Public Quality, Safety & Experience Committee

Tue 18 July 2023, 14:00 - 16:00

MS Teams

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 09.05.23

Ceri Phillips

1.4 Public QSE Minutes 09.05.23.pdf (7 pages)

1.5. Action Log – Following the meeting held on 09.05.23

Ceri Phillips

1.5 Action Log.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

14:10 - 15:25
75 min

2. Items for Review & Assurance

2.1. CD&T Clinical Board Assurance Report

30 minutes *Jason Roberts*

2.1 CDT Assurance Report July 2023.pdf (30 pages)

2.2. Quality Indicators Report:

20 minutes *Jason Roberts*

- *Deep Dive into Complaints (Presentation)*
- *Wales Cancer Patient Experience Survey* ***(located under supporting documents)***

2.2b Cover Report Wales Cancer Patient Experience Survey.pdf (3 pages)

2.3. MBRRACE – Verbal Update

10 minutes *Jason Roberts / Meriel Jenney*

2.4. HIW Activity Report

10 minutes *Jason Roberts / Meriel Jenney*

- 2.4 HIW Update.pdf (6 pages)

2.5. Board Assurance Report – Patient Safety

5 minutes *James Quance*

- 2.5 BAF Report QSE July 2023 Covering Report.pdf (3 pages)
- 2.5a BAF QSE July Patient Safety.pdf (2 pages)

15:25 - 15:45
20 min

3. Items for Approval / Ratification

3.1. Policies

5 minutes

3.1.1. Mental Health Clinical Risk / Risk Mitigation Management Policy (UHB 119)

Jason Roberts

- 3.1.1 MH Clinical Risk and Risk Mitigation Policy report.pdf (2 pages)
- 3.1.1a UHB 119 Clinical Risk Assessment and Management Policy.pdf (12 pages)
- 3.1.1b UHB 119 EHIA.pdf (39 pages)

3.1.2. a) Clinical Audit Policy (UHB 509) and b) Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group Procedure (UHB 510)

Meriel Jenney

- 3.1.2a Clinincal Audit Policy QSE 20230603.pdf (34 pages)
- 3.1.2b Cover Report NICE and HTW Procedure.pdf (2 pages)
- 3.1.2b NICE HTW and AWMSG Procedure Final.pdf (13 pages)

3.1.3. Labelling of Specimens submitted to Medical Laboratories Policy (UHB 017) & Labelling of Specimens submitted to Medical Laboratories Procedures (UHB 452)

Paul Bostock

- 3.1.3 Policy Cover Report.pdf (2 pages)
- 3.1.3a PD-LAB-SpecLabPolicy UHB 017.pdf (19 pages)
- 3.1.3b PD-LAB-SpecLabPolicy UHW 452.pdf (39 pages)

3.1.4. Nutrition and Catering Policy (UHB 221) & Procedure for Inpatients (UHB 367)

Fiona Jenkins

- 3.1.4 Nutrition and Catering Policy Report.pdf (3 pages)
- 3.1.4a Nutrition and Catering Policy and EQHIA 2023.pdf (30 pages)
- 3.1.4b Nutrition and Hydration Procedure 2023.pdf (34 pages)

3.2. Cardiff and Vale of Glamorgan Winter Respiratory Vaccination Plan 2023/24

5 minutes *Fiona Kinghorn*

- 3.2 CAV Winter Respiratory Vaccination Plan Cover Report.pdf (4 pages)
- 3.2a CAV Winter Respiratory Vaccination Plan.pdf (11 pages)

3.3. Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25

5 minutes *Fiona Kinghorn*

- 3.3 Hepatitis Joint Recovery Plan 2023-25 v1.pdf (4 pages)
- 3.3a Hepatitis (B and C) Joint Recovery Plan 2023-25.pdf (28 pages)

3.4. Quality, Safety & Experience Terms of Reference

5 mins *James Quance*

- 3.4 QSE Committee Terms of Reference.pdf (2 pages)
- 3.4a QSE TOR amendments July 2023.pdf (4 pages)

15:45 - 16:00
15 min

4. Items for Noting & Information

4.1. Executive Summary of Child and Adult Practice Reviews

5 minutes *Jason Roberts*

- 4.1 Regional Safeguarding Board Child and Adult Practice Reviews.pdf (4 pages)

4.2. Clinical Audit Strategy

5 minutes *Meriel Jenney*

- 4.2 Clinical Audit Strategy Paper.pdf (2 pages)
- 4.2a CAV Clinical Audit Strategy final.pdf (9 pages)

4.3. Unpaid Carers Annual Report

5 minutes *Jason Roberts*

- 4.3 Carers (Unpaid) Cover Report.pdf (2 pages)
- 4.3a Upaid Carers Annual Report.pdf (23 pages)

4.4. Minutes from Clinical Board QSE Sub Committees:

Medicine Clinical Board – 20.04.2023

Surgical Clinical Board – 21.03.2023

PCIC – 30.05.2023

Clinical, Diagnostics & Therapies Clinical Board – 23.01.2023, 20.03.2023, 12.04.2023 & 12.05.2023

Mental Health Clinical Board – 16.02.2023

Specialist Clinical Board - 16.02.2023

- 4.4a MCB QS Minutes 20.04.2023.pdf (8 pages)
- 4.4b SCB QS Minutes 21.03.2023.pdf (7 pages)
- 4.4c PCIC QS Minutes 30.05.2023.pdf (8 pages)
- 4.4d CDT QS Minutes 23.1.23.pdf (15 pages)
- 4.4e CDT QS Minutes 20.3.23.pdf (13 pages)
- 4.4f CDT QS Minutes 12.4.23.pdf (11 pages)
- 4.4g CDT QS Minutes 12.5.23.pdf (15 pages)
- 4.4h MH QS Minutes 16.02.2023.pdf (8 pages)
- 4.4i Specialist QS Minutes 16.02.2023.pdf (8 pages)

16:00 - 16:00
0 min

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

Ceri Phillips

16:00 - 16:00
0 min

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

i. *Private Minutes*

ii. *Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*
iii. *MBRRACE Report*
iv. *Cyber Security Internal Audit Report*

16:00 - 16:00
0 min

7. Any Other Business

Ceri Phillips

16:00 - 16:00
0 min

8. Review of the Meeting

Ceri Phillips

16:00 - 16:00
0 min

9. Date & Time of Next Meeting:

Wednesday 30th August 2023 at 1pm via MS Teams

16:00 - 16:00
0 min

10. Declaration

Ceri Phillips

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

Unconfirmed Minutes of the Quality, Safety & Experience Committee

Held on 09.05.23

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Keith Harding	IM	Independent Member – University
Rhian Thomas	RT	Independent Member – Capital & Estates
In Attendance		
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
James Quance	JQ	Interim Director of Corporate Governance
Aron White	AW	Nurse Informatics Lead
Observing		
Cerys Jones	CJ	Student
Lucy Jugessur	LJ	Audit Manager NWSSP
Frances Rees	FR	Student
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Marcia Donovan	MD	Head of Corporate Governance

QSE 23/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh	**Action**
QSE 23/05/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/05/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/05/004	**Minutes of the Committee meeting held on 11 April 2023** The minutes of the Committee meeting held on 11 April 2023 were received. **The Committee resolved that:** a) The minutes of the meeting held on 11 April 2023 were approved as a true and accurate record of the meeting.	
QSE 23/05/005	**Action Log following the Meeting held on 11 April 2023** The Action Log following the Meeting held on 11 April 2023 was received. **The Committee resolved that:**	

	a) The Action Log from the meeting held on 11 April 2023 was noted.	
QSE 23/05/006	**Chair's Actions** No Chair's Actions were raised.	
QSE 23/05/007	**Quality Indicators Report** The Quality Indicators Report was received. The Executive Nurse Director (END) advised the Committee that he would take the report as read and highlighted the following key elements: • Duty of Quality – It was noted that the report provided valuable insight with regards to the steps the Organisation was taking to embed that Duty into everyday process. • Duty of Candour – it was noted that the report detailed how the Duty of Candour was intended to promote a culture of transparency, openness, and learning within the Health Board by being open and honest about adverse events and that healthcare providers could improve patient safety, learn from mistakes, and prevent similar incidents from happening in the future. The END advised the Committee that early learning from the Duty of Candour data showed that 37% of the Health Board's incidents were being regraded because it had been found that staff had been scoring the incidents higher than they should have been and that learning would be shared with Clinical Boards around scoring correctly. • Incident Reporting & Falls – The END advised the Committee that the key messages reported at previous Committee meetings remained the same. • Nationally Reportable Incidents (NRIs) – It was noted that an improvement had been observed which reflected the focus and hard work of the Clinical Boards and Patient Safety Team. • Infection, Prevention & Control (IPC) – The END advised the Committee that there was variability in the data with Cdiff seeing a reduction in the last 4 months and the MSSA being stagnant where reductions were not being observed. The END added that the Cdiff oversight group was now also looking at MSSA to see if improvements could be made. • Concerns – It was noted that through December 2022 and January 2023, the Patient Experience Team was reporting a reduction in the number of concerns being managed in time, but in February and March 2023, the performance had improved (over 80%). That improvement was on the back of the highest number of concerns received into the Organisation in March 2023. The END advised the Committee that the Civica 'Once for Wales' platform went live in October 2022 and that the Patient Experience Team was surveying up to 600 patients daily via SMS with a month on month improvement in return rates for patient data. He added that a deep dive into the Civica data would be brought back to the Committee in August 2023. The Executive Medical Director (EMD) advised the Committee that she would take the report as read and highlighted the following key elements: • Mortality – It was noted that although there was a lot of data within the report, the EMD advised that there were no specific areas to comment on. She added that the report was not where she wanted it to be and that whilst benchmarking was extremely important in mortality data, that could not be undertaken at the moment. It was noted that what was reported regularly to the Committee was the cumulative benchmarking position from September 2021 to January 2023 against other Health Boards' in relation to Myocardial Infarction (MI) and fracture neck of femur.	**JR**

	It was noted that age standardised mortality data was also presented to the Committee previously and that Cancer mortality data required more time to be considered. The EMD concluded that in relation to Perinatal Mortality data, the Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries (MBRRACE) report would be published and more detail would be provided to the Committee in August 2023. The Chief Operating Officer (COO) advised the Committee that he would take the report as read and highlighted the following key elements: • Ambulance Patient Handover Improvement Trajectories – It was noted that the Health Board had done well on reducing the number of ambulatory waits and that Cardiff and Vale were the best Health Board by far within Wales. The COO added that the Health Board had moved towards a zero tolerance to 2 hour holds instead of 4 and that some of the data for April 2023 was really impressive which would be reported to the Committee in a later report. • Emergency Department (ED) – The COO advised the Committee that due to the improved ambulatory data, an increased risk was being observed within the Emergency Department (ED). He added that more and more patients were being added to the ED and to mitigate that risk, on-boarding was occurring onto wards to improve safety. It was noted that the ED was designed for 45 patients and that 140 patients had been in the department and so ways to mitigate those risks and increase patient safety were being considered in collaboration with the Medicine Clinical Board. • Stroke – It was noted that the Health Board was not where it wanted to be in regards to Stroke but that improvements were being made with a lot of organisational focus on the Stroke data with stroke summits being held. The COO advised the Committee that 33% of patients had been admitted to a Stroke ward within 4 hours which was an improvement and noted that further data could be provided to the Committee once the next summit had occurred. The Chief Executive Officer (CEO) noted that in terms of assurance, a number of the graphs within the report did not provide benchmarking against other Organisations which was crucial when reporting data. She added that some of the charts were also unclear as to whether improvements had been observed compared to previous months and asked for the relevant Teams to ensure that accurate data was included which could provide the Committee with the assurance it required. It was noted that conversations had been held between the CEO and the Assistant Medical Director, Clinical Effectiveness & Safety (AMD) with regards to getting the reports ready for the Committee. The CEO advised the Committee that in relation to the still-birth data within the report, there was a point on the chart where the still-birth rate was identified for 2020 and that no assurance or comments had been provided on the number. The EMD responded that the data would be presented to the Committee at a future meeting under the MBRRACE report and that work would be undertaken to address the CEO's comments. The CC welcomed a deep dive on stroke data at the July 2023 Committee meeting. **The QSE Committee resolved that:** a) The content and the developing process to monitor Quality Indicators was noted.	**MJ** **PB** **PB**
QSE 23/05/008	**Ward Accreditation & Improvement** The Ward Accreditation & Improvement presentation was received.	

The END advised the Committee that Tendable had been discussed at the QSE Committee previously and that it was the foundation and the platform which could be built upon for Ward Accreditation.

He added that the Nurse Informatics Lead (NIL) would provide the Committee with a presentation on the updates on Tendable and Ward Accreditation.

The NIL presented an overview of the plans and ambitions for Ward Accreditation to the Committee.

It was noted that Wards were increasingly using digital platforms to measure quality and record patient outcomes and so the Ward Accreditation programme was a way to benchmark how Wards were doing based on the data that could be obtained.

The NIL advised the Committee that Ward B1 was the first area with the Ward Accreditation platform and noted that the Ward had been run through 4 different Ward Accreditation frameworks from NHS England to see how they measured up against different standards.

He added that Wards would only be eligible to apply for Ward Accreditation if they had enough baseline data which included:

- Tendable – Audit compliance at 75% in 6 months and 50% of senior/lead nurses completion in 6 months.
- SafeCare Compliance – 80% in 3 months, staffing register and patient acuity would be required.
- Direct Nominations – As part of “Releasing Time to Care”, the Shaping Change Team could directly refer wards onto the Ward Accreditation pathway.

The NIL advised the Committee that once a Ward was on the programme, they would be asked to hold off on making improvements initially because an intense data trawling exercise would occur which included:

- Tendable – Peer reviews by the Bronze Team and Specialist Teams.
- Rostering Review Meeting to see how effectively a ward deployed its roster.
- Patient Feedback & Staff Survey
- Review of Clinical Incidents
- Review Other Available Data Sets

It was noted that once the data was collected, the Ward would be told how they measured up against the Ward Accreditation Framework consisting of 5 pillars:

- Quality & Safety
- Resources
- “Our People”
- Patient Experience
- Leadership & Improvement

The NIL advised the Committee that the Ward would then undertake the improvement work and would have dedicated data analytics support which would be bespoke reporting for Improvement Projects and Outcome Measures.

He added that once the relevant areas had been completed by the Ward, they would have a final external visit to confirm and start the road to the Silver accreditation.

The IMCE asked how staff felt regarding the Ward Accreditation.

The NIL responded that it had been really well received by the Wards and the Team had been taken aback at how much they had engaged with it.

The IMCE added that the challenge would be in relation to operational pressures.

	The NIL responded that the aim was to run the programme at every quarter. The Independent Member – University (IMU) asked how much of the sense of wellbeing was taking the Health Board's staff away from the frontline of the day to day Ward work. The NIL responded that the time staff were taking off the Ward was very minimal – ie was for 2 hour sessions in 3 months. He added that an extensive staff survey was undertaken to address staffing concerns. The END added that time had to be invested in the Ward Accreditation programme which could create huge opportunities and benefits which had been observed on Ward B1. **The QSE Committee resolved that:** a) The Ward Accreditation & Improvement information was noted.	
QSE 23/05/009	**Board Assurance Report – Patient Safety** The Board Assurance Report – Patient Safety was received. The Interim Director of Corporate Governance (IDCG) advised the Committee that he would take the paper as read. He added that a lot of the risks on the report linked to the discussions held by the Committee, such as Stroke, and noted that the deep dives actioned for future meetings would need to be aligned to the Board Assurance Framework (BAF). The CC noted that it made more sense to delve into specific risks such as Stroke rather than a broad overview which was received by the Board at its meetings. The EMD added that clarity was required on issues that required the Committee's attention and the risks it was trying to mitigate. The CEO added that the Committee did not yet have a measure on the confidence of the data quality and asked how assurance could be provided that data was valid. She added that the conversation needed to be considered on a range of areas which included: • Timeliness • Validity • Quality **The QSE Committee resolved that:** a) The proposed reporting cycle of BAF risks assigned to the Quality, Safety and Experience Committee was approved b) The approach in the Committee Chair's report to the Board on 25th May 2023 was noted.	
QSE 23/05/010	**CHC Reports: Transport to Health Services** The CHC Report: Transport to Health Services was received. The END advised the Committee that the Executive Director of Strategic Planning (EDSP) had provided assurance that the Health Board had looked at the report which outlined a range of considerations that the Community Health Council (CHC) had wanted to make the Health Board aware of. He added that many of the considerations were around the University Hospital of Wales (UHW) site and noted that it was a hospital in a City Centre and so parking was challenging. The Independent Member – Capital & Estates (IMCE) noted that the report had contained areas that were already known to most and added that the report contained a lot of content for very few points.	

	She added that now that the CHC had transitioned to the Llais Service, it would be good if they could contribute to the ongoing consultations around future hospitals. She asked if they had been invited to address the concerns. The END responded that they had been and noted that considerable discussions were being held with Llais as part of the Citizen's Voice. The Senior Service Improvement Programme Manager (SSIPM) advised the Committee that it was important to appreciate the response had from the CHC and that it served as a reminder that the Organisation was trying to move away from planned care outpatient appointments and move more towards patient see-on-symptoms, virtual follow up and virtual consultations. She added that there was hope that as the work continued across the organisation with the Clinical Boards, the outpatient footfall would reduce and less would attend the hospital sites which would mitigate some of the areas identified within the report. **The QSE Committee resolved that:** a) The CHC Report: Transport to Health Services was noted.	
QSE 23/05/011	**Minutes from Clinical Board QSE Sub Committees:** The Minutes from Clinical Board QSE Sub Committees were received. The END advised the Committee that assurance was required that the Clinical Board's Quality & Safety Groups were sitting for meetings and that further action would be looked at to improve the visibility of minutes received by those Clinical Boards. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/05/012	**Radiation Protection Group Chairs Report** The Radiation Protection Group Chairs Report was received. The Executive Director of Therapies and Health Sciences (EDTHS) advised the Committee that the report came from the Health Board's Radiation Protection Group meeting held on 24th January 2023. She added that the Radiation Protection Service (RPS Cardiff) had undertaken a review of compliance against the Ionising Radiation Regulations 17 within the Health Board. It was noted that there were 2 actions for the Health Board which included: • To consider implementing a Health Board wide policy on training of non-radiation workers in radiation areas. • To review the radon risk assessment. The EDTHS concluded that the actions had been looked at and the need to develop a training policy was noted and would be discussed by the CD&T Clinical Board in a meeting held that week. **The Committee resolved that:** a) Assurance could be given that the Health Board had a functioning committee for radiation protection, which oversaw regulatory requirements and compliance for the Health Board. b) The fact that there is a need to implement a Health Board-wide policy on training of non-radiation workers in radiation areas, which will be progressed was noted.	
QSE 23/05/013	**Items to bring to the attention of the Board / Committee:** No items were raised.	

QSE 23/05/014	**Agenda for Private QSE Meeting** *i) Private Minutes -* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *iii) Pressure Damage – Children's Hospital Update (Confidential Discussion)*	
QSE 23/05/015	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: Tuesday, 6th June 2023 at 2pm via MS Teams.	

Action Log

Quality, Safety & Experience Committee

Update for meeting 19 July 2023
(Following the meeting held on 9 May 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
Actions in Progress					
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	**18.07.2023**	Jason Roberts	**Update on 18 July 2023** Agenda item 2.4
QSE 23/05/007	**Perinatal Mortality data**	Once MBRRACE report is published more detail to be provided to the Committee	**18.07.2023**	Meriel Jenney	**Update on 18 July 2023** Agenda item 2.3
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 23/05/007	**Civica "Once for Wales" platform**	To undertake a deep dive into the Civica data	**29.08.2023**	Jason Roberts	**Update in August 2023** *To note that a report is being received by the Board on 27/07/23*

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 23/05/007	**Stroke**	Committee to receive a deep dive with regards to Stroke data	**29.08.2023**	Paul Bostock	**Update in August 2023**
QSE 23/04/007	**Children & Women's Clinical Board Assurance Report**	revisit the waiting list issue identified in 6 months' time to provide more assurance. Full Clinical Board assurance report not required	**10.10.2023**	Jason Roberts	**Update in October 2023**
QSE 23/04/009	**Pressure Damage**	An update report to be brought back to the Committee in 6 months' time.	**10.10.2023**	Jason Roberts	**Update in October 2023**
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					
UHB 23/05/015	**Integrated Performance Report: QSE**	Mortality data assurance to be provided to November Board following a deep dive at a QSE Committee meeting in September	**28.09.2023**	Meriel Jenney	**Update on 28 September 2023**
UHB 23/03/013	**QSE Chair's Report**	A deep dive with regards to stillbirths to be considered at the QSE Committee in the next couple of months.	**29.08.2023**	Jason Roberts/Angela Hughes	**Update in August 2023**

Report Title:	Clinical Diagnostics and Therapeutics Clinical Board Assurance Report				Agenda Item no.	2.1
Meeting:	Quality, Safety and Experience Committee		Public	x	Meeting Date:	July 18th 2023
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Executive Director of Nursing - Jason Roberts					
Report Author (Title):	Helen Luton, Director of Nursing & Multi-Professional Teams for Clinical Diagnostics and Therapeutics Sarah Lloyd, Interim Director of Operations for Clinical Diagnostics and Therapeutics					

Main Report

Background and current situation:

Background:

This report details the arrangements, progress and outcomes taking place to improve quality, safety and patient experience within Clinical Diagnostics and Therapeutics (CD&T) Clinical Board. It outlines the achievements and innovations leading to improved quality and care for patients. It also describes some key risks and the mitigations we have in place in order to continue into 2023/24.

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

During the year 2022/23 the Clinical Board consisted of 6 directorates:

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

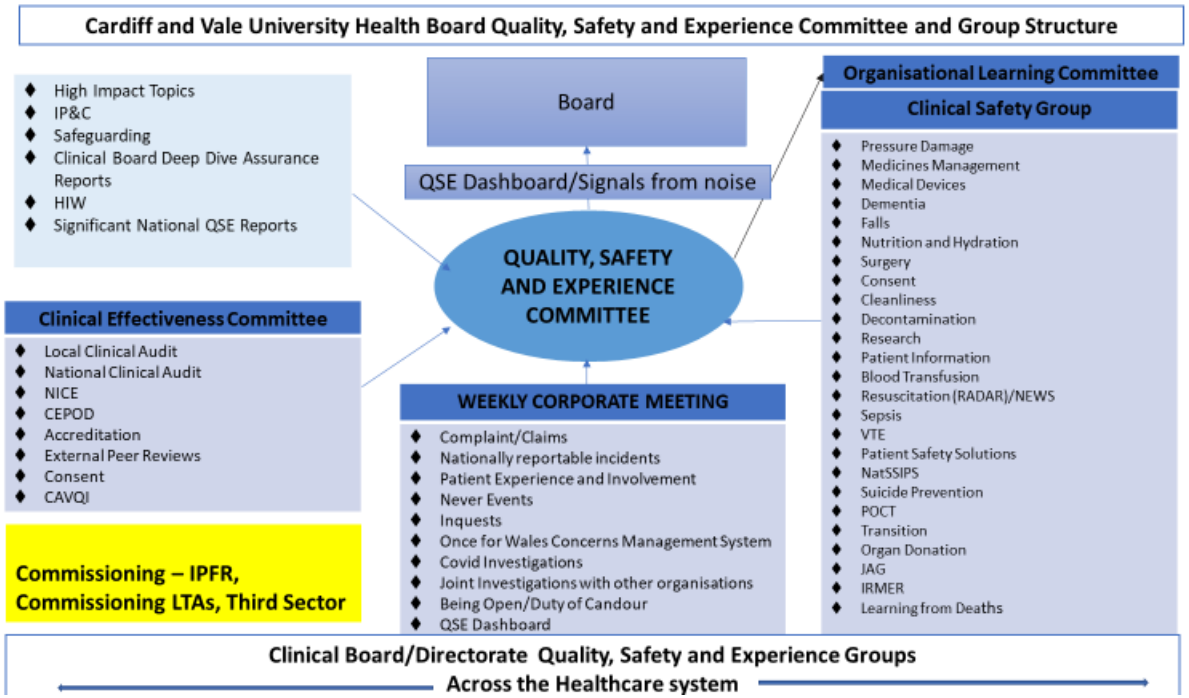
The Clinical Board has also taken governance responsibility for development and oversight of Glan Ely Ward in St David's Hospital which transitioned from Medicine Clinical Board to CD&T in November 2022. At the same time the model of care changed from transitional care to a step down to recover model of care. The existing workforce was increased to provide a 7-day therapy service. There are 19 beds for patients requiring a short period of intense rehabilitation to reduce the care need on discharge and increase independence.

The clinical board has a budget of £108 million and 2,195 whole-time equivalent members of staff across a range of staff groups.

Professional Group	WTE
ADD PROF SCIENTIFIC AND TECHNICAL	215.37
ADDITIONAL CLINICAL SERVICES	451.78
ADMINISTRATIVE & CLERICAL	388.55
ALLIED HEALTH PROFESSIONALS	673.81
ESTATES AND ANCILLIARY	17.00
HEALTHCARE SCIENTISTS	288.16
MEDICAL AND DENTAL	107.89
NURSING AND MIDWIFERY REGISTERED	53.04
Grand Total	**2,195.60**

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
- Health and Care Standards
- Patient Experience
- Financial and Information Governance
- Organisational Development and Workforce Planning
- Regulatory Compliance



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.

Quality Audits and Performance

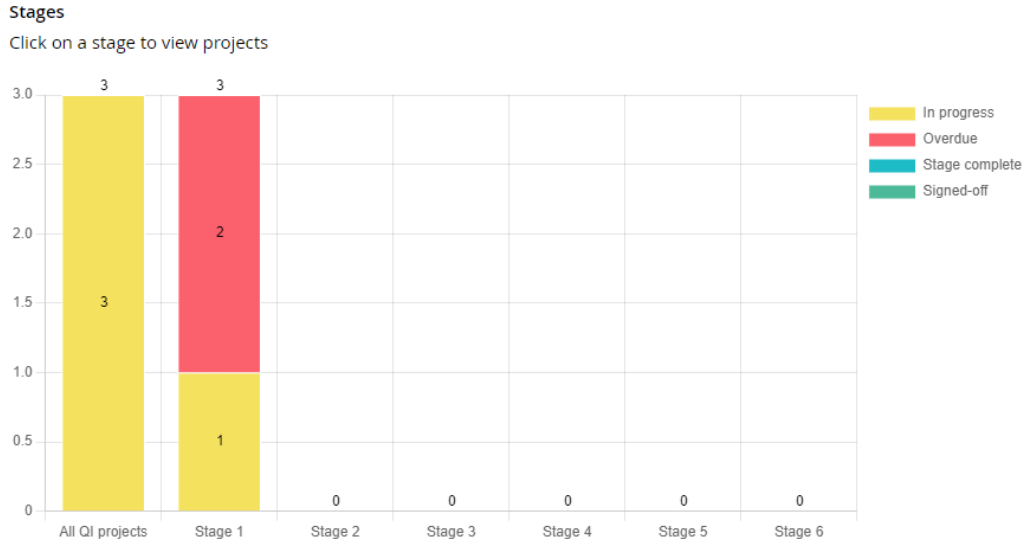
Governance

The Quality, Safety and Patient Experience (QSPE) agenda is a key priority for the Clinical Board. QSPE meetings are held monthly, and the Terms of Reference are reviewed annually. The QSPE meeting agenda has been shaped to align with the six domains of quality and this is replicated at Directorate QSPE meetings. There is good attendance and representation from across the clinical board.

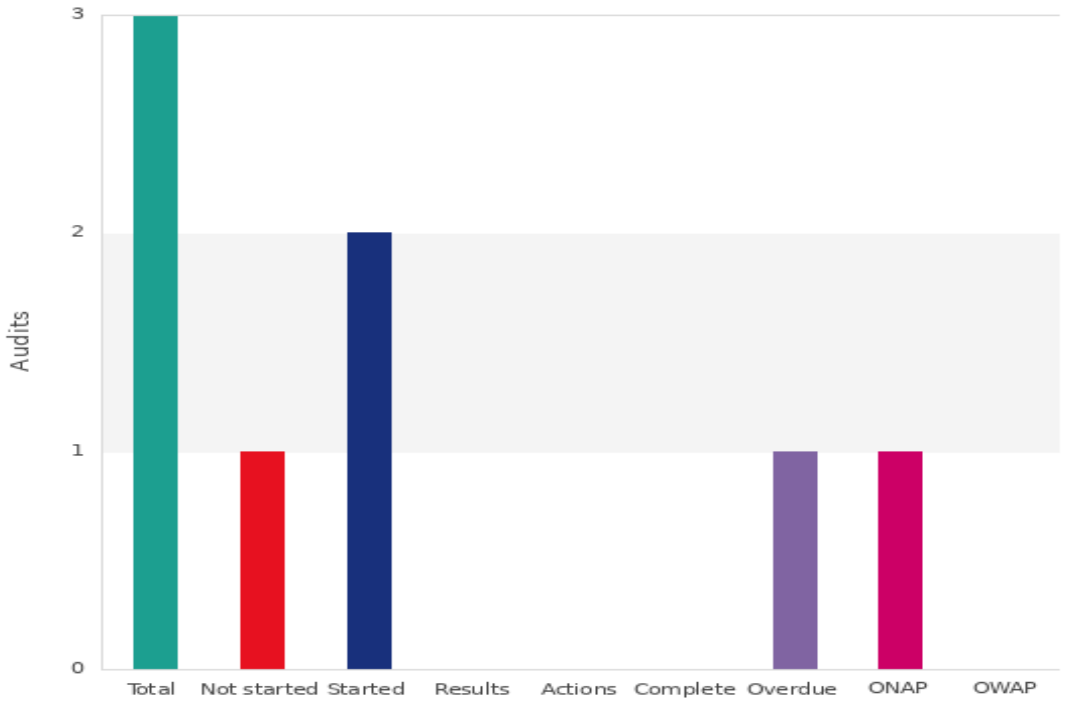
Assurance is received through the QSPE group and other formal meetings, multi-professional representatives from each directorate are present. We have quality managers well embedded within out laboratory, pharmacy and radiology teams who focus on ensuring

services deliver safe, effective and quality care to patients and comply with the legislation that regulate those areas. Within those areas the use of Q pulse provides a platform for storing polices, incidents, audits and action plans and provides assurance. The adoption of AMAT, (audit management and tracking), outside of these areas is a focus for the clinical board in the next 12 months. AMAT will allow learning from investigations and clinical audits to be accessible and securely stored in one place.

Quality improvement project activity



Clinical Project Activity



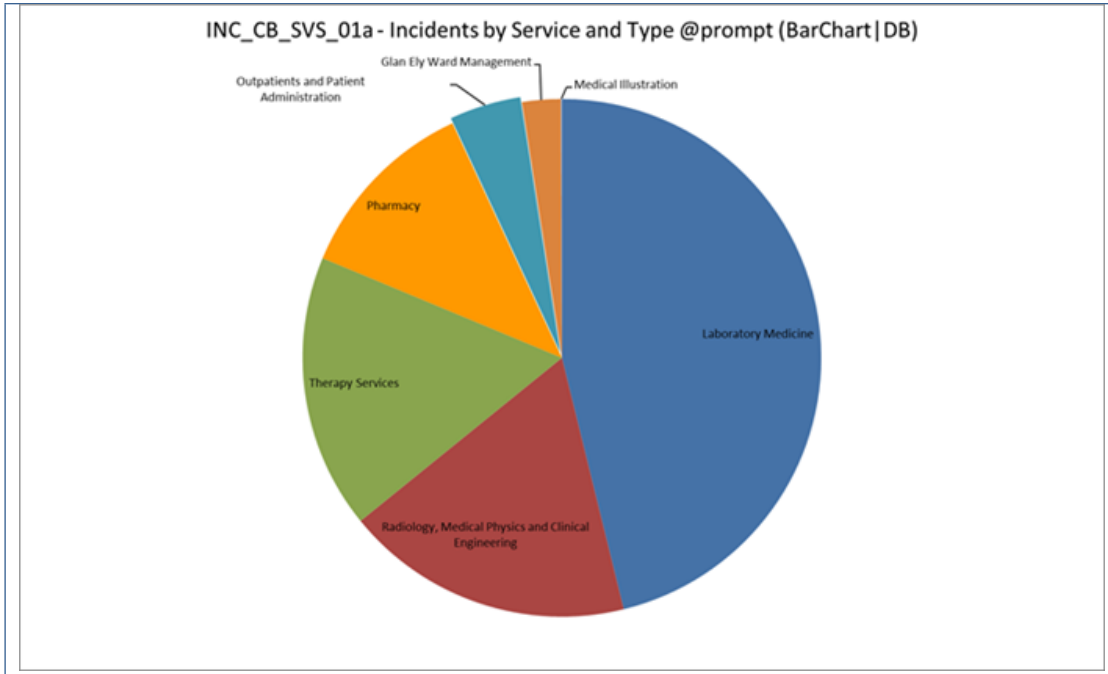
The QSPE group has sub-groups that report to it: Health and Safety group, Regulatory Compliance group and Research and Development group. Health and safety group meet bi-monthly and regulatory compliance on a monthly basis. The research and development group meet every 2 months. All have formal terms of reference and are minuted.

Through both QSPE and Health and Safety the aim is to identify themes and share learning from incidents and action plans.

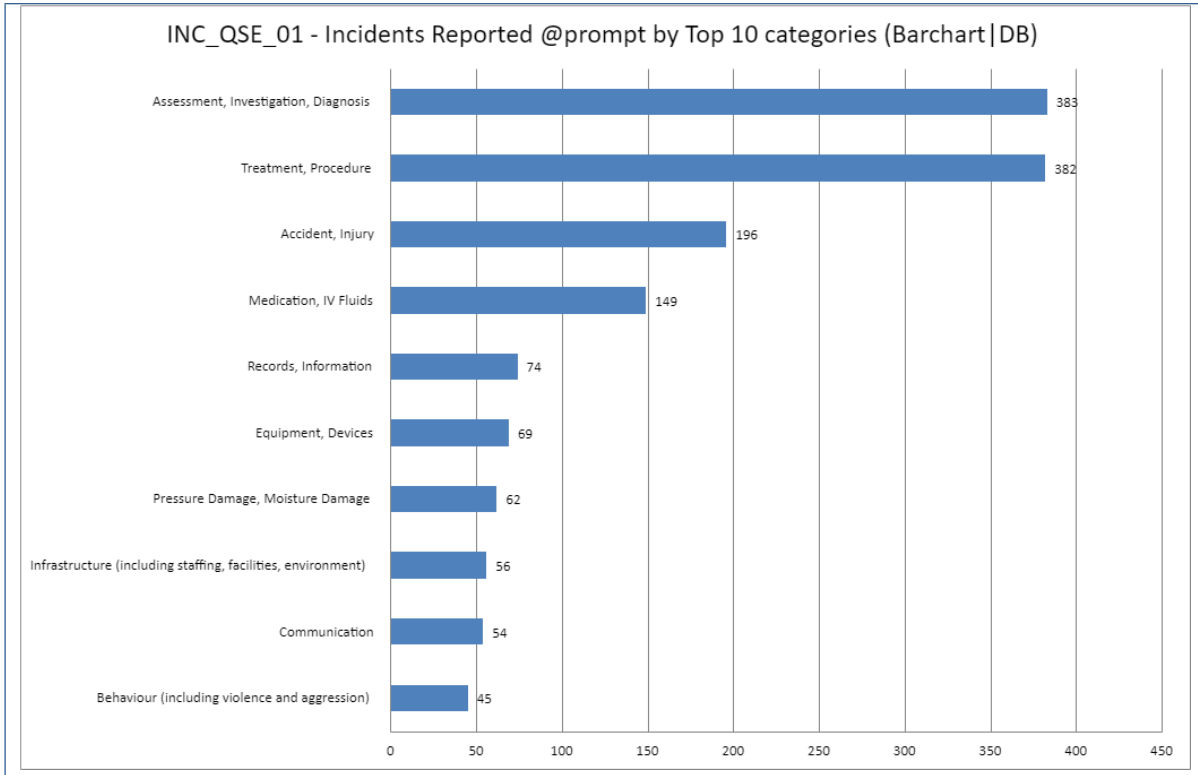
Incident reporting

The total number of incidents reported by Clinical Board staff using e-Datix during the period 1st April 2022 to 31st Match 2023 was 1,657, compared to 1,359 the previous year, demonstrating a strong reporting culture across the board.

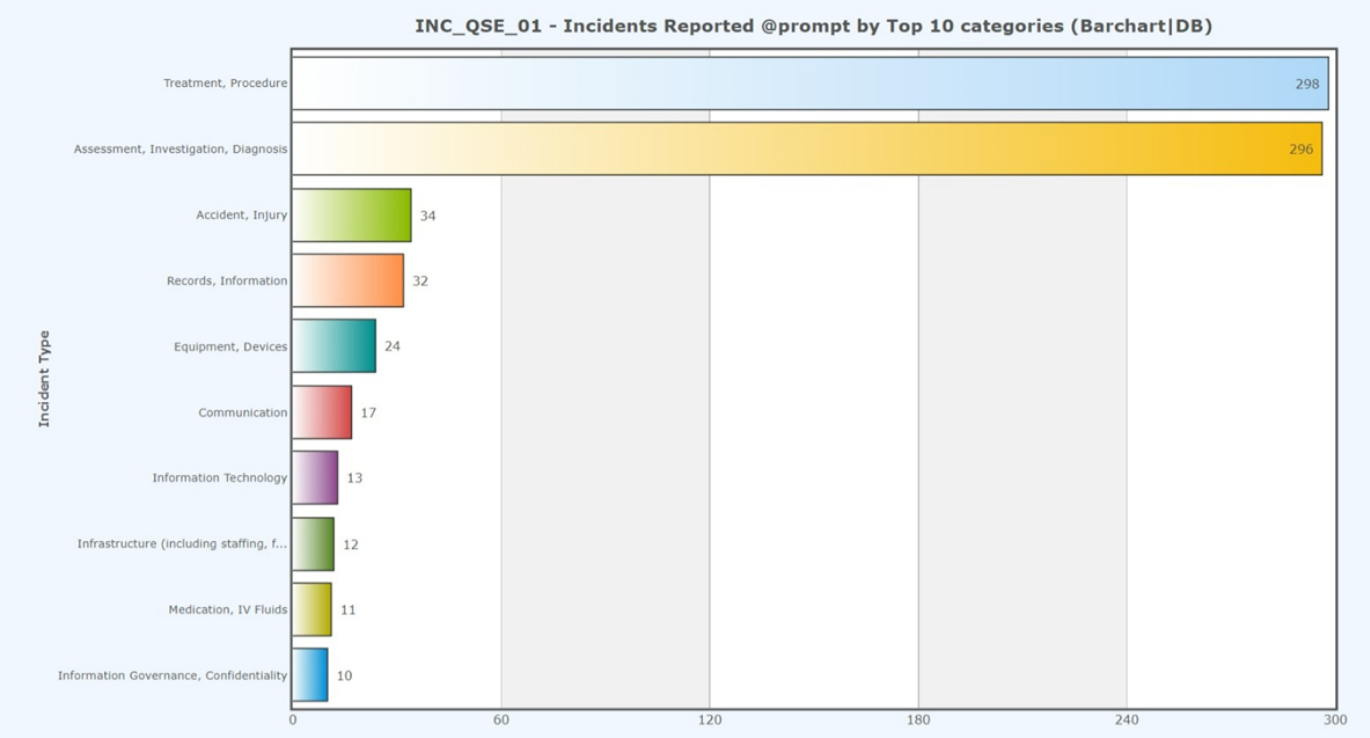
Datix queues are regularly reviewed and managed to reduce the number of open incidents. The introduction of a Lead Nurse post within CD&T is helping to focus support in areas where we have historically had high numbers of incidents that are left open or not reviewed for long periods of time.



Directorate	Number of Incidents
Laboratory Medicine	765
Radiology, Medical Physics and Clinical Engineering	298
Therapy	284
Pharmacy	195
Outpatients/ Patient administration	74
Glan Ely Ward	40
Medical Illustration	1



Laboratory Medicine have an excellent reporting culture, with the highest number of reported incidents within the top two incident types reported across the clinical board and have the highest overall number of incidents.



The Lab Medicine incidents include

- Delay in testing/processing
- Treatment or procedure delayed
- Demographic mismatch
- Failure to follow protocol/SOP
- Inappropriate request for test/treatment/procedure
- Incorrect result reported
- Laboratory technical error/ mishandled samples
- Missing/unavailable specimen
- Sample mix-up (found before result entry)
- Specimen mislabelled or unlabelled
- Test results / reports - failure / delay to interpret or act on
- Traceability

Reportable Incidents:

The clinical board has a robust review of all reportable incidents including those under the ionizing radiation (medical exposure) regulations, through initial fact-finding meetings, with subsequent progress meetings, followed by a closure and action planning meeting. The clinical board has a number of staff trained in conducting such investigations and have recently started to use the patient safety learning review tools with positive feedback.

Each report is also presented through Clinical Board QSPE meetings and shared more widely as appropriate.

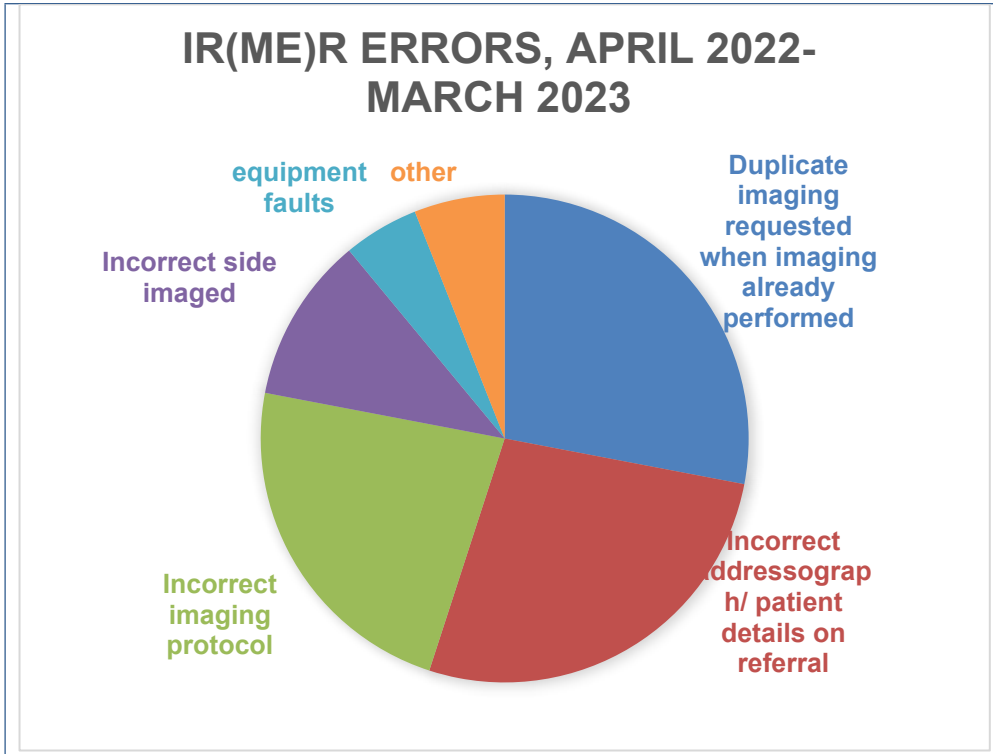
From 1st April 2022 to 31st March 2023, we reported 6 nationally reportable incidents, compared to two in the previous 12-month period. These were:

ID 3145 (April 2022)	HTARI incident reported in foetal pathology involving pregnancy remains that entered the sensitive disposal pathway before post-mortem took place.
ID 4123 (May 2022)	Radiology incident, midway through deployment of a stent in a complex neuro-embolisation the imaging equipment stopped working for a period of 20 minutes where imaging was unavailable for the equipment in the brain to be seen. The patient suffered a post procedure bleed and had symptoms of a dense stroke. It was not possible to make a direct correlation between the fault and the outcome. The procedure is highly complex with recognised risks.
ID 21070 (August 2022)	A potential mis diagnosis of PML on a surveillance MRI scan. MRI surveillance has been shown to improve outcomes as PML can be detected at a pre-symptomatic stage when the prognosis is much better for patients with multiple sclerosis.
ID 16847 (October 2022)	The delay in diagnosis of a malignant melanoma leading to delay in treatment commencing and potential harm

ID 22207 (November)	Dispensing error, epilepsy titrating doses were not dispensed in full leading to a delay in starting additional epilepsy medication. Child was subsequently admitted to hospital and required a short stay in ITU. It is not possible to say that if the medication had been dispensed that this type of seizure would have been avoided.
ID 25423 (February)	Patient attended a dermatology appointment in October 2022 for a biopsy of a suspicious lesion. The histopathology results were not available until February 2023 which showed a malignant melanoma, with CT showing widespread metastatic disease. The patient died on 24th February. Investigation ongoing.

IR(ME)R Incidents

Between 1st April 2022 and 31st March 2023 there were 333,391 examinations involving radiation. 12 incidents were reported to Health Inspectorate Wales in line with IR(ME)R legislation. 0.003% of examinations were IRMER reportable. This is in line with a similar number in 21/22 (10).



A summary of all incidents with key learning points will be shared across the UHB

Health and safety

The current training compliance for the clinical board is:

Training Compliance by Directorate

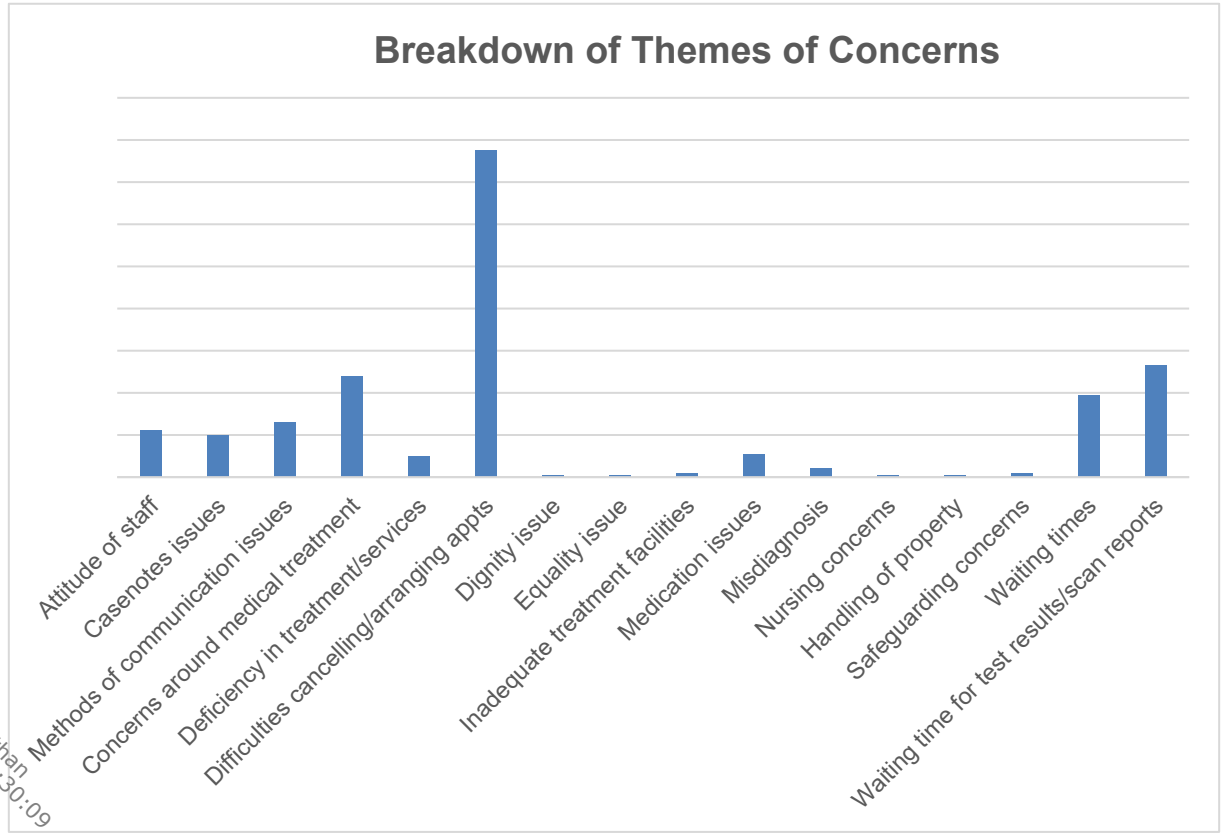
Org L5	Manual Handling - E Learning	Manual Handling - Objects - Classroom	Manual Handling - Patients - Classroom	Violence and Aggression Module A - E Learning	Violence and Aggression Module B - E Learning	Violence and Aggression - Module C - Classroom	Violence and Aggression - Module D Classroom	Fire Safety Training	Health, Safety and Welfare - E Learning
001 Clinical Diagnostics and Therapeutics Management	92.31%			84.62%	100.00%			71.79%	82.05%
001 Laboratory Medicine	89.81%	23.97%		90.23%	80.84%	7.69%		75.80%	84.29%
001 Medical Illustration Directorate	100.00%	50.00%		93.10%	88.46%	60.00%		93.10%	100.00%
001 Outpatients & Patient Admin Services	85.85%		22.22%	83.02%	77.07%	48.65%		77.83%	82.55%
001 Pharmacy & Medicines Management	77.43%	5.23%	0.00%	81.43%	60.24%	4.19%		73.14%	66.00%
001 Radiology, Medical Physics & Clinical Engineering	94.08%	55.88%	55.84%	91.03%	83.81%	24.52%		80.53%	89.69%
001 Therapeutics & Poisons	90.74%			92.59%	87.50%	0.00%		66.67%	83.33%
001 Therapies	93.17%	64.90%	43.29%	91.65%	80.84%	49.48%		80.15%	86.77%

In the period between 1st April 2022 and 31st March 2023 there have been 4 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable incidents, no change from the previous 12-month period.

All 4 incidents involved staff slipping or tripping. No common area involved. Two incidents involved slipping on water in clinical areas and a lack of wet floor signs to alert them to take care. The 3rd incident involved slipping/ tripping due to damaged flooring, signage put in place immediately and urgent request to estates to make safe. The final incident involved slipping on ice outside of the multi-story car park. All cases have been investigated and managed with the support of the health and safety advisors.

Concerns & Compliments

499 concerns received during Apr 2022 to Mar 2023, 361 managed via early resolution with 138 through PTR. On average across the year 97% of formal concerns responded to within 30 days.



In contrast, 104 compliments were received by the Clinical Board in the same period, an increase from 86 in the previous 12-month period. It is pleasing to note the positive reports received from patients for all of our services.

A focus for the coming 12 months is to further embed the value of patient feedback into our areas, utilising electronic platforms such as Civica or designing bespoke QR codes to collate patient feedback.

Regulatory Compliance

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

Many areas in the Clinical Board are tightly regulated and subject to regular inspection and assessment against legislation, regulation and standards. In 2022/23 the following inspections took place:

11th & 12th October HIW Inspection IR(ME)R UHL (UNIVERSITY HOSPITAL LLANDOUGH)

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection diagnostic imaging at UHW. HIW reported that staff had a good awareness of their roles and responsibilities in line with IR(ME)R 2017. There was very positive feedback provided from patients about their experiences when attending the department. HIW requested action was taken to actively collect patient feedback on their experience of visiting the department. The team have piloted a questionnaire accessible via QR code and paper copies in this department with a view to wider roll out across the directorate. It was observed that arrangements were in place to promote privacy and dignity of patients and found that staff treated patients in a kind, respectful and professional manner. Discussions with staff throughout the inspection provided assurances that arrangements were in place to ensure that examinations were being undertaken safely.

7th December 2022 UKAS Accreditation Biochemistry

Re-accreditation visits against ISO15189 in Biochemistry resulted in successfully maintained accreditation. Accreditation ensures safe delivery of services, technical competence, timely, accurate and reliable results, and good quality management. The assessors recognised the expertise of the staff in the labs, the complexity of the service provided and high levels of compliance.

Feedback from QMS demonstrated plenty of conformity and competency, high levels of quality management with well embedded policies and processes. What was particularly encouraging to hear was that the assessors noted that whilst high levels are being maintained the team are also identifying areas for improvement and innovation, so the service is always developing.

25th April 2023 UKAS Accreditation Haematology

Re-accreditation visits against ISO15189 in Haematology resulted in successfully maintained accreditation. The UKAS Quality Manager and the peer reviewers were very complimentary and reflects again the efforts made by the team in this service.

25th April 2023 HSE Inspection of Radiopharmacy and Nuclear Medicine UHW

The purpose was to Inspect work in relation to the Health Board's consents to administer radioactive substances to people, add radioactive materials to products and discharge radioactive material. A formal report is not issued by the HSE unless there is a breach of the regulations. Verbal feedback was provided throughout the day and during the closing meeting.

The feedback was positive overall with the inspectors stating there is a good safety culture with strong routes for escalation of concerns or incidents. It was evident that staff were well trained and knowledgeable. It was commented that the Radiation Risk Assessments and Local Rules were of a high standard and in depth, some minor suggestions for improvement were made. Discussion with trade union representatives confirmed and reassured the inspectors that staff felt their voices were heard and there were appropriate escalation methods in place, and these were well known. Contamination monitoring is already in place, but the probe used for hand and feet monitoring was deemed not to be adequate due to the small probe surface. This should be replaced to ensure accurate monitoring. The Clinical Board Director of Operations provided assurance that funding would be sought to ensure adequate equipment was in place.

All Wales Quality Assurance of Aseptic Preparation Services UHL 22nd November 2022
The inspection highlighted issues relating to the facility's age, including general fabrication and the air handling units. Deficits in the PQS team due to long term sickness and vacancies had impacted on the ability to progress changes and implement action plans in a timely manner. Target dates for closing actions were frequently missed. Decisions around the long-term future of the unit are related to the regionalisation of aseptic services as part of the transforming access to medications programme (TrAMS), which will see a move of production to a regional hub. A timeframe for this is unclear, but significant investment would be required into PSU to address this inspection's findings. The MHRA (Medicines and Healthcare products Regulatory Agency) have also recently inspected the licensed activity of PSU and found similar findings. A formal response back to the MHRA is being drafted.

Internal Audit of Medical Records
In January 2023, a Final Internal Audit Report on Medical Records Tracking was published. It found there to be 'Limited Assurance' regarding the tracking of acute (secondary care) medical records.

The report outlined seven recommendations, all with an associated set of agreed management actions. Two actions sit directly within CD&T Clinical Board, one is shared, with the remaining disseminated amongst all acute bed holding Clinical Boards, Digital & Health Intelligence and CD&T. Broadly the recommendations cover, Governance, Operational and Wider system improvement. Actions have already been undertaken to improve the tracking of medical records and by the 5th June all filing libraries will be closed and access restricted to medical records staff.

Workforce.

The Clinical Board remain committed to delivering the values and behaviours of the UHB to all our staff. During the last 12 months there has been a particular focus on staff completing a values-based appraisal, with directorates providing trajectories to achieve 85% by July 2023. Despite an encouraging trajectory at the end of the Summer into Autumn the momentum has not been sustained and we have seen operational pressures and the focus on delivering clinical care impact further improvement. Compliance with value-based appraisals will continue to be a focus for the directorate teams in the coming months.
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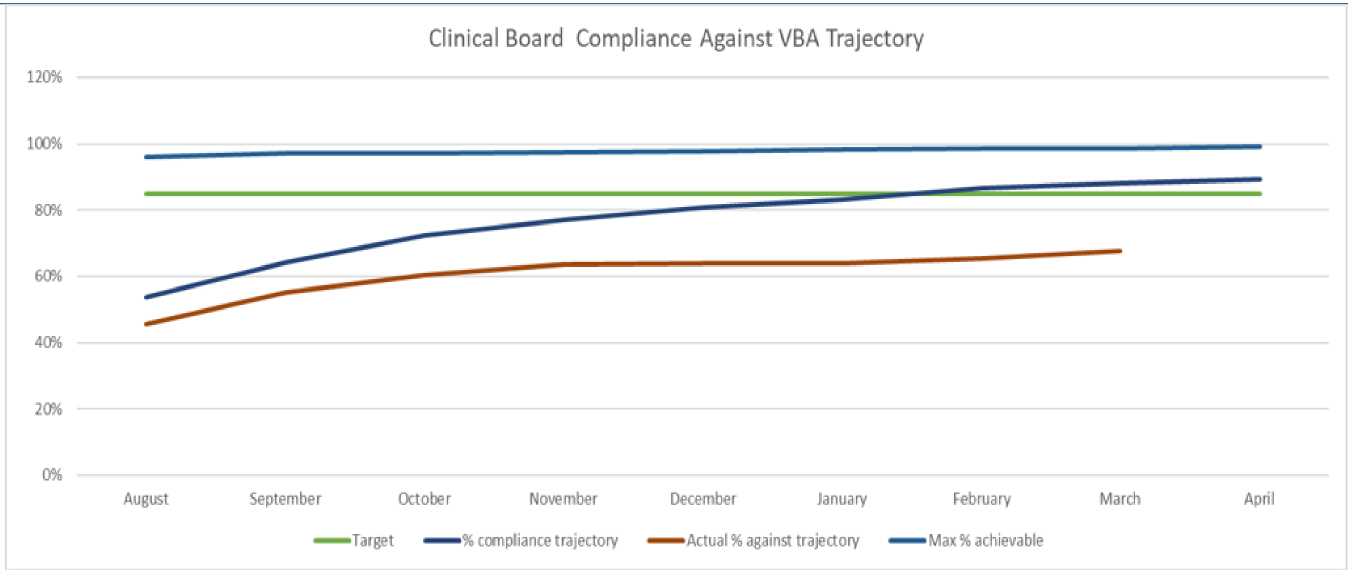


Performance - March 2023					
Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand
13.24%	5.22%	67.76%	90.00%	36.49%	83.01%

Turnover of around 13% has remained steady over the last 12 months, turnover amongst the phlebotomy workforce is one of the main drivers. The phlebotomy transformation programme, whose vision is '**Convenient, timely, flexible, prudent & joined-up Phlebotomy for all CAV patients'**, is reviewing the workforce along with future models of delivery which may address some of the reasons staff move on.

The Clinical Board are developing actions to deliver on the inclusion agenda. The monthly Inclusion Ambassador meetings are well attended. Specific points of interest are added as matters arising, meetings are facilitated from a learning aspect, reflecting individual and collective learning from the appointed Inclusion Ambassadors. In order to share this learning throughout CD&T, useful articles and papers have been uploaded onto a Sharepoint site and shared via a Teams channel. Developing the 'safe space' initiative set up by trade unions is an area in development in the board and working in partnership with staff side colleagues are working on creating an environment where staff can speak up without fear of retribution and any concerns can be addressed. This agenda is being taken forward at directorate levels within therapies. Physiotherapy support a CSP (Chartered Society of Physiotherapists) rep for racial equality and physiotherapy staff have established an Equality, Diversity and Belonging group.

The 'Civility Saves Lives' work is ongoing within Laboratory Medicine.

Risks For Escalation

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

The key risks from the risk register include:

IT/Digital Risk rating 16

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

The Clinical Board is fully engaged with the National Programme to work towards standardisation and interoperability, e.g. LINC and RISP. The timescale for implementation of LINC is behind schedule with a risk the contract on the current system will expire before a new system is fully deployed. The loss of such IT system would impact the volume of samples the laboratories could process, increase risk of transcription errors, loss of inventory in blood fridges.

Estates and Facilities Risk Rating 20

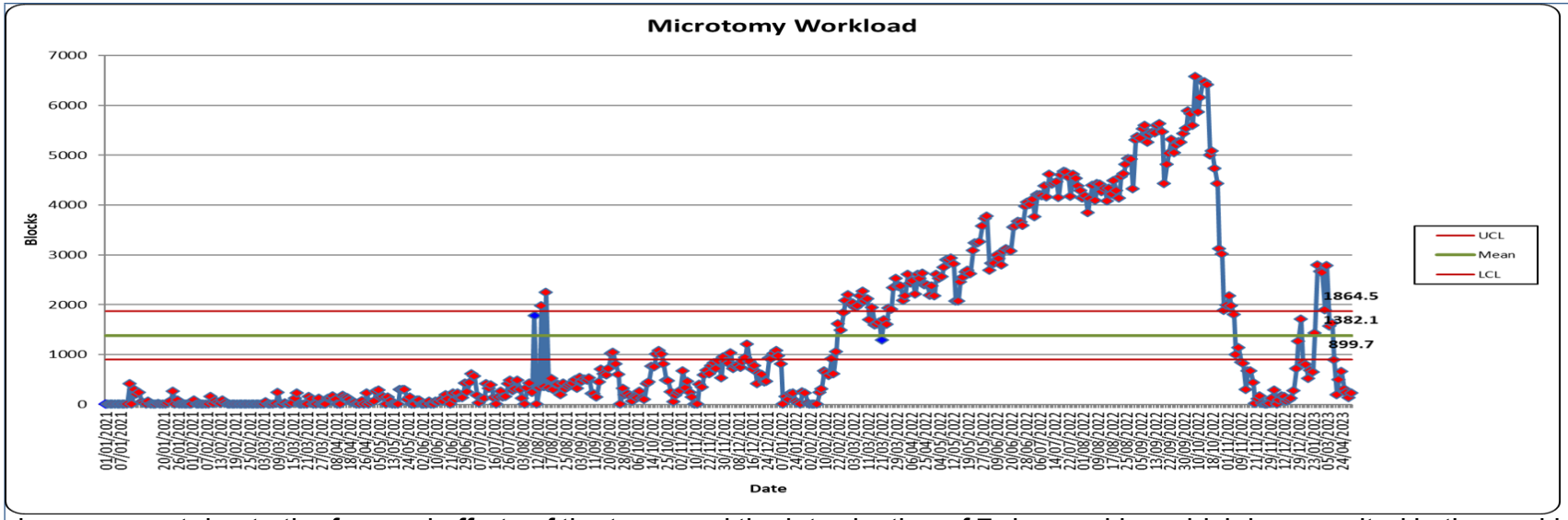
The fabric of some estate is suboptimal to delivery of modern, safe and sustainable healthcare and fails to meet regulatory requirements.

