is at the core of all that we do within Children and Women's Clinical Board, and our operating framework is described below.

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

During the financial year 2022/23, the Clinical Board comprised three clinical Directorates with associated clinical services and sub-specialties. The Clinical Board delivers a number of highly specialised services serving the South East region, South and Mid-Wales region and wider all Wales population, as well as providing secondary care services to the local Cardiff and Vale population.

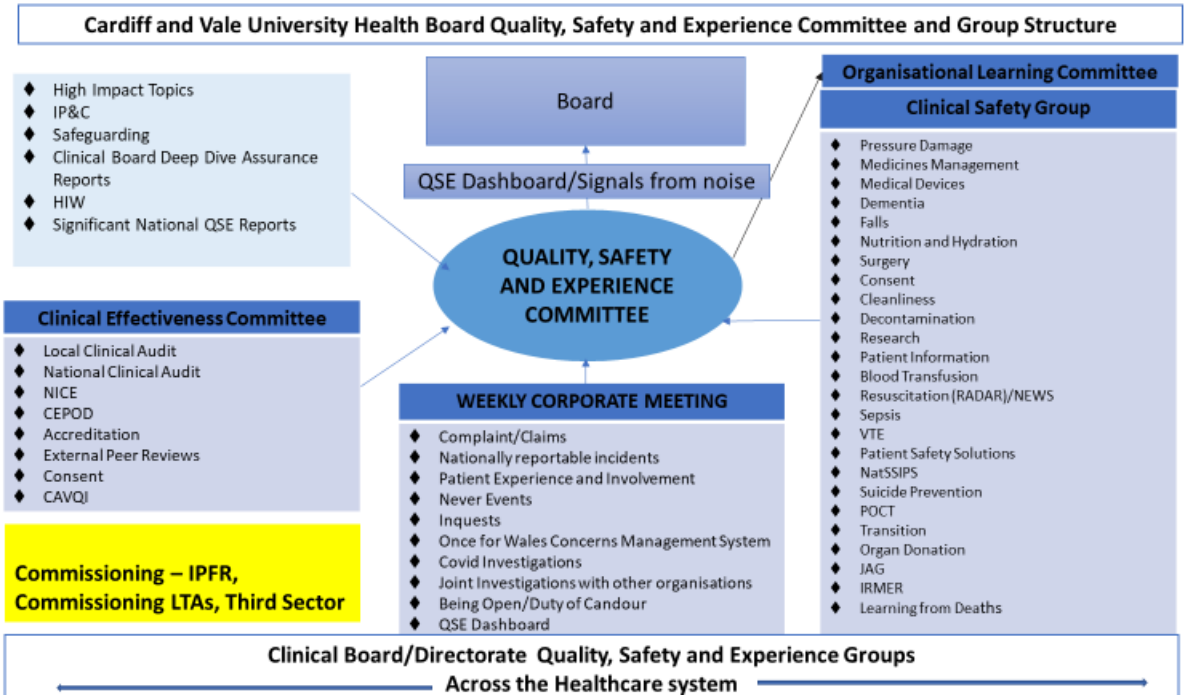
The Clinical Board has a budget of £132,405,880 and an establishment of 2037.98 WTE staff.

Services are structured through the Directorates below:

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

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

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

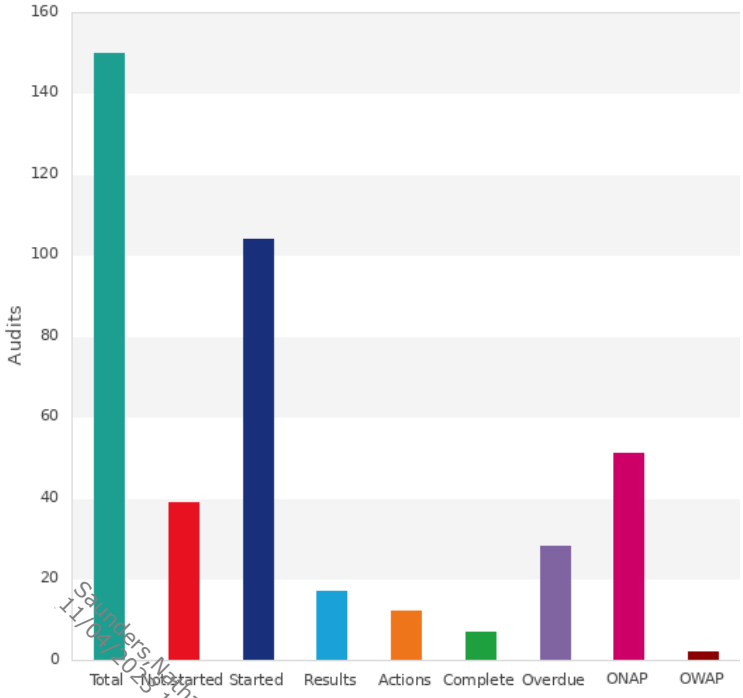


Overview Quality, Safety and Patient Experience Practices and Improvements.

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

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

Clinical project activity



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

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

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

This structure is replicated in each of the Clinical Directorates. The QSPE group has two key sub-groups that report to it; C&W CB NRI/RCA Governance Sub-Group (Previously called Extra Ordinary Q&S) and Infection Prevention and Control (IP+C) group.

The C&W CB NRI/RCA Governance Sub-Group meets monthly and provides a forum for robust discussion of NRI's, RCA's and incidents as well as reviewing action plans and learning from events to ensure safety and quality is embedded. The second is the Infection Prevention and Control group which will meet bi-monthly. They have formal terms of reference, will be formally minuted and have a range of stakeholders to attend to ensure that there is wide engagement in the overarching quality and safety agenda.

Through both of these agendas the aim is to draw themes and learning opportunities together so the Clinical Board can share actions, learning and service developments collaboratively.

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

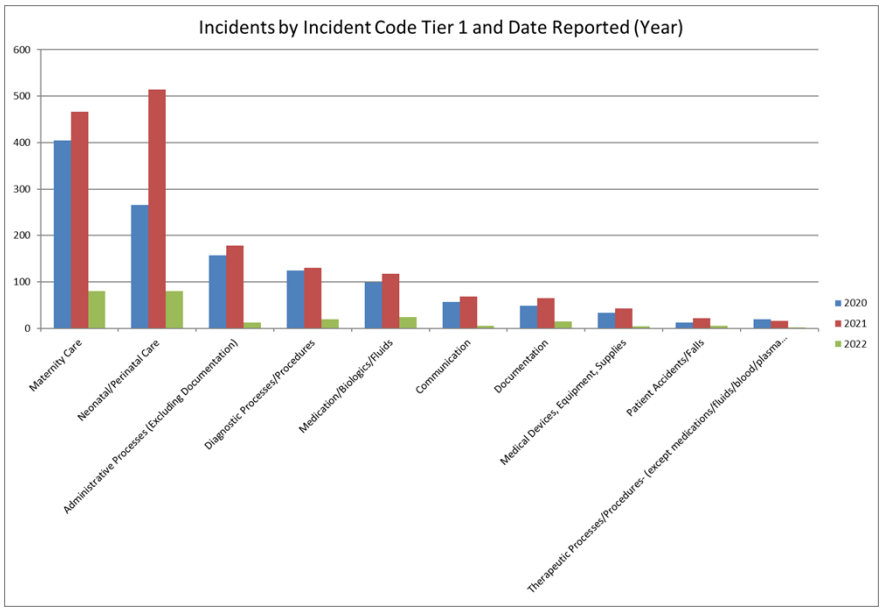
Q and S updates

Annual Data	2020	2021	2022	**Mean 20 - 22**
Responsible Incidents	3164	3545	3161	**3,290**

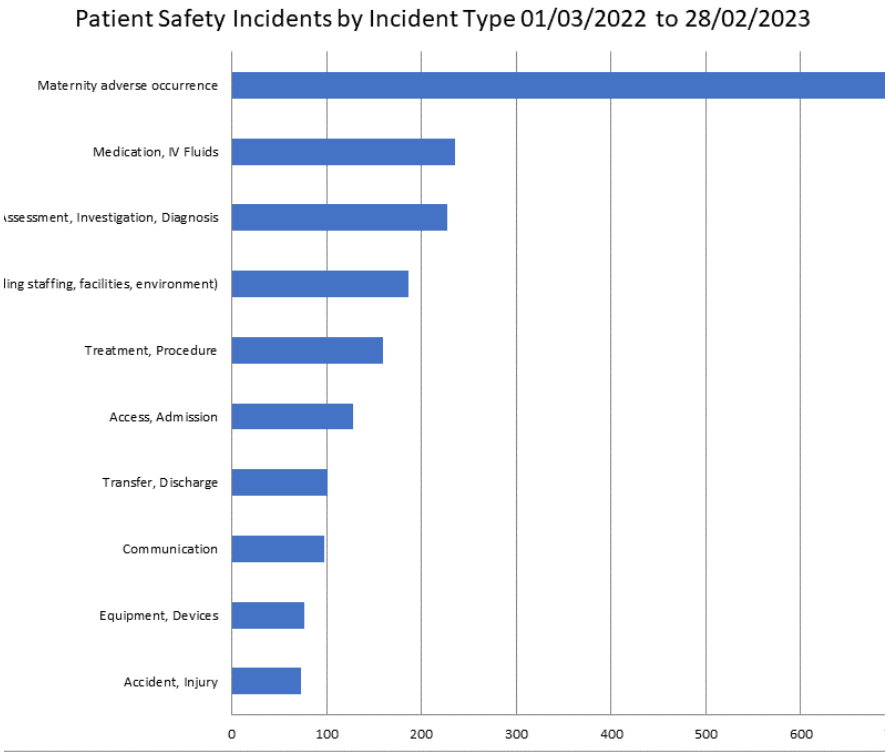
It is pleasing to see the significant incident reporting within the Clinical Board demonstrating our commitment to a culture, that is open, transparent and psychologically safe – the optimal conditions within which to deliver safe, high quality care and patient experience.

Through March 2022 we successfully transitioned our Datix management to the new E Datix system. This was also an opportunity to reinvigorate engagement with incident reporting and allow staff an opportunity to undertake training. A significant amount of work was undertaken to close historic Datix reports down and move into Datix Cymru with minimal reports outstanding. The Clinical Board incidents are summarised below;

Old Datix System



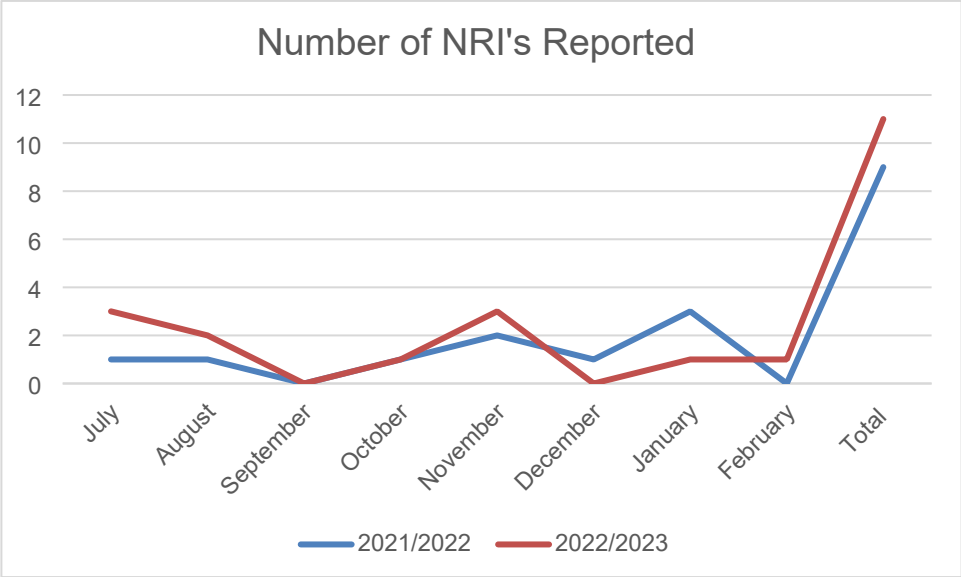
New Datix Cymru System



Total incidents open and those that have not been reviewed;

	Total Open Datix Incidents	Total not reviewed for 7 days	Total not reviewed for 30 days
C&W Clinical Board	1060	183	107

Overall, the Clinical Board have seen a slight increase in the number of National Reported Incidents reported in 2022/23 (11) compared to the same period in 2021/2022 (9).



Of our current 11 NRI's the breakdown is as follows:

- 4 investigations have been completed (x1 awaiting closure form to be completed, x2 in external review process, with a further x1 possible external review. Three of these cases are also awaiting coroners' inquests (x2 maternal deaths relating to sudden unexpected death in Epilepsy (SUDEP) and x1 HIE Neonatal Death)
- 2 cases reported with Children's Hospital for Wales (CHFW) - x1 case pertaining to stoma care for surgical baby on NICU and x1 case relates to a patient who suffered a pneumothorax potentially as a result of high-pressure bagging. Investigations are ongoing
- X1 case relates to a patient who suffered a ruptured ectopic pregnancy and potential management of transfer a deteriorating patient which is being investigated in conjunction with EU department. Investigation is ongoing.
- X3 cases pertaining to inappropriate level of review within the Obstetric Assessment Unit (x1 eclamptic fit, x1 postnatal readmission, patient suffered subarchnoid haemorrhage grade 1 and x1 neonatal HIE Grade 2). Investigations are ongoing
- X1 case relating to hypernatremia. Investigation is ongoing

There is also a further case which is being reported as part of a retrospective review following feedback received through the case being discussed through the Stillbirth review forum in July 2022 and a plan for a detailed review to be undertaken. The investigation is nearing completion.

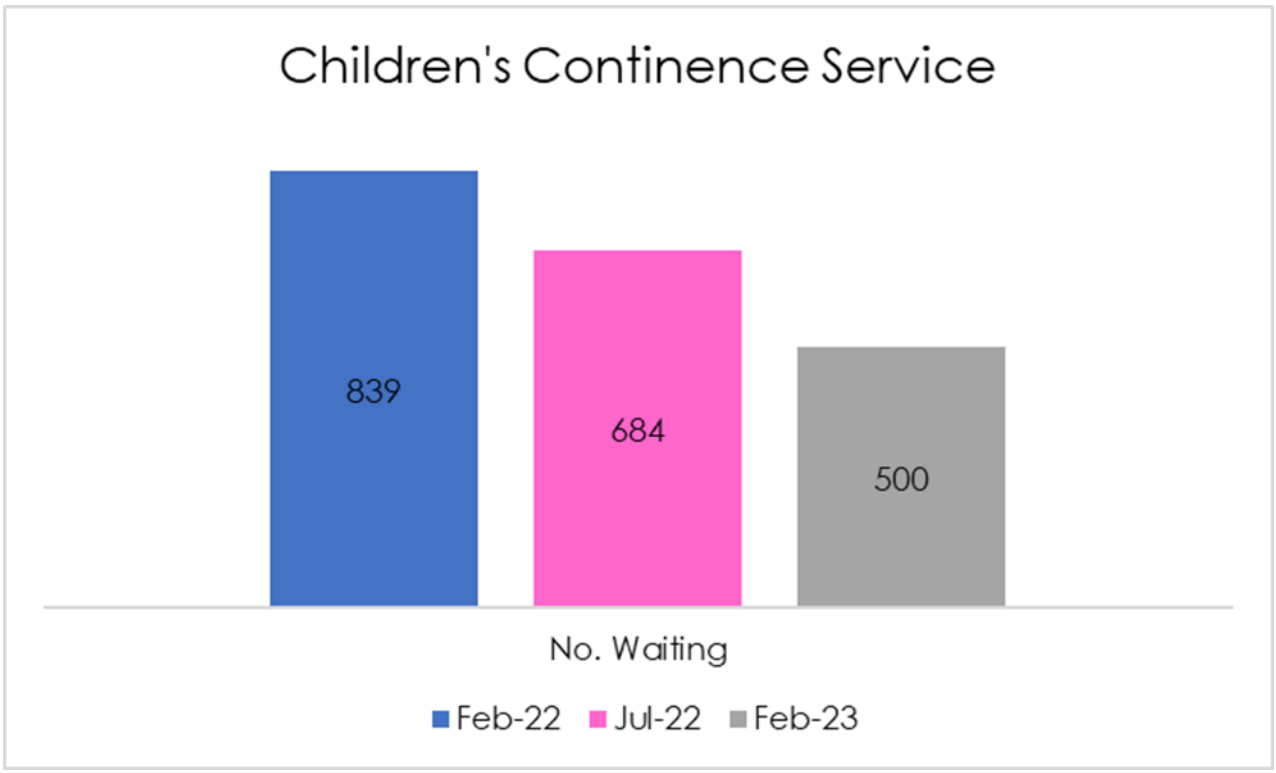
The Clinical Board has a robust review of all NRI's through initial fact-finding meetings, with subsequent progress meetings, followed by a closure and action planning meeting. The clinical board is in the process of establishing post closure meetings at regular intervals to ensure actions are completed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

Service level examples of impactful Quality, Safety and Experience **initiatives**

Metrics That Matter

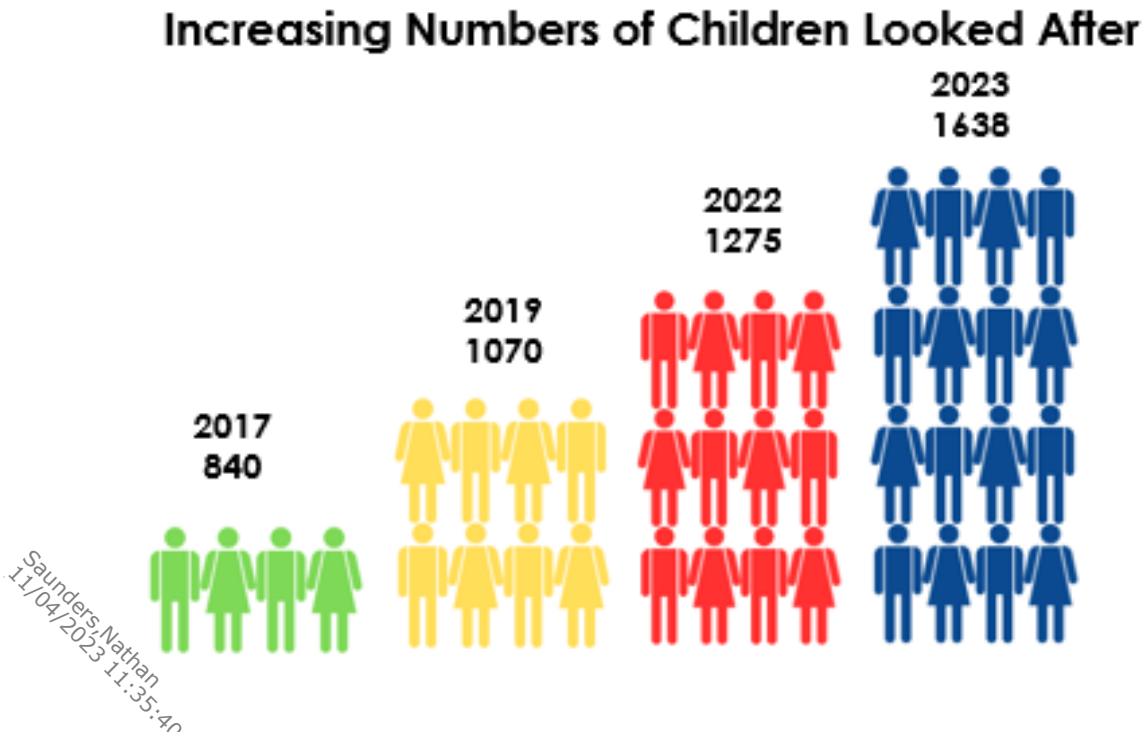
Many of our services, particularly those delivered within the community, do not traditionally fall under traditional performance management mechanisms, and as such these services can often seem lost or unheard. These services however whilst not always visible, are hugely impactful on our young people and shaping their lives for the future. As such as a Clinical Board we have developed a Metrics that Matter approach to these services that has allowed them to become more visible and gain significant investment over the past year. Some examples of such services, where the investment in our frontline teams is improving the reach and access to these vital services within our community.

Childrens Continence Service



Looked after Children Service

The Looked After Children Service provides Health assessments and holistic support to children in residential, foster or adoptive care. It is well recognised that children in care experience adverse health outcomes, so the physical health assessments are aimed at improving health outcomes and reducing health inequities as well as ensuring health and wellbeing needs are actioned and monitored. It is well recognised that Children have been disproportionately impacted by the Covid 19 pandemic, and the diagram below describes significant growth in demand for the service since 2019.



Demand continues to outstrip capacity for this service but several mitigating actions have been put in place such as the recruitment of 2.8 wte nursing posts, a change in model of care that enables the nursing team to see the children from the age of 5 rather than 10, and contribution to the assessment process from a team of

junior doctors. This creates assessment capacity to address the backlog of children waiting and reduce the current caseload the team are supporting despite the increase in demand.

Patient Story - Verbal Update

Child and Adolescent Mental Health Services (CAMHS)

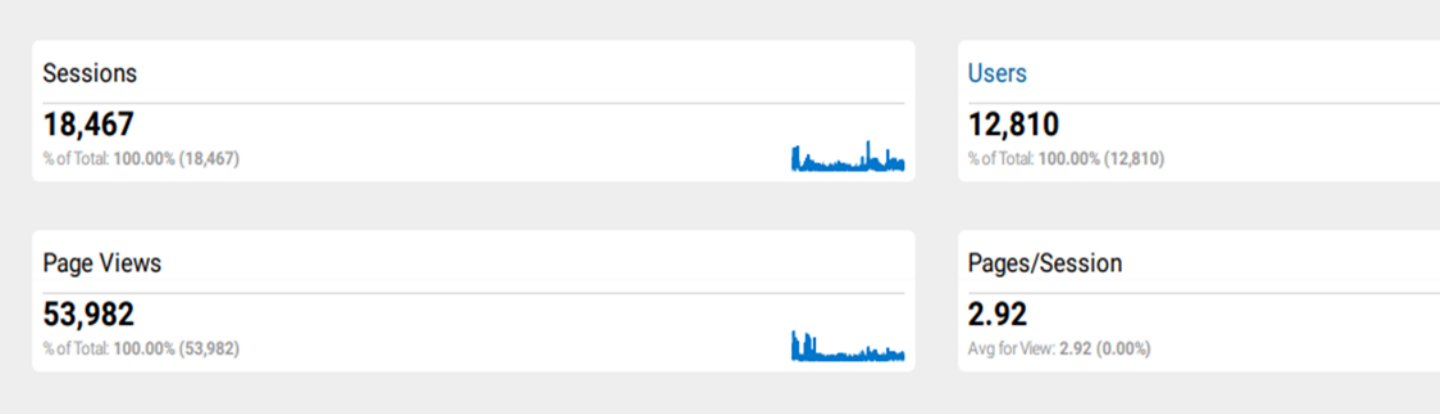
The impact of the Covid 19 pandemic, lockdown, and a return normality, has had a well-documented impact on the mental health of children and young people, with all services seeing huge increases in demand. Many of our services have developed, innovated and transformed in order to meet this demand, implementing digital solutions, expanding partnership working with education, local authorities and the third sector and implementing new models of care. The service recently relaunched and described its new and progressive offer in an event at Cardiff City Stadium that was attended by over 200 of our partners, service users, and staff.

Some of the new and innovative ways of reaching out and providing support to our children and young people, in ways in which are meaningful to them are described below.

CAV Young Peoples website

The website is an online platform to signpost Children, young people and their families to information, and guidance on how to access support when and if they need it and is described below

- Developed based on feedback from Children and Families
- Developed in conjunction with the Youth Board
- Ongoing development of content
- Working with Promo Cymru to develop a video around the Emotional Wellbeing & Mental Health offer for children & young people



Social Prescribing Project

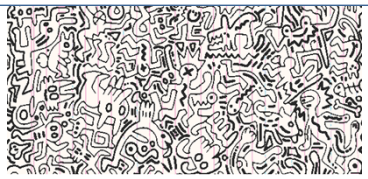
Social prescribing is pilot project until the end of March 2024, funded by NHS Health Charities.

The service will be offering young people aged 11 to 18 years old 12 weeks (roughly 8 sessions) with a Community Connector. This is for lower level emotional wellbeing challenges, with the aim of providing quick access to support when the young person first asks for help.

The service had a soft launch in January 2023, accepting referrals from the Single Point of Access and have started expanding their offer across the Emotional Wellbeing & Mental Health Care Group including the Assessment and Intervention teams as of February 2023.

The service will also be offering consultation to professionals within the Care Group to provide colleagues with information and advice so that they are able to incorporate social prescribing into their daily practice.

The service has completed an engagement report and finalised their wellbeing journal which will be used by children and young people. We have also worked with young people to select the logo for the service



Wellbeing Journal
Community Connections

Community Connections
Cysylltiadau Cymunedol

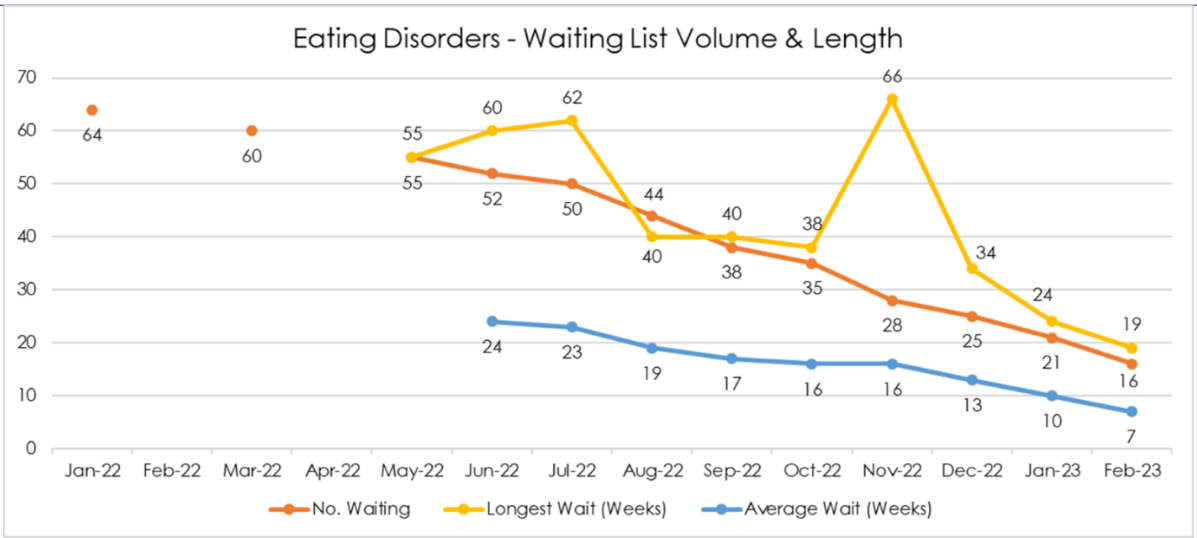
Our findings - what we learned

Eating disorders

Over the past year the team have extended the scope and reach of the team such that assessments for the team are completed in pairs as per the Maudsley model which is recognized as the gold standard model of care for this group of children in the UK. The team have also utilised triage calls to support young people which has prevented 49 young people requiring a formal Eating Disorder assessment and therefore being added to the Eating Disorder caseload since March 2022.

The service has now also set up a Multi-Family Group Therapy which is very well received.

The developments the team have made in this service are evident from a quality, safety and experience perspective as in addition to providing a holistic service to the patient, times to access the service and the numbers waiting have also significantly decreased as shown below.



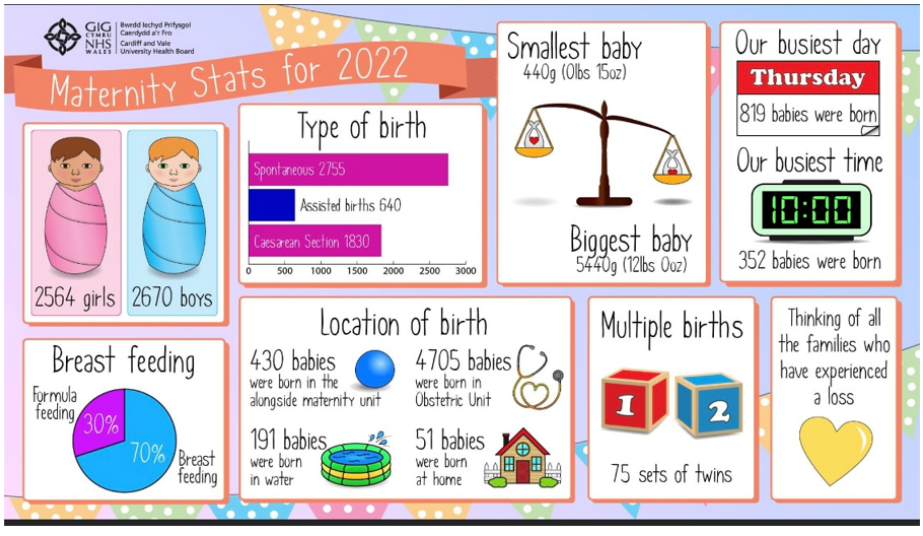
The service user feedback below is testament to the difference this service is making to patients and their families

"Additionally, I just wanted to say thank you for all the support you are giving to us. Whilst I'm extremely proud of our young person, I'm shocked at how quickly she's managed to eat more since we have been coming to you. Whilst obviously I'm still worried about her, I have a lot of hope that physically she's now going to be ok and in time we will get her there mentally. I also know how lucky we are as things could be far worse. We have a lot to be grateful for. But I wanted to thank you as you have been extremely invaluable to get our daughter where she is today. Thanks just isn't enough but thank you. We really do appreciate and value all your support."

"Rebecca & The Eating Disorder Team,
I wanted to write to say a huge thank you to you and your wonderful team. The support we have received whilst our young person was under CAMHS was amazing, you were all kind, considerate and helpful throughout. Without you, we would not be living the life we are today, we are able to do all the things we couldn't do whilst our young person was ill, holidays, meals out, work etc. Our young person is also living a life that is typical of a 17-year-old, she is a more confident, happier person - this is down to the help and support we received from you and your team. Nothing was too much trouble, along the way there were a few emergency phone calls which were always dealt with quickly and were so important to us. We are also extremely grateful to have been given the opportunity to attend the multi-family therapy group. This was life-changing and a huge turning point for all of us. We can never thank you enough!
We will never forget you,
Parents"

Obstetrics and Gynaecology

It has been another busy year for Obstetrics and Gynaecology !



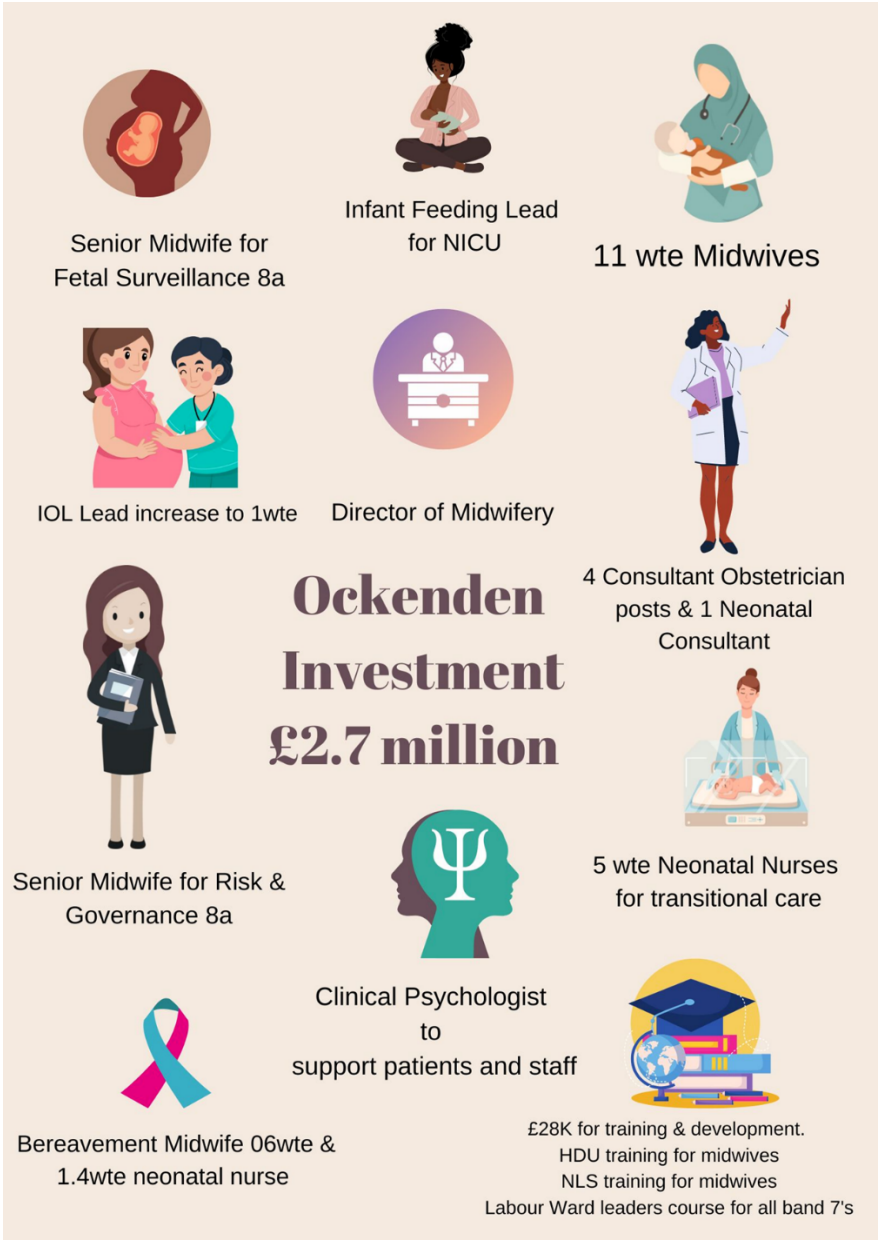
Ockenden

The recommendations of the Ockenden Review into maternity services in England were published at the end of March 2022. The review is based on tens of thousands of families' experiences and outcomes and is mature in that it recognises not just maternity services, but their symbiotic relationship with Perinatal Care. The Ockenden Review and its recommendations is very much in the public domain and attracted significant coverage from the media.

Cardiff and Vale Maternity Services were subject to an inspection by Health Inspectorate Wales (HIW) in November 2022.

The service undertook a robust gap analysis of our current service and the Ockenden report, and successfully completed a business case to secure funding such that the service becomes compliant with all of the Ockenden recommendations. It is anticipated that the Ockenden investment will also support the implementation of the HIW recommendations when they are received.

A pictorial depiction of the investment is seen below



The benefits of investment in the posts and training shown above outlined in this case include:

- Improvement in caesarean section rates towards the UK standard
- Reductions in length of stay, to improve patient experience and quality
- Ambitions to reduce all still births, aligned to NHS England targets

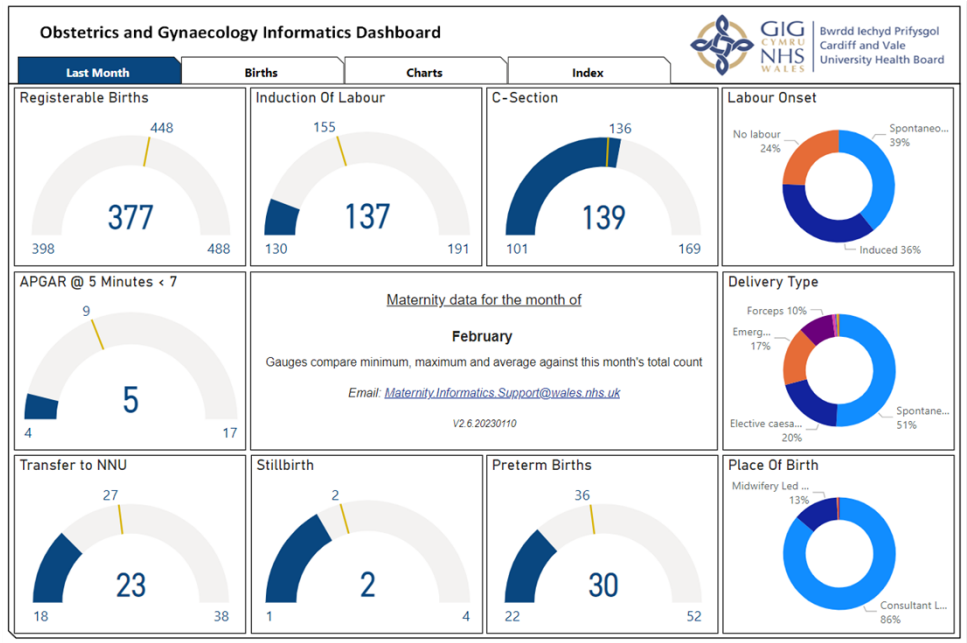
- A reduction in unplanned admissions to neonatal critical care
- A reduction in clinical negligence claims

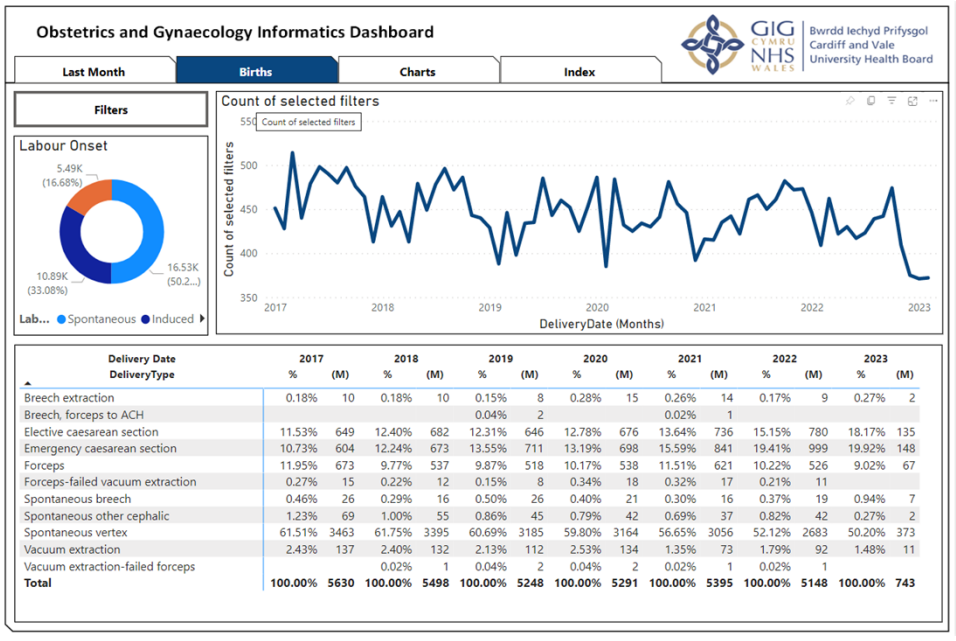
Maternity Dashboard

The Midwifery Team have embraced technology, and have designed a dashboard that updates in real time to provide the data from which to monitor the safety of the service. The dashboard is being used as an exemplar across Wales.

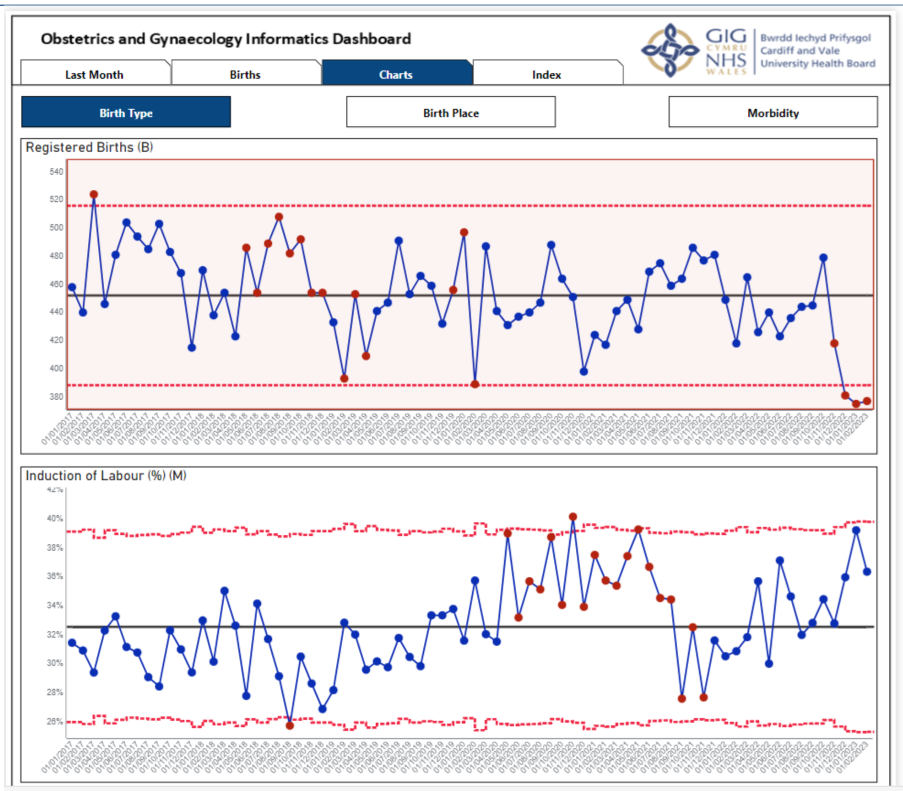
The dashboard enables monitoring of maternity red flags, and benchmarking with centres across the UK, and will provide the data to evidence the quality and safety benefits that will be seen as a consequence of investment in the Ockenden recommendations, such as reduction in transfer rates to Intensive Care, full review of all unexpected admissions to Neonatal Intensive Care, learning from NRIs to be implemented and measured within six months etc, in addition to being the platform from which to drive continuous improvements in the service.

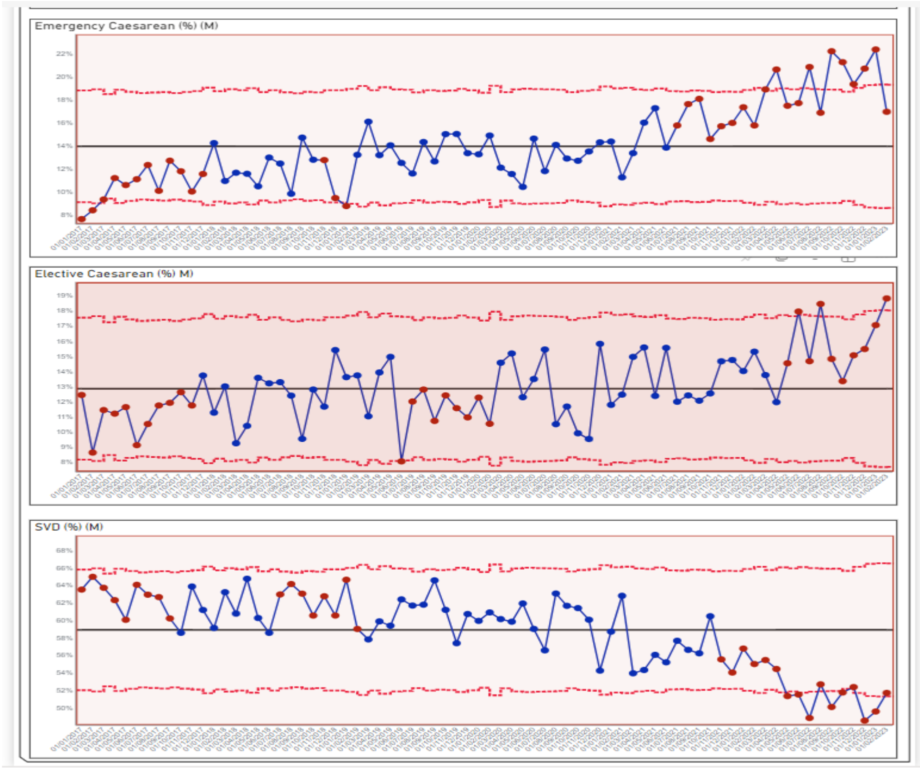
Some examples of the metrics measured within the dashboard are seen below.





Delivery Date / DeliveryType	2017 %	2017 (M)	2018 %	2018 (M)	2019 %	2019 (M)	2020 %	2020 (M)	2021 %	2021 (M)	2022 %	2022 (M)	2023 %	2023 (M)
Breech extraction	0.18%	10	0.18%	10	0.15%	8	0.28%	15	0.26%	14	0.17%	9	0.27%	2
Breech, forceps to ACH					0.04%	2			0.02%	1				
Elective caesarean section	11.53%	649	12.40%	682	12.31%	646	12.78%	676	13.64%	736	15.15%	780	18.17%	135
Emergency caesarean section	10.73%	604	12.24%	673	13.55%	711	13.19%	698	15.59%	841	19.41%	999	19.92%	148
Forceps	11.95%	673	9.77%	537	9.87%	518	10.17%	538	11.51%	621	10.22%	526	9.02%	67
Forceps-failed vacuum extraction	0.27%	15	0.22%	12	0.15%	8	0.34%	18	0.32%	17	0.21%	11		
Spontaneous breech	0.46%	26	0.29%	16	0.50%	26	0.40%	21	0.30%	16	0.37%	19	0.94%	7
Spontaneous other cephalic	1.23%	69	1.00%	55	0.86%	45	0.79%	42	0.69%	37	0.82%	42	0.27%	2
Spontaneous vertex	61.51%	3463	61.75%	3395	60.69%	3185	59.80%	3164	56.65%	3056	52.12%	2683	50.20%	373
Vacuum extraction	2.43%	137	2.40%	132	2.13%	112	2.53%	134	1.35%	73	1.79%	92	1.48%	11
Vacuum extraction-failed forceps			0.02%	1	0.04%	2	0.04%	2	0.02%	1	0.02%	1		
Total	**100.00%**	**5630**	**100.00%**	**5498**	**100.00%**	**5248**	**100.00%**	**5291**	**100.00%**	**5395**	**100.00%**	**5148**	**100.00%**	**743**





Obesity

Women with BMI 35-39.9 in pregnancy with no further co morbidities follow our healthy pregnancy pathway with an aim of birth in the Midwife led unit. The Maternal obesity dietician based is based healthy pregnancy clinic and provides support for all women with BMI over 40, this includes around 3 1:1 session in the antenatal period and follow up postnatally.

The foodwise in pregnancy course continues to run and is now available via an app as part of a Bevan exemplar, this was also presented as a poster at the All-Wales dietetic conference in September 2022. The service was also nominated for the Allied Health awards which our dietetic lead for maternal health won in November 2022.

The service also plays an active role in the Obesity strategy group chaired by Public Health Wales. The groups remit is to review community pathways to support obesity reduction in the postnatal period, this is part of the healthy weight, healthy Wales workstream.

The Women's Well Being Clinic

Female Genital Mutilation carries with it significant health consequences, including both physical and psychological health impact. Women and young girls are particularly affected during sexual intercourse and childbirth with increasing morbidity lasting several years post mutilation. Therefore, establishing this as a public health issue within our communities. The practice is illegal in the UK under the Female Genital Mutilation Act (2003) and Serious Crime Act (2015) which extends to any acts performed on UK residents. A statutory duty of 'mandatory reporting' applies to those under 18, and with a majority of mutilations occurring in childhood, this represents a major safeguarding concern.

The Women's Wellbeing Clinic is a fast-track midwife led clinic supporting women who have experienced Female Genital Mutilation (FGM) pregnant or non- pregnant. The referral to this service is either by electronic referral via UHW (University Hospital of Wales) or via partner agencies or by self- referral with identified appointments. Our specialist midwife for women seeking sanctuary and survivors of harmful practices offers a consultation to women who have consented and wish to be seen in the clinic, where they provide a holistic health care assessment. Types of FGM are discussed and an assessment made of any physical, psychological issues relating to FGM.

Gynaecology

One Stop Hysteroscopy

The one stop hysteroscopy clinics were introduced in October 2022, and are intended to reduce the number of appointments and time taken for diagnostics and treatment. Since the clinic commenced in October 2022 600 women have attended, 100 of who had their hysteroscopy in clinic, the remainder were either discharged on the day or contemporaneously referred on to radiology significantly shortening their overall pathway.

•**Patient benefits:**
•One stop - Rapid service thus reduced anxiety and waiting time for patients
•Speed and comfort of the procedure
•Avoidance of General Anaesthesia and hospital stay
•Less invasive technique – faster patient recovery and improves safety in comparison to conventional hysteroscopic resection and general anaesthesia.

•Reduced risk of missed or delay diagnosis (tissue fragments are available for histological examination).
•Faster recovery – avoidance of post-operative pain
•
•**Service benefits:**
•Efficient use of outpatient operating time
•Additional theatre capacity and a reduction in waiting times for surgery – 3 v's 5 cases
•Reduced inpatient and day-case costs
•Mean treatment time and patient turnaround time is shorter – promoting increased productivity
•No requirement for staff changes

The one stop hysteroscopy clinic is now being used as a Bevan exemplar.

Childrens Hospital For Wales

Paediatric Observation Chart

In response to learning from a Coroners Case, a Paediatric Observation Chart has been developed. Developing the chart was a significant piece multi-disciplinary working across several clinical boards. The chart is used for acute admissions of any child from birth to 13 plus. The chart is designed to follow the child throughout their admission from the Emergency department, right through to discharge. The chart covers Pain Scores, Neurological Assessments and the Sepsis Pathway as well as standard observations. The use of a single document enables staff to better identify a deteriorating child as they move through all of the services supporting their care and is a significant development supporting patient safety within the Childrens Hospital.

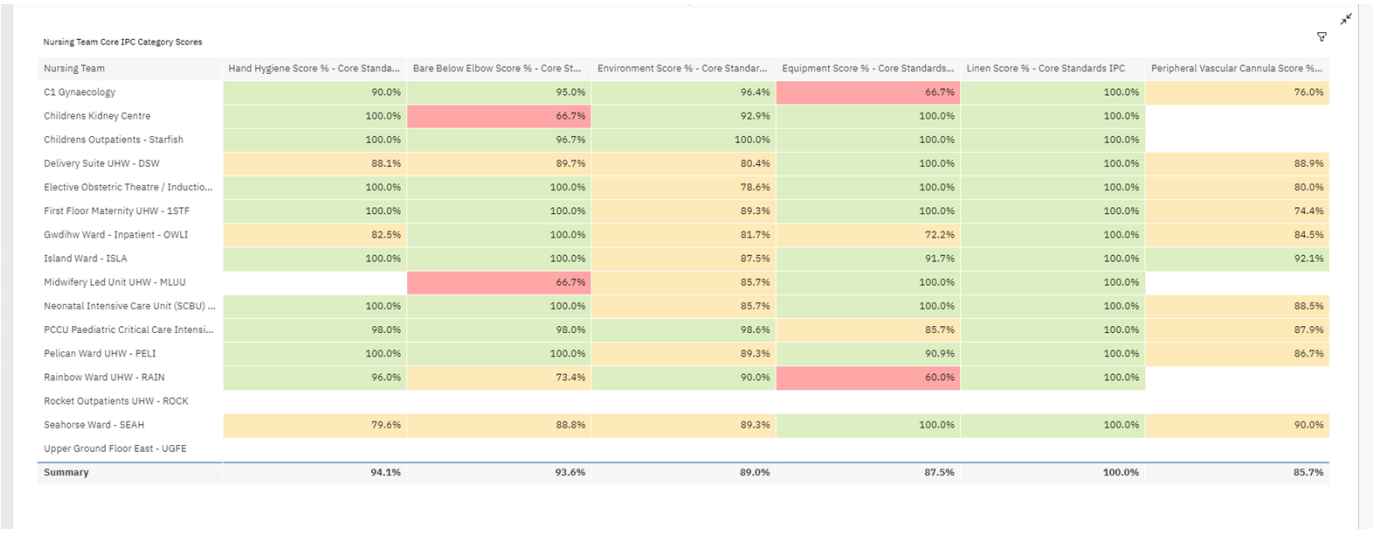
Research and Development

Research and development are at the heart of driving the quality agenda through evidence-based care within the clinical board and we have active and well regarded research programmes throughout the clinical board. The latest Obstetric and Gynaecology research newsletter details all of the current studies, trials and publications the team have delivered, and is attached as appendix 1.

Quality Audits and Performance.

In 2022 Tendable was launched across the health board and has been welcomed by the Clinical Board as a platform to measure the quality and experience of our clinical areas and to demonstrate actions taken.

The dashboard below is an overview of the core standards within the clinical areas currently as we increase the use of the app since launch. As can be seen it provides a quick snapshot of hotspots to focus on across the clinical board and then also allows detailed insight into specific clinical areas and progress with actions over time.



Nursing Team Core IPC Category Scores

Nursing Team	Hand Hygiene Score % - Core Standa...	Bare Below Elbow Score % - Core St...	Environment Score % - Core Standar...	Equipment Score % - Core Standards...	Linen Score % - Core Standards IPC	Peripheral Vascular Cannula Score %...
C1 Gynaecology	90.0%	95.0%	96.4%	66.7%	100.0%	76.0%
Childrens Kidney Centre	100.0%	66.7%	92.9%	100.0%	100.0%	
Childrens Outpatients - Starfish	100.0%	96.7%	100.0%	100.0%	100.0%	
Delivery Suite UHW - DSW	88.1%	89.7%	80.4%	100.0%	100.0%	88.9%
Elective Obstetric Theatre / Inductio...	100.0%	100.0%	78.6%	100.0%	100.0%	80.0%
First Floor Maternity UHW - 1STF	100.0%	100.0%	89.3%	100.0%	100.0%	74.4%
Gwdihw Ward - Inpatient - OWLI	82.5%	100.0%	81.7%	72.2%	100.0%	84.5%
Island Ward - ISLA	100.0%	100.0%	87.5%	91.7%	100.0%	92.1%
Midwifery Led Unit UHW - MLUU		66.7%	85.7%	100.0%	100.0%	
Neonatal Intensive Care Unit (SCBU) ...	100.0%	100.0%	85.7%	100.0%	100.0%	88.5%
PCCU Paediatric Critical Care Intensi...	98.0%	98.0%	98.6%	85.7%	100.0%	87.9%
Pelican Ward UHW - PELI	100.0%	100.0%	89.3%	90.9%	100.0%	86.7%
Rainbow Ward UHW - RAIN	96.0%	73.4%	90.0%	60.0%	100.0%	
Rocket Outpatients UHW - ROCK						
Seahorse Ward - SEAH	79.6%	88.8%	89.3%	100.0%	100.0%	90.0%
Upper Ground Floor East - UGFE						
Summary	**94.1%**	**93.6%**	**89.0%**	**87.5%**	**100.0%**	**85.7%**

Infection Prevention and Control -

Safeguarding

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

Workforce

The Clinical Board remain committed to delivering the values and behaviours of the UHB to all our staff, and are committed to developing a culture within which great teamwork creates great care. B Inclusivity is central to this and therefore implemented inclusion ambassadors across our Directorates.

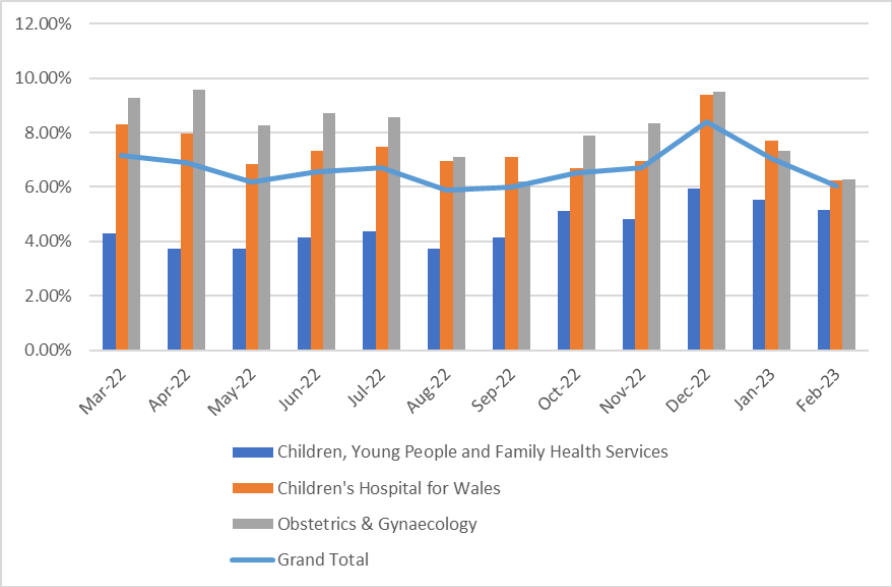
Protected Characteristics Inclusion Ambassadors

The role of the Inclusion Ambassadors is to promote and raise awareness of the protected characteristics as set out in UK law through the Equality Act 2010. The aim of the Inclusion Ambassadors is

- To effectively communicate information to support inclusion and diversity in the workplace, seeking to ensure C&V UHB is a safer, kinder and more inclusive place to receive care and also to work.
- To engage with the wider protected characteristic group for which you are an Inclusion Ambassador, the UHB Equality Team and 3rd sector Networks in order to bring information back into the Clinical Board for sharing and learning.
- To communicate key events linked to the protected characteristic and support these where possible in order to reduce inequalities, promote inclusion and respect diversity.

The team meets Bi-monthly and has a team's channel to communicate key information across the Clinical Board.

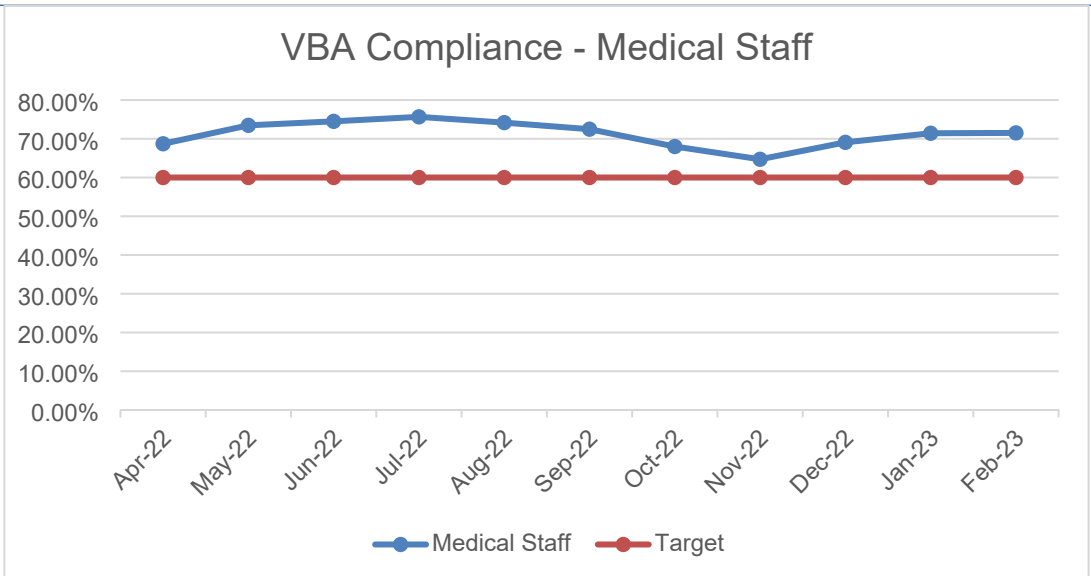
The Clinical Board has seen an overall drop in sickness from its peak in December, but the overall reduction in sickness masks some real challenges in hotspot areas such as Paediatric Intensive Care (PICU), Neonatal Intensive Care, Owl Ward, Community care Nursing and Maternity. Our sickness data is displayed below;

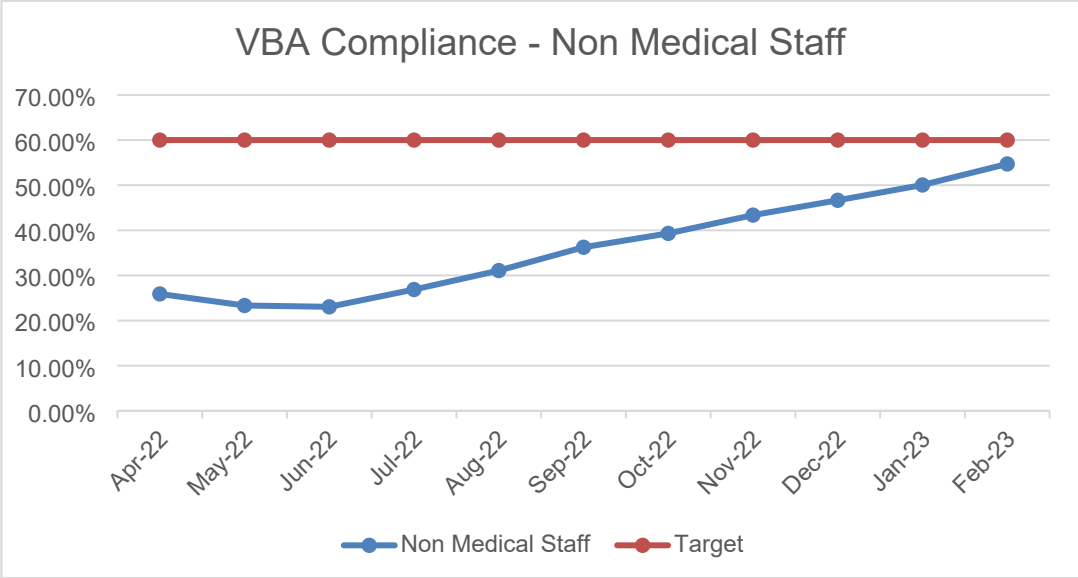


The Clinical Board recognises that recruitment alone will not be sufficient to support our workforce as services develop, and alongside an active recruitment strategy have made significant efforts to support the retention and well being of our staff as outlined below

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

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





Risks for escalation

There are a number of enduring risks within the clinical board, including:

Workforce

PICU, NICU and Maternity continue to endure significant workforce deficits due to high maternity leave, sickness and attrition. This is exacerbated by the fact at present there is only one outtake per year of newly qualified midwives and paediatrics which significantly compromises timely recruitment throughout the year. The primary cause described by the staff for leaving the Clinical Board is moving out of their clinical area to support risk across the system in times of peak demand. The vicious circle this creates is described below

The Clinical Board have worked hard to mitigate these risks over the past year and implemented many actions designed to support workforce wellbeing, retention and recruitment

Despite these actions significant workforce fragility endures, however there are several strategic opportunities that the Clinical Board are committed to progressing over the next year to mitigate risk further, the themes of which are seen below.