We continue to engage with schemes to update/replace our aging estate and equipment, e.g. The business case for the refurbishment of the mortuary has been submitted for Welsh Government consideration. The refurbishment will also increase the capacity of the mortuary which was tested during the winter when business continuity plans were enacted to provide additional capacity
The equipment in both Neurovascular Interventional suites is in need of urgent replacement. A task and finish group is working to a tight timescale for replacing equipment.

The Radiopharmacy Unit and the air handling units and chillers in both Aseptic Pharmacy Production Units are not fit for purpose and would require significant investment if they were to remain within CAV UHB. The strategy to regionalise the aseptic production through the TrAMS programme in an, as yet, unannounced location, makes local investment in these areas untenable. However, there is a risk that high-cost equipment or remedial estates works will be required whilst awaiting the transfer of services, with delays already incurred in the TrAMS programme. Delivery of all of these schemes will be essential to satisfy the regulating bodies.

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

The department of Cellular Pathology has a backlog of pathology cases, resulting in risk of increased morbidity and mortality due to a suboptimal turnaround time. This could lead to a delay in cancer or critical illness diagnosis and has inevitably led to an increase in concerns. Two NRI's have been declared as a result of delays within cellular pathology impacting on patient pathways. Backlogs had accrued in all areas within the cellular pathology pathway, at one point seeing a backlog of over 6000 cases in the microtomy section (the area in the laboratory where sections of tissue are sliced and prepared onto slides for reporting). There has been



significant improvement due to the focused efforts of the team and the introduction of 7-day working which has resulted in the workload reducing to a manageable operational level of around 100 specimens in the laboratory at any one time. However, issues remain in later stages of the Cellular Pathology pathway.

The introduction of a third immunohistochemistry platform, where additional complex staining of samples can aid accurate diagnosis will also improve turnaround times. Immunohistochemistry is a laboratory method that uses antibodies to check for certain markers in a sample tissue. The antibodies are usually linked to an enzyme or fluorescent dye. After the antibodies bind to the antigen in the tissue sample, the enzyme or dye can be seen under the microscope. IHC helps to diagnose diseases such as cancer and can be used to help tell the difference between different types of cancer. There is still work to do and outsourcing reporting will continue to manage the reporting backlog. New technologies and scientific reporting are also being explored to further manage the demand.

Service Updates and Developments

Pharmacy

Covid Antivirals - we have deployed 2,652 courses of Paxlovid compared to 939 during April 22 to March 23 and 1,479 compared to 647 treatment courses of Molnupiravir and have referred patients for 1,339 compared to 1,496 doses of infusion at their local health board units during the same period.

Covid vaccine allergy service - we have advised on the safe administration of COVID-19 vaccines to individuals with allergies, we have received 222 referrals a fall from 1324 times the last 12 years, a reflection on the experience gained with ongoing use of COVID vaccinations.

Service Improvement Initiatives

- Kidzmeds Cymru- spread and scale project- launched 12th May, aims to switch children from liquids medications to tablets by attending Pill School
- Medicines Story- admission to discharge, this is a Bevan exemplar project looking at what medications' patients bring into hospital, what supplies they have already got at home and what they are discharged with. The aim is to reduce waste and improve patient safety
- Medical gases- Nitrous Oxide project, 2 manifolds closed UHL and UHW work ongoing with Dental
- 3 CAV pharmacists have successfully credentialed at consultant level: Tom Wyllie, Rhys Oakley and Sarah Isles

Medical Illustration

<u>Teledermoscopy</u>

Around 20,000 teledermatology referrals are reviewed by dermatology consultants in Cardiff and Vale University Health Board (UHB) each year, including urgent suspected cancer (USC) referrals. The rising cases of skin cancer has led to an increase in two-week-wait for USC referrals to dermatology from primary care. This, combined with the huge backlog created by the COVID-19 pandemic, where a decline in USC referrals for skin cancer were estimated at 60%, leading to a surge in referrals post-COVID-19 has put pressure on the dermatology service.

The introduction of the teledermoscopy service in November 2022, reduces the demand on the dermatology service, by removing the requirement for all referrals to have an initial face to face appointment where clinically appropriate, redirecting capacity to patients with greater health needs, who need to be seen in outpatient setting. A patient survey undertaken of the service, revealed that 99% of patients rated the service ≥8/10, the survey concluded that most patients were highly satisfied with the teledermoscopy service, however, over a third felt that more information was needed before their appointment. This is outside the control of Medical Illustration; however, this feedback is being acted upon by the Medicine Clinical Board

Eye Care Centre
Medical Illustration provides retinal imaging support to the NHS Wales University Eye Care Centre, (NWUECC) in the Cardiff University School of Optometry and Vision sciences building. These retinal and corneal images are used for diagnostic and treatment planning for Virtual Glaucoma clinics, Age-Related Macular Degeneration in the medical retina clinic and the screening of Hydroxychloroquine patients for retinal toxicity. These clinics have developed and increased allowing patients to be seen, quickly and effectively in virtual and Optometrist-led clinics in the community.

Therapies Directorate

Rehabilitation Model and Operating Model
Since updating the Rehabilitation Model the service has taken action to communicate and embed the model throughout the UHB. This change in model was recognised by:

- **United Kingdom AHA awards 2023 winner** of the Welsh Government Award for Value based care: making the best use of resources to maximise outcomes.
- AHA Awards Cymru 2022 Cardiff and Vale Rehabilitation Model **winner of Award for Excellence in Rehabilitation and overall winner**

We have established our Directorate operating model through a series of workshops with two outputs: a co-produced vision and strategy and an outward facing 'handy guide.' This guide articulates our vision and strategy, lists each service's leadership teams, and illustrates our Rehabilitation Model and Operating Model.

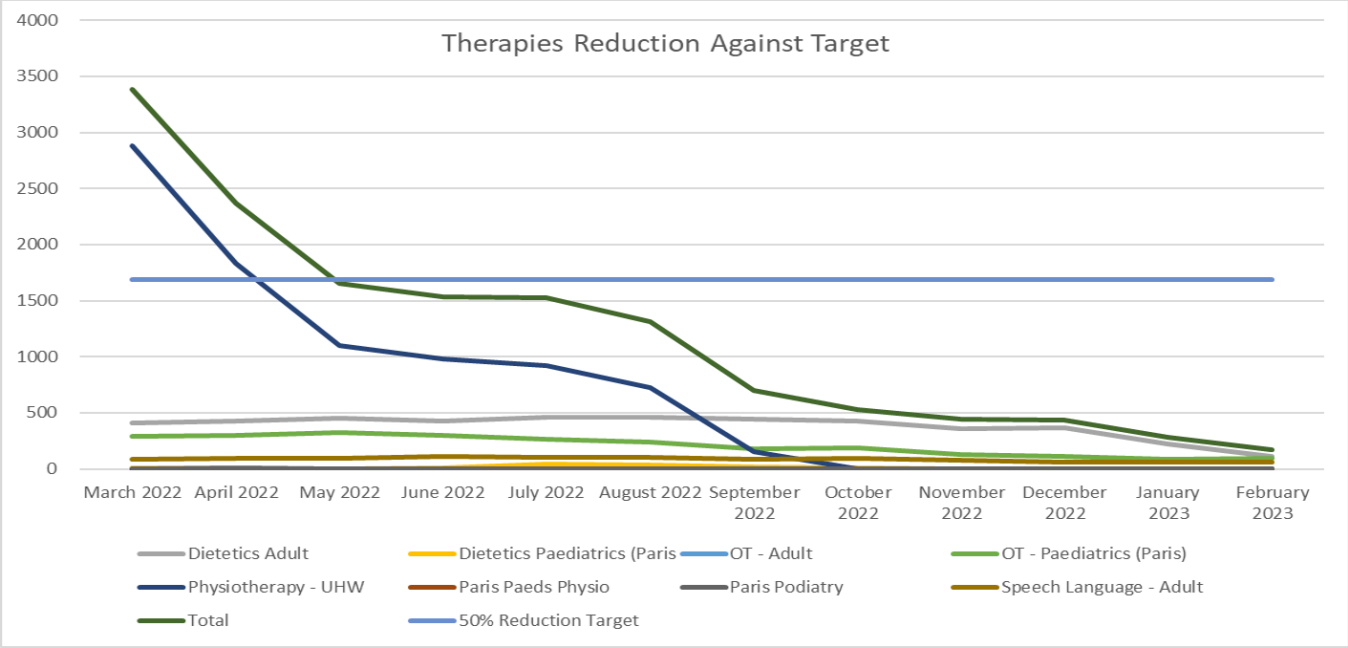
Our co-production forum has supported us to develop the Live Well service identifying what benefits the service needs to provide and how the service may deliver these. The co-production forum has also supported programmes for optimisation for surgery including co-producing material for the Keeping Me Well website as well as a user held booklet 'Stepping Stones' to support those with long term conditions as they interact with health and support services. The forum meets monthly on-line and has hosted 4 in-person events in the last year. Over 200 individuals and organisations are engaged with the forum with approximately 35 regularly involved. This has established a highly effective network supported by the temporary establishment of a co-production lead post.

We have developed materials to support colleagues with meaningful conversations making every contact count and have trained 130 colleagues in Bridges self-management.

In 2022/2023, several schemes for improvement across Therapy disciplines were supported through COVID Recovery funding, including:

- Right Bed First Time – enhanced MDT (Multidisciplinary Teams) within A1 And A1L to improve patient experience and outcomes, shortening response times and implementing a 7-day service, allowing a consistent service every day.
- Frail Trauma- MDT to frail trauma wards in UHL, compliance with hip fracture standards, prompt mobilisation to reduce the recovery period, improved outcomes, patients returning to place of choice.

- Therapy waiting lists – backlogs in Physiotherapy and Dietetic Level 2 Weight Management services have been eradicated. The graph below demonstrates the reduction of the Therapy backlog. The ministerial target of reducing the backlog by 50% from March 2022 numbers was met in May and has continued to improve.



Specialist Rehabilitation and Stroke

- WHSSC funding secured for 11 rehab coaches and a Band 7 team lead to be employed across spines and brain injury rehabilitation to provide goal orientated care over 7 days.
- New specialist PDOC service in place (phase one) with second business case agreed in principle to uplift staff towards BSRM standards so that post discharge follow up and acute in reach to other health boards can occur. Successfully ran first 'Specialist MDT management of PDOC' virtual course to interested parties in both England and Wales.
- The Multi-Professional Rehabilitation Assistant service within Stroke has demonstrated improvement in the amount of therapy delivered, therapy groups run on the ward and shown improvements in patients' quality of life score following the secondment of a 0.5 WTE band 7 service manager and this has now received permanent funding.
- A 6 week 'releasing time to care' service improvement project was undertaken with Stroke rehab MDT on SRC (Stroke Rehabilitation Centre) Llandough and has resulted in several improvements in record keeping, organisation, communication, and statistical management, improving efficiency throughout the team.

Other Therapy Highlights

Speech and Language Therapy highlights include a number of educational projects working in partnership with other agencies, including:

- Collaborative working with Cardiff Council to deliver training for health and social care staff, i.e., from care homes and care agencies.
- Communication Partner Training project ongoing in collaboration with VCRS.
- Cardiff CRT SLT staff presented at the MNDA 'Newly Diagnosed Day', educating people with MND and their loved ones about our role.
- Two awards from Royal College of Speech and Language Therapy for contribution to profession

A number of new roles and services were introduced to enhance the patient offer and experience:

- Neuro-oncology service established November 2022 - leading awake craniotomy service and improving outcomes for patients with brain tumours
- SLT role in Acute Oncology - first in Wales and currently mapping and scoping service and patient needs
- New joint diagnostic clinic starting with respiratory for Inducible Laryngeal Obstruction. Aiming to integrate care and provide improved service user experience and outcomes

Occupational Therapy

The leadership team has co-produced the strategy for the Occupational Therapy Service. This provides a shared vision for the service supported colleagues to make empowered decisions and aligning our endeavour. Occupational Therapy Week 2022 ‘Celebrating and Raising the Profile of Occupational Therapy – Lift Up your Everyday’ brought the strategy to life through delivering 22 bitesize CPD (Continual Professional Development) opportunities virtually over the week. These were themed to align with the strategy ‘Doing only what we can do, delivering care at the right time in the right place with a suitably skilled and enabled workforce’ and were aimed at giving something back to our workforce following the Covid pandemic.

On 29th September 2022, the Occupational Therapy Service hosted Eluned Morgan at St. David’s Hospital and had a round table discussion with her about the value of occupational therapy in admission avoidance, rehabilitation and reablement and supported discharge. The visit clearly had an impact as the Minster followed up the visit on two occasions seeking resources, we had presented to her, raised the impact of therapies in the Senedd and has subsequently funded additional AHP provision into supporting individuals to remain in the community.

<u>Education</u>

- New part-time UG programme in Occupational Therapy at University of South Wales. Members of the service were involved in curriculum design, recruitment of faculty and student selection. We are also pleased to have been able to support once of our HCSW’s to take up the HEIW (Health Education and Improvement Wales) flexi route bursary for this programme.
- 63 undergraduate placements delivered, 170 staff undertaken practice educator training. 103 placements to be delivered this academic year.

- Partnership with Cardiff University providing service improvement project opportunities to undergraduates, completion of analysis of AusTOMS in stroke.
- Delivery of the Agored Diploma in Occupational Therapy Support for Band 3 and Band 4 Support Staff. 30 learners enrolled on the Diploma.
- Partnership with Improvement Cymru to embed Cognitive Disability Model into UG programmes and all Wales resources.
- Bevan Exemplar in collaboration with all Wales Occupational Therapy Group to develop, deliver and evaluate virtual 'Recovery Through Activity'.

Service improvement work

- Cancer Pre-habilitation establishing occupational therapy
- Care Aims into CRT
- Continued expansion of virtual delivery across the services including
- Virtual environmental access visits in stroke rehabilitation- significant impact releasing time for direct clinical provision, improving efficiency and developed as a quality improvement project to support wider services
- Virtual delivery of Upper limb Activity programme, Fatigue Management in Community Neuro Service.
- Delivery of virtual assessment/intervention in MS Team, Neuropsychiatry Service
- Hand Therapy
- Following Pacesetter funding establishment of two occupational therapy posts in Primary Care in line with ambitions of Strategic Programme for Primary Care workforce organising principles.

Physiotherapy

The Physiotherapy Department has continued to shape the service to optimise patient access, outcomes and experience. With the nature of Physiotherapy services, it is important to provide services in ways that engage patients, with their input and feedback at the heart of service development. In addition to the Keeping Me Well Programme, a number of improvements have been implemented:

- In collaboration with Radiology, the MSK primary care imaging pathway was redesigned, resulting in significant reductions in MSK radiology demand and waiting times.
- A secondary care shoulder interface clinic has been developed to enhance timely decision making around complex and urgent surgical interventional needs
- A Physiotherapy clinic has been co-located with Podiatry with a view to reducing the number of visits by patients.
- Bevan funding has enabled the continued development of a Physiotherapy-led Paediatric Orthopaedic clinic based in community clinics and GP practices.
- The Pelvic Health team has developed 'Keeping Well in Pregnancy' educational sessions.
- On PICU, an early mobilisation pathway has been introduced.

- Lymphodema has seen the introduction of a new network pathway which has a virtual first model and collection of LymPROMs
- A new cellulitis pathway has been implemented
- Funding has been approved to implement the 'On the Ground Educational Programme' (OGEP) which highlights patients earlier in the pathway who may be at risk of developing Lymphodema
- A project has commenced to review early mobilisation of post-thrombosis stroke patients which has led to development of a Standard Operating Procedure that will ensure patient safety and timely discharge from hospital.
- A second physiotherapy botulinum toxin injector has been trained to masters level to assist in management of the stroke spasticity population.
- A collaboration between SRC MDT, Cardiff Met design team and Stroke Hub Wales was initiated by the physiotherapy team and has resulted in improved and appropriately designed patient/career/rehab space.
- There is strong Physiotherapy team engagement both locally and nationally in the stroke programmes of improvement and change.
- A poster presentation "The effectiveness of a Prehabilitation physiotherapy service for patients undergoing haematopoietic stem cell transplantation (HSCT) and chimeric antigen receptor T-cell therapy (CAR-T (Chimeric Antigen Receptor T cell)) was presented at the 49th Annual Meeting of the EBMT, Paris, France and won award at BSBMTCT conference in London 2023
- An electronic patient records system has been established in outpatients with the roll out of PARIS.

Podiatry

The C&V Podiatry Strategy (https://nhswales365.sharepoint.com/sites/CAV_Podiatry/SitePages/Podiatry-Strategy.aspx) is robust and clear with a patient centered approach. The strategy focuses on outcomes that matter to people, service clinical priorities, sustainability, and our culture. These areas are supported by a detailed governance structure to ensure patient safety, quality and experience. 2022/23 has been the first full year of implementation and it has been a huge success.

The service has implemented and established many aspects of our strategy and built the foundations on which to grow and achieve our aims and objectives.

Highlights of Service Priorities:
Education – A new service level agreement has been introduced to formalise the close working relationship between CAV Podiatry and Cardiff Metropolitan University (CMet) to support undergraduate education. A pilot of PACE – Podiatry: Accessible Care for Everyone was undertaken in CMet as a complement to our Values Based Healthcare offering high patient value interventions with low technical/allocative value to patients that which to cover the cost of providing the intervention.
Outreach and Medicines Management – Our community offering has seen an expansion of our scope of practice introducing Patient Group Directions (PGD) for Antibiotics as well as three team members qualified in independent prescribing.
Wellness of Future generations – This is a new post within the service and has championed the utilisation of SOS and PIFU pathways operationalising our PAMs and VBH offering maximising impact and efficiency. The ambitions of the role will look to address health inequalities and focus on prevention and coproduction moving away from the historic paternalistic approach of the past.

Research and Development – Podiatry was awarded the top recruiting site for the OSTRICH Trial across all 18 sites in the UK.

Nutrition and Dietetics
Leadership: 2022-2023 has been a year of notable change within the senior leadership of the Nutrition and Dietetic service with the retirement of Judyth Jenkins MBE after 47 years of dedicated work within the NHS. It was fitting that in 2022 Judyth was awarded the Advancing Healthcare Wales AHP of the year award. Other awards include Orla Adams, winner of AHA awards Cymru 2022 Public Health and Prevention, for her work with midwifery services supporting women with obesity during pregnancy; Rebecca Romain, runner up in BDA Critical Care Awards;

The ward based dietetic support worker roles have increased across the UHB and continue to deliver food and hydration support to patients, helping to improve outcomes and reduce length of stay. Recruitment of Registered Dietitians remains a challenge with an increasing number of posts across Wales. Student training numbers are increasing to address the shortfall. During 2022-2023 the service has created its first two dietetic consultant posts for Intestinal Failure and Eating Disorders.

Prevention and Early Years- This year has seen the establishment of several early years' programmes supporting obesity prevention and management. Nylo has expanded to include a dedicated programme, PIPYN, for families from Black, Asian and Ethnic Minority communities. These programmes offer education and cooking skills for families with young children. A website and digital offer have been developed to support these programmes www.nylo.co.uk .

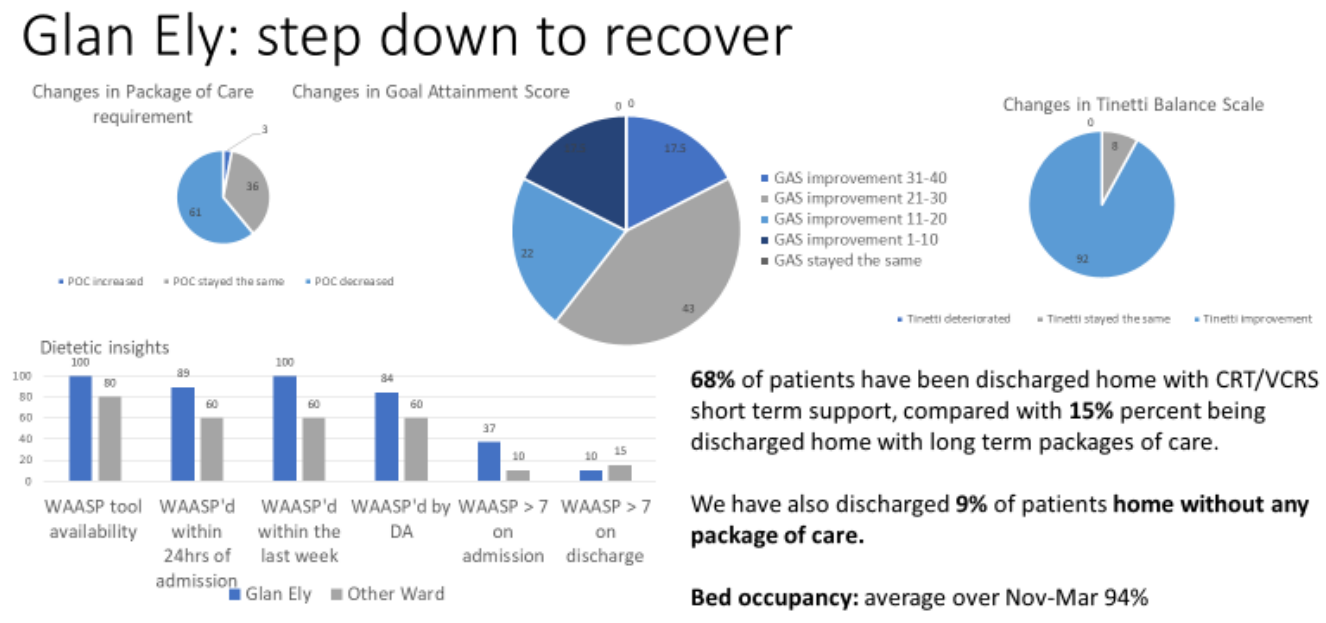
The service continues to offer Nutrition Skills for Life training to build nutrition skills and knowledge amongst professionals and community members, building community assets and capacity. In total 48 accredited courses and 209 non-accredited courses have been delivered this year, supporting 1111 learners. The increase in food poverty continues to impact on the most deprived in our communities and we have worked closely with community partners to expand the alternative retail provision across Cardiff and Vale. www.yourlocalpantry.co.uk.

Chronic Condition Management- the Nutrition and Dietetic service has led the implementation of the weight management pathway for Cardiff and Vale. We now have services for adults and children across levels 2 and 3. Services are delivered in partnership with other professionals and the inclusion of psychology has enabled us to expand our trauma informed approach and offer more support to services users on implementing and maintaining behaviour change.

Specialist services- Nutrition and Dietetics continues to offer a range of secondary and tertiary specialist services in both inpatient and outpatient settings. The service leads the Wales Intestinal Failure service which has been expanded this year to meet the needs of this specialist population across Wales who require total parenteral nutrition. The service also leads the local Enteral Nutrition service and currently supports 450 patients to remain in a community setting on home enteral feeding.

Glan Ely

A change in the model of care to a step down to recover model began in November 2022 when the governance and management of the ward came under C D &T. Below demonstrates the impact the model has had on patients and the levels of independence they can achieve.



Tendable data, core standards

Nursing Team	Clinical Area S...	Staff Question...	Patient Checks...	Pressure Dam...	Nutrition Scor...	Falls Score % -...	Bed Rails Scor...	Deteriorating ...	Core Dementia...	Patient Experi...	Learning Disab...
Glan Ely Transi...	83.3%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The improvement in Tinetti balance scale demonstrates an improvement in patients' ability to complete the activities of daily living with greater independence and increased confidence to engage in day-to-day activities. The goal attainment score (GAS) is an outcome measure used in Occupational Therapy. All goals are individual to each patient. The higher the GAS score the better the outcome and level of achievement for patients.

Radiology, Medical Physics and Clinical Engineering

During the last 12 months an ambitious programme of installation of new equipment has been undertaken.

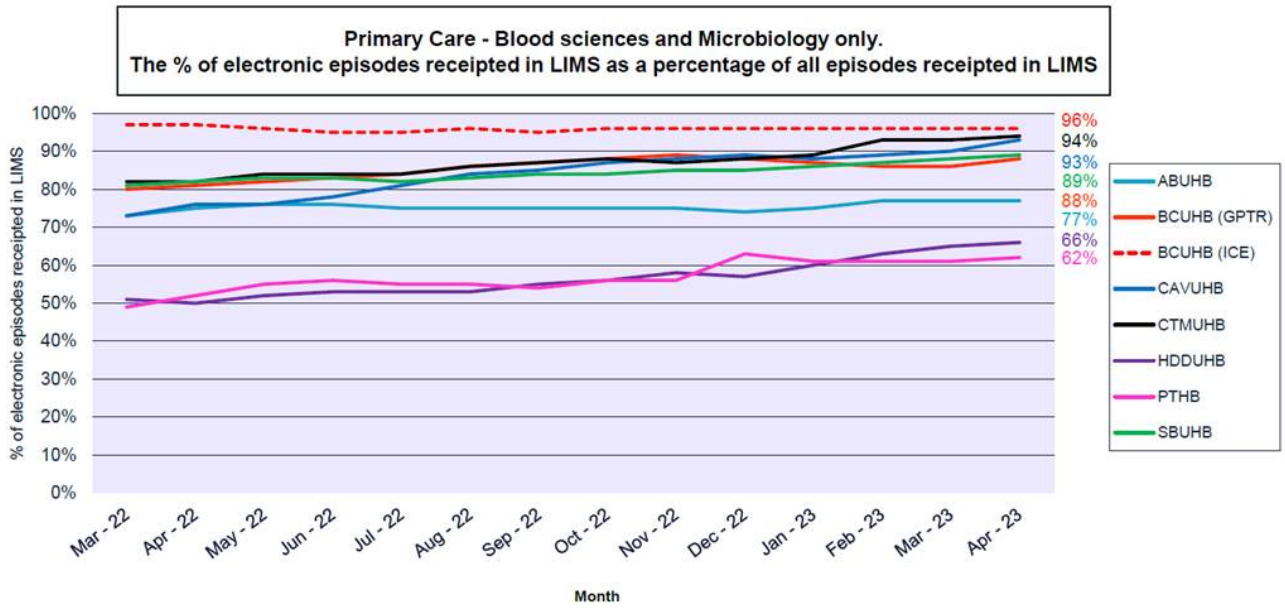
- Two new X-ray rooms have been installed as part of the fracture clinic move back to UHW site
- Replacement of X-ray equipment in two rooms in the emergency department
- Fluoroscopy suite upgraded in UHL

- Refurbishment of CT room in UHL
- Replacement of the MRI scanner in UHL
- Refurbishment of the Cath Lab A in UHW

Clinical Engineering: Medical Equipment and Devices final internal audit report was published in October 2022. The purpose of the audit was to review the arrangements in place for recording, monitoring and replacing medical equipment and devices. Reasonable assurance was given, identifying the UHB has an up-to-date policy and procedure in place, with effective processes for the purchase and maintenance of Medical Equipment and Devices. Risk assessments are being undertaken on new items and actions are taken following reported incidents.
Several medium priority recommendations were made relating to;
The increased awareness and dissemination of the updated Medical Equipment Policy and Procedure
Formal approval of the Policy by Quality, Safety and Experience Committee
The accuracy of location and presence of loaned and substantive medical equipment as stated within the Medusa database
Absence of medical equipment contamination documentation
Available evidence to support training undertaken of equipment prior to first use.

Lab Medicine
Electronic Test Requesting (ETR) and GP Test Requesting (GPTR) for Laboratory Medicine roll-out is well established. The target when the programme began in November 2020 was for 90% uptake of both ETR and GPTR by December 2022.

Monthly Usage Figures – GPTR Tests Receipted in LIMS



The positive impact of electronic requesting on patient safety can be seen in the information below comparing errors in 2021 to 2023 and when comparing ETR with non ETR requests.

	2021	2023
Total requests	35923	44362
ETR Requests	1372 (4%)	40094 (90%)
Remainder – Actual errors	**1232 (3.4%)**	**817 (1.8%)**
ETR errors	323 (1%) of total requests	767 (1.8% of total requests)
Non ETR	2753 (90% of errors)	205 (21% of errors)

Resources

The financial position at the end of March 2023 was an overspend of £382k against a control total of £391k. Summary below shows position for Month 12.

Summary	This Month	Year to Date
	£'000	£'000
Covid Response costs – including Glan Ely	78	0
PPE – Gloves (National funded programme)	0	0
Operational overspend	88	382
Total reported deficit	**167**	**382**

The 2022/23 financial year was extremely challenging for the clinical board, with the requirement to deliver recurrent savings of £1.2m and manage shortfalls against prior year savings targets of £1.3m. The operational position was supported by a significant pay underspend which totaled £3.5m for the 2022/23. The clinical board will continue to review the financial performance of all directorates as part of the performance management arrangements.

ASSURANCE is provided by:

- The governance processes embedded in the core business of the Clinical Diagnostics and Therapeutics Clinical Board and its Directorates
- Evidence of regular performance management reporting
- Monthly review of Clinical Board Risk Register by Clinical Board Team
- 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
- 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

Recommendation:

The Quality Safety and Experience Committee is asked to:

- **NOTE** the progress made by the Clinical Board to date
- **NOTE** the content of this report and the assurance given by the Clinical Diagnostics and Therapeutics 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
The most pressing risks have been highlighted in the Risk for Escalation section.
Safety: Yes
As above
Financial: Yes
The Clinical Board has a favourable in year financial position. This has been achieved largely on account of the vacancy rate across the clinical board and non-recurrent opportunities. As recruitment rates improve an underlying deficit will become apparent.
Workforce: Yes
As outlined in the body of the report the board has significant challenges with certain specialty posts
Legal: No
Reputational: Yes
Reputational risks are outlined in the body of the report.
Socio Economic: Yes

The clinical board provides services to patients from across Wales for a variety of social economic backgrounds. Where possible we provide services closer to home to mitigate some of the costs associated with regional health models.
Equality and Health: Yes
As above. *Link to Staff well-being newsletter produced by Pharmacy team* *https://sway.office.com/ub1SAW65XpJltFCi?ref=Link*
Decarbonisation: Yes
The board has a green group that meets monthly to review and share sustainability projects. *Medical gases work* *Kidzmeds Cymru project* *Walking aid amnesty and refurbishment projects. The Walking Aids service has refurbished and reissued around £40k of kit throughout the UHB this year at a very low cost (cleaning materials, ferrules). The service has worked in partnership with JES and the Probation Service to maximise refurbishment*

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

Report Title:	Wales Cancer Patient Experience Survey				Agenda Item no.	2.2 b	
Meeting:	Quality, Safety and Experience Committee		Public	X	Meeting Date:	18th July 2023	
			Private				
Status *(please tick one only):*	Assurance	√	Approval		Information		
Lead Executive:	Jason Roberts Executive Nurse Director						
Report Author (Title):	Annette Beasley Macmillan Lead Cancer Nurse						

Main Report
Background and current situation:

The third Wales Cancer Patient Experience Survey (WCPES) was conducted by IQVIA in 2021 on behalf of the Wales Cancer Network and Macmillan Cancer Support and was reported in 2023.

The report can be found under the supporting documents folder on AdminControl and the Public papers on the Cardiff and Vale UHB website.

This survey was designed to measure and understand patient experience of cancer care and treatment in Wales, to help drive improvement both nationally and locally. The survey findings will help celebrate what is working well and inform ongoing improvements in cancer care throughout Wales by highlighting areas of importance, raised by patients across Wales, and their associated findings.

We are hugely grateful to the 935 people living with cancer who took part in the survey for providing such detailed feedback on their experiences of diagnosis, treatment and care in Cardiff and Vale UHB. 92% of the respondents rated their overall care in Cardiff and Vale UHB as 7 or more out of 10; this was the top rating across all Health Boards in Wales.

There are key areas in which patients have highly rated their care and experience:

Positive scores

- 90% of patients said they were always treated with dignity and respect while they were in hospital
- 94% of patients said they were always given enough privacy when they were being examined or treated
- 93% of patients said they were given all the information they needed about their operation and their tests
- 92% of patients said hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital

There are some less positive scores. We are committed to strengthening these areas to improve the care and experience of people with cancer:

Less positive scores

- 49% of patients were offered the opportunity to discuss their needs and concerns and 30% had been offered a written care plan
- 37% of patients said their healthcare team completely discussed with them or gave them information about the impact cancer could have on their day-to-day activities (for example, their work life or education)
- 37% of patients said their family or someone else close to them definitely had enough opportunity to talk to a healthcare professional
- 28% of patients said that, after leaving hospital, they were definitely given enough care and help from their GP and the GP practice
- 29% of patients said that, since their diagnosis, someone had discussed with them whether they would like to take part in cancer research (e.g. clinical trials)

In comparison with the last survey undertaken in 2016, the 3 largest improvements were related to CNS's and Key Worker (usually the Cancer CNS):

1. 66.6% of respondents reported it was easy for them to contact their CNS 56.3% in 2016 (+10.3%)
2. 91.6% of respondents reported their care included access to a CNS 86.6% in 2016 (+5.0%)
3. 92.8% of respondents reported they were given the name and contact details of their Key Worker – 89.1% in 2016 (+3.7%)

These results reflect the concentrated service improvement undertaken following the last survey. They are also reassuring given the context of a Covid 19 pandemic when a significant number of the cancer specialist nurse workforce were depleted due to redeployment and absence from work.

The 3 largest declines related to care after leaving hospital and support at home:

1. 28.3% of respondents reported that after leaving hospital, they were definitely given enough care and help from their GP and the GP practice – 54.3% in 2016 (-26.0%)
2. 47.7% of respondents reported that they were definitely offered practical advice and support in dealing with the side effects of their treatment at home – 62.4% in 2016 (-14.7%)
3. 55.8% of respondents reported that after leaving hospital, they were definitely given enough care and help from health or social services – 67.3% in 2016 (-11.5%)

It is important to recognise the context of the Covid 19 pandemic when interpreting these results. During this period there were unprecedented changes to the delivery of clinical and social services. Despite these challenges, staff went above and beyond during this time to continue to care for people and keep people well.

We have presented the findings from the Wales Cancer Patient Experience Survey at the Health Board's Executive Cancer Board and the report has been shared with the patient experience team, clinical board triumvirates and the cancer workforce. To facilitate and enable service improvement to strengthen areas in which people with cancer reported less positive experiences, we will engage with clinical boards and clinicians for their contribution to the action plan. When completed, the action plan will be presented to the Executive Cancer Board. Ongoing monitoring of progress will be by the new Person Centered Care in Cancer Board and the Cancer Stakeholder Reference Group.

As a means to capture more frequent patient experience and to measure the effectiveness of service improvement, we have co-produced a patient experience questionnaire with our specialist cancer nursing workforce and the patient experience team. The questions focus on a number of identified themes within the Wales Cancer Patient Experience Survey and the questionnaire will be used by all site-specific teams. Once notable service improvement has been made within these areas, the focus of questions will be changed to enable another cycle of service improvement and evaluation to begin.

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

The third Wales Cancer Patient Experience Survey (WCPES) was conducted by IQVIA in 2021 on behalf of the Wales Cancer Network and Macmillan Cancer Support and was reported in 2023. 935 patients took part in the survey.

The report highlights both the positive experiences described by patients and the progress in improvements since 2016. The report also advises ongoing work with clinical teams to ensure continued improvements in areas that scored less positive.

Recommendation:

The Committee is requested to:

a) note the content of this report.

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: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: Yes/No
Decarbonisation: Yes/No

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

Saunders,Nathan
18/07/2023 09:30:09

Report Title:	Healthcare Inspectorate Wales Activity			Agenda Item no.	2.4
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	January 2023
		Private			
Status *(please tick one only)*:	Assurance X	Approval		Information	
Lead Executive:	Jason Roberts, Executive Nurse Director				
Report Author (Title):	Assistant Director of Quality and Patient Safety				

Main Report
Background and current situation:

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the reviews and inspections carried out by Healthcare Inspectorate Wales (HIW). The paper seeks to assure the Committee that action is already being implemented in response to the findings of inspections and that appropriate monitoring of progress against the actions is being undertaken.

HIW is the independent inspectorate and regulator for health care in Wales. The core role of HIW is to review and inspect the NHS and Independent Healthcare organisations in Wales so that assurance can be given to patients, public, Welsh Government (WG) and healthcare providers that services are safe and of good quality.

Inspections are a means of providing assurance that services are meeting the Health and Care Standards (2015) and are meeting any other relevant professional standards and guidance. Inspections are a structured process and are underpinned by the view of Francis (2013), who emphasised the importance of undertaking direct observations of a service and care provided. Unannounced inspections undertaken by HIW allow them to see services in the way they usually operate and focus on the following themes:

- Quality of the patient experience
- Delivery of safe and effective care
- Quality of management and leadership
- Delivery of a safe and effective service

Activity/Published Reports Since January 2023 QSE Committee Report

Pine Ward and Ash Ward Hafan Y Coed

HIW undertook an unannounced inspection of Pine and Ash Wards, Adult Mental Health, Hafan Y Coed from the 9th to the 11th of January. The inspection team found there to be sufficient and appropriate recreational and social activities for patients and noted that both wards provided a calm and therapeutic environment for patients in keeping with their needs. Legal documentation to detain patients under the mental health act was noted to be well completed and was compliant with legislation and patient were involved in their Care and Treatment Plans.

HIW noted that there was inadequate compliance with Strategies and Interventions for Managing Aggression (SIMA) training on both Ash and Pine Ward and noted that some staff who had received training but who were due refresher training had been involved in restraints. An education plan was immediately developed to address the training delays that had occurred due to a cessation of face to face training during the Covid pandemic. It was identified that members of staff who had never received SIMA training had not been involved in the restraint of patients.

The full report and improvement plan can be accessed at : 20230420HafanYCoedEN_0.pdf (hiw.org.uk) - https://www.hiw.org.uk/system/files/2023-06/20230420HafanYCoedEN_0.pdf

Llandough Hospital E12 and E16

HIW undertook an unannounced inspection of wards 12 and wards 16, mental health services for older people in the University Hospital Llandough on 20th, 21st and 22nd March 2023. The inspection team found a dedicated staff team that were committed to providing a high standard of care to patients. Staff demonstrated a caring, kind and compassionate attitude towards patients and noted that staff interacted and engaged with patients respectfully, there was good team working and motivated staff and the staff team communicated well with patients. However, they also noted that there was some worn furniture in the dining rooms on both wards and in some areas the environment needed improvements. There was no information available on either ward on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales.

There were facilities for patients to see their families in private. Rooms were also available for patients to spend time away from other patients according to their needs and wishes. Arrangements were in place for patients to make telephone calls in private. Records for patients who were detained under the Mental Health Act (the Act) were reviewed and it was noted that documentation required by legislation was in place.

Ward staff assessed patients for their risk of falling and made efforts to prevent falls. Patient falls were noted to be reported via the health board electronic incident recording system. Staff explained that the incident reporting system would be followed to ensure lessons were learnt and acted on appropriately

The full report and action plan can be accessed at: 20230616Llandough-Full-EN_0.pdf (hiw.org.uk) - https://www.hiw.org.uk/system/files/2023-06/20230616Llandough-Full-EN_0.pdf

Ward B5 and T5 Nephrology and Transplant UHW
HIW undertook an unannounced inspection on nephrology and transplant wards B5 and Ward T5 in the University Hospital of wales on 7th and 8th March 2023.

Several Immediate Assurance requirements were issued to the Health Board following the inspection. These included

- the safe storage of medication
- Compliance with mandatory training
- Storage and removal of clinical waste

Immediate measures were implemented to ensure medication cupboards could be locked and the safe storage of insulin. Wards inspections and audits have been implemented to provide assurance that these improvements have been sustained.

Alternative arrangements for the collection of clinical waste have been implemented in the immediate term while the service lift is being repaired.

A mandatory training plan has been developed to support the necessary improvements in training compliance.

The full report will be published on 6th of July 2023 and an overview of the report and full improvement plan will be reported to the committee following publication.

Maternity Services University Hospital for Wales

Maternity services were subject to an unannounced Inspection by HIW on the 9th, 10th 11th November 2022. A number of immediate assurances recommendations were issued following the inspection, which were accepted by HIW in March 2023. A follow up inspection was undertaken on 27th 28th and 29th March 2023 and several immediate improvements were re-issued and several further immediate assurance issues were identified. A combined report that provided oversight of both inspections and the overarching improvement plan was published on 21st June 2023.

HIW found that staff worked hard to provide patients with a positive experience despite the pressures on the department. Staff were observed providing kind and respectful care, and patients we spoke to were generally positive of the care they received from staff. However, some patients raised concerns about staff availability and sufficient support. This negatively impacted timely care, and patient dignity and privacy.

HIW identified a number of areas where patient experience could be improved and these included:

- Clearer signage to different areas of the service
- Patients should be cared for within the right clinical areas for their stage in pregnancy
- The induction of labour ward environment should promote patient privacy and dignity
- Women with low risk pregnancies should be given the choice to receive their care in a non-medicalised environment
- Further work needs to take place to support patients from Black, Asian and minority ethnic backgrounds.

Further improvements were also required to support

- The safe storage of medicines
- Improvements in environmental Infection prevention and control measures
- Equipment checks and maintenance.

A full action plan has been developed to support the requisite improvements and internal inspection and audit is being undertaken on a regular basis to provide assurance that these improvements are being sustained.

The Cardiff and Vale Maternity dashboard links with the Euroking maternity data system and the Perinatal Mortality Review Tool (PMRT) to provide accurate information on outcomes for women, including those from minority ethnic backgrounds. Data from MBRACE-UK Saving Lives, Improving Mother's Care report 2021 was presented at the Directorate Quality and Safety Meetings with oversight from the Clinical Board Quality and Safety Meeting to ensure an adequate response. Data relating to inequalities in outcomes are shared with staff on mandatory training days by our Specialist Midwife for women seeking sanctuary and survivors of harmful practice. Cardiff is the only UHB in Wales to have this specialist role. This specialist midwife supports families from ethnic minorities, supporting them to experience safe and equitable maternity care required, the role is further supported by the ELAN team who provide support to vulnerable families within our communities.

Since the initial inspection recruitment with mandatory training including Practical Obstetric Multi-Professional Training (PROMPT) training has improved. Recruitment efforts have resulted in an improved midwife and medical establishment. The Maternity Directorate collect patient experience using the CIVICA system and this information is considered at the quality and safety meetings. An environment coordinator has been appointed and they are responsible for the upkeep and maintenance of equipment.

The full report and improvement plan can be accessed at: 20230621UHWMaternity-Full-EN_0.pdf (hiw.org.uk) - https://www.hiw.org.uk/system/files/2023-06/20230621UHWMaternity-Full-EN_0.pdf

Ward A7 University Hospital of wales

An unannounced inspection was undertaken on ward A7 in the University Hospital of wales on 12th and 13th June 2023. HIW identified immediate improvements that were around the safe storage of medicines during the inspection. Immediate actions were implemented to ensure the requisite improvements.

The full report is yet to be published and an overview of the report and full improvement plan will be reported to the committee following publication.

Dental Hospital University Hospital for wales

A planned inspection of the University Dental Hospital was undertaken on 24th April 2023

The full report is yet to be published and an overview of the report and full improvement plan will be reported to the committee following publication. No immediate assurance issues were identified during the inspection.

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

There have been four unannounced inspections, one follows up inspection in maternity services and one planned inspection in the University Dental Hospital since HIW activity was last reported to the committee in January 2023.

Improvement plans have been developed following the Hafan Y Coed, Pine Ward and Ash Ward Inspection, University Hospital Llandough, wards East 12 and East 16 and the University Hospital of Wales Maternity Services Inspections and have been accepted by HIW. The full reports and associated improvement plans have been published and continue to be monitored and reviewed.

Reports remaining pending for the Nephrology and Transplant, B5 and T5, ward A7 and the University Dental Hospital.

Recommendation:

The Committee are asked to:

NOTE the assurance provided by the response to HIW inspections and the actions implemented to address immediate assurance issues where identified.

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	X	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	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		Long term		Integration	X	Collaboration	X	Involvement	

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:

Saunders,Nathan
18/07/2023 09:30:09

Report Title:	**Board Assurance Framework** – Patient Safety			Agenda Item no.	2.5
Meeting:	Quality, Safety and Experience Committee	Public	x	Meeting Date:	18th July 2023
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Director of Corporate Governance				

Main Report
Background and current situation:

The Board Assurance Framework is reported to every meeting of the Board and contains 15 risks. Six risks have been assigned by the Board to the Quality, Safety and Experience Committee to monitor and provide assurance to the Board that controls are operating effectively, assurances are robust and mitigating actions are being implemented in accordance with agreed timescales. These risks are:

1. Patient Safety
2. Maternity Care
3. Critical Care Capacity
4. Cancer Services
5. Stroke Services
6. Planned Care
7. Health Inequalities

At the May 2023 meeting of the Quality, Safety and Experience Committee it was agreed that a reporting cycle is required for these risks in order to ensure that the Committee is able to afford sufficient time to discussing each of them on a regular basis to fulfil its responsibility to the Board. The cycle is commencing from July due to the postponement of the June meeting of the Committee.

The cycle enables the Quality, Safety and Experience Committee assurance to link more closely with the 'deep dive' approach into reporting of quality measures and in order to do so the cycle is not fixed as it may be expedient to report a particular BAF risk to coincide with the reporting of further detail into a particular area, for example as the result of regulatory or internal review. The Corporate Governance Team is maintaining a schedule of reporting the risks in order to ensure that each is reviewed by the Committee on a regular basis.

The Patient Safety risk is reported to this meeting of the Committee.

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

The Board Assurance Framework is presented to each meeting of the Board after discussion with the relevant Executive Director. It 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 risk is a key risk to the achievement of the organisation's Strategic Objectives.

Recommendation:

The Quality, Safety and Experience Committee is asked to:

(a) Review the attached risk in relation to Patient Safety
(b) Provide assurance to the Board on 27th July 2023 on the management /mitigation of this risk.

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	
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	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please 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~~

At the Board Meeting to be held on 26th May 2022 the following nine risks were approved for inclusion on the BAF as the key risks to the Health Board delivering its Strategic Objectives:

1. Workforce
2. Patient Safety
3. Leading Sustainable Culture Change
4. Capital Assets
5. Risk of Delivery of IMTP 2022-2025
6. Staff Wellbeing
7. Exacerbation of Health Inequalities
8. Financial Sustainability
9. Urgent and Emergency Care

However, further risks were added to the BAF at the Board Meeting held at the end of November 2022. These are:

10. Cancer
11. Critical Care
12. Digital
13. Maternity
14. Stroke
15. Digital Strategy and Road Map

These additional risks align to other Committees of the Board so do not impact upon the programme of BAF risk reporting to this Committee.

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	27th July 2023

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) • Monthly Clinical Board reviews to map progress		
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 March 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	30.09.23	Work ongoing. 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	Complete
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	Complete

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

Report Title:	Mental Health Clinical Risk and Risk Mitigation Management Policy			Agenda Item no.	3.1.1
Meeting:	QSE Committee	Public	x	Meeting Date:	18/07/2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Jason Roberts, Executive Nurse Director				
Report Author (Title):	Rachel Rushforth, Interim Directorate Lead Nurse, Adult Mental Health				

Main Report

Background and current situation:

The previous Clinical Risk policy was significantly overdue to be reviewed (2015). Following the implementation of the MHCB safety and stability Programme risk assessment practices have been changed. This change is in-line with best practice and features in improvement plans. This change meant that Form 4 on Paris (adopted from FACE risk assessment) was ceased, and WARRN risk formulations became the baseline risk assessment the MHCB. This change in practice occurred April 1st 2023. The policy highlights the rationale behind the change and expectations of staff. To support the change additional WARRN training was completed in 2022/23 to ensure staff were skilled in risk formulation.

The policy was developed with the aid of a working group, and was then taken through the Mental Health Clinical Board's Controlled Document Oversight Group, where no feedback was received. The Clinical Board then worked with the Corporate Governance Department to publish the draft policy and completed EHIA for consultation and no feedback was received from that consultation period.

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

Recommendation:

The Committee is requested to:

a) approve the Mental Health Clinical Risk and Risk Mitigation Management Policy (UHB 119).

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	x
2. Deliver outcomes that matter to people	x	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	x	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	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Prevention	x	Long term	x	Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
This has been addressed in the main body of the report
Safety: Yes
This has been addressed in the main body of the report
Financial: No
N/A
Workforce: No
N/A
Legal: No
N/A
Reputational: No
N/A
Socio Economic: No
N/A
Equality and Health: Yes
An EHIA has been completed and found there to be no impact and no key actions have been identified.
Decarbonisation: No
N/A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Mental Health Clinical Board Controlled Documents Oversight Group	27/01/2023
Sharepoint consultation	26/03/23 – 26/04/23 (No comments received)

Reference Number: UHB 119 Version Number: 2	Date of Next Review: Jan 2026 Previous Trust/LHB Reference Number: UHB 119

Mental Health Clinical Risk and Risk Mitigation Management Policy

Introduction and Aim

This policy details the framework for the assessment and management of service user risk in Cardiff and Vale University Health Board (UHB). To deliver effective care staff must be able to demonstrate sound judgement in clinical risk assessment and develop, when possible, a co-produced risk and safety management plan which is derived from that assessment.

The UHB is committed to ensuring that the Mental Health Clinical Board have robust clinical risk assessment and risk management strategies in place that will reduce risk of harm to service users and others in contact with mental health services, whilst supporting recovery and ensuring the safety of patients, families, carers, staff, and members of the public.

Objectives

The Risk Assessment and Risk Management Policy details the principles and framework currently utilised in the Mental Health Clinical Board to identify risk areas and manage those risks effectively.

The objectives of the Policy and Procedure are:

1. To ensure that a Welsh Applied Risk Research Network (WARRN) Formulation is completed for all service users in secondary mental health services is undertaken.

Secondary mental health services provide care and treatment for individuals suffering with more severe and/or enduring mental disorders where the level of need, risk and complexity requires the provision of specialist care. The services provided at secondary level will include services for individuals subject to the provisions of the Mental Health Act 1983, inpatient hospital care, community mental health teams for adults and older adults, and specialist mental health services at Tiers 3 (Welsh Government, 2019).

2. To ensure that risk assessment is included within any assessment undertaken by primary mental health services and services that overarch

primary and secondary. For example, community liaison services, GP (General Practice) liaison service, primary mental health support service.

3.To highlight the importance of risk and safety management plans which are aligned to the risk assessment.

4. To highlight the requirement to reassess a service users risk status at regular intervals and as their presentation dictates.

5. To ensure that there is a clear understanding of individual professional responsibilities in relation to risk assessment and risk management.

Scope

This procedure applies to all our staff in the Mental Health Clinical Board, in all locations including those with honorary contracts and students within our Clinical Board.

Equality and Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has been completed and found there to be no impact and no key actions have been identified.*
Documents to read alongside this Procedure	Clinical Risk Assessment must not be considered in isolation from other UHB mental health policies and procedures. This policy should therefore be read and acted upon in conjunction with: • Cardiff and Vale UHB Admission, Discharge and Transfer Procedure • Cardiff and Vale UHB Observation & Enhanced Engagement Procedure • Cardiff and Vale UHB policies relating to the Mental Health Act 1983 • Mental Capacity Act • Cardiff and Vale UHB Child Protection Good Practice Guidelines • All Wales Child Protection Procedures • Cardiff and Vale UHB Guidelines on the Sharing of Information • South Wales Guidance on the Protection of Vulnerable Adults

	• The action plan in response to Violence Against Women, Domestic Abuse and Sexual Violence
Approved by	Mental Health Clinical Board Controlled Document Operational Group, Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	Dr Neil Jones Medical Director Mental Health Clinical Board
Author(s)	*Rachel Rushforth (review Jan 2023)*
Disclaimer **If the review date of this document has passed, please ensure that the versior you are using is the most up to date either by contacting the document autho or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
2	*27th January 2023*		Change of risk assessment process.

1. Introduction

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) state: “The assessment of clinical risk in mental healthcare is challenging but provides an opportunity to engage with patients, and their carers and families to promote the patient’s safety, recovery, and wellbeing. A

good risk assessment will combine consideration of psychological (e.g., current mental health) and social factors (e.g., relationship problems, employment status) as part of a comprehensive review of the patient to capture their care needs and assess their risk of harm to themselves or other people" (NCISH 2018, page 5).

Risk assessment and management should be based on the principle that the assessment of risk is structured and informed by a holistic needs' assessment, which is consistent to evidence base. Consistency in practice is essential for effective communication across services and agencies.

The use of clinical risk assessment tools, specialist or generic, are an aid to the clinical decision-making process and are not a substitute for it. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (2022) advise all patients' management plans should be based on the assessment of individual risk and not on the completion of a checklist. The National Institute for Health and Care Excellence (NICE) (2022) state that mental health professionals should undertake a risk formulation as part of every psychosocial assessment**.**

It should be acknowledged and emphasised that, while we focus on risks which may be considered negative, there is a need to practice positive risk taking and in doing so mental health staff work collaboratively with service users, families, carers, and other service providers, irrespective of whether they are statutory or non-statutory providers.

2.Responsibilities

Cardiff and Vale UHB undertake responsibility to ensure that all mental health service users both in primary and secondary care have a risk assessment. This assessment considers risks of harm to themselves and others such as suicide, self-harm, self-neglect, violence and aggression, abuse (both psychological and physical) and falls.

The Mental Health (Wales) Measure 2010 does not prescribe a particular risk assessment process or tools, LHBs and Local Authorities should ensure that in all cases risk assessments should seek to identify and minimise the potential for:

- social vulnerabilities

- harm to self (including deliberate self-harm);
- suicide;
- harm to others (including violence);
- self-neglect;
- neglect or abuse of children
- neglect or abuse of adults for whom they provide care
- adverse risks associated with the abuse of alcohol or substance.
- risk of becoming institutionalised

All care and treatment planning processes should consider risk mitigation arrangements and co-produced safety plans.

Considering this, The Welsh Applied Risk Research Network (WARRN) Formulation tool is to be used as a baseline risk assessment and management tool, as recommended by Welsh Government (Snowden et al. 2019). All service users in contact with **secondary/tertiary mental health services** will have a WARRN completed.

Further in-depth assessment tools such as HCR-20 may be used for service users who are presented with current or historical forensic risk factors and when the practitioner is suitably trained. Advice can be gained from low secure services.

It is imperative that risk assessments and information regarding risk is shared and discussed amongst the Multi-Disciplinary Team (MDT) and includes where appropriate, other agencies such as child protection, or police, ambulance services and probation. It may also be necessary to share information about risk with other sectors including statutory and voluntary housing agencies. Information about risk should only be shared on a need-to-know basis. Staff should be aware of and consider the national and local sharing of information and confidentiality procedures when disclosing information.

Within the MDT it is everyone’s responsibility to ensure they are up to date with the risk assessment and management plan There will be some

circumstances where staff members do not have access to PARIS and the assessor will need to communicate the risk assessment and management plan, both verbally and in written form.

Where conflicts arise between professional responsibilities, accountabilities and service user autonomy, individual professionals are still responsible for attempting to reduce risk to an acceptable level. This level should be agreed both with the service user and the multi-disciplinary team. For supporting individuals with complex presentations, the MDT can refer to the Mental Health Clinical Board Risk Reference Panel.

Risk / potential risk to children ***must*** be considered in the risk assessment. Contact must be made with relevant disciplines involved with children if a risk / potential risk is perceived and a Multi-Agency Referral Form (MARF) must be completed and shared with the safeguarding team. Contact should be made initially by phone to ensure the information has been received, this should be followed up with the referral form, or an email or Paris notification dependant on risk known.

Please ensure that all information regarding dependants or carer responsibilities are updated on Paris within the central index.

3. Positive Risk Management

"Positive Risk Management means being aware that risk can never be eliminated. Therefore, management plans inevitably must include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user." (Department of Health (DoH) 2009, page 11)

Positive risk management must include working with the service user to identify and develop plans and actions that support positive outcomes and priorities as stated by the person and minimise the risk to the service user or others.

There must be consultation, consideration, and inclusion of the views of families, carers and others when deciding a plan of support and subsequent actions where appropriate. The service user, family member, carer and others who may be affected must all be fully informed of the decision, the reasons for it and the associated plans. Views of family members, carers and others should be recorded on Paris within the Care

and Treatment Plan, risk assessment or case notes under the following heading: carer contact.

All who are involved in the decision making of positive risk management must be aware of the potential benefits and the potential risks and the decision must weigh up the benefits and harm of choosing one action against another.

5. Training

Cardiff and Vale UHB are committed to ensuring that the opportunity for staff to attend risk assessment training is made available.
All staff involved in risk mitigation and management should receive relevant training, which should be updated at least **every three years** (DoH 2009).

The training provided which supports this policy is:

WARRN provides training on asking difficult questions and strategies for formulation:

- *The Four P's for formulating the person's problems*
- *The Five W's for formulating the person's risk.*

Assessment and formulation of risk are done for the sole purpose of MANAGING this risk.. The goal of risk assessment is to develop a feasible and workable risk management and safety plan. We use the identified risk factors (e.g., psychosis, drug, and alcohol abuse) and the formulation to devise risk management plans where we can intervene to lower the risk. This has led to WARRN becoming our baseline risk assessment.

Awareness and Mitigation training starts from the assumption that all suicidal thoughts need to be taken seriously and met with compassion and understanding on every occasion, to engage positively with the person. The training aims to assist staff working with people experiencing suicidal thoughts to understand and assess the impact of relevant individual risk factors, to offer acceptance, and to help agree a safety plan in collaboration with the patient. Completion of the first module will give staff the skills to complete an immediate safety plan. Full completion of all 3 modules will equip relevant staff to complete an enhanced safety plan using a mitigation framework (a SAFETool document). It should be noted that this training is a pilot project due to be reviewed

It is the responsibility of all managers within clinical settings to have a clear understanding and log of all employees that have undertaken risk assessment training, and to ensure that all employees are aware of their

personal responsibility to ensure they have attended and understood the risk training offered by the MHCB. For each of the clinical areas' compliance with the risk assessment training will be monitored at the Directorate Performance meeting. It is the manager's responsibility to ensure that any employee out of compliance is supported to address this in a timely manner.

The assessment of staff competency to undertake risk assessment is the responsibility of the employee's line manager and evaluated during their performance review.

The employee is responsible for ensuring that they have access and have read and understood the available clinical information, including known historic risk to inform their decisions and practice.

All staff members will be individually responsible for ensuring that they are applying up to date knowledge and skills in practice and must identify any training needs to line managers at the earliest opportunity to ensure that access to training and support is identified at the earliest opportunity.

6. Procedure

- WARRN has been adopted as the baseline approach to aid staff and service users to understand the individual's risk in relation to their mental health. This has replaced the use of a Form 4 on PARIS and applicable to all secondary and tertiary services.

- In primary care areas where Form 4 has not historically been completed, risk assessment discussions and outcomes as part of their psychosocial assessment should be identified and recorded on their assessment in PARIS/ GP notes (depending on area of work). If risk is identified that requires a further assessment and support from secondary mental health services a referral should be made following their usual practices.

- A WARRN formulation is accessed via the PARIS electronic record system.

- A WARRN would not replace the clinical need for specific assessments such as the multifactorial falls risk assessment to assess and manage risk of falls.

- The WARRN should be co-produced with the service user, it is acknowledged that this may be difficult in some clinical areas, and therefore it should be documented when a WARRN is not co-produced.

- Where applicable a WARRN should include information from the service user's wider network such as family, carers, friends, documented history, agencies, and clinicians involved in their care

- Risk assessment and management plans should be completed where possible by the Multi-Disciplinary Team, however there will be situations where a service user is only known to one clinician, or an assessment has been undertaken autonomously. In these instances, this needs to be documented on the WARRN.

- As risk is dynamic, we will need to continually consider new information and integrate that info our risk formulation. The following situations could trigger a review (list not exhaustive):
  - Admission to hospital
  - 72 hours following admission to hospital
  - Discharge from hospital
  - Transfer between wards
  - Change in MHA (Mental Health Act) status
  - Change in care team
  - Change in presentation
  - Change in risk

  - As a minimum, service users should have their risk formulation reviewed on an annual basis.

  - An initial risk assessment must be completed within two weeks following a routine review / non-urgent referral

  - A risk assessment must be completed at the time of any urgent / emergency referrals or assessments

  - If risks are identified there must be a formulated risk management plan with consideration to the use of more specialised tools such as HCR-20 where clinically indicated.

  - The risk management plan must be embedded in the full suite of clinical care documents such as intervention plans and Care and Treatment Plans. For example, if a service user is supported by close observations due to their risk of falls or suicide, the reason behind the close observations is evidenced in the intervention plan.

- All risks are to be identified in the care planning process and with the use of 'risk alerts'

- Any risks identified must be communicated to the relevant team, staff must ensure acknowledgement and adherence to the consent to share information agreement

- Risk assessments and risk management plans (including risk alerts) must be reviewed by the care co-ordinator / primary nurse at each review meeting.

- Identified risks must be documented in a descriptive manner containing as much information as possible

- Information to aid risk assessment must be gathered from a range of sources such as, service user, family, carers, historical, partner agencies, voluntary agencies.

7. Equality

Cardiff and Vale UHB are committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups.

We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age, or other characteristics.

The assessment found that there was little impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equality's legislation

8. Audit

The prevalence of risk assessment and risk management tools will be performance managed. Periodic audits on the quality of risk assessment

will be undertaken as directed by the Clinical Board. At a minimum this will be on an annual basis within inpatient settings.

9. Review

This policy and procedure will be reviewed every three years or sooner if appropriate.

10. Distribution

This policy and procedure will be made available on the UHB Share Point and Internet sites. The document will also be circulated to the members of the controlled document oversight group and mental health quality and safety group.