Maternity Lifts

Risk of serious harm to women and babies from potential delays in emergency treatment due to lifts failing on demand.

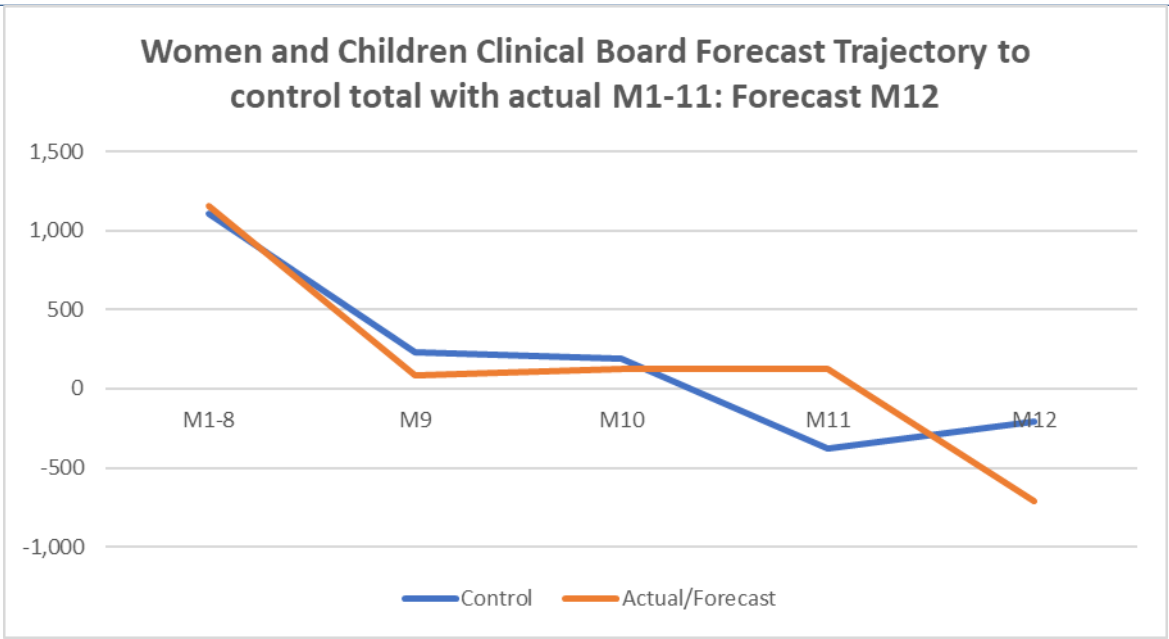
Lifts are part of the UHB Lift Refurbishment Programme. Regular review and assessments undertaken and any issues escalated directly to Estates Team for support/resolution. Interim plans implemented where required to manage/mitigate risks of any lift failure.

Resources

Children and Women's Clinical Board Financial Position as at Month 10

Month 10 Cumulative Variance (£1.527 M))

1. Month 11 Cumulative Total Variance **£1.527m**
   - Operational variance £1.473m
   - Core CIP variance £0.000m
   - COVID Variance £0.054m (consequentials)



Headline Year to Date Issues

- Medical Staffing - £1.612m [CHFW & O&G], premium cover for significant rota gaps, LTFT/ML/SL and other vacancies
- WHSSC LTA Performance - £0.290m overperformance to date. Core contracts underperforming by £0.490m offset by overperformance against Welsh PICU & NICU contracts
- Continuing Care - £1.043m incl. exceptional patient
- Net Vacancies, primarily nursing & midwifery – (£2.070m)
- Underlying Deficit, incl. CIP Delivery - £1.231m

ASSURANCE is provided by:

- The governance processes embedded in the core business of the Children & Women's Clinical Board and its Directorates
- Evidence of regular performance management reporting
- Monthly review of Clinical Board Risk Register by Clinical Board Team
- Independent review of the business of the Clinical Board by internal and external bodies such as Internal audit, CHC, HIW, Welsh Risk Pool, Welsh Government
- Temperature gauge activities such as Cancer peer review, local audits (IPC, environmental), Clinical Board walkabouts, benchmarking, unannounced inspections, acuity audits, healthcare standards, patient experience questionnaires and kiosks
- Nursing dashboard overview
- The Clinical Board recognises the key areas of improvement and actions required to further improve quality, safety, and patient experience and is committed to delivering these

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

The Significant investment following recommendations Ockendon Review March 2022 to enhance Maternity services
The Assurance provide by Children & Women Clinical Board to improve and enhance services across a breadth of complex specialties.

Recommendation:

The Committee is requested to:

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

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

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

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

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

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

Saunders,Nathan
11/04/2023 11:35:40

DECEMBER 2022

Obstetric and Gynaecology Research Newsletter

Cardiff and Vale University Health Board

A Word from the R&D Lead

Dear all,

I'm excited to be sharing with you the last R&D newsletter of 2022. I know all of us are looking forward to celebrating the festive season out of lockdown. It has been a busy and difficult year culminating with both an HIW inspection and a nursing strike. I was proud that our R&D achievements were highlighted as an area of excellence in the recent HIW inspection, and this has been no doubt due to the fantastic engagement we have had from all staff despite your very busy clinical commitments. You are making such a difference to ensuring women are given the best evidence -based care. Our team has continued to expand with 2 new very welcome additions to the team, a trials manager, Angela Strang and a trials data administrator, Jodie Foran. I'm pleased to share with you that we have been busy with publications this year and were delighted to be able to showcase Cardiff work in our manuscript ' Immune -metabolic adaptations in pregnancy: A potential stepping - stone to sepsis' accepted for publication in the Lancet -eBiomedicine.

Thank you to each and every one of you for your continued enthusiasm and passion for furthering research. Wishing you all a very merry Christmas and a happy new year form all at the research team.

Regards,
Su Zaher
R&D Lead

Follow Us

@OGResearchTeam1
@zaher_summia
@maryannebray31
@drsadiejones
@ResearchCath
@AngelaStrang8

Inside this issue:

Spotlight on GBS3

This long anticipated trial has now progressed to the Cardiff site being randomised to the Routine testing strategy arm (Antenatal enriched culture testing at 35-37 weeks gestation). We will have the green light to go ahead soon! There are currently 80 hospitals across England, Scotland and Wales involved in the study and everyone in Cardiff is excited to be one of the new sites!

The current UK strategy 'risk factor screening' is believed to be imperfect. Some babies are missed and develop group B Strep and some women with risk factors do not carry group B Strep. One possible solution is to test all women during pregnancy to determine if they carry group b Strep.

This GBS3 trial is looking at whether testing pregnant women for Group B Streptococcus reduces the risk of infection in newborn babies compared to the current strategy in place in the UK. The current strategy in the UK is to offer antibiotics during labour to women who are considered at raised risk of their baby developing a group B Strep infection.

There are two different tests, which we are comparing against the current strategy.

- Lab Based Test at 3-5 weeks before anticipated delivery date (Enriched Culture Medium Testing)
- Bedside Test at start of labour (Intrapartum Rapid Testing)

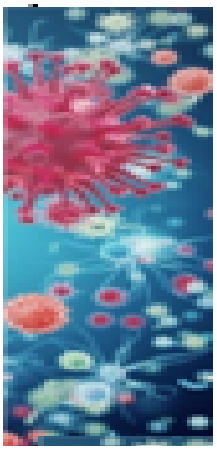
The arm we have been randomised in to is the Lab based Test.
This test involves a swab to be taken from patients that are approximately 35-37 weeks pregnant. This can be taken by a health care professional or the patient can do it for themselves. The swab will be sent to the laboratory for testing and the patient will be informed of the results.

If the result is positive for group B Strep, the patient will be offered routine intra-partum antibiotics as per current protocol.

Obstetric Updates

The Big Baby Study has been running successfully for a number of years here in Cardiff. We have surpassed the recruitment target. The study has now closed as of October 2022. We have enjoyed being part of the study and look forward to the results. Thankyou for all your hard work in making this study a success!

mSeP Update



Our home grown study mSeP, which was looking closely at markers in the blood to find a new blood test for sepsis, has finished its recruitment phase for all cohorts! Thankyou so much for all your hard work and determination in recruiting patients, obtaining samples and spreading awareness of the study!

Stay tuned for the analysis and outcomes of the study!

Gynaecology Updates

Follow the team

@Drsadiejones

@ResearchCath

New Gynaeoncology Research Fellow !

We have a new fellow starting in the new year called Josh McMullan.

He is an ST6 trainee from Belfast who will join our team for one year to help with the prehabilitation work. We will embarrass him with a photo in the next newsletter!

All Wales Journal Club Meetings 2023

Keep and eye on your emails for the upcoming dates in 2023!

Each meeting, we discuss recently published research articles related to our everyday practice.

All Wales Ovarian Cancer Prehabilitation Programme

34 advanced ovarian cancer patients from the Southeast Wales gynaecology oncology group have been recruited into this all Wales prehabilitation programme. The programme has now closed but has been well received by patients and now plans are in place for incorporation of prehabilitation as standard of care. Collaboration with several other regions evaluating the impact of prehabilitation is underway and our new gynaecology oncology research fellow has been appointed to further assess patient factors affecting uptake.

PICCOS Study

£2.6million has been awarded through the NIHR EME funding scheme for the multicentre RCT - PICCOS. This trial will investigate the efficacy of delivering chemotherapy as an aerosol at the time of laparoscopy to patients with peritoneal metastases from ovarian cancer. Ms Sadie Jones is the Chief Investigator along with Mr Jared Torkington and things are progressing well for the first patient recruitment in May 2023. Lots of local research opportunities will arise from this trial so do get in contact with the team if you are interested.

Ovarian Biomarkers Study

The Ovarian Biomarkers study has opened in Cardiff and so far we have recruited 6 patients! There will be a hiatus to recruitment over the Christmas period. Recruitment will restart on the 5th of January.

REINFORCE

REINFORCE
Real-World Evaluation of Robot-Assisted Surgical Services

The gynaecology oncology team have now performed their first 10 cases of robotic surgery and it's going extremely well! Truly exciting time for our patients and our service with this state-of-the-art technology that will enable us to push surgical boundaries and improve patient experience. We are now recruiting patients to the REINFORCE study to help us better understand the impact implementation of robotics has on healthcare UK wide. We have recruited 17 patients to date and recruited the first patient for the study!

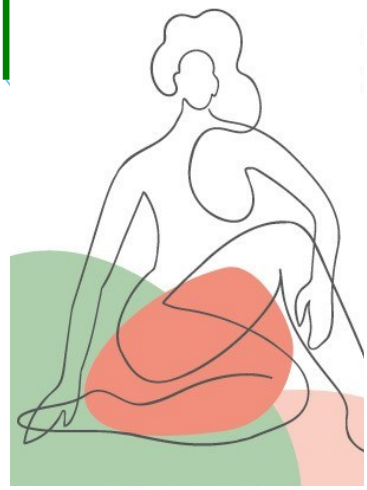
TECHNIQUE

We have launched the TECHNIQUE study - a global evaluation of service designed to help better understand the impact different surgical techniques used to perform inguinofemoral lymph node dissection in patients with vulval cancer. This is a trainee led project (Gemma Owen's and Hassan Zeinah from Cardiff) supported by ARGO. 7 centres have currently signed up for recruitment.

ROCkeTS and ROCkeTS GEN

The ROCkeTS and ROCkeTS Gen study will be closing in March 2023, so we now have a last big push for recruitment in the last stage of the study!

Spotlight on CF113



CF113-302

CF113 is a multicentre, phase III, double-blind, randomised clinical trial to assess the efficacy and safety of LPRI-CF113 in the treatment of endometriosis versus placebo after 3 medication cycles followed by 3 open-label medication cycles.

This is a multi-centre clinical trial in postmenarcheal and premenopausal female subjects ≥ 15 and ≤ 45 years of age with a laparoscopically confirmed diagnosis of endometriosis and with an EAPP score ≥ 3 during the last 3 months before trial entry.

Endometriosis is a chronic, oestrogen-dependent, inflammatory disease, it affects 5 to 10% of women of reproductive age and is associated with pelvic pain and infertility

Most frequent endometriosis-associated pain symptoms include dysmenorrhoea, non-menstrual pelvic pain (NMPP), dysuria and dyspareunia. Theses pain symptoms can have a substantial effect on the patient's quality of life.

LPRI-CF113 contains drospirenone (DRSP) as active ingredient which is a fourth-generation progestogen, derived from spironolactone. has been on the market as a combined oral contraceptive (COC) in the US and Europe for nearly 10 years

The clinical trial consists of a screening period (up to 100 days), a treatment period consisting of 3 placebo-controlled, double-blind medication cycles and an open-label extension period during which all subjects will receive active treatment with LPRI-CF113 for 3 cycles. Subjects are allowed to take nonsteroidal anti-inflammatory drugs (NSAIDs) or paracetamol as rescue medication during the trial as needed.

Cardiff, at the beginning of December, became the first of 3 sites in the UK to open, and the first UK site to have its first screening recruitment! Recruitment will close at the end of December or earlier in study targets are met early!

For more information please visit the study website:

endometriosisclinicaltrialcf113-302.com

Or contact :
catherine.smith5@wales.nhs.uk

Key Facts

Total screening target
236 subjects

Total randomisation target

212

Randomisation Ratio

3 : 1

Cardiff Screening Target

10

No screened to date in Cardiff

2

Open sites

Hungary, Germany, Czech Republic, Slovakia, Poland and the 3 sites in the UK!

Primary Investigator

Mr Anthony Griffiths

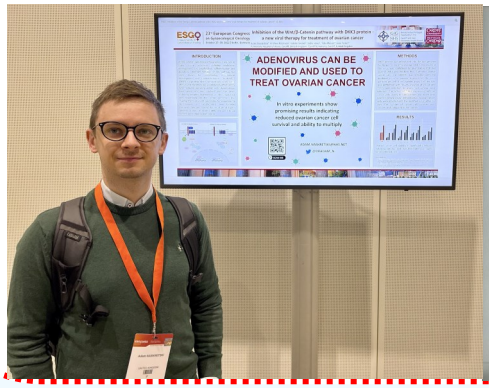
Sub PI

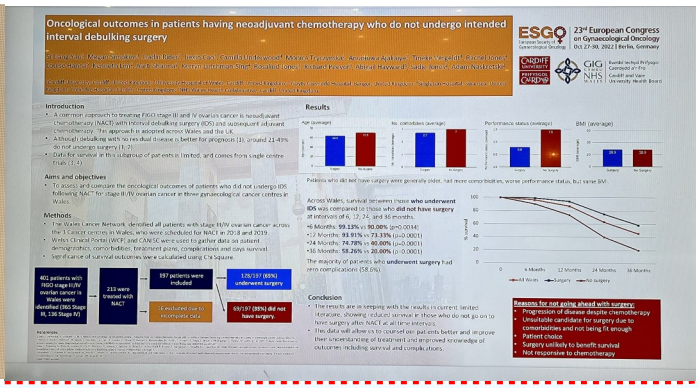
Ms Angharad Jones

ESGO

This year two posters were presented at the European Society of Gynaecological Oncology in Berlin, in October. Dr Adam Naskretski presented some of his initial work on using viruses to treat ovarian cancer while Dr Megan Simpkins and Dr Siliang Yao, now junior doctors but in their final year of medical school, they spent their Student Selected Component working with the gynaecology oncology team. In their project, they analysed and compared outcomes of ovarian cancer patients undertaking debulking surgery after neoadjuvant chemotherapy with those, who didn't have the surgery.

We also presented results of the All Wales Ovarian Cancer Audit at the All Wales Annual Gynaecology Network Meeting in Wrexham. Presentation was well received and we are hoping to publish the full report in the new year.





World Sepsis Day

World Sepsis day was on 13th of September. Research midwives Claire Bertorelli and Emma Pugh had abstracts accepted and presented at the Wales and South West Maternity and Midwifery festival 2022. Claires poster on mSeP was flying the flag for World Sepsis Day.

Sepsis in the Digital Age was a Project Sepsis live webinar covering topics from mathematical modelling to VR simulation tools to learn more about developmnents in technology that could revolutionise the diagnosis and treatment of sepsis! Don't worry if you missed it, this years webinar is available to view on Youtube. Use the link or QR code below!

Sepsis In the Digital Age

https://youtu.be/WNCEJLIU14I

Hello, I'm Angela and I've recently joined the R&D team as Clinical Research Trials Manager.

My background is in science research, after gaining a MSc in Virology, I spent the first part of my career primarily working on a variety of virology research projects investigating the interplay between viruses and the hosts innate immune responses as well as working on better diagnostics. I have worked across academia, healthcare industry and the NHS giving me a wealth of experience to deliver on a range of projects.

Prior to starting my current role, I was working as trial manager for Project Sepsis at Cardiff University. Working on projects covering three clinical platforms; neonates, paediatrics and maternal sepsis. My current research interest is around maternal health and I am very excited to be joining the team here and looking forward to working on expanding my knowledge on women's health issues and further promoting and developing research in this under represented area. If you want to find out more about what a trial manager does or research in general come and say Hi!

ECRU

(Entonox Carbon Reduction Units)

Did you know that nitrous oxide in Entonox is a greenhouse gas?

In Cardiff and Vale, our Entonox use is equivalent to emitting 4495 tonnes of CO_2 every year. This equates to driving 930 times around the world in a petrol car!

In order to improve our carbon footprint and make Entonox use more climate friendly we have introduced Entonox Carbon Reduction Units. Developed in Sweden, these collect exhaled Entonox and 'crack' it into nitrogen and oxygen – normal components of air.

We are the first maternity unit in Wales to use this technology and have a 12 month period in order to evaluate their use.

Patients and staff have demonstrated great enthusiasm and commitment towards reducing environmental impacts and embracing new methods of care. We are really proud of the hard work the team has put in to get us to this point, challenging norms that have been around for decades and allowing us to bolster our commitment to reducing our environmental impact. Further project work is planned to evaluate their impact on air quality in delivery rooms and we hope that this is just the start for Sustainable Maternity Care.

ECRU units are currently in use on the MLU and Delivery Suite and can be used by any woman using Entonox. For further information please speak to Sarah James (MLU), Steph (ECRU champion for delivery suite), Emma Pugh and Maryanne Bray (Research midwives) or George Pitchers and Charlotte Oliver (Anaesthetists).

Awards and Conferences

Publications

Have a read of some recently published work from mSep and Dilapan studies.

Simran Sharma, Patricia R.S. Rodrigues, Summia Zaher, Luke C. Davies, Peter Ghazal **Immune-metabolic adaptations in pregnancy: A potentialstepping-stone to sepsis.** eBioMedicine, Volume 86, 2022. (https://www.sciencedirect.com/science/article/pii/S2352396422005199)

Sharma S, Zaher S, Rodrigues PRS, et al. **mSep: investigating physiological and immune-metabolic biomarkers in septic and healthy pregnant women to predict feto-maternal immune health – a prospective observational cohort study protocol**. BMJ Open 2022;12:e066382. doi:10.1136/ bmjopen-2022-066382

Kate F. Walker, Summia Zaher, Rafael Torrejon Torres, Sita J. Saunders, Rhodri Saunders, Janesh K. Gupta, **Synthetic osmotic dilators (Dilapan-S) or dinoprostone vaginal inserts (Propess) for inpatient induction of labour: A UK cost-consequence mod-**

International Confederation of Midwives

We are proud to announce that three members of the team, M.Bray, C.Bertorelli and S.Zaher, have had abstracts accepted for the upcoming 2023 International Confederation of Midwives Congress. The team will be presenting their work on induction of labour pathway, mSeP (maternal sepsis study) and informing informed consent.

International Confederation of Midwives

Strengthening Midwifery Globally

Hi I'm Jodie Foran!
Previously I was the stop smoking maternity care assistant for UHW. I was running the in house stop smoking service for in and out patients, I worked closely with public health wales and help me quit and provided smoking cessation and support to pregnant patients and their families.

Currently I am on a secondment to the Obstetric and Gynaecology Research Team as a trial administrator. My role is to support the nurses and midwives with collecting and reporting of information needed for their projects and studies.
I will be helping identify patients that are eligible for studies across obstetrics and gynaecology. As well as administratively supporting the whole team.
Jodie.Foran@wales.nhs.uk

2023 Conferences

RCM Wales St Davids Day Event on 1st March at the Principality Stadium Cardiff.

RCM Education and Research Conference 2023 on 28th—29th March at the Leonardo Hotel, Birmingham.

BGCS Annual Scientific Meeting on 28th—30th June at the P&J Stadium, Aberdeen

ESGO , on 28th September to 1st October in Istanbul.

Current Study Recruitment Numbers

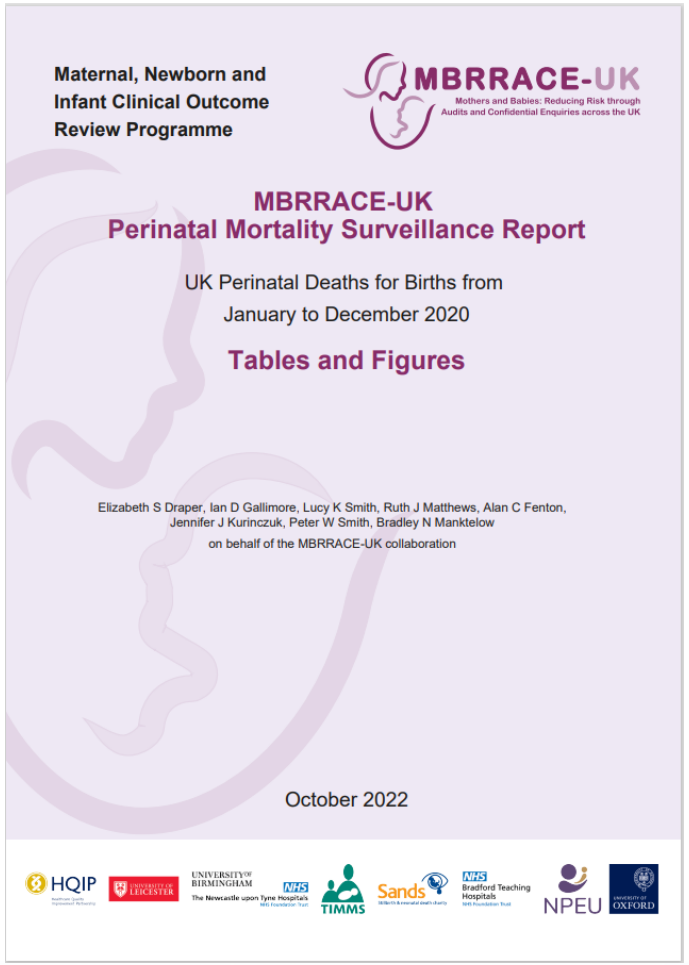
Obstetric Studies

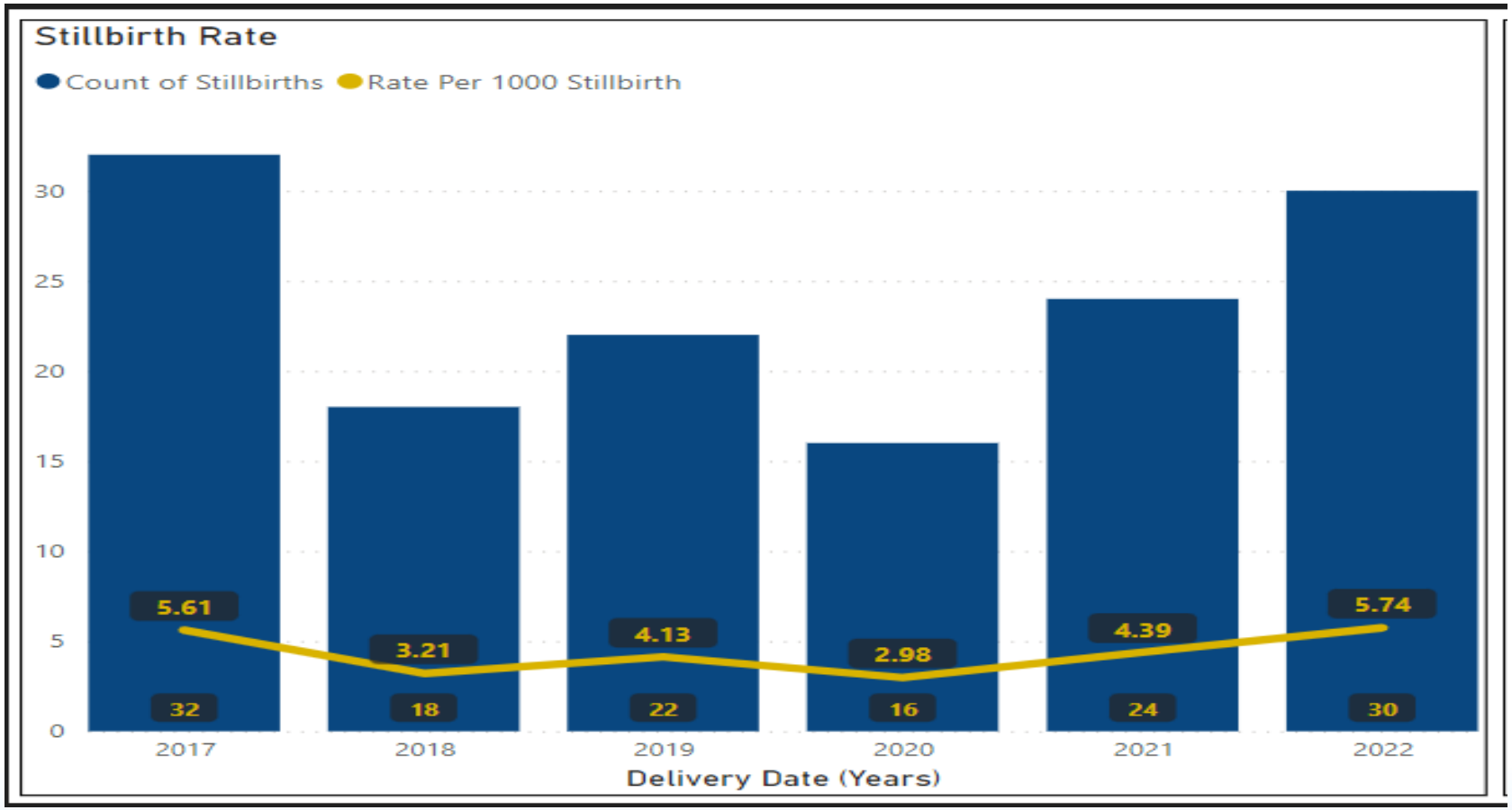
BigBaby CLINICAL TRIAL	104	CRAFT	130
Giant Panda	14	Rainbow Clinic	36
WILL	7	stich2 C-Stitch 2	1
Dilapan-S	330	ohana	0
 m-SeP Cohort A m-SeP Cohort B	100 153	Breech	0

Gynaecology Studies

ROCkeTS and	162	REINFORCE Real-World Evaluation of Robot-Assisted Surgical Services	14
PROTECTOR Preventing Ovarian Cancer Through early Excision of Tubes & late Ovarian Removal	25	CF113-302	2
All Wales Ovarian Cancer Prehabilitation Programme	34		
Identifying Ovarian and Blood Biomarkers For Ovari-	6		

Cardiff and Vale UHB Stillbirth





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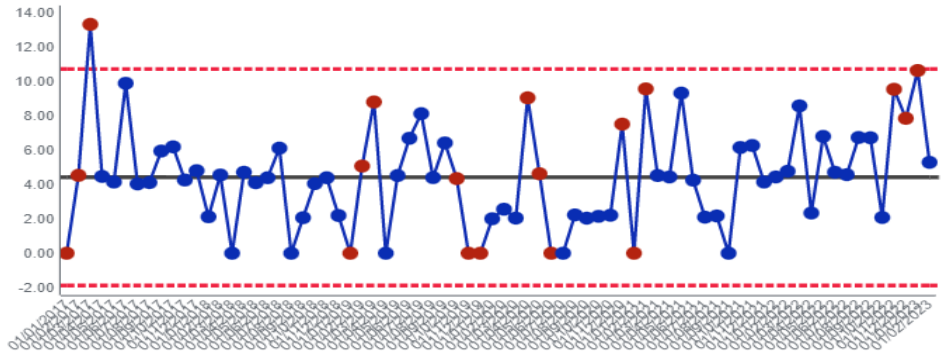
Stillbirth

Control chart shows Outcome = Stillbirth as a as rate per 1000 registered births



Delivery Date (Years)	Stillbirth (n)	Stillbirth (%)	Stillbirth (per 1000 registered births)
2023	**6**	**0.80%**	**7.98**
January 2023	4	1.07%	10.67
February 2023	2	0.53%	5.31
2022	**30**	**0.57%**	**5.74**
2021	**24**	**0.44%**	**4.39**
2020	**16**	**0.30%**	**2.98**
2019	**22**	**0.41%**	**4.13**
2018	**18**	**0.32%**	**3.21**
2017	**32**	**0.56%**	**5.61**
Total	**148**	**0.44%**	**4.42**

Date Selector for Ethnicity Table — From 01/01/2021 — To 28/02/2023

Outcome by Ethnicity

Mothers Ethnicity	R-Birth in Group	StillBirth Count	Stillbirth %
White: Irish	78		
White: British	7709	36	0.47%
Other Ethnic Group: Chinese	68		
No Data	126	3	2.38%
Mixed: White and Black Caribbean	127	2	1.57%
Mixed: White and Black African	71		
Mixed: White and Asian	49	1	2.04%
Black or Black British: Caribbean	27	1	3.70%
Black or Black British: African	554	6	1.08%
Asian or Asian British: Pakistani	345	3	0.87%
Asian or Asian British: Indian	227	3	1.32%
Asian or Asian British: Bangladeshi	242		
Any other White background	799	2	0.25%
Any other mixed background	219	1	0.46%
Any other Ethnic group	474	2	0.42%
Any other Black background	41		
Any other Asian background	290		
Total	**11446**	**60**	**0.52%**

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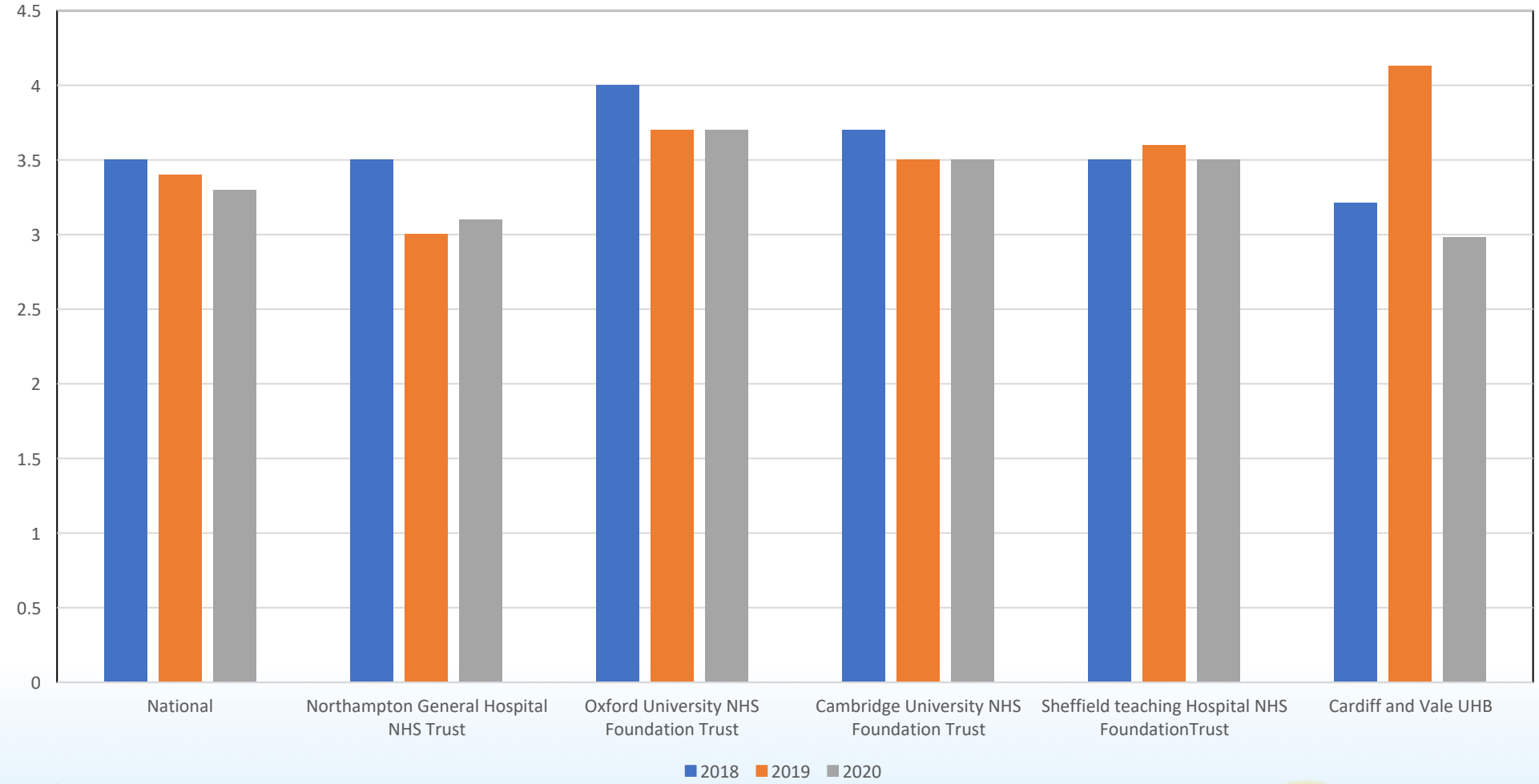
Benchmarked Stillbirth Rates per 1000 births



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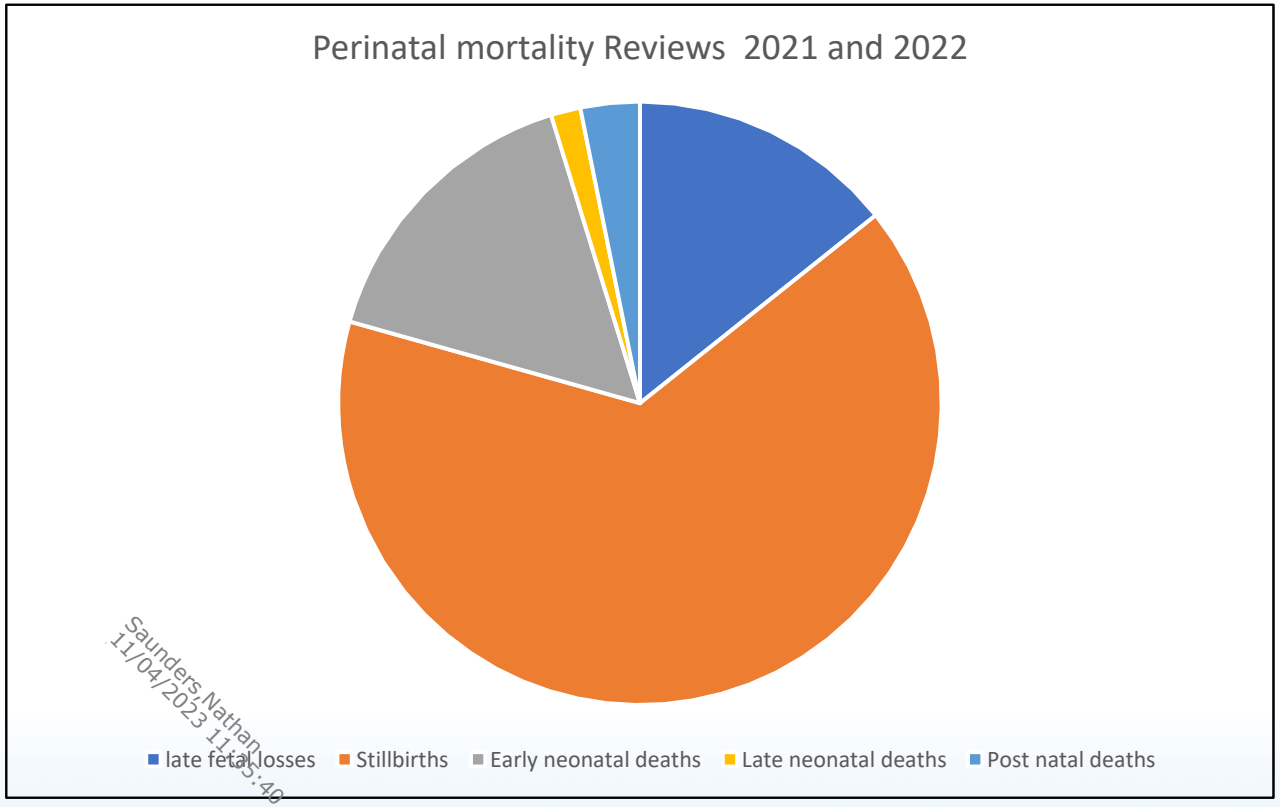
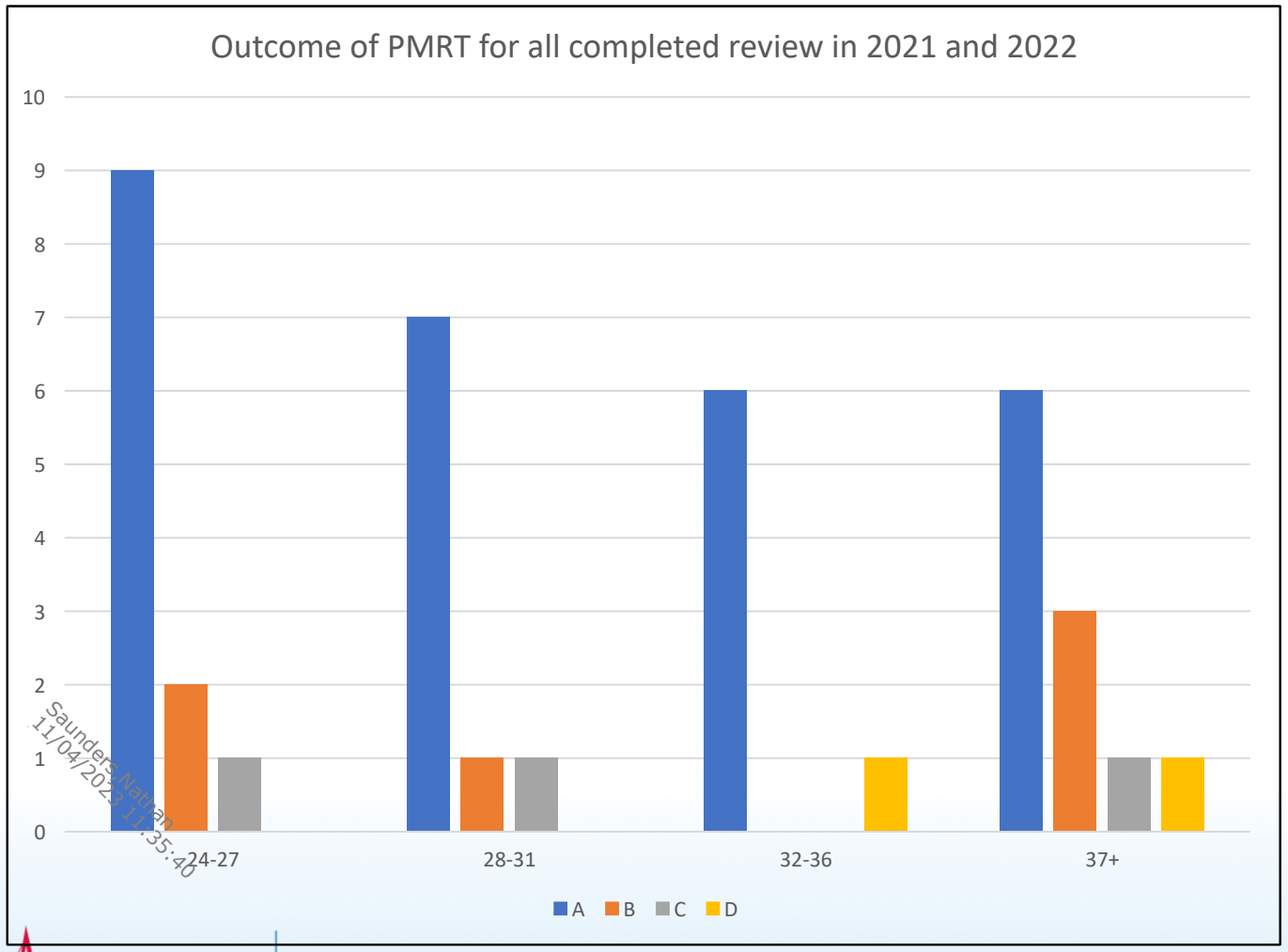
Perinatal Mortality Review Tool



Perinatal Mortality Review Tool

- Patients perspective of care
- Social circumstances
- Antenatal care
- Screening for gestational diabetes and fetal anomalies
- Growth screening
- Management of fetal movements
- Development of significant obstetric complications
- Intrapartum care
- Fetal Monitoring

PMRT Outcome



A The review group concluded that there were no issues in care identified up to the point that the baby was confirmed as having died

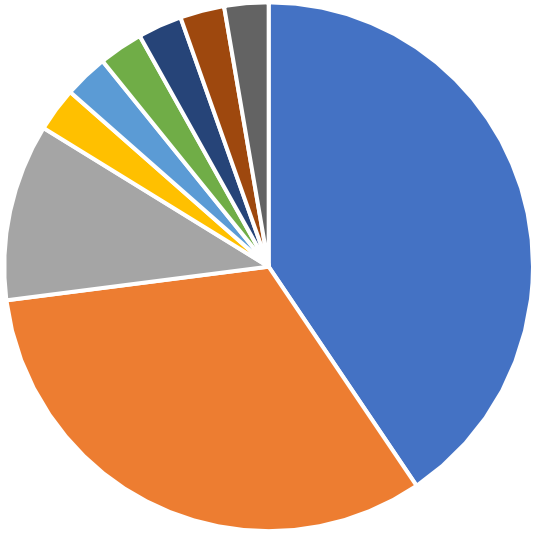
B The Review Group identified Care Issues that they considered would have made no difference to the outcome of the baby

C The review group identified care issues that they considered may have made a difference to the outcome of the baby

D The review group identified care issues which they considered were likely to have made a difference to the outcome of the baby

PMRT
Supporting high quality local perinatal reviews

C&V UHB Cause of death in stillbirths 2021/22



- Placental
- Unknown
- congenital
- fetomaternal haemorrhage
- Twin to twin transfusion
- intraprtum unterine rupture
- diabteic fetopathy
- maternal diabetes with associated covid
- cord

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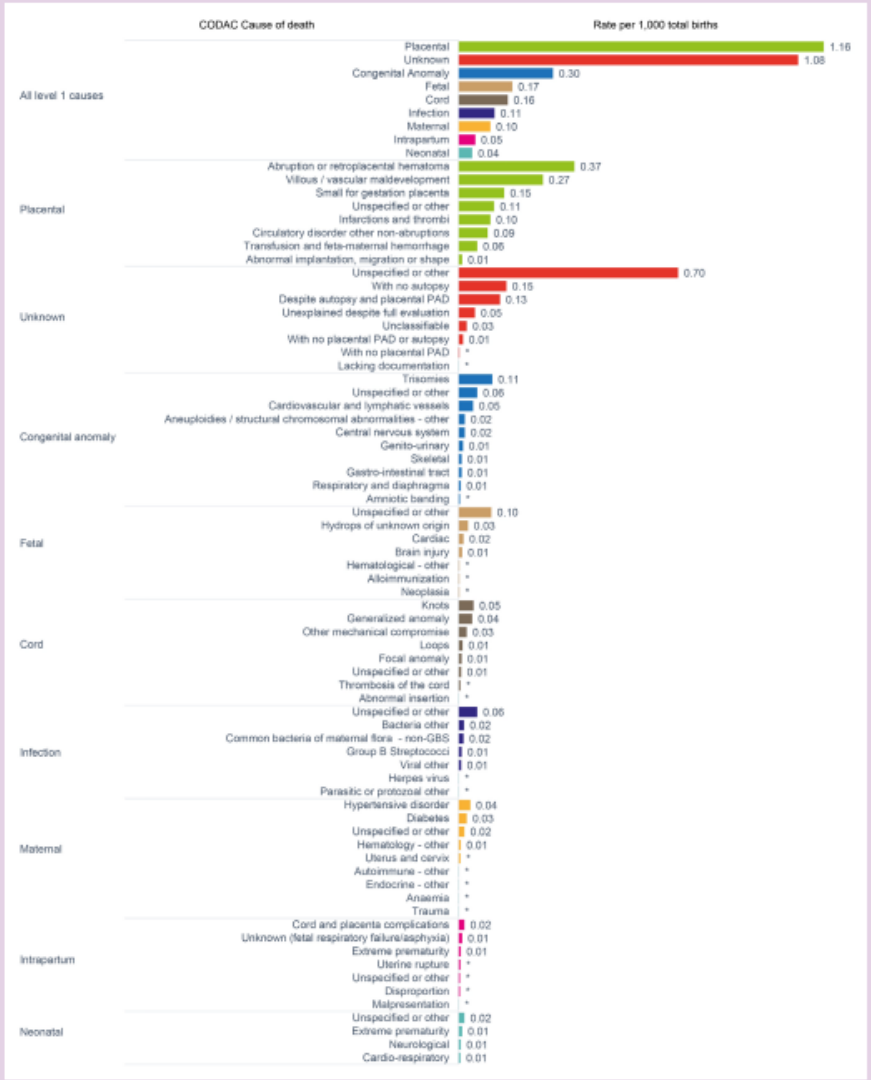
Figure 8: Stillbirth rates by CODAC level 2 cause of death: United Kingdom and Crown Dependencies, for births in 2020



Excluding terminations of pregnancy and births <24+0 weeks' gestational age.
* Rate supressed due to small numbers.
Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey.

All cases categorised as D where there were issues that were likely to have contributed to the death of the baby are reported as Nationally Reportable Incidents.

Introduction of electronic plotting of growth scan to avoid manual error

Incidental Learning

<u>Aspirin prescribing</u>

- Implementation of the shared decision making aids
- Development of sticker for the 16 week community midwife check
- Reinforce requirement for aspirin risk assessment at booking

<u>Histological Examination of Placenta</u>

- Obstetric and midwifery training relating to storage of placenta and sending for histology

Perinatal Mortality Review Forum 2021

24 stillbirths

4/1000

24 Intrauterine Death Cases reviewed in 2021

- 23 Cases highlighted good care or concerns which may not have made a difference to the outcome
- 1 case highlighted concerns with care which could have made a difference to the overall outcome with lessons learnt and feedback to teams
- 1 Intrapartum Stillbirth (known palliative)

Themes

- 68% of stillbirths identified SGA.
- 29% of stillbirths were Black and minority ethnic backgrounds
- Total with BMI over 30 in pregnancy N=1848 of which N=10 (0.7%) had a stillbirth.
- Total pregnant smokers N=595 (11%) of which N= 9 (2%) had a stillbirth.
- Around half of cases had pre-existing mental health issues or vulnerability under ELAN team.
- Almost half of the cases presented with altered fetal movements in pregnancy
- Inconsistent writing of discharge letters
- Improved documentation around screening for domestic abuse and aspirin assessment

100% were offered a Postmortem

38% accepted a full Postmortem investigation

Service Challenges

- Limited pathology resources with increasing waiting times for reports
- Inconsistent bereavement counselling following stillbirth or neonatal death.
- No external reviewer for each review.

Actions Achieved

- Sands letters continue to be used to gain parents perspectives and all families offered Postnatal debrief with named obstetrician
- Positive comments recived around compassionate care to families following stillbirth.
- Fundraising initiatives to improve services for women and families through rainbow clinic.
- Improvement in memory making equipment for families.
- Post incident de-brief sessions and offer of Psychology to staff following adverse events.
- Increased AN surveillance for all pregnant smokers.

Full MDT

Involvement and PMRT commenced at every review

Future Work

Fetal Surveillance midwife and smoking cessation HCSW recruited in 2021

Exploration to increase sustainable counselling services for families across maternity and neonatal services

External reviewer to be present at every review meeting

Internal audit around post-mortem acceptance rates and pathology resource

Perinatal Mortality Review Forum 2022

30 stillbirths
6 late miscarriages

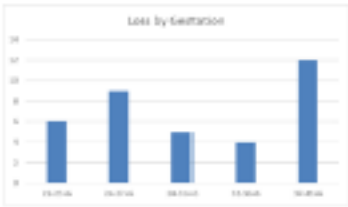
5.7/1000

Demographic data

56% of stillbirths identified SGA.
27% of stillbirths were Black and minority ethnic backgrounds
Total with BMI over 30 in pregnancy N= 1639of which N=9 (0.5%) had a stillbirth.
Total pregnant smokers N=562 of which N=7 (1.2%) had a stillbirth
20% had pre existing mental health issues or vulnerability under ELAN team.
100% were offered a PM, 45% accepted.

Themes from reviews

- Just under half of women presented to OAU with altered fetal movements
- Delays in accessing OAU
- Improvement of writing of discharge letters
- Inconsistent CO monitoring in pregnancy



Service Challenges

- Limited pathology resources with increasing waiting times for reports.
- Inconsistent bereavement counselling following stillbirth or neonatal death.
- No external reviewer for each review
- Placement of Bereavement room .

Actions Achieved

- All cases had a MDT rapid review prior to full review
- PMRT commenced on all cases
- Full review completed with full PM reports.
- Positive comments received around compassionate care to families following stillbirth.
- Electronic feedback from parents.
- Recommencemnt of CO monitoring
- Aspirin self assesssmnet for patient
- 16 week AN prompt stickers
- Prompt cards for women in top 5 most commonly used languages
- Increase use of cuddle cots at home and in hospital
- Bulsness case submitted for Psychologist to support Rainbow service.
- Wellbeing midwife appointment to support rainbow service.

Full MDT

Involvement and PMRT commenced at every review

Future Work

Fetal Surveillance lead to be appointed

External reviewer to be present at every review meeting

PM training dates to be set for the year

Band 5 smoking cessation advisor to be appointed

Report Title:	**Pressure Damage Collaborative Work plan**			Agenda Item no.	**2.3**
Meeting:	**Quality, Safety and Experience Committee**	Public	✓	Meeting Date:	**11 April 2023**
		Private			
Status *(please tick one only):*	Assurance ✓	Approval		Information	
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Director of Nursing Surgery Clinical Board**				

Main Report
Background and current situation:

The purpose of this report is to provide assurance to the Executive Committee that Quality, Safety and Patient Experience of the plan for reducing heath care acquired pressure damage with the Health Board

The Director of Nursing for Surgery Clinical Board is the Professional lead on a piece of work for the UHB that looks at reducing the occurrence of healthcare acquired pressure damage within Cardiff and Vale UHB.

To ensure that there is a Multidisciplinary approach to this scheme of work a Collaborative has recently been formed that encompasses both Primary and Secondary Care. The aim of the Collaborative is:

- reduce the incidence of healthcare acquired pressure damage with the Health Board
- speed up adoption of innovation into practice to improve clinical outcomes and patient experience

The Collaborative has secured input from the Patient Safety, Improvement and Organisational Learning Team to help progress existing work and help identification and to support learning and improvement. The Collaborative will help focus and drive forward improvements in care. Every team member is invested in solving the problems face and developing innovative solutions. We have created a collaborative to structure a system to support our leadership methodology and continually communicated our vision and our plans.

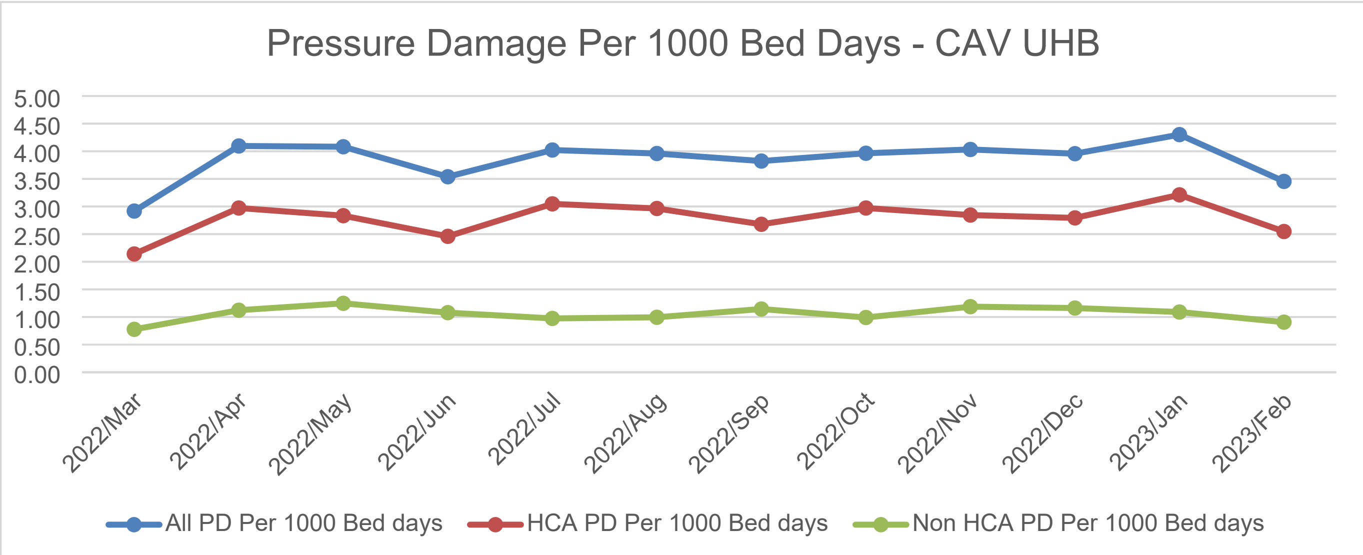
Pressure ulcers are painful and debilitating and, if left untreated, can lead to serious harm and death (National Patient Safety Agency, (NPSA) 2010; Whitlock et al, 2011). Every year up to 20% of patients in acute care in England and Wales are affected by pressure ulcers.

It was reported in 2015 that pressure ulcers accounted for 9% of all wounds managed by the NHS. After adjustments for co morbidities, the cost attributed to these wounds is estimated to be between £507-£530 million a year.

Pressure ulcers increase the length of stay by an average of five to eight days per pressure ulcer (Bennett, Dealey and Posnett, 2012). In Wales pressure ulcers affected 8.9% of all in hospital patients (Clark, Semple, Irvins et al, 2017).

Extensive work through previous All Wales initiatives such as 1000 Lives Plus and Fundamentals of Care has helped raise the profile of pressure damage and driven the development of rigorous and practical ways of recording and preventing pressure ulcer incidents. Initiatives such as SKIN bundles were introduced in Wales in 2009 through Transforming Care and aimed to improve patient care by reducing pressure ulcers. However, when pressure damage unfortunately occurs, the learning from such an incident must be effective if the risk to further patients suffering the same harm is to be reduced.

The Pressure Damage collaborate has been in place since May 2021 follows on from work that was carried out by the previous UHB pressure damage task and finish group



The graph above shows the Pressure Damage per bed 1000 bed days across all inpatient care which has been on a fairly stable trajectory over the last year

As previously discussed the goal of the pressure damage collaborative was to **reduce** the incidence of healthcare acquired pressure damage with the Health Board by **25% by July 2022**.The previous data available to the pressure damage collaborative and shared at QSE in April 2022 showed that the pressure damage per 1000 bed days had reduced from 3.51 in May 2021 to 2.61 in March 2022 for inpatient areas which was a reduction of 24%, which at a very high simplistic level would indicate that the reduction goal had already been met.

The most recent data available to the pressure damage collaborative now show that the current figure for February 2023 for “Health Acquired Pressure Damage “(red line) is 2.55 which would indicate that the initial goal has of 25 % reduction has been met and exceeded as it is now 27%

However, the caveat does need to be made that we are using data from 2 different datix systems and that with the newer datix system (since April 2022) data has to be manually extracted and added to the BIS dashboard as there is still no availability to have a clear data pull
This manual effort is labor intensive and means we have not yet been able to move forward with the reliable data sets that were intended. This is an all Wales issue with the new Datix system which has been escalated via other routes.

Assessment and Risk Implications

The Pressure Damage Collaborative since its formation in April 21 has already progressed with a information gathering session with key stakholders. This work has led to the development of 7 subgroups follow the initial scoping episode lead by experinced clinical leads from the HB under the following headings

- Information and Data
- Eduaction and training
- Incident Management and SI process
- heel offloading products.
- Pressure redistribution work stream
- Documentation
- Perfect Ward roll out

The collaborative has been in the in the process of developing a QI dashboard for pressure damage which will triangulate data from both e-datix and our business intelligence system (BIS) to provide a more robust streamlined reliable data set and measurement. The 8 metrics will be

- Total number or pts with pressure damage
- Breakdown of stage (moisture lesion, 1,2,3.4 etc)
- Pressure damage that occurred in our care – Acute
- Pressure damage that occurred in our care - Community
- Percentage of patients whose pressure damage deteriorates
- What pressure damage is reported comes in on admission to organisation vs what develops in a clinical area
- Length of time taken for pressure damage to develop
- Number of days pressure damage free per clinical area

However the Collaborative have been unable to press forward with this piece of work due to the inability to have a direct data stream from the Once for Wales e-datix system to the BIS system

The collaborative have continued to meet bimonthly and the following achievments s are to be noted by the QSE commitee

- Mattress selection posters updated (appendix 1)
- Recirculation of medical illustration guidance
- Wound Care Chronicle -Autumn edition
- Tendable focus on January/ February on pressure damage audit's
- STOP the pressure week in Nov. – focused on improving completion of purpose T Risk assessments
- Regular Pressure Ulcer Prevention and Management sessions for 2023
- PAM role profile developed and two-day training programme timetable drafted
  First PAM cohort planned for January 2023 – Pilot wards in Surgery Clinical Board and Medicine Clinical Board and Critical Care identified.

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

- The Collaborative has met the ambitious goal by raising the profile of pressure ulcer prevention and equipping staff with effective interventions holistic proactive and preventative approach to skin care.

- The data continues to be difficult to pull and the collaborative have been unable to move forward with the 8 metrics until the data stream is solved and the All Wales datix system is able to integrate with local health board systems

Recommendation:

The Committee is asked to:

a) NOTE the contents of this report and the actions being taken forward to address areas for improvement.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

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

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

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

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

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

Mattress Selection Pathway - Acute

medstrom healthcare
SPECIALIST PRODUCTS • UNIQUE SERVICES
Improving outcomes in the patient environment

Please reassess your patient consistently, along-side the pressure ulcer risk assessment and use a 'step up' and 'step down approach' to make the best use of a limited resource. To ensure the timely provision of equipment Medstrom undertake regular monitoring to ensure there is availability to prevent risks associated with surface selection.

To contact Medstrom call 0845 3711717. **Please note that out of hours this number is for emergencies only.** For TVN **authorisation of products only** call 07977 503 23.

All patients with heel redness/PAD or diabetes must have their heels off-loaded with Repose wedge or boots

NOT AT RISK

↓

Foam or P.R.O Matt without pump or Aria Flex without pump

No pressure ulcer but AT RISK

comorbidities which may make an individual more vulnerable to skin damage

↓

Heel off-loading must be used for at risk heels

P.R.O. Matt without pump or Aria Flex without pump

CATEGORY 1 PRESSURE ULCER OR MORE

• Category 1-2 pressure ulcer or a previous pressure ulcer • Warmth or alteration in colour to the heels • Can be repositioned or sits out • comorbidities which may make an individual more vulnerable to skin damage **Pressure ulcer to heel - heel off-loading must be used**	→ P.R.O. Matt without pump or Aria Flex without pump Consider pump only if patient is not tolerating side to side repositioning
• Category 3-4 pressure ulcer • Able to reposition or be repositioned • Sits out in chair for short periods only • Multiple comorbidities which may make an individual more vulnerable to skin damage **Pressure ulcer to heel - heel off-loading must be used**	→ P.R.O Matt with pump or Aria Flex with pump
• Non-healing or multiple category 2 pressure ulcer or category 3-4 pressure ulcer • Not able to be repositioned easily or does not sit out e **Pressure ulcer to heel - heel off-loading must be used** • Patient cannot reposition and does not sit out • Multiple comorbidities which may make an individual more vulnerable to skin damage	→ Duo 2/Aria Pro Must be authorised by TVN or Medstrom clinical staff
• Non-healing or extensive tissue damage • Extremely underweight • Flap surgery • Open abdo/chest where repositioning is challenging • Pain management including end-of-life care • Patients who are non-concordant with repositioning • Multiple comorbidities which may make an individual more vulnerable to skin damage **Pressure ulcer to heel - heel off-loading must be used**	→ Dolphin Therapy Must be authorised by TVN, Medstrom clinical staff or Senior Nurse

All patients must have documented evidence of pressure area care, equipment in use, frequency of repositioning and a skin assessment. Purpose T must be completed for all patients and updated if there is any change in the patient's condition. All patients with category 3, 4, unstageable pressure damage or suspected deep tissue injury should be referred to the Tissue Viability Team. Any pressure ulcers below the ankle should be referred to Podiatry. Any P.R.O Matt pumps, Duo 2 or Aria pro ordered after 3pm will be delivered the next day.

Tissue Viability Team/Medstrom October 2022 Version 2.0

Report Title:	**Quality of Care Assurance in Commissioned Services in response to the Operation Jasmine and the Flynn Report (2015) and subsequent 2021 Coroners Inquests**			Agenda Item no.	2.4
Meeting:	**Quality, Safety and Experience Committee**	Public	X	Meeting Date:	**11 April 2023**
		Private			
Status *(please tick one only):*	Assurance ✓	Approval		Information	
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Deputy Director of Nurse, PCIC**				

Main Report

Background and current situation:

BACKGROUND

Operation Jasmine was a major and wide-ranging investigation carried out by Gwent Police between 2005 and 2013 into the deaths of 63 individuals living in residential and nursing care homes in South East Wales. There were many victims, some of whom were resident in homes owned by Puretruce Health Care Ltd owned by a Dr Das a General Practitioner in the Gwent area. (See Appendix 1 for more detail)

In January 2010, the Crown Prosecution Service (CPS) formally advised Gwent Police that there was insufficient evidence to support a reasonable prospect of prosecution for either gross negligence manslaughter or willful neglect.