11. References

Department of Health (2009) [online] Best practice managing risk: principles and evidence for best practice in the assessment and management of risk to self and others in mental health services Available at: Best Practice Managing Risk Cover (publishing.service.gov.uk) (Accessed 10.01.2023)

National Confidential Inquiry into Suicide and Safety in Mental Health (2022) Personalised risk management [online] Available at: NCISH | The University of Manchester. (Accessed 10.01.2023)

National Institute for Health and Care Excellence (NICE) (2022) Self-harm assessment, management and preventing re-occurrence [online] Available at: Self-harm: assessment, management and preventing recurrence (nice.org.uk) (Accessed 10.01.2023)

Snowden et al. (2019) WARRN – a formulation-based risk assessment process: it's implementation and impact across a whole country. *Journal of Mental Health Training, Education and Practice*. 14 (6) 399-410.

Welsh Government (2019) Welsh Government Policy Implementation Guidance on Local Primary Mental Health Support Services and Secondary Mental Health Services for the purposes of the Mental Health (Wales) Measure 2010 and related subordinate legislation [online] Available at:

Microsoft Word - primary Secondary PIG 19 March FINAL _2_.doc (gov.wales). (Accessed 10.01.2023)

Equality & Health Impact Assessment for

Mental Health Clinical Risk and Risk Mitigation Management Policy

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required[1]
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

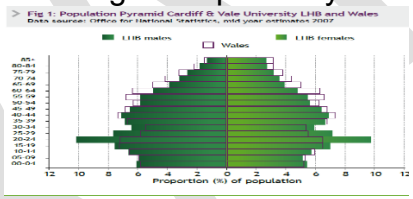
1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board
3.	Objectives of strategy/ policy/ plan/ procedure/ service	

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

		The Risk Assessment and Risk Management Policy details the principles and framework currently utilised in the Mental Health Clinical Board to identify risk areas and manage those risks effectively. The objectives of the Policy and Procedure are: 1. To ensure that a Welsh Applied Risk Research Network (WARRN) Formulation is completed for all service users in secondary mental health services is undertaken. *Secondary mental health services provide care and treatment for individuals suffering with more severe and/or enduring mental disorders where the level of need, risk and complexity requires the provision of specialist care. The services provided at secondary level will include services for individuals subject to the provisions of the Mental Health Act 1983, inpatient hospital care, community mental health teams for adults and older adults, and specialist mental health services at Tiers 3 (Welsh Government, 2019).* 2. To ensure that risk assessment is included within any assessment undertaken by primary mental health services and services that overarch primary and secondary. For example, community liaison services, GP liaison service, primary mental health support service.

		3.To highlight the importance of risk and safety management plans which are aligned to the risk assessment. 4. To highlight the requirement to reassess a service users risk status at regular intervals and as their presentation dictates. 5. To ensure that there is a clear understanding of individual professional responsibilities in relation to risk assessment and risk management.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's	**Related policies and procedures -** • Cardiff and Vale UHB Admission, Discharge and Transfer Procedure • Cardiff and Vale UHB Observation & Enhanced Engagement Procedure • Cardiff and Vale UHB policies relating to the Mental Health Act 1983 • Mental Capacity Act • Cardiff and Vale UHB Child Protection Good Practice Guidelines • All Wales Child Protection Procedures • Cardiff and Vale UHB Guidelines on the Sharing of Information • South Wales Guidance on the Protection of Vulnerable Adults

[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf

	‘Shaping Our Future Wellbeing’ Strategy provides an overview of health need[3].	• The action plan in response to Violence Against Women, Domestic Abuse and Sexual Violence **Related documents** – please see list of references in policy **Stakeholders -** Service Users, families, carers, colleagues within the Mental Health Clinical Board **Population Data** - Cardiff & Vale University Health Board is the smallest and most densely populated health board in Wales, primarily due to Wales’ capital city: Cardiff. 72.1 and 27.9 percent of the health board area population live within Cardiff and the more rural Vale of Glamorgan respectively  **Age –** According to National Confidential Inquiry in Suicide and Safety in Mental Health (2019) data on deaths by suicides between 2009-2019 indicate that of those deaths 22% of males ended their life aged 45-54. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per

[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		cent of care home residents (Mind “Our Communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016). Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in

		retirement age. These rates have not significantly changed since the 2014 health survey. *The Mental Health Clinical Risk and Risk Mitigation Management policy relates to services within the Mental Health Clinical Board. Therefore, children and young people known to Children and Adolescence Mental Health Service are not included in this policy*. **Disability -** Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health) Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people *The proposed policy will be relevant to all individuals in contact/known to mental health services, regardless of a disability.*

		Gender - There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics. *This policy will apply regardless of gender.* **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff

		relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** A central aim of the Risk Reference Panel is to bring together senior staff, with the goal of ensuring that risk management plans are coherently and collaboratively formulated and delivered to support the individual needs of service users with highly complex needs and risk profiles, ensuring their human rights are maintained. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016

		Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. *This policy will apply regardless of whether patients are pregnant and any associated known risks identified and recorded on an individuals risk assessment. Part of a management plan for an individual may include referring to specialist perinatal teams.* **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation 'Mind', the admission rate for 'other black'

		groups is six times higher than average, suggesting discrimination within the mental health system. Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, "Our Communities, Our Mental Health") *The proposed policy will apply regardless of the race / ethnicity of patients or staff.* Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity.

		The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice. A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures A proportion of patients first language may not be English or Welsh. Access to an interpreter is available and translation of written information can be obtained as and when required to support risk assessment. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health"). There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs

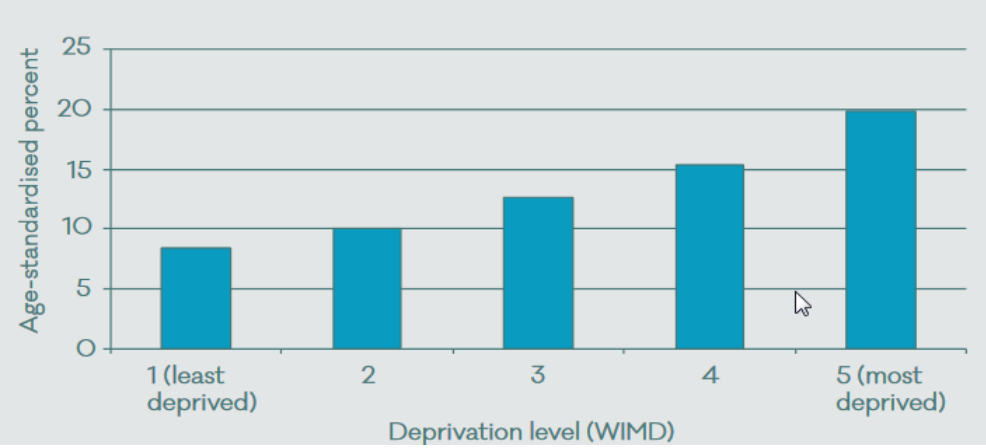
		and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. *The proposed policy will apply regardless of the religion or belief of patients or staff.* **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind "Our Communities, Our Mental Health"). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey. With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not

		being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. *The proposed policy will apply regardless of the sexual orientation of the patients or staff.* **Welsh Language -** No evidence of disproportional representation to date regarding mental health and complex needs, but a proportion of service users may be Welsh speakers and welsh speaking staff and translation services can be used to support risk assessment. **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in

		1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers. **The impact of mental ill health on employment rates** A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002). Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in ‘elementary’ jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys

reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).

People according to where they live



Findings from the 2015 survey found, that there was poorer mental

		health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth. There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position

		on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of poverty. Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression. It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).[3] However, it is now becoming

		clear that the presence or absence of positive mental health or 'wellbeing' *also* influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004). *This policy will apply regardless of where a person lives.* (From: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf **Homeless** Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such

		as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships. It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common *This policy will apply regardless of where a person lives.* **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home

		country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf *This policy will apply, regardless if a patient is seeking asylum.* **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%. 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder. 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the

		general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **Information in relation to multiple protected characteristics -** Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. These risk factors may be present in any protected group.

5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Service users: all service users assessed/ under secondary mental health services in Cardiff and Vale will have a WARRN risk formulation completed. Staff: the policy outlines the requirements of a risk formulation and the change of WARRN becoming the base-line assessment completed.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	This policy is not applicable to individuals under CAMHS.	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability,	Positive – the policy ensures all service users known to secondary mental health	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	services have a risk formulation. WARRN training covers learning disability and cognitive impairments. The policy highlights the need for gathering risk information from other sources		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any	No impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	No impact	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No impact	N/A	N/A
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Negative – english PARIS notes completed	Recommends translation services are used to support gathering risk assessment information as a mitigating	

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		factor for non-English speaking service users. A translation service would need to be used to translate PARIS notes into the language of the service user in order to provide a copy of their risk assessment.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No impact	N/A	N/A
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	No impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	Negative – english PARIS notes completed	Recommends translation services/ welsh speaking staff are used to support gathering risk assessment information. Translation services to be used to provide copies to service users.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No impact	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation	**Positive – all service users in secondary mental health services will have a risk formulation. This allows for**		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
and/or those experiencing health inequalities Well-being Goal - A more equal Wales	**equity no matter what service team has completed an assessment**		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc	Positive – risk formulation management plans may include these elements depending on the individual		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	N/A		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure	Positive – physical environment should be considered as part of the risk formulation and management plan		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	Positive – these aspects will be considered as part of a risk formulation		

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

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	The change in policy which now includes all service users in secondary mental health service to have a WARRN risk formulation allows for equity across the service and ensures a management plan is indivdiualised

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Agreement on how risk assessments can be translated into the spoken language of the service user			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	N/A			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Policy and procedure – to be ratified in clinical board controll documents oversight group			

Appendix 1

Equality & Health Impact Assessment

Developing strategies, policies, plans and services that reflect our Mission of 'Caring for People, Keeping People Well'

Guidance

The University Health Board's (the UHB's) Strategy 'Shaping Our Future Wellbeing' (2015-2025) outlines how we will meet the health and care needs of our population, working with key partner organisations to deliver services that reflect the UHB's values. Our population has varied and diverse needs with some of our communities and population groups requiring additional consideration and support. With this in mind, when developing or reviewing any strategies, policies, plans, procedures or services it will be required that the following issues are explicitly included and addressed from the outset:-

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)[4]

This explicit consideration of the above will apply to strategies (e.g. Shaping Our Future Strategy, Estates Strategy), policies (e.g. catering policies, procurement policies), plans (e.g. Clinical Board operational plans, Diabetes Delivery Plan), procedures (for example Varicella Zoster - chickenpox/shingles - Infection Control Procedure) and services /activity (e.g. developing new clinical services, setting up a weight management service).

Considering and completing the Equality & Health Impact Assessment (EHIA) in parallel with development stages will ensure that all UHB strategies, policies, plans, procedures or services comply with relevant statutory obligations and responsibilities and at the same time takes forward the UHB's Vision, 'a person's chance of leading a healthy life is the same wherever they live and whoever they are'. This process should be proportionate but still provide helpful and robust information to support decision making. Where a more detailed consideration of an issue is required, the EHIA will identify if there is a need for a full impact assessment.

Some key statutory/mandatory requirements that strategies, policies, plans, procedures and services must reflect include:

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)[5]

[4] http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015
[5] http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en

- Equality Act 2010[6]
- Well-being of Future Generations (Wales) Act 2015[7]
- Social Services and Well-being (Wales) Act 2015[8]
- Health Impact Assessment (non statutory but good practice)[9]
- The Human Rights Act 1998[10]
- United Nations Convention on the Rights of the Child 1989[11]
- United Nations Convention on Rights of Persons with Disabilities 2009[12]
- United Nations Principles for Older Persons 1991[13]
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance[14]
- Welsh Government Health & Care Standards 2015[15]
- Welsh Language (Wales) Measure 2011[16]

This EHIA allows us to meet the requirements of the above as part of an integrated impact assessment method that brings together Equality Impact Assessment (EQIA) and Health Impact Assessment (HIA). A number of statutory /mandatory requirements will need to be included and failure to comply with these requirements, or demonstrate due regard, can expose the UHB to legal challenge or other forms of reproach. This means showing due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups.

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (i.e. their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues.
They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently on the basis of where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to

[6] https://www.gov.uk/guidance/equality-act-2010-guidance
[7] http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
[8] http://gov.wales/topics/health/socialcare/act/?lang=en
[9] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782
[10] https://www.equalityhumanrights.com/en/human-rights/human-rights-act
[11] http://www.unicef.org.uk/UNICEFs-Work/UN-Convention
[12] http://www.un.org/disabilities/convention/conventionfull.shtml
[13] http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx
[14] http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf
[15] http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en
[16] http://www.legislation.gov.uk/mwa/2011/1/contents/enacted

ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

The **EHIA** brings together both impact assessments in to a single tool and helps to assess the impact of the strategy, policy, plan, procedure and/or service. Using the EHIA from the outset and during development stages will help identify those most affected by the proposed revisions or changes and inform plans for engagement and co-production. Engaging with those most affected and co-producing any changes or revisions will result in a set of recommendations to mitigate negative, and enhance positive impacts. Throughout the assessment, 'health' is not restricted to medical conditions but includes the wide range of influences on people's well-being including, but not limited to, experience of discrimination, access to transport, education, housing quality and employment.

Throughout the development of the strategy, policy, plan, procedure or service, in addition to the questions in the EHIA, you are required to remember our values of *care, trust, respect, personal responsibility, integrity and kindness* and to take the Human Rights Act 1998 into account. All NHS organisations have a duty to act compatibly with and to respect, protect and fulfil the rights set out in the Human Rights Act. Further detail on the Act is available in Appendix 2.

Completion of the EHIA should be an iterative process and commenced as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

For further information or if you require support to facilitate a session, please contact Susan Toner, Principal Health Promotion Specialist (susan.toner@wales.nh.uk) or Keithley Wilkinson, Equality Manager (Keithley.wilkinson@wales.nhs.uk)

Based on

- Cardiff Council (2013) Statutory Screening Tool Guidance
- NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools and templates[17]
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide[18]

[17] http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf (accessed 4 January 2016)

[18] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782 (accessed on 4 January 2016)

Appendix 2 – The Human Rights Act 1998[19]

The Act sets out our human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights':

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers, issues of patient restraint and control
3. Article 4 Freedom from slavery and forced labour
4. Article 5 Right to liberty and security. NHS examples: issues of patient choice, control, empowerment and independence, issues of patient restraint and control
5. Article 6 Right to a fair trial
6. Article 7 No punishment without law
7. Article 8 Respect for your private and family life, home and correspondence. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers, the right of a patient or employee to enjoy their family and/or private life
8. Article 9 Freedom of thought, belief and religion. NHS examples: the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person
13. solely because of their age, patients presented with health options without the use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home
14. Protocol 1, Article 1 Right to peaceful enjoyment of your property
15. Protocol 1, Article 2 Right to education
16. Protocol 1, Article 3 Right to participate in free elections
17. Protocol 13, Article 1 Abolition of the death penalty

[19] https://www.equalityhumanrights.com/en/human-rights/human-rights-act

Appendix 3

Tips

- Be clear about the policy or decision's rationale, objectives, delivery method and stakeholders.
- Work through the Toolkit early in the design and development stages and make use of it as the work progresses to inform you of those most affected and inform mitigating actions
- Allow adequate time to complete the Equality Health Impact Assessment
- Identify what data you already have and what are the gaps.
- Engage with stakeholders and those most affected early. View them as active partners rather than passive recipients of your services.
- Remember to consider the impact of your decisions on your staff as well as the public.
- Record which organisations and protected characteristic groups you engaged with, when you engaged with them and how you did so (for example, workshop, public meeting, written submission).
- Produce a summary table describing the issues affecting each protected group and what the potential mitigations are.
- Report on positive impacts as well as negative ones.
- Remember what the Equality Act says – how can this policy or decision help foster good relations between different groups?
- Do it with other people! Talk to colleagues, bounce ideas, seeks views and opinions.

Report Title:	Clinical Audit Policy			Agenda Item no.	3.1.2a
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	18 July 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Medical Director				
Report Author (Title):	Head of Patient Safety and Quality Assurance				

Main Report
Background and current situation:

An Internal Audit of the Clinical Audit arrangements within the UHB was undertaken in 2021 and gave a grading of 'Limited Assurance'. The audit found that the UHB had insufficient documents to support ineffectively manage clinical audit within the organisation. Consequently, the Clinical Audit Policy (Appendix 1) was developed to strengthen and provide effective management of Clinical Audit.

The policy delivers clarity on the clinical audit process of the requirements for producing local clinical audit plans and their oversight and directs, mandates and provides consistency, across the Clinical Boards and their Directorates.

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

A follow up Internal Audit was undertaken in April 2023 of the Clinical Audit Arrangements in the UHB. The follow up Audit gave a grading of 'Substantial Assurance'. This Policy was in the ratification process at the time of re-audit and is one of the remaining actions to completion along with the Clinical Audit Strategy which is for noting.

Recommendation:

The Committee is requested to: **Approve** the Clinical Audit Policy (UHB 509)

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

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
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.		9.	
5. Offer services that deliver the population health our citizens are entitled to expect		10. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
6. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		11. 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: Yes/No
Decarbonisation: Yes/No

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

Saunders.Nathan 18/07/2023 09:30:09

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

Clinical Audit Policy

Policy Commitment

What is the UHB committing to do and briefly indicate how?

Supporting Procedures and Written Control Documents

This Policy and the [*insert document title if only one otherwise say 'supporting procedures'*] describe the following with regard to [*insert Policy Subject].*

- Cardiff and Vale UHB Information Governance Policy - CAV IT Security & IG - CV IG policy v0.7.pdf - All Documents (sharepoint.com) –

  https://nhswales365.sharepoint.com/sites/CAV_IT_Security_IG/Shared Documents/Forms/AllItems.aspx?id=%2Fsites%2FCAV%5FIT%5FSecurity%5FIG%2FShared%20Documents%2FCV%20IG%20policy%20v0%2E7%2Epdf&parent=%2Fsites%2FCAV%5FIT%5FSecurity%5FIG%2FShared%20Documents

Other supporting documents are:

- The Eight Caldicott Principles – National Data Guardian The Eight Caldicott Principles - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942217/Eight_Caldicott_Principles_08.12.20.pdf

- UK GDPR Principles – Information Commissioners office Guide to the UK GDPR Regulation - https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/

- HQIP (Healthcare Quality Improvement Document) Guide to Ensuring Data Quality in Clinical Audits HQIP CA PD 028 - Guide to Ensuring Data Quality in Clinical Audits 220212:Layout 1.qxd - https://www.hqip.org.uk/wp-content/uploads/2018/02/hqip-guide-to-ensuring-data-quality-in-clinical-audits.pdf

Scope

This Policy applies to all of our staff in all locations including those with honorary contracts.

In addition to the responsibilities detailed within the procedure, staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been considered and not required. Equality and Diversity aspects are addressed within the Policy.
Health Impact Assessment	A Health Impact Assessment (HIA) - as above.
Policy Approved by	Senior Leadership Board (SLB).
Group with authority to approve procedures written to explain how this policy will be implemented	Quality, Safety and Patient Experience Committee.
Accountable Executive or Clinical Board Director	Executive Medical Director.

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New policy*
2			

Table of Contents

1. Introduction/Overview

A Healthier Wales: A long term plan for health and social care, was published in 2018 and outlines how quality is key to making the health and social care system in Wales both fit for the future and one which achieves value. It outlines the expectation that, going forward, health and social care services are brought together so they are designed and delivered around the needs and preferences of individuals. The plan sets out several aims including the explicit requirement to put quality and safety above all else, providing high value evidence-based care for patients and integrating improvement into everyday working to eliminate harm, waste and variation.

NHS organisations in Wales are required to exercise their functions in a way that considers how they can improve quality on an ongoing basis. The Health and Social Care (Quality and Engagement) (Wales) Act reframes the concept that organisations will strengthen the approach to high quality, safe care.
The Act introduces a Duty of Quality which sets out that all decisions are made to secure improvement in the quality of services provided and to strive for continuous improvement and excellence. The purpose of the Act is therefore to ensure quality becomes a system-wide way of working and a focus is placed on outcomes.

The National Clinical Framework provides a clinical interpretation of A Healthier Wales and describes a learning health care system, centred on clinical pathways that focus on the patient.

The National Quality and Safety Framework sets out the requirement for a robust quality assurance framework that brings together quality planning, quality control and quality improvement. The Framework is explicit in the requirement for Health Boards and Trusts to drive an effective quality management system.

The National Clinical Audit and Outcome Review Plan contains a series of clinical projects mandated by Welsh Government. The programme is designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data and therefore plays an important role in the delivery of the quality and safety strategy in the NHS in Wales.

2. Policy Statement

Cardiff and Vale University Health Board is committed to using clinical audit, to support an assurance mechanism and to inform a programme of quality improvement. As part of this process, clinical audit provides assurance regarding compliance with accepted evidence based clinical standards within the services provided by the Health Board. This Policy, along with the Clinical Audit Strategy, aligns with the Health Board's wider governance and

assurance mechanisms that will inform and enhance the process of improving clinical services.

3. Purpose

The purpose of this policy is to set out the rationale for clinical audit and also provide a framework to support a prudent clinical audit programme designed to provide assurance and to drive improvement around quality and safety priorities.

- Patient safety priorities
- Recommendations resulting from external inspection and peer reviews
- Increased mortality rates
- Implementation of new NICE/HTW/AWMSG guidelines
- National Clinical Audit and Outcome Review Programme

Service evaluation projects can assess current clinical practice and generate useful information to aid local decision making, service evaluations can stand alone as individual projects, or may be used as a baseline for future clinical audits, research or benchmarking.

4. Objectives

The policy aims to support a culture of best practice in the management and delivery of clinical audit; and to clarify the roles and responsibilities of all staff involved and ensure the following:

- Participation in all relevant projects associated with the National Clinical Audit and Outcome Review Plan, national confidential enquiries and inquiries, and national service reviews relevant to the services provided.

- All clinical audit activity within the UHB, or conducted in partnership with external bodies, is registered both locally (**CAV AMaT**) and nationally as appropriate, and conforms to nationally agreed best practice standards (see HQIP's guide, Best practice in clinical audit).

- The annual programme of clinical audit activity meets Board assurance framework objectives, and includes all of the clinical audits necessary to meet the requirements of regulators and commissioners.

- Records of reviews of the annual programme of clinical audit, individual clinical audit projects, as well as the results of national clinical audits, national confidential enquiries and inquiries, and national service reviews, should be maintained.

- To support the development of Clinical Board clinical audit forward plans aligned to key Clinical Board Quality and Patient Safety risks and priorities.

- To ensure health professionals engage in meaningful audits as part of their ongoing development.

- To ensure service evaluation activity within the UHB is registered locally along with the monitoring and reporting arrangements at the time of registration.

- All participation in clinical audit/service evaluation projects provide valuable evidence for re-registration/revalidation must ensure service line management/audit group have approved the project. All project should be registered locally CAV AMaT.

5. Scope

This policy applies to anyone engaged in clinical audit projects within the health board, including:

- All staff, including management, senior management, and Health Board members, both clinical and non-clinical, and those on short-term or honorary contracts.
- Students and trainees in any discipline.
- Patients, carers, volunteers, and members of the public.

This policy also applies when clinical audit is undertaken jointly across organisational boundaries.

The Health Board promotes a commitment to involving patients, carers, and members of the public in the clinical audit process, either indirectly through the use of patient surveys and questionnaires, or directly through participation of patient, carer, and members of the public on clinical audit project steering groups or quality improvement patient panels (QSE Framework, 2021)

6. Roles and Responsibilities

Lead	Responsibilities
Chief Executive Officer	The Chief Executive is accountable for the statutory Duty of Quality, and takes overall responsibility for this Policy, for effective prioritisation to participate in national clinical audit, and for decisions about local clinical audit and service evaluation.

Executive Medical Director	The Executive/Board lead for clinical audit is the Medical Director. Their responsibilities in respect of clinical audit are: • To ensure that the Health Board's Clinical Audit Strategy and annual programme of work are aligned to the Board's strategic interests and concerns. • To ensure that clinical audit is used appropriately to support the Board's assurance framework. • To ensure this policy is implemented across all clinical areas. • To be aware of any investigative projects and should give formal approval where required. (For example, larger scale projects which do not constitute research, but which may impact on other departments or involve an element of risk). • To ensure that any serious concerns regarding the UHB's policy and practice in clinical audit, or regarding the results and outcomes of national and local clinical audits, are brought to the attention of the Board.
Associate Medical Director for Quality and Safety	The Associate Medical Director of Quality and Safety has responsibility for Clinical Effectiveness and is the Chair of the Clinical Effectiveness Committee which oversees the implementation and monitoring of clinical standards including NICE guidance and the outcomes of clinical audits, service evaluations and associated improvement plans.
Assistant Director of Patient Safety and Quality	The Assistant Director is responsible for leading the development of Health Board Clinical Audit Policy and Strategy in relation to support the development of a clinical audit programme that provides assurance and supports meaningful programmes of quality improvement.
Head of Patient Safety and Quality Assurance	The Head of Patient Safety and Quality Assurance is the Health Board's professional lead on specific aspects of quality governance and quality assurance ensuring compliance with quality related statutory and regulatory requirements, national and local policy, ensuring that quality governance and assurance processes are embedded throughout the Health Board. The Head of Patient Safety and Quality Assurance

	leads on the development of the Clinical Audit Policy and Strategy.
Clinical Board Directors	The Clinical Board Director has responsibility for the provision of safe and effective care within their Clinical board and consider the use of clinical audit in a quality management system approach in delivering this function. Clinical Board Directors should ensure all service evaluation projects are registered, for any projects that cross Directorate/Clinical Board relevant parties will be informed accordingly.
Clinical Directors	All Clinical Directors must ensure that a senior clinician within their Directorate is nominated as the Directorate lead for clinical audit (they may choose to take on this role themselves). The responsibilities of the Directorate leads for clinical audit are: • To ensure that this policy is implemented throughout their Directorate. • To ensure that all clinical audit activity within their directorate is registered on the UHB database and complies with nationally accepted best practice standards. • To ensure that their directorate participates in all national clinical audits, national confidential enquiries and inquiries, and national service reviews that are relevant to the services provided. • To work with clinicians, service managers, Directorate/Clinical Board governance and quality managers, and clinical audit staff, to ensure that the clinical audit programme meets all clinical, statutory, regulatory, commissioning, and Health Board requirements. The Clinical Directors have the responsibility to prevent duplication of service evaluations. They should prioritise projects and maximise the impact of the findings.
Clinical Leads for National Clinical Audits	The Clinical Leads are responsible for the delivery of patient-centred care to ensure best practice within their clinical practice, including the facilitation of the audit.

Clinical Audit Leads /Quality & Patient Safety Lead for Clinical Audit	The QPS Lead for clinical audit is responsible for the operational management of the Clinical Audit Programme and facilitation of the AMaT system. (see guidance for clinical audit leads).
Clinical Effectiveness Committee (CEC)	The Clinical Effectiveness Committee supports the quality and safety agenda to promote continuous improvement in the standard of quality and safety across the whole organisation – continuously monitored through the Health and Care Standards for Wales; Welsh Risk Pool Standards, Regulatory Frameworks for health and safety and other quality measures which are appropriate.
Quality, Safety and Experience Committee (QSE)	The Quality, Safety and Experience Committee has powers delegated by the Board seeks assurance that arrangements for the provision of high quality, safe and effective healthcare are sufficient, effective, and robust, including the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services.
Clinical Board Quality and Safety Forums	The Clinical Board Quality and Safety Forums ensure the arrangements for the provision of high quality safe and effective healthcare within the Clinical Boards are sufficient, effective, and robust including the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services.
Healthcare professional/Teams	Healthcare professionals can legitimately initiate and carry out investigative projects if the project falls within their remit and level of competence. The normal arrangements for clinical/management supervision and standards of good practice should be sufficient to safeguard the project and its participants. The healthcare professional undertaking the clinical audit or service evaluation project must communicate fully with everyone who is likely to be affected by the project and consult with the clinical audit team where appropriate. Arrangements should also be made to ensure all clinical audits and service evaluations are registered with arrangements to share the findings of their project. (CAV AMaT).

All staff employed by the Trust have a responsibility for the continual improvement of the quality of the service they provide, and all clinical staff are individually accountable for ensuring they audit their own practice in accordance with their professional codes of conduct and in line with the standards set out within this Policy.

The Clinical Effectiveness Committee is the corporate committee tasked with oversight and scrutiny of the Health Board's clinical audit activities, prioritisation of participation in national clinical audit, decisions about local clinical audit, and the review of audit reports, including progress through repeated clinical audit cycles.

7. Clinical Audit

7.1 Definition of Clinical Audit

Clinical audit is a quality improvement process that seeks to improve practice and outcomes through systematic review of practice against explicit criteria and the implementation of change. (Healthcare Quality Improvement Partnership (HQIP) 2010).

Clinical audit measures against evidence-based standards as part of an ongoing, planned annual quality assurance programme that ensures that high quality care is always delivered. Although there are similarities, the clinical audit cycle should not be confused with the Plan, Do, Study, Act cycle, which is a separate quality improvement tool used to drive and increase compliance with a standard against which there is an identified shortfall, or to investigate the impact of changes to practice within a defined timeframe. Further information available in 'Best Practice in Clinical Audit' (HQIP, 2020).

Diagram 2. demonstrates the clinical audit cycle.

7.2 Clinical Audit process

Clinical audit involves measuring clinical practice against explicit standards of best practice. Standards may already exist locally or nationally in the form of guidelines or protocols. National standards are available for certain treatments and conditions in the form of NICE/HTW/AWMSG/Royal College/Professional body guidelines.

7.3 Definition of Service Evaluation

Service evaluation does not require systematic comparison against a pre-determined standard, but by evaluating current care delivered can generate useful information to aid local decision making. Service evaluation can be a stand-alone project, or may be used as a baseline for future audits, research or benchmarking.

Service evaluation and research are often used to describe similar activities. Both use systematic investigation to increase knowledge, both include the collection and analysis of data, and may share similar data gathering methods. However, an evaluation is different from pure scientific research by its practical nature. Service evaluation is intended to be of use to those needing information in order to decide an action and involves judging value.

All Service evaluation projects should be reviewed and approved by the Clinical Directors for the relevant specialty area, to ensure the project aligns with service priorities and satisfies the Health Board governance arrangements. All service evaluation projects will require local registration onto AMaT (CAV AMaT), where the research team will have oversight to ensure the projects meets all ethical requirements.

Please refer to the Service Evaluation Procedure for more information.

8. Quality Management System

Clinical audit has an important function in the implementation of a quality management system, supporting the measurement of care against an explicit set of standards and informing quality improvement.

Service evaluation can act as a significant contributor to the healthcare provision and determines the quality and effectiveness of a service. An evaluation can ensure that a service provider is continuously improving the delivery of services for patients.

Quality assurance in healthcare is the planned and systematic monitoring of activity to ensure that the standards for safe, clinically effective services and positive patient experience are met. Quality assurance aims to provide confidence and certainty in the quality of services.

While clinical audit is fundamentally a quality improvement processes that provides the opportunity for ongoing review and service development, they also play an important role in providing assurance on the quality of services.

Diagram 3 below illustrates the four components of quality management systems, Quality Planning, Quality Control, Quality Assurance and Quality Improvement.

Diagram 4 illustrates tools within those four components of quality management systems.

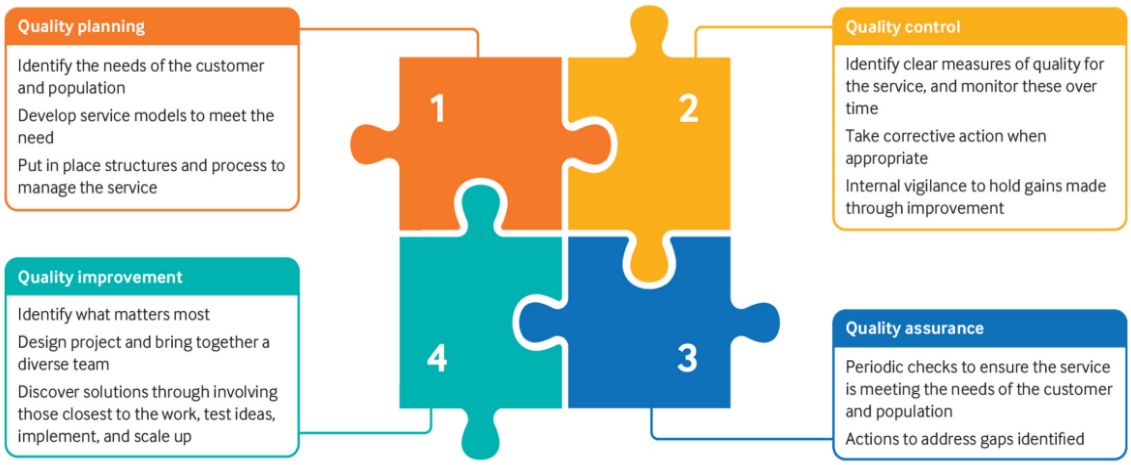


Diagram 3 (ShaH, 2020)

Tools Within the Quality Management Systems

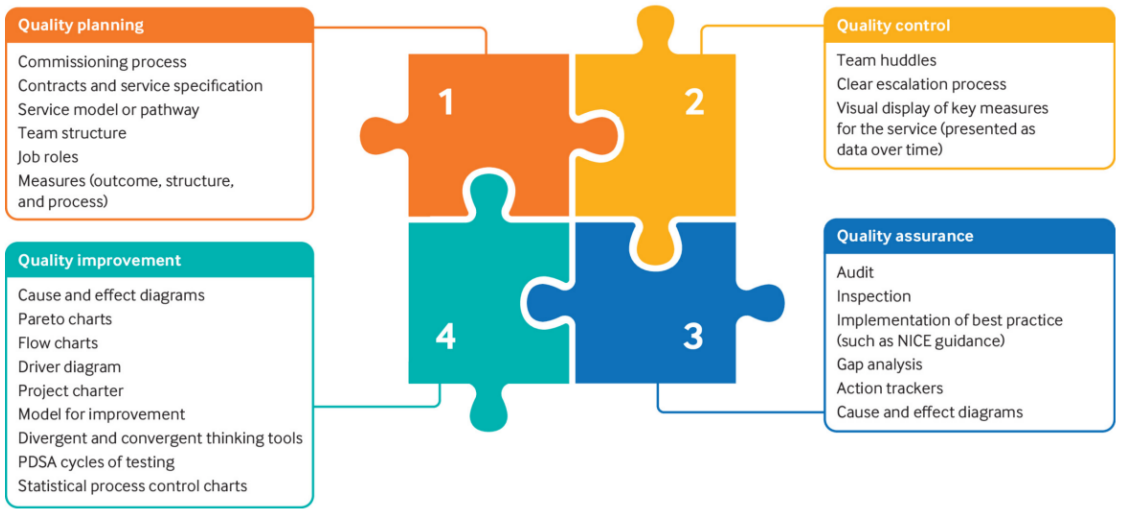


Diagram 4 (ShaH, 2020)

9. Clinical Audit Programme

Prior to the start of every financial year, the Health Board will agree an appropriate planned programme of clinical audit activity. This programme should meet the Health Board's corporate requirements for assurance, but must be owned by clinical services.

The Health Board is committed to supporting locally determined clinical audit activity to significantly contribute to the process of continuous service quality improvement.

9.1 Clinical Boards Clinical Audit Activity

A programme of Clinical Audit should be developed by each Clinical Board to provide assurance and where required to inform the necessary improvements associated with directorate quality and patient safety priorities (Refer to Section 3).

It is acknowledged that individual clinicians may initiate a clinical audit project on the basis of personal interest or personal development. Where a clinician wishes to undertake a clinical audit for the purpose of CPD, or as part of an educational or training programme, a discussion must take place with the Clinical Director to ensure that where ever possible the Directorate's quality and patient safety priorities and assurance requirements are considered in the first instance.

For each clinical audit project:

- An audit proposal form must be completed by the project lead.
- The proposal must be approved by the clinical director and directorate clinical audit lead.
- All clinical audit activity must be registered with the Clinical Audit Department, irrespective of the level of facilitation being requested of the department, to ensure project consistency.
- All Audits should be reported through the appropriate Clinical Board Quality and Safety meetings with oversight of the requisite improvement plans and regular monitoring for quality assurance purposes to ensure that they are progressed appropriately.
- Inclusion on the Clinical Board Risk Register should be undertaken if the audit demonstrates that care provision falls below the required standard.

9.2 Process for National Clinical Audits

The Welsh Government publishes a National Clinical Audit and Outcome Review Programme on an annual basis.

Health Organisations is Wales are expected to fully participate and ensure the necessary resources are allocated to ensure appropriate levels of case ascertainment and data completeness.

As the Duty of Quality is implemented across Wales, Health Boards will be required to develop an Annual Quality Report and National Clinical Audit Performance and Progress Report to ensure that improvement plans have been completed and implemented.

Where a Health Board's performance in any of the national clinical audits falls outside two standard deviations from the target the organisation is deemed to be at Alert level and three standard deviations from the target then they are deemed to be at Alarm level. In this situation the Health Board will receive formal notification of outlier status from the collegiate body if at Alarm level and in many cases when at Alert level.

A National Clinical Audit Outlier Standard Operating Procedure (appendix 2) ensures a standardised approach to investigating and responding to Outlier Notifications and the development and monitoring of an improvement plan.

9.3 Clinical Audit Annual Report

A bi-annual clinical audit report will be presented to the Clinical Standards and Effectiveness Group and a bi-annual clinical audit report encompassing national, local and corporate clinical audits will be presented to the Patient Quality Safety and Outcomes Committee.

9.4 Database - AMaT (Audit Monitoring and Tracking CAV AMaT)

The Heath Board has procured the Audit Monitoring and Tracking (AMaT) system which will be implemented throughout the organisation during 2022/23 and will be a central quality assurance management system.

9.5 Clinical Audit and Service Evaluation Registration

All clinical audit and service evaluation activity must be registered and managed on the AMaT system (CAV AMaT). The Clinical Audit Team will provide training for staff and host the system.

Once the clinical audit project registration process has been completed, the Clinical Audit Team will receive a notification and will review the project to ensure it meets the relevant criteria before approval. Service evaluation will have a slightly different approval process, submissions will be shared with the Research Team and I&I for approval to ensure that any governance issues can be addressed prior to project commencement, please refer to Service Evaluation Procedure.

From 1st December 2022 all clinical audit and service evaluation project proposals should be submitted via AMaT.

Data provided at registration will be used to compile a database of all clinical audit and service evaluation activity undertaken throughout the Health Board. AMaT is a live system and should be updated regularly by the appropriate quality leads/managers to inform Directorates, Clinical Boards and the Clinical Effectiveness Committee about the progress and outcome of projects undertaken.

9.6 Clinical Audit and Service Evaluation Results

All clinical audit and service evaluation results must be entered onto the AMaT system (CAV AMaT) either by undertaking data collection on AMaT or by uploading the results to the AMaT system on completion of the project. The individual Directorates are responsible for quality control of the clinical audits and service evaluation projects that are conducted in their area and must ensure there is a mechanism in place for this e.g. Safety and Quality Sessions (Audit session) or Quality and Safety forums.

Diagram 3 gives guidance on structuring clinical audit reports and presentations.

Diagram 3. Guidance for structuring Clinical Audit Reports or Presentation

9.7 Dissemination and Sharing Learning

Regular clinical audit summary reports, together with recommendations, should be communicated to all relevant areas of the organisation and Health Board committees. A robust audit carried out in one area of the UHB may be transferable to other parts of the organisation; a search can be undertaken on AMaT by topic. Once a round of data collection has been completed and the data has been analysed, the results and findings should be presented at the Safety and Quality Sessions (audit meetings) for discussion, agreement on action plans and a commitment to complete another audit cycle within a designated timeframe. Clinical audit reports and action plans will be reported to the clinical Effectiveness Committee on completion.

9.8 Action Plans and Improvement

The main purpose of clinical audit is to deliver improvements in clinical practice. Where the results of a clinical audit indicate sub-optimal practice, an action plan must be developed and implemented and its effects monitored. A systematic approach to the development and implementation of clinical audit action plans is essential for effective improvement.

Improvement plans should be specific, measurable, achievable, realistic and timely (SMART). They must have clear implementation timescales with identified leads for each action. Improvement plans should be developed in conjunction with the relevant head of service or manager and should be subject to ongoing monitoring through the appropriate Quality and Patient Safety Forum.

If compliance is sub-optimal, a re-audit should occur once the necessary improvements have been achieved and sustained. All improvement plans must be completed on AMaT where they can be monitored and progressed.

The Directorate and Clinical Board will monitor the implementation of actions, ensuring that any required changes are incorporated into practice and relevant business plans and/or risk registers as appropriate. The Clinical Effectiveness Committee will have oversight of progress and completion of clinical audit activity as well as actions plans.

Not all clinical audits or service evaluations will require an action plan e.g. where an audit shows that standards are consistently being met, and practice/service is effective. For such audits there should be an explicit statement within the summary report that no further action is required, along with the reason(s) for this.

9.9 Repeating Audit Cycles

The clinical audit cycle is not complete until agreed actions are implemented according to the corresponding action plan, and evidence is obtained regarding the impact of the action plan on compliance with standards. This may be achieved by repeating data collection or

by instituting a programme of ongoing monitoring. Repeated cycles of clinical audit may be carried out to ensure criteria and standards are consistently met and practice is effective. The Annual Clinical Audit Plan should consist of a plan for re-audit cycles.

10. Governance and Ethics

10.1 Ethics and Consent

The Clinical Director is responsible for approving all clinical audits and service evaluation that take place within their Directorate. The Clinical Effectiveness Committee will have ethical oversight of clinical audit across the organisation to ensure the following:

- The programme of clinical audits is managed efficiently to make best use of resources, and to ensure that performance management issues associated with poor audit design, poor execution, or failure to deliver improvements in patient care, are addressed.

- Any ethical concerns that arise during the design and planning of individual clinical audits are addressed.

- Any serious shortcomings in patient care that come to light through clinical audit are communicated to the clinical director of the service involved at the earliest opportunity, and appropriate steps are taken to address them.

- Risk management issues identified through clinical audit results are addressed with robust action plans, which are implemented effectively.

Any person who has concerns regarding the ethics of a clinical audit should refer them to the Chair of the Clinical Effectiveness Committee.

10.2 Equality and Diversity

The UHB aims to ensure that its healthcare services and facilities are not discriminatory and, wherever possible, attend to the physical, psychological, spiritual, social, and communication needs of any patient or visitor, showing no discrimination on the grounds of ethnic origin or nationality, disability, gender, gender reassignment, marital status, age, sexual orientation, race, trade union activity, or political or religious beliefs.

The process for determining the choice of clinical audit projects, and the manner in which patient samples are selected, should not inadvertently discriminate against any groups in society based on their race, disability, gender, age, sexual orientation, religion, or belief. Any person who has concerns regarding the ethics of clinical audit activity within the Health Board should refer them in the first instance to the Clinical Effectiveness Committee, who may require equality impact assessments to be undertaken and/or equality data to be

collected as part of clinical audit activity, in order to determine whether any particular groups of patients are experiencing variations in practice.

10.3 Information governance: Collection, Storage and Retention of Data and Confidentiality

All clinical audits must adhere to information governance policies and standards, paying special attention to the Data Protection Act and the Caldicott Principles, whereby data should be:

- Adequate, relevant, and not excessive
- Accurate
- Processed for limited purposes
- Held securely
- Not kept for longer than is necessary

11. Overall Organisational Approach

11.1 Training and Development

Some aspects of clinical audit require specialist knowledge and skills in order to apply the correct clinical audit methodology. This Policy sets out how the UHB will ensure that all staff members who conduct and/or manage clinical audits are given the appropriate time to develop the knowledge and skills necessary to facilitate the successful completion of clinical audit cycles. Clinical audit education and training are key to the delivery of this Policy, in order to promote activity led by healthcare professionals.

Training raises the profile of clinical audit and best practice standards, builds capacity and capability for the reflective practice of all those involved, and acts as a driver for quality improvement.

11.2 Provision of Clinical Audit Training

The UHB will make available suitable training, awareness and support programmes to all relevant staff regarding the systems and arrangements for participating in clinical audit. This will ensure:

- An introductory clinical audit training session is available to any member of staff.
- An ongoing programme of clinical audit training of different levels is available to all staff to enable them to undertake clinical audit.
- Training for local, regional, and national clinical audit activities, and bespoke training, will be given to groups and individuals on request.

- Educational resources on clinical audit processes will be available on the Quality Assurance and Clinical Effectiveness page of the Patient Safety and Quality SharePoint page https://nhswales365.sharepoint.com/sites/CAV_Patient%20Safety%20and%20Quality/SitePages/Quality-Assurance-and-Clinical-Audit.aspx

11.3 Employment and development of clinical audit staff

The UHB will employ a team of suitably skilled clinical audit staff to support the programme of clinical audit activity. The UHB will also ensure that staff have access to further relevant training in order to maintain and develop their knowledge and skills.

12. Monitoring

12.1 Monitoring the Effectiveness of Clinical Audit Activity

The implementation of AMaT will support the UHB to ensure that:

- The Clinical Board Quality and Safety forum is discharging its responsibilities.
- Staff are receiving clinical audit training.
- There is a rigorous system for determining what is represented in the annual clinical audit programme.
- Stakeholders are being involved.
- Clinical audits are approved and registered.
- Clinical audits are based on standards and conducted in line with this Policy.
- Projects are meeting data protection and confidentiality guidelines.
- Results are being reported and disseminated.
- Action plans are being agreed and implemented.
- Timely progress reports are being provided to the Clinical Effectiveness Committee, QSE committee and the Management Executive Team as appropriate.

12.2 Corporate Clinical Audit

A Cardiff and Vale Quality Assurance Framework will be developed to formulate a structured approach to provide an effective programme of clinical audit for corporate Quality Assurance Activities.

Currently there are corporate groups and committees aligned with each standard contained in the Health and Care Standards (2015). However, at the time of writing this Policy the Health and Care Standards were under review by Welsh Government as part of the work streams for the Duty of Quality.

The Corporate Clinical Audit section of this Policy will be revised to incorporate the new standards from the Duty of Quality, as well corporate clinical audit related to the Clinical Safety Group currently being established, and ensure that it is aligned with the Quality Assurance Framework.

All audits will be required to be registered on the AMaT quality assurance system, the results and improvement plans should also be monitored through this system.

Each group should consider the evidence available to provide assurance associated with each component of the Health and Care Standards. This could include training records, numbers of patient safety incidents etc. Consideration should be given to the delivery of a specific audit to provide assurance where no other evidence is available.

An example of this might include:

The Falls Group commissioning an audit of Multi Factorial Risk Assessment to provide assurance in relation to Health and Care Standard 2.3 Falls Prevention, *People are assessed for risks to their own safety and the safety of others. A plan for managing risk is agreed between the person being cared for and those caring for them.*

All Audits must be reported through the Health Board group or committee that commissioned the audit where the necessary actions or improvements will be implemented and monitored.

13. Resources

All national clinical audits should be resourced from the Clinical Board in which they sit.

Where a new service is being commissioned by the Health Board consideration should be given as to whether it is subject to a mandated national audit and how this will be resourced.

14. Implementation

Clinical Board and corporate clinical audit plans will be subject to bi-annual reporting to the PQSE Committee.

Evidence of audit outcomes and associated improvement plans will be considered at the Clinical Board performance reviews.

15. References

CAV Clinical Audit Strategy.

Wales National Clinical Audit and Outcome Review Plan 2022.

Quality and Safety Framework: learning and improving Welsh Government
https://gov.wales/sites/default/files/publications/2021-09/quality-and-safety-framework-learning-and-improving_0.pdf

Best practice in Clinical Audit Healthcare Quality Improvement Partnership 2020
https://www.hqip.org.uk/resource/best-practice-in-clinical-audit/

16. Appendices

1. National Clinical Audit Reporting and Monitoring Standard Operating Procedure

2. National Clinical Audit Outlier Standard Operating Procedure

Appendix 1

Standard Operating Procedure
National Clinical Audit Reporting and Monitoring Procedure

Document Information	
Purpose	Standard Operating Procedure
Name	National Clinical Audit Reporting and Monitoring Procedure
Author	Head of Patient Safety and Quality Assurance
Date	November 2022
Target Audience	Corporate services, Executive Medical Director and Clinical Board Triumvirate
Overview	To standardise the approach to reviewing, investigating and responding to outlier notification
Review Date	November 2024

Purpose

The purpose of the Standard Operating Procedure (SOP) is to ensure a standardised approach to reporting national clinical audit outcomes as well as developing and monitoring associated improvement plans.

Overview

The National Clinical Audit and Outcome Review Plan (NCAORP) is a mandated programme of national audit designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data. The programme supports benchmarking against other health organisations in the UK. The outcomes and results of national audits are published annually, with local performance data being made available to the clinical team and is in the public domain.

The National Quality and Safety Framework requires health boards to have robust processes to ensure that data obtained through clinical audit, will lead to meaningful and improved outcomes for the population.

The SOP sets out the process for reporting national clinical audit outcomes and developing and monitoring associated improvement plans.

Process

- All National Clinical Audits must be registered on AMaT by the National Audit Lead.

- On publication of a national clinical audit, the Quality and Patient Safety Team review the results and outcomes and develop a set of highlight slides.
- The national report and highlight slides are shared with the clinical board triumvirate and relevant Clinical Audit Lead. A provisional improvement plan should be developed by the clinical board to address the requisite improvements.
- The Clinical Board Triumvirate and Clinical Audit Lead will be invited to present the audit findings and improvement plan at the Clinical Effectiveness Committee.
- The responsibility for the monitoring and review of the associated action plan will sit with the Clinical Board. Where an improvement plan sits across two or more Clinical Boards a lead Clinical Board will be identified for each improvement. This will be undertaken using the AMaT system.
- The improvement plan should be monitored and reviewed on a regular basis in the relevant Clinical Board Quality and Safety Forum and consideration given to including it in the Clinical Board Risk Register. Clinical Boards should develop exception reports as required and report to the Quality, Safety and Experience Committee.
- The Clinical Board will provide an update to the Clinical Effectiveness Committee on publication of the next annual report and/or on an agreed interval if required.

Clinical Effectiveness Committee

Each Clinical Board should ensure adequate representation at the Clinical Effectiveness Committee to support the necessary scrutiny of national clinical audit results and improvement plans.

Annual Quality Report

Welsh Government will require all health boards and to produce an Annual Quality Report as part of the Duty of Quality. The results of each audit and progress of each national clinical audit improvement plan will need to be included in the annual report.

Appendix 2: Standard Operating Procedure National Clinical Audit Outlier Procedure

Standard Operating Procedure
National Clinical Audit Outlier Procedure

Document Information	
Purpose	Standard Operating Procedure
Name	National Clinical Audit Outlier Procedure
Author	Head of Patient Safety and Quality Assurance
Date	November 2022
Target Audience	Corporate services, Executive Medical Director and Clinical Board Triumvirate
Overview	To standardise the approach to reviewing, investigating and responding to outlier notification
Review Date	November 2024

Purpose

The purpose of the Standard Operating Procedure (SOP) is to ensure a standardised approach to considering and responding to outlier notification in relation to national clinical audits.

Overview

The National Clinical Audit and Outcome Review Plan (NCAORP) is a mandated programme of national audit designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data. The programme supports benchmarking against other health organisations in the UK. The outcomes and results of national audits are published annually with local performance data being made available to the clinical team and is in the public domain.

When a Health Board care provision falls below the necessary standard of care they are identified as an outlier and the Health Board will receive correspondence from the relevant collegiate body or Welsh Government to notify them of this status.

The SOP sets out the process for considering the outlier notification and defines the roles and responsibilities in responding to the notification.

Process

1. The outlier correspondence will be received by corporate services and will be shared with the Executive Medical Director copying in the relevant operational Clinical Director.

2. If the outlier process fall out of process and an outlier letter is received directly by the clinical audit lead or Clinical Board, it is their responsibility to make the Medical Director's office or Patient Safety and Quality Team are made aware and forward the notification of outlier status as soon as possible.
3. A response letter/email will be sent to the referring organisation from the Medical Director's office within 5 working days to acknowledge receipt of the correspondence.
4. The outlier correspondence will be shared with the Assistant Director of Quality and Patient Safety and Head of Patient Safety and Quality Assurance who will liaise with the relevant Clinical Board to agree the terms of reference of a review.
5. A response to the outlier notification will be drafted collaboratively between the Patient Safety and Quality Team, clinical audit lead and Clinical Board Director, detailing the data accuracy and relevant review findings and actions. This will be shared and agreed by the Executive Medical Director before the deadline for response.

Clinical Effectiveness Committee

The Clinical Effectiveness Committee will have oversight of all outlier statuses, involving key individuals with the skills, knowledge and authority to support a review of the data and the underlying performance to implement the requisite improvements. Outlier notification and responses will be noted and agreed in the Clinical Effectiveness Committee. Membership of the Clinical Effectiveness Committee is available in the CEC Terms of Reference.

Governance and Monitoring

A detailed action plan should be developed to address the requisite improvements by the Clinical Board. The outcomes of the national audit and the action plan should be presented at the Cardiff and Vale Clinical Effectiveness Committee as per the National Clinical Audit SOP.

The responsibility for the monitoring and review of the associated action plan will sit with the Clinical Board. Where an action plan sits across two or more Clinical Boards, a lead Clinical Board will be identified for each action on the AMaT system.

The action plan should be submitted on AMaT and monitored and reviewed on a regular basis in the relevant Clinical Board Quality and Safety Forum and consideration given to including it in the Clinical Board Risk Register. Outcomes and progress of the action plan will be presented at CEC within an agreed timeframe to ensure progress and completion of actions.

Appendix 3: Guide to Developing Clinical Board Annual Clinical Audit Plans

This guide is aimed at helping Clinical Boards develop a forward plan of clinical audits to be carried out in its clinical services and ensure that people working in these services carry out the designated audits.

In order to progress a topic through clinical audit, you must have:

- A specific, focused clinical audit question;
- Published evidence, to provide evidence-based standards;
- An ability and willingness in your clinical team to improve practice in this area.

You will find included in this guide:

- A template for your Clinical Audit Plan and
- A topic identification tool to aid your selection of audits to be included in your plan.

Step One: Identify potential audits to include in your plan and prioritise these clinical audit topics should be chosen systematically. Projects take time and resources so the topics that you choose should be of potential benefit to the service as a whole.

Consider the following:

- Does the suggested audit reflect UHB and clinical service priorities i.e. is the project important to the Directorate/Clinical Board/UHB rather than simply the personal interest of an individual clinician?
- Concerns regarding clinical care are often identified through the various facets of patient safety and quality; these concerns can be used to inform a clinical audit project and may be key audits for your plan.
    - You may select topics that are of concern to patients, raised by way of a complaint;
    - Adverse incident/Never Event/near miss reporting can highlight potential topics to audit;
    - Claims data may direct your audit.
- Quality and safety priorities such as items on the Risk Register or items included in your IMTP.
- NICE Guidance.
- Mandatory audit.
- Follow-up from implementation/improvements.
- Re-audit.

The topic identification tool below is a simple mechanism that can be used to firstly identify potential topics to audit with your Directorates/Directorate Clinical Audit Lead and secondly to prioritise these topics for inclusion in the Clinical Board forward plan.

Step Two: Your prioritised list of topics must to be reviewed to ensure that the projects are suitable for clinical audit.

You should at this stage:

- Identify a Nominated Project Lead for each audit.
- Submit your proposed plan to the Clinical Audit Department with supporting Clinical Audit Proposal Form for each audit topic identified (available on the 'Useful Documents' tab of the Clinical Audit intranet page) – this will enable y Clinical Audit Facilitators to discuss the suitability of your topics and if necessary help you identify key subjects in your clinical area.

Step Three: Sign off your Annual Clinical Board Plans

You should:

- Obtain Clinical Board sign off for plan approved by the Clinical Audit Department via your Clinical Board Quality, Safety and Experience Group.
- Confirm sign off (including date of meeting) to Clinical Audit Department.

Summary

- Focus your efforts where there is greatest potential for improving the quality of care. Do not waste valuable time looking at areas where realistically you know there is little possibility of making improvements.
- Get all your stakeholders, colleagues, managers, etc on board from the start and make sure that they understand clearly what you are trying to achieve.
- Clinical audit needs to be justifiable in terms of the benefits it will bring about for patients balanced against the amount of time and resources it takes. For each proposed project topic, ask yourself:
  - What is the benefit for the patient of doing this project?
  - Will it take a disproportionate amount of time and/or funds to complete?

Please note:
Tier 1 audits - National Mandatory Audits
Tier 2 audits - Patient Safety Priority Audits
Tier 3 Audits - Personal Interest

Source of Audit	Audit Topic	Direct Impact on Patient Care y/n	High Risk y/n	High Cost y/n	High Volume y/n	Relates to UHB Priorities y/n	Relates to Directorate Priorities y/n	Direct Patient Involvement y/n	Multi-disciplinary y/n	Interface y/n	Re-audit y/n	Score (number of Yes responses)
Recommendation from National Confidential Enquiry												
Welsh Risk Pool												
Published NICE Guidance												
National Patient Safety Agency												
National Service Framework												
National Audit												
Royal Colleges / National Body												
Published Research												
Local/regional guideline												
Patient feedback/ complaints												
Adverse incident/near miss/Never Event												
Patient Clinical Pathway												

Appendix 4 **TOPIC IDENTIFICATION TOOL**

Clinical Audit Forward Plan

Clinical Board: **Directorate:**

Audit Title/Topic	Tier 1 (mandatory) or Tier 2 (Patient Safety Priority Audit)	Reason for Topic Selection (i.e. NICE/Royal College/Adverse Incident)	Standards/ Guidelines Auditing Against	Nominated Project Lead	Anticipated Start Date	Anticipated Presentation Date (to Safety & Quality Session)

Appendix 5 **ANNUAL CLINICAL AUDIT PLAN**

Report Title:	Procedure for Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group			Agenda Item no.	3.1.2b
Meeting:	Quality Safety and Experience Committee	Public	X	Meeting Date:	18 July 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Medical Director				
Report Author (Title):	Assistant Director of Quality and Patient Safety				

Main Report
Background and current situation:

The policy delivers clarity on the process for reviewing evidence-based guidance and assessing care delivery against these standards.

The AMaT clinical audit system will be used to disseminate guidance and to collate position statements relating to the implementation of each element of the guidance. This system will oversight by each of the Clinical Board in understanding levels of implementation and where necessary mitigating risks of non-implementation. The policy also provides clarity around the organisational oversight of non-implementation and where necessary risk assessment and mitigation.

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

The Procedure for Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group provides a standardised approach to overview of evidence-based guidance assessment of implementation and governance and risk assessment relating to non-implementation.

Recommendation:

The Committee is requested to:

Approve the Procedure for Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group (510).

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

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
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		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	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:

Reference Number: *TBA unless document for review* **Version Number:** 1	**Date of Next Review:** *TBC* **Previous Trust/LHB Reference Number:** *N/A*

Procedure for Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group

Introduction:

Rationale: The purpose of this document is to describe how guidance is disseminated and implemented across Cardiff and Vale University Health Board to provide assurance.

Principles: Cardiff and Vale UHB (University Health Board) is committed to implementing evidence-based practice to improve the quality of health and social care and reduce variation of care. Cardiff and Vales UHB will provide assurance to Welsh Government that national guidance has been reviewed, implemented and appropriately risk assessed and appropriately actioned. Where national guidance may not be considered as best practice, the UHB will provide evidence to Welsh Government that the guidance has been considered and the rationale for not implementing the guidance will be provided.

Policy Commitment

All guidance published by national guidance which include guidance issued by NICE, Health Technology Wales (HTW) and the All Wales Medicines Strategy group (AWMSG) will be reviewed, implemented and risk assessed.

NICE guidance covers:
NICE guidelines
TAG (Technology Appraisal Guidance)
Diagnostic guidance
Medical technology guidance
Interventional procedure guidance
Highly specialised technology guidance

HTW guidance covers:
Any non-medical technology and models of care

AWMSG covers:
The use, management and prescribing of medicines in Wales

All staff have a duty to be aware of all national guidance applicable to their speciality.

Supporting Procedures and Written Control Documents

- **Clinical Audit Policy**

Scope: This guidance is intended for all staff engaged with guidance review and implementation within the Cardiff and Vale UHB.

This includes all staff, clinician, management, senior management, and board members both clinical and non-clinical. Those with short term or honorary contracts, students, trainees in any discipline.
This guidance also applies to any work jointly undertaken across all professional boundaries. This document should also be read in conjunction with the Clinical Audit and Service Evaluation Policy.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) Has been considered and not required.
Health Impact Assessment	A Health Impact Assessment (HIA) As above
Policy Approved by	QSE Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Clinical Effectiveness Committee
Accountable Executive or Clinical Board Director	Executive Medical Director

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New Document*

Contents:

1 Introduction

National Institute for Health and Care Excellence (NICE)

The National Institute of Health and Care Excellence (NICE) (https://www.nice.org.uk) was established as a Special Health Authority in April 1999 and is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. In April 2013 NICE also gained responsibilities for providing guidance for those working in social care. NICE recommendations are based on independent reviews of evidence for clinical and cost effectiveness or interventions. Once NICE guidance is published health professionals, commissioners and organisations are expected to take the guidance fully into account when deciding what services, treatments, or advice to offer to service users and carers.

Implementing NICE guidance offers benefits to patients and carers, healthcare professional and organisations. A clear process for the management of NICE guidance helps ensure that care provided to patients is high quality and cost effective.

The treatment and care should consider individuals needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment in partnership with their healthcare professionals. The UHB is expected to take NICE recommendations fully into account to ensure a continuous review of services to provide the best outcomes of care. The process and systems in place for responding to best practice guidance published by NICE will help support the UHB in developing high quality services to ensure they're providing a safe and effective service.

Health Technology Wales (HTW)

Health Technology Wales (HTW) (https://healthtechnology.wales) is a national body working to improve the quality of care in Wales. HTW collaborate with partners across health, social care and the technology sectors to ensure an all-Wales approach.

HTW are an independent organisation which are funded by Welsh Government and hosted within NHS Wales. Their remit covers any technology or model of care and support in health and social care that isn't a medicine.