During 2011, responsibility for leading the investigation was transferred to the Health and Safety Executive (HSE) and charges were subsequently laid under the Health and Safety at Work Act. The trial was halted in 2013 because Dr Das sustained head injuries following a burglary at his home and he subsequently died without conclusion of any prosecution or charges.

Acknowledging that the absence of a judgement or legal resolution compounded the families' grief and sense of grievance in December 2013 the Rt Hon Carwyn Jones AM, First Minister of Wales, announced that he was setting up a Review of Operation Jasmine and the events associated with it 'in order that we may learn for the future.' The review was led by Dr Margaret Flynn and involved consultation and workshops with key stakeholders across Wales including involvement from Cardiff and Vale UHB and Local Authority Commissioning Teams.

The purpose of the Review was to:

- Set out the experiences of those people and their families in residential care homes in Gwent identified via Operational Jasmine.
- Set out the key events
- Consider and set out actions that have been taken by the various parties involved in the interim
- Set out key lessons for the future alongside recommendations regarding policy or legislation, regulation and operational practice, for the various parties involved.

The review examined

- Experiences of people living in the care homes, and its impact on them and their families
- Policies and procedures, governance and practices of the owners involved
- Policies and procedures of the relevant agencies involved in the investigation
- Regulatory regime and the powers available
- The voice of those living in cares homes and their families.

In May 2015 WG published Dr Flynn's report 'In Search of Accountability a 328-page report containing 12 wide ranging recommendations for WG, regulators, Safeguarding Boards and commissioners of services with respect to legislative, safeguarding and quality assurance and governance systems with respect to individuals placed in residential and nursing care homes. It made specific recommendations as to the reporting and investigation of pressure damage as a key trigger for identification of neglect/poor care in residential care homes. It also recommended that inquests should be held into the deaths of 7 individuals who had been placed in Brithdir Care Home, Caerphilly.

These inquests were eventually held between January and March 2021 and the coroner concluded that the deaths of 5 people were contributed to by neglect. The coroner stated that people were being 'warehoused' and 'de-humanized' with poor staffing levels and a severe lack of monitoring, observation and care planning.

As part of the inquest the coroner also explored the role of state agencies including Caerphilly LHB, Caerphilly Borough Council and Care Standards and Inspectorate Wales in terms of what they knew, who they told and what action they took to protect people.

The key themes of the coroner's conclusions were:

- That at the time of the event's new legislation and frameworks in terms of care standards, safeguarding and escalating concerns were in their infancy and were unfamiliar to those having to operate within them
- At the time EMI nursing provision in the area was limited which led to Dr Das being given to many chances when more robust action should have been taken
- That although it was acknowledged that the LHB, Borough Council and Regulator worked in good faith they were sometimes too focused on systems and processes and lost sight of individuals.
- Individual service user reviews were not undertaken in a timely manner
- There were missed opportunities to act promptly and robustly to deal with failing and recognise patterns and themes.

Since both Operation Jasmine and the Flynn Report and its recommendation much has changed in how Local Authorities, Health Boards and the regulators operate and deal with monitoring, identifying and care concerns with residential and domiciliary care providers and there has been social care legislation introduced which helps reinforces and support this. E.g.

- Social Services and Well Being Act (2014)
- Regulation & Inspection of Social Care (Wales) Act 2016 (RISCA)
- Mental Capacity Act/Liberty Protection Safeguards
- Wales Safeguarding Procedures 2019

There are also now better opportunities for gathering triggers for concern and collating and analysing intelligence with:

- Greater involvement of core health services in residential homes on an operational Locality basis e.g. access to TVNs, dietitians and intermediate care therapies
- Better inter-agency working arrangements with LAs and CIW
- Better MDT information sharing
- Improved communications with families and formal advocates

PARTNERSHIP ASSURANCE MECHANISMS

KPI's which are monitored weekly and which can provide an early indication of risks to patient safety in care homes:

- Pressure Ulcers – Stage 3 and above pressure damage is reportable to CIW by care homes under the revised RISCA guidance on notifications
- Reg 60 notifications of incidents (CIW)
- Safeguarding referrals
- Contract monitoring visits
- Formal Advocacy services
- CIW Inspection reports – non-compliance notices

LOCAL POSITION/ASSURANCE

Cardiff and Vale UHB commission wholly or jointly with Local Authorities care from a range of independent sector care providers including but not limited to:

- The Funded Nursing Care Contribution (FNC) to all individuals who are placed in nursing homes in the Cardiff and Vale geographical area
- Entirely funding nursing and residential/supported housing placements for individuals assessed as eligible for Continuing NHS Health Care (CHC)
- C&V residents placed with residential providers under CHC outside of the Cardiff and Vale geographical area
- Domiciliary Care Packages for individuals assessed as eligible for CHC or joint funding arrangements

The majority of individuals placed and funded in the above are done so under the auspices of Primary, Community and Intermediate Care Clinical Board.

Individual

Individuals placed either in the community or in independent sector care homes under FNC or CHC are monitored and reviewed by teams of nurse assessors who are Locality based. Individuals needs are monitored and reviewed 3 months after placement and annually thereafter or sooner should their needs change and an earlier review be indicated.

There is liaison with individuals and families as part of the review and any concerns would be acted upon or referred on should a safeguarding referral be warranted.

The teams have a wider contract monitoring role within nursing homes particularly and should any more general care concerns about a provider be identified this would be escalated through the Locality nursing and Partnership Escalating Concerns procedures.

Escalating Concerns Procedures

In May 2009, the Welsh Assembly Government issued statutory guidance surrounding escalating concerns with, and the closure of, care homes that are registered with the Care Inspectorate Wales (CIW) to provide services to adults, including those providing nursing care. It set out local authorities' and local health boards' (LHB) responsibilities in this area and suggests ways in which these responsibilities can be discharged, including establishment of local / regional procedures.

The former LHBs in the Vale and Cardiff developed local procedures with their Local Authority partners as a result of the guidance.

In 2016 following the Flynn Report the UHB worked with both Cardiff and Vale Local Authorities to agree a Regional Cardiff and Vale of Glamorgan Escalating Concerns and Home Closures Procedures.

In 2021 commissioning partners in Cardiff and the Vale of Glamorgan Councils and the Cardiff & Vale University Health Board agreed that the management and assurance of quality services in line with contract agreements and arrangements in response to care home closures should have distinct and separate procedures and the 2016 procedure has recently been reviewed and replaced by Quality Services: Delivering What Matters Cardiff & Vale of Glamorgan procedures for contracted care and support services for children, young people and adults. This was signed off by each agency and at Regional Partnership and Safeguarding Boards These new procedures replace the former escalating concerns procedures and reinforce a focus on proactively assuring quality services (for children, young people and adults) and preventing (where possible) the need for care and support services entering into formal concerns process. The full document can be accessed at the link below. A flow chart outlining the process is included in Appendix 2.

https://cavrpb.org/quality-services-delivering-what-matters/

Contractual

There has been a joint contract and service specification for residential nursing care across Cardiff and Vale UHB and both Local Authorities since 2005 however this was out of date and did not reflect legislative changes and responsibilities.

Partner agencies undertook a significant piece of work during 2019/20 to review and update this and a joint Regional Common Contract for residential care was agreed and implemented across all agencies in 2021. The terms of the contract are clear and detailed with a focus on individual persons and services outcomes and assessment and monitoring against fundamental health and social care standards.

The regulatory requirement to report all stage 3 and above pressure damage to CIW is referenced and providers are required to utilise the All Wales Pressure Damage Investigation Tool to undertake root cause analysis when directed.

The three statutory agencies have been working to agree a joint Quality Outcomes Framework to support and standardised contract monitoring across agencies. With limited resources available to take forward the work within PCIC this is being supported by the Integrated Health and Social Care Partnership team however progress on the health element has been delayed given other competing priorities for the team.

Pressure Damage Reporting and Scrutiny

- Since the Flynn report avoidable Pressure Damage of grade 3 and above is required to be reported to WG through the Nationally Reportable Incident Process.
- The All Wales Pressure Damage Investigation Tool was developed to support robust review and root cause analysis of what factors may have contributed to the pressure damage and whether any acts or omission may have meant that the harm could have been avoided
- All pressure damage which is identified by community teams in the community or residential care homes e.g. District Nurses, TVN, CRTs is reported via DATIX.
- Weekly Locality based scrutiny panels led by the Locality Senior Nurse and review all reported incidents and the All Wales Pressure Damage tool to identify avoidable pressure damage and any patterns or themes.
- Where pressure damage was identified as avoidable action plans are developed and a referral is made to the Local Authority Safeguarding Team
- Since the Flynn report and the introduction of weekly scrutiny panels held within PCIC has dramatically reduced the number of avoidable Grade 3-4 or unstageable damage being reported to LA safeguarding teams.
- Community Pressure Damage Reporting and outcomes of scrutiny are reported via the Clinical Board QS&E committee

- Pressure Damage in nursing homes of grade 3 and above is reportable by providers via Regulation 60 to CIW and would be a key trigger for consideration of safeguarding referrals and/or escalating concerns if identified on review.

Governance and Reporting Arrangements

- The Locality Nurse Assessor Teams report to the Lead Nurse in each Locality and provider care concerns are reported through the Locality QS&E arrangements through to the Clinical Board QS&E Committee.

- There are also reporting lines through Locality and Clinical Board Operational Management Teams and the UHB Safeguarding Teams.

- Assessor Team review and monitoring activity is reported and monitored through monthly Locality Dashboards and Clinical Board Continuing NHS Health Care report

- Locality Nursing Teams attend the multiagency Joint Quality Management meetings in Cardiff and the Vale with Locality Lead Nurses representing the UHB on any Provider Performance Monitoring processes which are instigated and the Deputy Director of Nursing for PCIC representing the UHB should the highest level of Joint Inter-agency Monitoring (JIMP) be required. Embargoes of placements are discussed at and decided usually at JIMP level.

- Executive oversight and reporting are via the Clinical Board Director of Nursing through to the Executive Director of Nursing with respect to their safeguarding and QS&E portfolios

- The PCIC Deputy Director of Nursing and Finance represent the UHB on the Regional Commissioning Board which is chaired by the Vale Local Authority Director of Social Services

- It was agreed in December 2022 that the Deputy Nurse Director will attend the UHB Safeguarding Steering Group on a 6 monthly basis to give an overview of community safeguarding and escalating concerns and updates

- Multi-agency partnership working with statutory partners responsible for safeguarding arrangements in the region, are well structured and led by the UHB Corporate Safeguarding Team. The Wales Safeguarding Procedures (2019) are the basis for all safeguarding of children and at adults at risk. Reasonable assurance that arrangements to secure governance, risk management and internal control are applied effectively were awarded following the last internal audit in 2020

- The Executive Nurse Director and Head of Safeguarding are prominent members of the Regional Safeguarding Board ensuring that safeguarding standards involving the UHB are highlighted appropriately if required and highlight any areas of concern. The UHB has an open and transparent approach to safeguarding people

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

- Consider as part of Corporate Governance a regular/exception reporting of care home activity and performance into the UHB QS&E Committee to provide assurance to the Board that safeguards are embedded into business as usual

- Consider how resources can be made available through the Integrated Health and Social Care Partnership team to support the development of a partnership contract monitoring framework for use with providers

Recommendation:

The Committee is asked to:

- **Note** the recommendations of the Flynn Report and the current UHB and partnership arrangements in place to support quality assurance of care for commissioned placements in residential care homes in Cardiff and Vale

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

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

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

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

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

PCIC – CARE HOME QUALITY ASSURANCE REPORT – JANUARY 2023

Report includes data up to end of January 2023 or snapshot position if applicable

About this Report and Table of Contents

This report is designed to show a monthly snapshot of the Health Board's performance in a number of key areas that relate to the Quality Assurance of commissioned care within the following settings-

- Older Persons General Nursing Homes
- Older Persons Residential Homes
- Older Persons General Dual Registered
- Older Persons EMI Nursing Homes
- Older Persons EMI Residential Homes
- Older Persons EMI Dual Registered
- Specialist LD Residential Settings

NB This does not include information on individuals in supported living or extra care service models where the UHB may be commission packages of care

If you have any queries regarding the contents of this report please do not hesitate to contact:

Anna Mogie, Deputy Director of Nursing, PCIC Clinical Board
E Mail: Anna.Mogie@wales.nhs.uk

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Cardiff and Vale University Health Board

COMMISSIONED CARE DEMOGRAPHICS

Number/Breakdown of Older Peoples Residential Care Home beds registered with CIW

Area	General Nursing	General Residential	Dementia Nursing	Dementia Residential	Total
Cardiff N&W					
Cardiff S&E					
Vale					
Total					

Actual and Expected Changes to Registration/Bed Numbers

Area	Gen Nursing	General Res	EMI Nursing	EMI Reg	Total
Cardiff					
Number of homes with actual or expected changes to registration					
Impact on Bed Numbers					
Vale					
Number of homes with actual or expected changes to registration					

Impact on Bed Numbers					
Total					

Number of Funded Care Home Residents - Snapshot January 2023

Area	CHC – LONG TERM	CHC – FAST TRACK	FNC	JOINT FUNDED
Cardiff N&W				
Cardiff S&E				
Vale				
Total				

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QUALITY AND SAFETY

Numbers of Homes under Formal Escalating Concerns

Snapshot at month end compared to previous 2 months

GN – General Nursing GR – General Residential EMI N – EMI Nursing EMI R – EMI Residential

Area	GN at Nov 30th	GN at Dec 31st	GN at 31st Jan	GR at Nov 30th	GR at Dec 31st	GR at Jan 31st	EMI N at Nov 30th	EMI N at Dec 31st	EMI N at Jan 31st	EMI R at Nov 30th	EMI R at Dec 31st	EMI R at Jan 31st
Cardiff N&W												
Cardiff S&E												
Vale												
Total												

Improvement on previous month

No change from previous month

Worse against previous month

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Cardiff and Vale University Health Board

Numbers of Homes where admission suspended due to escalating Concerns or CIW Embargo with primary reason

Reason	N&W Nov 22	N&W Dec 22	N&W Jan 23	S&E Nov 22	S&E Dec 22	S&E Jan 23	Vale Nov 22	Vale Dec 22	Vale Jan 23
Quality									
Leadership and Mgt									
Training									
Staffing									
IPC									
Safeguarding									
Environment									
CIW embargo									
Multiple Reasons									

Reasons Where admission suspended due to Voluntary Embargo – January 2023

Reason	N&W	S&E	Vale
Change in Ownership			
Staffing			
Accommodation Upgrade			
Change in Registration			
Multiple Reasons			

Numbers of Registered and 'Available' Beds for admission – snapshot position provided by LA's

Area	Registered Gen Nurs	Available	Registered Gen Res	Available Gen Res	Registered EMI nursing	Available EMI NUrsing	Registered EMI REs	Available EMI res
Cardiff								
Vale								
Total								

FNC/CHC Review Activity – 3-month activity

All individuals placed should be reviewed within 12 weeks of placement and then annually thereafter

Cardiff N&W

	November 22			December 2022			January 2023		
	FNC	CHC	Total	FNC	CHC	Total	FNC	CHC	Total
Caseload									
Reviews undertaken									
Assessment/Review date breached									

Cardiff S&E

	November 22			December 2022			January 2023		
	FNC	CHC	Total	FNC	CHC	Total	FNC	CHC	Total
Caseload									
Reviews undertaken									
Assessment/Review date breached									

Vale

	November 22			December 2022			January 2023		
	FNC	CHC	Total	FNC	CHC	Total	FNC	CHC	Total
Caseload									
Reviews undertaken									
Assessment/Review date breached									

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Cardiff and Vale University Health Board

HEALTH PROTECTION/IMPROVEMENT

Uptake of Covid vaccination and booster in Care Home Residents/Staff (As of 31st January 2023)

		Vaccinations - DOSE 1					
	Target Comp dose 1	Planned Mode	Population	Completed	% Completed	Remaining	Completed (yesterday)*
Population							
Care Home Residents	31st January 2021	Mobile	2,031	3,142	155%	-1,111	0
Care Home Staff	31st January 2021	Mobile	3,018	3,895	129%	-877	0

		Vaccinations - DOSE 2						
		Planned Mode	Total Population	Completed	% Completed	Remaining	Completed (yesterday)*	% completed over 1st doses
Group	Population							
Group 1	Care Home Residents	Mobile	2,031	3,005	148%	-974	0	96%
Group 1	Care Home Staff	Mobile	3,018	3,825	127%	-807	0	98%

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			Vaccination - Boosters										
		Planned Mode	Population	B1 - Completed	B1 - % Completed	B1 - Remaining	B1 - Completed (yesterday)*	B2 - Completed	B2 - % Completed	B2 - Remaining	B2 - % Completed of B1	B2 - Remaining of B1	B2 - Completed (yesterday)*
Group	Population												
Group 1	Care Home Residents	Mobile	2,031	2,605	128.3	-574	0	2,203	129.2	-498	85%	402	0
Group 1	Care Home Staff	Mobile	3,018	3,011	99.8	7	0	1,551					0

Available Uptake of Flu Vaccination for Care Home Staff at a Community Pharmacy in 2022/23 as of end of December 2022

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Cardiff and Vale University Health Board

Social care / nursing staff working in a care home **273**

Domiciliary Care Workers **140**

413 in total

The Community Pharmacy data allows pharmacist to select more than one eligibility which may mean this information is considerable under-reported. CP has reported 9798 vaccinations of individuals in the 50-64 category a significant number which may be care home workers.

The Community Pharmacy team are doing some work with the local authorities and care homes identifying where they may require flu vaccination and have 25 sites that have come back requesting support and the team are liaising with them and Community Pharmacies to arrange vaccination

Training/Support

The following training has been provided to care homes across C&V over the last 3-6 months:

Report Title:	**Board Assurance Report – Patient Safety & Workforce**				Agenda Item no.	2.5	
Meeting:	Quality, Safety and Experience		Public	x	Meeting Date:	11th April 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Risk and Regulation						

Main Report
Background and current situation:

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee ("the Committee") with the opportunity to review the risks on the Board Assurance Framework (BAF) which impact upon Patient Quality, Safety and Experience.

At the Board Meeting held on the 30th March 2023 the following risks were reported on the BAF which impact upon said areas:

- Patient Safety
- Maternity Care
- Critical Care Capacity
- Cancer
- Stroke
- Urgent and Emergency Care
- Planned Care.

These risks will be reported to each meeting of the Quality, Safety and Experience Committee going forward to ensure that they are being appropriately managed and/or mitigated, so the Committee can provide assurance to the Board that this is the case.

The highest scoring net risks (which is after controls are in place) from the above are Patient Safety (20), Maternity (20) and Critical Care (20). Further details including cause, impact, controls and assurances are also detailed in the attached risks.

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

The Board Assurance Framework provides the Board with information on the key risks impacting upon the delivery of the Strategic Objectives of Cardiff and Vale University Health Board.

The attached Patient Safety, Quality and Experience Risks (last considered by the Board in March 2023) are considered to be key risks to the achievement of the organisation's Strategic Objectives.

There are also a number of risks on the Corporate Risk Register which relate to Patient Safety.

Recommendation:

The Quality, Safety and Experience Committee are requested to:

a) Review the attached risks in relation to Patient Safety, Quality and Experience to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.

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

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

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

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board	30th March 2023

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11/04/2023 11:35:40

1. Patient Safety – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

Patient safety should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.

Risk	There is a risk to patient safety: Due to post Covid recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list. Due to increased demand, post Covid 19, of unscheduled care of patients with higher acuity and more complexity which is adding to the pressure within the Emergency Unit (EU). Due to a sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care in a larger clinical footprint in relation to post Covid 19 recovery. Due to the ability to balance within the health community and the challenge in transferring patients to EU. Due to the current pressure in EU and inability to segregate patients due to the volume in the department.		
Date added:	April 2021		
Cause	Patients not able to access the appropriate levels of planned care since the onset of the COVID 19 pandemic creating both longer waiting lists for planned care. Resources re directed to address planned care demand leaving unplanned care/unscheduled care pathways with lower staffing		
Impact	Worsening of patient outcomes and experience, with an impact on patient outcomes Post Covid recovery sickness is having a significant impact on staff availability (see separate risk on workforce).		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Recovery Plans being developed and implemented across all areas of Planned Care • Maintaining Training/Education of all staff groups in relation to delivery of care • Use of Private Partner facilities. • In-house and insourcing activity • Additional recurrent activity taking place • Recruitment of additional staff • Workforce hub in place with daily review of nurse staffing by DoN in Clinical Boards to manage the risk • Hire of additional mobile theatres • Quality and Safety and Experience Framework Implementation underway • health and social care actions to assist the current risk in the system with work continuing to be embedded and implemented		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (3) • CAHMS position reviewed at Strategy and Delivery Committee (1) • Mental Health Committee aware of more people requiring support (1) • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives (1)(2) • Recent Executive review with Clinical Teams for understanding and review of front door pressures. (1)		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes and domiciliary care settings. Deterioration of quality of care provided to patients due to the availability of staff in some key clinical environments.		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions		Lead	By when	Update since January 2023
1. Review of hospital acquired COVID 19 and COVID deaths (wave 1) being undertaken and monitored through Nosocomial C&V Programme Board.		Jason Roberts	30.04.23	Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan Review of deaths continues in line with WG requirements with oversight from Nosocomial National Programme Board
2. Choices framework being utilised due to the quality of care and ability to provide safe care with current demand and pressures		Paul Bostock	31.03.23	Choice framework continues to be utilised
3. Programme of work in place and being led by the Chief Operating Officer, supported by Operational Teams to address the backlog		Paul Bostock	31.03.23 Review October 22	Programme currently been reviewed by COO
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**		**10 High)**

2. Maternity Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

The recommendations of the Ockenden Review into maternity services in England were published at the end of March 2022. The Ockenden review and its recommendations is very much in the public domain and attracted significant coverage from the media. Becoming compliant with the Ockendon requirements also brings opportunity benefits such as full compliance with the Cwm Taf and other formal reviews recommendations and achieving BAPM compliance in the Neo-Natal Unit.

The background to, and summary of the Ockenden report, is best understood in the quote from Donna Ockenden below

> **"This final report of the Independent Maternity Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve, and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives. "**

The report details 89 recommendations that should be enacted to improve maternity services across the UK. An immediate self-assessment of the service was undertaken against the requirements, which noted that 45 of the requirements were already met, 27 partially met, and 17 not met at all. The detail of where we are currently not meeting recommendations and the proposal to close that gap has been completed (appendix 1). The recommendations that we currently fail to meet can largely be grouped into 3 categories, patient safety, quality and experience, training, and workforce.

Whilst underlying actions to progress the plans to achieve the recommendations have developed and presented to Execs, UHB agreement of circa £2M recurrent funding is required to deliver progress.

In addition, the service has sustained pressure across Obstetrics and Maternity care system, mainly due to reduced workforce availability, increased interventional birthing as a result of NICE guidance, backlogs on critical incident investigation etc

Risk **Date added: 3/11/22**	We are currently unable to demonstrate compliance against a number of recommendations against the various external reviews and reports. We have a backlog of investigations, RCA's and concerns and as a result LFE delays Workforce concerns and adverse media
Cause	• In England 180 million pounds of funding was released to support each Trust in complying with all of the Ockenden Recommendations. Welsh Government have invested £1 million in to the Mat Neo Safety Programme across Wales, which is currently in its Discovery phase for circa 12 months, next steps of which are yet to be communicated. The operational view is that it is unlikely any further investment will be made available by Welsh Government to support implementation of the recommendations. • NICE clinical guidance Intrapartum care for healthy women and babies resulting in increased instrumental birthing practices. Patients presenting and subsequently admitted have a higher acuity and complexity, particularly in light of NICE guidance. • We continue to experience challenges in our ability to deploy sufficient workforce to cover community, Midwifery-Led and Obstetric-Led care setting services. We struggle with sustained workforce challenges from sickness, maternity leave, resignations, retirement and challenges of retention and recruitment. • One out-take of newly Qualified Midwives and Paediatric Nurses each year from Welsh Universities causing a limited flow of Midwives/Paediatric Nursing staff • Restricted Neonatal capacity continues to add an increased layer of complexity in managing patient flow.

	• T2 new area opened during Pandemic, but with no increase in staffing (loss of 6 beds on Delivery Suite, 14 opened on T2). • Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and MSWs. Reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives are undertaking the New-born and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home. • With the publication of the latest NICE guideline on Antenatal Care that recommends that all women be 'booked' by 12 weeks' gestation, more women are meeting their midwife earlier than previously happened before 10 weeks. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal. In most maternity services approximately 10% of women are 'booked' and then have no further contact with the midwife. • Constraints accommodating the increased number of Inductions of Labour (IOL) and instrumental deliveries within current footprint. • Good level of incident reporting but insufficient resources to complete investigations, action plans and learning from events actions. • Independent external Birth-rate+ re-assessment has been undertaken and verbal findings are circa 16 Midwives short.
Impact	• Closure of Community Home Birth Services and Maternity Led Unit due to lack of staff. • Delays in allocating IO's to investigations, subsequent delays in completing investigations, action plans and LFE • Rise in instrumental deliveries • Delays in IOL and constraints in accommodating elective caesarean sections due to lack of NICU capacity • Congested department and long waits for IOL & ECS • Insufficient consultant cover for labour ward, NCEPOD readmission reviews • Lack of specialist roles; labour ward leads, Foetal surveillance, bereavement, transitional care nursing. • Lack of training in Human factors, CTG, labour ward coordinator leadership. • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety) and run of adverse incidents.
Impact Score: 5	Likelihood Score:5 | Gross Risk Score: **25 (Extreme)**
Current Controls	• Induction of 27 Newly qualified Midwives (NQM) and 43 Newly Qualified Paediatrics nurses from Student Streamlining • Introduction of daily clinical huddles between each days Lead Midwife, Lead obstetrician, lead neonatologist and lead neonatal nurse each day • Rollout of 3 extra consultant sessions for obstetric governance and 1 extra consultant session Neonatology governance to enable allocation of IO's to investigations • RAG rating of position against national report recommendations, presentation of gap analysis to executives and to senior Leadership Board for support of required resources • Continued recruitment actions • Escalation of concerns to HEIW re single out-turn of midwives and paediatric nurses • Establishment of Ockenden Oversight group meeting on fortnightly basis • Team continue to support recruitment and retention, submission of request for oversea recruitment. • Daily SiteRep reporting introduced into maternity and Neonates and DoNM/HoM daily catch up

Current Assurances	• Operational position reported into Management Executive (Daily) (1) • Mechanisms in place to monitor key measures being strengthened into visible dashboard.(1) • Key operational performance indicators and progress against plans reported into the Maternity/Neonatal oversight Group being led by Executive Nurse Director. (1)		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	• Confirmation of additional funding resource to fill gaps in assurance mapping • Recruitment strategies to sustain and increase multidisciplinary teams (appendix 1). • Developing an effective, high quality and sustainable model of managing intrapartum care and current constraints • Several incidents out of time		
Gap in Assurances	• Data and benchmarking information • Resources to meet the national recommendations		

Actions	Lead	By when	Update since January 2023
1. Ongoing recruitment above establishment, increasing training places	AJ	31/03/23	This action continues to take place.
2. Reviewing current obstetric practice in line with NICE guidance	CR/SZ	01/01/23	This action continues to take place.
3. Senior daily oversight of obstetric /Neonatal capacity and escalation to Executives	AJ	31/03/23	This action continues to take place.
4. Continued maternity / Neonatology oversight meetings with Executive lead	JR/AJ	31/03/23	This action continues to take place.
5. Ongoing review of job planning and consultant establishment	CR/AT	31/03/23	Job planning undertaken further resource required to meet Ockenden recommendations. Supporting revenue case to Board for approval 30/3/23
Impact Score: 5 Likelihood Score: 3	Target Risk Score:		**15 (high)**

3. Critical Care Capacity – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

For a sustained period prior to the COVID19 pandemic there were recognised critical care capacity challenges in CAV. The sustainability of Critical Care Services in Cardiff is reported in the 2014 unmet needs study WG, and the 2019 FICM external review. Following the COVID19 pandemic these challenges remain and still needs to be addressed. Critical care department capacity is not in a position to deliver a sustainable service to the population it serves.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable critical care capacity.		
Cause	• There is a progressively deteriorating problem with access for critically ill patients to ICU in Cardiff as a direct result of capacity. This now means patients who would benefit from ICU admission and care are not able to have this. • Gap of 15 ICU beds in CAV (2014 unmet needs study WG) • Funded increase in tertiary workload has increased the overall demands on critical care services in CAV • Poor infrastructure within the critical care unit – limited access to cubicles • Patient at Risk Team (PART) only operate during daytime hours (7am-7pm)		
Impact	• Adverse impact upon the Emergency Department and theatre flow • Untimely patient access • Inequity of patient access • 15% of referrals not admitted to critical care • Impact other operationally e.g. anaesthesia and theatres • Impact tertiary development e.g. ECMO • Patient outcomes worse • Reputation, Professional & Legal risk • Workforce - Reduced Recruitment & Retention • Poor staff morale and retention due to the sustained pressures in the system • Delayed admission and discharge from critical care leading to poor patient experience and outcomes		
Impact Score: 5	Likelihood Score:5	Gross Risk Score:	**25 (Extreme)**
Current Controls	• Strengthened site-based leadership and management • Strengthened OPAT oversight and support for DTOCs • Workforce plans in place to support recruitment and retention • Registered nursing recruited to establishment • Local escalation plan in place and utilised when appropriate to support operational pressures • PART team provide daytime support patients not admitted to critical care • Ringfenced PACU to protect elective urgent and cancer surgery • Winter escalation plan in place to support delivery of critical care to the sickest patients during the winter months		
Current Assurances Saunders,Nathan 11/04/2023 11:35:40	• Operational position reported into OPAT (1) • Key operational performance indicators and progress against plans reported into the clinical board 6 weekly (1) • ICNARC audit to provide assurance on outcomes (2) • Plans in development to increase level 3 bed capacity by three beds during 2023/24.(1) • Project team established to address medium term infrastructure constraints.(1)		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**

Gap in Controls	Development and implementation of a capacity plan to address the 15-bed gap Achievement of standard to step down patients from ICU within 4 hours to improve efficiency and patient flow 24/7 PART team Development of a fit for purpose critical care unit (UHW2)			
Gap in Assurances	Able to meet the needs of the sickest or highest priority cases. Un-met not fully understood across the organisation.			
Actions		**Lead**	**By when**	**Update since January 2023**
1. Secure funding and develop implementation plan for further three ICU beds		PB	30/11/22	Funding not confirmed as at 03.02.23. Focus remains on utilising existing resource to rollout out to further clusters
2. Implementation of 24/7 PART team		PB	31/03/23	Plan developed. Funding not confirmed as at 03.02.23 and implementation on hold.
3. Implementation of the UHW site masterplan and critical care infrastructure programme a. Medium term development of additional cubicles and support facilities b. Development of a new unit as part of UHW2 development. c. Transfer of LTiV services to a bespoke facility in UHL		AH / PB	31.03.23	Implementation of de-escalation plan commenced – but behind timescale due to ongoing operational pressures and recent increase in covid admissions. Awaiting decision from WG on funding of stage 1 of the infrastructure programme
4. Ongoing development of recruitment and retention strategies		JR / RG	31.03.23	This piece of work continues
Impact Score: 5	Likelihood Score: 2	Target Risk Score:		**10 (high)**

4. Cancer Services – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

One of the Health Board's Strategic Objectives is to have sustainable cancer services that deliver the single cancer pathway standard to treat patients with a confirmed diagnosis of cancer within 62 days. To achieve this, the system needs to ensure sufficient capacity is prioritised to meet the predicted weekly demand for cancer patients at the outpatient, diagnostic and treatment stages of the pathway whilst also being sufficiently flexible to respond to peaks and troughs in demand. The recently published Welsh Government Planned Care Plan, the Wales Cancer Network's Quality Statement and the emerging Wales Cancer Network's Improving Cancer Services and Outcomes Action Plan reflect the high priority of cancer services.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments to see elective patients in a timely manner has also impacted on those waiting on a cancer pathway. • Referral demand for cancer is now greater than pre-Covid levels and our planned care system has struggled to respond to this increase in demand and carve out sufficient capacity for cancer at outpatients, diagnostics, and treatments stages • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff • Weaknesses in the central cancer team in terms of changes of leadership, structure, vacancies and temporary staffing leading to lack of clarity and consistency		
Impact	• Long waiting times for first contact and diagnostics contributing to lengthening of the overall pathway for cancer patients • Overall PTL has grown 3-fold since pre-Covid • Significant volumes of patients now waiting >62 days and >104 days • Potential for harm e.g. missing the window of opportunity for surgical intervention, delays to starting chemotherapy/radiotherapy • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety)		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**
Current Controls	• Strengthened governance and oversight • COO is now Executive Lead for Cancer • Cancer is one of the delivery programmes in the 2022/23 Operational Plan • SOP in place to support tracking process • Roles and responsibilities redefined • Training being rolled out to refresh understanding of SCP guidance • Workforce team continue to support recruitment and retention • Ambition clearly stated – first contact by day 10, diagnosis by day 28, treatment by day 62 • Two cancer summits held with senior leadership teams, directorate management teams and tumour site clinical leads • Demand/capacity work commenced		

Current Assurances	• Operational position reported into Cancer Oversight Meeting weekly tracking improvements[1] • Executive Cancer Board meets quarterly[1] • Mechanisms in place to monitor key schemes in Cancer as part of the Operational Delivery Plan [1] • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee [1] • Breach reports produced for every patient treated >62 days [1] • Harm reviews conducted for every patient treated >146 days [1] • Cancer reported as part of the Board Integrated Performance report [1]

Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**

Gap in Controls	• Continuation of demand/capacity work to inform how much capacity needs to be carved out for cancer • Undertake pathway work to streamline the journey for cancer patients and reduce the downtime between steps on the pathway • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)
Gap in Assurances	• Whilst a Cancer Oversight Meeting is in place, there is a need to establish a weekly PTL tracking meeting with General Managers/Directorate Managers • Breach reports need to be shared with the Directorates for validation and themes (e.g. risks/issues/constraints) need to be fed through a continuous improvement loop to ensure mitigation/solutions are put in place • The Cancer Strategy needs to be finalised and a workplan developed

Actions	Lead	By when	Update since January 2023
1. Continue to develop and iterate the demand/capacity work	HE/JC	31.3.23	D&HI team are engaged in the work
2. Undertake a review of the key tumour site pathways with a view to removing constraints and delays in the patients' journey	RL	31.3.23	Support from the WCN to undertake a number of deep dives – focus on lung and urology initially
3. Establish a weekly PTL meeting with General Managers/Directorate Managers	JC	30.01.23	Now in place
4. Finalise the Cancer Strategy and develop a workplan	RL/BW	31.3.23	Draft strategy completed and is on the agenda for Exec Cancer Board in November
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce

Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (High)**

5. Stroke Services – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

Stroke services within C&V UHB have declined since the COVID pandemic, caused by a reduction in clinical services, but an increase in demand, most noticeably in patients self-presenting to the Emergency Department. There has been a real drive to improve this service for the patients and improvement has been seen in thrombolysis rates, achieving >10% since June 22 and now at 10.9%. Challenges include patients self-presenting to ED, dilution of stroke cases within the very busy ED leading to delay in recognition of stroke, scanning and treatment. Despite increased thrombolysis rates, door to needle times are not improving to pre-pandemic performance. There is often no dedicated Stroke medic at the front door meaning Medics are faced with competing given the capacity constraints within the footprint.

In addition to thrombolysis treatment rates, there has been improvement in thrombectomy assessment, referral and procedures delivered both internally and referred to Bristol. There has also been focused training for acute medics on stroke assessment, thrombolysis and thrombectomy. The Stroke CNS role is being protected where possible; recognised that this team are the drivers and facilitators of the thrombolysis pathway.

Investment is needed for increased Stroke resource at the front door – allowing patients to be seen, diagnosed and treated in a timely manner, ultimately reducing mortality and improving outcomes for patients. The aims are to improve Tier 1 performance and most importantly, safer care for our Stroke patients

Risk **Date added:** **01/11/2022**	Poor compliance with SSNAP – currently a D grade centre.
Cause	• An increasingly busy ED (double the number of patients) has seen a high demand upon the Stroke Service. Patients are often self-presenting which may result in an initial delay to be triaged resulting in (i) delays to Stroke calls being put out (ii) delays to patients receiving CT scans within 1-hour (iii) delays in the recognition and subsequent delivery of thrombolysis to patients. • The Stroke Unit at UHW regularly runs at 100% occupancy. Every effort is made to ensure there is a bed available for new stroke admissions. The large volumes of patients in the ED mean there is often a delay in patients being triaged and assessed within 4 hours, making it difficult to get the patients to the acute ward within a timely manner. Patients awaiting admission to the stroke unit in September between them spent almost 70 days in the ED. • Pressures across the system mean that Stroke beds are often used for non-Stroke patients. These short-term gains have long term impact on Stroke affecting the ability to admit new stroke patients within 4 hours, which has knock-on impact on specialist MDT assessments, commencement of rehabilitation and supportive discharge planning. • Since additional capacity beds which were collocated with stroke closed in August 22, performance against the 4 hours admit target improved to 20% in September. Support is needed to protect stroke beds for patients on the stroke pathway • Stroke CNS being pulled into ward numbers due to poor staffing levels

Impact	• Delays in patients receiving their CT scans within 1 hour • Delays in patients being recognised as potential Stroke patients • Delays in patients receiving timely treatment such as thrombolysis • Delays in patients being recognised as potential thrombectomy patients • Patients not receiving swallow screening in a timely manner (<4 hours) • Delays in patients being admitted to the acute Stroke ward in a timely manner (<4 hours) • Delays in patients leaving the acute Stroke ward (long lengths of stay, non-stroke patients being admitted due to ambulance waits) • Poor patient outcomes • Lack of available CRT slots or inappropriate CRT slots meaning patients in SRC are unable to be discharged in a timely manner		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20**
Current Controls	• Awareness raising on the importance of early swallow screen assessment – investment in training over the summer needs reinforcement with the timing of swallow screen and its urgency. • Taking any golden opportunities, we can – whenever there is capacity on the stroke unit, the stroke team are driving and pushing the ED stroke pathway to achieve the 4 hours admit wherever we can. The stroke team are real champions of the principles of 'Think Thrombolysis, Think Thrombectomy' and are pushing the imaging pathway to reach diagnosis as early as possible and ensure all patients are considered and assessed for urgent treatments which could reduce the disabling impact of the stroke. • Stroke Service Manager in post since July; Clinical Director for stroke in post from October. Dedicated resource for focused work with ED, radiology and medicine to ensure the optimal stroke pathway is in place and applied for all patients. • Seeking investment for uplift of CNS resource and dedicated stroke medical resource to support the front door for stroke. • Wider programme of works is needed to continue momentum of a stroke service improvement programme, particularly given future requirements for regional network service delivery and for UHW to become the regional thrombectomy centre		
Current Assurances	• Operational position reported into MCB (Monthly) (1) • Mechanisms in place to monitor key schemes in Stroke Operational Group and MCB SMT/IM DPR (1) • Monthly touch point meeting with the Delivery Unit (1)		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	Lack of consistent cover to the ground floor by a dedicated Stroke Medic CNS cover not 7/7 Stroke beds not ringfenced SRC capacity		
Gap in Assurances	Competing demand on regional, thrombectomy and clinical board priorities		

Actions	Lead	By when	Update since January 2023
1. Nursing Uplift Stroke CNS cover to 12 hour shifts 7 days per week. **Benefits** Increased out of hours CNS support to Code Stroke, facilitation of thrombolysis and thrombectomy treatment pathways, 4 hours admit target and nurse assessments. **Interdependencies / Risks** Capacity and flow, medical support	DP/NW/NT/TH	31/01/2023	This is being undertaken

2. Medical Extend locum SHO for SRC in backfill of specialist middle grade moving to UHW front door (Mon-Fri 9-5) Collaboration with other specialities (e.g. neurology) to improve stroke junior doctor out of hours cover. May incur cost to medicine. Contribute 4 locum consultant sessions to a new post with ITU for a neuro critical care specialist with 4 stroke sessions **Benefits** Cross speciality working - more sustainable OOH model and offers training opportunities. Reviewing the structure of the out of hours rota will offer further support to the medical on call team. Specialist middle grade and uplift of consultant sessions would support TIA clinic reconfiguration and front door senior decision making. Improved selection of patients for C4 beds, improved management of mimics in ED, acceleration of stroke assessment and diagnostics, improvement in 4 hours admit. This model offers the service an interim solution for winter demands, reducing the urgency of consultant uplift, allowing for planned succession and recruitment. **Interdependencies / Risks** Uplift is needed both in and out of hours. Locum posts are expensive but it is unknown if the workforce is there for external middle grade or consultant recruitment.	TH/NT/SB	31/01/2023	Locum SHO secured which will allow 6 sessions of front door Stroke cover – achieved November 2022, sessions in place to support front door stroke and TIA assessments. Funding for 3 sessions reinvested from stroke service; funding for 4th session agreed by MCB Jan 23.
3. Capacity C4 beds only to admit those patients on the stroke pathway with a protected minimum of 4 beds. Until additional capacity Winter beds open the ask is to cap medical outliers to 4 on the ward at any one time. **Benefits –** median number of admissions per day = 3 in September. 4 beds protected should offer admission capacity for most new stroke patients and we would hope to see the 4 hours admit performance >50%. When necessary to relieve pressure across the system medical outliers would be admitted; the cap would attempt to minimise the impact of these admissions on stroke performance. **Interactions/Risks** – Ability to create 4 beds each day once used is uncertain. Exit strategy needed for any medical outliers and stroke mimics. Flow needed across whole stroke pathway; community services to be approached re options to prioritise stroke beds in CRT slot allocation if possible.	NT/DP/NW/SB	31/01/2023	SOP being produced for the ringfencing of beds Agreement being sought at Clinical Board and Health Board level for ringfencing of beds "Golden days" where beds are available at the beginning of the day to show the art of the possible
4. Diagnostics Daily imaging 'hot slots' for carotid dopplers/ MRIs/ CTA for stroke patients.	NT/TH	31/01/23	Ongoing discussions with radiology to create slots Use of the CD&T escalation email to prioritise Stroke

Benefits – Timely diagnoses and treatment for both stroke patients and stroke mimics. Improved discharge profile to support protection of beds. **Interactions and Risks –** hot slots may not be needed every day (would be booked by 10am and released back to radiology if not needed). Ideally would operate over 7 days.				patients for discharge dependent MRIs, etc.
Impact Score: 5	Likelihood Score: 2	Target Risk Score:		**10 (high)**

6. Urgent & Emergency Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

One of the Health Board's Strategic Objectives is to have a sustainable unplanned (emergency) care system that provides the right care, in the right place, first time. To achieve this, a whole system approach is required with health and social care working in partnership – both together and also with independent and third sector partners. The recently published Welsh Government Six goals for Urgent and Emergency Care span the whole pathway and reflect priorities to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration. The impact of the covid pandemic has had many consequences. This includes sustained pressure across the urgent and emergency care system and, whilst underlying actions to progress the plans to achieve the strategy have progressed, covid-19 has impacted on the speed of ongoing action and implementation of plans. The Sustainable Primary and Community Care risk reported in 2021/22 has been incorporated into this newly reported risk for 2022/23.

Risk **Date added: 09/05/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable urgent and emergency care as close to home as possible.		
Cause	20 The impact of the covid pandemic has resulted in sustained pressure across the urgent and emergency care system. Five factors have combined to cause current operational challenges: (i) Non-covid occupancy remains at a high level and we continue to experience challenges in our ability to achieve timely discharge of patients (ii) Covid continues to add an increased layer of complexity in managing patient flow (iii) Patients presenting and subsequently admitted have a higher acuity and complexity (iv) We have sustained workforce challenges (v) Social Care are experiencing similar workforce and demand challenges • Sustained pressure in Primary and Community Care, including an increased number of GP practices operating at a higher level of escalation, temporary list closures and practice closures • Poor consistency in referral pathways, and in care in the community leading to significant variation in practice • Rollout of multi-disciplinary team cluster models only in limited number of clusters • Lack of co-ordination and / or streamlined services across Health and Social care to ensure a joined-up response is provided and the patient gets the right care, in the right place, first time • Poor response times in the community from WAST due to significant delays in ambulance handovers • Longer length of stay for both medically fit patients and clinically unfit patients, significantly above pre-covid levels		
Impact	• Long waiting times for patients to access a GP • Patients attend the Emergency Department because they cannot get the care or timely care they need in Primary and Community Care • Referrals and admissions into hospital because there are no alternative options or staff are unaware of alternative options • Congested ED department and long waits for patients to be seen • Increase in ambulance handover delays and challenges in timeliness of ambulance response to community demand • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety)		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**

Current Controls	• Development of Primary Care Support Team to provide proactive support to fragile practices • Plans agreed and implemented for contract resignations and list closures • Rollout of MDT cluster model to further 2 clusters (1 already implemented) • Urgent Primary Care hubs in the Vale – c.2500 appointments per month • Cardiff CRT and Vale CRT support people to remain at home, avoid hospital admission and be discharged from hospital – but challenges do remain on capacity and timeliness • Implementation of CAV24/7 and transition to NHS Wales 111 • Strengthened site-based leadership and management • Urgent & Emergency Care is one of the five delivery programmes in the 2022/23 Operational Plan. Delivery Group in place. Urgent and Emergency Care System Plan developed, aligned to the National six goals – see actions. • Ambulance handover improvement plan developed and being implemented • Workforce team continue to support recruitment and retention • Local Choices Framework governance in place and utilised when appropriate to support operational pressures		
Current Assurances	• Operational position reported into Management Executive (weekly) (1) • Mechanisms in place to monitor key schemes in Urgent & Emergency Care Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee. Specific focus on Six Goals for Urgent & Emergency Care on 12th July 2022. (1) • Urgent and Emergency Care reported as part of the Board Integrated Performance report (1)		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	Actively scale up multidisciplinary cluster models Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce) Developing an effective, high quality and sustainable Acute Medicine model Reconfiguring our in-hospital footprint to improve efficiency and patient flow		
Gap in Assurances	Whilst an Urgent & Emergency Care Delivery Group is in place, the Six Goals Integrated Urgent & Emergency Care Transformation Board is yet to be established		

Actions	Lead	By when	Update since January 2023
1. Secure funding and develop implementation plan for further MDT cluster rollout and Urgent Primary care Centre in Cardiff	LD	30.11.22	UPPC in Cardiff CRI went live in December. Further roll out in Cardiff North planned for Feb. MDT Cluster work is separate and ongoing.
2. Development and implementation of one Urgent and Emergency Care Plan, aligned to the National six goals	PB	31/10/22	Complete - Delivery Board relaunched in January, approach agreed at SLB in December.
3. Introduce Medical Same Day Emergency Care Unit moving to new area whilst introducing senior clinical triaging and hot clinics	PB	30.11.22	Complete -MSDEC moved to interim location.
4. Introducing frail assessment service in emergency and assessment area UHW	PB	30.11.22	Complete - Frail service went live.
5. Develop SOP for A1 (medical short stay ward) and SOP for Zero four-hour ambulance handovers	PB	30.11.22	Complete - Both actions implemented. A1 has led to improved turnaround, reduced length of stay and more patients admitted and discharge.

				Ambulance handover performance improved.
6. Develop cohesive Winter Plan that introduces 150 beds or bed equivalents 7. Develop acute admission protocols		PB PB	30.11.22 30.11.22	Complete - Circa 150 beds / bed equivalents are being delivered through winter plan Action ongoing – aim for completion in February.
8. Continued development of joint Health and Social Care strategies to allow seamless solutions and services for patients with health or social needs		AH / PB	31.03.23	Partnership working continues. Joint action plans in place. Work progressing through RPB, SLG and JME with new IMT introduced bi-weekly chaired by SR to increase focus on actions
9. Introduce integrated care assessment unit as part of the Winter Plan to discharge patients into UHW Lakeside for focused social care intervention whilst maintaining care.		PB	31.10.22 - 31.01.23	Complete - IACU opened in LSW. Reduced length of stay for MFFD patients – increasing from 27 to 41 patients in next two weeks.
10. Implementation of the UHW site masterplan, including de-escalation of additional capacity and reconfiguration of the EU		PB	31.03.23	Implementation of de-escalation plan commenced – but behind timescale due to ongoing operational pressures and recent increase in covid admissions.
11. Development of recruitment and retention strategies		RG	31.03.23	See separate BAF risk on workforce
Impact Score: 5	Likelihood Score: 2	Target Risk Score:		**10 (high)**

7. Planned Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

One of the Health Board's Strategic Objectives is to have sustainable planned care services that deliver the ministerial measures of no-one waiting >52 weeks for a new outpatient appointment by December 2022 and no-one waiting >104 weeks for treatment (all stages) by March 2023. To achieve this, the system needs to ensure sufficient capacity to meet recurrent demand and to increase capacity and activity sufficiently above pre-Covid levels to make inroads into the backlog. The recently published Welsh Government Planned Care Plan reflects the high priority of planned care services.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable planned care services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments for urgent/emergency care has impacted on those waiting to access the system for planned care. • Referrals for planned care are at pre-Covid levels overall, however there is significant variation between specialities. Whilst our planned care system (outpatients, diagnostics, treatments) is almost back to full capacity, it has been challenging to achieve activity levels significantly above pre-Covid activity. • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff		
Impact	• Significant volumes of patients waiting for new outpatient appointments, diagnostics and treatment • Some patients are tipping over into waits of more than 3 years, some of these are still at the outpatient stage • Potential for harm in terms of clinical deterioration whilst patients are waiting, particularly at the outpatient stage where patients have yet to be seen by a secondary care clinician and priority determined • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety) • Organisational/reputational harm due to political and media interest and scrutiny		
Impact Score: 4	Likelihood Score:4	Gross Risk Score:	**16 (Extreme)**
Current Controls	• Planned Care is one of the delivery programmes in the 2022/23 Operational Plan • Demand/capacity work undertaken to model expected delivery against the ministerial measures • Additional capacity schemes funded through WG planned care monies are in place and delivering e.g. independent sector, mobile ophthalmology theatres, 2nd gynae treatment room commissioned, spinal unit commissioned, mobile endoscopy unit in place • Workforce team continue to support recruitment and retention • Suite of reports and dashboard created by the Digital and Healthcare Intelligence team to support Directorate teams and Clinical Board in terms of managing the planned care position		

Current Assurances	• Current position against 52/104weeks monitored via weekly Planned Care Performance meeting (1) • Operational position reported into daily/weekly 'hot' reports(1) • Elective Care Delivery Group in place monthly; suite of metrics reviewed at every meeting (1) • Monthly meeting with the Delivery Unit on Planned Care(1) • Mechanisms in place to monitor key Planned Care schemes as part of the Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee (1) • Planned Care reported as part of the Board Integrated Performance report (1)		
Impact Score: 4	Likelihood Score: 3	Net Risk Score:	**12 (High)**
Gap in Controls	• Further demand/capacity work required together with an indication of the ministerial targets to inform the plan for 23/24 and assess deliverability • Availability of planned care funding may mean that choices need to be made in terms of delivery • Further work required to maximise treat in turn • Solutions required to ensure all specialities can access sufficient capacity to enable a return to pre-Covid levels of activity • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Since the Operational Plan Delivery Group meeting has been stepped down, there is a need to consider the governance mechanisms by which key risks and messages from the Elective Care Delivery Group are escalated • Whilst a sub-group on supporting patients whilst they are waiting has been established, the group is in its infancy and needs to progress at pace		

Actions	Lead	By when	Update since January 2023
1. Continue to develop and iterate the demand/capacity work for 23/24 to inform the IMTP	AW/JC	31.1.23	Included in development of IMTP
2. Establish key priorities and a work plan for the supporting patients sub-group	EC	31.12.22	Complete. Group is in place and meeting monthly. Two sub-groups have been established with work due to commence in January.
3. Continue to progress plans to maximise activity and monitor via the Planned Care Performance group	JC	Weekly	Complete - Meetings in place
4. Agree formal reporting mechanisms from the Elective Care Delivery group through to SLB	PB/HE	31.12.22	Under consideration as part of review of COO meeting structures Proposal taken to SLB on 22.12.22
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 4 Likelihood Score: 2	Target Risk Score:		**8 (High)**

Report Title:	The National Collaborative Commissioning Unit Quality Assurance and Improvement Service Annual Position Statement.			Agenda Item no.	*4.1*
Meeting:	QSE	Public 2.2	✓	Meeting Date:	11/04/23
		Private			
Status *(please tick one only):*	Assurance	✓	Approval	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Assistant Director of Patient Experience				

Main Report

Background and current situation:

The purpose of the report is to provide an update to the CTMUHB Quality and Safety Committee (as host body) for assurance purposes. It has been shared with health Boards as it is a National overview.

Thereport 'NHS Wales Quality Assurance Improvement Service – National Collaborative Frameworks Mental Health and Learning Disabilities Annual Position Statement 2021-2022' provides the Committee with an overview of the three National Collaborative Frameworks which are overseen by the National Collaborative Commissioning Unit.

The National Collaborative Frameworks are as follows:

1. National Collaborative Framework Adult Mental Health and Adult Learning Disability Hospital Services ('Adult Hospital Framework').
2. National Collaborative Framework for Child Adolescent Mental Health Service (CAMHS) Low Secure & Acute Non-NHS Wales Hospital Services ('CAMHS Hospital Framework').
3. National Collaborative Framework for Adults (18+ years) in Mental Health and Learning Disabilities care homes & care homes with nursing for NHS and Local Authorities in Wales ('Care Home Framework')
4.

Legal Status

The NHS Wales National Collaborative Frameworks are formal agreements and mechanisms developed by the National Collaborative Commissioning Unit and NHS Wales: Shared Services Partnership-Procurement. This enables all signatory NHS Wales and Local Authorities to procure and performance-manage services under pre-agreed standards, costs, terms and conditions of a contract in a compliant manner in accordance with EU and UK Procurement Regulations and Health Board or Local Authority Standing Orders and Financial Instructions.

The Cardiff and Vale Specific data from the report is as follows- medium secure hospitals, low secure hospitals, controlled egress hospitals and uncontrolled egress hospitals

A comparison with 2020/21 saw two Health Boards had a decrease and three Health Boards had an increase and two remained the same in use of the Adult Hospital Framework as shown below:

- Aneurin Bevan UHB had an increase of 14% since 2014 and a 16% increase since last year.
- Betsi Cadwaladr UHB had an increase of 24% since 2014 and a 17% decrease since last year.
- **Cardiff and Vale UHB had a decrease of 13% since 2014 and 15% increase since last year.**

- Cwm Taf Morgannwg UHB had an increase of 36% since 2014 and a 10% decrease since last year.
- Hywel Dda UHB had a decrease of 50% since 2014 and the percentage stayed the same since last year.
- Powys Teaching HB had the same percentage of as 2014 and a 16% increase since last year.
- Swansea Bay UHB had a decrease of 30% since 2014 and the percentage stayed the same since last year.

The CAMHS and Care homes data is national and not specific to Health Boards. On 31 March 2022, there were six patients receiving assurance under the CAMHS Hospital Framework, which is one more than was placed at the same time in 2020/2021.

Between the 1 April 2021 and 31 March 2022, there were 22 placements made under the CAMHS Framework. CAMHS Hospital Quality Assurance Reviews

Of the 4 CAMHS units reviewed 2 maintained the standards with no further action required and 2 units received Performance Improvement Notice. In one of those cases the provider provided the required assurance and all the remedial actions had been rectified within the designated ten-day timeframe.

National Overview and Trends of the Care Home Framework
On the 31 March 2022 there were 370 Welsh residents receiving assurance under the Care Home Framework. This compares to 309 residents from the previous year, equating to a 20% increase

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

The Committee are asked to note the activity for the three National Collaborative Frameworks throughout 2021/22.

Recommendation:

The Committee are requested to: Note the content so the report and the developing process to monitor Quality Indicators

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The placements are needed by some of our most vulnerable patients
Safety: Yes
The frameworks review standards, safeguarding, incidents and complaints in commissioned services
Financial: Yes
Failure to identify learning from themes will lead to increased harm and litigation.
Workforce: No
Legal: Yes
We need to adhere to the relevant legislation.
Reputational: Yes
There is media interest in commissioned care
Socio Economic: Yes/No
Consideration of socio-economic disadvantage needs to be further explored -Placement of people a long distance from home can have a significant impact on family and friendships
Equality and Health: Yes
As above further work is need to demonstrate equality and health inequalities.
Decarbonisation: yes

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

AGENDA ITEM
6.1

QUALITY AND SAFETY COMMITTEE

NATIONAL COLLABORATIVE COMMISSIONING UNIT QUALITY ASSURANCE AND IMPROVEMENT SERVICE ANNUAL POSITION STATEMENT 2021-2022

Date of meeting	20/09/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Shane Mills, Director of Nursing, Performance and Quality
Presented by	Shane Mills, Director of Nursing, Performance and Quality
Approving Executive Sponsor	Managing Director of the National Collaborative Commissioning Unit / Chief Ambulance Services Commissioner
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
NCCU MANAGEMENT BOARD	JULY 2022	ENDORSED

ACRONYMS	
NCCU	National Collaborative Commissioning Unit
QAIS	Quality Assurance and Improvement Service
UHB	University Health Board

1. SITUATION/BACKGROUND

1.1 The purpose of the report is to provide an update to the CTMUHB Quality and Safety Committee (as host body) for assurance purposes.

1.2 The attached report at **Appendix 1**: 'NHS Wales Quality Assurance Improvement Service – National Collaborative Frameworks Mental Health and Learning Disabilities Annual Position Statement 2021-2022' provides the Committee with an overview of the three National Collaborative Frameworks which are overseen by the National Collaborative Commissioning Unit. The NCCU is hosted by Cwm Taf Morgannwg UHB and based in Charnwood Court in Nantgarw.

The National Collaborative Frameworks are as follows:

1. National Collaborative Framework Adult Mental Health and Adult Learning Disability Hospital Services ('Adult Hospital Framework').
2. National Collaborative Framework for Child Adolescent Mental Health Service (CAMHS) Low Secure & Acute Non-NHS Wales Hospital Services ('CAMHS Hospital Framework').
3. National Collaborative Framework for Adults (18+ years) in Mental Health and Learning Disabilities care homes & care homes with nursing for NHS and Local Authorities in Wales ('Care Home Framework')

Prior to 2012, externally provided mental health and learning disabilities hospital and care services were commissioned separately by each Health Board or through the Welsh Health Specialised Services Committee. These commissioning arrangements led to disparity in costs, contractual obligations, standards and performance management across NHS Wales. Oversight of these commissioned services was the remit of individuals or small teams within organisations with little or no collaboration.

An independent review in 2012 stated that the use of the independent sector and NHS England services by NHS Wales prior to the development of the National Framework was "inefficient, ineffective and inconsistent"[1] . In March 2012, a National Collaborative Framework for Medium and Low Secure Care was launched, and was successful in improving quality, enhancing assurance and reducing costs. Subsequently, the Chief Executives of the NHS Wales Health Boards considered that a broader suite of services such as locked and open rehabilitation required this level of assurance and the NHS Wales National Collaborative Framework for Adult Mental Health & Learning Disability Hospitals was launched in April 2014.

[1] Tayside Centre for Organisational Effectiveness (2013). Review of the NHS Wales Mental Health & Learning Disability Secure Services Procurement Project, a retrospective view. Cardiff: NHS Wales

In October 2015, a National Collaborative Framework for Children and Adolescent Mental Health Services Low Secure & Acute Non-NHS Wales Hospital Services was launched at the request of the Together for Children and Young People Programme.

In October 2016, a National Collaborative Framework for Care Homes Adults in Mental Health and Learning Disabilities Care Homes & Care Homes with Nursing launched and provides consistent quality, standards, placement process and contractual terms for all Health Boards and Local Authorities to commission placements.

Legal Status
The NHS Wales National Collaborative Frameworks are formal agreements and mechanisms developed by the National Collaborative Commissioning Unit and NHS Wales: Shared Services Partnership-Procurement. This enables all signatory NHS Wales and Local Authorities to procure and performance-manage services under pre-agreed standards, costs, terms and conditions of a contract in a compliant manner in accordance with EU and UK Procurement Regulations and Health Board or Local Authority Standing Orders and Financial Instructions.

Commissioning Responsibilities
The National Collaborative Frameworks provide the enacting mechanism for the commissioning of services. These services are provided once a patient or resident is placed through the National Collaborative Framework processes and an individual placement agreement is generated, and therefore a contract enacted, between the commissioner (Health Board, Local Authority or Welsh Health Specialised Services Committee) and provider.

Benefits
The National Collaborative Frameworks have been developed to enable:

- Consistent and sustainable high-quality service provision and improved outcomes for individuals.
- An approved directory of suitably qualified, financially viable providers to meet specified quality, service and cost criteria.
- The establishment of bespoke care standards, standard contract terms/conditions, and a transparent pricing framework.

Scope
The scope of services covered by the National Collaborative Frameworks is Independent and NHS England hospitals and independent care homes providing the following services:

- Medium secure mental health.
- Medium secure learning disability.

- Low secure mental health.
- Low secure learning disability.
- Controlled egress (formally locked rehabilitation) mental health.
- Controlled egress (formally locked rehabilitation) learning disability.
- Uncontrolled egress (formally open rehabilitation) mental health.
- Uncontrolled egress (formally open rehabilitation) learning disability.
- Care homes without continuous staffing mental health.
- Care homes without continuous staffing learning disability.
- Care homes with continuous staffing mental health.
- Care homes with continuous staffing learning disability.
- Care homes with nursing mental health.
- Care homes with nursing learning disability.
- Low secure care child and adolescent mental health.
- Acute care child and adolescent mental health.

National Nine-Year Trend by tier of service

There are four 'tiers' of service on the Adult Hospital Framework, which are medium secure hospitals, low secure hospitals, controlled egress hospitals and uncontrolled egress hospitals.