For health, this could include medical devices, diagnostics, procedures and psychological therapies. For social care, this could include equipment, or different models for supporting families, children, adults and the workforce. Workstreams consist of Identification, appraisals and adoption of health technologies.

The aim is to improve the quality of health and social care in Wales, by assessing the value and optimising the use of clinically and cost-effective technologies and models of care and support.

The process for identification, dissemination and implementation of HTW emulates the same process as for NICE guidance.

HTW also monitor the adoption of their guidance, and guidance from other organisations, across all of the local health boards in Wales and encourage adoption of guidance in social care. This not only includes uptake of new health and social care technologies, but also disinvestment in current technologies that are found to be less effective or obsolete.

All Wales Medicine Strategy Group (AWMSG)

The AWMSG advised Welsh Government about the use, management and prescribing of medicines in Wales. The role of AWMSG is to develop timely, independent and authoritative advice on new medicines. They advise Welsh Government about future developments in healthcare and help to develop a medicine prescribing strategy for Wales.

AWMSG will provide guidance for newly licensed and established medicines, they will conduct monitoring as part of its medicine optimisation programme. The optimisation programme aims to focus on patient and outcomes rather than process and systems and aims to support healthcare worker in advising patients on how they can achieve the best outcomes from their medicines.

AWMSG provide authoritative advice to Welsh Government and will assist with the implementation and audit of this advice within NHS wales. They will regularly analyse prescribing data in order to benchmark performance and drive improvements in the service.

1. Definitions

Best Practice - A best practice is a technique or methodology that, through experience and research, has proven to reliably lead to a desired result. A commitment to using the best practices in any field is a commitment to using all the knowledge and technology at one's disposal to ensure success.

Nice Guidance – NICE Guidance covers the following classifications

NICE currently develop and publish the following types of guidance

- NICE guidance
- Technology appraisal guidance
- Diagnostic guidance
- Medical technology guidance
- Interventional procedures guidance
- Highly specialised technology guidance

NICE guidelines	Cancer services guidelines	The focus is to guide the commissioning of services and is therefore different from clinical practice guidelines. Based upon the implementation of the NHS Cancer Plan
	Clinical guidelines	Provide guidelines on the appropriate treatment and care of patients with specific disease and conditions.
	Medicines practice guidelines	Provide recommendation for good practice for those individuals and organisations involved in governing, commissioning, prescribing and decision making about medicines. they have a wide range of audiences across both health and social boards.
	Public health guidelines	Make recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health.
	Social care guidelines	Aim to provide outcomes for people who use social care support by ensuring that social care services and interventions are effective and cost efficient.
Technology Appraisal guidance		Technology Appraisals provide guidance on the use of new and existing medicines, treatments and procedures within the National Health Service (NHS) These follow a slightly different process for assessment and implementation within the Trust to the other NICE Guidance listed above and therefore at the end of each subsection in section 6 a separate italicised statement has been made in relation to TAs.
Diagnostic guidance		Focus on the evaluation of innovative medical diagnostic technologies in order to ensure that the NHS can adopt clinically and cost-effective technologies more rapidly and consistently.
Medical technologies guidance		Focus specifically on the evaluation of innovative medical technologies (including devices and diagnostics).
Interventional procedures guidance		These recommend whether interventional procedures - such as laser treatments for eye problems or deep brain stimulation for Implementation of NICE Guidance Policy April 2020 Version 5 Page 3 of 17 chronic pain - are effective and safe enough for use in the NHS.
Highly specialised technologies guidance		Contain recommendations on the use of highly specialised technologies.

2. Duties and Responsibilities:

Medical Director: Is the Executive Lead with the overall strategic responsibility to ensure the system is in place to monitor compliance, ensuring all national guidance and quality standards published by NICE, HTW and AWMSG are implemented across the UHB, escalating any risks to the board

Identified guidance leads: Identified leads can be Clinical Directors, Heads of Specialities or anyone appointed by Clinical Directors to complete the baseline assessment, oversee, and implement any action plans.

Clinical Directors: The Clinical Directors are accountable for reviewing all guidance published by NICE, HTW and AWMSG and determining their relevance to the UHB or their clinical area. They are accountable for ensuring that a lead is appointed for all guidance that has been identified as relevant for their clinical speciality. They must ensure baseline assessments are completed and action plans are implemented.
The Clinical Directors also have the responsibility for ensuring that guidance is shared within their clinical area and discussed at Directorate Quality and Safety and appropriate governance meetings. They must ensure that they inform the Quality Assurance Team of any risks to the UHB when they are identified. They will ensure that the risk register is updated where non-compliance poses patients at risk.

Clinical Audit and Quality Assurance Lead: The Clinical Audit and Quality Assurance Leads are responsible for the coordination and distribution of new guidance/quality standards to Clinical Directors or designated clinical leads and will maintain the guidance database and they will provide support and advise to relevant staff. They will also provide reports to the Medical Director on an agreed basis.

The Head of Patient Safety and Quality Assurance/Deputy Head of Quality Assurance and Clinical Effectiveness Lead: Have overall responsibility to ensure compliance is monitored and reported to internal and external stakeholders. They are responsible for ensuring that the UHB compliance with all national guidance is monitored at the relevant Quality and Safety Meetings and raising any concerns to the Medical Director.

Clinical Effectiveness Committee: The committee will be the group responsible for overseeing this process and will receive assurance reports as per the reporting schedule.

Healthcare Professionals Groups: All healthcare professionals employed by Cardiff and Vale University Health Board are responsible for ensuring that they understand the significance, relevance, and impact on their daily practice of national guidance.

Other professional groups: All guidance and relevant quality standards must be brought to the relevant quality and safety groups/meetings where it can be discussed and disseminated including guidance for information only.

3. Procedure:

Identifying new guidance

NICE, HTW and AWMSG publish new and updated guidance which are available via their websites https://www.nice.org.uk , https://healthtechnology.wales , https://awttc.nhs.wales. New and revised guidance will also be added to the AMaT data base. The Clinical Audit / Quality Assurance Team will review and identify new and revised guidance by its published date and will disseminate the guidance via AMaT to the relevant Clinical Director / Clinical Team and request feedback of the guidance relevance to the UHB.

The Clinal Audit / Quality Assurance Team will require evidence of compliance of all guidance that has been adopted into the UHB. All new and revised NICE guidance will include a 'baseline assessment tool' which can be accessed via the NICE website (https://www.nice.org.uk).
The assessment is intended to identify whether there is currently sufficient evidence available for each recommendation within the guidance including whether the guidance is being followed and/or standards are being met. All guidance will require evidence of compliance and this evidence may come in different forms and consideration should be given to:

- Relevant policies and procedure may identify whether a guidance recommendation is already incorporated into the UHB expectations
- Electronic systems may hold various information which supports the assessment of whether the recommendation is being followed.
- The Clinical Audit Team will be able to provide previous audit data (if previous audit has been correctly registered with the UHB) which may be of use.
- Where information is not available this should be flagged within the relevant assessment tool.

Any evidence used to support completion of the assessment should be identified within the relevant assessment tool. It should also be clearly identified where data is not currently captured and where data is needed to determine compliance and any future data that will be required. (for inclusion in the action plan). All evidence will need to be uploaded onto AMaT.

It is expected that assessments will be completed on AMaT within 30 days. The Clinical Director / Clinical lead will therefore need to ensure the assessment has been presented to relevant groups for approval prior to being uploaded onto AMaT which will in turn notify the Clinical Audit / Quality Assurance Team.

4. Evidence to Support Assessment

NICE provide an assessment tool which can either be accessed via AMaT or their website (https://www.nice.org.uk). An assessment tool can be completed as either as an initial assessment or a re-assessment), the Clinical Director /Clinical Lead is expected to describe what evidence they have and must substantiate a status of compliance with each recommendation in the guidance.

Evidence to support compliance may include clinical audit results, patient surveys, policies, reports, data generated from an electronic system, service leaflets and / or other documentation.

Where evidence is not currently available, steps to obtain evidence should be included in an action plan

5. Statement of Compliance

For all guidance, a statement of compliance will be required which will be completed via the AMaT system (AMaT Guidance Module). The compliance review tool will include a text box for each recommendation to allow comments for any identification of risks where there is currently insufficient evidence of current. The Clinical Board will scrutinise the completed statement of compliance review and will be expected to consider the overall risk to quality of care where full compliance is not declared.

Determination of risk should consider:

- How many recommendations do not have sufficient evidence of compliance
- The significance of these recommendations
- Whether it is believed that the UHB is compliant but there is a lack of evidence available at this time, or whether it is believed that the UHB is not compliant
- The amount of work required to implement the recommendation
- What actions can be taken to mitigate against any risks

6. Approval of Statement Reviews

All completed statements will be submitted onto AMaT (Guidance Module). The Quality Assurance/Clinical effectiveness team will review, approve or request additional information if necessary for each assessment.

Where the compliance statement indicate that there are recommendations to which the health board is not compliant, or there is insufficient evidence of compliance, the Quality Assurance/Clinical effectiveness team will ask the clinical lead to attend the Clinical Effectiveness Committee to discuss the level of risk posed by non-compliance and consider inclusion of these risk/s within the relevant risk registers and describe the actions taken to mitigate against the risks

7. Action Plan

Once the completed statements of compliance have been submitted onto AMaT, the assessor or clinical lead will be responsible for generating an action plan to bring the health board into a position where it is compliant with the NICE, HTW and/or AWMSG guidance and/or is able to generate sufficient information to demonstrate compliance.

Common elements on an action plan may include:

- Undertake further assessment
- Amendments to relevant policies/procedures, including ongoing monitoring requirements (to provide ongoing evidence of compliance)
- Training of staff
- Communication to staff of changes to policy
- Audit (Local/isolated or inclusion on clinical audit plan)
- Re-assessment (this should be included on all action plans as re-assessment will need to occur once other actions are implemented.

In generating an action plan the clinical lead should identify whether they believe additional resources will be required to complete the action, which action these effects, and the extent to which the identified risk can be mitigated without additional resources being made available. These considerations should be submitted to the Quality Assurance/Clinical Effectiveness team at the same time as the action plan.

The action plan should be uploaded onto AMaT within one month of the statement of compliance has been completed. The Quality Assurance/Clinical Effectiveness team will approve the action plan and may request amendments and resubmissions for approval. Prior to uploading any/all documents/evidence/action plans it is expected that the Clinical Board Leads have reviewed and approved each document.

By approving each action plan, the Quality Assurance/Clinical Effectiveness team will ensure implementation of multiple guidance recommendations is co-ordinated and prioritised across the health board.

Common elements will be brought together and actioned ‘en-masse’ e.g. if 3 action plans contain amendments to insight then these will be brought together and 1 request for amendments made to the relevant technical team.

Clinical Audit requirements should be taken from the action plan and co-ordinated by the clinical audit leads/Governance leads within the directorate. These should be incorporated onto AMaT in an efficient and effective manner and may be included as part of the Annual Clinical Audit Forward Plan

8. Ongoing Evidence of Compliance

Clinical and Professional Directors are responsible for ensuing guidance and other best practice guidance are implemented as much as possible across the organisation. All staff providing care and treatment have the responsibility to provide care that is safe and effective and therefore compliance with best practice guidance is expected. When reviewing existing policies and procedures, or writing new ones, policy authors are responsible for ensuring that relevant guidance published by NICE, HTW and AWMSG and their recommendations are incorporated and that these documents describe a 'NICE, HTW or AWMSG COMPLIANT' service.

The Quality Assurance/Clinical Effectiveness will monitor ongoing evidence of compliance. As well as reassessments of guidance and implementation of the health boards policies, ongoing evidence may also include 'additional evidence' which will include other activities/developments within the health board that address recommendations and standards contained within the NICE, HTW and AWMSG guidance.

Ongoing evidence of compliance will in part be linked to policy monitoring and will be the responsibility of the group that is identified in the policy as having those responsibilities.

9. Decision not to Implement Recommendations

Where there are insufficient resources available to implement recommendations contained within NICE, HTW and AWMSG guidance, and a business case to secure funds has been unsuccessful, it will be expected that the clinical lead will notify the Clinical Effectiveness Committee.

Arrangements should be made to add a risk assessment to the risk register if one has not already been done. The Clinical Effectiveness Committee will expect the relevant clinical teams to implement a plan to mitigate against any risks, these plans should be presented to the Clinical Effectiveness Committee and escalated to the QSE as Exception.

10.Annual Review of Recommendation/s not Previously Implemented

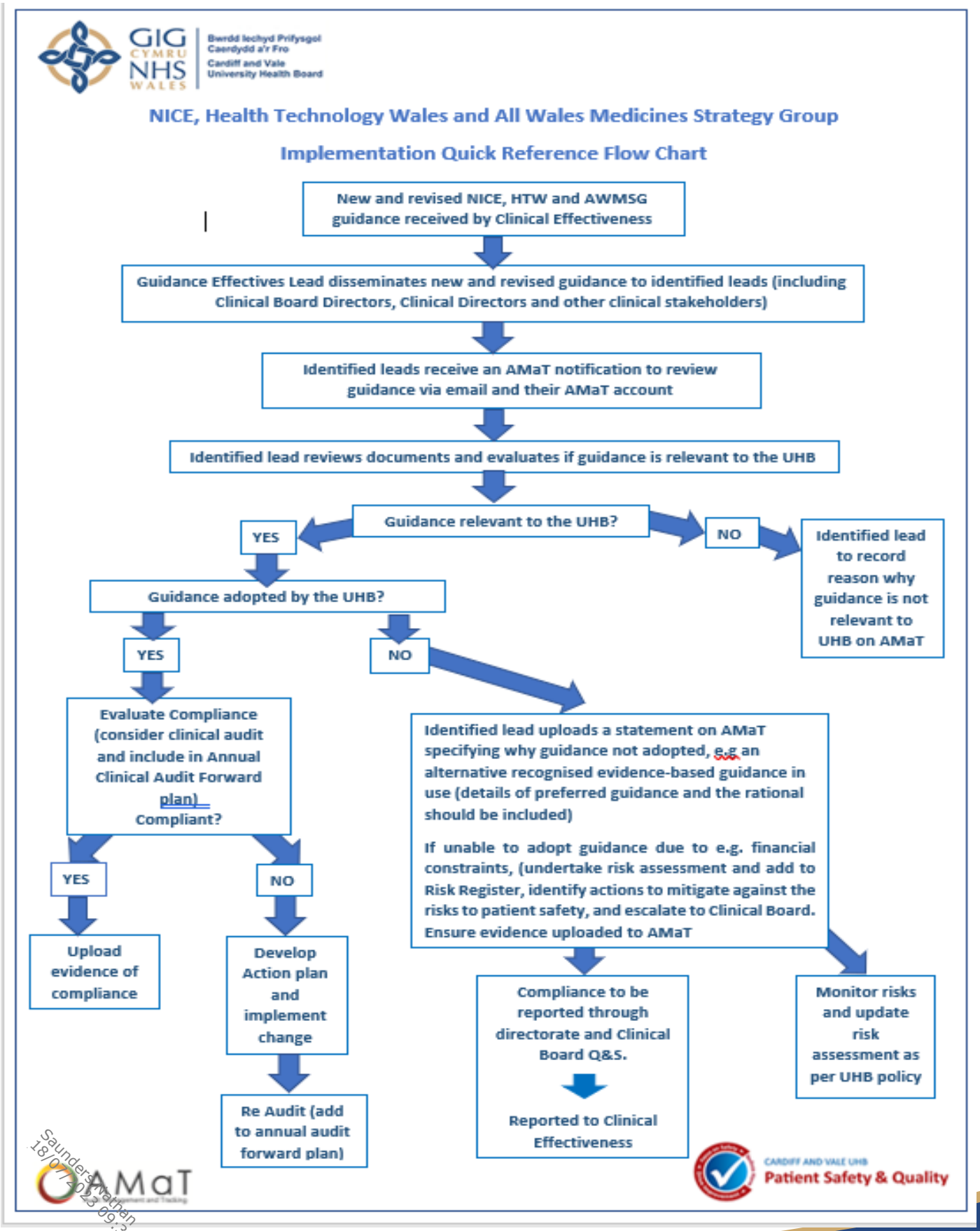
The time interval for the review of NICE, HTW and AWMSG guidance not implemented should be determined on the level of risk identified. Where reports have identified individuals/groups who have not complied with the processes and timeframes outlined in this policy the Assistant Medical Director will contact the individual/chair of the group. The Assistant Medical Director will request an explanation and agree a method of restabilising the process as soon as possible.

11. Reporting

The Quality Assurance/Clinical effectiveness Team will maintain a NICE, HTW and AWMSG compliance data on AMaT, this will include all the information necessary for monitoring the application of this policy.

The following should be submitted for guidance on AMaT

- All completed relevant assessment and accompanying risk assessment, in relation to NICE guidance.
- Action plans for approval
- A report outlining guidance where it has been decided not to implement recommendations, for approval
- A list of newly published guidance, identifying relevance to guidance



Report Title:	Labelling of Specimens submitted to Medical Laboratories Policy & Labelling of Specimens submitted to Medical Laboratories Procedures			Agenda Item no.	3.1.3	
Meeting:	Quality & Safety Committee	Public	X	Meeting Date:	18.07.2023	
		Private				
Status (*please tick one only*):	Assurance		Approval	X	Information	
Lead Executive:	Chief Operating Officer					
Report Author (Title):	Quality Manager					

Main Report

Background and current situation:

The Following Policy and Procedure is for review:

1. Labelling of Specimens submitted to Medical Laboratories Policy (UHB017) and Labelling of Specimens submitted to Medical Laboratories Procedures (UHB 452)

The policy and procedure have been reviewed within the relevant professional meetings and have been agreed there.

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

No significant changes have been made to the policy and procedure.

Recommendation:

The Committee is requested to:

Ratify the following attached policy and procedure: -

i) Labelling of Specimens submitted to Medical Laboratories Policy (UHB017) and Labelling of Specimens submitted to Medical Laboratories Procedures (UHB 452)

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
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	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration	X	Involvement	

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Clinical Board Q&S Sub-Committee	20th June 2023

Saunders,Nathan
18/07/2023 09:30:09

Reference Number: UHB 017 **Version Number:** 5	**Date of Next Review:** 16th May 2026 **Previous Trust/LHB Reference Number:** N/A

LABELLING OF SPECIMENS SUBMITTED TO MEDICAL LABORATORIES POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will advocate and promote the accurate labelling of specimens and accompanying laboratory request forms for safe and effective patient care. This policy describes the requirements for accurate positive identification of the patient from whom the specimen was taken, the clinical details surrounding the patient and the person and location where the result should be sent.

Policy Commitment

Cardiff and Vale University Health Board is committed to achieving excellence in providing safe, effective, efficient and compassionate care. In order to achieve this it is necessary to ensure that effective procedures are in place to ensure that all samples taken for laboratory investigations can be accurately and unambiguously assigned to the correct patient, and that all necessary information for analysis, interpretation and reporting is provided.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedures describe the following with regard to sample labelling and patient identification.

- UHB 101 Patient Identification Policy
- UHB 100 Consent to Examination or Treatment Policy
- UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure.
- UHB 149 Standard Infection Control Precautions Procedure

Scope

This policy relates specifically to the labelling of **specimens** submitted to Cardiff and Vale University Health Board medical laboratories for investigation and/or storage for subsequent investigation, and encompasses all body fluids and tissues, except blood components, blood products, cells or tissues for the purposes of transfusion or transplantation, or for storage for possible subsequent transfusion or transplantation.

Requirements for such transfusion related samples are described in the UHB 348 Blood Component Transfusion Procedure. Samples taken for point of care testing should follow the UHB 062 Point of Care Testing Policy.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a no impact.

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	For example: Health System Management Board
Accountable Executive or Clinical Board Director	Chief Operating Officer

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	14/10/2009	17/08/2010	
1	07/06/2011		No change
2	14/06/2012	04/06/12	Some sections clarified; requirement for full name of referring clinician, location and clinical details made mandatory (except where patient safety would be put at risk)
3	05/03/2013	08/03/13	Updated to clarify specimen forms need to state the Consultant initial and surname, not full name.
4	16/04/19	08/05/19	Updated to clarify the management of known high risk specimens.
5	16/05/2023		Updated links and Clinical Board contact details

Equality & Health Impact Assessment for

Labelling of Specimens Submitted to Medical Laboratories

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	No proposed change to Laboratory Medicine Service delivery. Document reviewed to provide clarity on sample labelling acceptance criteria and actions in the event of non-conformance with the policy.
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Clinical Diagnostics and Therapeutics, Dr Adam Christian Clinical Director Helen Luton Interim Director of Nursing and Multi-disciplinary Teams
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure that robust arrangements are in place to ensure that samples taken for laboratory analysis or storage can be accurately and unambiguously identified, and that all necessary information is supplied for appropriate and timely analysis, interpretation and reporting. In addition, any issues arising from the non-conformance with this policy will be reported via UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure to establish the root-cause of the issue to avoid recurrence.
4.	Evidence and background	Cardiff and Vale University Health Board (UHB) is one of the largest NHS

	information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	organisations in the UK, providing healthcare services for 475,000 people living in Cardiff and the Vale of Glamorgan. There are currently approximately 558 staff employed within the Laboratory Medicine Directorate that are involved in the collection, processing, testing, storage, reporting or management of patient specimens from both internal or external sources. On an average day we carry out 13,715 blood tests. Laboratory Medicine - Home (sharepoint.com) There are many papers that present the importance of accurate patient identification to the prevention of medical errors and demonstrate improvement after introducing and enforcing sample labelling procedures. The Laboratory Medicine Directorate service has dedicated intranet and internet pages that explain the service, the testing repertoire and turn-around times. Laboratory Medicine - Home (sharepoint.com) The Laboratory Medicine Directorate undertakes engagement with service users via user surveys, responding to compliments and concerns, incident management and service user engagement days.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Service users, patients, staff.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going	Negative, there may be an assumption that a name belongs to a specific gender traditionally but the gender recorded may be opposed to this and the conflict may be seen as an error in the absence of qualifying supporting information.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
			Mislabelled Specimens, Page 11.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.10 People according to their income related group:	Policy applied to all samples	Disseminate policy and	Mitigation captured in

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	encourage use of user hand books.	introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure	Policy applied to all samples but for paediatric samples, precious samples	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
and/or service	professional discrepancy can be applied within the appropriate laboratory.		Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered:	Policy applied to all samples but for paediatric samples,	Disseminate policy and encourage use of user hand	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	precious samples professional discrepancy can be applied within the appropriate laboratory.	books.	Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
7.4 People in terms of their use of the physical environment:	Policy applied to all samples but for paediatric samples, precious samples	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	professional discrepancy can be applied within the appropriate laboratory.		Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
7.5 People in terms of social and community influences on their health: Consider the impact on	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	be applied within the appropriate laboratory.		and under heading Mislabelled Specimens, Page 11.
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A globally responsible Wales			

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory. Patient identification may be misinterpreted in the case of a transgender patient presenting with opposite gender name and gender recorded on same episode.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Complete on issuing policy.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	N/A			
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure an • d/or service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts	continues unchanged as there are no significant negative impacts			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review				

Reference Number: UHB 452 **Version Number:** 2	**Date of Next Review: 16/05/2026** **Previous Trust/LHB Reference Number:** UHB 452

LABELLING OF SPECIMENS SUBMITTED TO MEDICAL LABORATORIES PROCEDURE

Introduction and Aim

Accurate labelling of specimens and accompanying laboratory request forms is very important for safe and effective patient care.

This policy describes the requirements for accurate positive identification of the patient from whom the specimen was taken, the clinical details surrounding the patient and the person and location where the result should be sent. These are the minimum requirements for accepting a specimen and logging it onto the laboratory database in line with the Right First Time Requesting Initiative launched in April 2013. Some laboratory tests have very specific requirements about how the specimen should be obtained, the preservative used (or not used) and the clinical information required to perform the correct test and interpret the results properly.

In some circumstances, e.g. where sequential specimens are taken, it is important to identify not only the patient but also the individual specimen (by date and time taken). Each laboratory produces a user guide, which should be consulted before sending specimens for specialist tests.
Laboratory Medicine Test Knowledge Base

Cardiff and Vale University Health Board is committed to achieving excellence in providing safe, effective, efficient and compassionate care. In order to achieve this it is necessary to ensure that effective procedures are in place to ensure that all samples taken for laboratory investigations can be accurately and unambiguously assigned to the correct patient, and that all necessary information for analysis, interpretation and reporting is provided.

Cardiff and Vale University Health Board is also committed to the health, safety and welfare of all its staff, by providing a safe workplace and systems of work. In order to achieve this it is necessary to ensure that staff have the necessary information when obtaining, transporting and processing hazardous biological materials

Objectives

The aim of this policy is to ensure that robust arrangements are in place to ensure that samples taken for laboratory analysis or storage can be -

- accurately and unambiguously identified
- all necessary information is supplied for appropriate and timely analysis, interpretation and reporting
- issues arising from the non-conformance with this policy will be reported via UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure to establish the root-cause of the issue to avoid recurrence.

Scope

This policy relates specifically to the labelling of **specimens** submitted to Cardiff and Vale University Health Board medical laboratories for investigation and/or storage for subsequent investigation, and encompasses all body fluids and tissues, except blood components, blood products, cells or tissues for the purposes of transfusion or transplantation, or for storage for possible subsequent transfusion or transplantation.

Requirements for such transfusion related samples are described in the UHB 348 Blood Component Transfusion Procedure. Samples taken for point of care testing should follow the UHB 062 Point of Care Testing Policy.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a no impact.
Documents to read alongside this Procedure	This Policy and the supporting procedures describe the following with regard to sample labelling requirements. . **Other supporting documents are:** • UHB 017 Labelling of specimens policy (EQIA) • UHB 350 Data Protection Act procedure • UHB 301 Information governance • UHB 053 Major Incident Plan • UHB 062 Point of Care Testing (POCT) Policy • UHB 068 Blood and Component Transfusion Policy • UHB 100 Consent to Examination or Treatment Policy • UHB 101 Patient Identification Policy • UHB 138 Incident, Hazard and Near Miss Reporting Policy • UHB 149 Standard Infection Control Precautions Procedure • UHB 348 Blood Component Transfusion Procedure • Infection Control Procedure for Needlestick and Similar Sharps Injuries • UHB 089 Control of Substances Hazardous to Health (COSHH) Procedure

Approved by	Laboratory Medicine Quality meeting

Accountable Executive or Clinical Board Director	Chief Operating Officer
Author(s)	Laboratory Medicine Quality group

Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	16/04/19	08/05/19	New procedure to replace previous UHB 017 Labelling of Specimens Submitted to Medical Laboratories Policy, including additional guidance on management of high risks samples.
2	16/05/23		Links throughout the document updated Changed name of Clinical board Director

Contents

1.0 Introduction

Accurate labelling of specimens and accompanying laboratory request forms is very important for safe and effective patient care.

This policy describes the requirements for accurate positive identification of the patient from whom the specimen was taken, the clinical details surrounding the patient and the person and location where the result should be sent. These are the minimum requirements for accepting a specimen and logging it onto the laboratory database in line with the Right First Time Requesting Initiative launched in April 2013. Some laboratory tests have very specific requirements about how the specimen should be obtained, the preservative used (or not used) and the clinical information required to perform the correct test and interpret the results properly.

In some circumstances, e.g. where sequential specimens are taken, it is important to identify not only the patient but also the individual specimen (by date and time taken). Each laboratory produces a user guide, which should be consulted before sending specimens for specialist tests.
Laboratory Medicine Test Knowledge Base

Cardiff and Vale University Health Board is committed to achieving excellence in providing safe, effective, efficient and compassionate care. In order to achieve this it is necessary to ensure that effective procedures are in place to ensure that all samples taken for laboratory investigations can be accurately and unambiguously assigned to the correct patient, and that all necessary information for analysis, interpretation and reporting is provided.

Cardiff and Vale University Health Board is also committed to the health, safety and welfare of all its staff, by providing a safe workplace and systems of work. In order to achieve this it is necessary to ensure that staff have the necessary information when obtaining, transporting and processing hazardous biological materials

2.0 Aims and Objectives

The aim of this policy is to ensure that robust arrangements are in place to ensure that samples taken for laboratory analysis or storage can be -

- accurately and unambiguously identified
- all necessary information is supplied for appropriate and timely analysis, interpretation and reporting
- staff that are involved in or detect issues arising from the non-conformance with this policy, that result in (near) patient harm, will be expected to report to the organisation in line with UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure to establish the root-cause of the issue to avoid recurrence. Incident reporting may be undertaken by the receiving laboratory but the investigation will remain the responsibility of the referring clinical area

3.0 Definitions

For the purposes of this document, **a specimen** means the quantity of tissue, fluid, or other sample submitted for testing, together with its container and the request form.

3.1 Inappropriate labelling describes any situation where the information provided on the specimen container or request form is incorrect or not adequate for the purposes of the laboratory investigation requested. This includes the following categories:

- **Unlabelled specimens** have an absence of labelling on either the container or the request form, or have no request form.

- **Mislabelled specimens** have a mismatch between the patient information on the specimen container and the accompanying form, or between the information supplied and information from another source (e.g. a previous specimen from the same patient, or data on PMS)

- **Inadequately labelled specimens** have insufficient information on the tube or request form for either the proper identification of the patient or the specimen, or for the correct performance, interpretation and communication of the analysis.

4.0 Scope of the Policy

This policy relates specifically to the labelling of **specimens** submitted to Cardiff and Vale University Health Board medical laboratories for investigation

and/or storage for subsequent investigation, and encompasses all body fluids and tissues, except blood components, blood products, cells or tissues for the purposes of transfusion or transplantation, or for storage for possible subsequent transfusion or transplantation.

Requirements for such transfusion related samples are described in the UHB 348 Blood Component Transfusion Procedure. Samples taken for point of care testing should follow the UHB 062 Point of Care Testing Policy.

5.0 Stakeholder Responsibilities

The responsibility for requesting a laboratory investigation lies with an authorised practitioner (normally a medical clinician). It is the responsibility of the requester to ensure that specimen containers are correctly labelled and request forms completed to an acceptable standard (see below). If another person, e.g. a phlebotomist, obtains specimens from a patient on behalf of a requesting practitioner they must ensure that the labelling meets these standards (see below). All staff who take Pathology specimens are responsible for ensuring they are collected in a manner that meets the requirements of the tests requested. It is also the responsibility of the person requesting an investigation or storage of a sample to ensure that they have obtained the necessary informed consent for all procedures requested (refer to UHB 100 Consent to Examination or Treatment Policy).

Managers and senior staff in clinical areas are responsible for ensuring that staff who collect samples are aware of this policy and are competent in sample collection, requesting and labelling. Managers and senior staff in clinical areas must also ensure that appropriate action is taken where incidents arising from breaches of this policy occur, including responding to or reporting incidents on Datix, conducting root cause analysis and assessing any feedback provided to them.

Phlebotomists and Laboratory staff are required to adhere and enforce this policy; they should therefore be treated in accordance with the UHB Dignity at Work Process. Laboratory staff who receive samples which cannot be processed due to breaches in this policy must ensure that departmental procedures for acceptance of samples are followed, incidents that result in (near) patient harm may be reported to Datix if appropriate.

The Lead Executive for Patient Quality and Safety is the Executive Director of Nursing, who in conjunction with the Executive Medical Director and the Executive Director of Therapies and Health Science have ultimate responsibility for ensuring effective clinical governance arrangements and the quality of patient care. This responsibility is discharged within the Clinical Boards and Directorates via the Clinical Board Directors, Laboratory/Clinical Directors, and appropriate senior managers.

It is the responsibility of Clinical Board Quality, Safety and Experience Groups to implement this policy, ensuring that appropriate up-to-date guidance is available and implemented at directorate level, and that compliance is audited at departmental level. Outcomes from audit and monitoring must be fed back to Directorates through the Clinical Board clinical governance structure.

6.0 Procedure for Labelling Specimens

6.1 Specimen Collection

6.1.1 Phlebotomists will not bleed a patient without a completed and signed request form. The form must include full patient identification, Consultant's initial and surname, location and clinical details. Incomplete request forms will be returned for completion before blood is collected.

6.1.2 Staff must ensure they have positively identified the patient, following the relevant UHB 101 Patient Identification Policy, before taking a sample.

6.1.3 Specimen labelling should be performed in the presence of the patient. Pre-labelling empty sample containers and leaving filled containers unlabelled for any period of time is extremely poor clinical practice which poses a high risk of mislabelling and must not be tolerated under any circumstance. In the event of the requesting clinician, or other member of staff, becoming aware of any errors in sample identification discovered after the specimen has been sent for processing, this must be reported immediately to the laboratory to prevent incorrect information remaining on the laboratory databases with the potential for an adverse clinical incident.

6.1.4 When using an addressograph label, staff should take special care that they are the correct ones for the patient.

6.1.5 The person who takes the sample should sign the request form and record the date and time the sample was taken.

6.1.6 The UHB is currently implementing electronic test requesting. The system allows clinicians to order requests electronically and print test labels to attach to specimens to facilitate the booking in process and improve legibility. The same principles must be employed, with regard to patient safety, when utilising an electronic request form.

6.2 Labelling the Request Form

6.2.1 Specimens will not be processed by the laboratory without an appropriate request form.

6.2.2 Laboratories require a minimum data set before a specimen can be registered to ensure safe and accurate retrieval of data. It is the requesting clinician's responsibility to enter these details **legibly** on the appropriate form.

6.2.3 In certain special situations, e.g. where patient anonymity must be protected, there are agreed protocols for specific investigations which do not require patient names.

6.2.4 In an emergency situation where the identity of the patient cannot be established or Patient Management Systems (PMS) are not working, the requesting clinician must notify the laboratory in order that temporary arrangements can be made, in compliance with the agreed protocol.

6.2.5 Minimum Data Set (excluding Blood Transfusion samples)

An addressograph label should be used whenever possible**.**
The following information is essential for patient identification:

1. Patient's NHS number and/or hospital number, AND
2. Patient's name (surname and first name – not initial), AND EITHER
3. Patient's address (minimum first line), including postcode, if known, OR[1]
4. Patient's date of birth

[1]If the patient is from a communal address, the date of birth is required

6.2.6 The following is essential for prompt and accurate reporting and to comply with Right First Time:

5. Clinician's Initial and Surname with overall responsibility for the patient (usually a Consultant or GP)
6. Ward / Department and Hospital, or other address to which the report should be sent
7. Relevant clinical information

6.2.7 The following information is required for scientific and clinical interpretation:

8. Date and time specimen **taken** (NOT when requested)
9. Patient's gender.

6.2.8 The following Information is required to contact the requestor (e.g. for critical results or in the event of problems with the sample):

10. Legible name and extension/bleep number of requesting clinician

6.3 Addressograph Labels

Addressographs must only be used for specimens taken from the person whose details are on them. They **must not** be modified or altered for use for other people's specimens, e.g. partners or siblings. The only exception to this is for certain requests regarding fetuses, when the mother's addressograph may be used with the fetal origin of the specimen clearly stated.

6.4 Labelling the Specimen Container

Each specimen container (**NOT** the lid or cap) must be labelled **by the person taking the specimen** with:

1. Patient's name (surname and first name – not initial)
2. Patient's date of birth
3. Patient's hospital number or NHS number (if available)

In addition it is desirable for the time and date the sample was collected to be annotated.

An addressograph is the preferred method of labelling in all areas of the laboratory service **except the blood transfusion laboratory** where hand-written details are required.

6.5 Recording the Collection of Specimens

When a blood sample is taken the date and time of collection and the name of the person who took the sample should be entered into the appropriate places on the request form. This information is important for ensuring the suitability of samples for analysis and appropriate interpretation of data. It is also useful in the event of enquiries about sample collection.

6.6 Biohazard Specimens

For specimens from patients who are known or suspected to be infected with a Hazard Group (HG) 3 agent (primarily blood-borne viruses) the container (and ideally the request form also) **must** be clearly identified with a yellow hazard 'danger of infection' warning sticker. This policy acknowledges the requirements to maintain patient confidentiality in addition to inform and protect staff, Appendix 1 provides a detailed literature review of the current guidance. Appendix 2 provides a detailed list of biological agents where there is a legal requirement for additional or enhanced precautions above Containment Level (CL) 2 and biological agent which pose a danger to an unborn child. If the referring clinician refers a sample which is suspected or known to contain a non-derogated HG 3 organisms or a biological agent

which poses a danger to an unborn child (appendix 2) then this must be clearly labelled with a 'danger of infection' sticker so that the laboratories can handle the samples safely. Although COSHH sets out the minimum requirements for each level of containment, certain HG3 agents can be worked with under reduced containment in particular circumstances.

N.B. hazard group 4 agents can only be handled by specialist laboratories.

All infectious or potentially infectious samples should also be double bagged. For samples other than blood, all UHB Procedures (especially UHB 149 Standard Infection Control Precautions Procedure) and National Guidelines relevant to the infectious agent (e.g. MRSA, TSE) should be followed. If in doubt, guidance should be sought from the laboratories or Infection Prevention and Control Team before taking samples. Failure to identify hazardous specimens is a breach of the duty of care under Health and Safety legislation. Patient confidentiality should be preserved by ensuring that the identity of patients is kept confidential in its packaging while being transported to the laboratory.

Forms and sample containers must be kept separated and **not** placed into the same plastic bag/compartment.

6.7 Procedure for Handling Inappropriately Labelled Specimens

(For definitions see 6 above)

6.7.1 Feedback to Requestors

A member of laboratory staff will attempt to contact the requesting clinician when practicable, and/or a report will be sent requesting a repeat sample.

6.7.2 Unlabelled Specimens

All unlabelled specimens will need to be retaken. Only rarely will exceptions be made when retaking is not a **reasonable** option, there are compelling clinical reasons, and there is clear evidence of patient identity. Such a specimen will need to have the patient's identity confirmed by the person responsible for collecting the specimen and that person will have to sign a laboratory record confirming this, thereby accepting responsibility for the identity of the specimen. A comment will be added to the Laboratory Information Management System (LIMS) to acknowledge the labelling error and any potential authorisation from clinician to proceed to analysis.

6.7.3 Mislabelled Specimens

All specimens with different patient's details on the request form and the container, will have to be retaken. Only rarely will exceptions be made when retaking is not a **reasonable** option, there are compelling clinical reasons, and there is clear evidence of patient identity. Such a specimen will need to have the patient's identity confirmed by the person responsible for collecting the specimen and that person will have to sign a laboratory record confirming this, thereby accepting responsibility for the identity of the specimen. A comment will be added to the Laboratory Information Management System (LIMS) to acknowledge the labelling error and any potential authorisation from clinician to proceed to analysis.

6.7.4 Inadequately Labelled Specimens

Where specimen labelling falls short of the full requirements of patient identification, initial and surname of Medical Practitioner, location and clinical details, samples will not be analysed, except, at the discretion of the laboratory, when:

- repeat sampling is not feasible, and
- not analysing could seriously compromise patient care (e.g. unrepeatable samples, such as CSF), and
- patient identity can reasonably certainly be deduced.

A member of laboratory staff will attempt to inform the requesting clinician either by telephone or report (if that person can be identified from the form) and:

- If there is an overriding clinical reason for processing the specimen, offer the opportunity to come to the laboratory and complete the labelling. The person completing or correcting the labelling must be the person who took the specimen, must be able to satisfy themselves of the identity of the specimen and must sign a laboratory record confirming this, thus accepting responsibility for the identity of the specimen.
- Inform the clinician that if this is not done within one day (or shorter period if the analyte is less stable), the specimen may be discarded. Cellular pathology specimens may be retained unprocessed for a limited period.
- Keep the specimen in a designated place for the agreed period of time.
- If specimens have to be discarded (or retained unprocessed for longer than one day) a record will be made in the laboratory computer system and an appropriate notification made to the requesting ward/department/practice.

A similar procedure will apply to all specimens that have been received in the laboratory for which, during processing, a member of the laboratory staff has good reason to doubt the identity of the specimen. A comment

will be added to the Laboratory Information Management System (LIMS) to acknowledge the labelling error and any potential authorisation from clinician to proceed to analysis.

6.7.5 Recording of Labelling Incidents

The laboratory will keep a record of all inappropriately labelled specimens. This record will include:

- precise details of the inappropriate labelling
- the name and address of the patient
- the name of the requesting clinician
- the ward, unit, or practice
- Consultant in charge of the case where possible

Where the laboratory agrees to analyse an inadequately labelled specimen, the name and department/section of the person taking responsibility for the specimen will also be recorded.

Labelling incidents that result in (near) patient harm will be treated as clinical incidents and dealt with according to the UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure.

When repeated labelling incidents can be identified as originating from a single Unit or Practice, an appropriate Consultant, General Practitioner or Practice Manager will be informed.

7.0 Resources

No resources are being made available specifically in response to the revision of this policy. The procedures described are already best practice in the UHB. This revision represents a more rigorous application of those practices, and decreased tolerance of substandard practice in the interest of patient safety. Some re-sampling of patients is anticipated.

8.0 Staff Training and Education

All new medical practitioners and other health care professionals should be made aware of local guidance and the importance of correct patient and sample identification. It is the responsibility of Clinical Boards to ensure that staff have access to appropriate training, and observe all UHB Policies and Procedures. Training of new medical practitioners and other health care professionals in laboratory usage should continue at induction. No facilities for any additional formal training required as a result of this policy will be available.

9.0 Review

This policy will be reviewed at least every 3 years and more frequently if any developments or changes in practice inform the Health Board otherwise.

10.0 Monitoring and Audit

The quality of information supplied with specimens will be audited regularly as part of the Laboratory Medicine internal audit programme and results reported to the Clinical Board Quality Safety and Experience Group.

11.0 Distribution

This policy will be available for viewing via the UHB share point pages.

12.0 Equality

An equality impact assessment has been undertaken to assess the relevance of this policy to equality and potential impact on different groups, specifically in relation to the General Duty of the Race Relations (Amendment) Act 2000 and the Disability Discrimination Act 2005 and including other equality legislation. The assessment identified that the policy presents a positive impact as all patients and colleagues will be treated equally under this policy.

Appendix 1 High risk labelling policy: Literature review

The Health and Safety Executive's (HSE) "*Approved List of Biological Agents*" states as a fundamental principle of good laboratory safety systems that:

> *"where there is a high risk of staff exposure to a hazard group 3 biological agent, laboratory staff may need additional information."*

The HSE builds on this advice in their *"Safe working and the prevention of infection in clinical laboratories and similar facilities"* guidance by suggesting that:

> *"The most common method of providing information on specimens known or suspected of posing a risk of infection is to use a 'danger of infection' label. Use of a standard label for all such specimens coming into the laboratory reduces scope for confusion. Reception staff need to send specimens bearing a danger of infection label directly to the appropriate laboratory department, unopened"*

This is a legal requirement. This is further supported by another legal requirement imposed by the Control of Substances Hazardous to Health Regulations (2002) (COSHH) to record exposure to Hazard Group (HG) 3 or HG 4 organisms:

> "Under COSHH employers must keep details about employees exposed to hazard group 3 or 4 biological agents, where there is a deliberate intention to work with or use the group 3 or 4 agent or, in the case of an incidental exposure, a risk assessment shows there is a significant risk. Employees should be considered as having been exposed unless exposure has been prevented, and not merely controlled. The details recorded should include:
>
> - the type of work the employee does;
> - the biological agents to which they have been exposed (where this is known);
> - records of accidents and incidents involving exposure to the biological agents concerned.
>
> These details should be kept for at least 10 years after the last known exposure, except in the case of certain exposures which may give rise to infections with longer-term implications, where they should be kept for 40 years."

Management of Health and Safety at Work Regulations 1999 (MHSW) also establishes the requirement to manage infection risks to new and expectant mothers in the workplace. Specific pathogens require the employer to make suitable adjustments to protect new and expectant mothers in pathology laboratories:

- Chlamydia psittaci
- Cytomegalovirus

Appendix 1 High risk labelling policy: Literature review

- Hepatitis A
- Hepatitis B
- Human immunodeficiency viruses
- Listeria
- Parvovirus
- Rubella
- Toxoplasma
- Varicella-zoster (chickenpox)

Advisory Committee on Dangerous Pathogens (ACDP) Guidance "INFECTION RISKS to new and expectant mothers in the workplace" also lists a range of microbes cause infections in the human population and may also infect pregnant women. These may or may not have an adverse effect on the baby

- Borrelia burgdorferi (Lyme disease);
- Coxiella burnetii (Q fever);
- Campylobacter spp. and Salmonella spp (gastroenteritis);
- Lymphocytic choriomeningitis virus (LCM),
- Mycobacterium tuberculosis (TB),
- Treponema pallidum (syphilis)

Accidents or incidents which result in or could result in the release or escape of a biological agent likely to cause severe human disease, i.e. a HG3 or HG4 agent (defined as a dangerous occurrence) also have to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR).

Therefore samples which are known, or suspected to contain HG 3 or HG 4 organisms must be labelled as such to allow employers to comply with the legal requirement established by a number of statutory implements.

It is anticipated that the revised General Medical Council (GMC) guidance "Confidentiality: good practice in handling patient information" read in conjunction with "Confidentiality: disclosing information about serious communicable diseases" will provide the following advice:

> *"If a patient who has been diagnosed with a serious communicable disease refuses to allow you to tell others providing their care about their infection status, and you believe that failing to disclose the information will put healthcare workers or other patients at risk of infection, you should explain to the patient the potential consequences of their decision and consider with the patient whether any compromise can be reached.*
>
> *Like everyone else, healthcare workers are entitled to protection from risks of serious harm. But disclosure of information about a patient's infection status without consent is unlikely to be justified if it would make no difference to the risk of transmission – for example, if the risk is likely to be managed through the use of universal precautions that*

> *are already in place. If the patient continues to refuse to allow you to tell other members of the healthcare team about their infection status, you must abide by their wishes unless you consider that disclosing the information is necessary to protect healthcare workers or other patients from a risk of death or serious harm."*
>
> *"If it is not practicable to seek consent, and in exceptional cases where a patient has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential.*
>
> *If you consider that failure to disclose the information would leave individuals or society exposed to a risk so serious that it outweighs patients' and the public interest in maintaining confidentiality, you should disclose relevant information promptly to an appropriate person or authority. You should inform the patient before disclosing the information, if it is practicable and safe to do so, even if you intend to disclose without their consent."*

The overarching legal principle contained within this guidance is that you must disclose information if it is necessary to protect healthcare workers or other patients from a risk of death or serious harm. Safety considerations always takes primacy over information governance. This requirement is explicitly laid out in COSSH and HSE guidance *"Safe working and the prevention of infection in clinical laboratories and similar facilities".*

In the context of the GMC guidance universal precautions, otherwise known as standard infection control precautions, are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents. The HSE clarify the standing of the term 'universal precautions' in their document *"Safe working and the prevention of infection in clinical laboratories and similar facilities"*:

> *"The use of the term 'universal precautions' is not helpful with regard to the*
> *measures needed for handling biological agents, as it is not clearly defined.*
> *Adopting universal precautions may result in a standard of practice which is not high enough. The precautions needed must be based on an assessment of the risks involved, which may be influenced by several factors, such as the biological agents known or suspected to be present and the type of work being carried out."*

Universal precautions in the context of pathology facilities would be dependent on the containment level of the laboratory. Therefore any sample

known or suspected to contain HG 3 or HG 4 organisms cannot be handled with the universal precautions deployed at CL2.

The HSE's "Approved List of Biological Agents" states that:

> *"working with HG 2 biological agents requires a minimum of Containment Level CL 2; HG3 agents being handled at a minimum of CL3"*
>
> *"CL3 or CL4 must be used, where appropriate, if the employer knows or suspects that such a containment level is necessary even if there is no intention to deliberately propagate and concentrate biological agents"*

Therefore there is a legal requirement for additional or enhanced precautions above CL 2 if the laboratory is referred a sample which is suspected or known to contain a non-derogated HG 3 organisms (appendix 2).

Although COSHH sets out the minimum requirements for each level of containment, certain HG3 agents can be worked with under reduced containment in particular circumstances. In order to be able to do this the employer must follow the relevant ACDP guidance agreed or approved by the Health and Safety Commission (HSC). The HG3 agents eligible for reduced containment are listed in the latest edition of the HSC's "*Approved list of biological agents".* In the Approved List, the agents for which this is relevant are indicated in the hazard group column with an asterisk (*) and are listed in Appendix 2. These are known as derogated organisms.

Derogation from CL3 does not imply that the work can be carried out at CL2, it simply allows certain physical containment requirements, normally expected at CL3, to be dispensed with. All other aspects of the work, in particular supervision and training, should reflect the high standards expected at CL3. Any decision to reduce containment measures should be made on the basis of a local risk assessment which takes into account the specific nature of the work.

Appendix 2

Biological Agent	Human Pathogen Hazard Group	Notes
BACTERIA		
Bacillus anthracis	3	Classified under Specified Animal Pathogens Order (SAPO)
Brucella abortus	3	Classified under SAPO Danger to unborn child
Brucella canis	3	Classified under SAPO
Brucella melitensis	3	Classified under SAPO
Brucella suis	3	Classified under SAPO
Burkholderia mallei (formerly Pseudomonas mallei)	3	Classified under SAPO
Burkholderia pseudomallei (formerly Pseudomonas pseudomallei)	3	
Chlamydophila psittaci (avian strains)	3	Danger to unborn child
Chlamydophila trachomatis	2	Danger to unborn child
Coxiella burnetti	3	
Escherichia coli, verocytotoxigenic strains (eg O157:H7 or O103)	3*	Toxigenic
Francisella tularensis (Type A)	3	
Listeria monocytogenes	2	Danger to unborn child
Mycobacterium africanum	3	
Mycobacterium bovis	3	
Mycobacterium leprae	3	
Mycobacterium malmoense	3	
Mycobacterium microti	3*	
Mycobacterium szulgai	3	
Mycobacterium tuberculosis	3	Danger to unborn child
Mycobacterium ulcerans	3*	
Rickettsia akari	3*	
Rickettsia canada	3*	
Rickettsia conorii	3	
Rickettsia montana	3*	
Rickettsia prowazekii	3	
Rickettsia rickettsii	3	
Rickettsia sennetsu (Ehrlichia sennetsu)	3	
Rickettsia spp	3	
Rickettsia tsutsugamushi	3	
Rickettsia typhi (Rickettsia mooseri)	3	
Salmonella paratyphi A	3*	
Salmonella paratyphi B/java	3*	
Salmonella paratyphi C/Choleraesuis	3*	

Appendix 2.

Biological Agent	Human Pathogen Hazard Group	Notes
BACTERIA (continued)		
Salmonella typhi	3*	
Shigella dysenteriae (Type 1)	3*	Toxigenic
Treponema pallidum (syphilis)	2	Danger to unborn child
Yersinia pestis	3	
FUNGI		
Blastomyces dermatitidis (Ajellomyces dermatitidis)	3	
Cladophialophora bantiana (formerly Xylohypha bantiana, Cladosporium bantianum)	3	
Coccidioides immitis	3	Allergen
Coccidioides posadasii	3	Allergen
Histoplasma capsulatum var capsulatum (Ajellomyces capsulatus)	3	
Histoplasma capsulatum var duboisii	3	
Histoplasma capsulatum var farcinimosum	3	
Paracoccidioides brasiliensis	3	
Penicillium marneffei	3	Allergen
Rhinocladiella mackenziei (formerly Ramichloridium)	3	
HELMINTHS		
Echinococcus granulosus	3*	
Echinococcus multilocularis	3*	
Echinococcus vogeli	3*	
Taenia solium	3*	
PROTOZOA		
Leishmania brasiliensis	3*	
Leishmania donovani	3*	
Naegleria fowleri	3	
Plasmodium falciparum (malaria)	3*	
Toxoplasma gondii	2	Danger to unborn child
Trypanosoma brucei rhodesiense	3*	
PRIONS - unconventional agents associated with transmissible spongiform encephalopathies (TSEs)		
Sporadic Creutzfeldt-Jakob disease agent	3*	Restrictions on post mortem examinations
Sporadic fatal insomnia agent	3*	Restrictions on post mortem examinations
Variably protease-resistant prionopathy agent	3*	Restrictions on post mortem examinations
Familial Creutzfeldt-Jakob disease agent	3*	Restrictions on post mortem examinations

Appendix 2.

Biological Agent	Human Pathogen Hazard Group	Notes
PRIONS - unconventional agents associated with transmissible spongiform encephalopathies (TSEs) (continued)		
Fatal familial insomnia agent	3*	Restrictions on post mortem examinations
Gerstmann-Sträussler-Scheinker syndrome agent	3*	Restrictions on post mortem examinations
Variant Creutzfeldt-Jakob disease agent	3*	Restrictions on post mortem examinations
Iatrogenic Creutzfeldt-Jakob disease agent	3*	Restrictions on post mortem examinations
Kuru agent	3*	Restrictions on post mortem examinations
VIRUSES		
Absettarov virus	3	Strain of Central European tick-borne encephalitis virus (Far Esatern subgroup)
Alkhurma haemorrhagic fever virus	3	Subspecies of Kyasanur Forest disaes virsu
Andes virus	3	
Australian bat lyssavirus	3	Classified under SAPO
B virus (Macacine herpesvirus 1)	4	
Banna virus	3	
Belgrade (Dobrava) virus	3	
Bhanja virus	3	
Borna disease virus	3	
Bundibugyo ebolavirus 4	4	
Bunyavirus germiston	3	Synonym: Germiston virus Subspecies of Bunyamwera virus
Central European tick-borne encephalitis virus	3	
Chapare virus	4	
Chikungunya virus	3*	
Crimean/Congo haemorrhagic fever virus	4	
Dengue viruses types 1–4	3	
Duvenhage virus	3	Classified under SAPO
Eastern equine encephalomyelitis encephalitis virus	3	Classified under SAPO
European bat lyssaviruses 1 and 2	3	Classified under SAPO
Everglades virus	3*	
Far Eastern tick-borne encephalitis virus (Russian spring–summer encephalitis virus)	4	
Flexal virus	3	

Appendix 2.

Biological Agent	Human Pathogen Hazard Group	Notes
VIRUSES		
Getah virus	3	
Guanarito virus	4	
Hantaan virus (Korean haemorrhagic fever)	3	
Hanzalova virus	3	
Hendra virus (formerly equine morbillivirus)	4	Classified under SAPO
Hepatitis B virus	3*	Danger to unborn child
Hepatitis C virus	3*	Danger to unborn child
Hepatitis D virus (delta)	3*	Synonym: Deltavirus Hepatitis delta virus Danger to unborn child
Hepatitis E virus	3*	Danger to unborn child
Herpesvirus simiae	4	
Human cytomegalovirus (Human herpsevirus 5)	2	Danger to unborn child
Human herpes simplex viruses 1 and 2	2	Danger to unborn child
Human immunodeficiency viruses	3*	Danger to unborn child
Human parvovirus 4, 5, B19	2	Danger to unborn child
Human pegivirus	3*	Formerly known as GB virus C; or Hepatitis G virus Danger to unborn child
Hypr virus	3	
Israel turkey meningitis meningoencephalomyelitis virus	3	
Japanese encephalitis virus	3	Classified under SAPO
Junin virus	4	
Kumlinge virus	3	
Kyasanur Forest disease virus	4	
La Crosse virus	3	Subspecies of California encephalitis virus
Lagos bat virus	3	Classified under SAPO
Lassa fever virus	4	
Louping ill virus	3*	
Lujo virus	4	
Lymphocytic choriomeningitis virus LCMV (all strains other than Armstrong)	3	
Machupo virus	4	
Marburg marburgvirus	4	
Mayaro virus	3	
Measles virus	2	Danger to unborn child
Middelburg virus	3	
Mobala virus	3	
Mokola virus	3	Classified under SAPO
Monkeypox virus	3	
Mucambo virus	3*	
Mumps virus	2	Danger to unborn child

Appendix 2.

Biological Agent	Human Pathogen Hazard Group	Notes
VIRUSES		
Murray Valley encephalitis virus	3	
Ndumu virus	3	
Negishi virus	3	
Ngari virus	3	Subspecies of Bunyamwera virus
Nipah virus	4	Classified under SAPO
Omsk haemorrhagic fever virus	4	
Oropouche virus	3	
Piry virus	3	
Powassan virus	3	
Primate T-cell lymphotropic viruses types 1 and 2	3*	Synonyms: Human T-cell lymphotropic viruses (HTLV) types 1 and 2
Rabies virus	3*	
Reston ebolavirus 4	4	Includes strain Siena
Rift Valley fever virus	3	Classified under SAPO
Rocio virus	3	
Rubella virus	2	Danger to unborn child
Sabia virus	4	
Sagiyama virus	3	Subspecies of Ross River virus
Sal Vieja virus	3	
San Perlita virus	3	
SARS-related coronavirus	3	
Seoul virus	3	
Severe fever with thrombocytopoenia syndrome virus (SFTS)	3	
Siberian tick-borne encephalitis virus	3	
Simian immunodeficiency virus	3*	
Sin Nombre virus (formerly MuertoCanyon)	3	
Snowshoe hare virus	3	Subspecies of California encephalitis virus
Spondweni virus	3	Subspecies of Zika virus
St Louis encephalitis virus	3	Classified under SAPO
Sudan ebolavirus 4	4	
Tai Forest ebolavirus 4	4	Previously known as Ebola Cote d'Ivoire virus
Tick-borne encephalitis virus	3	
Tonate virus	3*	
Variola virus (major and minor)	4	All strains including Whitepox virus
Venezuelan equine encephalitis virus	3	Classified under SAPO
Wesselsbron virus	3*	
West Nile fever virus	3	Classified under SAPO
Western equine encephalitis virus	3	Classified under SAPO
Yellow fever virus	3	
Zika virus	3	See Spondweni virus

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National Patient Safety Agency (NPSA) Safer Practice Notice (SPN) 14; Right Patient, Right Blood 2006

Public Health Wales information regarding service provision (e.g. microbiology, virology, gynaecology cytology) to C&V via a Service Level Agreement can be sought from -
http://www.publichealthwales.wales.nhs.uk/

RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013), No. 1471.

Equality & Health Impact Assessment for

Labelling of Specimens Submitted to Medical Laboratories

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

1	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	No proposed change to Laboratory Medicine Service delivery. Document reviewed to provide clarity on sample labelling acceptance criteria and actions in the event of non-conformance with the policy.
2	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Clinical Diagnostics and Therapeutics Clinical Board Director Dr Adam Christian Interim Director of Nursing and Multi-disciplinary Teams Helen Luton
3	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure that robust arrangements are in place to ensure that samples taken for laboratory analysis or storage can be accurately and unambiguously identified, and that all necessary information is supplied for appropriate and timely analysis, interpretation and reporting. In addition, any issues arising from the non-conformance with this policy will be reported via UHB 138 Incident, Hazard and Near Miss Reporting Policy and Procedure to establish the root-cause of the issue to avoid recurrence.
4	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings	Cardiff and Vale University Health Board (UHB) is one of the largest NHS organisations in the UK, providing healthcare services for 475,000 people living in Cardiff and the Vale of Glamorgan. There are currently approximately 558 staff employed within Laboratory Medicine that are involved in the collection, processing, testing, storage, reporting or management of patient specimens from both internal or external sources. On an average day we carry out 13,715 blood tests.

	• research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	There are many papers that present the importance of accurate patient identification to the prevention of medical errors and demonstrate improvement after introducing and enforcing sample labelling procedures. Patient Sample and Request Form Identification Criteria - Institute of Biomedical Science (ibms.org) The Laboratory Medicine service has dedicated share point and internet pages that explain the service, the testing repertoire and turn-around times. Laboratory Medicine - Home (sharepoint.com) Laboratory Medicine undertakes engagement with service users via user surveys, responding to compliments and concerns, incident management and service user engagement days.
5	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Service users, patients, staff.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or	Negative, there may be an assumption that a name belongs to a specific gender traditionally but the gender recorded may be opposed to this and the conflict may be seen as an		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	error in the absence of qualifying supporting information.		
6.4 People who are married or who have a civil partner.	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.9 People who communicate using the Welsh language in terms	Policy applied to all samples but for paediatric samples,	Disseminate policy and encourage use of user hand	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	precious samples professional discrepancy can be applied within the appropriate laboratory.	books.	Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
6.12 Consider any other groups and risk factors relevant to this	Policy applied to all samples but for paediatric samples,	Disseminate policy and encourage use of user hand	Mitigation captured in introduction –

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
strategy, policy, plan, procedure and/or service	precious samples professional discrepancy can be applied within the appropriate laboratory.	books.	Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
7.3 People in terms of their income and employment status: Consider the impact on the availability and	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	appropriate laboratory.		and under heading Mislabelled Specimens, Page 11.
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A globally responsible Wales			

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory. Patient identification may be misinterpreted in the case of a transgender patient presenting with opposite gender name and gender recorded on same episode.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Policy applied to all samples but for paediatric samples, precious samples professional discrepancy can be applied within the appropriate laboratory.	Disseminate policy and encourage use of user hand books.	Complete on issuing policy.	Mitigation captured in introduction – Laboratory Medicine Test Knowledge Base and under heading Mislabelled Specimens, Page 11.

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	N/A			
8.4 What are the next steps? Some suggestions:- • Decide whether th strategy, policy, plan, procedure an • d/or service propo ○continues unchanged as there are no significant negative impacts ○adjusts to account for the negative impacts ○continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)	continues unchanged as there are no significant negative impacts			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
○stops. Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review				

Report Title:	Nutrition and Catering Policy and Procedure for Inpatients			Agenda Item no.	3.1.4
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	18.07.2023
		Private			
Status *(please tick one only):*	Assurance		Approval ✓	Information	
Lead Executive:	Fiona Jenkins Executive Director of Therapies and Health Sciences Emma Cooke Deputy Director of Therapies and Health Sciences				
Report Author (Title):	Helen Nicholls UHB Head of Nutrition and Dietetics Joanne Jefford Nutrition and Dietetic Services Manager UHL, Maggie Price Lead Catering Dietitian UHL				

Main Report
Background and current situation:

The Nutrition and Catering procedure sets out the delivery of the Nutrition and Catering policy to ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. The procedure is set out to ensure the Health Board meets the diverse nutrition, hydration and dietary needs of all hospital inpatients.