1. Medium Secure Hospitals

Medium secure services are specifically designed to meet the needs of patients who present a serious risk to themselves or others, combined with the potential to abscond. In many cases, patients in medium secure care will have committed an offence or been referred to hospital by the court services.

2. Low Secure Hospitals

Low secure services are provided for those patients who have complex needs and cannot be safely cared for in non-secure units. These patients are usually detained under the Mental Health Act and present a level of risk to themselves and others that require specialist environmental security measures.

3. Controlled Egress Hospitals

Controlled egress services, previously termed 'locked rehabilitation', provide rehabilitative services to patients with complex needs and challenging behaviours. These units have locked or lockable doors to prevent unplanned egress.

4. Uncontrolled Egress Hospitals

Uncontrolled egress services, previously termed 'open rehabilitation', provide rehabilitative services to patients with longer-term needs. In general, these units only lock the entrances/exits at night for security purposes.

A comparison with 2020/21 saw two Health Boards had a decrease and three Health Boards had an increase and two remained the same in use of the Adult Hospital Framework as shown below:

- Aneurin Bevan UHB had an increase of 14% since 2014 and a 16% increase since last year.
- Betsi Cadwaladr UHB had an increase of 24% since 2014 and a 17% decrease since last year.
- Cardiff and Vale UHB had a decrease of 13% since 2014 and 15% increase since last year.
- Cwm Taf Morgannwg UHB had an increase of 36% since 2014 and a 10% decrease since last year.
- Hywel Dda UHB had a decrease of 50% since 2014 and the percentage stayed the same since last year.
- Powys Teaching HB had the same percentage of as 2014 and a 16% increase since last year.
- Swansea Bay UHB had a decrease of 30% since 2014 and the percentage stayed the same since last year.

Incidents are classified by 5 levels of severity. The level of severity of the each of the 11,475 incidents reported; a 24% decrease on the previous year and a point to note is that there was a 2% decrease in the number of patients receiving assurance of the Adult Hospital Framework during 1 April 2020 and 31 March 2021 is:

- 49% were classed as negligible in 2021/22 compared to 50% in 2010/21.
- 39% were classed as minor in 2021/22 the same that was reported in 2020/21.
- 11% were classed as moderate in 2021/22 compared to 10% in 2020/21.
- 1% were classed as severe in 2021/22 the same that was reported in 2020/21.
- 0% were classed as critical in 2021/22 as was reported in 2020/2021.

Complaints

All complaints reported are monitored by the QAIS team to highlight areas of investigation or improvement. Reported complaints by patients receiving assurance of the Adult Hospital Framework are categorised against a bespoke 53-point matrix of nine complaint areas with sub-categories in each. Complaints are monitored at a patient, unit, hospital and provider level

A total of 256 complaints were reported between 1 April 2021 and 31 March 2022, compared to 164 from the previous year and increase of 92 (56%).

Safeguarding
The QAIS monitor all potential safeguarding concerns involving patients receiving care under the Adult Hospital Framework. Local safeguarding teams set thresholds for local providers so when a provider reports a *potential* safeguarding concern the local safeguarding team confirms either that the concern meets the thresholds for reporting or not (noted as *unconfirmed*).

In 2021/22, 15% (100) of the 675 reported safeguarding concerns were validated as confirmed and 85% (575) as unconfirmed. The 675 potential safeguarding concerns constitute a 23% increase from the 575 reported in 2020/21.

Overview and Trends for CAMHS Hospital Framework

Providers
There were 8 companies, 8 Hospital Sites and 36 individual units providing or available to provide a service under the CAMHS Hospital Framework on the 31 March 2022.

On 31 March 2022, there were six patients receiving assurance under the CAMHS Hospital Framework, which is one more than was placed at the same time in 2020/2021.

Between the 1 April 2021 and 31 March 2022, there were 22 placements made under the CAMHS Framework.

Type of service
There are two of tiers of service on the CAMHS Hospital Framework, which are low secure hospitals and acute hospitals in a low secure hospital.

Low Secure Hospitals
Low secure services are provided for those patients who have complex needs and cannot be safely cared for in non-secure units. These patients are usually detained under the Mental Health Act and present a level of risk to themselves and others that require specialist environmental security measures.

Acute Hospitals
Acute services are designed to be short-term placements for rapid assessment and acute treatment, with lockable doors.

Maintaining the Quality of Care
There are 162 bespoke Welsh standards based on best service, experiential learning and good clinical practice across 25 areas.

CAMHS Hospital Quality Assurance Reviews

Of the 4 CAMHS units reviewed 2 maintained the standards with no urher action required and 2 units received Performance Improvement Notice. In one of those cases the provider provided the required assurance and all the remedial actions had been rectified within the designated ten day timeframe.

Incidents
There were a total of 1951 incidents involving patients receiving assurance under the CAMHS Hospital Framework between 1 April 2021 and 31 March 2022. Of these incidents:

- 744 or 38% were classed as negligible.
- 1188 or 61% were classed as minor.
- 16 or 1% were classed as moderate.
- 2 or 0% were classed as severe.
- 1 or 0% were classed as critical.

Complaints
A bespoke 53-point matrix of nine complaint areas with sub-categories in each. Complaints are monitored at a patient, unit, hospital and provider level to categorise complaints. A total of 4 complaints were reported between 1 April 2021 and 31 March 2022, compared to 0 from the previous year.

Safeguarding
- Forty-four potential safeguarding concerns that involved patients receiving assurance under the CAMHS framework between 1 April 2020 and 31 March 2021 were reported to local safeguarding teams.
- These safeguarding concerns are subsequently validated by local safeguarding teams, as an actual safeguarding concern or not, is called 'unconfirmed'. Between 1 April 2021 and 31 March 2022, 1 (2%) of concerns were confirmed and 43 (98%) were unconfirmed.

National Overview and Trends of the Care Home Framework

Providers of Care
On the 31 March 2021, there were 116 providers and 335 individual care homes providing able to provide services as part of the Care Home Framework.

National Trend:

On the 31 March 2022 there were 370 Welsh residents receiving assurance under the Care Home Framework. This compares to 309 residents from the previous year, equating to a 20% increase.

Distance from significant postcode:

The QAIS want to ensure that the National Collaborative Frameworks, wherever possible and with due regard for quality, provide placements that are as close as possible to the residents community of choice. Within the placement process, we mandate that the commissioner enters a 'significant postcode' for the resident and distance to the provider is calculated from this geographical point.

The list below shows the distance of placement from significant postcode

- 67% of residents received care between 0-10 miles
- 15% of residents received care between 11-20 miles
- 5% of residents received care between 21-30 miles
- 6% of residents received care between 31-40 miles
- 4% of residents received care between 41-50 miles
- 4% of residents received care of 51+ from the significant postcode.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 To note the activity for the three National Collaborative Frameworks throughout 2021/22.

2.2 On the 31 March 2022, there were 24 companies, 76 hospital sites providing or able to provide services as part of the Adult Hospital Framework.

2.3 Although the numbers of adult patients receiving assurance under the Adult Hospital Framework since 2014 has fluctuated by a small degree

each year. There was exactly the same number this year as there was when figures were first collated in 2014, i.e. 339 Patients.

2.4 The use of the Care Home Framework Agreement has seen an exponential rise over the past five years. There were 370 residents receiving assurance under the National Care Homes Framework Agreement as of 31st March 2022. That is an increase from 309 (20%) the previous year.

2.5 The Hospitals Frameworks (Adult and CAMHS) ceased on 31st March 2022 and the new Adult and CAMHS Hospitals Framework agreement commenced on 1st April 2022.

3. KEY RISKS/MATTERS FOR ESCALATION

3.1 This is an annual position statement to describe arrangements across Wales.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The whole report aims to demonstrate that the national frameworks ensure patients receive safe and effective care
Related Health and Care standard(s)	Safe Care
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
	However, the frameworks ensure value for money in line with the right quality of care for patients
Link to Main Strategic Objective	To Improve Quality, Safety & Patient Experience

Link to Main WBFG Act Objective	Service delivery will be innovative, reflect the principles of prudent health care and promote better value for users

5. RECOMMENDATIONS

5.1 The Quality and Safety Committee is asked to:

- **NOTE** the National Collaborative Frameworks Mental Health and Learning Disabilities Annual Position Statement 2021/22.

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 24th January 2023 at 8.30am
Via Microsoft Teams

Present:		**Title**
Clare Rowntree	CR	Clinical Board Director, C&W Clinical Board
Janice Aspinall	JA	Lead H&S Representative, Staff Side
Lois Mortimer	LM	Interim Deputy Head of Midwifery, O&G Directorate
Alison Lewis	ALewis	Patient Safety Facilitator
Matt McCarthy	MM	Patient Safety Facilitator
Paula Davies	PD	Lead Nurse, CYPFHS Directorate
Rim Al-Samsam	RAS	Clinical Director, CHFW Directorate
Anthony Lewis	AL	Clinical Board Pharmacist
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Ian Morris	IM	Clinical Lead/Consultant Neonatologist, CHFW Directorate
Laura McLaughlin	LM	Risk Manager, O&G Directorate
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Catherine Wood	CW	Director of Operations, C&W Clinical Board
Abraham Theron	AT	Clinical Director, O&G Directorate
In Attendance		
Annette Beasley	AB	Macmillan UHB Lead Cancer Nurse
Secretariat		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Apologies:		
Martin Edwards	ME	Asst Clinical Director, CHFW Directorate
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board

Item No	Agenda Item	Action
CWQSE/ 2023/001	**1.1 Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2023/002	**1.2 Apologies for Absence** **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2023/003	**1.3 Minutes of the previous Q&S Meeting held on 22nd November 2022** The minutes of the meeting were agreed to be an accurate record. **The CWQSE resolved:** a) The minutes were noted and agreed as an accurate record.	
CWQSE/ 2023/004	**1.4 To note and update the action log of the meeting of 22nd November 2022** Updates were provided on the actions from the last meeting and it was noted that a number of actions have been resolved. The outstanding actions were noted as:	

	Maternity Services Data Presentation to be provided on work being taken forward within Cardiff and Vale UHB Maternity Services by DJ, Digital Midwife. Action closed, date confirmed for March 2023. **Guidance for Use of Analgesia** Action complete. Guidance complete and switch of use of strength of codeine on the unit. Pethidine guidance has been updated with dose banding according to weight. Induction of labour drug chart sticker has also been developed for implementation as a further mitigation to any risks going forwards. Requests were made that the implementation of the sticker is audited. **Patient Safety Learning Review Tool** It was agreed that a formal presentation will be provided at an upcoming meeting. Action closed by exception, date being arranged. **The CWQSE resolved:** a) Updates noted and all actions from 22nd November meeting have been closed.	
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		
CWQSE/ 2023/005	**2.1 NRI Investigation – Patient LMD** AB was welcomed to the group and provided an update on a recent NRI Investigation undertaken relating to a 5yr old child who presented initially to GP in July 2021 with symptoms of sore throat, pyrexia and feeling unwell. Initially it was diagnosed as tonsillitis and was prescribed antibiotics. Over the period of 3 months, further contact was made with the GP as the child remained symptomatic and was becoming increasingly unwell. Contact was made through face to face and via telephone (as per triage process due to COVID pandemic). Patient was referred for a tonsillectomy and was assessed via virtual nurse led clinic. Patient continued to deteriorate, including progressive symptoms of headache, significant weight loss and pain in her neck etc. Urgent referral was made to General Paediatrics, and an emergency appointment to EU and referral to ENT team. Through this appointment a large mass was found, and a cancer diagnosis was provided to the parents at an outpatient appointment and with further diagnostics biopsy being arranged. Patient was diagnosed with a large nasopharyngeal tumor, large pelvic lesion and renal masses. Plan was made for emergency chemotherapy and airway management, with a tracheostomy tube being inserted. Patients family were fully engaged with the investigation process and shared their experience throughout the process. Notable practice, the timeline of events took place during the COVID Pandemic which impacted on the number of face to face appointments on offer and pressures in maintaining services. Root causes were noted: • There was a failure to recognise, co-ordinate and appropriately expedite the care of an unwell child with progressing symptoms. • Ineffective communication between teams. e.g. Referrals from primary care to secondary care. o Episodes of care and consultations were not linked. o Delay in letters from secondary care to GP.	

	• Cancer in the nasopharyngeal area – a rare site for cancer in children. A number of recommendations were identified and an action plan has been developed in partnership with Surgery and PCIC Clinical Board, and all actions are progressing. The investigation will also be shared through all governance processes to share lessons learnt and changes in practice to be embedded. Full report has been shared with the family and an offer to meet with the family. Family stated the report was very clear and comprehensive and assurance was provided that the action plan is being progressed. Discussion ensued with regards to the significant weight loss and how we can ensure that this can be embedded into practice as a red flag and how we can ensure that all actions are delivered. Improving education of deteriorating patients is key and regular education sessions take place through PCIC with specific update to be provided on ENT cancer and access to consultant connect, along with continuing to raise awareness via the primary/secondary care interface work being taken forward. Queries were raised as to whether there were any further contacts with other health professionals such as health visiting. It was noted that this is not known. Parents repeated visits were concerning and it was felt that this should have enabled an immediate visit to CAU. It was agreed that pathways criteria would be reviewed to ensure that the deteriorating child is clear within the process. It was also acknowledged that due to human error, the referral was downgraded to routine from urgent which did cause a delay in being seen, however work has been undertaken on the process to ensure that this is mitigated going forwards. It was agreed that the action plan would be discussed in 6months time to review and ensure that all actions have been embedded into practice. **The CWQSE resolved:** a) The update was noted. b) Action Plan to be brought back for discussion in 6months time.	**EB/KH**
CWQSE/ 2023/006	**2.2 Health & Care Standards Directorate QSE Exception Reporting** The detailed report was shared for information and an update was provided on the key highlights from the report. **2.2.1 CHFW Directorate Report** • RCA within NICU with regards to ventilation tubing used for transport from theatre is being progressed • NICU staffing and acuity is highest risk. OCP process has commenced. Model outlines the senior nursing team and flow through the unit to manage and support outreach and nursery. Hope to implement the new model within the next few months. • Review of vacancies across all areas being reviewed as part of a rotational posts programme. • NICU Annual report has been completed and it was noted that a presentation will be provided at the next meeting. The annual report outlines the work and support required to increase flow across the Unit. • Medical devices risks were noted. • Strep A cases have decreased recently, however there has been an increase in this last week with respiratory related issues • Tendable audits have been implemented and have a 100% completion	

	rate. Results will help to support any necessary improvements/changes across the CHFW. Patient questionnaire has been implemented and feedback will be provided as this work develops. • Medical staffing junior workforce gaps within Paediatrics. Recruitment continues. Some suitable candidates are also being delayed as part of the GMC registration process, whilst awaiting registration. • New General Manager for CHFW has been appointed and will commence in post in February 2023. **Timely Access** • Working with WHSSC to look at options for outsourcing some of the Paediatric surgery cases to help support the work to reduce the waiting lists and this continues • ENT Lists taking place over weekends to help support long waiting patients until end March 2023. • Endoscopy lists continues to be an issue, specifically with regards to diagnostics. It was noted that there have been some issues with delays in patients getting diagnosed with IBD and the impact this is having when they are presenting to the service and requiring longer treatment. Queries were raised as to whether these incidents are being reported through Datix due to the delay of treatment. RS/KM agreed to follow up to ensure that this is being undertaken in order to outline the impact and risks of this. • Increased concerns relating to waiting times/cancellations and work continues to manage this. **The CWQSE resolved:** a) The report provided was noted for information and key highlights and actions were recorded.	
CWQSE/ 2023/007	**2.2.2 CYPFHS Directorate Report** • Medical safeguarding rota risk assessment associated with the tier 1 and tier 2 safeguarding cover. This is impacting on the recruitment of medical staff within the department. Work is being undertaken with regards to GP specialist roles to support the rota and that support need to be mandatory going forward. This is however having a significant impact on their clinical workload and the level of support needed by the trainees. • Increase in Datix incidents at present due to workforce pressures, and awareness training is being undertaken with regards to closure and investigation of incidents. • HV SBAR noted, unable to recruit to Health Visitors until September which is impacting on service provision. Recruitment is ongoing for additional band 5's as a temporary measure and band 5's will be taking on a caseload and support health visitors with lower level care. Revised staffing plan has been developed and as part of this plan the 15month and 27month reviews for low level risk children will cease temporarily and letter and guidance will be shared with all families to advise of the guidance should there be any concerns (which is in line with All Wales HV Policy). High level and safeguarding will continue as per the normal process. • Concerns over 100 days are being reviewed and require consultant input which is being reviewed to support and manage to closure. • MVC taken over the 2-3yr old and school age children catch up and this is being supported. Walk in appointments are working well. Fluenz uptake is still quite low and the main theme relates to capacity to canvas families and spend time in the schools to build relationships with support	

	from Public Health. Agreed that education work on immunisation is key in order to target engagement with the schools themselves and families. Discussion ensued and it was felt that school governors should also be linked in as they would be a key support. It was noted that the vaccine is not available until first week in October which impacts on the capacity to facilitate. Concern was raised with regards to some of the lack of engagement received from the schools and it was felt that this will be raised through the strategic immunisations board to raise awareness. • Pressures in LAC service which is impacting on initial health assessment. Additional nursing resource has been recruited and plan in place to work through backlog. Discussions are taking place to review the age of the children seen and capacity and volume of health assessments. • CCNS have significant vacancies and sickness within the teams. Work is being undertaken with regards to the gap in service and what can be done to improve this situation. External agencies have been approached but currently unable to help. The risk assessment needs to be reviewed to ensure that all pressures, risks and mitigations are reflected. **Timely Access (taken from Directorate Report)** • At the end of December 2022, there were 1,720 children and young people waiting for an ND assessment. The longest wait for an assessment has increased and was 151 weeks. • At the end of December 2022, the Primary Mental Health waiting list had decreased to 139 patients waiting for an assessment with a longest wait of 4 weeks. Part 1A compliance for the month was recorded as 93%. • The CAMHS waiting list increased during the month of December due to seasonal demand and at the end of the month there were 61 patients waiting for an assessment. The longest wait for the service was has significant reduced and was 4 weeks. • At the end of December 2022, there were 606 patients on the waiting list for Continence and the longest wait for the service was 116 weeks. • At the end of December 2022, there were 448 patients waiting for children's therapies with the largest waiting list sitting in OT where there were 244patients waiting. OT had a longest wait of 35 weeks with 111 patients waiting 14 weeks and over. • At the end of December 2022, there was a backlog of 124 initial health assessments to be completed within the Looked After Children service. The service is currently failing to meet the statutory target of completing all initial health assessments for children who enter care within 28-days and in December 2022, 0% of CYP were seen within 28-days of entering care and 10% were seen within 28-days of notification. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Raise awareness of challenges with engagement for immunisation programme from schools via Strategic Immunisation Board	**CW**

CWQSE/ 2023/008	**2.2.3 O&G Directorate Report** The detailed report was shared for information and an update was provided on the key highlights from the report. • Continued dietician support for the Healthy Pregnancy Clinic which is available for all women with a BMI over 40. • Funding from Public Health Wales received for a band 5 advisor to support smoking cessation to commence in April 2023 • Women's Wellbeing service psychology session has been agreed and appointed. • Flu vaccinations continues across clinical areas and work is ongoing with regards to gathering data. • Bereavement care – baby loss awareness. Plans to move the teardrop suite and discussions taking place with SANDS Charity • Significant change to Datix numbers, since the appointment of the Datix midwife and work continues to manage the incidents position. • HIW action plan submitted and awaiting formal response and assurance work continues. • Work continues on the RCA/Case Reviews and a number have been completed for noting with further cases ready for discussion at the next NRI/RCA Governance Sub Group. Ongoing cases include 3 NRIs, 3 Gynae RCA's, 4 Obs RCA's, 2 BIT's and 5 case reviews. • No pressure areas reported in December • X2 incidents reported for Falls. No harm caused to patients and appropriate actions taken. • Concerns raised regarding departmental environment and work is being undertaken in order to help address. • X5 Medication errors reported – x1 within Gynaecology and x4 within Maternity. • Blood management – reported as an NRI and investigation has been completed. • Ongoing issues with the maternity lifts and a no surprises was submitted to Welsh Government due to all lifts being out of use. • Mandatory training reporting is being undertaken through Q&S Meetings and ensure all actions are progressed and Mandatory training weeks will be re-implemented from April 2023. • Introduction of GAP and GROW is progressing and it is anticipated that the system will go live from March 2023 with a gradual rollout and transition period. • Fetal Surveillance Band 8 has been appointed • Recruitment is progressing for 10 Research studies, with a trials manager and administrator now in post. • IT and information – Maternity Dashboard is now live. • Virtual workshops for women and families for induction of labour are available and positive feedback received. • PADR compliance is low but work is progressing order to improve the position. It was noted that the current Health Board target is at 60% and it was felt that this may be difficult to achieve. It was however acknowledged that significant work has been undertaken and the position is improving, recognising the challenging situation. • Obstetric job planning has been completed which is helping with the RCA/NRI process. • Sickness is currently at 11%. Queries were raised with regards to the Datix process within O&G, and it was noted that a team's channel has been set up which outlines the current	

	Datix incidents and the actions that are being undertaken. It was agreed that request would be made for Emma O'Connor to link with KM to share the process. **Timely Access** No update available for the meeting. Detail to be shared retrospectively. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Datix midwife to link with CHFW Lead Nurse re Datix process c) Timely access update to be shared.	**LMc** **RJ**
CWQSE/ 2023/009	**2.3 Waiting Times Update** The waiting times update was noted as part of the Directorate QSE Exception Reports in item 2.2 above **The CWQSE resolved:** **a)** The update was noted	
CWQSE/ 2023/010	**2.4 New Risks to be considered for the Clinical Board Risk Register** **Psychology Risk Assessment** JH was welcomed to the meeting to highlight the risk assessment undertaken for the child LD service. There is only x1 psychologist in post at present and is due to go on maternity leave shortly. A plan has been developed to cover the 6-month period and minimise risk as much as possible for new referrals including signposting advice etc. It was noted that the service works directly with social services and education for high risk referrals, however all new referrals have been put on hold and all referrers have been notified of this. Consultation will continue to be provided to Cardiff and Vale Social Services, and any children who present with high risk will be followed through process. Further plans are in place to support the current waiting list as much as possible, with a number of referrals being triaged and one-off review and assessment appointments being provided to discuss required next steps. Some children have been discharged as a result of this work. Queries were raised as to whether HEIW are aware of how short the service is for psychological support and requirement of addressing as part of the training programme. It was noted that HEIW have been undertaking significant work in relation to this and also other AHP services. It was confirmed that this feedback has been provided. It was agreed that further discussion would be undertaken through operational processes in order to review what can be further explored. **Paediatrics Risk Assessment** Significant absence within the secretarial support for General Paediatrics. Overtime and additional hours have been offered in order to help support the service to manage the backlog. Queries were raised with regards to electronic dictation and whether this would help support the process. CR agreed to discuss with the Directorate outside of the meeting as a possible option that is being rolled out across the Health Board. It was agreed that any incidents should be reported if there is an impact on any patients coming to harm.	

	Paper Medical Records for Abortion Clinic New risk has been added to the Directorate Risk register. **The CWQSE resolved:** a) The new risk assessments were noted b) Discussion to be held regarding digital dictation	**CR/RS**
SAFE CARE		
CWQSE/ 2023/011	**3.1 Update on Serious Incidents** There was no specific update for this meeting. All NRI's are progressing and updates will be provided as the investigations are completed.	
CWQSE/ 2023/012	**3.2 SI's/RCA's/Closure Forms for discussion** **Patient MG – IN6551** Maternal Death due to suspected Sudden Unexpected Death in Epilepsy (SUDEP). This is also a coroner's inquest and the outcome awaited. Background to the case was provided (full detail within supporting SBAR and RCA). Pre-conception visits were undertaken on a number of occasions which covered the seizure frequency and major seizures were noted as being around once per month with no specific pattern noted. Care continued with the Epilepsy team within Cardiff. Patient self-referred to the Pregnancy Advisory service in March 2022 and discussions were held as to whether she wanted to continue with the pregnancy. Plan was to continue with the pregnancy and in view of medical history was referred to the Consultant Obstetrician with Special interest in Epilepsy. On 23rd May at 14+5weeks the patient was reviewed by a Consultant Obstetrician and an Epilepsy Nurse Specialist. It was noted that the seizures had increased and plan of care was discussed. Information was sent in a letter also so that the patient could read through in her own time. Tragically on 4th June, the patient was found unresponsive by her mum, and the unexpected and unexplained death was reported by Police to HM Coroner where a post mortem was performed, the result of which is outstanding. The focus of the investigation was to review the patient's antenatal care considering the Epilepsy Antenatal service as a whole. It was noted that until the conclusion of the post mortem examination is known the cause of death cannot be confirmed with certainty but the working diagnosis is that of SUDEP. Care provided to the patient was in line with national RCOG and NICE Guidelines. Recommendations and Lessons Learnt (taken directly from the SBAR); **Lessons learned** MG had an unplanned pregnancy and was initially unsure about continuing with the pregnancy. She may have benefited from more robust contraceptive advice and early pregnancy advice by a specialist Obstetrician and Neurologist about pregnancy choices, including safety of her current medication regime. This should have included counselling around the option of termination of pregnancy and alteration of medication to that with a more acceptable safety profile for the unborn child prior to embarking on a planned pregnancy. If her epilepsy was such that her medication could not	

	have been altered to improve the safety profile for the unborn child then this should also have been discussed. **Recommendations** Expansion of the service to include joint pre-pregnancy counselling by the specialist Obstetrician and Neurologist with appointments linked to the antenatal service. Process for checking for appointments to ensure appointments are cancelled (neurology appointments had not been cancelled following the patient's death). The report was completed jointly between the Obstetrician and Neurologist. The report has been shared with the family. Due to the concerns raised by the family of the impartiality of the report, it has been agreed that an external review be undertaken. Discussions have also been undertaken with the Coroner to advise of the way forward being undertaken. The post mortem result is awaited. The family have requested that the final closure form not be completed whilst the external review of the care is undertaken. This has been agreed, albeit that the internal review has been undertaken and is a final report. Discussion ensued with regards to the external review and whether this needs to be reviewed for all specific cases such as Maternal Deaths, and it was agreed that this should be considered going forward. Queries were raised with regards to the other similar maternal death SUDEP case that is currently being investigated, and further concerns have been raised as to whether an external review be undertaken for this case also. It was noted that whilst there will be a low threshold for external review, we need to ensure that this would be what the family want following the completion of the internal review. It was agreed however that this should be discussed with the family and ensure that the same process is followed should this be what is wanted. **The CWQSE resolved:** a) Final internal report was noted. Further update to be provided from external review when complete	**LMc**
CWQSE/ 2023/013	**3.3 To note the draft minutes from the Clinical Board NRI/RCA Governance Sub Group Meeting held on 14.10.2022** The minutes of the meeting held on 14th October was shared for information. There were no specific exceptions to note for this meeting. **The CWQSE resolved:** a) The minutes were noted.	
CWQSE/ 2023/014	**3.4 SI's/RCA/Closure Forms for noting/exception reporting (discussed as part of NRI/RCA Governance Sub Group)** It was noted that all cases have been discussed in detail as part of the Clinical Board NRI/RCA Governance Sub Group and an overview was provided on the cases, with root cause, recommendations and lessons learnt shared. action plans have been developed for all which are progressing with lessons learnt being shared. There were no exceptions to note and agreed that the cases could be progressed for sharing.	

	• Patient AM (ID3605) • Patient JM (ID2811) • Birth Injury Tools • Patient LD (IN161599) • Patient SA (ID1273) • Patient ENA (ID4225) • Patient NS (ID8656) • Patient SH (ID10947) • Patient RR (ID7047) • Patient SC (ID13140) **Patient JP (ID16027)** Further discussion ensued with regards to blood transfusion and it was noted that blood transfusion competency assessment is currently not mandated. It was noted that if you are involved in cross matching and provision of blood, it was agreed that should be mandated within the service. Further discussion to take place outside of the meeting on an appropriate plan for implementation. **The CWQSE resolved:** **a)** The cases were noted and agreed for sharing b) Discussion to take place with regards to mandating of blood transfusion competency/compliance	**CR/AJ**
CWQSE/ 2023/015	**3.4 Infection Prevention Control Update Report** Siwan Jones will be the Clinical Board IPC Link from April 2023. Update was provided on the current position against the HCAI data. C Diff progress has made a significant improvement from last year. MRSA target has been exceeded this year, however it was noted that this was predominantly due to the outbreak within Maternity, although acknowledging that the numbers are not large. It was noted that C Diff RCA reviews (led by Jason Roberts, Richard Skone and the IP&C team) will be undertaken every 6weeks on current cases and any learning that can shared from the case and what can be done to improve going forward. MSSA target has been exceeded with 5 cases this year compared to 3 last year. E Coli cases have remained the same compared to last year. Pseudomonas target should be achieved this year with 1 case being reported compared to x3 last year. It was noted that pseudomonas cases are difficult to avoid. It was noted that water sampling has been undertaken and no evidence has been found that there are any contributory factors. Audit data will be shared outside of the meeting for information. Hand Hygiene ranges between average of 80-100% and BBE is mainly 100% compliant. COVID numbers (across the region) were down by 55% from previous week. Flu numbers for December 2022 were 187 cases across the Health Board and so far for January the position is at 164 cases. **The CWQSE resolved:** a) The update was noted. b) Audit data to be shared outside of the meeting.	**YH**

CWQSE/ 2023/016	**3.5 Safeguarding** There was no update available for safeguarding for this meeting. It was agreed that an update would be requested following the meeting and confirmation of attendance for future meetings **The CWQSE resolved:** a) Update and confirmation of attendance to be requested	**KH**
CWQSE/ 2023/017	**3.6 Patient Safety Alerts (internal/external)/Welsh Health Circulars** • CPhO MedsLet 2023 002 - Norditropin (somatropin) Flexpro solution for injection pre-filled pens (002) • CEM/CMO/2022/28 - Seasonal influenza - Actions for Wales (follow up) • CPhO/MedsLet/2022/54 - Sulfasalazine 250mg in 5ml oral suspension sugar free • CPhO/MedsLet/2022/53 - Dalteparin (Fragmin) 10000units per 1mL solution for injection ampoule • CPhO/MedsLet/2022/52 - Pilocarpine hydrochloride 4% eye drops The safety notices were noted and have been shared widely across the Clinical Board. There were no exceptions to note for this meeting. **The CWQSE resolved:** a) The safety alerts were noted.	
CWQSE/ 2023/018	**3.7 NICE Guidance – Update on Progress** The new guidance received in month was shared and noted. • TA837 – Pembrolizumab for adjuvant treatment of resected stage 2B or 2C melanoma • NG226 – Osteoarthritis in over 16s: diagnosis and management • TA832 – Relugolix–estradiol–norethisterone acetate for treating moderate to severe symptoms of uterine fibroids Assurance was provided with regards to work being undertaken with regards to medications and all NICE guidance is discussed through the Medicines Management Group process. **The CWQSE resolved:** a) The new guidance was shared for review and action. Updates to be provided as appropriate following the meeting.	**ALL**
CWQSE/ 2023/019	**3.8 Reporting Adverse Drug Reactions** Guidance was noted for information. Noted that low reporting rates are an issue and work is ongoing to raise the profile of yellow card reporting and training packages will be available for all healthcare professionals. Queries were raised as to whether this should be included as part of the induction programmes for all junior doctors and it was noted that this is part of the plan. Queries were raised with regards to neutropenia for chemotherapy within Oncology. It was noted that every death within Oncology needs to be	

	discussed through M&M process, and shared with the Medical Examiner however it would not be yellow card reported as this is already listed in the BNF as an expected side effect. It was agreed that a presentation would be useful to be provided as part of the Audit Meetings or Staff Forum by a member of the Yellow Card Team to raise awareness on process. **The CWQSE resolved:** a) Update noted. b) Presentation to be provided as part of Audit Meetings or Staff forum to raise awareness on the yellow card process.	**AL**
TIMELY CARE		
CWQSE/ 2023/020	**4.1 Directorate concerns & assurance update** Discussed as part of the directorate reports. **O&G Update – December 2022** Shared for information. **The CWQSE resolved:** a) The update was noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2023/021	**5.1 CSW call and recall system, CSIMS and Transgender Individuals** Shared for information. **The CWQSE resolved:** a) The profile was noted.	
CWQSE/ 2023/022	**5.2 C Section SSI Report – Quarter 1 2022** The C Section SSI report was shared for information. It was agreed that going forwards this information would be shared as part of the Maternity Dashboard information. **The CWQSE resolved:** **a)** The report was noted for information	
ANY OTHER BUSINESS		
CWQSE/ 2023/023	**6.1 Designated Paeds Resus Practitioner** Concern was raised with regards to there being no designated Paediatric resus practitioners within the service which is impacted significantly on training across paediatric and neonatal services. Discussion ensued with regards to the requirement of working resusitare for Neonatal Life Support Course. This is part of the PROMPT training package within Maternity/Neonates. If this is a recommendation for a working resusitare, consideration may need to be given to where the training is held. It was noted that this is a wider issue that affects the Health Board and there is a need for further discussion as to how this can be addressed. CR agreed to raise at the next Clinical Board Directors meeting in order to discuss the requirement for an appropriate way forward across the Health Board.	

	The CWQSE resolved: a) Concerns were noted and agreed that further discussions regarding the Paediatric Resus Practitioner requirement to take place outside of the meeting.	**CR**
CWQSE/ 2023/024	**6.1 Date and Time of Next Meeting** **Tuesday 27th February 2023 (H&S Focus Meeting), 8.30am, Microsoft Teams**	**ALL to note**

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 28th February 2023 at 8.30am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, Children & Women's Clinical Board
Linda Hughes Jones	LHJ	Head of Safeguarding
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Abigail Homes	AH	Head of Midwifery, Obstetrics & Gynaecology Directorate
Laura Hutchinson	LH	Senior Nurse, CYPFHS Directorate
Alison Lewis	AL	Patient Safety Facilitator
Stephen Bennett	SB	Fire Safety Officer
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer (DECLO)
Becci Ingram	BI	General Manager, CYPFHS Directorate
Ashleigh Trowill	AT	Operational Service Manager, CYPFHS Directorate
Annie Burrin	AB	Midwifery Governance Support
Catherine Wood	CW	Director of Operations, Children & Women's Clinical Board
Rachael Sykes	RS	Assistant Head of Health & Safety
Martin Edwards	ME	Asst Clinical Director, CHFW Directorate
Rim Al-Samsam	RAS	Clinical Director, CHFW Directorate
Samuel Barrett	SB	General Manager, CHFW Directorate
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Cerys Scarr	CS	Consultant Obstetrician / Clinical Risk Lead, Obstetrics & Gynaecology Directorate
Suzanne Davies	SD	Senior Nurse, CHFW Directorate
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Lois Mortimer	LM	Interim Deputy Head of Midwifery, Obstetrics & Gynaecology Directorate
Secretariat		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Apologies:		
Clare Rowntree	CR	Clinical Board Director
Paula Davies	PD	Lead Nurse, CYPFHS Directorate
Janice Aspinall	JA	Lead H&S Staff Side Representative
Anthony Lewis	AL	Clinical Board Pharmacist

Item No	Agenda Item	Action
CWQSE/ 2023/025	**1.1 Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2023/026	**1.2 Apologies for Absence** **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2023/027	**1.3 Minutes of the previous Q&S Meeting held on 24th January 2023** The minutes of the meeting were agreed to be an accurate record.	

	The CWQSE resolved: a) The minutes were noted and agreed as an accurate record.	
CWQSE/ 2023/028	**1.4 To note and update the action log of the meeting of 24th January 2023** Updates were provided on the actions from the last meeting and it was noted that a number of actions have been resolved. The outstanding actions were noted as: **Paediatrics Risk Assessment** Discussion to be held regarding digital dictation. AJONES agreed to follow up on progress outside of the meeting. **Patient MG – IN6551** Internal report has been completed and progress is being made in relation to the external review for the case which is being led by Patient Safety Team. Further updates will be provided once this has been concluded to share findings and lessons learnt. **Patient JP (ID16027)** Work ongoing regarding the possibility of mandating of blood transfusion competency/compliance and refresher training following findings within a recent investigation. It was noted that 12 cascade trainers implemented within maternity services and work is progressing to ensure that all training is completed. EB agreed to review options for cascade training and e-learning within CHFW also. **The CWQSE resolved:** a) Updates noted and actions noted.	**AJONES** **EB**
CWQSE/ 2023/029	**1.5 Safeguarding Update** Update provided on the safeguarding team structure and the service provision across the Health Board. Supervision is provided to staff across the Health Board in the form of group supervision and ad hoc where required. Regular mandatory training undertaken via ESR and work is progressing with regards to more face-to-face training sessions also. VALDASV Group 1 training available on ESR for all staff. All front facing staff will also need to complete the Group 2 VALDASV, as part of the national training framework which are booked through safeguarding team and sessions undertaken via Microsoft Teams. For Safeguarding Adults Training 68.3% compliance and for Children Training 69.6% compliance. Group 1 training at 69.5% compliant. Work continues to increase the amount of training completed across the Health Board. Since 2020 there has been an increase in safeguarding workload. 8 child practice reviews in process, 5 adult practice reviews with 1 case which is awaiting publication. Single Unified review pilot is being undertaken within the Health Board. There has been a significant increase within the MASH service. There has been a significant increase in child sexual exploitation and criminal exploitation strategies which results in increases movement in safeguarding and looked after children's services. IDVA has been appointed within Paediatric Emergency Department and commenced in November 2022 and this is having a positive impact to the service being provided. Child Exploitation project being undertaken within Midwifery working with the	

	Elan Team and work is progressing. Feedback received to date has been positive. **The CWQSE resolved:** a) Safeguarding update was noted.	
CWQSE/ 2023/030	**1.6 NICU Annual Report** The NICU annual report was shared for information. **The CWQSE resolved:** a) The report was noted.	
HEALTH & SAFETY		
CWQSE/ 2023/032	**2.1 Latest Health & Safety Report** The report was shared for information. RIDDOR incidents reported between October 2022 – February 2023. X2 reported for CHFW, x2 reported for Community and x1 reported for Obstetrics & Gynaecology. It was noted that there is a change of the way that the RIDDORS are noted through the H&S process and that updates will be required on progression with investigations from the Directorate teams. Discussion ensued as to the best way for the information to be provided, and it was agreed that as Directorate Reports are already produced for the Q&S meeting, that a section would be added to include H&S feedback such as RIDDORS, significant H&S issues, serious H&S incidents etc which would then be used to populate the Clinical Board Exception Reports for the UHB Q&S Meeting. All were asked to ensure that this is added to reports going forward. **The CWQSE resolved:** a) Updates noted b) H&S section to be included in the Directorate Reports going forward	**ALL**
CWQSE/ 2023/033	**2.2 Feedback from last UHB Operational H&S Meeting** Update provided on Manual Handling Projects being undertaken including roadshows for bariatric patients, manual handling workplace competency assessor course and if staff are interested, further information can be provided. Discussion ensued with regards to the competency assessor course and it was acknowledged that it would be beneficial for a bespoke programme within maternity, however it was noted that there is an inability for staff to be released for the 3-day training at the present time. Work is progressing to increase staff compliance and is an ongoing action. It was acknowledged that this would be a similar situation across other areas within the Clinical Board. **H&S Dashboard – January 2023** Dashboard was shared for information and noting. **C&W Clinical Board Exception Report – November 2022** The report was noted for information. It was requested that any new issues or updates requiring inclusion be highlighted outside of the meeting. **The CWQSE resolved:** a) Updates noted. b) New issues/updates requiring inclusion in the exception report to be	**ALL**

	shared outside of the meeting.	
CWQSE/ 2023/034	**2.3 Latest COSSH Report** The latest COSSH report was noted. There are a few areas that require an updated COSSH assessment and all were asked to review and ensure information is updated as appropriate prior to the next Health & Safety Meeting. **The CWQSE resolved:** a) Updates noted and review of COSSH assessments to be undertaken where required.	**ALL**
CWQSE/ 2023/035	**2.4 Fire Safety Update** The current fire safety compliance ranges between 61 – 76% across the Directorates. Information was provided on the ECOD drop in sessions that are available, which does not need to be booked in advance. It was noted that the links for the training are available via the H&S Dashboard link for distribution. There are no fire risk assessments outstanding within Children & Women's Clinical Board at present. Update was provided with regards to a recent fire associated with a fan heater and it was noted that these should now all be replaced by oil filled radiators. The group were asked to disseminate the message across all areas to ensure that the fan heaters are no longer used, and replaced where required. **The CWQSE resolved:** a) Update noted. Information to be circulated regarding replacement of fan heaters in all areas.	**ALL** **ALL**
CWQSE/ 2023/036	**2.5 Feedback from H&S Staff Side** No update provided for the meeting. Request was made to ensure that the workplace inspections are being progressed across all areas where necessary. **The CWQSE resolved:** a) Workplace inspections to be progressed	**ALL**
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		
CWQSE/ 2023/037	**3.1 Health & Care Standards Directorate QSE Exception Reporting** The detailed report was shared for information and an update was provided on the key highlights from the report. **3.1.1 CHFW Directorate Report** • Risk Assessment completed for Cardiology Surgery waits which has been added to the risk register for monitoring and review. 17 welsh patients awaiting cardiac surgery at Bristol where surgery has been delayed • X3 Stoma incidents and x1 TPN incident reviews are progressing. • NICU and PICU remain a high area of risk which has resulted in some surgical cancellations as a result of capacity. Continual monitoring through x3 daily huddles. • Interpreter devices have been implemented on all wards across CHFW, which is a great addition to the wards. • Recent guidance has been ratified through quality & safety process including introduction of neonatal post discharge, head circumference pathway, ketogenic diet guidelines, cow's milk allergy updated guidelines and Paediatric stroke pathway guidelines.	

	• Therapies Starfish Outpatients department work is being progressed to revert the area back to being appropriate for therapies, which is anticipated to be completed by the end of March 2023. • Recruitment continues. 13wte band 5 vacancies which are being progressed, and also x2 Band 6 posts. • Infant feeding lead has been appointed. • Surgical ENT lists are taking place over the weekends through February and March which have been successful. • No specific themes identified through concerns received and some compliments have been received across PICU, Island and Sea Horse wards. • There are 17 tertiary non-surgical patients waiting for admission. Work continues on admissions as soon as there is availability. **Timely Access** Cancellations are continuing due to staffing pressures and work is being undertaken in partnership with WHSSC in relation to outsourcing of some patients to Cardiff Nuffield and Birmingham to support treating patients over 52weeks, predominantly daycase patients over 3yrs. Continuing to validate the waiting list whilst support continues. Review of Cwm Taf UHB patients is being undertaken as to the possibility of use of hub theatres if surgical team are happy to use. These discussions are currently ongoing. General Paediatric outpatient backlog issues continue, and also 7 children between 36 – 49weeks awaiting a cardiology outpatient department. Work is progressing on demand and capacity to support and address the backlog. Discussion ensued with regards to surge capacity/HDU and the need for further discussions with WHSSC with regards to appropriate baseline LTA and duration. Further consideration to be given to tertiary HDU and the appropriate model going forwards. **The CWQSE resolved:** a) The report provided was noted for information and key highlights and actions were recorded.	
CWQSE/ 2023/038	**3.1.2 CYPFHS Directorate Report** • Recruitment made to 2.8wte for the LAC service. Discussions have taken place with regards to the waiting times for the initial health assessment and work is being progressed to look to address the backlog to ensure equitable approach across the service. The service will start with the over 5yr old cohort and also agreement from the junior doctor workforce being discuss to contribute and support these health assessments. • Recruitment continues within the CCNS service and it was noted that due to vacancies this is impacting on the packages of care and end of life care packages being provided. The risk assessment has been reviewed and revised and is now being reported as a risk rating of 20. Recruitment has been made to the Band 3 posts and advertisements will continue. Assurance mapping will also be completed. • Reduced staffing plan within the Health Visiting service in relation to ensure provision of delivery specifically to high risk and vulnerable families. This is continually reviewed as per Welsh levels of care and risk assessment. • Electronic prescribing is being explored. X1 medication error within the community in relation to incorrect dosing received from GP. No harm caused as medication not provided. • Safeguarding concerns with regards to lack of completion of MARFS by local	

	authority. Communication continues with regards to more timely MDT response and approach going forward to manage risks. It was agreed that further information would be shared if this continues to be a problem. • Primary Mental Health 112 crisis line has been implemented for children & young people to access support. Hoped that this will have a positive impact for children & young people accessing necessary support. • Redaction of records work continues and requests have been made for requests for unredacted notes and the need to manage the risks associated. There has been an agreed approach and covering letter drafted in these instances. • Special Needs HV Service Model changing to an advisory model and this will be a significant change for the population. It was agreed that further discussions to take place with regards to communication of the changes and it was agreed that a presentation would be provided at the next meeting. **Timely Access (taken from Directorate Report)** • Continue to hit Part 1a compliance target with Primary Mental Health • CAMHS – just below target in January with 79%. Hoped to recover performance by the end of the month. • Part 1b target for Primary Mental Health dropped to 19% compliance in January 2023. It was noted that there are issues with the reporting on the PARIS system which is currently being reviewed to understand the data issues and how this can be rectified going forward. Although acknowledging that the waiting list has reduced at the end of January 2023, which may not be reflective of the Part 1b compliance reporting. Action plan is in place which is also hoped will improve the overall performance going forward. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Presentation to be provided at the next meeting regarding the changes to the Special Needs HV Service Model	**PD**
CWQSE/ 2023/039	**3.1.3 O&G Directorate Report** The detailed report was shared for information and an update was provided on the key highlights from the report. • Compliant with Gap and Grow compliance with Smoking Cessation and currently the smoking rates are the lowest in Wales. Funding for the role has been secured from Public Health Wales for a year and new post holder will commence from April 2023. • Psychology support for bereaved families is being progressed • Emotional Mental Health Midwives now in post and feedback received has been very positive. Infant feeding lead has been appointed and is being finalised through the recruitment process • Relocation of the teardrop suite is being progressed, working with SANDS Charity. • Key messages from the MBRRACE report has been shared through Q&S and presentation provided to all staff. • Datix incidents position is improving with 154 reported in January 2023. Advert for Datix midwife is being progressed. • Awaiting HIW report, no confirmation date received on final report. • Investigations ongoing. External review has been received and has been shared with the family. • Maternity lifts ongoing issue. Daily lift updates are being received. Only x2 maternity lifts available at present. This is impacting on the progress for the refurbishment programme however there is a need to ensure that there are	

	at least 2 of the others to be working before this can progress due to impact on services. Work continues. • Fluid balance Fridays are being completed as a result of some recent themes with fluid balance and hypernatremia. Infographic shared with women and further consideration given with regards to communicating these types of messages. • Mandatory training is slowly increasing. Full study week will commence in April. PROMPT training up to 78% CTG training is circa 90% NLS training is slightly lower but work continues to improve this. • Midwifery passport being progressed across all Health Boards. • Transfer meetings have been reimplemented and home birth service is now up and running. • March will be VBA Month in order to improve compliance and completion. • Improved position for NRI/RCA investigations and the Patient Safety Learning Review tool has been very helpful in targeting the approach to the incident investigation whilst ensuring families questions are embedded as part of the process. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2023/040	**3.2 New Risks to be considered for the Clinical Board Risk Register** No risks to note. The group were asked to send in the latest risk registers and assurance maps. **The CWQSE resolved:** a) Latest Directorate risk registers to be submitted	**ALL**
CWQSE/ 2023/041	**3.3 Action Plan – MBRRACE Report 2022** The action plan was noted for information. Work is progressing with a specific focus on languages and methods of communication with patients who are non-English speaking, or where English is not their first language. **The CWQSE resolved:** a) The action plan and update were noted.	
CWQSE/ 2023/042	**3.4 Duty of Candor Legislation** The Duty of Candor legislation is due to be implemented from April 2023 and information sessions are available and review resources available. All were asked to review information and book into the information sessions where possible. **The CWQSE resolved:** a) Update was noted b) Encourage attendance at information sessions	**ALL**
SAFE CARE		
CWQSE/ 2023/043	**4.1 Patient Safety Update** There are x9 NRI's open at present, with x2 new NRI's recently reported. All NRI's are progressing and updates will be provided as the investigations are completed.	
CWQSE/ 2023/044	**4.2 SI's/RCA/Closure Forms for noting/exception reporting (discussed as part of NRI/RCA Governance Sub Group)** It was noted that all cases have been discussed in detail as part of the Clinical	

	Board NRI/RCA Governance Sub Group and an overview was provided on the cases, with root cause, recommendations and lessons learnt shared. action plans have been developed for all which are progressing with lessons learnt being shared. There were no exceptions to note and agreed that the cases could be progressed for sharing. • SBAR – MC (Datix Ref 353075) • SBAR – BF (Datix Ref 8081) • SBAR – AG (Datix Ref 332697) • SBAR – LC (Datix Ref 14337) • SBAR – EB (Datix Ref 15509) Postscript - *Meeting has taken place to share the report and the patient has requested to meet with the toxicologist and while this does not change the fundamental findings of the RCA it might alter a small detail. Further update will be shared once meeting has taken place* • Patient Safety Learning Review – BD (Datix Ref 12798) • Birth Injury Review Tool – RG **The CWQSE resolved:** **a)** The cases were noted and agreed for sharing.	
CWQSE/ 2023/045	**4.3 SI/RCA's for Discussion** **SBAR – PED (Datix Ref ID19998)** Content of the report has been agreed for factual accuracy between the Children & Women's Clinical Board and Specialist Services Clinical Board and it was agreed that this report can now be shared with the family. It was agreed that the action plan would be completed and shared for ratification through the quality & safety processes on the recommendations. **The CWQSE resolved:** a) Update noted. Report to be shared with the family b) Action plan to be completed and shared for ratification through both C&W and Specialist Clinical Board Q&S processes.	**AB** **AB**
CWQSE/ 2023/046	**4.4 Update on Clinical Negligence Claim – Patient MD** Update was provided on a recent clinical negligence claim that had been received within the CHFW relating to care provided. On review of the case, the case was sent for expert opinion and this supported that the management of case and support provided by the CHFW was appropriate. There has been no harm to the patient and on the basis of support of the expert witness, good practice has been undertaken and the claim has been responded to. **The CWQSE resolved:** a) Update noted	
CWQSE/ 2023/047	**4.5 Infection Prevention Control Update Report** No update available for the meeting	
CWQSE/ 2023/048	**4.6 Mental Health Admissions to CHFW – 2022 Stats** There has been a significant growth within the last 3 yrs, which has caused significant challenge for the teams and work is ongoing with local authority	

	colleagues in relation to tier 4 beds and management of dysregulated children to implement a formal process going forward. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2023/049	**4.7 Patient Safety Alerts (internal/external)/Welsh Health Circulars** • ISN 2023 001 - BD BodyGuard MicroSets • UKHSA Health Protection Briefing Note 2023/002: Tuberculosis (TB) Testing and potential interactions with COVID-19 vaccinations The safety notices were noted and have been shared widely across the Clinical Board. There were no exceptions to note for this meeting. **The CWQSE resolved:** a) The safety alerts were noted.	
CWQSE/ 2023/050	**4.8 NICE Guidance – Update on Progress** No new NICE Guidance to note for this meeting.	
TIMELY CARE		
CWQSE/ 2023/051	**5.1 Directorate concerns & assurance update** Discussed as part of the directorate reports. **O&G Update – December 2022** Shared for information. **The CWQSE resolved:** a) The update was noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2023/052	**6.1 CSE Information and Posters** Shared for information. **The CWQSE resolved:** a) The information and posters were noted for sharing	
CWQSE/ 2023/053	**6.2 C Civica Summary Report** The civica patient feedback report was shared for information. Consideration will be given as to how this can be shared widely with staff. Paediatric friendly versions are also being developed for implementation within the CHFW. The system is being piloted within Health Visiting and positive feedback has been received. **The CWQSE resolved:** **a)** The report was noted for information	
ANY OTHER BUSINESS		

CWQSE/ 2023/054	**7.1 Maternity/Neonatal Safety Programme Report** The programme report has been received and it was noted that meetings are being scheduled to discuss the report in more detail. **The CWQSE resolved:** a) Report to be shared for information following the meeting.	**AH**
CWQSE/ 2023/055	**7.2 Clinical Effectiveness Meeting** Presentation was provided on national Asthma Audit and concerns raised with regards to the requirement to support the national audits. It was noted that further discussions are required with regards to planning how the requirements can be supported. **The CWQSE resolved:** a) Further discussion required to	
CWQSE/ 2023/056	**7.2 Date and Time of Next Meeting** **Tuesday 28th March 2023, 8.30am, Microsoft Teams**	**ALL to note**

Report Title:	Committee Effectiveness Survey 2022-2023			Agenda Item no.	4.3
Meeting:	Quality, Safety and Experience Committee	Public	x	Meeting Date:	11 April 2023
		Private			
Status *(please tick one only):*	Assurance	x	Approval		Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report
Background and current situation:

Routine monitoring of the effectiveness of the Board and its Committees is a vital part of ensuring strong and effective governance within the Health's Board's governance structure. Under its Standing Orders (SO 10.2.1), the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Further, and where appropriate, the Board may determine that such evaluation may be independently facilitated.

The Health Board undertook an annual review of the effectiveness of its Board and its Committees during February to March 2023 using survey questions derived from best practice guides, including the NHS Handbook, and using the following principles:

- the need for Committees to strengthen the governance arrangements of the Health Board and support the Board in the achievement of the strategic objectives;
- the requirement for a Committee structure that strengthens the role of the Board in strategic decision making and supports the role of non-executive directors in challenging Executive management actions;
- maximising the value of the input from non-executive directors, given their limited time commitment; and
- supporting the Board in fulfilling its role, given the nature and magnitude of the Health Board's agenda.

For the 2022-2023 self-assessment, surveys were disseminated via Microsoft Forms to all Board and Committee Members and Board and Committee attendees, enabling an efficient yet effective reflection on Board effectiveness and mirroring the method used for the Committees.

The purpose of this report is to present the findings of the Annual Board Effectiveness Survey 2022-2023, which relate to the Quality, Safety and Experience Committee (attached as **Appendix 1**).

This year, as part of the annual review, it is proposed that a workshop will take place with the Board Committee Chairs and/or Board Committee members to discuss any common themes and wider learning arising from the Committees' survey results. Any actions flowing from the same will be set out in the action plan to be presented to the Audit and Assurance Committee on 11 May 2023.

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

- The survey questionnaires for the annual Board/Committee Effectiveness Surveys 2022-2023 were issued in February 2023.

- The individual findings of the Annual Board Commmittee Effectiveness Survery 2022-2023 relating to the Quality, Safety and Experience Committee are presented at Appendix 1 for information. Some areas were identified for improvement, including in relation to the organisation of the Committee meetings and allowing appropropriate time to discuss relevant issues, and in relation to the agenda setting process. To that end, Committee Members will be aware that from April 2023, the Committee will be meeting on a monthly for the foreseeable future in order to ensure sufficient time is afforded to quality improvement.

- Overall the findings were positive and that provides an assurance that the governance arrangements and Committee structure in place are effective, and that the Committee is effectively supporting the Board in fulfilling its role.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

To ensure effective governance the Board Committee Effectiveness Survey is undertaken on an annual basis, in accordance with the provisions of the Standing Orders for NHS Wales.

The next self-assessment will be undertaken in March/April 2024 to coincide with the end of financial year reporting requirements of the Annual Governance Statement 2023-2024.

Recommendation:

The Committee is requested to:

a) **Note** the results of the Annual Board Effectiveness Survey 2022-2023 relating to the Quality, Safety and Experience Committee.

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

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

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

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Audit and Assurance Committee	11 May 2023

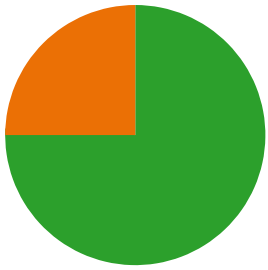
Saunders,Nathan
11/04/2023 11:35:40

Annual Board Effectiveness Survey - Quality, Safety and Experience

8 Responses

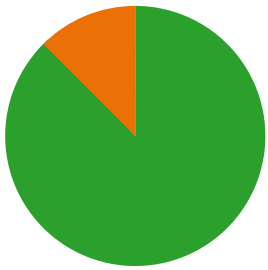
1.The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	6
Adequate	2
Needs Improvement	0



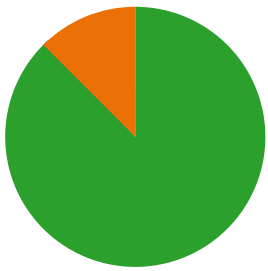
2. The Board was active in its consideration of Committee composition.

Strong	7
Adequate	1
Needs Improvement	0



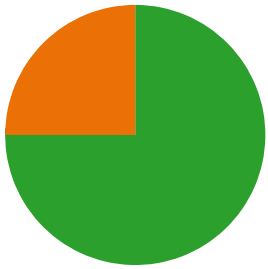
3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

Yes	7
No	0
Unsure	1



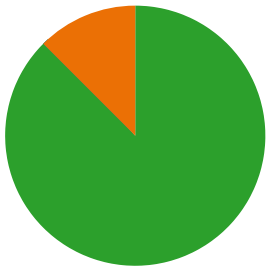
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

Yes	7
No	0
Unsure	2



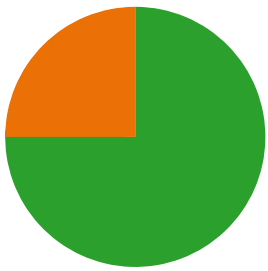
5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

Yes	7
No	0
Unsure	1



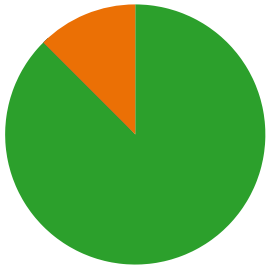
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	6
Adequate	2
Needs Improvement	0



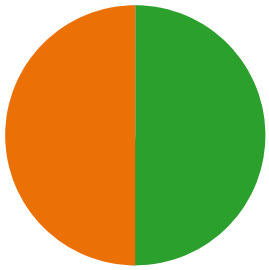
7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

Yes	7
No	0
Unsure	1



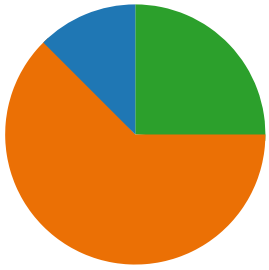
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

Strong	4
Adequate	4
Needs Improvement	0



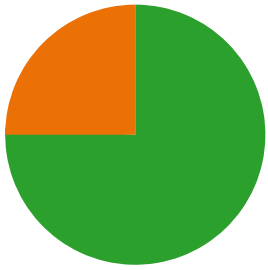
9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

Strong	2
Adequate	5
Needs Improvement	1



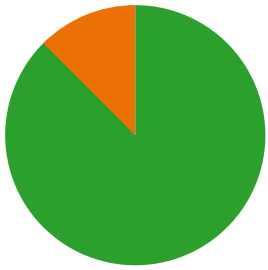
10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

Strong	6
Adequate	2
Needs Improvement	0



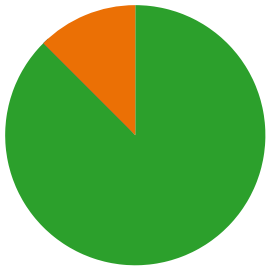
11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

Strong	7
Adequate	1
Needs Improvement	0



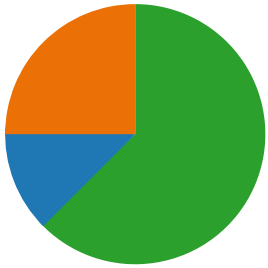
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

Yes	7
No	0
Unsure	1



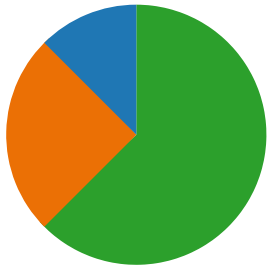
13. Are Committee members independent of the management team?

Yes	5
No	1
Unsure	2



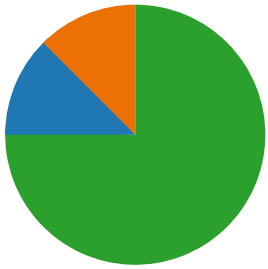
14.The Committee agenda-setting process is thorough and led by the Committee Chair.

Strong	5
Adequate	2
Needs Improvement	1



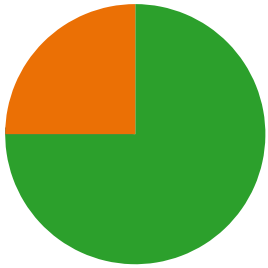
15. Has the Committee established a plan for the conduct of its work across the year?

Yes	6
No	1
Unsure	1



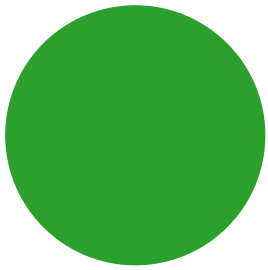
16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

Yes	6
No	0
Unsure	2



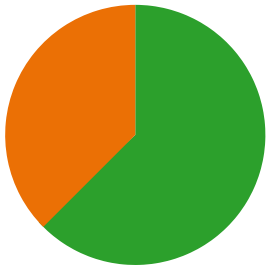
17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

Yes	8
No	0
Unsure	0



18. The Committee's self-evaluation process is in place and effective.

Strong	5
Adequate	3
Needs Improvement	0



19. What is your overall assessment of the committee?

- Very good - the format, frequency and papers for routine consideration are under review with an expected improvement in performance and outcome from the Committee
- The committee works extremely well and is very thorough in its work.
- there needs some review regarding frequency, duration and rationalisation of the agenda however the discussion which occur are very in depth and provide useful challenge from the independent members
- adequate
- Agenda often long , chairing struggles to keep to time
- The Committee agendas tends to promote a rather reactive approach, with the loops not always being closed. It would be useful for the Committee to be more proactive and a greater emphasis on improvement aligned to the enhancement of quality and safety.
- Committee performs well, with appropriate independent scrutiny to deliver assurance
- Functions well. Work plan content needs to be revisited to include wider Quality scope in line with our refreshed strategy.