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

The Nutrition and Catering Policy and the supporting documents describe how the Health Board can meet the diverse nutrition and hydration needs of its inpatients.
The current All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011) are due for a revision to ensure they remain fit for purpose, and are aligned with current nutritional evidence base.
It needs to be highlighted that bringing the nutrient standards in line with current evidence is likely to have cost implications for hospital catering services. Ambitious food quality that optimally meets the nutritional needs of patients, improves patient experience, reduces recovery times, improves clinical outcomes - supporting reduced costs to the NHS through flow, will require a review of funding for patient catering in the future in the near future.

Recommendation:

The Committee is requested to:

a) **Approve** the Nutrition and Catering Policy for Inpatients (UHB 221); and
b) **Approve** the Nutrition and Catering Procedure for Inpatients (UHB 367).

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

This policy is an overarching document which ensures the nutritional needs of all our patients regardless of age, race, gender, or illness, are met, and all patients receive the best possible nutritional care to aid recovery.
The overall impact of this policy is positive in meeting the equality and diversity needs of all patients admitted to hospital.

Safety: No

The Catering IT system has been in use for several years now and has delivered improvements in terms of patient safety, transparency of menus and improved bedside meal choices for patients, and reduction in food waste across the food pathway.

Financial: No

More recent challenges faced by catering services are due to significantly increased provision costs, coupled with supply chain issues, which are a potential risk to quality and patient experience of food, as caterers find it more difficult to source high- quality products on contract, and the increasing cost of provisions may lead to compromise of menu quality or food availability, for example, reduced access to snacks between meals.
There needs to be recognition that bringing the nutrient standards in line with current evidence is likely to have cost implications for hospital catering services.
The cost of living is having severe impact on population health and nutritional status. Therefore, people who change their dietary patterns for economic reasons may present to the health board with a range of nutritionally-related disorders that may complicate in hospital food provision.

Workforce: No

The policy acknowledges the importance of a multi-professional approach to achieving good nutritional care. Many staff and volunteers contribute along the patient food pathway from procurement to plate, and all have an important role to play in the coordinated approach necessary to provide patients with the high-quality meal, snack and beverage services required for both the prevention and treatment of ill health.
Accredited All-Wales Training for Catering and Food Service staff is still in the development stage; it is suggested a revision of the standards identifies the requirement for appropriate training for ward-based caterers, food production staff and those supervising the meal pathway. This is an important factor in achieving the successful delivery of high-quality meal and beverage services to patients

Legal: No

There is ongoing requirement for the Health Board to comply with Food Safety and Food allergen legislation.

Reputational: Yes

The Health Board utilizes agreed All Wales Menu Framework recipes, these are geared toward meeting the nutritional needs of adults with higher energy, fat, sugar and salt tolerances. Infants, children and adolescence have very different nutritional requirements, and very differing tastes. Future catering for the Children's Hospital, and staff nurseries, requires remodeling of the meals and menus to ensure an emphasis is placed on promoting wholesome and healthy foods over and above processed foods, and demonstrates the Health Boards strong positive commitment to the health and nutritional needs of its younger patients and staff's children.

A risk Assessment and SBAR has been prepared for the Women's and Children's Clinical Board with the recommendation to source an external supplier who can provide suitable children's meals

Socio Economic: No

The Nutrition and Catering Policy and procedures seeks to provide strategic intent to ensure all patients, in all clinical areas receive the most appropriate nutrition and hydration care.
Ongoing patient or user feedback is sought to help shape services and reduce any inequalities.

Equality and Health: Yes/No

An Equality Health Impact Assessments (EHIA) has been completed and sent with the Nutrition and Catering Policy
Several actions were identified

- Complete a Risk assessment and SBAR regarding the meal provision to the Children's Hospital and Staff nurseries
- Consider changes in population food preferences over recent years and ensure these are reflected and appropriately addressed within the main patient menu eg plant-based eating
- Present the menus in different ways and in different languages
- Source an increased range of vegan and kosher texture modified meals, and snacks
- Develop and deliver more accessible ward-based catering training

Decarbonisation: No

The revised All Wales Food Standards are likely to consider key government objectives on the Environment, Sustainability and Foundational Economies.
The review of the Standards will consider the value of seasonal menus, including the use of more locally grown foods, less meat but of better quality, increased use of plant-based meals, and use of sustainably sourced UK fish.
In addition, by identifying the importance of reducing the amount of food wasted by the NHS in hospital settings, the Standards will support the Health Board to be more socially responsible and a beacon of good health and good citizenship.

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

Reference Number: UHB 221 **Version Number:** 3.3	**Date of Next Review:** 05.01.2026 **Previous Trust Reference Number:** T259

Nutrition and Catering Policy for Inpatients

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, this policy will ensure that the nutrition and hydration standards set out in the procedure are the focus for all staff involved in the provision of food, fluid or nutrition services, ensuring the Health Board meets the diverse nutrition, hydration and dietary needs of all hospital inpatients.

Policy Commitment

The policy will ensure that the diverse nutrition and hydration needs of its inpatients will be screened, assessed, addressed and met.

Supporting Procedures and Written Control Documents This Policy and the supporting documents describe how the Health Board can meet the diverse nutrition and hydration needs of its inpatients.

Other supporting documents are:

- Cardiff and Vale Nutrition and Catering Procedure for Inpatients (UHB 367 V3.3)
- Insertion of a Nasogastric Tube, Confirmation of Correct Position and Ongoing Care in Adults, Children and Infants and Neonates Procedure (UHB 114)
- Insertion, management and removal of the nasal bridle fixation device for naso-enteral tubes in adults procedure (UHB 067)
- All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011) http://www.hospitalcaterers.org/media/1158/wales-food-fluid.pdf
- Health and Care Standard 2.5 Nutrition and Hydration http://www.wales.nhs.uk/governance-emanual/standard-2-5-nutrition-and-hydration
- NICE (2012) Quality standard 24 Nutritional Support in Adults Overview | Nutrition support in adults | Quality standards | NICE Hydration tool kit Health in Wales | New toolkit encourages good hydration for hospital patients
- BDA Digest NutritionHydrationDigest.pdf (bda.uk.com)
- English Nutritional standards for healthcare food and drink NHS England » National standards for healthcare food and drink
- NHS Wales Estates and Facilities Alert Food Allergens January 2020
- BDA Practice Toolkit – Blended diets with enteral feeding tubes November 2021 Contents (bda.uk.com)

Scope
This policy applies to all of our staff in all locations including those with honorary contracts.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and is found to have a positive impact. Key actions have been identified and these can be found within this supporting EHIA document.

Policy Approved by	Quality Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	UHB Nutrition and Catering Steering Committee
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Sciences or Deputy Director of Therapies and Health Sciences

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	01/03/2014	24/04/2014	New document to replace policy of Health Board. Policy revised in line with new Welsh Government Policy Guidance 2011 and National and Professional documents
2	01/09/2016		Updated and reviewed policy in line with University Health Board changes, Welsh Government and Professional standards
3	12/09/2017	3/11/17	Updated to reflect new practice and to split the existing policy and procedure into two separate documents
3.1	15/5/2018	15/5/18	Governance Department administrative update. No changes following update of NG Tube procedure (UHB 114) other than a change in the title of that supporting procedure and electronic links inserted into associated documents.

			Action agreed by Director of Therapies and Health Sciences.
3.2			Review date. No changes following the update of bridal procedure (UHB 067)
3.3	TBC	TBC	Update of policy and procedure

Equality & Health Impact Assessment for

Cardiff and Vale UHB Nutrition and Catering Policy and Procedure for Inpatients

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Cardiff and Vale UHB Nutrition and Catering Policy for Inpatients UHB 221 and Supporting Procedure UHB 367
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Nutrition and Catering Steering Group chaired by the Executive Director of Therapies and Health Sciences or Deputy Director of Therapies and Health Sciences
3.	Objectives of strategy/ policy/ plan/ procedure/ service	Implementation of this policy will ensure that the nutrition and hydration standards are the focus of all staff involved in the provision of food, fluid or nutritional services, and the diverse needs of all hospital patients are met.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages	The WHO asserts that the global food price crisis threatens public health and jeopardizes the health of the most disadvantaged groups such as women, children, the elderly and low-income families. Economic factors play a crucial role and could affect personal nutrition status and health. Economic decision factors such as food price and income do influence people's food choices. Moreover, food costs are a barrier for low income-families to healthier food choices. Several studies indicate that diet costs are associated with dietary quality and also food safety. Food prices have surged over the past couple of years and raised serious concerns about food security around the world. Rising food prices are having severe impacts on population health and nutritional status. Therefore, people who change their diet pattern for economic reasons may develop a range of nutritionally-related disorders and diseases, from so-called over-nutrition to or with under-nutrition even within the one household. This is likely to increase with growing food insecurity.UK

	Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	adults say that the cost of living crisis is having a negative impact on their mental health, such as leaving them feeling anxious, depressed or hopeless. 1 in 5 UK adults (21%) say they have felt "unable to cope" due to the rising cost of living further negatively compounding physical and nutritional health. The population of Cardiff and Vale is growing and diversifying rapidly, higher than the average seen across Wales, with a consequence of higher demand for health and wellbeing services. Climate change can directly impact our economy, livelihoods and health. Supply and disruptions caused by extreme weather events can cascade across regions and sectors, resulting in job and income losses and impacts on food availability and nutritional health. Climate change will impact on food availability and nutrient availability affecting the health of the Cardiff and Vale population. Supply chain issues and food prices are likely to have a knock on effect to the pricing and availability of patient and visitor food options. People are living longer, with the over 65 years forming approximately 25% of the inpatient population. Over half of these will have one or more chronic conditions. The population of Cardiff and Vale is predicted to increase rapidly over the next 10 years, with the 85 years and over growing faster than any other part of the population. These over 85's are likely to become increasingly frailer with multiple co morbidities, cognition issues (inc dementia), with complex physical and social care needs, and subsequent increasing LOS (lengths of hospital stay) The ethnic diversity of Cardiff and Vale is also growing, with over 94 different languages spoken, inc English, Welsh, Arabic, Polish, Chinese and Bengali, all with diverse religious and cultural dietary needs and preferences. 1 in 10 people in Wales report long term health problems or disabilities, and with life expectancies increasing due to ongoing advances in medical science, it poses a greater challenge for the Health Board to meet patient's nutritional and dietary needs. In Wales the prevalence of malnutrition in hospitals in 1 in 4 adults (26%) Wales having the greater prevalence than England. The Risk of malnutrition

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		increases significantly with age and patients have a 3-fold greater risk of complications following surgery, require more medications and a higher risk of mortality compared to the well-nourished. Challenges are also faced by unhealthy life styles such as respiratory disorders from smoking, obesity and diabetes, alongside alcohol and drug, and social and economic deprivation. The public have been made aware that the care of older patients within care settings, have been suboptimal, through the Francis and Andrews reports, where the most basic elements of care was neglected such as nutrition and hydration, the Health Board has a duty of care to ensure the needs of all patients within Cardiff and Vale receive the best nutrition and hydration care that meets their specific needs. The policy document is an overarching document which must be considered in meeting the standards specified in the 'All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients', the All Wales Nutritional Care Pathway and Health and Care standards 2.5 Nutrition and Hydration. The policy has been written with assistance and involvement from the above staff groups via the Nutrition and Catering Steering Group and/or work streams as appropriate. Patient feedback is sought via, regular All Wales Patient Mealtime surveys, annual Health and Care monitoring, meal time service audits, HIW inspections Community Health Council surveys and patient stories. Patient representatives from the Community Health Council form part of the nutrition and catering working groups.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	To ensure the effective delivery of good nutrition and hydration in a hospital setting a team approach is absolutely essential. Procurement, Catering management, Production staff, Ward based catering staff, Dietitians, Medical and Nursing staff and Therapies such as Speech and Language therapy, Occupational Therapy and Physiotherapy all have an important role to play in achieving this policy.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	All patients will be nutritional risk screened on admission to hospital, and their needs addressed. Suitable menu items are provided for all client groups from babies to the elderly. Specific or targeted menus include Texture modified menus, Children's menus, Maternity menus, Adult Mental Health, Mental Health for the Older Person menus and longer stay Neuro rehabilitation. As best as possible menus have been reviewed and amended to meet the needs of different patient groups and lengths of stay	Ongoing patient feedback is sought to support menu development. Bespoke children's menu that caters for their specific nutritional needs	The catering IT system will enable us to identify popular and slow-moving dishes in real time and help support timely changes to the menus when required. Currently developing a business case children's specific meal

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes Saunders,Nathan 18/07/2023 09:30:09	Menus are designed to meet the needs of patients with specific disabilities such as swallowing problems, diabetes, dexterity issues, and self-feeding issues. Targeted menus are available e.g. texture modified menus and finger food menus. There are areas where social dining is encouraged to support the communication and nutritional needs of vulnerable patients. All patients have access to coloured crockery with a unique design which creates greater opportunity for independence in eating and drinking. The Nutrition & Hydration bed plan is available to assist the identification of patient's physical needs in relation to eating and drinking. Certain patients, such as patients with mental health issues, patients with swallowing	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for these groups of patients. There needs to be increased access to adapted cutlery for patients with self-feeding and dexterity issues across the Health Board	The Health Board dietitians are actively involved in the procurement of food items that can be used to increase the range and variety of foods/meals that meet patient's specific needs and meet the food and fluid standards. Patients with communication difficulties will need to have their menus in appropriate forms e.g. pictorial menus may be used so that they will be accessible to more people. The electronic point of choice system will enable patients to see what they are choosing. Work is ongoing to develop a portfolio of images to upload to the system. Ongoing patient feedback is used to provide information to make any relevant menu changes

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	disabilities or dementia may be negatively affected due to their extended length of stay, and the limited number of menu choices can result in menu fatigue. Snack items are also limited for this category of patients. Availability of adapted cutlery is limited.	Work is ongoing at an All Wales level to source an increased range of snacks to meet the differing needs of our patients.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There is no evidence to suggest that the policy impacts adversely on patients who have or are undergoing gender reassignment. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well-being of each	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to make any relevant menu changes

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	patient regardless of background.		
6.4 People who are married or who have a civil partner.	There is no evidence to suggest that the policy impacts adversely on patients who are married or in a civil partnership. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well-being of each patient regardless of background.	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to make any relevant menu changes
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There is a maternity specific menu for patients who have very different needs compared to the main hospital population. The menu reflects the high	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to make any relevant menu changes

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	ethnic diversity of the Cardiff and Vale population.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The menu reflects the high ethnic diversity of the Cardiff and Vale population. An increased range of Halal, Kosher, vegetarian and vegan choices are now available. We are aware that the needs of some smaller ethnic groups in Cardiff are not fully met within the UHB menus. We currently do not have menus available in the other languages of our diverse population. The Nutrition & Hydration bed plan is available to assist the identification of patient's cultural or religious needs in relation to eating and drinking. Cardiff and Vale has a legal duty of care to all its patients as does each professional	There needs to be a long-term plan to translate menus into different languages for those patients that require it. There is ongoing work to expand the range of vegetarian and vegan dishes. Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients. There is a portfolio of meal images that are uploaded to the Catering IT system, which will enable informed meals choices for patients with communication difficulties	Pictorial menus will support patients to make informed meals choices. The UHB are currently unable to source Kosher suitable meals in the texture modified diet range. Vegan modified texture meals are available but are very limited and costly. NWSSP as All Wales partners are looking at alternative sources of these products. Ongoing patient feedback is used to provide information to support any relevant menu changes. Work is still required to enable patients to access menus in Welsh, and other languages

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well-being of each patient regardless of background.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	The menu reflects the high ethnic diversity of the Cardiff and Vale population. Increased Halal and Kosher, Vegetarian and Vegan choices are available. The Nutrition & Hydration bed plan is available to assist the identification of patient's specific religious needs in relation to eating and drinking.	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes. The UHB are currently unable to source Kosher suitable meals in the texture modified diet range. Vegan modified texture meals are available but are very limited and costly. NWSSP as All Wales partners are looking at alternative sources of these products.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	There is no evidence to suggest that the policy impacts adversely on patients who are	Ongoing patient feedback must be used to provide information to support any	Ongoing patient feedback is used to provide information to support any relevant menu changes.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)	attracted to people of the opposite or same sex. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well-being of each patient regardless of background.	relevant menu changes if needed for this group of patients.	
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is no evidence to suggest that the policy impacts adversely on patients who speak Welsh. The written menu is not available in Welsh	The written menu should be available in Welsh. Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	There is a long-term plan to translate the UHB menus into Welsh for those patients that request it. Ongoing patient feedback is used to provide information to make any relevant menu changes.
6.10 People according to their income related group:			

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is no evidence to suggest that the policy impacts adversely on patients of differing incomes. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well-being of each patient regardless of background.	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There is no evidence to suggest that the policy impacts adversely on patients depending on where they live. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	to comply with all relevant legislation and consider the nutritional well-being of each patient regardless of background.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	The menu does promote healthy choices where appropriate. A range of menu items including fruit, salads, jacket potatoes, desserts and other lower fat and salt items are included in the menu. We currently comply with the Food and Fluid Healthy eating guidance. The Nutrition & Hydration bed plan is available to assist the identification of patients with particular requirements in relation to eating and drinking. The Catering IT system provides electronic meal ordering devices that provide	Consideration needs to be given to developing specific menus to meet the health and nutritional needs of client groups on these sites. Completion and accuracy of the Nutrition and Hydration Bed plan needs to be tightened up in some clinical areas	Ward based Caterer training includes healthy lifestyle, and how best to meet the needs of patients who are nutritionally well. Ongoing patient feedback is used to provide information to support any relevant menu changes. Ongoing training and education of nursing staff regarding the use of the nutrition and hydration bed plan is required. Raising the awareness of the importance for patient safety in terms of food allergies and intolerances.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	patients with “at the point of choice” information regarding food allergens and diet suitability. This alongside the Nutrition and Hydration bed plan will ensure the right meal gets to the right patient.		

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	There is no evidence to suggest that the policy impacts adversely on patients living in areas of deprivation and/or experiencing health inequalities. Cardiff and Vale has a legal duty of care to all its patients as	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
	does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well-being of each patient regardless of background.		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	The menu does promote healthy choices where appropriate. A range of menu items including fruit, salads, jacket potatoes, desserts and other lower fat and salt items are included in the menu. We currently comply with the Food and Fluid Healthy eating guidance. The Nutrition & Hydration bed plan is available to assist the identification of patients with particular requirements in relation to eating and drinking.	An increased range of healthier meal options have been incorporated into menus for specific areas eg longer stay neuro rehabilitation and adult mental health.	Ward based Caterer training includes healthy lifestyle, and how best to meet the needs of patients who are nutritionally well. Ongoing patient feedback is used to provide information to support any relevant menu changes.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
	The main focus of the menus is to improve patient's nutrition and nutritional health in illness and therefore healthier options can appear to be limited. For those patients wanting additional lifestyle advice and support, the ward teams can refer the patient on to appropriate community advice and support groups.		
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	There is no evidence to suggest that the policy impacts adversely on patients with differing levels of income or employment status. Cardiff and Vale has a legal duty of care to all its patients, as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
	nutritional well-being of each patient, regardless of background.		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales Saunders.Nathan 18/07/2023 09:30:09	There is no evidence to suggest that the policy impacts adversely on patients in terms of their use of the physical environment. Cardiff and Vale has a legal duty of care to all its patients, as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well-being of each patient, regardless of background etc. Cardiff and Vale UHB has a responsibility to improve health and prevent ill health in the local population, as well as providing	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
	patient care. Predominately healthier snack and meal options are available for purchase by visitors and staff at all of the restaurant and retail outlets across the HB. The Health Board works in partnership with Shared Services regarding the procurement of food items/ingredients for use within staff, visitor and patient catering supports and promotes the use of sustainable foods where possible, with minimal local and global environmental impact, with thought given to the amount of energy and water required to transport, and packaging.		
7.5 People in terms of social and community influences on their health: Consider the impact on family organization and roles; social	There is no evidence to suggest that the policy impacts adversely on patients in terms of	Ongoing patient feedback must be used to provide information to support any	Ongoing patient feedback is used to provide information to support any relevant menu changes.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	their social and community influences. Cardiff and Vale has a legal duty of care to all its patients, as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well-being of each patient, regardless of background.	relevant menu changes if needed for this group of patients.	
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	The Health Board works in partnership with Shared Services regarding the Procurement of food items/ingredients for use within staff, visitor and patient catering supports and promotes the use of sustainable foods where possible, with significant positive local and global environmental impact, with thought given to the	Where possible consideration will be given to sourcing food products as locally as possible and seasonally.	The health Board will continue to work with Shared Services for the procurement of food products that meet the ‘sustainability policy’

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
	amount of energy and water required to transport, and with packaging. The sustainability policy does have financial implications for the Health Board, and it is not always possible to source food items locally, within season, or in sufficient quantities.		

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Cardiff and Vale University Health Board has a legal duty of care to all its patients, as does each profession employed by them. Implicit in this duty of care is the necessity to comply with all the relevant Welsh Government food and fluids standards and relevant legislation, as well as the Welsh Government Health and Care standards relating to nutrition and hydration. This policy considers that all patients admitted to hospital be treated in a consistent and dignified manner irrespective of their religion, age, gender, disability or beliefs. This policy is an overarching document which must be considered in ensuring the nutritional needs of **all** our patients regardless of age, race, gender, or illness, are met, and **all** patients receive the best possible nutritional care to aid recovery. The overall impact of this policy is positive in meeting the equality and diversity needs of all patients admitted to hospital. **Positive impacts** • All patients admitted to the HB are weighed and screened for the risk of malnutrition, with the patient's therapeutic and dietary needs documented (including cultural, ethnic and religious requirements) and communicated to appropriate staff via the nutrition and hydration bed plan. Nursing staff refer patients on for specific therapy input as appropriate. • Menus used within the HB meet the needs of all ages of patients from babies to the very elderly, as best as possible • Specific menus exist to meet patients specific therapeutic, dietary, religious and cultural needs of patients • The menus used promote healthy choices and comply with food and fluid healthy eating guidelines. • Patient feedback is sought and used to drive menu changes as appropriate. • All staff involved in delivering nutritional care and meal services have access to appropriate training. **Areas for improvement**

	• The current menu for the children's hospital does not meet the specific requirements for the different age groups in terms of nutrition, growth and development • The range of texture modified suitable snacks is limited. • A range of vegan and kosher texture modified meals need to be sourced • The range of vegetarian and, especially vegan meals, incorporated into the main menu needs improving. • There needs to be reduced reliance on meat and dairy protein across the menus and more use of plant-based proteins as a health benefit to all patients. • Ability to access menus in Welsh and other languages is not available • Patients access to a physical menu needs to be addressed • The main focus of the menus is to meet the nutritional needs of the nutritionally vulnerable, healthier options can appear limited. • There needs to be increased access to adapted cutlery to help patients remain independent where possible. • Staff uptake of available training relating to nutrition and hydration can be poor. Catering, Dietetics and Nursing need to explore different options and platforms for learning, education and development.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	• To complete a risk assessment of the current provision to the Children's Hospital and assess viability of procurement of child specific meals • To procure an increased range of snacks suitable for the different texture modified diets. • Source a range of vegan and kosher texture modified meals • Increased incorporation of vegetarian and vegan meals into the main menu • Increased reliance on plant-based proteins, and conversely reduced use of meat and dairy protein • Work with Synbiotix to enable presentation of the menus in other languages inc Welsh • Make physical menus more accessible across the Health Board • Review of access to adapted cutlery across the Health Board • Continued compliance with the Food and Fluid Healthy eating guide lines. • Development and delivery of accredited training for ward-based catering and nursing staff that includes basic nutrition, food	ALL BY;- Dietetic and Catering working group and the HB's Nutrition and Catering Steering group	ongoing	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
	hygiene, food safety and customer care.			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No action required, other than the above development work.			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	The identified actions to be achieved in th next year.	Nutrition and Catering working group	Ongoing	

Reference Number: UHB 367 **Version Number:** 1.3	**Date of Next Review:** TBC 2024?? **Previous Trust/LHB Reference Number:** Split from Trust policy T259

Nutrition and Catering Procedure for Inpatients

Introduction and Aim

The Nutrition and Catering procedure sets out the delivery of the Nutrition and Catering policy to ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. This procedure will ensure that the nutrition and hydration standards set out in the document are the focus for all staff involved in the provision of food, fluid or nutrition services, ensuring the Health Board meets the diverse nutrition, hydration and dietary needs of all hospital inpatients.

Objectives

- To identify a service in which nutritional screening, assessment of patient's dietary requirements, hospital food, patient hydration, nutritional support, monitoring, audit and informed redesign of food provision are seen as a vital component of patient care.
- To consider how management, catering, financial, procurement and clinical services might work together to improve the nutritional care of patients by providing a more cost-effective service targeted to patient needs.
- To consider the importance of monitoring and audit leading to modification of procedures in the light of new evidence and experience.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this was found to be positive. Key actions have been identified and are incorporated within this procedure.
Documents to read alongside this Procedure	Nutrition and Catering Policy for Inpatients UHB 259
Approved by	Quality Safety and Experience Committee on…TBC
Accountable Executive or Clinical Board Director	Executive Director of

	Therapies and Health Sciences
Author(s)	UHB Head of Nutrition and Dietetics Nutrition and Dietetic Services Manager UHL, Lead Catering Dietitian UHL

Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	12th September 2017	3.11.17	The procedure has been separated from policy UHB 221
1.1	15th May 2018	15.5.18	Governance Department administrative update. No changes following update of NG Tube procedure (UHB 114) other than a change in the title of that supporting procedure and electronic links inserted into associated documents. Action agreed by Director of Therapies and Health Sciences.
1.2	12th November 2020		Update of NG bridle procedure (UHB 067) Allergy section added (5.1)
1.3	12th November 2020		Food Allergies and Patient Safety
1.4	December 2022		Safe Management of Food Bought in by Visitors and Appendix 4
1.5	December 2022		Standard Operation Procedures for blended diets in adult and paediatric clinical areas

Cardiff and Vale UHB Nutrition and Catering Procedure for Inpatients

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1.0 Introduction

Appropriate nutritional care is vital for all patients who are admitted to hospital as those that receive nutritious appetising food which is safe to eat and meets their therapeutic, religious or special nutritional needs may have shorter hospital stays, fewer post-operative complications and less need for drugs and other interventions This does present a challenge to caterers as the hospital population is varied and the food service will have to meet the needs of all patients from the very young to the very old with differing nutritional requirements due to their physical condition and/or illness.

The Welsh Government clearly recognises the importance of nutrition and catering as an essential component of the care patients receive in Welsh hospitals with the development of a number of initiatives and guidance documents providing the focus for us all. These include the Health and Care Standards for Wales 2015, All Wales Nutrition Care Pathway and the 'All Wales Food/Fluid Record Charts', and the 'The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients'. These have been referenced alongside BDA digest, National food strategy 2022, A Healthier Wales / healthy weight healthy Wales, NHS Wales Estates and Facilities Alert Food Allergens January 2020

A major challenge facing caterers and clinicians is the number of patients entering healthcare facilities in a malnourished state. Many patients who are ill in hospital have poor appetites or a compromised ability to eat, thus potentially exacerbating a malnourished state. McWhirter and Pennington's sentinel work found that 75% of hospital patients assessed to be undernourished on admission lost more weight during their stay. BAPEN reported in 2008 that a number of studies have demonstrated a 20-75% increased length of stay in malnourished compared to non-malnourished patients. Malnourished patients have a threefold greater complication rate during surgery, they require more medication, and their mortality risk is higher than well-nourished patients. The British Association of Parenteral and Enteral Nutrition (BAPEN) estimate that 33.6% of hospital inpatients will be malnourished at any single time during their stay. The cost of malnutrition to both patients and the Health Service cannot be over stated. Data from BAPEN (2008 and 2009) showed that the risk of malnutrition increases significantly with age. Older people are more likely to remain undernourished during their admission, and are more likely to have longer hospital stays.

Children are especially vulnerable to poor nutrition with their extra requirements for growth and development. Changes in their environment are also more likely to affect them than adults. The SACN dietary reference

values 2011 set out what should be considered in terms of energy and nutrition when catering for children and adolescents.

So, whilst there is this group to consider there are also patients who can be classified as 'healthy' individuals and may only be admitted for a short length of time. This will include patients who may be hospitalised due to a minor illness and are 'nutritionally well', maternity patients not experiencing complications, and previously fit healthy people whose illness does not/will not affect their food and fluid intake such as those having minor elective surgery. It would be appropriate for these patients to be provided with a diet that is based on general healthy eating principles.
While the NHS has a responsibility to promote education in healthy eating, it should be remembered that this will represent only a sub section of the hospital population for a relatively short period of time.

A healthy diet for people with diabetes, renal, dyslipidaemia, hypertension or cardiovascular disease is considered an essential part of treatment and maybe beneficial in preventing further co-morbidities.

The healthier options on the patient menu must make provision that maintains a normal nutritional status and meets the target nutrient specification for the hospital menu.

To ensure the effective delivery of good nutrition in a hospital setting a team-based approach is absolutely essential. Caterers, kitchen staff, dietitians, nurses, doctors, speech and language therapists, allied health professionals, ward housekeepers, porters and other healthcare staff all have an important role to play in achieving this policy.

Cardiff and Vale University Health Board recognises and supports a multidisciplinary approach to the nutritional management of patients and strives to ensure that the nutrition and catering standards are met and maintained. This is achieved through the Cardiff and Vale Nutrition and Catering Steering Group which is led by the Executive or Deputy Director of Therapies and Health Sciences and consists of a wide membership of senior staff from the relevant disciplines. This group reports directly to the Executive Director of Therapies and Health Sciences who may bring issues to the Quality, Safety and Experience Committee if necessary.

This procedure is aimed at adults and children who are admitted to Cardiff and Vale hospitals, as inpatients, or those who attend day or unscheduled care units. This does not cover the needs of staff as these are covered under the Cardiff and Vale UHB Hospital Restaurants and Retail Catering Outlets Policy. Our aim is to provide high quality equitable services that meet the needs of all patients who receive care in our hospitals.

2.0 Procedure Statement

Cardiff and Vale University Health Board is committed to meeting patient nutrition and hydration standards by identifying departmental responsibilities from Executive level to all departments involved in the food chain.

This document is an overarching document which must be considered in meeting the standards specified in the 'The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients', Health and Care Standards, All Wales Food Record Chart and Nutritional Care Pathway.

This procedure will be supported by other documents including:

- Cardiff and Vale Nutrition and Catering Procedure for Inpatients (UHB 367 V3.3)
- Insertion of a Nasogastric Tube, Confirmation of Correct Position and Ongoing Care in Adults, Children and Infants and Neonates Procedure (UHB 114)
- Insertion, management and removal of the nasal bridle fixation device for naso-enteral tubes in adults procedure (UHB 067)
- All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011) http://www.hospitalcaterers.org/media/1158/wales-food-fluid.pdf
- Health and Care Standard 2.5 Nutrition and Hydration http://www.wales.nhs.uk/governance-emanual/standard-2-5-nutrition-and-hydration
- Introduction | Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition | Guidance | NICE Hydration tool kit Health in Wales | New toolkit encourages good hydration for hospital patients
- BDA Digest NutritionHydrationDigest.pdf (bda.uk.com)
- English Nutritional standards for healthcare food and drink NHS England » National standards for healthcare food and drink
- NHS Wales Estates and Facilities Alert Food Allergens January 2020
- BDA Practice Toolkit – Blended diets with enteral feeding tubes November 2021

This procedure applies to all hospitals within the Health Board where inpatient services are delivered.

3.0 Aim of The Procedure

Implementation of this procedure will ensure that nutrition and hydration standards are the focus for all staff involved in the provision of food, fluid or nutritional services and to meet the diverse needs of all hospital patients.

4.0 Objectives

The objectives of this procedure are: -

4.1 To identify a service in which nutritional screening, assessment of patients' dietary requirements, hospital food, patient hydration, nutritional support, monitoring, audit and informed redesign of food provision are seen as a vital component of patient care.

4.2 To consider how management, catering, procurement, financial and clinical services might work together to improve the nutritional care of patients by providing a more cost-effective service targeted to patient needs.

4.3 To consider the importance of monitoring and audit leading to modification of procedures in the light of new evidence and experience.

5.0 Legislative and NHS Requirements

Cardiff and Vale University Health Board has a legal duty of care for all its patients, as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient regardless of age, race, gender or illness. The Welsh Government and also the Healthcare Inspectorate Wales requires there to be auditable systems in place to ensure nutritional requirements of patients are met.

It is important to recognise the patients' rights within this procedure and reinforce that:

- The feeding and hydration of patients at ward level is identified in the Code of Conduct of the NMC (Nursing and Midwifery Council) advice, as a nursing responsibility. The Code (nmc.org.uk)
- All patients will have all aspects of their nutritional management explained, discussed and agreed with them.
- Patients have the right to expect to receive all the information they require to enable them to make informed choices about their nutritional care.
- A clear and understandable explanation of the patient's nutritional management will be provided to the patient, family and carers by the appropriate health care professional.
- Patients, family and carers will be appropriately advised and trained so as to feel secure in the use of any products or equipment.
- The views of the patient, family, carers and other relevant health care professionals will be considered when nutritional management is planned. Decisions should be multidisciplinary.
- Following discharge patients will have access to professional advice through attendance at community clinics and via domiciliary visits.
- Patients or their legally authorised representatives, have the right to accept or refuse nutritional support.

5.1 Food Allergens and Patient safety

- Cardiff and Vale University Health Board has a legal responsibility to ensure patients with food allergies or intolerances are provided with information regarding the presence of food allergens within the food served, and have the risk of cross contamination minimised during procurement, storage, preparation and service. (NHS Wales Estates and Facilities Alert Food Allergens January 2020)

- The Nutrition and Hydration Bed Plan developed by the dietitians is the UHB safety procedure for identifying and communicating patient's food allergies, food intolerances and therapeutic/ standard diet to the catering staff, and wider ward team, enabling appropriate meal and snack provisions.
- Patients should be able to make informed choices regarding their food and have the ability to choose from a range of Free From foods should they require absolute assurance of no cross-contamination risk.
- It is the responsibility of the nursing staff at admission to document on the Nutrition and Hydration Bed Plan any special diets or known food allergies or intolerances, and update the information as clinical needs change.
- It is the nursing staff's responsibility to ensure the Bed Plan is printed off daily for the Catering staff to inform them when catering for the ward.
- It is the responsibility of the UHB to ensure all staff involved in the preparing and serving of food have the appropriate training in allergen management.
- It is the Catering staff's responsibility to understand how to use diet and allergen coding for food products and should be aware of the possibilities of cross contamination, and work in a way to minimise this.
- Any issues arising from allergens should be reported through the UHB incident reporting system, Datix, and any incidents are fully investigated and relevant actions taken.

5.2 Safe Management of Food Bought in by Visitors

see appendix 4 for full document

- The Health Board is obligated to comply with the requirements of the Food Hygiene (Wales) Regulations 2013, Food Safety Act 1990 and associated legislation.
- Cardiff and Vale University Health Board aims to support all patients in hospital to meet their nutrition and hydration needs by offering patients a healthy balanced menu with a range of hot and cold food and drinks and snacks.

- We appreciate that patients may like to have food brought in by a relative or a friend. It is important that this is done safely to reduce the risk of infection, food poisoning and unwanted interaction with prescribed medication.
- Guidance has been developed for the safe management of food bought into for patient consumption Dec 2022.
- The guidance includes advise on storage in ward fridges and bedside locker, length of storage, high risk foods to avoid, when to risk assess and staff responsibilities.

6.0 Accountability

The Chief Executive is responsible for ensuring delivery of a safe and nutritious catering service and for providing a nutritional support service.

7.0 Responsibility

7.1 Corporate

- The Executive or deputy Director of Therapies and Health Sciences is the nominated Board Level Director with lead responsibility for catering, nutrition and food hygiene whether provided in house, by external contractors or through voluntary services.
- The Nutrition and Catering Steering Group, a senior multidisciplinary team, has responsibility for co-ordinating nutritional care, and services, developing strategy, approving training programmes, monitoring performance against all nutrition related nursing, catering and dietetic standards and delivery of high standards of patient experience relating to nutrition and hydration At least on an annual basis, the group will provide assurance against Healthcare Standard 2.5 (Nutrition and Hydration) to the Quality Safety and Experience Committee.
- For in-house catering the organisation must appoint Catering Managers with appropriate qualifications and experience in all matters relating to catering management, nutrition and therapeutic diets, food hygiene, contract management, cost control and budget management and food related legislation and good practice.
- Key indicators capable of showing improvements in catering services and food hygiene and the management of associated risk are used at all levels of the organisation including the Board.
- The system in place for food safety is monitored and reviewed by the Health Board through the Health and Safety Committee in order to make improvements to the system.

- The patient food budget should be valued as an essential clinical service and treatment.

7.2 Operational

Dietitians

Registered Dietitians (RD) are the only qualified health professionals that assess, diagnose and treat dietary and nutritional problems at an individual and wider public health level.

- Dietitians work as integral members of multi-disciplinary teams to assess, diagnose and treat complex clinical conditions with dietary and nutritional advice. Dietitians work to help people to make appropriate dietary changes and to translate the complex and often confusing science of nutrition into simple food choices.
- A Registered Dietitian is responsible for providing a more in-depth nutritional assessment for patients identified as 'at risk' following initial nutritional screening.
- Dietitians provide specialist advice to other professionals, both clinical and non-clinical, on the nutritional needs of patients.
- Dietitian's provide support to catering and nursing staff in the provision of good nutrition in our hospitals, and ensure that the Health Board meets the national standards for nutrition, and develop menus which contain a sufficient range of meals to meet individuals' therapeutic, religious and cultural needs

Speech and Language Therapy

- A nominated Speech and Language Therapist will provide guidance in relation to meeting the needs of patients identified with swallowing problems.
- The Department of Speech and Language therapy will advise on a universal system of terminology for texture and consistency of fluid and food items for patients requiring texture modified diets. Written information will be provided to all relevant staff involved in the production and service of patient meals.

Occupational Therapy and Physiotherapy

- The Occupational therapy department will provide guidance in relation to patients requiring feeding aids and adaptations to assist patients with independent feeding.
- Physiotherapy will provide guidance and support around positioning to aid independent feeding.

Nursing and Midwifery

- The Registered Nurse or Midwife, working to the Code, Standards of Conduct performance and Ethics for Nurses, Midwives (NMC 2018 The Code (nmc.org.uk)) and Health Board policies, protocols and procedures are in the front line when it comes to identifying and addressing the nutritional needs of patients. It is the nurse's responsibility to ensure that patients in hospital receive the appropriate nutrition and fluids to aid their recovery.
- Nurses must complete a nutrition risk screening tool on every patient on admission to identify patients at risk of malnutrition through use of the nutrition screening tool. Nurses identifying a patient who is malnourished or at risk of malnutrition can initiate an early referral to the dietetic team and can reduce morbidity rates.
- A Senior Nurse must lead on nursing policy and operational procedures which relate to nutrition.
- Ward Sisters and Charge Nurses will be responsible for the implementation of protected mealtimes, and adopt the principles that supports Johns campaign. Ward areas should have a clear procedure in place which is understood by all ward staff, clinical teams and visitors to the ward. Completion of the Nutrition and Hydration bed-plan on clinical workstation is essential to identify patients dietary and hydration requirements on and throughout their period of admission and should comply with the Protected Mealtime Standard as in Appendix 3.

Catering

- The Catering Manager is responsible for delivery of a safe quality assured catering service which meets agreed nutritional, food hygiene and operational service standards. Managers are responsible for identifying and monitoring staff training at induction and at agreed intervals.
- Procurement and Supplies officers must liaise with the relevant dietetic and catering colleagues to ensure procurement of foods and drinks are from sustainable and safe sources and are of good nutritional value for money to ensure they meet the nutritional needs of the hospital population.

Audit

- At operational level, the organisation will routinely monitor compliance with all aspects of the system which includes nutritional standards, meal service quality, training standards and the required corrective actions taken where necessary. Where appropriate, these will be carried out at different periods, including weekends and Bank holidays.
- As appropriate, routine continuous monitoring and/or periodic audit reviews will be co-ordinated by the Nutrition and Catering Steering

Group that will ensure compliance through internal audits, nutritional assessments by Dietitians and routine unannounced checks.

- Health and Care Standard 2.5 *Nutrition and Hydration* will be assessed on an annual basis to continuously monitor performance, identify areas for development and provide internal assurance to the Health Board.

The Adult Nutrition Support Teams are responsible for:

- Preparing relevant nutritional support policies, protocols, procedures and / guidelines to address specific nutritional issues working closely with all relevant members of the multidisciplinary team and following guidance laid down by BAPEN and NICE.
- Ensuring such policies, protocols, procedures and / or guidelines are subjected to the UHB formal approval process.
- Identifying training needs and developing a training programme as required in order to meet standards and competencies compatible to their level of involvement.

Job descriptions should reflect the responsibilities and duties of all levels of executive, management, supervisory and other staff involved in the process of ensuring that appropriate nutrition is identified, prepared, delivered and presented to patients.

8.0 Standards

The following standards are taken from the document 'The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients' and other documents outlined in the list of references.

8.1 Nutritional Risk Screening Standards – Adults

- All Wales Hospital Nutrition Care Pathway Protocol and UHB Nutritional Screening Compliance.
- Within 24 hours of admission to hospital all patients should be weighed and screened for risk of malnutrition using a validated nutritional screening tool.
- Patients identified with swallowing difficulties should be referred for formal assessment by a Speech and Language Therapist. A referral to a Dietitian should be made if advice on a textured modified diet or artificial nutritional support is required. In patients where, enteral nutrition is contra-indicated total parenteral nutrition should be considered. When a nutrition risk score and weight has been established a multi-professional nutrition care plan should be implemented. The care plan developed will depend on the nutrition

risk. Any patient identified as at risk will be assessed regularly and appropriate action taken.

- Identification of a patient at nutritional risk should be followed by a thorough nutritional assessment, treatment plan including dietary goals, monitoring of food intake and body weight, and adjustment of treatment plan. The nutritional treatment plan should be reviewed on at least a weekly basis.
- Documentation in patients' notes will include screening/ re-screening assessment and actions taken.
- Weighing scales will be regularly checked for accuracy and maintenance requirements. Ward managers are responsible for ensuring appropriate weighing scales are available within their ward areas.
- The screening process (initial and ongoing) will be monitored by Ward Sisters /Charge or Senior Nurses. As a minimum, compliance with nutritional screening will be recorded on a monthly basis using the All Wales Nursing metrics system.
- Wards will identify nutritionally vulnerable patients and ensure they follow the nutritional care pathway, to meet the nutrition and hydration needs of all patients, with the necessary encouragement and assistance with eating.

In addition to the need for nutritional screening of all patients, an assessment of each patient's dietary needs should also form part of their individual nutrition care plan, such needs as:

- Eating and drinking, likes and dislikes
- Food Intolerances and allergies
- Need for therapeutic diets
- Cultural, ethnic and religious requirements
- Therapeutic dietary requirements
- Social, environmental mealtime requirements
- Physical and or sensory difficulties with eating and drinking
- Aids and adaptations e.g. adaptive cutlery or crockery requirements
- Ability to communicate
- The level of assistance and support required to eat and drink.
- Identified family member or carer wishing to support the patient to eat and drink.

A plan of how these needs will be met should be developed, implemented and monitored. Relevant information for each patient must be added to the ward Nutrition & Hydration Bed plan to ensure good communication between disciplines.

It is important to remember that individuals' dietary needs can change with changes in their medical condition(s) and thus monitoring individuals' requirements is important to inform appropriate food provision.

8.2 Nutrition Risk Screening Standards for Children admitted to hospital

- All children admitted to hospital should be assessed on admission to hospital using the appropriate screening tool, with their height and weight measured with values plotted on appropriate growth charts.
- Every child should be weighed at timely intervals with the child's care plan during their admission. Weighing scales will be regularly checked for accuracy and maintenance requirements. Ward managers are responsible for ensuring appropriate weighing scales are available within their ward areas.
- Documentation in the nursing notes will include monitoring of dietary intake, physical ability to eat and drink and body weight.
- Consideration should be made to refer the child to the Dietitian if there are any concerns with the child's growth and/or there are concerns regarding the child's dietary intake.

8.3 Food Service Standards

- All patient menus must meet the All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients – Wales Government and contain a sufficient range of meals to meet individuals' therapeutic, religious and cultural needs. Further menu planning guidance is detailed in British Dietetic Association document entitled The Nutrition and Hydration Digest: Improving Outcomes through Food and Beverage Services, 2nd edition 2017 The British Dietetic Association.
- Patients are provided with sufficient information to enable them to make an informed choice as close to the meal service time as possible and written information is presented in an appropriate manner e.g. child friendly menus, large print menus, pictorial menus and menus in a range of languages.
- The dietary needs of all patients taking oral nutrition should be met, taking account of patients' preferences through meals that meet their nutritional requirements and these offered as a choice of dishes on a written menu.
- Patients are offered a choice of portion size. Nutritional enhancement is provided where the portion does not meet the determined minimum nutritional content. All meals should be presented in a way that facilitates and encourages independent feeding, including the provision of specialist crockery and/or cutlery.

- Nutritional information will be routinely obtained from the food commodity suppliers during the tendering process in order to assess compliance with nutritional standards. The process for nutritional assessment of food commodities will be agreed with all the relevant parties.
- Ward provisions must be provided to ensure patients have access to a range of different snacks and beverages when the hospital kitchen may be closed.
- Contingency arrangements are in place to ensure the delivery of safe nutritious food in the event of total or partial failure of normal arrangements.
- Services should be flexible with recognised procedures that provide for the dietary and nutritional needs of patients who cannot achieve their energy and protein requirements from the hospital menu or who miss a meal at normal service time.
- A missed meal service must be provided for all patients who did not have the opportunity to have a meal at the normal meal time and must provide a minimum 300 kcal and 18 g protein per main course.
- Main meals should be available every 4 to 6 hours during the day.
- The maximum period between the last main meal at night and the following breakfast should not exceed 14 hours.
- Assistance to eat must be given to all those who require it. Family members or carers should feel welcomed to support patients were possible.
- Food hygiene training will be available supported by appropriate procedures, which identify how relevant food hygiene and food safety requirements are satisfied.
- All staff involved in serving food to patients should be trained in how to do so properly which includes basic nutrition and food hygiene.

8.4 Nutrient and Food Based Standards-Adults

Hospital menus must be able to meet the nutrient specifications, and provide foods that meet both food and nutrient based standards for the hospital population; these are detailed in the Appendix - Table 1.
All menus must meet the nutritional requirements of patients of all ages i.e. Dietary Reference Values (DRV's) for Food Energy and Nutrients for the United Kingdom. Where a menu must meet the needs of the 'nutritionally well' and the 'nutritionally at risk', then ensuring that both 'healthy choices' and 'higher energy and nutrient dense' choices are available at each eating occasion should enable all patients to choose a diet that meets their nutritional requirements.
Menus should be nutritionally analysed to ensure that they have the capacity to meet the nutrient standards set for the 'nutritionally at risk' patient and enable individuals to choose a healthy balanced diet

through selection of healthy choices. For more information refer to Chapter 4 Section 4.9 of the document The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients'-Wales Government-

Menus must meet the needs of those patients with therapeutic dietary, cultural or religious needs. Patients must be given choice for all food and fluid options provided, including therapeutic and/or texture modified diets

Hospitals whose populations require certain therapeutic diets irregularly and in minimal numbers must include in their procedure a formal contingency for the provision of these diets in the event they are required, for example by using an a la carte menu.

All foods purchased for use within the patient meal service at either an All Wales or local level must be assessed by a dietitian against the nutritional specifications and standards to ensure the best nutritional value for money has been achieved[1]

Chapter 6 of the document The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients'-Welsh Government states there must be a hospital protocol for the provision of all therapeutic diets.

8.5 Nutrient and Food Based Standards- Children

Menu Planning Groups and hospitals should produce a specially designed menu for children and allow them to make their food choice as close to the point of service as possible.

The role of nutrition in health and disease is well recognised, and children are particularly vulnerable to poor diet and nutrition, because of their extra requirements for growth. Additionally, children's intakes and appetites can be much more adversely affected or influenced by external factors than adults. There is increasing evidence that children can be influenced to maximise their diet and health, but this needs to be done as early as possible. The role and influence of hospital catering is absolutely paramount when trying to make improvements relating to the nutrition of children and young people. Health and behaviour developed during childhood and adolescence is often carried through into adulthood and can affect health later in life.

SACN dietary reference values 2011 provide guidance when catering for children and adolescents.

- It is good practice to have a separate children's menu with child friendly/ familiar dishes as well as dishes that promote healthier

meals, with variable portions sizes for the children of all age groups and stages of development.

- Menus should reflect a diet that does not put children and adolescents at long term risk of obesity, dental decay and cardiovascular harm. The menu should provide scope for education in health and disease management.
- Menu planning groups should work closely with children, parents and carers in planning the menu for children considering likes and dislikes and making sure that suitable choices are available for the different ages and stages of development of the children being catered for.
- Diets must be tailored to suit young children's nutritional and energy needs and also their stage of development. Guidance has been produced for early years childcare settings that includes a variety of menus. It is best to provide young children with smaller, more frequent meals.
- Snacks such as bread, fruit, sandwiches, and yoghurts are preferred to those high in fat, sugar and salt. The provision of foods high in sugar should be kept to a minimum, especially between meals and the use of highly salted foods/meals and addition of salt to foods should be discouraged.

For further information refer to Chapter 5 in document 'The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients'-Welsh Government

8.6 Standards for Fluid Provision

- There must be provision to ensure patients are able to access a minimum of 1.5 litres of fluid per day.
- Water must be available at all times throughout the 24 hours; preferably this should be chilled mains water.
- Water jugs should be changed three times per day.
- 7-8 beverages should be offered in any 24-hour period.
- Where All Wales fluid charts are used to monitor patients' fluid intakes these must be fully completed and signed in line with policy.
- Ensure fluid is available in the most appropriate drinking cups or utensils.

8.7 Environmental Standards

- Meals and refreshments will be delivered in an environment conducive to their consumption, and at times that are flexible and sensitive to specific care groups' needs and preferences. The food should be presentable and palatable, thus cold foods should be served as soon after removal from refrigerated storage and hot

foods maintained above 63°C prior to serving, and with individuals' subsequent nutritional intake monitored.

- Interruption of patient meals by ward rounds and procedures should be minimised and each ward should have a clear protected meal-times policy in this respect. The environment at meal times should be made as conducive to eating as possible with any activity that may cause anxiety in the period leading up to the meal time kept to a minimum. Refer to Appendix 3 for protected mealtimes standards.
- A family member or carer should feel welcomed to support patients eating and drinking, as often as they are able, and wish to.
- Attention should be given to washing hands, positioning, dental needs and any special aids required.

8.8 Blended Diet Guidance – Adults and Children (Appendix 5)

- There is increasing public interest in the use of liquidised or blended food as an alternative to commercial food formulations for tube feeding particularly for children. Many of these children are now entering into adult services.
- Risk assessments and Standard Operating Procedures have been completed for adult and child inpatient services

9.0 Training

All staff that influence the successful outcome of nutrition, safety and enjoyment of meals, are trained to carry out their duties and responsibilities effectively. Training commences at induction and is updated regularly. Managers are responsible for ensuring staff undertake relevant training and that appropriate records are kept and maintained. All nurses will be expected to complete the 'All Wales Food Record Chart Competence programme' e-learning package, all food handlers are expected to complete food hygiene, and food allergen training
The Nutrition and Catering Steering Group will be informed of the nutrition education and training programmes that are carried out for all staff groups annually.

9.1 Training Implications

There will be training implications relating to this policy and procedure for many staff groups, some of which will be mandatory e.g. basic food hygiene training for all 'food handlers', and allergen awareness. Individual line managers are responsible for identifying individual staff training needs within the member of staff's personal development plan. Training records will be kept and continuously updated. Training will be provided in house where possible. The training required will vary for various members of staff depending on their role profile.

10.0 Equality and Health Impact Assessment

An Equality and Health Impact Assessment has been undertaken to assess the relevance of this policy to equality and the potential impact on different groups, specifically in relation to the Equality Act 2010.

11.0 Implementation

This procedure provides a framework to meet the core elements of the All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients – Welsh Government and the Health Care Standards for Wales. It establishes the line of responsibility at both corporate and operational level that includes the Executive through to in-house catering management and members of the multidisciplinary team to achieve patients' optimal nutritional status.

The procedure will provide an agreed basis for developing a Nutrition and Catering Strategy with aims and objectives that will inform Directorate operational plans and reflect the key components of clinical governance.

12.0 Further Information

Local guidelines and toolkits exist to support the Nutrition and Catering policy and may be accessed through relevant departments

- All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients http://www.hospitalcaterers.org/media/1158/wales-food-fluid.pdf
- Welsh Government. Health and Care Standards for Wales April 2015 Health standards framework english (gov.wales)
- 32 NICE (2012) Quality standard 24 Nutritional Support in Adults Overview | Nutrition support in adults | Quality standards | NICE
- Hydration tool kit Health in Wales | New toolkit encourages good hydration for hospital patients
- BDA Digest NutritionHydrationDigest.pdf (bda.uk.com)
- English Nutritional standards for healthcare food and drink NHS England » National standards for healthcare food and drink
- NHS Wales Estates and Facilities Alert Food Allergens January 2020
- BDA Practice Toolkit – Blended diets with enteral feeding tubes November 2021 Contents (bda.uk.com)

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Appendix 1: Table 1 - Nutrient and Food Based Standards – Adults

Menus need to aim for: -

- 1900-2625 Kcals and 55-90g protein to meet the needs of the nutritionally well and nutritionally vulnerable adult

Please note: - the majority of the hospital population are of a mixed age and nutritional need so will demand a menu which meets the higher level

- Fibre (NSP) 18g/day for nutritionally well adults and 12-18g Fibre /day for the nutritionally vulnerable

Menu should include: -

Breakfast: –

- A minimum of 380kcals and 8g Protein and a fortified High energy high protein option for nutritionally vulnerable e.g. cooked breakfast or fortified porridge

Mid Day and Evening meals that include: -

- A main course meal providing 300kcals and 18g protein (12g for vegetarian option). To achieve this the main protein part of the meal should contain 12-14g protein or 9-10g for vegetarian
- A fortified high protein high energy main course option to provide a minimum of 500kcals and a minimum of 18g protein
- 2 first course items
- 3 main courses as a minimum 2 of which should be hot
- 3 dessert course items 1 of which should be hot (custard alone is not adequate is not considered as a hot option

Desserts

- At least one fortified or high protein high energy dessert minimum of 300kcals and 5g protein at mid day and evening meals

Snacks

- within the standard menu to provide 100kcal energy and 1.5g protein
- an evening snack for patients
- snacks of higher energy and protein density to meet a minimum of 200kcal and 2.5g protein each must be offered to those patients identified as at moderate and high risk of malnutrition from Nutrition Risk Screening

Milk allowance

- 500ml milk per patient for cereals and drinks as ward allowance

Soup

- Soup where served of a minimum of 150cals and 4g protein in a 175ml serving and must be offered with bread and spread.
- If offered as a hot main meal choice the whole meal must meet 300-500kcals and 18g protein (dependent on patient's nutritional needs)

Fruit Juice

- Should be offered as a first course item on 2 occasions in order to achieve the minimum vitamin C nutrient specification of 40mg
- Meal and snack items that meet healthy eating principles
- Vegetarian options at each meal
- A combination and balance of foods from all 5 food groups with a variety of cooking methods used to include Bread cereals, potatoes and other starchy foods, Fruit and vegetables, Milk and dairy foods, Meat, fish and alternatives, foods containing fat and sugar
- Codes to indicate healthier choices, fortified and high energy items and vegetarian items as a minimum. Too many codes can be confusing.

Fluid

- There should be 7-8 beverage periods throughout the day offering both hot and cold drinks. This will provide approximately 1500mls of fluid. Drinks should be served immediately after lunch and evening meal.

Appendix 2: Standard for Protected Mealtimes and Red Tray Scheme (Applies to all mealtimes)

Protected mealtimes in Cardiff and Vale UHB are: -

"Mealtimes in which patients are prepared to eat appropriately. As a minimum expectation, this incorporates appropriate positioning, the offer of hand hygiene for patients, the environment is cleared and conducive to eating, non-urgent clinical activity ceases, and in conjunction with the catering staff the nursing focus is to provide support to patients during the mealtime. Relatives and carers are encouraged and welcomed to participate in feeding should they so wish."

Activity	Rationale
Nursing staff work with catering staff to identify patients' requirements for meals	Patients needs identified
Patients are offered toileting opportunities prior to meal service	To reduce the need for interruptions and ensure the patient is prepared to eat
Nursing staff prepare patients for eating, e.g. position appropriately	To enable patients to eat and drink safely
Hand hygiene is prompted or delivered prior to meal service	To reduce the risk of HCAI
The environment is made as conducive as possible prior to mealtimes (bed tables cleared etc)	To encourage the patient to eat well
All non-urgent clinical activity ceases in the patient environment during the meal time	To reduce interruptions
The caterer and nursing staff work jointly to ensure patients needs/choices are met	To ensure a quick seamless food service is delivered meeting patients needs
The Nutrition & Hydration bed plan is the accepted tool which is used as a flagging mechanism and is understood across the ward area.	To ensure those at greatest risk receive optimum care and support
All nursing staff are available and help patients who require assistance to eat and drink and complete all appropriate documentation	To ensure patients are assisted as quickly as possible and actions taken are documented
Nursing Staff encourage relatives and carers to feed their loved ones should they so wish	To encourage increased intake by patients
Protected mealtimes will be limited to no longer than 1 hour	To prevent delays to medical treatment
Nursing staff need to adopt a flexible	To ensure patient care is not

approach when implementing protected mealtimes. Consideration of the movement of the meal service around the ward and the ability to deliver care in the area not receiving a service at that time.	compromised by the exclusion of other services (e.g. phlebotomy radiology and therefore lengths of stay increase)

Appendix 3: Training Requirements for Staff Involved in the Patient Meal Service

Catering Staff

- Roles & Responsibilities of key staff
- Basic Nutrition and the importance of food and nutrition standards
- Therapeutic, religious and cultural diets
- Dysphagia /modified consistency/ food allergy
- Nutritional supplements and enteral feeds
- Basic / intermediate / advanced food hygiene training dependent on role
- Standard recipe production
- Menu planning
- Catering practices/processes/use of equipment

Ward Based Catering Staff

- Roles & Responsibilities of key staff
- Basic Nutrition and the importance of food and nutrition standards
- Therapeutic, religious and cultural diets
- Dysphagia /modified consistency/ food allergy
- Nutritional supplements and enteral feeds
- Basic / intermediate / advanced food hygiene and safety training dependent on role
- Ordering, serving and presenting meals
- The importance of time/temperature control / regeneration and record keeping
- Customer care and communication

Housekeeping Staff

- Roles and responsibilities of key staff
- Basic Nutrition and the importance of food and nutrition standards
- Therapeutic, religious and cultural diets/ food allergy
- Ward beverages and nutritional supplements
- Importance of modified consistency drinks/ meals
- Basic Food Hygiene/safety dependent on role

Nursing Staff including trained Nurses, Health Care Assistants

- Roles & Responsibilities of key staff

- Basic Nutrition and the importance of food and nutrition standards
- Using Nutrition pathway including food & fluid charts
- Therapeutic, religious and cultural diets/ food allergy
- Malnutrition and the hospital patient
- Nutritional screening
- Dysphagia /modified consistency
- Nutritional supplements and enteral feeds
- Basic food hygiene and safety

Appendix 4: Safe Management of Food Bought into a Hospital Setting for Patient Consumption

December 2022

The Health Board is obligated to comply with the requirements of the Food Hygiene (Wales) Regulations 2006, Food Safety Act 1990 and associated legislation.
Please refer to the Health Boards food safety policy and EU Food Information to Consumers (FIC) food legislation introduced in December 2014
Cardiff and Vale University Health Board aims to support all patients in hospital to meet their nutrition and hydration needs by offering patients a healthy balanced menu with a range of hot and cold food and drinks and snacks.

We appreciate that patients may like to have food brought in by a relative or a friend. It is important that this is done safely to reduce the risk of infection, food poisoning and unwanted interaction with prescribed medication.

Special Diets
The nutrition and hydration bed plan must be completed by nursing staff, for all patients, and especially those with special dietary requirements, food allergies or intolerances. It is important for visitors to check with nursing staff that certain foods are suitable for patients before bringing food or drinks in. Patients with swallowing problems may require food or drinks of a specific texture or thickness e.g. a ‘Easy to Chew’ or ‘Puree’, please check with the ward staff before bringing in any food or drink.

Food Storage
If visitors are bringing food items into hospital they should be encouraged by the ward team to bring single portions for same time / day consumption and this food should be clearly labelled with the patients name and the date the food was brought into hospital. For baked goods and biscuits to stay fresh they need to be individually pre-packed or kept in an airtight container. Wards have very limited refrigerator storage space and any food will be disposed of after 24 hours. Please be mindful of bed area and locker space too.

The following guidelines must be adhered to for all patients:

- Small amounts of foods not requiring refrigeration should be kept in the suitable containers on/in the bedside lockers.
- Food brought in should be from the low risk food products list.
- Food should ideally be in a single portion size that the patient can eat without delay.
- All food brought in that does require refrigeration must be labelled, dated and timed.
- Due to limited refrigerator storage space, a small amount of goods can be kept in the ward kitchen.
- Any refrigerated food must be disposed of after 24 hours.
- Where food is allowed to be brought in it should not normally be re-heated in any way; in the exceptional circumstance where there is agreement that food requiring heating can be bought in from home, a full risk assessment must be completed by the nursing staff.
- Foods listed in the high-risk foods must be discouraged and the risks associated with such foods made explicit.

Examples of 'low risk' foods	Examples of 'high risk' foods
Fresh fruit and wrapped fruit products. Dried Fruits	Raw meat or fish/shellfish, cooked meat and poultry
Pre-packed muffins, tea cakes. Pancakes, scones or similar	Cooked meat, fish/shellfish or egg products
Pre-wrapped biscuits, crackers and cakes	Pre-wrapped sandwiches (all fillings)
Pre-wrapped chocolate or sweets	Fresh or artificial cream products e.g. yoghurts, mousse, cakes and ice cream
Packets of crisps (individual packets), popcorn, other wrapped savoury snacks	Items with added alcohol e.g. chocolate liqueurs, stolen and similar festive foods
Preserves e.g. jam, marmalade, honey, Marmite, Bovril, Nut Butters (in small plastic jars)	Any other food item which requires refrigeration or heating e.g. pies pasties, sausage rolls, cheese, eggs, scotch eggs, take away meals including pizzas, beef burgers and kebabs
Pre-wrapped nuts and seeds (provided patient doesn't have any	Soft or blue veined or mould ripened cheeses, meat or fish pâté

related allergies)	
Bottled drinks (plastic only) e.g. squash or carbonated drinks. Fruit juice or Fruit smoothies	Any foods containing cooked rice

If the food required is outside of the list of low risk snacks and beverages, permission to bring food in should be sought from the ward sister who will make decisions on the most appropriate action. This will be based on a risk assessment and in conjunction with advice from the catering department. Further advice should be obtained from the Senior Nurse Manager and the Infection Prevention & Control Team as appropriate. If it is agreed, following a risk assessment, that food can be bought in for a patient, the processes to be followed must be clearly defined and documented.

All healthcare workers who handle food, or are responsible for the provision of food for patients, are legally food handlers. Food handlers must be aware of the Health Boards food hygiene and food safety policies.
The Health Board has a statutory responsibility to ensure that, as far as practicable, any food, regardless of source, when provided for patients, is fit for consumption. Any food bought into the hospital for patient consumption, whether shop bought or home prepared cannot be guaranteed as having the same robust hygiene controls as food provided by our own internal catering services. As such this presents a potential risk to patients who consume the food.

Staff are advised to be

- Aware of Best before and use by dates
- Only use ‘low risk’ foods
- Promptly and appropriately refrigerate foods
- Dispose of any foods after 24 hours
- Only use food that can be served at ambient temperatures or served straight from the fridge
- Be aware of patients with food allergies or intolerances
- Keep packaging as a reference to allergen content.
- Where possible access basic food hygiene training

Appendix 5 Blended Diets for Adults in Hospital

Blended Diets for Adults in Hospital

The accepted gold standard feed for patients receiving enteral tube feeding is ready to use liquid commercial food formulations.

These are usually nutritionally complete within a specific volume; rarely cause tube blockage; are easy to prepare and administer; and are sterile.

There is increasing public interest in the use of liquidised or blended food as an alternative to commercial food formulations for tube feeding particularly for children. Many of these children are now entering into adult services.

Compared with commercial food formulations there is increased preparation time and uncertainty about the nutritional value and an increased risk of bacterial contamination of blended diets, and tube blockage.

Although there are numerous anecdotal reports from patients, carers and health professionals of potential benefits, there is little published research available to support the use of blended foods for enteral tube feeding.

The clinical team must discuss and record the reasons for the patient (also covers carer, family, parent, partner) wanting to continue with blended food via enteral feeding tube whilst an inpatient, and ensure all alternative commercial food formulations and feeding strategies are considered that might provide an alternative to blended food.

The patient should be fully informed of the risks and limitations involved if they do choose to continue with a blended diet. A Patient Information and Disclaimer form must be given to the patient/carer to sign, and copy kept in their medical records.

The team must, in consultation with the patient, complete a risk assessment (a Risk Assessment Template for Enteral Tube Administration of Liquidised Diet has been developed by the Parenteral and Enteral Nutrition Group of the BDA **http://www.peng.org.uk/pdfs/hcp-resources/risk-assessment-template.pdf)** Layout 1 (peng.org.uk) This will identify the generic risks but also individual patient related risks that may also apply, and help identify how these risks can be reduced.

Enteral feed pumps are designed to be used with commercial food formulations, not blended food. No pump manufacturer supports the administration of blended food via a pump. Pump feeding of blended foods is also not recommended due to the risk of microbial contamination with prolonged hang times, and the potential nutritional inadequacy of more dilute blends.

Bolus administration of blended food is most practical via a 60ml syringe.

The patient or carer will be responsible for choosing, blending and administering the blended diet.

Blended diet in adult tube fed patients
Standard Operation Procedure for Nursing and Dietitians

NB Only for patients who are already established on a blended diet tube feed, new blended diet patients will only be started in the community.

Patient is admitted to UHW adults ward on an established blended diet regime.
Note that blended diets will **ONLY** be prepared and administered by the patient or carer (on an adult ward) **NOT** the staff.

↓

Nursing staff to record the reason for a patient or carer wanting to commence blended diet.
The Dietitian will provide advice on reason why this is not considered best practice in hospital, and highlight risks. Out of hours, nursing will issue an information leaflet and disclaimer form
Dietitian discusses alternative feed strategies for consideration – especially if the patient is unwell.

↓

If patient still wishes to commence blended diet the Nursing staff or Catering Supervisor will contact the dietitian (Ext 44294) who is covering the ward, to make them aware of patient's admission. Ward dietitian to make Ally Ewins or Fran Labaton aware that there is a patient on the ward requiring a blended diet.

↓

Dietitian to contact the community/ paediatric dietitians for patient's regime. Please make patient/career aware that hot meals are only prepared on the ward at 8am, 12 midday and 5pm

↓

Ward dietitian to supply the ward with the high-powered blender and metal sieve – kept in the SAC building. To complete the "blender + sieve record" excel spread sheet - to track the blender to the ward. **S:\Dietetics\Enteral feed discharges\Blended diet in adults**. It is the responsibility of the ward dietitian to return the blender to the SAC building when patient is discharged. and sign it back in.

↓

Ward dietitian to update ward bedpan/explain to catering staff their responsibilities (see SOP for Caterers), and complete the paperwork – found on the S Drive S:\Dietetics\Enteral feed discharges\Blended diet in adults

↓

Ward Dietitian to discuss with the paediatric team if they have any concerns that the blended diet is not reaching patients requirement and hand back to the appropriate dietitian on discharge.

Blended diet in adult tube fed patients
Standard Operation Procedure for Catering staff

NB Only for patients who are already established on a blended diet tube feed, new blended diet patients will only be started in the community.

1. A patient is admitted to UHW adults ward and is requesting a blended diet.

2. Nursing staff or Catering Supervisors must alert the dietetic department on 02921 84 4294 (or the on-call dietitian if it is on the weekend)

3. Ward dietitian to supply ward with x1 high powered blender and x1 metal sieve for patient/patient's carer use only. The dietitian will highlight that patient is on a blended diet on the bed plan.

4. WBC (ward-based caterer) to make a space in the kitchen to store the high-powered blender and the metal sieve, and make the patient/carer aware of this.

5. The patient/patient's carer to choose suitable main meals from the menu, before meals – code **BD** Blended Diet (please note all level 4 and level 6 meals will also be suitable) The meal must be regenerated as close to the administration as practically possible.

6. WBC to regenerate meals as normal, at usual meal times, and temperature probe the meal (>80 degrees centigrade for 6 seconds). The blended food must not remain at room temperature for more than 1 hour. **After 1 hour any food remaining must be discarded**

7. WBC to make the patient/carer aware the meal is ready and leave it with extra gravy and/or milk/water.

8. Caterer to leave the meal in the kitchen with additional bowls or jug for the blended mixture. The patient or carer may need additional cutlery /wet wipes and cling film left for them. After 1 hour any food remaining must be discarded**. Blended food cannot be reheated**

9. The patient/patient's carer (with protective clothing – supplied by the caterers) enters the kitchen, and washes their hands and cleans the work surface to be used.

10. The patient/patient's carer to mix the meal with the extra gravy and/or water. Blend for approx. 3 minutes. The food should have a 'double cream' consistency and be completely smooth.

11. The Patient/patient's carer to strain the mixture through the clean metal sieve into a food bowl and cover with clingfilm (supplied by the caterer) and exit the kitchen with the food bowl.

12. WBC to clean and disinfect the sieve and the washable parts of the blender in the dishwasher. The patient/ carer will be asked to leave the used blender and sieve by the dishwasher.

13. WBC to store the clean and disinfected sieve and the blender safely in the kitchen ready for the next meal.

14. Once the patient was discharged home, the blender and the sieve will be collected by the ward dietitian.

Suitable foods to blend outside of meal times include

- Yoghurts
- Custard and Rice pots
- Bananas
- Fruit pots (not Pineapple)
- Ice Creams
- Lemon drizzle or Carrot Cake (blend with a wet product such as Custard/Rice pots or Yoghurt)

Additional fluids used could be milk, supplement drinks and water

Blended diet in adult tube fed patients
Patient/Carers Information and Disclaimer form

C&V understand that you are using blended or liquidised food via a feeding tube at home.

While you are in hospital we advise that you use commercial feeds for the following reasons:

- For patient safety, C&V are obliged to abide by the manufacturer's instructions for the use of the tubes that they make
- C&V also need to consider the risk of food being contaminated with bacteria if they are blended on the ward - food poisoning would be very harmful to you
- The texture of blended food cannot be guaranteed and there could be the potential for the tube to block
- C&V cannot be sure that blended foods will provide the best possible nutrition while you are in hospital

addressograph

I wish to continue with a blended diet administered via a gastrostomy tube, whilst in hospital, and I am fully aware of the reasons why you advised against this. I take full responsibility for my decision

C&V will not be responsible for the choice of food to blend from the hospital menu

C&V is not responsible for the microbiological safety of the blended food prepared on site, or any blended food bought in. Any cooked and blended food must not remain at room temperature for more than 1 hours. **Blended food cannot be reheated on the ward, any blended food bought in must be used immediately**

C&V is not responsible for the preparation of the blended meals and ensuring it is the right consistency.

C&V is not responsible for the administration of the blended meals via the gastrostomy, and not responsible for any tube blockages that may occur.

C&V cannot accept responsibility for any harm that may occur from using the staff only kitchen facilities on the ward.

The kitchen is a busy area and you will need to respect the work of the staff using it.

The kitchen area used must be left clean and tidy. Do not use the dish washer, but leave the blender and sieve by the dish washer for the kitchen staff to clean and disinfect, and replace in the storage area provided

I agree to comply with basic food hygiene guidelines when accessing the kitchen

- **DO NOT access the ward** when you have symptoms of gastrointestinal infections, influenza or COVID
- Hand washing before entering the kitchen
- Wear protective aprons whilst in the kitchen
- Clean the work area before and after blended meal preparation
- No blended food can be stored in the ward fridge for later
- Food bought in cannot be reheated in the ward microwave, and must be used immediately.

PRINT NAME
SIGNATURE
RELATIONSHIP TO THE PATIENT

SIGNATURE OF HEALTH CARE PROFESSIONAL
PRINT NAME
DATE

Report Title:	Cardiff and Vale of Glamorgan Winter Respiratory Vaccination Plan 2023/24			Agenda Item no.	3.2
Meeting:	Quality, Safety and Experience Committee	Public	✓	Meeting Date:	18 July 2023
		Private			
Status *(please tick one only):*	Assurance		Approval ✓	Information	✓
Lead Executive:	Executive Director of Public Health				
Report Author (Title):	Head of Operations, Mass Immunisations and Testing/Consultant in Public Health Medicine				

Main Report
Background and current situation:

1.0. Background:
Vaccination is one of the most effective public health interventions to protect people against infection and reduce pressure on health and social care services over the busy winter period. Maximizing Influenza (flu) and Covid-19 vaccine uptake is an important Health Protection solution to protect our most vulnerable citizens from severe illness, with those from older age groups, residents in care homes for older adults, and persons with certain underlying health conditions, continuing to be disproportionately at risk of developing severe illness in response to flu and/or Covid-19 infection.

In 2022/23, for the first time, Cardiff and Vale University Health Board (UHB) delivered the flu vaccination programme alongside the Covid-19 Autumn booster vaccination campaign in an effort to maximise uptake and protect as many vulnerable people as possible. Co-administration of flu and Covid-19 is a key principle outlined in Welsh Government's Winter Respiratory Vaccination Strategy (https://www.gov.wales/winter-respiratory-vaccination-strategy-autumn-and-winter-2022-2023-html) published July 2022, and remains a key priority for the 2023/24 winter vaccination campaigns. With the integration of the flu and Covid-19 campaigns, a Winter Respiratory Vaccination Plan has been developed alongside Key Vaccination Programme Stakeholders within and external to Cardiff and Vale UHB. The Plan outlines the aims and objectives of the Winter Respiratory Vaccination Programme, detailing key Stakeholders responsible for Programme and the crucial actions required to deliver the Programme.

2.0. Current Situation:
The 2022/23 Winter Respiratory Vaccination Programme
During 2022/23, the majority of flu vaccines were delivered through GP practices, with the exception of the health and social care workforce. Social Care staff received their vaccination through Community Pharmacies (436) and UHB staff receiving their flu vaccine through the Mass Vaccination Centres (MVCs), Occupational Health sessions or via Flu Champions (6223 vaccines). A Welsh Government directed influenza mop-up was initiated in January 2023 which provided citizens the opportunity to choose where they wanted to access their flu vaccine, through their GP, local Community Pharmacy or MVC.

In contrast, the majority of Covid-19 vaccinations were delivered through the UHB's MVCs.
Thirteen community pharmacies (12 community pharmacies and a mobile unit) delivered 10,604 Covid-19 vaccinations to Social Care staff and over 80s. Seventeen General Practice (GP) surgeries delivered 5,894 Covid-19 vaccinations, to people aged over 80years, in addition to their Influenza Vaccination Programmes.

Co-administration of flu and Covid-19 vaccine for the general population was generally not possible during 2022/23 as flu vaccine was predominantly ordered by and delivered in General Practice and Community Pharmacy (as part the GMS contractual agreement) whereas the majority of Covid-19 vaccination was delivered through the UHB's Mass Vaccination Centres. The majority of UHB staff

members received their vaccinations simultaneously with over 6,000 staff members accessing co-administration.

The 2022/23 Winter Respiratory Vaccination Programme was challenging due to changes to the operational landscape and a perceived lack of motivation or hesitancy ('vaccine fatigue') amongst citizens to get their influenza and/or COVID-19 vaccination. Despite these challenges and the ongoing pressures of the COVID-19 pandemic, winter respiratory vaccinations have been delivered to a large proportion of the Cardiff and Vale population.

Summary of vaccination coverage/uptake during 2022/23:
All Health Boards saw a reduction in flu and Covid-19 uptake across the majority of eligible cohorts (with the exception of Aneurin Bevan UHB and Betsi Cadwaladr UHB who observed a minor increase in flu uptake amongst 50 to 64 year old cohorts). Cardiff and Vale UHB maintained excellent levels of uptake amongst citizens aged 65 and over with over 75% vaccinated for flu and 80% vaccinated for Covid-19.

Inequities remain across our region with overall vaccine uptake for both vaccines being lowest across the City and South Cluster (56.1% for flu and 43.1% for Covid-19) and highest across the Western Vale Cluster (81.7% for flu and 76.9% for Covid-19). The Health Board did observe a reduction in the flu uptake gap across the Primary Care Clusters with an uptake gap of 25.6% in 2022/23 compared to 29.4% in 2021/22. However, the Covid-19 uptake gap between Cardiff and the Vale of Glamorgan Local Authorities increased to 6.9% in 2022/23 (previously 3.1% in 2021/22).

The overall uptake of flu vaccination for UHB staff with direct patient contact was 37.9% in 2022/23, a decrease of 15% when compared to 2021/22 uptake. This pattern was also observed for Covid-19 with uptake being 56.8% for UHB staff with direct patient contact. Staff reported difficulty attending two separate MVC appointments for flu and Covid respectively and there was perceived fatigue/hesitancy amongst staff members to receive vaccination with staff prioritising Covid-19 vaccine over flu vaccine in some cases. Uptake figures were also hampered by a large number of vaccination records not being able to match to the UHB staff records (2,600 records required manual validation).

When compared to 2021/22 uptake, Fluenz uptake amongst school-aged children reduced for both primary and secondary school aged children. 57.2% vaccine uptake was seen in primary school-aged children (60.6% in 2021/22) and 41.6% in secondary school-aged children (57.3% in 2021/22). Both these performances fell below the Wales averages of 63.9% and 54.4% respectively.
The Health Board has a population that is ethnically very diverse, with a wide range of cultural backgrounds making up the population. This, in conjunction with workforce and resource challenges, has resulted in poorer performance when compared to other Health Boards in Wales. Workforce and resource constraints have negatively impacted on the Health Board's ability to equitably promote the Fluenz Programme within schools and to support parents with the necessary education & information to promote informed consent. With one Cardiff School reporting 92 different languages being spoken by pupils family, language barriers remain a challenge.
For two to three-year olds, overall Health Board flu uptake was 43.8% (44.5% in 2021/22), which compares to a Welsh average of 44%.

For further information see the Appendix. Winter Respiratory Vaccination Plan, which contains a summary of 2022/2023 Covid-19 and Flu vaccination uptake and Health Board comparison data.

3.0. Plan for the 2023/24 Winter Respiratory Vaccination Programme
The Winter Respiratory Vaccination Programme will be operationally led by the Mass Immunisation and Testing Business Unit with strategic oversight from Public Health and delivered in line with Joint Committee for Vaccination and Immunisation

(JCVI Covid-19 Link - https://www.gov.uk/government/publications/covid-19-vaccination-programme-for-2023-jcvi-interim-advice-8-november-2022 ;

Influenza Link - https://app.box.com/s/t5ockz9bb6xw6t2mrrzb144njplimfo0/file/1079253178131) and Welsh Government advice and guidance.)

Welsh Government has confirmed that the priority remains to vaccinate groups who are most at risk from becoming very ill with winter respiratory viruses and/or infecting other members of the community. Eligibility criteria (https://www.gov.wales/sites/default/files/publications/2023-06/the-national-influenza-immunisation-programme-2023-24.pdf) for the flu vaccine were published on 22 June 2023. The interim advice for Covid-19 for 2023/24 mirrors the recommendation for the 2022/23 season however, full eligibility remains unconfirmed at the time of submission.

The Winter Respiratory Vaccination Plan is included in the Appendix.

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

- The Influenza and Covid-19 vaccination Programmes will be fully integrated into a Winter Respiratory Vaccination Programme. The Plan seeks opportunities to promote more effective and efficient planning, delivery and evaluation strategies/tools which, in turn, will improve vaccine equity and access for citizens and staff.

- To represent the integration of the UHB staff vaccination programmes, Flu Leads and Flu Champions will be rebranded, becoming Vaccination Leads and Vaccination Champions respectively.

- The Plan promotes strong leadership and governance arrangements through the Immunisation Operational Board.

- The Plan includes actions from key multi-agency stakeholders, outlined in the Plan's Appendix. Specific actions will be undertaken to meet the Plans aims and objectives.

Recommendation:

The Committee is requested to:

a) NOTE: The progress to date
b) APPROVE: The Winter Respiratory Vaccination Programme Plan 2023/24
c) PROVIDE: Leadership and support to the implementation of the Plan

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: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Strategic Leadership Board	13 July 2023
Quality, Safety and Experience Committee	18 July 2023

Cardiff and Vale of Glamorgan Winter Respiratory Vaccination Plan 2023/24

1.0. Introduction

Vaccination is the most effective way to protect against ill health, preventing severe illness and death within our citizens, communities and workforce. Acknowledging the significant impact immunisation has on public health, Welsh Government published their transition plan, Together for a Safer Future (https://www.gov.wales/wales-long-term-covid-19-transition-pandemic-endemicDraft SLB Cover Paper_Winter Respiratory Vaccination Programme 2023_24_SW comments.docx): Wales' long-term Covid transition from pandemic to endemic, in March 2022, which set out the principles that Health Boards should apply when planning and implementing a public health approach to respiratory viruses.
This was later supported by the Winter Respiratory Vaccination Strategy - https://www.gov.wales/winter-respiratory-vaccination-strategy-autumn-and-winter-2022-2023 (September 2022) which set out Welsh Government's priorities for the protection of those at greatest risk from respiratory illness. The ambition of the Strategy, to identify opportunities to co-administer Covid-19 and influenza vaccinations, demonstrated their ongoing commitment to the development of a fully integrated vaccination programme that offers improved citizen experience and access to vaccines thus, increasing uptake, providing greater health protection for communities and providing service efficiencies for Health Boards.

In order to protect our patients, staff, families and communities from infection-related morbidity and mortality, Cardiff and Vale University Health Board ensure that all eligible citizens and staff are aware that they are eligible for vaccination, are actively invited to receive the recommended winter respiratory vaccination(s), are provided and supported with relevant accessible information to make an informed decision and are provided with accessible options to receive the vaccination(s). Our ambition is that this should improve uptake and reduce inequities.

2.0. Purpose

Our Vision

Protect our local population through safe, innovative, timely, person-centred and equitable immunisation delivery, maximising uptake in the process.

The Purpose of the Cardiff and Vale of Glamorgan Winter Respiratory Vaccination Programme 2023/24 is to effectively protect our local population against vaccine preventable diseases.

This Plan sets out Cardiff and Vale University Health Board (UHB)'s ambitions for the Winter Respiratory Vaccination Programme, outlining how we will offer both the influenza (flu) and Covid-19 vaccines to our eligible citizens and staff., and reduce any health inequities.

3.0. Aims and Objectives

Deploying our Winter Respiratory Vaccination Plan is a committed approach to the integration of Cardiff and Vale University Health Board's annual winter vaccination programmes that are delivered across the Clinical Boards. The aims and objectives of the Programme utilise the good practice and lessons identified from existing and previous vaccination programmes to establish and implement future changes that will promote better outcomes for our citizens, staff and services.

3.1. Aims

- The Winter Respiratory Vaccination Programme aims to protect our citizens, health and care staff and services by minimising the spread of vaccine preventable respiratory disease.
- The aim of this Plan is to outline the actions that will be undertaken to maximise the uptake of both flu and Covid-19 vaccines for everyone who is eligible, enabling the Health Board to consistently achieve, or exceed, national vaccine uptake targets and reduce inequities.

3.2. Objectives

To help achieve our aims:

- A **Collaborative planning approach** will be employed, utilising the skills, experience and influence of Key Stakeholders, from across the UHB and Local Authority to **co-produce** the Winter Respiratory Vaccination Programme Action Plan that is informed by data, experience and insights.
- **Access to vaccinations** will be improved, ensuring that citizens and staff are offered reasonable opportunities to access their vaccinations.
- **Effective and efficient workforce deployment** opportunities will be explored and implemented where appropriate to promote improved vaccine uptake.
- **Digital solutions**, that promote easier, safer and more efficient data access and recording, will be utilised.
- Various formats (digital and non-digital), will be utilised to **communicate and engage with citizens and staff**, adapting methods to meet the differing needs of our population including those that are seldom heard.
- Undertaking annual Programme evaluation and employing **continuous improvement** principles

Equity is at the core of the Cardiff and Vale University Health Board's approach to vaccination. The aims and objectives of this Plan take into consideration the themes and priorities within the Cardiff and Vale UHB's Vaccine Equity Strategic Plan and the National Immunisation Framework for Wales, ensuring that equitable vaccine uptake is achieved across all our communities and workforce. The actions that we will undertake, to meet our objectives (detailed in Section 7.1.), ensure that:

- Everyone eligible for a vaccination is appropriately offered an appointment (and recalled when necessary) and can access a vaccination.
- Everyone is supported with the information that they need to make an informed decision on vaccination based upon reliable sources.

This will require a proactive approach, targeting specific actions to seldom heard groups, specific population groups and/or geographical areas.

4.0. Scope of the Winter Respiratory Vaccination Programme

The Winter Respiratory Vaccination Programme includes the vaccine preventable respiratory illnesses Covid-19 and Influenza.

The following vaccination cohorts are included within the scope of the Programme and Plan:

- UHB staff Influenza and Covid-19 vaccinations
- Health and Social Care staff Influenza and Covid-19 vaccinations
- Adult Influenza & Covid-19 vaccinations
- In-Patient Influenza and Covid-19 vaccinations
- Pregnancy Influenza and Covid-19 vaccinations
- School aged children Influenza vaccinations
- Clinically vulnerable Influenza and Covid-19 vaccinations
- Care home resident Influenza and Covid-19 vaccinations
- Seldom heard groups Influenza and Covid-19 vaccinations (See Appendix One for further details)

5.0. Governance Arrangements

Strong leadership and role modelling, at both the Executive and Clinical Board level, is required to embed the Winter Respiratory Vaccination Programme in the established service and governance arrangements.

The Winter Respiratory Vaccination Programme is operationally led by the Mass Immunisation and Testing Business Unit with strategic oversight from Public Health.

Programme review and escalation will occur through the Immunisation Operational Board, chaired by the SRO for Immunisation.

Key Stakeholders (See Appendix Two for details), involved in the planning and delivery of either the flu or Covid-19 vaccination campaigns, will have roles and responsibilities specific to their area of delivery. However, all Clinical Boards have a responsibility to support the delivery of the Winter Respiratory Vaccination Programme (See Appendix Three for details)

6.0. Progress to date

The National Influenza Vaccination Programme is long established, with annual flu vaccination being offered to high risk citizens since the 1960s and to all over the age of 65 years for more than 20 years. The Programme has also been extended to offer vaccination to health and social care staff working with vulnerable citizens. The majority of these vaccinations are administered within Primary Care. The childhood flu vaccination programme has also progressed since its inception, now including children between the ages of 2 and 15 years, with the majority of this group receiving a flu vaccine at their school.

The Covid Mass Vaccination Programme, established in early December 2020, in response to the global pandemic, has delivered more than 1.3 million vaccinations to date in Cardiff and Vale of Glamorgan. The Programme has progressed in stages offering primary courses and booster doses to the most vulnerable within the population. The majority of the vaccinations have been delivered through Health Board Mass Vaccination Centres (MVCs) however, there has also been delivery through GP practices and Community Pharmacy, as well as a mobile team delivering to care homes, housebound and seldom heard groups.

Inequity in vaccine uptake is observed by geographical area and ethnicity throughout Cardiff and the Vale of Glamorgan. In particular, we experience lower vaccine uptake in Clusters were there are higher levels of socio-economic deprivation, according to the Welsh Index of Multiple Deprivation (e.g. City and Cardiff South and Cardiff South East). Also, within these geographical areas we have a higher proportion of people from ethnic minority communities.

Figure 1 below demonstrates 2022 Covid-19 Autumn Boosters uptake in eligible groups by ethnic groups in Cardiff and Vale UHB at 08/12/22. Of particular note, people from the Black community have a particularly low uptake.

Eligible groups	Ethnic Group	Denominator	Uptake (%)	95% CI
Aged 80+	White	21,100	87.0	(86.8-87.5)
	Black	200	38.0	(35.4-45.7)
	Asian	600	55.8	(54.3-60.3)
	Mixed	200	62.6	(59.6-70.4)
	Other	100	48.9	(45-59.5)
	Unknown	2,300	51.7	(51-53.9)
Aged 70-79	White	35,300	86.7	(86.6-87.1)
	Black	300	45.3	(43-51.9)
	Asian	900	67.3	(66.2-70.4)
	Mixed	400	70.7	(68.9-75.5)
	Other	300	49.7	(47.2-56.8)
	Unknown	3,300	60.6	(60.1-62.4)
Aged 60-69	White	45,800	77.4	(77.4-77.9)
	Black	700	43.3	(41.9-47.2)
	Asian	1,900	60.4	(59.6-62.7)
	Mixed	900	51.7	(50.5-55)
	Other	500	43.5	(41.9-48.3)
	Unknown	6,500	45.5	(45.2-46.8)
Aged 50-59	White	51,400	64.0	(63.9-64.4)
	Black	1,300	30.5	(29.6-33.2)
	Asian	3,300	49.7	(49.1-51.4)
	Mixed	1,400	38.9	(38-41.6)
	Other	900	28.7	(27.7-31.9)
	Unknown	10,100	30.4	(30.2-31.4)
Aged 5-49 at clinical risk	White	28,600	39.4	(39.3-40)
	Black	1,000	14.3	(13.6-16.7)
	Asian	2,400	31.1	(30.4-33)
	Mixed	2,200	20.0	(19.4-21.8)
	Other	700	19.4	(18.4-22.8)
	Unknown	4,200	27.1	(26.7-28.5)
Total	White	182,000	70.6	(70.5-70.8)
	Black	3,300	29.6	(29.2-31.3)
	Asian	8,900	49.0	(48.7-50.1)
	Mixed	4,900	35.9	(35.5-37.3)
	Other	2,300	31.9	(31.2-33.9)
	Unknown	26,200	39.2	(39.1-39.9)

Figure One. 2022 Autumn Boosters in eligible groups by ethnic groups in Cardiff and Vale UHB at 8/12/2022

6.1. Flu Vaccination Uptake 2022/23

Table 1: Summary of Influenza Uptake across eligible groups in Cardiff and the Vale of Glamorgan and Wales.

Eligible Group	2022/23 Uptake in Cardiff and Vale *	2022/23 Uptake across Wales
2-3 years olds	43.8%	43.8%
Primary School-aged children (Reception to Year 6)	57.2%	65.2%
Secondary school aged children (Years 7-11)	41.6%	54.4%
6 months to 64 years at risk	39.7%	44.2%
50 to 64 years	38.9%	42.0%
65 years and over	75.7%	76.3%
Pregnant**(*)	994	6909
NHS Wales Healthcare workers (direct patient contact)	41.1%	47.2%
Social Care/Domiciliary Workers & Unpaid Carers **	934	6856

** Provisional data from PHW as at 25 April 2023*
*** No denominator available*
**** Data source: General Practice data collected through Audit+ Data Quality System*

All Health Boards saw a reduction in flu uptake across the majority of eligible cohorts (with exception of ABUHB & BCUHB who observed a minor increase in uptake amongst 50-64 years cohort). Cardiff and Vale University Health Board (UHB) maintained excellent levels of uptake amongst citizens aged 65 years and over with over 75% vaccinated.

Despite a reduction in the flu vaccination uptake gap across the Primary Care Clusters (uptake gap of 25.6% in 2022/23 compared to 29.4% in 2021/22), inequities remain across our region with an uptake of 56.1% in City and South Cluster and 81.7% in Western Vale.

6.2. COVID-19 Winter Vaccinations 2022/23

Table 2: Summary of COVID-19 vaccination uptake across eligible groups in Cardiff and the Vale of Glamorgan and Wales.

Eligible Group	2022/23 Uptake in Cardiff and Vale *	2022/23 Uptake across Wales
Severely Immunosuppressed	74.2%	77.0%
Care Home Residents	87.3%	89.0%
Care Home Staff	42.1%	42.0%
Health Care Staff	64.5%	57.3%
Social Care Staff	56.9%	52.2%
65 years and over	82.9%	82.7%
50-64 years	62.8%	60.3%
COPD Patients	28.3%	25.8%
5-49 years in a clinical risk group	39.4%	35.0%

** Data from PHW as of 29 March 2023*

All Health Boards saw a reduction in Covid-19 uptake across the eligible cohorts when compared to the previous 2022/23 programme. Despite this reduction, Cardiff and Vale UHB maintained excellent levels of uptake amongst: citizens aged 65 years and over and residents in a care home with over 80% vaccinated. Our uptake levels for all cohorts are comparable to the Welsh averages.

Inequity of Covid-19 vaccine uptake was observed with City and South Cluster achieving 43.1% uptake compared to 76.9% in Western Vale. The uptake gap between Cardiff and the Vale of Glamorgan Local Authorities also increased to 6.9% (previously 3.1%).

Inequity was exhibited for people with a GP recorded learning disability in 2021/22 with Public Health Wales Vaccine Preventable Disease Programme (VPDP) and Communicable Disease Surveillance Centre (CDSC) reporting an uptake of 75% in this group compared to 79% in the whole population. Data is not yet available to draw a comparison for the 2022/23 autumn booster campaign.

7.0. Plan for Winter Vaccination Programme 2023/24

We have seen the impact that Covid-19 has had on the health of the population and the risk of this being compounded by the numbers that become unwell and die from influenza. As we transition from pandemic to endemic, the Health Board is scaling back the services and resources put in place to manage the pandemic whilst continuing to provide a decisive response to winter respiratory infections. The Health Board will implement a Regional Health Protection System that will see the planning and delivery of a Winter Respiratory Vaccination Programme to deliver co-administered Covid-19 and influenza vaccination wherever appropriate. This Winter Respiratory Vaccination Programme will be operationally led by the Mass Immunisation and Testing Business Unit with strategic oversight from Public Health, delivered in line with Welsh Health Circular 2022 (031) (https://www.gov.wales/reimbursable-vaccines-and-eligible-cohorts-2023-2024-nhs-seasonal-influenza-flu-vaccination) and interim Joint Committee for Vaccination and Immunisation (JCVI) advice

(Covid-19 Link -https://www.gov.uk/government/publications/covid-19-vaccination-programme-for-2023-jcvi-interim-advice-8-november-2022 ;
Influenza Link - https://app.box.com/s/t5ockz9bb6xw6t2mrrzb144njplimfo0/file/1079253178131).

Welsh Government has confirmed that the priority remains to vaccinate groups who are most at risk of becoming very ill with winter respiratory viruses and/or infecting other members of the community. The eligibility criteria - https://www.gov.wales/sites/default/files/publications/2023-06/the-national-influenza-immunisation-programme-2023-24.pdf for the flu vaccine were published on 22 June 2023. The advice for Covid-19 for 2023/24 mirrors the recommendations for the 2022/23 season however, a decision will be made by Welsh Government, following analysis of 2022/23 uptake and publication of JCVI recommendations around the COVID-19 Autumn booster programme.

7.1. Strategic Action Plan to Deliver the Winter Respiratory Vaccination Programme 2023/24

Objective	Strategic Driver(s)	Cohort	Setting	Action	Action Owner(s)	By When	Progress (Outstanding/In Progress/Complete)
Collaborative Planning Approach	Vaccine Equity Strategic Plan: Stakeholder Engagement National Immunisation Framework: Deployment & Governance WHC/2022/031	All	All	Instigate WRVP Group and co-produce & implement 2023/24 WRVP Action Plan • Review Staff WRV Policy • Rebrand Flu & Covid-19 Vaccine Programmes into WRVP	Head /DHo Operations, MI&T /Head of Service, Occupational Health	July 2023	In Progress
	Vaccine Equity Strategic Plan: Stakeholder Engagement Evaluation and Continuous improvement National Immunisation Framework: Vaccination Equity WHC/2022/031	All	All	Identify risks and issues to vaccine uptake by exploring challenges/ barriers and facilitators to vaccine delivery. Identify action(s) to mitigate or exploit risks and issues. • Engage with Key Programme Stakeholders • Engage with community representatives • Establish Action Plan & risk/Issue log	Head /DHo Operations, MI&T	Sept 2023	In Progress
Improved Access to Vaccinations	National Immunisation Framework: Vaccination Equity & Eligibility Vaccine Equity Strategic Plan: A data-informed approach WHC/2022/031	All All UHB Staff All	All All UHB All	Use uptake data to plan targeted and tailored support and interventions Intervention(s) identified for: • Establish community-based vaccination provision to improve accessibility and ensure target seldom heard groups • Support UHB Occupational Health to undertake data cleansing to improve data accuracy and quality • Implement up to date training package for WIS data input/entry (Primary Care/Vaccine Champions/Child Health)	Head /DHo Operations, MI&T /Mass Imms Equity Lead /Immunisation Coordinators /Head of Service, Occupational Healt /Heads of Service / Operational Manager & Senior Nurse, MI&T	March 2024	Outstanding
	National Immunisation Framework: Vaccination Equity Vaccine Equity Strategic Plan: A data-informed approach WHC/2022/031	All	All	Targeted data collation / linkage where information is not routinely or readily available • Care home staff survey to explore barriers to uptake • Explore delivery model for care home staff	Head /DHo Operations, MI&T /Social Care Liaison(s)	March 2024	Outstanding
Effective and Efficient Workforce Deployment	National Immunisation Framework: Deployment	All	All	Implement training package to upskill vaccinators to co-administer influenza and Covid-19 vaccinations across all Clinical Boards.	Operational Manager & Senior Nurse, MI&T	March 2024	In-Progress
	Vaccine Equity Strategic Plan: Evaluation and Continuous improvement	All Care Home Residents	All Care Home	Collaborative working to administer vaccines/alternative delivery model to realise efficiencies • Task & finish group to explore opportunities to develop a nursing home immunisation model	Head /DHo Operations, MI&T /Head of Primary Care / Social Care Liaison(s)	Jan 2024	Outstanding Outstanding

	WHC/2022/031	School aged children Covid-19 Cohorts	School / UHB /GP	(https://primarycareone.nhs.wales/tools/community-infrastructure-ci-programme/) • Task & finish group to establish Continuity Plan for withdrawal of National Protocol for Unregistered Vaccinator Workforce	/Lead Nurse, Child Health / Senior Nurse, MI&T	Aug 2023	Outstanding
Digital Solutions	National Immunisation Framework: Digitally Enabled Vaccination Vaccine Equity Strategic Plan: A data-informed approach WHC/2022/031	All	All	Utilise the WIS functionality to standardise data recording and reporting. • Use the WIS for recording all Covid-19 & Influenza vaccinations • Use the vaccine stock control element of WIS to enable accurate tracking of vaccines through the UHB • Provide up to date information and training for WIS (Primary Care/Clinical Boards/Occupational Health/Child Health)	Head /DHo Operations, MI&T /Heads of Service / Vaccination Leads	March 2024	In-Progress
		All	All	Explore and take opportunities to - integrate vaccination records where possible, employ digital consent, improve booking services, communication and recording functionality.	All Stakeholders	March 2024	Outstanding
Communication and engagement	National Immunisation Framework: Vaccination Equity Public Vaccination Literacy Vaccine Equity Strategic Plan: Communication WHC/2022/031	All	All	Targeted communications to persons with protected characteristics, Socio-economic disadvantage or within a marginalised or underserved group • Improved vaccine information, in a non-written form, to residents of HMP • Implement findings from horizon scanning report on vaccine acceptance (https://phwwhocc.co.uk/resources/international-horizon-scanning-and-learning-report-communication-campaigns-for-vaccine-acceptance/)	Head /DHo Operations, MI&T / Equity Lead, MI&T , Immunisation Coordinator / Patient Experience Officer / Communication Officer / Head of Healthcare, HMP	March 2024	Outstanding
		All	All	Encourage citizens & staff to accept the offer of co-administration of Covid-19 and influenza vaccination • Promotion of the Public Health Wales COVID/Flu One Module and targeted myth busting communications • Proactively invite citizens & staff for vaccination through issuing individual letters/text message to inform of vaccine eligibility and what they need to do to obtain their vaccine	Head /DHo Operations, MI&T / Equity Lead, MI&T , Immunisation Coordinator / Patient Experience Officer / Communication Officer	March 2024	Outstanding
		All	All	Influence community & religious leaders and multicultural links to address vaccine hesitancy	Head /DHo Operations, MI&T / Equity Lead, MI&T , Immunisation Coordinator / Patient Experience Officer / Communication Officer	March 2024	Outstanding
		All	All	Ensuring that communications, education and training and engagement are culturally and linguistically appropriate and accessible	Head /DHo Operations, Immunisation Coordinator / Patient Experience Officer / Communication Officer	March 2024	Outstanding
		Care Home Staff Residents	CP Care Home	Develop and cascade communications and info resources in a variety of formats	/ Patient Experience Officer / Communication Officer /Public Health Team	March 2024	Outstanding
Continuous Improvement	National Immunisation Framework: Vaccination Equity Digitally Enabled Vaccination Deployment Vaccine Equity Strategic Plan: Evaluation and Continuous improvement WHC/2022/031	All	All	Track progress of the Winter campaign on a regular/at least monthly basis to inform action. Undertake an annual evaluation / lessons learnt exercise for Winter Respiratory Vaccination Programme with a focus on improved planning and implementation for next Programme	Monthly from September 2023 All Key Stakeholders	Monthly until March 2023 March 2014	To commence in September 2023 In-Progress

Appendix One.
Seldom Heard Groups/Targeted Cohorts Included in The Winter Respiratory Vaccination Programme

The seldom heard/targeted cohorts included within the scope of this plan are in line with the principles of the Cardiff and Vale UHB Vaccine Equity Strategy. These individuals include:

- People with protected characteristics under the Equality Act 2010 including people from ethnic minority backgrounds and people with disabilities;

- Those at socio-economic disadvantage living in communities with high deprivation or social exclusion and

- Those within marginalised or under-served groups such as asylum or sanctuary seekers, people experiencing homelessness, people involved in the justice system, people with mental ill-health and people from traveller communities who do not regularly access traditional healthcare services.

Targeted planning, delivery and intervention activities will be undertaken for the following seldom heard cohorts:

- Individuals who are pregnant
- Prison residents
- Carers
- Individuals registered as having a learning disability
- Care home residents

- Individuals who are housebound
- In-patients
- Individuals who identify as an ethnic minority

Appendix Two. Key Stakeholders

Role	Involvement with:
Stakeholders: Planning and Delivery	
C&V UHB PH Consultant Immunisation Lead	All
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Immunisation Coordinator, Influenza Lead	All
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Immunisation Senior Nurse, Mass Imms & Testing	All
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Head/Dep Head of Operations, Mass Imms & Testing	All
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Immunisation Admin Support, Mass Imms & Testing	All
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Immunisation Digital Support, Mass Imms & Testing	All
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Senior Communication and Engagement Officer	All
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Head of Service, Occupational Health	Staff Winter Vaccination Programme
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Acute Pharmacy Contact	

CARDIFF AND VALE UNIVERSITY HEALTH BOARD Primary Care Immunisation Lead / Manager	Primary Care Winter Vaccination Programme
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Senior Nurse Primary Care	
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Lead for Community Pharmacy	
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Midwifery Lead/Directorate Lead Nurse	Pregnancy Winter Vaccination Programme
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Assistant Director of Nursing	In-Patient Winter Vaccination Programme
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Lead Nurse, Child Health	School Flu Programme
CARDIFF AND VALE UNIVERSITY HEALTH BOARD Patient Experience Support Advisor	Targeted Cohorts Winter Vaccination Programme
Stakeholders: Engagement and Communication	
Universities Advocate: Occupational Health Depts	Student Winter Vaccination Programme
Operational Manager	Care Homes Winter Vaccination Programme (Staff)
Unpaid Carers Advocate, Vale of Glam' Local Authority	Targeted Cohorts Winter Vaccination Programme
Unpaid Carers Advocate, Cardiff Local Authority	
CARDIFF AND VALE UNIVERSITY HEALTH BOARD, South and East Cardiff Locality Manager	
Directorate Manager for Learning Disabilities services, SB UHB	
Lead Nurse, SB UHB	
Service Manager for Learning Disabilities services, Cardiff	
Service Manager for Learning Disabilities services, Vale of Glam	
Advocate for Home schooled/out of school programme children	

Appendix Three. Clinical Board Roles and Responsibilities

- Maintaining strong leadership and role modelling
- Continuing the invaluable role of the Clinical Board Vaccination Lead role
- Nominating Vaccination Leads and Vaccination Champions respectively for the Programme
- Supporting Vaccine Champions to be given protected time with the expectation that Vaccine Champions will vaccinate both Covid-19 and Flu, in a variety of areas to support the staff programme across the Health Board (e.g. mini-mass vaccination sessions)
- Encouraging staff to accept the offer of co-administration of Covid-19 and influenza vaccination through the promotion of the Public Health Wales COVID-19/Flu One Module and targeted myth busting communications
- Investigating and addressing, where appropriate, staff perceptions of the risks associated with vaccination, not only for themselves but their families, colleagues and their patients.
- Ensuring accurate stock control and record keeping for Vaccination Champions within the Clinical Board

- Ensuring that WIS is available for recording all Covid-19 & Influenza vaccinations given to UHB staff
- Utilising vaccine stock control element of WIS to enable accurate tracking of vaccines through the UHB

Report Title:	Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25			Agenda Item no.	3.3
Meeting:	Quality Safety and Experience Committee	Public	X	Meeting Date:	18/07/2023
		Private			
Status *(please tick one only):*	Assurance		Approval X	Information	
Lead Executive:	Executive Director of Public Health				
Report Author (Title):	Specialty Registrar in Public Health				

Main Report
Background and current situation:

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

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

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

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

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

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

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

Cardiff and Vale Eliminating Hepatitis (B and C) Joint Recovery Plan Oversight Group was established in March 2023, chaired by the Executive Director of Public Health, to facilitate the development of the Joint Recovery Plan for Cardiff and Vale University Health Board, which is now ready for approval by the Health Board ahead of submission to Welsh Government.

Where we are now
As part of the plan development, the Oversight Group undertook work to identify 'where we are now' in terms of our structures, processes and outcomes with hepatitis (B and C) activity. This included mapping exercises of our services and key partner services, identification of populations at high-risk, reviews of our current service process, and a review of data currently available. Some of this took place within the Health Board, whilst other aspects took place in collaboration with other Health Boards in Wales and Public Health Wales.

This work ultimately led to identification of five Challenge Areas:

- Challenge Area 1: Infection Prevention
- Challenge Area 2: Case Finding and Testing
- Challenge Area 3: Treatment
- Challenge Area 4: Re-engagement
- Challenge Area 5: Data

Where we want to be
Our regional aim is for elimination and prevention of hepatitis (B and C) in Cardiff and Vale of Glamorgan by 2030.

Our objectives to achieve this aim are:
- Vaccination of all high-risk and eligible individuals against hepatitis B.
- Increase Needle Syringe Programme attendance and paraphernalia coverage.
- Identify, screen and confirmatory test all high-risk individuals.
- Complete treatment with all positive cases of hepatitis C.
- Re-engage with all positive cases of hepatitis C who have not completed treatment and achieved SVR (cured).
- Record and collate data accurately and completely, with accessible tools for monitoring and evaluation of service performance and outcomes.

How we will get there
Following a review of 'where we are now', and the challenge areas for getting to 'where we want to be', we have identified 37 actions across five action areas to facilitate the achievement of our aim and objectives (see the Recovery Plan for full details).

The work on these action areas will also be part of the Cardiff and Vale Health Protection Plan for a new system model for an integrated and sustainable health protection model in Cardiff and Vale, which is currently in development.

Some aspects of the action areas will require collaborative partnership working on a national level with the other health boards and Public Health Wales, whilst others are specific actions for Cardiff and Vale UHB.

The timescale for the identified actions is the first two years following publication of this Joint Recovery Plan, with the majority of actions targeted in the first year.

The facilitation and implementation of the actions outlined in the 5 action areas will require significant resources. This will require a combination of utilising current services and staff within the system to incorporate the additional pieces of work, as well as likely requiring additional new staff resources on top of these.

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

Hepatitis B and C infections can cause significant adverse health impacts and deaths. In line with the World Health Organisation and Welsh Government, our aim is to eliminate hepatitis C and prevent cases of hepatitis B by 2030 at the latest.
Our Joint Recovery Plan sets out five action areas for the next two years to achieve this, covering the themes of infection prevention, case-finding and testing, treatment, re-engagement, and data.
To enable implementation of these actions we will need to review and evolve the various service components we currently have in the system, and in addition to this will also require several new resources to accommodate the additional work.
We require approval of the Joint Recovery Plan from the health board prior to submission of the plan to Welsh Government in July 2023.
The Joint Recovery Plan was taken to Senior Leadership Board on 13th July 2023.

Recommendation:

The Quality Safety and Experience Committee is requested to:

- Approve the Cardiff and Vale Eliminating Hepatitis (B and C) Joint Recovery Plan 2023-25 for submission to Welsh Government.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration		Collaboration	X	Involvement	

Impact Assessment:

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

Risk: Yes

Achievement of the actions in this plan will reduce the risk of hepatitis (B and C) amongst our population and the associated health risks.

Safety: Yes

Implementation of this plan will improve safety for people at risk of hepatitis (B and C) by reducing their risk of adverse health impacts as a consequence of these infections.

Financial: Yes
The implementation of the recovery plan in full will require additional resources. These will be met within existing departmental budgets where possible or brought to investment group where this is not possible.
Workforce: Yes
Implementing this recovery plan will require some changes to working processes for involved services and likely require additional workforce roles.
Legal: No
Reputational: Yes
This plan is required following a Welsh Health Circular from Welsh Government, requesting a plan from each health board in Wales.
Socio Economic: No
Equality and Health: Yes
A number of the actions in this plan involve addressing health inequalities amongst high-risk populations to improve access to testing and treatment for hepatitis.
Decarbonisation: No

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

Cardiff and Vale University Health Board

Hepatitis (B and C) Joint Recovery Plan

2023-2025

Part of the Cardiff and Vale of Glamorgan Health Protection Plan

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

Cardiff & Vale APB
Achieving better substance misuse outcomes

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Contents

Foreword

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

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

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

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

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

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

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

Fiona Kinghorn
Executive Director of Public Health
Cardiff and Vale University Health Board

Dr Bazga Ali
Consultant in Infectious Disease and Microbiology
Clinical Blood Borne Virus lead for Cardiff and Vale
Clinical Migrant Health lead for Public Health Wales

Glossary of Key Abbreviations

APB – Area Planning Board

BBV – Blood Bourne Virus

CAVDAS – Cardiff and Vale Drug and Alcohol Service

CAVHIS – Cardiff and Vale Health Inclusion Service

DoSH – Department of Sexual Health

MDT – Multidisciplinary Team

NICE – National Institute of Clinical Excellence

NSP – Needle Syringe Programme

PHW – Public Health Wales

SMTF – Substance Misuse Treatment Framework

SVR – Sustained Virological Response

UHB – University Health Board

WCP – Welsh Clinical Portal

WDS – Welsh Demographic Service

WHDM – Welsh Health Data Mart

WHO – World Health Organisation

1 Background and context

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

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

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

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

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

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

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

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

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

2 Where we are now

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

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

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

2.1 Structures and processes (inputs)

2.1.1 Infection prevention

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

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

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

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

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

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

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

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

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

2.1.2 Case-finding and testing

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

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

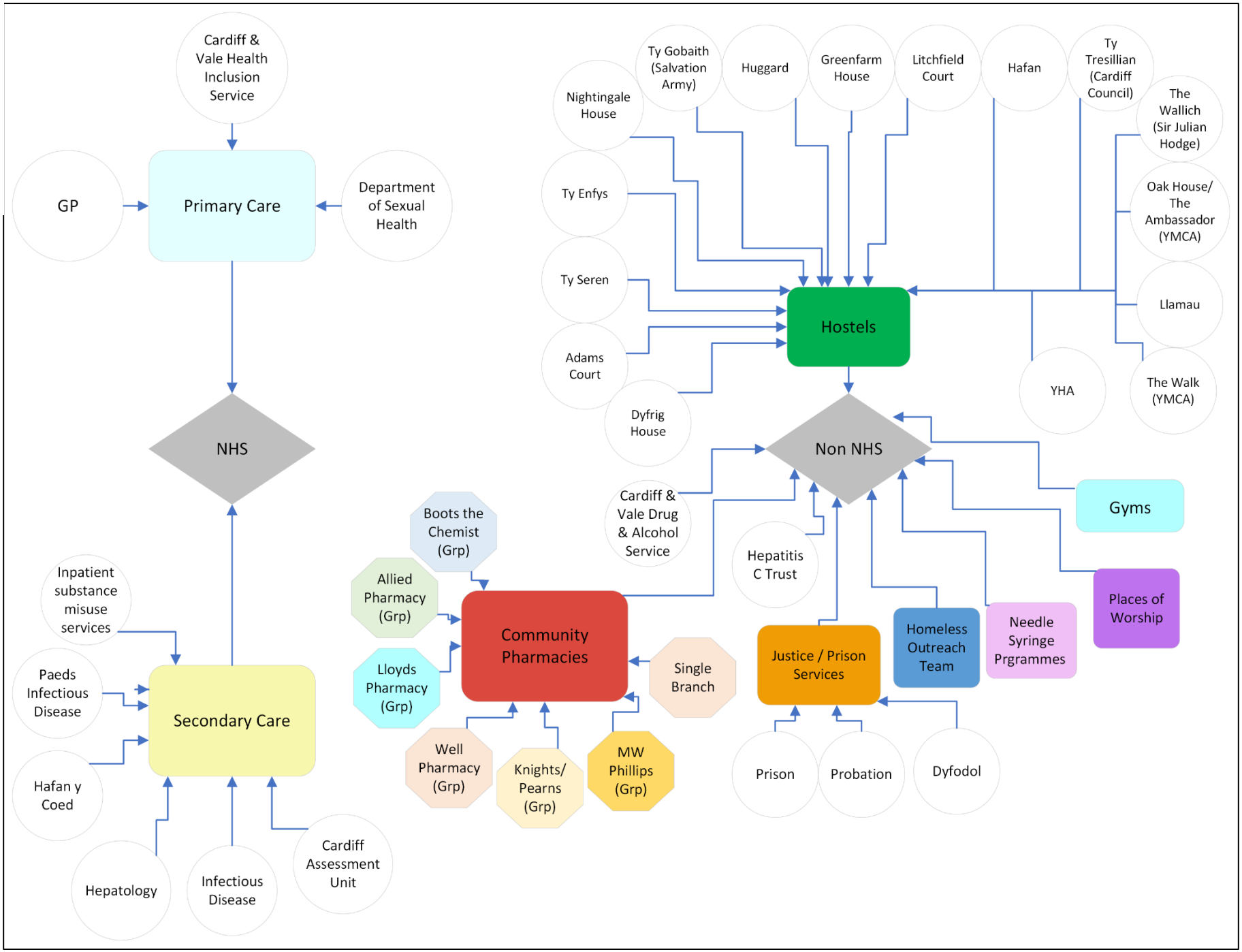
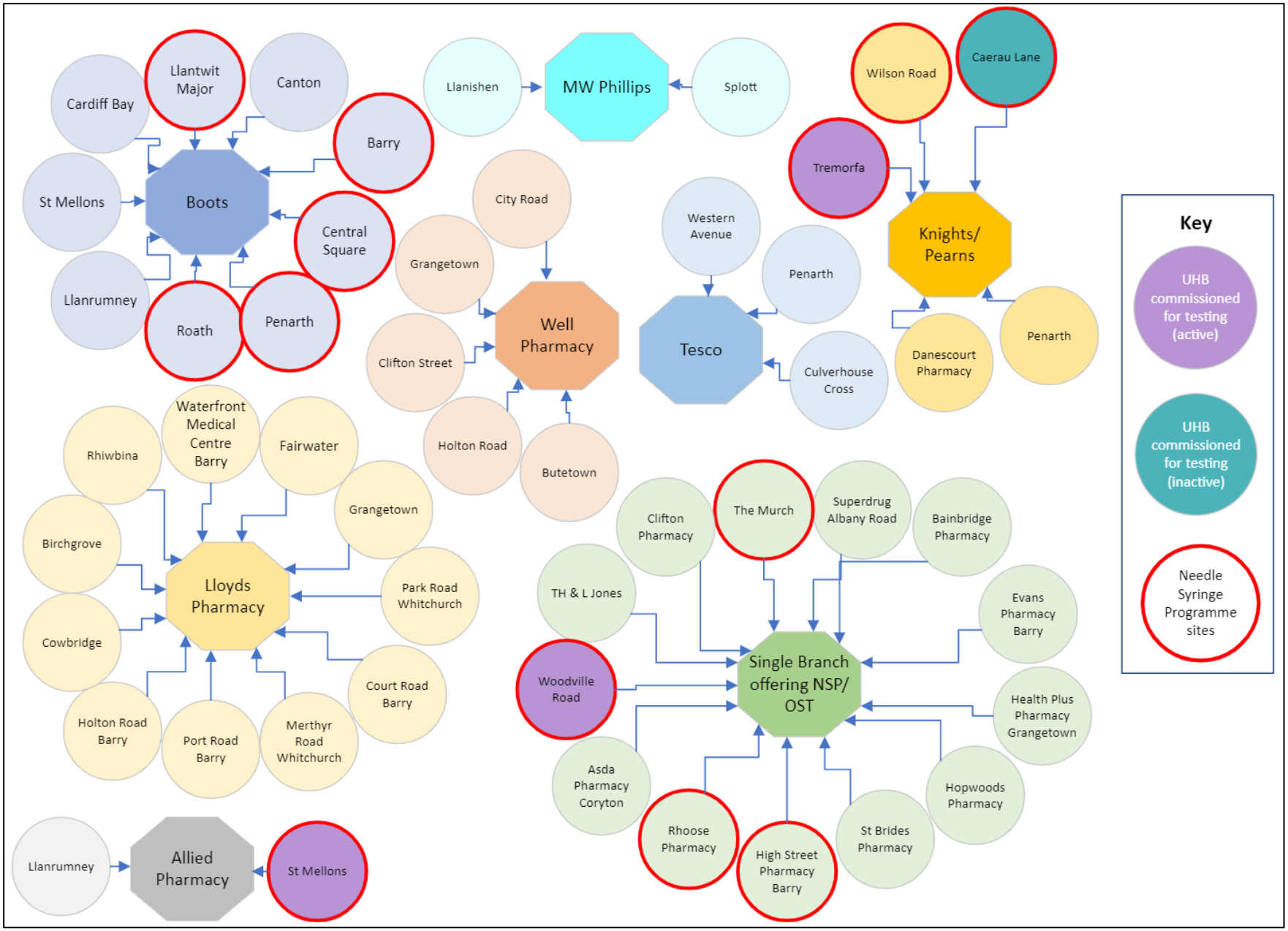


Figure 2: *Community pharmacy sites with links to hepatitis work in Cardiff and Vale UHB, including those currently commissioned for BBV testing and Needle Syringe Programme sites.*



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

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

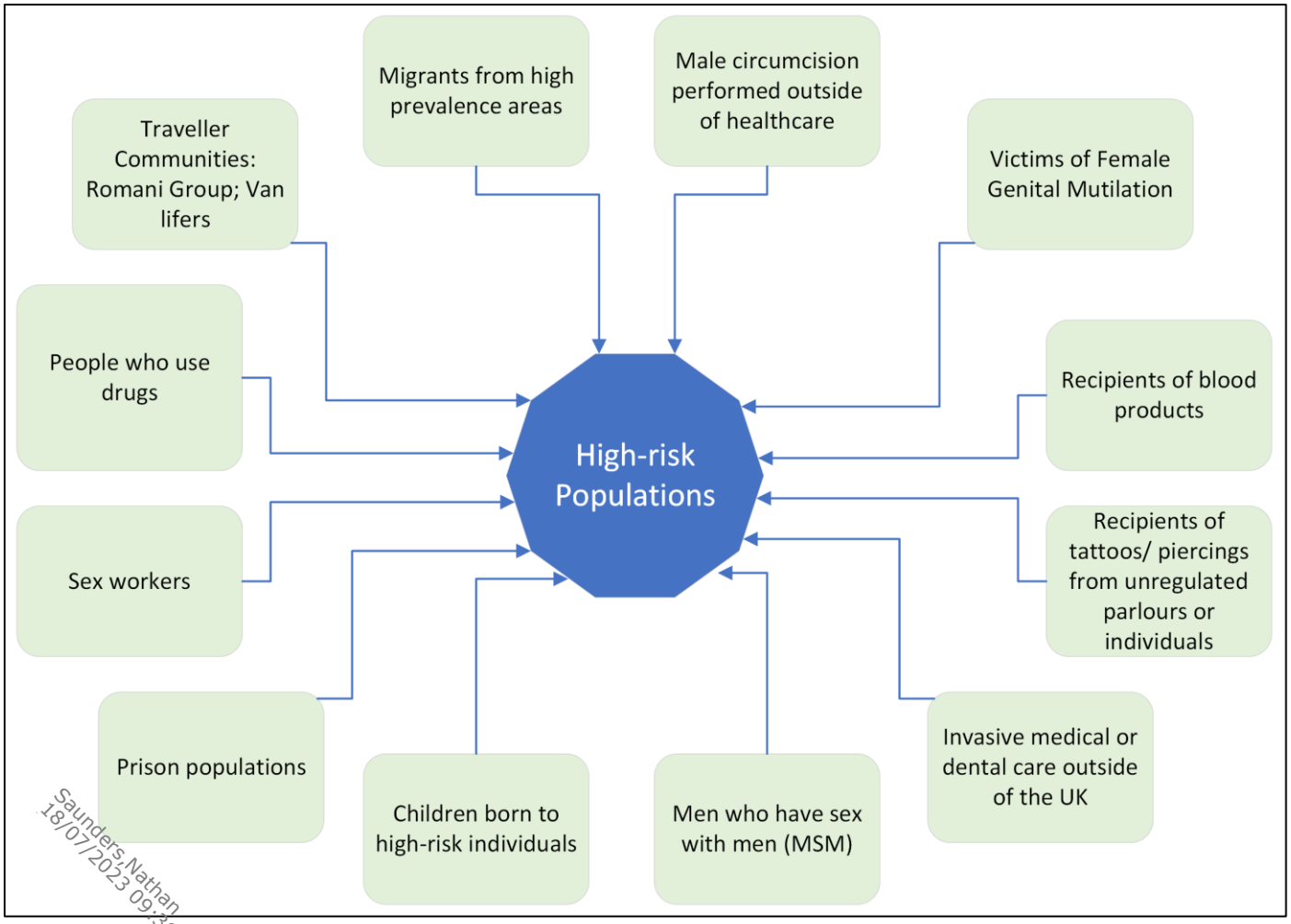


Figure 3: *Hepatitis (B and C) high-risk populations[11 12 13 14 15].*

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

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

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

Testing is accessed and completed via the following routes:

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

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

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

2.1.3 Treatment

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

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

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

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

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

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

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

2.1.4 Re-engagement

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

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

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

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

2. Make contact.

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

4. Consultation: repeat full BBV screen and assessment.

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

2.2 Outcomes

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

2.2.1 Infection prevention

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

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

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

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

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

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

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

2.2.2 Case-finding and testing

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

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

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

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

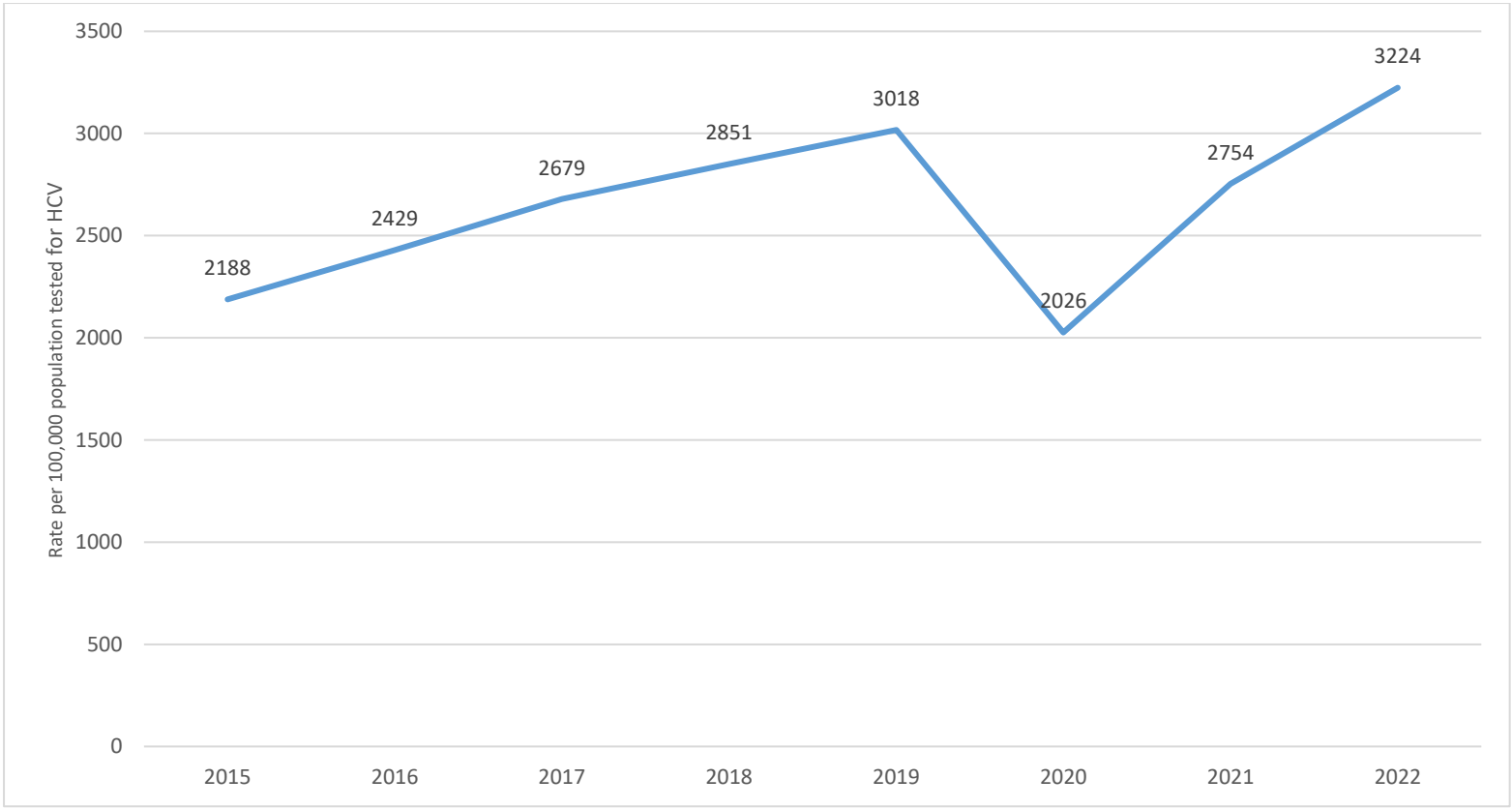


Figure 4: *Rate per 100,000 population tested for HCV (anti-HCV or HCV-RNA) resident in Cardiff and Vale UHB by year, 2015-2022*[6].

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

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

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

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

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

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

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

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

2.2.3 Treatment

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

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

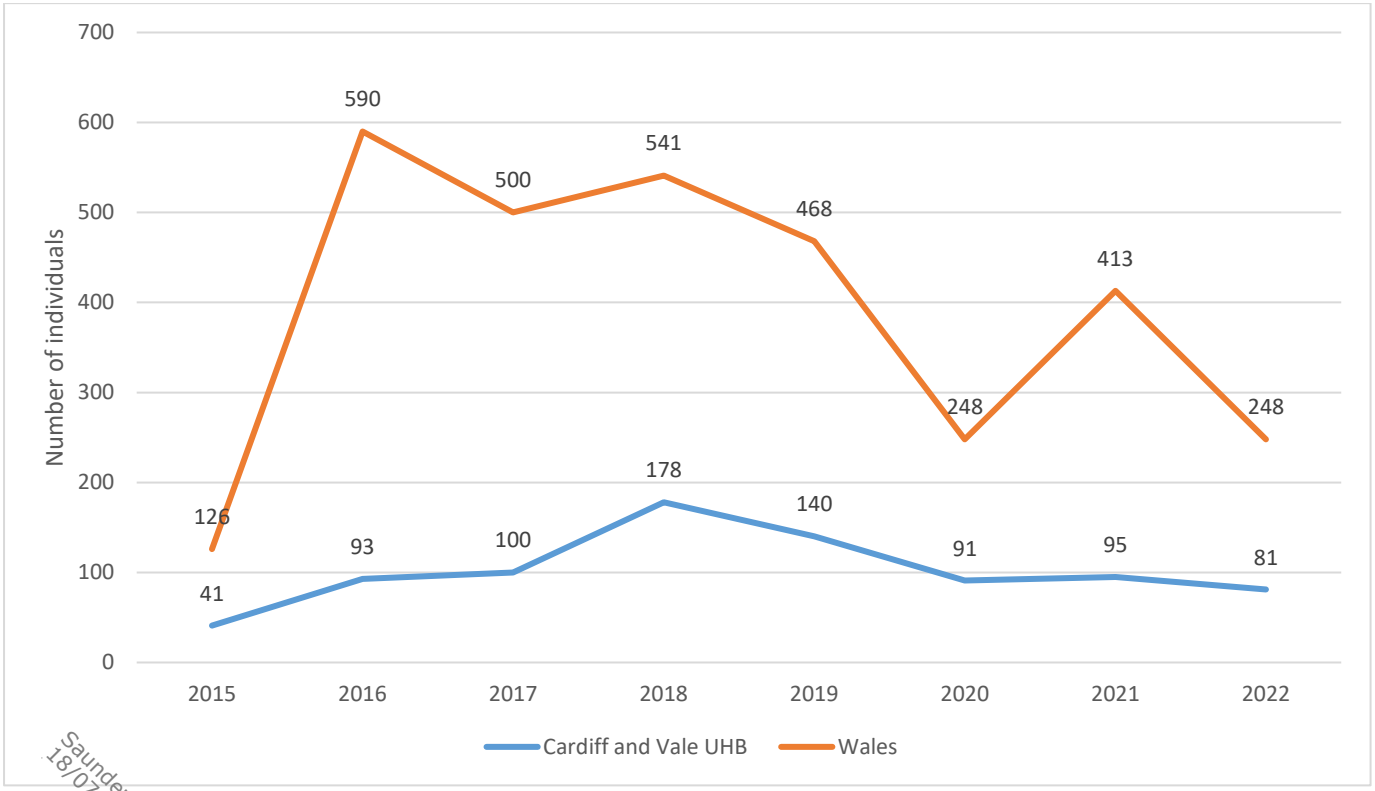


Figure 5: *Number of individuals commencing HCV treatment in Cardiff and Vale UHB and Wales, by year, 2015-2022*[6].

2.2.4 Re-engagement

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

2.3 Current Challenge Areas

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

Challenge Area 1: Infection prevention

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

Challenge Area 2: Case-finding and testing

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

Challenge Area 3: Treatment

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

Challenge Area 4: Re-engagement

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

Challenge Area 5: Data

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

3 Where we want to be

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

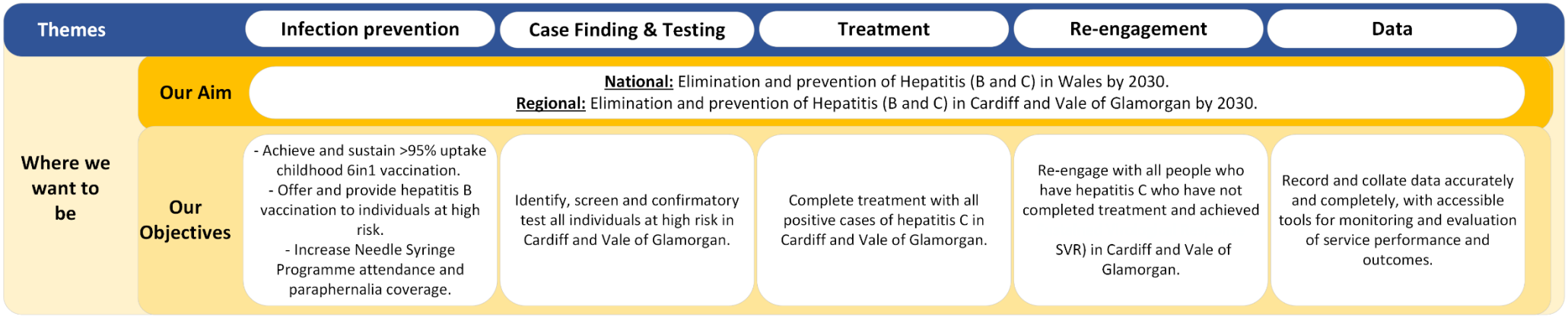


Figure 6: *Where we want to be: our aim and objectives for the prevention and elimination of hepatitis (B and C).*

4 How we will get there

4.1 Action Areas

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

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

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

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

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

4.2 Action Plan

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

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

	2.3 Ensure website improvements for signposting information for testing.	tbc	Year 1	Clear testing signposts online are operational and monitored.
	2.4 Conduct investigations to identify the barriers to engagement of testing services at community pharmacy sites, both in terms of staff engagement and service-user engagement.	tbc	Year 2	Completed report on the barriers with recommendations.
	2.5 Explore the potential of increasing the number of community pharmacy test sites; provided either by pharmacy staff or via in-reach peer-to-peer provision within pharmacy settings. Identification of additional sites will require investigation of the most effective locations to facilitate.	Pharmacy	Year 1	An increased number of active community pharmacy test sites.
	2.6 Explore website self-referral functions and processes based on the Frisky Wales test and post scheme.	Pharmacy	Year 1	Completed report on feasibility with recommendations.
	2.7 Explore options for BBV team having access to community Cepheid machines for outreach testing.	tbc	Year 2	Completed report on feasibility with recommendations.
	2.8 BBV screening to be implemented as part of substance misuse service harm reduction initiatives.	Substance Misuse Service	Year 1	Successfully implemented BBV screening in substance misuse service initiatives.
	2.9 Recommence testing in HMP Cardiff following discussions with Primary Care and Public Health Wales Prison Health Protection team.	tbc	Year 1	Active BBV testing in HMP Cardiff with data.
	2.10 Consider potential for the introduction of home test kits, following evaluation of the scheme in England.	tbc	Year 2	Completed report on feasibility with recommendations.
	2.11 Seek to identify opportunities to source funding for expansion of the Hepatitis C Trust Peer support services, with a remit across wider populations.	tbc	Year 2	Completed report on options for expansion with recommendations.
	2.12 Ensure opt-out testing protocols are implemented across all substance misuse treatment and support services through replication of BBV testing/treatment pathway mapping work undertaken by CAVDAS, BBV Clinical Nurses, Hepatitis C Trust, APB Support Team, Gilead, and Public Health Wales.	tbc	Year 1	Achievement of implementation of opt-out testing protocols.
	2.13 Implement opt-out induction testing across hostels and homeless services, as per current process in the Salvation Army hostel with the Hepatitis C Trust.	tbc	Year 2	Achievement of opt-out testing processes in hostels and homeless services.
	2.14 Explore new settings for POCT that are not currently used, based off the findings of action 2.1.	tbc	Year 2	Completed report on potential sites for POCT with recommendations.
	2.15 Explore the potential for Emergency Department opt-out testing by performing a pilot at the University Hospital of Wales Emergency Department.	Infectious Diseases team	Year 1	Completed pilot of emergency department testing with write-up and recommendations.
3. Treatment	**3.1** Develop a 'screening to treatment pathway' across all services, which includes integrated care planning with allied services to ensure individuals complete treatment.	tbc	Year 1	An active screening to treatment pathway in place.

	If clinically appropriate, patients will potentially be able to commence treatment the same day via Rapid Treatment Pathways (such as in HM Prison). Our aim will be for all positive cases to commence treatment within two weeks of testing, where appropriate.			
	3.2 Develop robust processes for ensuring that non-UHB providers are able to access results in a timely and sustainable manner.	tbc	Year 2	Processes in place for non-UHB providers to access results.
	3.3 Raise awareness of the effectiveness, side-effects and requirements of treatment, and dispel myths around these. (linked with action 2.2)	tbc	Year 2	Active awareness campaign launched in Cardiff and Vale and Wales.
	3.4 Increase use of Video-based therapy (VOT): This is live now as an All-Wales approach. It is for patients that fail first line therapy for hepatitis C through poor compliance. As a result VOT will aim to improve adherence to therapy and achievement of SVR.	Pharmacy	Year 1	Completed evaluation of impact of VOT, with recommendations for further use.
	3.5 Incentivise test completion via £10 'Love to Shop' vouchers, with subsequent incentive vouchers for completing treatment and attending an SVR test.	tbc	Year 1	Active incentive scheme in place.
	3.6 Use of Hepatitis C Trust Peer Support services to support treatment adherence.	tbc	Year 2	Completed review of Hepatitis C Trust peer support service activity.
4. Re-engagement	**4.1** Obtain an updated re-engagement list from Public Health Wales for acting on by the BBV team.	tbc	Year 1	Receipt of phase 2 re-engagement list by BBV team.
	4.2 Produce a clear process for cross-referencing and cleaning of the re-engagement list by the BBV team.	tbc	Year 1	Agreed process produced and in use.
	4.3 Produce a clear step-process for making contact with individuals on the re-engagement list; to include identification of support needed (staff, identification pathway, communication and promotion and any joint sharing of information protocols).	tbc	Year 1	Agreed process produced and in use.
	4.4 Use of Hepatitis C Trust Peer Support services to improve re-engagement.	tbc	Year 2	Hepatitis C Trust peer support services in place with re-engagement work.
	4.5 Regular monitoring and evaluation of the re-engagement list.	tbc	Year 1	Completed report on re-engagement activity.
5. Data	**5.1** Ensure improved recording of data at point of testing and treatment on the E-form database and Harm Reduction Database Wales, including quality assurance measures for completeness of data inputs.	tbc	Year 1	Agreed quality standard in place with processes for audit.
	5.2 Improve data availability and accessibility, working collaboratively with the other health boards in Wales and Public Heath Wales Communicable Disease Surveillance Centre (CDSC) to develop indicators (based on the WHO 'progress to elimination targets'[16]), and scope out an information tool to monitor this going forwards.	tbc	Year 1	Active data tool available to Health Boards in Wales.

4.3 Resources required

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

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

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

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

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

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

4.4 Implementation, monitoring and reporting mechanisms

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

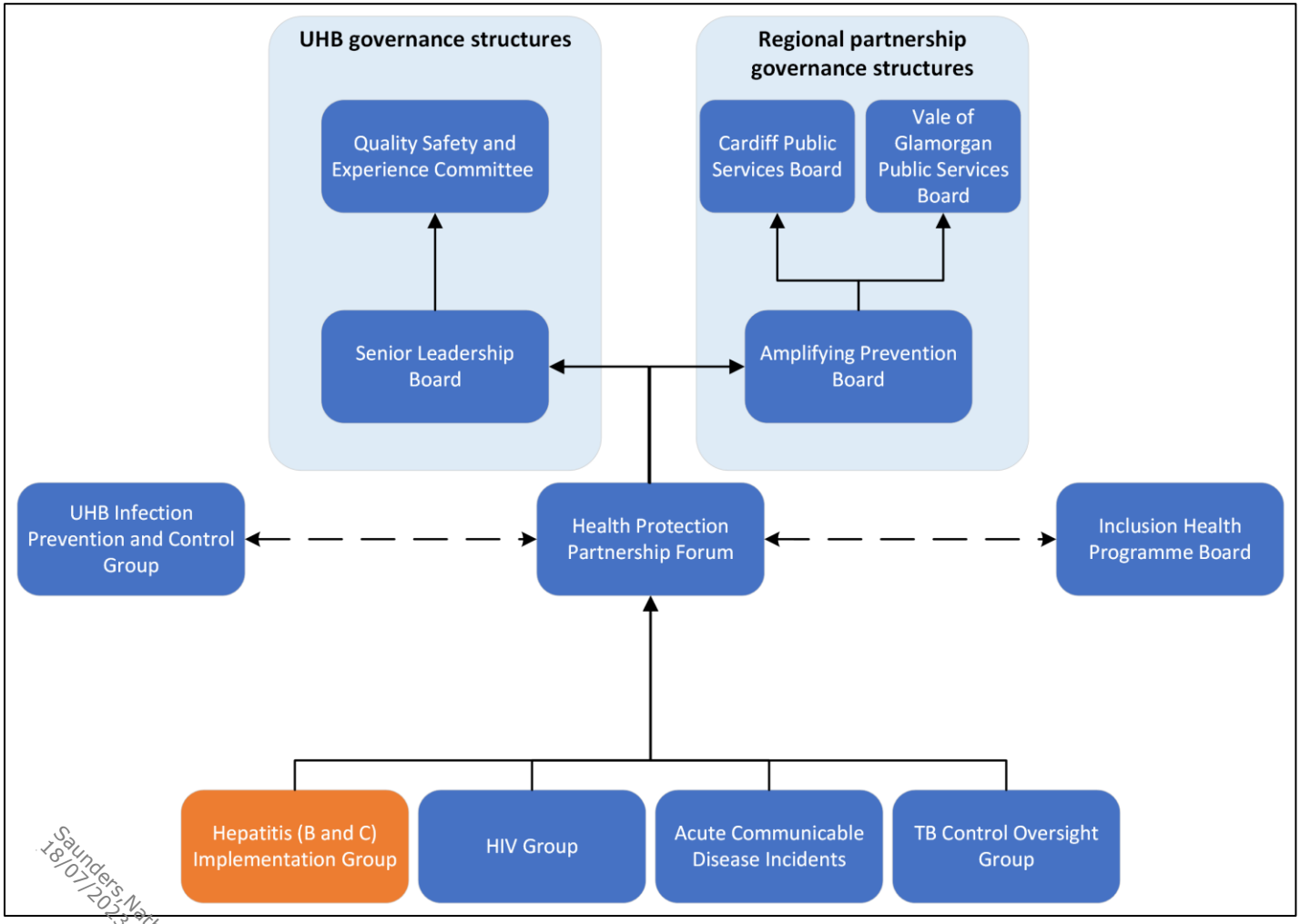


Figure 7: *The reporting mechanisms for the hepatitis (B and C) implementation group.*

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

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Report Title:	**Update to Terms of Reference – Quality, Safety and Experience Committee**			Agenda Item no.	3.4
Meeting:	**Quality, Safety and Experience Committee**	Public	x	Meeting Date:	11th July 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	**Director of Corporate Governance**				
Report Author (Title):	**Director of Corporate Governance**				

Main Report
Background and current situation:

In line with the UHB's Standing Orders, each Committee established by or on behalf of the Board must have its own detailed terms of reference and operating arrangements, which must be formally approved by the Board.

The Terms of Reference for the Quality, Safety and Experience Committee were last reviewed in full in January 2023.

This report provides Members of Quality, Safety and Experience Committee with the opportunity to review a number of proposed amendments to the Terms of Reference and to recommend the revised Terms of Reference to the Board for approval.

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

The development of the Terms of Reference of the Finance & Performance and People & Culture Committees has resulted in clarification regarding the reporting of a number of matters in respect of equity, equality and population health which has an impact upon the Terms of Reference of the Quality, Safety and Experience Committee.

The appended extract from the Terms of Reference for the Quality, Safety and Experience Committee contains a number of proposed amendments highlighted in red text that have arisen from this clarification.

The Committee will note that these relate to clarifying the Committee's role in assuring and advising the Board on meeting its strategic objectives in respect of equality, equity, experience and patient safety.

Recommendation:

The Committee is requested to:

(a) Review the proposed amendments included in the extract of the Quality, Safety and Experience Committee Terms of Reference;
(b) Ratify the amendments to the Terms of Reference; and
(c) Recommend them for approval to the Board on 27th July 2023.

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

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	

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	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: N/A
Safety: N/A
Financial: N/A
Workforce: N/A
Legal: N/A
Reputational: N/A
Socio Economic: N/A
Equality and Health: N/A
Decarbonisation: N/A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board	27th July 2023

Saunders,Nathan
18/07/2023 09:30:09

EXTRACT FROM PROPOSED REVISED QUALITY, SAFETY AND EXPERIENCE COMMITTEE TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The University Health Board (UHB) Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders (and the UHB Scheme of Delegation), the Board shall nominate a Committee to be known as the **Quality, Safety and Experience Committee**. This Committee's focus is on ensuring population, patient and citizen quality, equity and safety including but not limited to activities traditionally referred to as 'clinical governance'. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Experience Committee "the Committee" is to provide:

- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to quality, safety and experience of health services;
- ***assurance*** to the Board on the setting of local organisational Quality and Safety standards and supporting an organisational safety culture.
- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality, safety and experience of public health, including health improvement, healthcare public health and health protection activities;
- ***assurance*** to the Board in relation to the UHB arrangements for safeguarding and improving the quality and safety of patient and citizen centred health improvement and care services in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales;
- ***assurance*** to the Board in relation to improving the experience of patients, carers citizens and all those that come into contact with our services including those provided by other organizations or in a partnership arrangement

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its ***provision of advice*** to the Board:

- Oversee the initial development of the UHB plans for the development and delivery of high quality, equitable and safe healthcare and health improvement

services consistent with the Board's overall Strategy and any requirements and standards set for NHS bodies in Wales.

- Consider the implications for quality, safety and experience arising from the development of the UHB Strategy, Integrated Medium Term Plan or plans of its stakeholders and partners, including those arising from any Joint Committees of the Board.
- Consider the implications for population, patient and citizen experience arising from internal and external review/investigation reports and actions arising from the work of external regulators.
- Consider the outcomes for patient feedback methodologies in line with the National Clinical Services Framework: A Learning Health and Care System.
- Review achievement against the Health and Care Standards in Wales to inform the Annual Quality and Annual Governance Statements.
- Consider and approve policies as determined by the Board.
- Review and monitor the implementation of the Health Board's Quality, Experience and Patient Safety Framework and oversee the necessary developments to deliver the eight key areas:
  - Organisational Safety Culture
  - Leadership and the prioritisation of quality, safety and experience
  - Patient experience and involvement in quality, safety and experience
  - Patient safety learning and communication
  - Staff engagement and involvement in safety, quality and experience
  - Patient safety, quality and experience data and insight
  - Professionalism of patient safety, quality and experience
  - Quality governance arrangements
- Ensure that the Health Boards Framework aligns to the Welsh Government Quality and Safety Framework 2021: Learning and Improving and that the organisation functions as a quality management system to ensure that care meets the six domains of quality; care that is safe, effective, patient centred, timely, efficient and equitable.
- Review and monitor the implementation of an Equity, Equality, Experience and Patient Safety Framework throughout the Health Board.

3.2 The Committee will, in respect of its ***assurance role***, seek assurances that quality governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and improvement services across the whole of the UHB activities and responsibilities.

3.3 To achieve this, the Committee's programme of work will be designed to ensure that, in relation to all aspects of quality, safety and patient and citizen experience:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;
- the organisation, at all levels has a citizen centred approach, putting citizens, patients and carers, patient safety and safeguarding above all other considerations;
- the care planned or provided across the breadth of the organisation's functions is consistently applied, based on public health principles, sound evidence, clinical effectiveness and meets agreed standards;
- the organisation, at all levels has the right systems and processes in place to deliver, from a patient, carer and citizen perspective - efficient, effective, timely and safe services;

- the organisation has effective systems and processes to meet the Health and Care Standards;
- the workforce is appropriately selected, trained, supported and responsive to ensure safe, quality and patient centred services ensuring that regulatory arrangements, professional standards and registration/revalidation requirements are maintained;
- there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation;
- there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;
- risks are actively identified and robustly managed at all levels of the organisation;
- decisions are based upon valid, accurate, complete and timely data and information including accurate and timely clinical coding;
- there is continuous improvement in the standard of quality, equity and safety across the whole organisation – continuously monitored through the Health and Care Standards in Wales;
- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, equity and safety of care provided, and in particular that:

  - sources of internal assurance are reliable, e.g., internal audit and clinical audit teams have the capacity and capability to deliver;
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis;
  - appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims, known collectively as 'concerns;' and
  - data quality around the Equality Act and Socio-economic Duty is improved and used routinely in the organisation to drive improvement.

3.4 The Committee will advise the Board on the adoption of a set of key indicators of safety, quality, patient and citizen experience against which the UHB performance will be regularly assessed and reported on through the Annual Quality Statement (if required).

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee, Sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees and Groups

3.8 Within the Quality, Safety and Experience Framework the Board has approved the following Sub-Committees shall report into the Quality, Safety and Experience Committee:

- 7 Clinical Board Quality and Safety Sub-Committees
- Clinical Effectiveness Committee
- Clinical Safety Group
- Learning Committee
- Concerns Group
- Operational Groups (by exception)

These Committees will report in the Quality, Safety and Experience Committee on a rolling programme as set out in the Annual Work Plan of the Committee and after each of their respective meetings.

3.8 Other Quality, Safety and Experience Committee related Groups will also report into the Committee, once established, and as and when required.

3.9 The Committee has authority to establish short life task and finish groups which are time limited to focus on a specific matter of advice or assurance as determined by the Board or Committee.

Report Title:	Executive Summary of Child and Adult Practice Reviews			Agenda Item no.	4.1
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	18.07.2023
		Private			
Status *(please tick one only)*:	Assurance		Approval		Information X
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Head of Safeguarding				

Main Report
Background and current situation:

Cardiff and Vale Regional Safeguarding Board (RSB) has completed three reviews that were published during May 2023. A summary of the published reports is detailed and enclosed for the Board for awareness and information There are two adult reviews and one child practice review. Cardiff and Vale University Hospital (UHB) Safeguarding Team Nurses are fully involved in each review undertaken. This may be as Chair for the review or panel members, gathering and sharing all appropriate health information for the multi-agency panel meeting. The current review process will soon be referenced under the Welsh Government Single Unified Safeguarding Review (SUSR) following the consultation process and final guidance. There are no direct implications or recommendations for the UHB

Child/ Adult Practice Reviews are agreed by multi-agency partners at an RSB sub-group where referrals are considered for either a full review or a Multi-Agency Professional Forum (MAPF). The RSB cover both Cardiff and Vale of Glamorgan locality and generate a number of reviews throughout the year. There are currently nine open reviews that are in process with five additional MAPF, one of these are for out of area. The Domestic Homicide Reviews (DHR) and the current pilot Single Unified Safeguarding Review (SUSR) are in addition to the above reviews.

A Regional Safeguarding Board (RSB) must commission a child/ adult, concise or extended practice review where it is identified and agreed by partners that a child or adult “at risk” has died, sustained potential life- threatening injury or sustained serious and permanent impairment of health. A review will commence and consider multi-agency information held for the individual from 6 months (concise review) or 2 years (extended review).

Early learning from the Child Practice Review identified information sharing processes that required immediate improvement and were addressed and actioned.

Adult Practice Review (APR) 1: Details the case of an 18-year-old that was stabbed to death in Cardiff. The case has been shared in the media and a full police investigation and Court process completed. Three adults were charged with his murder. The victim was known to police prior to the incident and deemed to be involved in organised crime due to the fact that he was in possession of weapons and known for drug dealing offences prior to the incident. He had been considered as at risk of criminal exploitation, he had previously expressed concern about his safety in the community. There was a lack of multi-agency meetings for the young person leading up to the fatal incident which happened in June 2019. This event precedes the development of the health Violence Prevention Team based in Emergency Department (ED) since November 2019. Should this young person attend or become known to health today there are more robust measures in place to capture and recognise risk taking behavior both in ED, Multi-Agency Safeguarding Hub (MASH) and within the UHB safeguarding team; where staff are more experienced and equipped to give appropriate advice and training to support young people at risk of Contextual Safeguarding.

APR 2: This gentleman sadly died at the age of 53 years old at home in January 2020. He had been diagnosed with bi-polar affective disorder since 1993, he was known to previously have an active

social life and attended a local art college using his wheelchair to access and present his work in 2019. The gentleman was known to UHB Mental Health Services and last reviewed in 2018, there had been a previous suicide attempt which resulted in his life changing injuries, he was known to use alcohol excessively. He was housed in a housing association first floor accommodation, care was supported by the community mental health team (CMHT) who commissioned an agency to support domestic tasks on a weekly basis. A deterioration in his health and accessibility to community services was recognised in 2019 following a six- month in-patient stay. This resulted in self-neglect of his personal care, domestic support, poor nutrition and the use of alcohol and excessive smoking. He was assessed as having mental capacity to make decisions about his own health by a number of professionals. The safeguarding of self-neglect with a person that has capacity is a difficult area to navigate. The review highlights and acknowledges good practice demonstrated by the CMHT.

Child Practice Review (CPR): The report gives details around the life and sad death of a 16-year-old child in January 2019. The child was known to a number of multi-agency services from across borders at the time of her death. Three months prior to her death the child became a “Child Looked After” by the Local Authority and placed in a therapeutic placement out of area due to difficulty in managing her own emotional regulation. The child was open to UHB Child and Adolescent Mental Health Service (CAMHS) at the time of being placed out of area. The young person expressed frustration at the need to transfer to a local CAMHS in the area where she was accommodated and there were concerns in relation to a gap in provision. Previous contact with UHB CAMHS had been direct contact three times a week which ended at the time of transfer. The young person was found hanging in her bedroom and died three days later from injuries sustained. The report details vast history of contact with services from September 2018. Inconsistencies revolve around effective multi-agency approaches to support young people, meaningful and efficient information-sharing, smooth transition of services and information sharing with Children’s Services by using the appropriate referral form each time a situation arises. Early learning from the review identified that a Wales Applied Risk Research Network (WARRN) risk assessment should be shared by CAMHS with other agencies involved such as Children’s Services at the earliest opportunity and prior to a transfer out of area. This is now in place within the UHB.

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

The recommendations identified within all three reviews are not the responsibility of the UHB in isolation. There has been good practice identified by UHB services and immediate change in practice where this is required. Improved ways of working across agencies is referenced in the reviews and on-going learning to improve services that we deliver. It is a concern that information sharing and documentation is consistently an area of learning and has been this way for many years. Learning lessons in this area is a persistent feature, it is captured in all training and supervision opportunities, none the less it is always raised in sad cases such as the reviews enclosed. The RSB and USB recognises this consistent requirement and endeavours to improve practice at every opportunity.

The Corporate Safeguarding Team endeavour to raise awareness at every contact and opportunity relating to these topics. Sharing learning is addressed through mandatory safeguarding training, supervision, presentations at the Safeguarding Steering Group, Child Health Forum, Paediatric Peer Review and Clinical Board meetings as required. In addition, there is a full day Level 3 UHB study day planned in October 2023 to Learn Lessons from Reviews. The committee is requested to raise awareness across the UHB to the importance of sharing safeguarding information that is disseminated to all Clinical Boards from the UHB Safeguarding Steering Group across all service groups. Ensuring that all staff members at every level have the opportunity to have access to safeguarding information and safeguarding mandatory training will reduce the risk of missed opportunities to safeguard people and provide safe care with knowledge, respect and dignity.

Recommendation:

The Committee is requested to:

a) Note the summary of recently published Regional Safeguarding Board Child and Adult Practice Reviews.

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	x	7. Be a great place to work and learn	x
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	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	
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: Yes
Detail enclosed in the full reports could be upsetting for some readers. Safeguarding sometimes raises individuals' emotions which require additional support. The risk to the UHB of not recognizing safeguarding concerns around neglect or abuse would may cause harm to an individual.
Safety: Yes
Ensuring that people are cared for in a safe environment by people that have awareness and knowledge of safeguarding indicators is essential. Mandatory training compliance is monitored across the UHB on a bi-monthly basis through the Safeguarding Steering Group.
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: Yes
Safeguarding across the region of the UHB is a multi-agency function. The UHB is a fully participating partner in the Regional Safeguarding Board.
Equality and Health: No
Decarbonisation: No

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

Report Title:	Clinical Audit Strategy			Agenda Item no.	4.2
Meeting:	QSE Committee	Public	X	Meeting Date:	18 July 2023
		Private			
Status *(please tick one only)*:	Assurance		Approval	Information	X
Lead Executive:	Executive Medical Director				
Report Author (Title):	Head of Patient Safety and Quality Assurance				

Main Report
Background and current situation:

An Internal Audit of the Clinical Audit arrangements within the UHB was undertaken in 2021/22 and gave a grading of 'Limited Assurance'. The audit identified that the Health Board does not have a Clinical Audit Strategy. HQIP suggests a Clinical Audit Strategy is a key necessity for the effective management of Clinical Audit. In response to these findings this Clinical Audit Strategy has been developed to improve strategic alignment of Clinical Audit.

The attached Clinical Audit Strategy Appendix 1) will support a clinical audit programme designed to:

- Provide assurance of compliance with evidence based clinical standards
- Identify and minimise risk waste and inefficiencies
- Improve the quality of care and patient outcomes

The strategy will aim to support the use of clinical audit as a process to ensure clinical quality at all levels of the organization between now and 2025, focusing on creating a culture that is committed to learning and continuous organizational development through measurement of evidence-based practice.

Delivery of the strategy focuses on the implementation of AMaT, the health Board clinical audit platform, providing a clinical audit education and development programme and the development of a clinical audit forward plan aligned to quality and patient safety priorities.

The Health Board Clinical Audit training programme has achieved Agored Cymru accreditation ensuring a nationally recognized clinical audit qualification for UHB staff that delivers measurable learning outcomes.

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

A follow up Internal Audit was undertaken in April 2023 of the Clinical Audit Arrangements in the UHB. The follow up Audit gave a grading of 'Substantial Assurance'. This Clinical Audit Strategy was in draft and nearing completion at the time of re-audit, and is one of the remaining actions to complete along with the Clinical Audit Policy which is for approval.

Recommendation:

The Committee is requested to:

a) **Note** the assurance provided by the 2023-2025 clinical audit strategy.

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

Saunders,Nathan
18/07/2023 09:30:09

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

CARDIFF AND VALE UHB
Patient Safety & Quality

CLINICAL AUDIT STRATEGY 2022 - 2025

Executive Statement

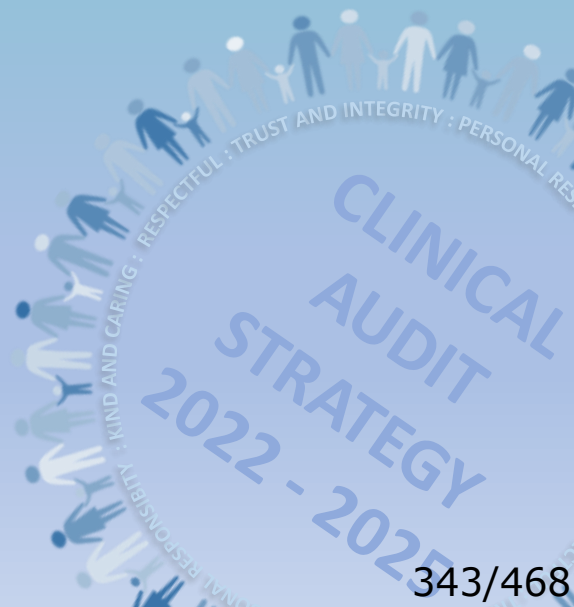
Cardiff and Vale UHB is committed to delivering effective clinical audit in all the clinical services it provides. The Health Board sees clinical audit as essential to continually evolve, develop and maintain high quality patient-centred services.

When carried out in accordance with Best Practice Standards, clinical audit:

- Provides assurance of compliance with clinical standards
- Identifies and minimises risk, waste and inefficiencies
- Improves quality of care and patient outcomes

The UHB is committed to ensuring that clinical audit delivers these benefits, and has adopted a policy on the governance and practice of clinical audit, which applies to all staff.

Achieving the objectives set out in this strategy will ensure that the UHB policy is implemented and effective, resulting in sustained improvements to the quality of care provided to patients.



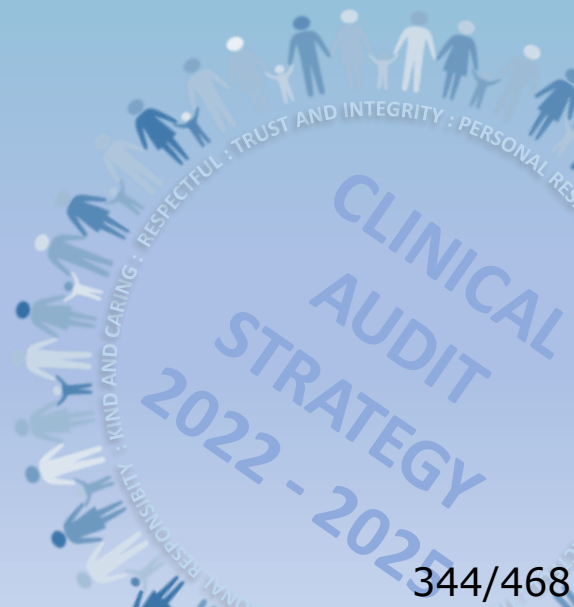
Organisational Context

The Health and Social Care (Quality and Engagement) (Wales) Act introduces a new duty of quality placed on NHS bodies and Welsh Ministers (in relation to their health-related functions). This enhanced legal duty sets out that all decisions that are made are to secure improvement in the quality of the services provided within the Welsh NHS, and to deliver improved outcomes for the people of Wales.

This legislation emphasises the need for organisations to go beyond simply maintaining their services, and to strive for continuous improvement and excellence with as much focus on health improvement and protection as sickness management.

Cardiff and Vale University Health Board is committed to using clinical audit, to support a total management system to inform a programme of quality improvement. As part of this process, clinical audit provides assurance about compliance with accepted clinical standards within the service provided by the Health Board.

This strategy aligns with the Health Board's wider governance and assurance mechanisms that will inform and enhance the process of improving clinical services.

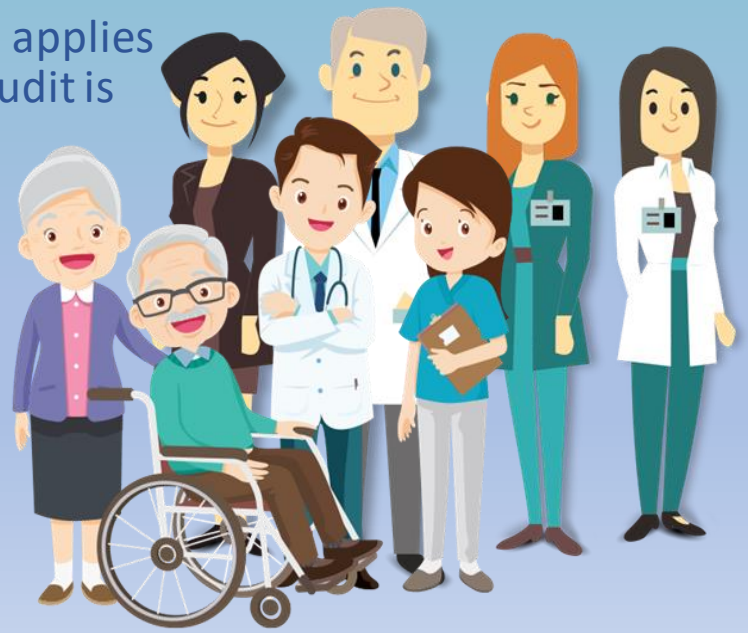


Scope

This policy applies to anyone engaged in the clinical audit process within the UHB, including:

All staff, including management, senior management, and Trust Board Members, both clinical and non-clinical, and those on short-term or honorary contracts Students and trainees in any discipline Patients, carers, volunteers, and members of the public.

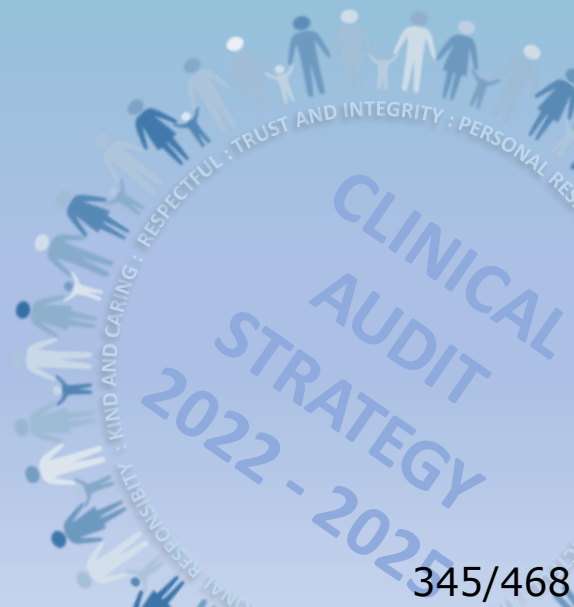
This policy also applies when clinical audit is undertaken jointly across organisational boundaries.



Definition of Clinical Audit

Clinical audit is a quality improvement process that seeks to improve practice and outcomes through systematic review of practice against explicit criteria and the implementation of change. Healthcare Quality Improvement Partnership (HQIP) 2010

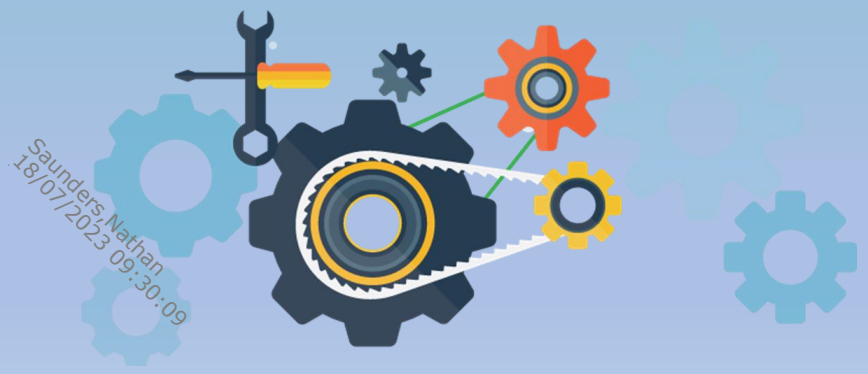
Clinical audit measures against evidence-based standards as part of an ongoing, planned total quality management system that ensures that high quality care is always delivered. Although there are similarities, the clinical audit cycle should not be confused with the Plan, Do, Study, Act cycle, which is a separate quality improvement tool used to drive and increase compliance with a standard against which there is an identified shortfall, or to investigate the impact of practice defined timeframe.(HQIP, 2020)



Strategic Aim

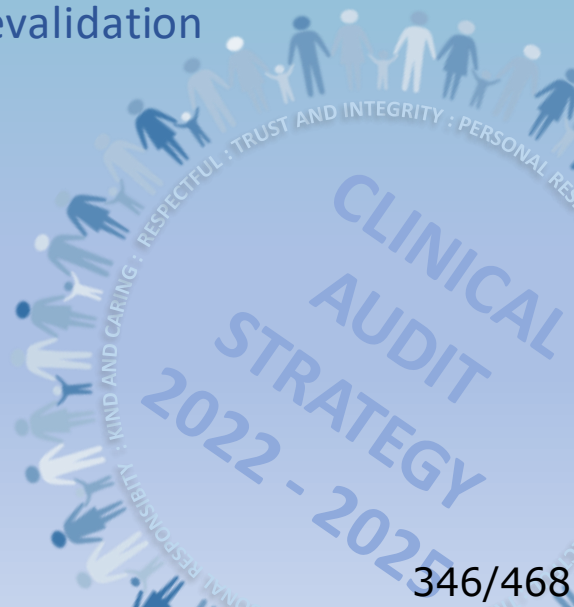
The aim of this strategy is to use clinical audit as a process to ensure clinical quality at all levels of the organisation over the next three years.

The strategy focuses on creating a culture that is committed to learning and continuous organisational development through measurement of evidence-based practice to deliver demonstrable improvements in patient care.



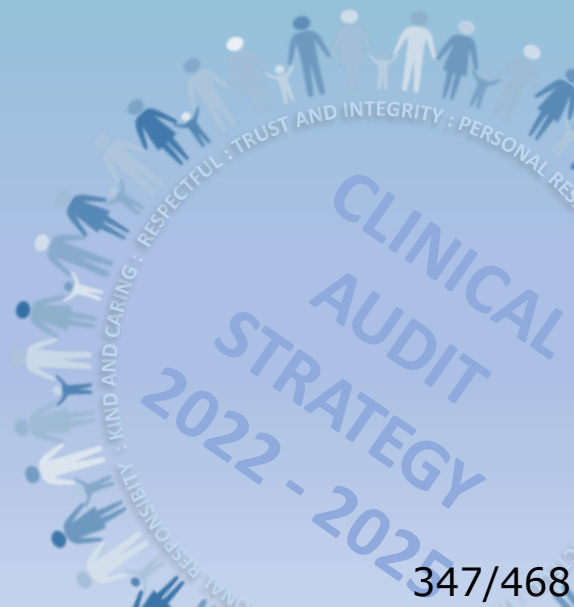
Objectives

- To overcome barriers to healthcare staff participating in clinical audit
- To develop a partnership approach to clinical audit
- To establish a robust system for reporting the outcomes of clinical audit activity
- To ensure that staff have the necessary competency, support and time to participate in clinical audit
- To ensure that the UHB is fully compliant with the requirements of the National Clinical Audit and Outcome Review Plan
- To link clinical audit to appraisal and revalidation
- To ensure organisational compliance with regulatory standards
- To demonstrate and celebrate the benefits of clinical audit and share learning
- To ensure clinical audit activities are fully integrated with other quality improvement approaches and programmes



Operational Action Plan

- Implement AMaT (Audit Monitoring and Tracking) central management system throughout the Health Board to capture all clinical audit and related clinical effectiveness and assurance activity
- Support clinical boards and directorates in developing robust clinical audit plans that reflect their patient safety priorities and risks to ensure that this process is embedded within their quality and safety processes to provide quality assurance to the Board on standards of care delivered to patients
- To ensure there is adequate clinical audit training and resource to support staff to undertake robust and meaningful clinical audits that advise and aid prioritisation of quality improvement projects
- Maintain a process of appraising mandatory national clinical audits and the completion of robust improvement plans to provide assurance to the Health Board on the quality and safety of care
- Promote sharing of learning from clinical audit throughout the organisation and encourage cross -directorate and multi-professional working



	OBJECTIVE	ACTION	DATE
1	Ensure the Health Board is fully compliant with the requirements of National Clinical Audit and Outcome Review plan, implementation of relevant NICE guidance and regulatory guidance and standards	▪ Implement AMaT system throughout the organisation ▪ Revise the NICE implementation process and establish a NICE reference group ▪ Support clinical boards and directorates to embed clinical audit and NICE implementation in their quality and safety processes and utilising their risk register as mechanism for escalation	2023
2	Develop a strategic approach that managers and clinical audit leads can adopt to evaluate patient quality and safety priorities and risks to prioritise improvement projects and develop an annual clinical audit forward plan	▪ Provide education and support to clinical risk managers and audit leads to work collaboratively to identify patient quality and safety priorities and themes and trends from incidents ▪ Promote the accessibility and use of data ▪ Give clinical boards and directorates ownership of their annual clinical audit plans and support meaningful clinical audit project improvements that matter to patients	2023/24
3	Improve the audit process in order to ensure timely completion of the clinical audit cycle, ensure robust improvement plans are developed in response to recommendations, completion and re-audit and to demonstrate compliance with data protection legislation and information governance policies	▪ Mandate the implementation of AMaT across the organisation for capture specific clinical audit activity which will allow for monitoring and tracking of national and local clinical audits, NICE implementation, completion of projects, improvement plans and re-audit as necessary ▪ Provide training for staff to use AMaT ▪ Ensure all clinical audit projects are approved and registered on AMaT	2023/24

4	Improve accessibility to clinical audit training and resources for staff that undertake clinical audit projects	▪ Undertake a gap analysis to establish clinical audit training requirements across the UHB ▪ Increase number of clinical audit personnel with the skills to provide clinical audit training for UHB staff ▪ Allocate a clinical audit facilitator to each clinical board as a point of contact for advice and support ▪ Revise the SharePoint page and resources available for staff ▪ Develop online training package for staff on undertaking clinical audit	**2023/24**
5	Promote sharing of learning from clinical audit throughout the organisation and encourage cross directorate and multi-professional working	▪ Use the functionality of AMaT to search for clinical audits by topic ▪ Share learning via the establishment of the organisational learning committee ▪ Revise Clinical Effectiveness and Quality Assurance page on the Patient Safety and Quality Sharepoint page	2023/24

Developing an Annual Clinical Audit Forward Plan

WHY?

- Demonstrate compliance with NACORP mandatory requirements
- Demonstrate effectiveness and safety of care and reduce variation
- Ensure meaningful clinical audits are undertaken reflecting patient safety priorities and risks
- Support prioritisation of improvement projects
- Ensure improvements are effective and embedded into practice

WHAT?

- NCAORP — Mandatory Tier 1
- National Clinical Audits (Non-mandatory)
- NICE Implementation
- Themes and trends from incidents
- Re-audit Improvements from e.g. NRI's, reg 28

Patient Safety priorities and Risks – Tier 2

HOW?

MDT discussion with risk /governance lead, quality/audit lead to develop annual clinical audit plan to reflect patient safety priorities and risks

↓

Annual clinical audit forward plan agreed and signed-off by clinical director

↓

Presented and agreed in directorate quality and safety forum

↓

Presented at Clinical Board Quality and Safety forum

↓

Shared with Patient Safety and Quality and presented at QSE Committee

Undertake Clinical Audit

- **Identify clinical audit lead**
- **Complete clinical audit proposal and register on AMaT**
- Use AMaT to collect data or upload project onto AMaT
- **The supervising consultant and clinical audit lead to ensure quality control**

Learning & Improvement

- **Present at Quality Session and consider data quality and results**
- **Present findings at directorate Q&S**
- **Share Results and Learning with Staff**
- **Develop Improvement/ Action plan on AMaT**

Embedding & Assurance

- **Present summary of audit and improvement plan at clinical board Q&S meeting**
- **Update AMaT and annual audit forward plan**
- **Re-audit and ensure improvement is effective and embedded**

Report Title:	Unpaid Carers Annual Report 2022/23			Agenda Item no.	4.3
Meeting:	Quality, Safety and Experience Committee	Public	X	Meeting Date:	18 July 2023
		Private			
Status *(please tick one only)*:	Assurance		Approval		Information X
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Assitant Director of Patient Experience				

Main Report
Background and current situation:

This report sets out the report for 2022/23 of the Cardiff and Vale University Health Board, Cardiff and Vale of Glamorgan Local Authorities, Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS), highlighting the achievements made working towards the improvement of the hospital discharge process for unpaid carers and in line with the three original national priorities:

- Supporting life alongside caring
- Identifying and recognising carers
- Providing information, advice and assistance

It will also describe how the funding allocation from Welsh Government has been utilised to support carers throughout Cardiff and the Vale of Glamorgan.

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

The transitional funding has ceased and the Unpaid Carers work is part of the Regional Partnership Board (RPB)- the Patient Experience Team are pleased to continue to work in partnership with the RPB to support carers needs across the UHB (University Health Board) and communities

Recommendation:

The Committee is requested to: **note** the report

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

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
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 Carers national priorities are ministerial ones
Safety: Yes
Support for Carers is vital to ensure they are able to provide care for their loved ones and that they don't let their own health deteriorate
Financial: Yes
Failure to deliver on the priorities can increase the financial cost of healthcare as Carers are unable to provide the care needed
Workforce: Yes
Staff can be primary or/ and secondary carers
Legal: Yes
Potential for litigation
Reputational: Yes
There is an active Media interest in people who are Carers
Socio Economic: Yes
Consideration of socio-economic disadvantage needs to be further explored through interrogation of the quality indicators to the level of low super output areas of social deprivation in comparison to areas of affluence.
Equality and Health: Yes
Many quality indicators when reviewed in detail demonstrate equality and health inequalities.
Decarbonisation: No

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

Saunders,Nathan
18/07/2023 09:30:09

MAY 2022 - APRIL 2023

ANNUAL UNPAID CARERS REPORT

INTRODUCTION

This document sets out the report for 2022/23 of the Cardiff and Vale University Health Board, Cardiff and Vale of Glamorgan Local Authorities, Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS), highlighting the achievements made working towards the improvement of the hospital discharge process for unpaid carers and in line with the three original national priorities:

- Supporting life alongside caring
- Identifying and recognising carers
- Providing information, advice and assistance

It will also describe how the funding allocation from Welsh Government has been utilised to support carers throughout Cardiff and the Vale of Glamorgan.

The most recent statistics from the census, undertaken in 2021, reported that within Cardiff and Vale of Glamorgan we have approximately 41,913 unpaid carers. This is a decrease in reported numbers of unpaid carers from the last census in 2011. However, it is important to remember that during the Covid-19 pandemic the number of unpaid carers increased dramatically. At the height of the pandemic a report by Carers Wales stated that, in Wales alone, the number of unpaid carers rose to 683,000. It was also reported that throughout the pandemic unpaid carers saved public services, in Wales, £33 million every day. In addition when looking at the 2021 census statistics, for unpaid carers, we must take into consideration the following factors;

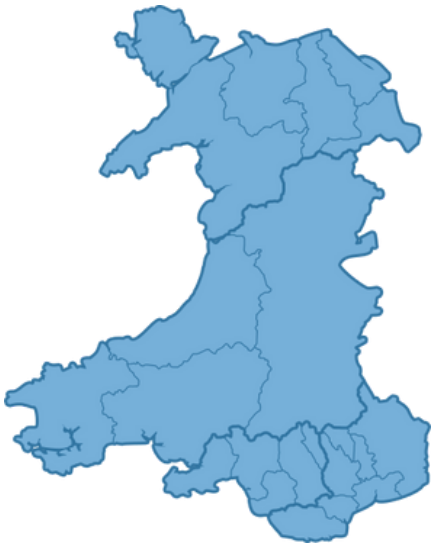
- The 2021 Census asked “Do you look after, or give any help or support to, anyone because they have long-term physical or mental health conditions or illnesses, or problems related to old age?”. This was a change from the 2011 Census question, which asked “Do you look after, or give any help or support to family members, friends, neighbours or others”. The change in the wording may have had an impact on the numbers of people self reporting as unpaid carers.
- Reduced travel and restrictions to households mixing during Covid-19 may have meant that situations where previously the caring responsibilities were shared one individual may have taken on all aspects of care, again impacting on the numbers of people self reporting as an unpaid carer.
- Identification of unpaid carers remained a challenge during the pandemic and confusion was added when the public were asked to 'Clap for Carers' when talking about paid staff in the care profession.
- Finally, in 2021 excess deaths, due to the pandemic, were at their peak and were highest amongst the older population, which in turn may have led to a need for unpaid care.

When trying to understand 2021 census data and the lower percentage of people reporting that they provide unpaid care, compared with previous years, it is important to also note that this decline was mostly seen in those providing 19 hours or less of care. In Wales, since 2011, there has been an increase in the number of people providing 20 or more hours of unpaid care. The increase in the hours unpaid carers are providing care could be as a result and long term effects of the Covid-19 pandemic and the current cost of living crisis.

Improving the lives of unpaid carers continues to be a priority of Cardiff and Vale University Health Board, Cardiff and Vale of Glamorgan Local Authorities, Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS) but there is still much to be done to provide support for all unpaid carers, ensuring they feel visible and their contribution is valued and appreciated.

32%
of unpaid carers in Wales said that they often or always felt lonely

24%
of unpaid carers in Wales reported their physical health was bad or very bad



34%
of unpaid carers in Wales said their mental health was bad or very bad

42%
of unpaid carers in Wales haven't had a break in the last year.

THE REAL COST OF CARING

Over the last year, as a society, we have started to move out of the Covid-19 pandemic but the lasting impact on unpaid carers is undeniable. In addition unpaid carers, along with the rest of the UK, are now facing a cost of living crisis. As evidenced throughout the 2022 Carers Wales - State of Caring Report, providing unpaid care for a family member or friend already comes at a huge personal and financial cost, to the unpaid carer, and this is only compounded by the cost of living crisis. This report highlights that **72%** stated that they were 'extremely' worried about managing their monthly costs. There is currently lots of advice on how we can try and cut back and make savings, however, this can be difficult for some unpaid carers who are required to fund essential equipment, or need to ensure that the person they care for is kept warm. The report continues to illustrate this with **87%** of unpaid carers said that the main challenges they will face over the coming year is the rising cost of living.

The added financial burden that unpaid carers have faced this year has inevitably had a negative impact on their mental and/or physical well-being with **24%** reporting bad or very bad physical health and **34%** reporting bad or very bad mental health. This is further emphasised by unpaid carers reporting low life satisfaction and happiness scores. Unpaid carers in Wales rated both their life satisfaction and happiness at and average score of **4.5**, this is just below the UK average for unpaid carers and significantly lower than the general UK populations average of 7.8. In addition what asked how anxious they were unpaid carers, in Wales, scored an average of **5.2** compared to a general UK populations average of 3.2.

These issues, plus numerous others, highlight the increased need for urgent local support for unpaid carers. There is a clear commitment from Cardiff and Vale University Health Board, Cardiff Council, Vale of Glamorgan Council, and our Third Sector partners to identify and support unpaid carers at the earliest point and improve services.

PRIORITY: HOSPITAL DISCHARGE

The recent State of Caring Wales report asked unpaid carers in Wales their experiences of hospital discharge and although **27%** stated that they had been involved, in the decisions around discharge, **48%** felt they had not. Unpaid carers are still not feeling listened to throughout the process with **65%** reporting that they were not asked about their willingness to provide care in addition across healthcare services in general **46%** of unpaid carers felt that staff did not recognise their knowledge or treat then as a partner in care. Unfortunately this years State of Caring Wales report is typical of the last few years where carers are feeling undervalued and that they do not have a voice within the Healthcare system.

In line with the priority on hospital discharge, set out by Welsh Government, and in response to the concerns that unpaid carers themselves are raising, in regards to the discharge process, we developed the Hospital Discharge Pilot. The aim of the pilot was to support unpaid carers while the person they care for is in hospital, including through the discharge process, with a focus on improving their experiences.

Hospital Discharge Pilot

The Hospital Discharge Pilot is made up of a number of workstreams with its main aim being to ensure that unpaid carers are supported while the person they care for is in hospital. This involves providing information about the services available to them in the community, helping them understand the discharge process and ensuring they know their rights and what they are entitled to as an unpaid carer, within the hospital context. The pilot was set to launch in May 2021, unfortunately, due to the restrictions placed on hospital settings throughout the pandemic the project was placed on hold. However, during Carers Week, June 2022, with visiting restrictions beginning to ease and more people started attending hospital settings, as part of the pilot we were able to launch our Unpaid Carers Information Service. The service is led by the Carers Lead, Information and Support Manager and a small group of Volunteers.

This year the Unpaid Carers Information Service, through the Information and Support Centres, have signposted and given advice to **221** unpaid carers, in relation to hospital discharge, community support, financial and grant information, and Carers Assessments.

CASE STUDY: An unpaid carer came to our Information Service as he was worried about the discharge of his father. Our Information and Support Centre Manager sat with the gentleman and talked him through the discharge process, and provided him with leaflets. The Information and Support Centre Manager was also able to signpost him to the British Legion for support, as his father had been in the Armed Forces. The gentleman thanked our Information and Support Centre Manager and said she had been the first person to take the time to listen to him and helped to explain things in a way he could understand.

Workstreams under pilot

Drop in Unpaid Carer Information Sessions

As part of the pilot we trialled running an unpaid carers drop in session at the Information and Support Centre in University Llandough. We thought it may be helpful for unpaid carers to have a dedicated time, when they could speak with one of the team. Unfortunately, after the initial two sessions, held on a Thursday afternoon, numbers started to drop significantly. Despite advertising the sessions widely, on a number of occasions, no unpaid carers attended. In order to try and encourage attendance we changed the time of the sessions, to see if unpaid carers found it easier to drop in and see us earlier in the day. However, we found that this change did not make a difference and that we were seeing more unpaid carers outside of theses session times. In total **17** drop in sessions where held with only **7** unpaid carers supported. It was for this reasons that we decided to develop a new volunteer role to increase the reach of the Unpaid Carers Information Service.

Volunteer Unpaid Carer Navigators

In partnership with the Volunteering Team we developed the Volunteer Unpaid Carer Navigator role, which was launched in Carers Week 2022. The main aims of the new role were;

- to make unpaid carers feel welcome
- to assess their information and support needs
- to provide basic information and signpost more complex queries onto the Carers Lead or Information Centre Manager
- to offer a listening ear.

Six Volunteers have been recruited into this role and were provided with a bespoke unpaid carers awareness session, this included topics such as;

- Who are unpaid carers and what they do
- barriers unpaid carers face
- and signposting information

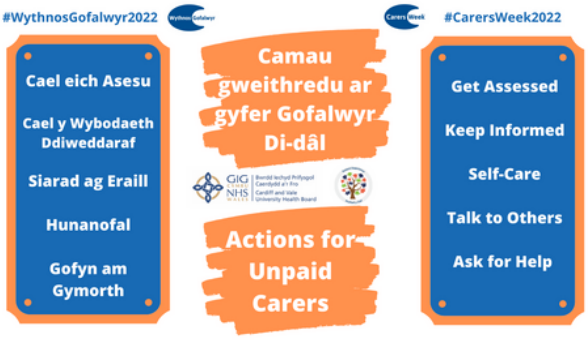
The Unpaid Carers Information Service is a small team so the Volunteer navigators play a crucial role in helping unpaid carers get the right support, at the right time, to help manage a wide range of needs.

Unpaid Carer Information

The Unpaid Carers Information Service has been assessing the information within the Health Board for unpaid carers, as well as mapping what information is currently available on a national level. At the height of the Covid-19 pandemic wards we asked to remove all leaflets from their areas and although the Infection, Prevention and Control team have since agreed that these could be reintroduced we have found on ward walk arounds that this has not happened. In discussion with the Ward Managers we will be providing these wards with relevant information for them to share with their unpaid carers. It has been agreed that our Information Centre volunteers will support the areas ensuring the information is kept stocked and up to date.

The Carer's Lead also represents Cardiff and Vale Health Board on the Carer Aware Health Board Carer Lead Roundtable, chaired by Carers Trust, with discussions at these meetings taking place around a national approach to discharge information. In line with the discharge information work currently ongoing we have started to look at our general Unpaid Carers information ensuring it is up to date and improving its accessibility.

In addition the team, along with our volunteers, have supported the Palliative Care Team in the development of their Unpaid Carers information. This information is aimed to support unpaid carers who are looking after people at end of life, whose wish is to be discharged from hospital to die at home. We have also been involved in the development of a Health Board internet site to support patients, at home, who have been placed on an outpatient follow up pathway. This allowed us to provide feedback from an unpaid carers point of view and what information they would need if they were caring for someone who was on one of these pathways.



Next Steps

Undertaking the Hospital Discharge pilot, in University Hospital Llandough, over the last year has allowed us to trial some initiatives assessing their effectiveness and testing their transferability across other sites. It has also helped us to identify gaps is service, such as availability of information on wards and the lack of access to the First Point of Contact Hospital Team for patients and unpaid carers in the Vale of Glamorgan, as this is a Cardiff Council funded service.

The pilot has also highlighted the need for the team to educate unpaid carers of their rights during the hospital discharge process, and of our service, at an earlier stage. Unpaid carers tell us that had they had the information before the process had started they would have felt more in control of the situation. Often once the person they care for has been admitted their only concern is the health and well-being of the person they care for, so locating information on discharge is not their priority. This means many do not know their rights as an unpaid carer during this process and often report afterwards that they did not feel included or listened to during the discharge process. It is proposed that the main focus of the Unpaid Carers Information Service moving forward should include;

- Continue to reengage with the Carers Champions as part of the GPs Carers Accreditation in Cardiff and the Vale of Glamorgan with the addition of discharge information.
- Increasing our outreach and community sessions and link in with the Community Hubs
- Improving our unpaid carers information and continue working on a national level to produce discharge information/toolkit
- Roll out of John's Campaign on the University Hospital Llandough and St David's Sites
- Work closely with the Butetown Multi-Cultural Team, who sit within Patient Experience, to work with Black and Ethnic Minority Communities to understand their experiences of being and unpaid carer, their interactions with Healthcare Professionals and their experiences of the hospital discharge process.

Although these workstreams are not directly involved in the discharge service they will have an impact on the discharge process. Through identifying unpaid carers and providing information, and access to our Unpaid Carers Information Service, we will be empowering unpaid carers as they will be aware of, and understand, their rights during the discharge process. We hope this awareness and understanding will help unpaid carers speak up if they feel they are not being listened to or involved in care planning and also to know that as a team we are here to help if they need additional support.

PRIOTIRTY: IDENTIFYING AND RECOGNISING CARERS

The identification of unpaid carers continues to be a challenge with one of the barriers being the confusion around the term 'carer' and some believing this is a paid role undertaken by Health or Social Care teams. In recognition of this we continue to ask 'Do you look after someone?'. We hope that this approach will help to identify some of the hidden carers in our communities, and that as a result we will see an increase to the numbers of identified carers reported. Identifying unpaid carers earlier is one of our main priorities so we can ensure they receive, information, support and advice at the right time.

The latest State of Caring Wales report has highlighted that many unpaid carers can take up to three years to recognise their caring role. Only **32%** of unpaid carers reported recognised their caring role immediately. Worryingly **52%** took over a year to recognise their caring role and **36%** took over three years to recognise themselves as an unpaid carer. In addition **60%** of unpaid carers in Wales stated that they would like better understanding and recognition of their role from he general public.

It is vital that we are identifying unpaid carers as early as possible so we are able to advise them in maintaining their own health and well being which, in turn, will enable them to continue in their role. This support can be successfully provided by healthcare teams working in partnership with local authorities and the third sector.

TRAINING AND AWARENESS SESSIONS

One of our priorities this year has been to relaunch our GP Carers Accreditation Programme across Cardiff and the Vale of Glamorgan and as part of this re-launch we have been providing refresher training for existing GP Carer Champions as well as training Champions who are new to the programme.

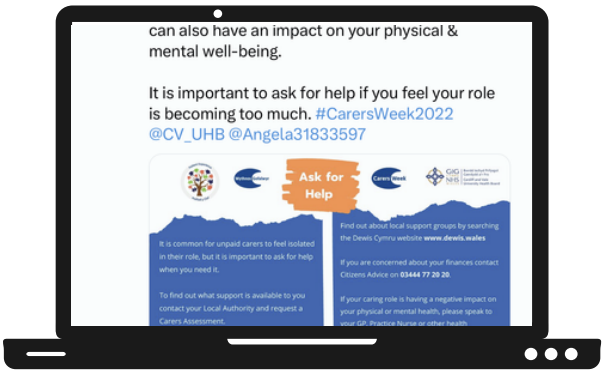
The Unpaid Carers Information Service has also worked in partnership with the Discharge Liaison Team ensuring that the Unpaid Carers Information Service is now included as part of the Discharge training they provide to Health Board staff which we hope will continue to aid in the increase of unpaid carers being signposting to the service.

Finally we are developing a carer awareness session that will be delivered by the Volunteer Unpaid Carer Navigators. This session will be used with existing volunteers within the Emergency Unit and on Ward Areas who are in the position to identify unpaid carers and signpost them directly to the Unpaid Carers Information Service.

SOCIAL MEDIA

As a team we have continued to increase our social media presence, using it not only to increase awareness of unpaid carers, but to also inform unpaid carers of our service and how we an support them.

The Carers Lead and Information and Support Manager have started to work towards a more targeted approach to our social media messaging and have explored the use of Instagram to cater to a different demographic of unpaid carers. Currently our presence on this social media platform is minimal but we would like to increase this in the future. We continued to use Twitter as a way to let staff and the community know who they can contact if they need support, to raise awareness of carers, advertise carer's events, and promote national campaigns such as Carers Week, Carers Rights Day and Young Carers Awareness Day.



Through continued use of our social media platforms we have been able to improve the quality of the content of our promotion campaigns, by understanding how to effectively use the platforms and get engagement from our followers. An example of this was our 2022 Carers Week Campaign, where we themed each days content around one single topic, such as Carers Assessments, to avoid confusing unpaid carers with too many messages, and on our final day we re-capped all of the important highlights from the week. Over the course of the week we tweeted **24** times creating **15,134** impressions and had **510** engagements with our posts. From this campaign we have been able to identify the time of the day we got most interaction with our tweets and the type of tweets that prompted the most engagement. We will be using this information to inform our Carers Week Campaign for 2023 and future information campaigns.

COMMUNITY EVENTS

This year with the restrictions within community settings fully removed a number of community engagement events have taken place. Over the last few months the Carers Lead and Information and Support Centre Manager have attended **3** community events and signposted and provided information to **58** unpaid carers.

UNPAID CARER STORY

While providing an unpaid carer support within our Information and Support Centre, in the University Hospital of Wales, the unpaid carer asked the Information and Support Centre Manager what the Carers Policy was within the Emergency Unit setting. On further investigation the Information and Support Centre Manager discovered that the unpaid carer had attended the Emergency Unit with her son, who had learning difficulties, and had left the area feeling undervalued and embarrassed by the way she had been treated. The unpaid carer agreed to share her experience as a digital story and we hope to use it as a learning tool to highlight how the smallest things, like offering an unpaid carer a cup of tea, can have a huge impact on the experience of someone who is already in a stressful situation. In this case not acknowledging the unpaid carer, and the fact they may have their own needs, left the unpaid carer who could not leave her son with no food or drink for the whole time her son was in the Emergency Unit It also meant that the unpaid carer was unable to use the toilet facilities as she could not leave her son on his own. *(Please follow the link or scan the QR Code for the full story)*

https://youtu.be/A4ajhtRF0x8

The story was shared with at the Executive Board meeting and at the Unpaid Carers Board as an example of how the implementation of the Unpaid Carers Charter could make a difference in this area.

PRIORITY: PROVIDING INFORMATION, ADVICE AND ASSISTANCE

The recent pandemic made accessing information difficult for unpaid carers due to lockdowns, shielding, and services such as GP Surgeries, Community Hubs, libraries and Community Centre's having to close. Thankfully now these restrictions have lifted and services are open again unpaid carers have better access to reliable sources of information. However, the lasting effect of the pandemic has meant some unpaid carers do not feel comfortable attending community venues for fear of catching Covid. It is vital we find ways for unpaid carers to be able to access the right information at the right time in a place and format that is suitable to them.

Worryingly the recent State of Caring Wales report has highlighted that **52%** of unpaid carers did not feel that NHS staff provided then with the information, advice or support they needed to be able to undertake their role well and safely. The same report also highlighted that **50%** of unpaid carers would not make a complaint about services received as they felt like it would make little or no difference. We rely on feedback from patients and unpaid carers to help us understand their experiences and how we can improve, therefore, it is important that we clearly demonstrate to unpaid carers that they are being heard and provide feedback on improvement that are being made from any feedback they provide.

The following section sets out the work that services have undertaken to adapt to new ways of working as well as improving information and signposting for carers. This work will enable carers to access the vital information and services that they need, when they need them.

39%

of unpaid carers in Wales said the barrier to having as Carers Assessment was not knowing what it was

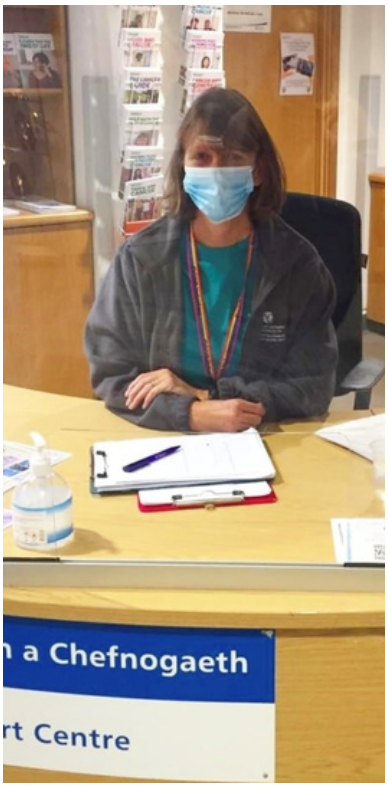
34%

of unpaid carers in Wales wanted more information and advice in regards to thier caring role.

40%

of unpaid carers in Wales stated that not knowing what services were available was a barrier to accessing support

INFORMATION AND SUPPORT CENTRES



In line with Infection, Prevention and Control advice all three of the Information and Support Centres are now open fully and provide a great resource of information for patients, carers and staff. A number of volunteers at the centres have had additional unpaid carer awareness training to help them identify and support unpaid carers. Over the following months we are planning to role this training out to all of the volunteers within the Information and Support Centre setting.

Although the enters are fully open to the public we are still seeing relatively low numbers compared to the pre-covid statistics, however, numbers continue to increase. We are also seeing an increase in the number of Third Sector organisations, such as Bowel Cancer UK, Carers Wales and People Well-being services, engaging with the centres and using them to provide, patients, staff and unpaid carers with a variety of information and support.

CARDIFF AND VALE CARERS SUPPORT AND INFORMATION NETWORK GROUP (CSING)

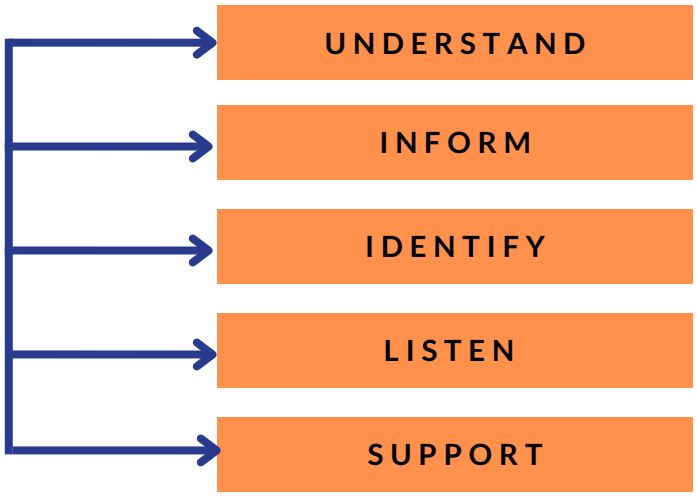
Cardiff and Vale Carers Support and Information Network Group (CSING) brings together staff from the third sector, local authorities and health board who plan and deliver services for carers in the region.

CSING is facilitated by GVS, in liaison with Cardiff Third Sector Council (C3SC), and has been meeting for over 15 years, beginning as a Vale group before expanding to Cardiff. It now has over 40 members. The network continues to be a virtual forum which has continued to help increase attendance. Cardiff and Vale Carers Gateway host the quarterly meetings and the forum provides a good opportunity to share information, highlight current and new services, identify gaps and issues which affect carers and support partnership working across sectors. Issues raised can be highlighted via regional partnerships and planning groups.

UNPAID CARERS GP ACCREDITATION

National and Regional Carers Reports continue to highlight that for many carers the first place they contact for help and support will be their local GP Practice. Therefore it was a priority of the team, once Covid-19 restrictions allowed, to re-engage with our GP Carer Champions. The Carers Champion play a vital role within the community as the are able to provide support and advice to unpaid carers and are the primary point of contact for the Carers Lead and Information and Support Centre Manager. Due to the restrictions and pressures the Covid-19 pandemic placed on GP Surgeries we had to place the Accreditation on hold and during this time many of our established Carers Champions retired or moved to new roles. This has meant that a number of Carers Champions are having to be trained and have an introduction session to the Accreditation Scheme.

The GP Carers Accreditation consists of two criteria levels, Bronze and Silver, where GP Surgeries are assessed against a set of 5 unpaid carers standards in order to gain the award.



Currently representatives from the Health Board are involved in the assessment and support process, however, this process is has been updated and the Volunteer Unpaid Carer Navigators will be involved in the new assessment process.

Since late 2022 the Carers Lead and Information and Support Centre Manager have been re-engaging with GP Practices across Cardiff and the Vale of Glamorgan. To date we have undertaken one GP Carers Champion meeting in the Cardiff area with another meeting currently being arranged for the Vale of Glamorgan. We have re-engaged with **26** Surgeries across Cardiff and the Vale and currently supporting **8** Surgeries through the revalidation process.

JOHN'S CAMPAIGN

In early 2023 the Carers Lead and Dementia Care Lead for the Health Board began working on the re-introduction of John's Campaign. Originally launched in 2018 John's Campaign aims to improve the support we provide unpaid carers when the person they care for is admitted into hospital, and to value their input in to the patients care and discharge plans. As with the original campaign we understand that is not possible for some of our wards to commit to John's Campaign fully, instead we are asking them to adopt the principles of the campaign. The main principles of the campaign are;

- to help with early identification of unpaid carers,
- help us understand the unpaid carer experience,
- to ensure unpaid carers have a voice and are listen to,
- to help those unpaid carers, who wish to, to continue their caring role while the cared for is in hospital,
- and improve the knowledge base of staff.

During the pilot phase the Carers Lead and Dementia Carer Lead have identified three wards to work with and help them to achieve the John's Campaign standards. The wards have been chosen as they all have different layouts and are under different Clinical Boards, and not just Mental Health Services for Older People. Taking learning from the original roll out in 2018 we are taking a much slower, more involved, approach to support areas to fully implement the principles of the Campaign. This will allow the Carers Lead and Dementia Care Lead visit each area to assess what they are currently doing to support unpaid carers and discuss with the Ward Managers how the principles can be adopted within the context of their ward.

Within the pilot phase of the campaign we are also going to be scoping the development of an unpaid carer engagement group that can become a critical friend, to ensure that any initiatives or literature we propose to take forward provides a meaningful improvement to the unpaid carer experience.

PRIORITY: SUPPORTING LIFE ALONGSIDE CARING

Maintaining a life alongside caring is vitally important for unpaid carers, unfortunately for many this can be too difficult and not a reality for them. Although some positive new measures have been introduced within many workplaces, due to the Covid-19 pandemic, more work needs to be done. There continues to be definite barriers to unpaid carers achieving a work-life balance, many are still finding it increasingly difficult to juggle a career and their unpaid caring role. The recent State of Caring Wales report highlighted **55%** of respondents had had to reduced their hours at work, while a further **24%** felt they needed help to manage their caring responsibilities.

Although many unpaid carers acknowledge that work can give them a break from the caring role, they are also reporting that the reality of trying to juggle work, alongside their caring responsibilities, is having a negative impact on work. It has been identified in the latest State of Caring Wales report that **69%** of unpaid carers felt anxious about caring while they are working, while **76%** stated that they felt tired at work because of their caring role. Many unpaid carers have had to reduce their hours at work, or quit their job entirely because they do not get enough support in work, or with their caring responsibilities, to be able to juggle both successfully. This adds to the financial pressures that carers are already facing during this cost of living crisis, and is only highlighted further with **26%** of unpaid carers reporting cutting back on essentials like food or heating, this has nearly doubled from last year.

Cardiff and Vale Health Board are acutely aware of the difficulties faced by unpaid carers in trying to maintain a life alongside caring. We continue to work alongside third sector and local authorities, amongst others, to enable and support carers. The following section outlines the work that has been undertaken to support life alongside caring.

11%

of unpaid carers in Wales need a more supportive employer to stay in work

26%

of unpaid carers in Wales said they needed better support to return or maintain paid work

77%

of unpaid carers in Wales worry about their ability to continue jugging work and their caring role

STAFF UNPAID CARERS

The Carers Lead continues to offer information and advice to the Health Boards staff unpaid carers via email and over the telephone. With the Health Board adapting through the pandemic and offering new ways of working, enquiries around the work life balance policy have reduced, however, there is still some disparity across services as to how much support unpaid carers are receiving from their managers.

Over the next year the Carers Lead, along with the Information and Support Centre Manager, will be looking at the training we can provide to managers on how they can effectively support unpaid carers within their teams. We will also be scoping the support provided in other organisations across the public and private sector to identify good practice and assess how transferable it is into the Health Boards culture and practice.

EDUCATION PROGRAMME FOR PATIENTS AND CARERS (EPP)

The Health Board's Education Programme for Patients and Unpaid Carers continues to run short online coursed for unpaid carers. Understanding that the pandemic has presented many challenges for unpaid carers over the last two years, they have created a 2.5-hour online workshop focusing on physical and mental wellbeing. Topics covered include;

- Practical ways to create islands of calm in your day
- Mindfulness
- The importance of sleep

These courses are free to unpaid carers and are held approximately four times a year.

The EPP Team has also developed a referral/signposting form that can be used in the community, if a community organisation identifies an unpaid carer and is unsure what support is available. Once EPP team receive the form they can then register the unpaid carer onto one of their courses or signpost to a more relevant service.

VALE OF GLAMORGAN CARERS SUPPORT WORKERS AND CARDIFF CARERS TEAM

The Carer Support Workers in the Vale of Glamorgan and Carer Assessment Workers in Cardiff support carers by undertaking Carers Assessments, for carers over the age of 18, to look at their needs. The Carer Assessment Workers contact the carer to talk about the help the cared for person needs, the type of help the carer is providing and the amount of care they are giving. These discussions help the carer and Carer Support Worker and Carer Assessment Workers identify how the caring role is affecting the carers;

- Health and wellbeing
- Job and work life balance
- Social life and/or potential loneliness and isolation
- and personal life in general.

Depending on the outcome of the carer's assessment the assessors Carer Support Workers are able to signpost the carer to local groups, activities and services to ensure that they are able to continue to have a life alongside the caring role.

CARDIFF
CAERDYDD

VALE of GLAMORGAN
BRO MORGANNWG

UNPAID CARERS LANYARD SCHEME

In 2022 the Unpaid Carers Information Service team started to explore ways improve the experience of unpaid carers, while they were in a ward environment. The State of Caring Wales reports often highlight that unpaid carers have to keep repeating to staff that they are the persons unpaid carer when attending a hospital setting, especially when they wish to continue care, are visiting outside of normal hours, or asking to be involved in care and discharge planning. It was decided that a brightly coloured lanyard would be an easy way to identify unpaid carers. In addition a card will be attached to the lanyard, however, this is detachable for those unpaid carers who do not wish to wear a 'label'. In these cases the unpaid carer can place the card in the wallet/purse and show it when required, for example to gain entry to a ward on multiple occasions on one day.

The lanyard scheme is set to be piloted alongside John's Campaign which will launch in June 2023. The aim of the lanyard scheme aligns with the principles of John's Campaign as we want to upskill ward staff and other health professionals to be able to identify unpaid as early as possible, provide those identified with information and support and enable them yo have a voice in all elements of the care and discharge planning process.

Along with the lanyard unpaid carers will be given a small amount of information that may be helpful to them while they are in the hospital setting. This information will include an explanation of the lanyard scheme, John's Campaign leaflets and the contact details of the Unpaid Carers Information Service. The pack will also include a the link to a short survey which will ask the unpaid carer about the usefulness of the lanyard scheme to enable us to evaluate it's effectiveness, and identify any improvements.

Thoughts have already been given to the second phase of the lanyard scheme and what it could be used for after the unpaid carers leaves the hospital setting. Some suggestions we will be proposing are that the unpaid carer keep the card and place it in their wallet. Therefore, if they were to be in an emergency situation people would be aware that there was someone who relied on them for support. It was also suggested that the card could also be used within the Emergency Unit and at Outpatient appointments. This would help staff identify unpaid carers and ensure they were included, where appropriate, in the treatment planning. Both of these proposals will require the education of the staff involved around the not only the lanyard scheme but unpaid carer awareness in general. Once the first phase of the scheme has been evaluated we will begin to engage with staff across the wider Health Board.

YOUNG CARERS

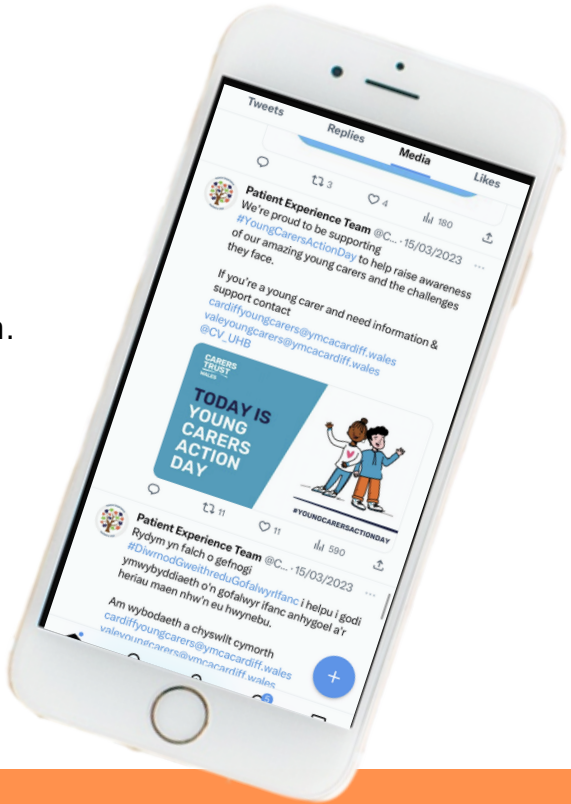
We are committed to continue to build upon the work we have undertaken in previous years to improve the experiences of young carers. Our priorities are built around the consultations we have had, in previous years, with young carers and the feedback that have given us, expressing a lack of awareness of their role. In addition they feel that there is also a lack of support both with practical issues and issues regarding their health and emotional well-being. This feedback is central to all initiatives that we develop to help improve the experience of young carers with in Cardiff and the Vale of Glamorgan.

The Welsh Government 2022 Strategy for Unpaid Carers states that in Wales we have approximately 30,000 unpaid carers who are under the age or 25 (young or young adult unpaid carers). In addition Welsh Government statistics highlight that **63%** of young unpaid carers (aged 16 to 24) spent between 1 and 5 hours a week supporting someone else with **4%** reporting they spent 50 or more hours per week caring. The increased awareness of young unpaid carers through initiatives such as the Young Carers in Schools Programme has seen an increase in the number of young unpaid carers being identified. This is a positive shift, however, we now must ensure that there is support in place to help young carers have a life alongside their caring role and reach there potential in life.

Cardiff and Vale University Health Board and both of the Local Authorities have been working on raising awareness of young carers the roles they undertake and the issues they face. Working with Third Sector partners training has been provided to schools and health colleagues. The following sets out the work being undertaken to strengthen our young carer's agenda across Cardiff and the Vale of Glamorgan.

YOUNG CARER ACTION DAY 2023

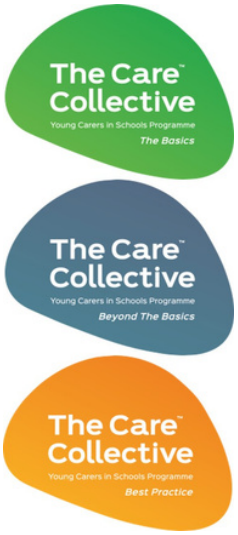
In March 2023 Young Carers Action Day was celebrated across Cardiff and the Vale of Glamorgan. This year we once again used social media to raise awareness of young carers. Over the course of the day we tweeted 4 times creating **1630** impressions and had **87** engagements with our posts.



YOUNG CARERS IN SCHOOLS AWARD

The Care Collective (formally Carers Trust South East Wales) Young Carers in Schools Programme provides schools with the tools and resources to support young carers, giving them the same access to education, opportunities and future life chances as their peers. Schools are asked to produce, collate and submit evidence around five key themes which is reviewed by the Peer Review Panel.

There are three stages of the Young Carers in Schools Programme:



The Basics

Beyond the Basics

Best Prectice

Overall, this year there has been an increase in engagement across Cardiff and the Vale of Glamorgan schools. This was due to the lessening impact, on schools, from the pandemic, less staff sickness, inspections completed and settling in well to the new school curriculum. There has also been a **200%** increase in Primary school engagement. This has been as a direct result of the Young Carers in Schools team reaching out to more primary schools, via email, ensuring even schools who are not currently engaging in the programme are send invites to events, resources and information.

This year the team have found that schools have struggled to be able to fit in face to face staff training due to schools' capacity. Therefore online training and engagement has been provided to encourage an increase in the uptake. Despite these challenges the team have undertaken **17** training sessions with a total of **128** staff members attending. Feedback from the training continues to be positive.

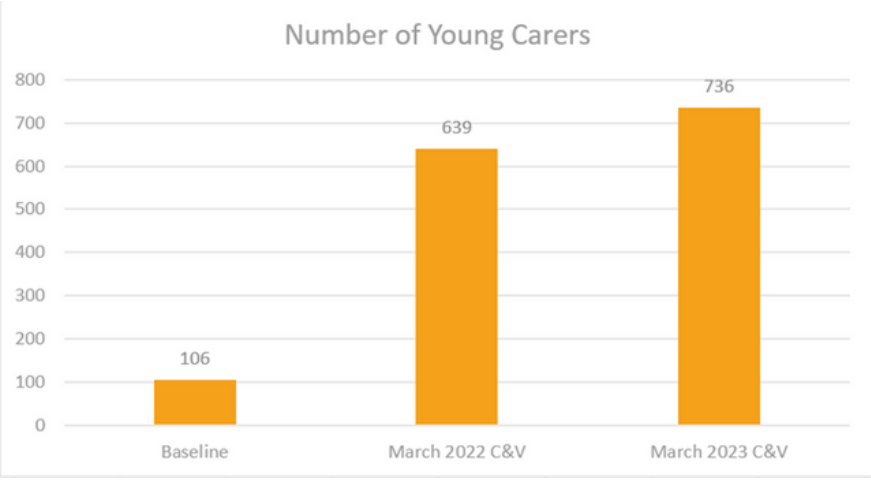
"THANK YOU FOR RUNNING THE SESSION IT WAS REALLY HELPFUL AND DEFINITELY CONTAINED VITAL INFORMATION!"

"I LIKED THAT THE TRAINING FORCED STAFF TO ENGAGE WITH QUESTIONS. IT KEPT MY INTEREST AFTER A LONG DAY."

In the last year the team have supported the Llantwit Major to successfully achieve the Best Practice award.

The following schools are nearly ready to pass:
The Basics: Corpus Christi, Willows High, Llanishen High, Ysgol Gymraeg Glantaf
Beyond the Basics: Fitzalan High, Whitchurch High, Pencoedtre High, Victoria Primary,
Best Practice: Whitchurch High, Whitmore High

The Young Carers in Schools team have reported that a number of high schools that they have been working with for a while have re-engaged with the programme, which has been a positive step for the region. In addition they have taken on a total of **5** new primary schools who are working hard to achieve the Basics. As a result of the work that the team has undertaken we can see that between March 2022 and March 2023 there has been a **42%** increase of identified young cares in the schools involved. Overall, from baseline, the number of identified young carers in Cardiff and the Vale of Glamorgan Secondary schools has increased from **106**, to date this has increased to **736**.



Over the next year The Young Carers in Schools team will be continuing to build on the positive relationships they have built with schools in Cardiff and the Vale of Glamorgan. In 2023 they will be hosting transition events, in partnership with Young Carers Services, in each of the counties for both Primary and Secondary Schools to attend.

EXPENDITURE AND FINANCIAL POSITION

The Cardiff & Vale Partnership was allocated funding of £144,000. The table below illustrates how the funding was utilised.

WORK STREAM	PRIORITIES ADRESSED
Young Carers in Schools Programme	• Identify and recognise unpaid carers • Support a life alongside caring • Providing information, advice and assistance
Hospital Discharge Project	• Identify and recognise unpaid carers • Support unpaid carers through hospital discharge • Providing information, advice and assistance
Carer Friendly Scheme	• Identify and recognise unpaid carers • Providing information, advice and assistance

CONCLUSION

This report illustrates the partnership work being undertaken during 2022/23, which has been over seen by the Regional Partnership Board, in line with the three national priorities set out in 2018. It highlights new initiatives as well as ongoing progress in multiple areas supporting young carers as well as adult and working carers. For more information on any of the work set out in the report please email Pe.cav@wales.nhs.uk

Minutes of the Medicine Clinical Board
Quality, Safety & Experience Committee Meeting
Held on 20 April 2023 14:30 – 16:00, Via MS Teams

Present:	
Sian Rowlands	Head of Quality and Clinical Governance (Chair)
Louise Platt	Director of Operations, MCB
Aneurin Buttress	Consultant Respiratory Physician
Suzie Cheesman	Patient Safety Facilitator, Patient Safety & Quality Team
Kath Prosser	Quality & Governance Lead, Medicine
Emma Keen	Deputy General Manager, Integrated Medicine
Vicci Page	Deputy General Manager, Specialised Medicine
Derek King	Clinical Nurse Specialist, Infection Prevention & Control
Liz Vaughan	Practice Development Nurse, Integrated Medicine
Barbara Davies	Lead Nurse, Specialised Medicine
Ceri Richards-Taylor	Lead Nurse, Integrated Medicine
David Pitchforth	Lead Nurse, Integrated Medicine
Jenna McLaren	Senior Nurse, Acute & Emergency Medicine
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Gill Spinola	Senior Nurse, Integrated Medicine
Shannon Bakan	Service Manager, Gastroenterology, Endoscopy, Hepatology
Marianne Jenkins	Emergency and Acute Consultant Nurse
Linda Hughes-Jones	Head of Safeguarding
Manon Richards	Pharmacist
Andrew Brown	Deputy Ward Manager
Niki Turner	Stroke Service Manager
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Alun Tomkinson	Clinical Board Director, MCB
Lyndsey MacDonald	Consultant, Acute & Emergency Medicine
Jane Murphy	Director of Nursing, MCB
Diane Walker	Deputy Director of Nursing, MCB
Angela Jones	Senior Nurse, Resuscitation Service

Item No	PRELIMINARIES	Action
MCBQSE/ 2023/0051	**A1. Welcome & Introductions** – were undertaken.	
MCBQSE/ 2023/0052	**1.1 To receive the minutes of the previous meeting** The group resolved: the minutes were agreed and accepted.	
MCBQSE/ 2023/0053	**1.2 Matters arising**: for outstanding actions, please see the action log at the end of the minutes. The actions below do not require any further action to be taken. **MCBQSE/ 2023/0022: Concerns update/datix** – following a recent drive, more staff are now using the new datix system. Action closed. **MCBQSE/ 2023/0032: Duty of Candour and Duty of Quality** – staff have been in contact with SR regarding how each directorate feels they need to share this information within their areas, to ensure that all colleagues are aware of the new duties and how they will impact on the Health Board (HB). Action closed. **MCBQSE/ 2023/0033:** SR has met with Debbie Jones to discuss the use of AMaT in MCB. Action closed.	

	MCBQSE/ 2023/0035: Infection Prevention and Control – all actions from last month's meeting have been carried out. Actions closed.	
MCBQSE/ 2023/0054	**1.3 Directorate QSE minutes** - were noted. **Acute & Emergency** – no issues highlighted. **Integrated Medicine** – no issues highlighted. The group resolved: to read appropriate minutes. **Action from discussion** – none.	
6 DOMAINS OF QUALITY		
SAFE		
MCBQSE/ 2023/0055	**2.1 Concerns and Compliments Report** No concerns update received. No compliments shared with KP this month. BD advised IM concerns = 15 currently open. 11 for UHW and 4 for UHL. At a recent Lead Nurse meeting JM shared patient experience feedback. The group resolved: to ensure compliments are fed into this meeting. **Actions from discussion:** SR will liaise with Angela regarding obtaining useful patient feedback to be discussed at these meetings.	Sian Rowlands
MCBQSE/ 2023/0056	**6. National Reportable Incidents, updates and closures** There are eight open NRI's, three of which are overdue, two of which are being presented today. One overdue NRI relates to a lady who was not given prescribed Hydrocortisone with known Addison's Disease and non compliance with PSN057 Adrenal Crisis. Progressing the investigation report is proving difficult, awaiting Coroner's inquest. **Changes in NRI updates** – if an in-patient dies of health care acquired COVID-19, NRI reporting will sit with each Clinical Board and Directorate and not sit with the Covid Investigation Team. **ID21341** – a gentleman presented to the ED, via WAST. He was generally unwell, had reduced mobility and was not coping well at home. A background history was noted as CVA, Lung Cancer, Dementia and COPD. Following a wait on an ambulance outside the Emergency Department the patient was transferred into the Majors area, and provided with a nurse call bell, although it was unclear if he understood how to use it secondary to the history of Dementia. When the falls focus review was completed staff could not find the multi-disciplinary documentation to see whether multi-factorial risk assessments had been completed. An Agency Nurse had used the incorrect Emergency documentation which would prompt them to complete the required MFRA's. The risk assessment was therefore not completed within an hour of the patient's arrival in line with best practice. The gentleman passed away four weeks post this injurious fall, and the fracture was noted on part 2 of the Death Certificate. The patients death was referred to the Coroner. **Learning** – audits on Tendable show 100% compliance. There is a falls noticeboard in Majors to support staff on the expected standards and best practice. Information has been shared with Temporary Staffing and information shared locally at the Units well embedded Safety Huddles specifically relating to falls and the completion of MFRA's. **In150666** – this gentleman was on the surveillance pathway, with annual reviews for Pan Ulcerative Colitis. Whilst on this pathway for approximately ten years, there were discussions regarding potential Colonoscopy procedures. The patient had an annual review in December 2017 and was due to return for annual review in 2018. The next contact staff had with this gentleman was in February 2021 when he was re-referred into the service by his GP. The incident relates to 'lost to follow up' and the impact that had on his treatment plan. He re-presented with iron deficiency anaemia and red flag indicators. A Consultant Gastroenterologist saw the patient in a virtual clinic and requested the patient have an urgent colonoscopy. The patient chose to defer (for 8 months) due to the pandemic. He was later diagnosed with colorectal cancer and proceeded to surgery. **Learning** – as the patient was 'lost to follow up' he missed the opportunity to have discussions regarding surveillance options, such as Colonoscopy, and then was found to have colorectal cancer. The root cause of the incident was human error. Comms 2 work is progressing with digital health intelligence to refine further the IT systems to support patients being flagged if appointments have not been allocated. An overarching action plan for endoscopy is being kept updated by the Directorate with Clinical Board oversight.	

	In157046 – this gentleman was referred via his GP on an Urgent Suspected Cancer pathway in 2021. At the time the department was trialling Faecal Immunochemical testing (FIT), this was a national framework pilot. The gentleman had a negative FIT and the referral was returned to his GP with safety netting advice. He then had a private colonoscopy which identified a tumour. He was referred back for further diagnostics in the NHS. There was 8 months delay in the cancer diagnosis. **Learning** - the investigation found FIT was a reasonable tool to be used. FIT has since been adopted as a national framework. This patient had surgery, chemotherapy and immunotherapy and is doing well. The gentleman does not have any concerns and feels that he was treated well on the background of negative FIT results. The group resolved: all to note the above. **Actions from discussion** – none.	
MCBQSE/ 2023/0057	**7. Infection Prevention and Control up-date** 262 days since last MRSA bacteraemia (UHL E7) 26 days since last MSSA bacteraemia (UHL W2) 86 days since last *C difficile (LSGF 1)* 5 days since last E. *Coli* bacteraemia (UHL E2) 62 days since last Pseudomonas bacteraemia (UHW C) 5 days since last Klebsiella bacteraemia (UHW B7)	

Outbreaks / Period Increased Incidence

Date	Ward	Organism	No. Patients Affected	No. Staff Affected	Bed days Lost
14/04/2023	A7	COVID	5	0	1
14/04/2023	A1L	COVID	4	1	0
07/04/2023	B7	COVID	6	2	0
16/04/2023	C6	COVID	1	0	1
15/04/2023	C7	COVID	3	0	0
April 2023	B7	Klebsiella	3	-	-
Total	6		19	3	2

There are 6 ongoing incidents / outbreaks within the MCB.

- DMT scores – All wards within MCB are compliant for the last 4-week period.
- No 2022-2023 HCAI reduction goals were achieved for 2022-2022
- However significant reductions were achieved on 4 of the identified organisms based on last year's rates.
- MCB position based on year end 2021-2022:
  - 23% reduction with *C. difficile*
  - 11% reduction with *E. coli*
  - 40% reduction with *Pseudomonas*
  - 12% reduction with SAUR Bacteraemia
  - 30% increase has been seen *with Klebsiella*
- 35 RCA's remain outstanding (note for RCA's sent before the end of February 2023 only). Please review the tables.
- Environmental audits in March were below MCB average. Action plans received.
- IP&C 'back to basics' teaching session monthly.
- IP&C at MCB induction training to commence.
- MCB IPIC meetings to re-commence in May.
- Covid community cases have fallen this month, but this drop has now plateaued.
- Influenza rates (and other respiratory viruses) have risen slightly over the past two weeks. Flu remains above baseline levels.
- PDN's will ensure IP&C training is included in new ward staff inductions. The number of new nurses starting are quite small.

The group resolved: to note the above.
Actions from discussion – DK will share the IP&C monthly training dates with LV. — Derek King

MCBQSE/ 2023/0058	3.3 Patient Safety Alerts/MDA's/ISN's: Medstrom SOLO split bed rail. The group resolved: this has been widely shared throughout MCB. **Actions from discussion** – none.	
MCBQSE/ 2023/0059	**Duty of Quality Statutory Guidance 2023 and Quality Standards Update** A lot of work is being done to support staff regarding the correct reporting of levels of harm. Support continues to be provided by the Duty of Candour Team. The group resolved: to note the above.	

	Actions from discussion – none.	
MCBQSE/ 2023/0060	**Medical Device/ Equipment Point of Care Testing** The group resolved: no issues raised. **Actions from discussion** – none.	
MCBQSE/ 2023/0061	**Safeguarding update** There are currently 12 professional concerns for MCB open, of which 6 professional concerns are for adult referrals. Safeguarding cases for adults = 33 cases open across the Clinical Board. Regular meetings take place with Rebecca Aylward, Linda Hughes-Jones (LH-J), Jane Murphy and People Services. An outcome must be achieved before a case can be closed. **MCB Compliance** Level 2 Safeguarding for adults = 60%. Level 2 Safeguarding for children = 55%. Level 1 domestic abuse training = 57%. Compliance should be 75% as a Health Board. 1/2/23, Level 2 domestic abuse became mandatory for all public facing staff. If any staff need to be compliant with the mandatory training regarding a pay progression, let LH-J team know and they will slot the person in for training. Prevent Awareness Training (counter terrorism) dates will be available shortly. **Multi Agency Safeguarding Hub (MASH)** – is based at Cardiff Bay Police Station. **Regional Safeguarding Board** – C&VUHB are a partner agency for this board which covers Cardiff and the Vale. The board has a number of sub-groups, such as, the Child and Adult Practice Review. A Safeguarding Nurse advisor sits on the panel for reviews. Three adult practice reviews are due to commence. **Single Unified Safeguarding Review** – driven by Welsh Government (WG) to draw mental health reviews; domestic homicides; children and adults practice reviews together so that one report is done for all, to avoid duplication of work. **Safeguarding Maturity Matrix** – in place for 5 years, work to improve and maintain a safeguarding standard around Wales. A UHB report will be submitted in July 2023. **Training benchmarking** - compliance is quite similar for all clinical boards in C&VUHB. The group resolved: to note the above. **Actions from discussion: none.**	
MCBQSE/ 2023/0062	**Health and Safety Issues** The group resolved: to consider how to bring this into a governance structure. **Actions from discussion**: all to look at this link and view their own areas.	
TIMELY		
MCBQSE/ 2023/0063	**Initiatives to improve access to services** The group resolved: all to engage and share initiatives in their work area. **Actions from discussion** – NT will deliver a Stroke update at the next meeting.	Niki Turner
MCBQSE/ 2023/0064	**Performance with National Targets** The group resolved: no issues raised. **Actions from discussion** – none.	
EFFECTIVE		
MCBQSE/ 2023/0065	**Feedback from UHB QSE Committee** The group resolved: read and note the key headlines and corporate discussions. **Actions from discussion** – none.	
MCBQSE/ 2023/0066	**Service Improvement Initiatives** The group resolved: no issues raised. **Actions from discussion** – none.	
MCBQSE/ 2023/0067	**HIW/CHC reports and improvement plan updates** - this needs to be updated and uploaded to AMaT where actions will be captured. Need assurance around actions taken. Ensure AMaT has all the evidence recorded. **Acute and Emergency Medicine HIW action plan update –** no issues raised. The group resolved: to note the above. **Actions from discussion** – none.	
MCBQSE/ 2023/0068	**Tendable Group feedback** - discussions are on-going around compliance. Ward accreditation will be discussed at NMB shortly. A dashboard will be introduced. A Tendable Summit will be arranged to look at how to take the information forward.	

	The group resolved: to note the above. **Actions from discussion** – none.	
EFFICIENT		
MCBQSE/ 2023/0069	**Yellow Card Centre Wales Survey Results** - a survey asking key questions was carried out with doctors, nurses and pharmacists. A lot of staff did not know what the yellow card was for, or how to use it. Need to educate teams regarding the yellow card. This was discussed at the IM QSE meeting. If staff need training regarding the Yellow Card, Manon Richards will provide details of the Lead Pharmacist to contact for this. The group resolved: to note the above. **Action from discussion** – Sian Rowlands to contact Manon Richards to arrange to discuss what learning could be shared with staff.	Sian Rowlands
MCBQSE/ 2023/0070	**Mortality Group Feedback** Preparing to get ready for the next steps of mortality reviews. SR now has the database of the ME referrals in relation to MCB and will review this to see if there is learning to be shared. CR-T is a member of the Mortality Group for MCB. The ME will be reviewing all deaths and C&VUHB will be getting reports through requesting to review cases. The group resolved: to note the above. **Action from discussion** – none.	
MCBQSE/ 2023/0071	**Medicine Clinical Board KPI Information** The group resolved: to note the above. **Action from discussion** – none.	
MCBQSE/ 2023/0072	**Clinical/Internal Audits:** Medstrom Pressure Ulcer Prevalence Audit 15-18 May. The group resolved: all to note the above for information. **Action from discussion** – none.	
MCBQSE/ 2023/0073	**LFE claims/concerns** **239/RED57** This case was investigated using the All Wales Pressure Damage Review Tool and was also investigated as a Concern. It was identified there were various contributory factors for the development of Category 2 pressure damage including the patient declining to reposition as a result of her condition and medical history. However, the breaches of duty identified which are felt to have been contributory or causative of the pressure damage were noted as: A delay in the pressure area risk assessment being completed on initial admission to EU. A failure to undertake 2 hourly repositioning secondary to the ward operating below agreed staffing levels. Additional actions have been completed to reduce avoidance including the introduction of a Clinical Board Pressure Damage Learning and Scrutiny Panel, additional education for ward staff and educational boards. Greater focus on empathises on capacity and how this is documented and escalated. Introduction of real time documentation to improve accessibility to evidence care. **RED7A4-0166** A patient who required a cannula for intravenous fluids and antibiotics developed infective Phlebitis resulting in an excision and drainage of the site which required on going care in the community before healing. The investigation concluded there was no evidence of the Insertion Bundle being followed with insufficient documentation around VIP scores and monitoring of the site. Also identified there was outdated information relating to ANTT compliance at the time. Since this incident there has been greater focus on cannula care, highlighted through Tendable audits. On the area where the incident occurred it was raised as a focus of the ward safety briefing for a period of time. An audit across the medical wards at the time showed variable standards of documentation from both nursing and medical staff. **RED7A4-0173** A patient was admitted in July 2021 with a CVA. The patient had a positive D-Dimer and was later diagnosed with a PE. Whilst through examinations there had been no evidence of a DVT, which can be a precursor to developing a PE in Stroke patients. Following a review by clinicians had Intermittent Pneumatic Compression stockings been used on arrival to the ward, this would have reduced the patients risk of developing a DVT/PE. This resulted in 21 days of additional pain as a result of the PE.	

	Actions taken, and in place include all staff trained and educated in using IPC stockings. Continuous auditing of compliance monitored via audits available on Tendable. Full engagement with the medical team with a change in practice and the routine prescribing of IPC stockings. Care plans written and implemented. All Stroke patients are checked each shift by nursing staff to check for signs/symptoms of DVT development. **The group resolved**: Welsh Risk Pool are imposing financial penalties on Health Boards. **Action from discussion** – AMaT will be used for capturing audit evidence. Relevant staff to register with AMaT if not already done so. AMaT training will then be available.	ALL relevant staff
EQUITABLE		
MCBQSE/ 2023/0074	**Feedback from Clinical Board Inclusion Ambassador Group** The group resolved: info for sharing regarding Religion and Belief. **Actions from discussion –** none.	
MCBQSE/ 2023/0075	**Equality and Diversity Issues** The group resolved: no issues were raised. **Actions from discussion** – none.	
PERSON CENTRED		
MCBQSE/ 2023/0076	**Patient Story, Specialised Medicine,** delivered by Barbara Davies BD presented this story to the Executive Board in Nov 22 relating to how staff had to navigate systems of care for someone with Functional Neurological Disorder in acute care. A 34-year-old female was admitted in February 2022 to UHW. Her length of stay (LOS) was 194 days on first admission. The reason for admission was difficulty in swallowing following a chest infection with Covid 19. She had complex history of PTSD from childhood trauma relating to physical abuse associated with eating and drinking. The patient was wheelchair bound without a physical cause for that. **Interventions** – the patient had 3 general anaesthetic procedures during this admission. **An early MDT approach** - was taken and Dr Thomas from Neuro Rehab was of great support to the patient. Assembly Member Prof. Mark Drakeford showed an interest in this case regarding the patient's care pathway. **Primary care need** - whilst in hospital was felt to be psychology, rather than acute. She received notice of eviction from her care home advising they could not meet her psychological needs. Multiple concerns were raised by her Mother regarding delays in having procedures. The patient did not engage with Mental Health Services, there was a breakdown in relationships. For a patient to access Psychology services, they must be under Mental Health Services. An eating disorder was considered, however, did not fit the criteria to access the eating disorder service. There was nowhere to move the patient on to. The patient had capacity. **Turning points** – secured a new specialist placement. Psychology services were not available via the NHS and the patient paid for Psychology Services herself. **Discharge planning** – the patient was discharged in August 2022 to a new specialist placement. Staff continued to work with colleagues in the radiology day unit. 5 days post discharge, the patient presented to EU with a potassium level of 2.6, but returned to primary care for management. 13 days post discharge, there was a further EU presentation and the patient was re-admitted to A7. Further discharge planning took place. The placement worked with UHB staff and held a bed for the patient. The patient was successfully discharged to the care home of choice without an NG Tube on 16/11/22. **Learning** – failure to engage the GP in MDT approach added to re-admission. There was no functional Neurological Disorder Service; no access to psychology; patient paid for her own psychology; incredibly difficult for acute or any care services to navigate this scenario. Patients such as this do not fit within existing service templates, therefore, ownership becomes challenging with an increased LOS. **Clinical Portal** - Jenna McLaren suggested complex patients have a detailed plan placed on clinical portal, to be accessible to all clinicians. Link in with the frequent attender lead to get the information uploaded. The group resolved: to note the above. **Actions from discussion** – BD and JM to liaise about uploading a detailed plan to clinical portal, to be accessible to all clinicians.	Jenna McLaren

		Barbara Davies
MCBQSE/ 2023/0077	**Initiatives to promote the health and wellbeing of patients and staff** The group resolved: no issues raised. **Actions from discussion** – none.	
ITEMS TO BE RECORED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE		
MCBQSE/ 2023/0078	- **MCB Quality, Safety and Experience Committee – Workplan** - **MCB Quality, Safety and Experience Committee – Terms of Reference and Operating Arrangements** The group resolved: any comments on both the above to be sent to KP and SR. **Actions from discussion** – none.	
MCBQSE/ 2023/0079	**AOB** **New Incident charts -** will be available the third week in May. Information/ education will be shared soon.	
MCBQSE/ 2023/0080	**7.3 Date & time of next Meeting –** 2.30pm to 4pm on 18/5/23.	

Medicine Clinical Board Quality, Safety & Experience Committee Meeting
Held on 20/4/23 14:30 – 16:00, Via MS Teams
Action Log

Item	Subject	Action	Allocated to	Date allocated	To be completed by	Completed Y/N
MCBQSE/ 2023/0003	Stroke bed protection SOP	Find out if this needs to come back to MCB QSE following sign off at MCB Formal Board	Diane Walker	16/2/23	16/3/23 Carry over to 20/4/23	Emma Keen will follow up with Niki Turner
MCBQSE/ 2023/0019	Infusion Charts	DW to contact Dave Mcrae about potentially using the infusion charts elsewhere in MCB	Diane Walker & Dave Pitchforth	16/2/23	16/3/23 Carry over to 20/4/23	No update
MCBQSE/ 2023/0042	Treatment Escalation Plans	AJ will share the presentation with KP. KP will then send this out with the minutes.	Angela Jones/ Kath Prosser	16/3/23	20/4/23	Kath Prosser will ask Angela Jones for the presentation
MCBQSE/ 2023/0055	Concerns/ Compliments	SR will liaise with Angela regarding obtaining useful patient feedback to be discussed at these meetings.	Sian Rowlands	20/4/23	18/5/23	
MCBQSE/ 2023/0057	IP&C	DK will share the IP&C monthly training dates with Liz Vaughan	Derek King	20/4/23	18/5/23	
MCBQSE/ 2023/0063	Initiatives to improve access to services	NT will deliver a Stroke update at next month's meeting	Niki Turner	20/4/23	18/5/23	
MCBQSE/ 2023/0069	Yellow Card Centre Wales Survey Results	SR to contact Manon Richards to arrange to discuss what learning could be shared with staff	Sian Rowlands	20/4/23	18/5/23	
MCBQSE/ 2023/0073	LFE Claims/ Concerns	Audits - AMaT will be used for capturing audit evidence. Relevant staff to register with AMaT if not already done so. AMaT training will then be available	All staff involved with audits	20/4/23	18/5/23	
MCBQSE/ 2023/0076	Patient Story, Specialised Medicine	BD and JM to liaise about uploading a detailed plan to clinical portal, to be accessible to all clinicians, just in case the patient comes back to ED.	Barbara Davies/ Jenna McLaren	20/4/23	18/5/23	

Minutes of the SCB Q&S Meeting
Held On 21st March 2023
Via MS Teams

Present:		
Clare Wade	CW	Director of Nursing (Chair)
Claire Dunstan	CD	Consultant Anaesthetist
Adrian Turk	AT	Pharmacist
Alexandra Scott	AS	Corporate Nursing
Angela Jones	AJ	Senior Nurse
Annabel Green	AG	Workforce Programme Manager
Barbara Jones	BJ	Educational Lead
Beverly Withers	BW	Interim Director Manager for Dental
Carlos Loureiro	CL	Clinical Audit
Carolyn Alport	CA	SCB QSE Lead
Catherine Evans	CE	Patient Safety
Catherine Twamley	CT	Interim Lead Nurse
Charlotte Oliver	CO	Consultant Anaesthetist
Cherie Rogers	CR	Acute Pain Nurse
Christopher John	CJ	Clinical Governance Lead
Debbie Jones	DJ	Patient Safety
Hayley Dixon	HD	Director of Operations
Laura Hodges	LH	Lead Nurse T&O
Naomi Goodwin	NG	Clinical Director – Peri-op
Nia Angharad Humphry	NAH	Geriatric Consultant
Nicholas Swetenham	NS	Infectious Disease Registrar
Paul Warman	PW	Lead nurse
Rafal Baraz	RB	Consultant Anaesthetist
Rhian Davies	RD	Directorate Manager – Ophthalmology
Rhiannon McDonald	RM	Programme Manager – Prehab2rehab
Richard Coulthard	RC	Consultant
Shannon O'Callaghan	SOC	Specialty Manager – General Surgery
Susan Mogford	SM	Senior Nurse
Tesni Fox	TF	Specialty Manager – Urology
Tracy Johnson	TJ	Practice Development Nurse
Vince Saunders	VS	IP&C
Secretariat		
Zoe Sweetman	ZS	Surgery Business Support Manager
Apologies:		
Rowena Griffiths		Governance & Quality lead manager

Item No	Agenda Item	Action
SCB/QS: 23/23	**Welcome & Introduction** The Chair welcomed everyone to the meeting.	
SCB/QS: 23/24	**Apologies for Absence** a) The apologies given were noted.	
SCB/QS: 23/25	**Action Log** Actions closed from last QSE	

SCB/QS: 23/26	**Pop's Team – Where are we now?** **NH** gave verbal presentation about NELA. • Emergency stream, Planned Care Pilot and Future Plans. • Older frail patients over 65 do worst after emergency laparotomy. • 0% before October 2020. • 88% Last quarter of 2021. • Peri op Delirium is being worked on with upskilling staff and Planned care pilot. • Frailty assessments over 65 from POAC, Prehab to Rehab. • More demand than capacity. • Increased training and awareness for Post op delirium. • Shared decision making -16% of patients not choosing surgery. • Currently working on business case for sustained service.	
SCB/QS 23/27	**Consent forms -Acute Pain Team** **CR** gave verbal presentation • Newly developed specific analgesia information leaflets and procedure specific consent forms for Rib fracture patients. • Designed to educate and encourage patients to be more active in making decisions about their care. • Consent is able to be given more ethically. • Band 7 nurses to be trained on taking consent and therefore streamlining wait times.	
SCB/QS 23/28	**Penicillin DE labelling** **NS** gave verbal presentation • Assessing patients who are labelled as allergic to penicillin. • Important as all-cause mortality is higher with penicillin allergy.	

	• Direct oral amoxicillin in low risk patient within the hospital setting. • If test was successful, de-label would happen with formal notification on medical records. • Automatic de-label for patients with intolerance history. • 78 patients assessed, 46 patients were DE labelled. • Ward teams need support from pharmacy and microbiology to de-label patients. • Hoping to became standard practice.	
SCB/QS: 23/29	**1 GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY** **Patient story** No representative available **Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes –** No update **Amat Update** - **DJ** shared newsletter and advises all departments to update onto the national database. She also advised that T&O top five reported incidences are due to pressure damage and falls.**DJ** advises pilot scheme happening on A6 to complete purpose t assessments. **DJ** encourages directorate leads to complete the statements of compliance. **DJ** encouraged Action plans to be filled in and saved so that they are able to be accessed years later if needed. **Revised procedure for U18s surgery at UHL** **BJ** advises that the guidance has now been updated and verified and is ready for sharing. **Feedback from UHB QSE Committee** **AS** Advises that agenda set meetings are now monthly. Implementation of Duty of Quality to understand what makes good care. Health board is developing equalities and inequity framework. **AS** Advised that they are working on developing a framework to standardise clinical governance. Developing quality dashboards. **Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities** **Peri-operative** **CJ** Verbal update – • Renshaw Robot failed on two occasions and was looked into and it appears to be software issue, this is now awaiting update from the company. • Riddor incidence, closed and staff member back in work.	

	• Theatre lights in 3 and 8 Ophthalmology. Lights are said to be unrepairable. • BDM epidural lines had a safety notice, were withdrawn on paediatric patients, however MRHA have said they can be used on patients over 5kg. • Chloro prep sticks have not been replaced as of yet. • Theatre scrubs are unavailable, finance has been secured for more, however stricter measures need to come into place. **Anaesthetics** – **RB** updated group that the Incident of awareness from November QSE has been resolved. Safety measures have now been put in place to avoid this occurring again. Raised issue regarding the danger of the similarity between two drugs and packaging. **General Surgery – CT** updates to the group, Two NRI'S outstanding and are being investigated. **Urology –** Nothing to report **ENT/H&N –** Nothing to report **Ophthalmology –** Five incidents are being investigated**.** **T&O –** Investigation ongoing regarding facilliac block. Findings will be reported in due course. **Dental – BW** advises there is a planned HIW visit in April and outcome will be updated. **Pharmacy – AT** updates that shortages are ongoing • Local anaesthetic, particularly individual bags. • Povidone Iodine is sporadic as only one supplier. • Tisept and Unisept has been discontinued and no replacement as of yet. • Alteplase is affected and is a national problem **PREHAB** - Nothing to report **2 HEALTH PROMOTION PROTECTION AND IMPROVEMENT** **Initiatives to promote health and wellbeing of:** **Patients** **SCB H&S/IPC meeting update** **CA** gave presentation. • 96 Riddor to date, 82 to HSE. • More claims regarding needle stick injury due to wrong waste in wrong bins. • Improvement is need to increase Mandatory training.	
SCB/QS: 23/30		

	• V&A training needs to be up taken due to increase in incidents of V&A • DNA rates for staff training lessons are high and need to be challenged as departments are being charged. H&S are going to share reports to individual CB • Fit testing records to be kept together and available for auditing if needed. • 2 out of 3 lifts not working, pipework and Asbestos risk within dental. • Theatre changing rooms need updating. • Peri op ventilation data-several estate issues. **CA** Advises MRSA rates are 0, C Diff is 28, MSSA 0, Klebsiella 1 **Decontamination group update** **BJ** explained to the group that she hasn't attend any meeting since last Q&S meeting so nothing to report. **Water safety Group Update** **BJ** Nothing to report **Ventilation Group** **CW** Advises ventilation compliance report is back from estates and there will be a meeting next week to go through the Findings.	
SCB/QS: 23/31	**3 SAFE CARE** **Patient Safety Incidents** **NS** SharePoint document available. **Patient Safety Alerts (internal/external)** **CA** advises all safety alerts have been circulated and compliance back to patient safety. Nothing is outstanding. **HCAI rate** **DJ** advises that audit on skin prep solutions has been completed and data will be shared in due course**.** **Any key patient safety risks:** **Q&S performance data -** **CW** Advises that Datix numbers need to reduce by 15%and support will be becoming available for managers struggling to close their queue. CA advises that 141 Datix have been closed in the past week. Reduced and close the outstanding NRI's.	

	Falls reduction and Pressure and tissue damage reduction and prevention **LH** States that T&O have had two injurious falls, one requiring surgery. **Medicines management issues/incidents/audit findings** - **AT** SBAR needs updating regarding licensed and unlicensed medicines. **Safeguarding** Nothing to update. **Medical Equipment group** No update given. **Blood management/ Zero Tolerance Report**- **CJ** no updates as of yet. **Q&S Workplan 2022-2023-** **CW** asks for everyone to review and feedback please. **Mortality data analysis** - No update	
SCB/QS: 23/32	**4 Effective care** **Implementation of key Nice Guidance** - **CW** highlighted to the group that Nice Guidance Spreadsheet is regularly updated and saved, a paper copy is also sent to clinicians and now it would be uploaded to AMat system too. **Research and development update -** No representative on the meeting.	
SCB/QS: 23/33	**5 Dignified Care** **HIW/CHC, Deci (dignity and essential care inspections) reports and improvement plans** **CW** to invite CD to present next meeting on Tendable.	
SCB/QS 23/34	**6 Individual care** **Ombudsmen report PT Mr JG** **CW** informs the group of a public case and the outcome**.**	

SCB/QS 23/35	**7 Staff and Resources** **Staffing levels** **CW** Mentioned that safer staffing levels are due to be signed off in August with the Executive Nurse, Director, the Finance Director and the director of People and Culture. **AJ** asks if it can be considered from a service perspective **CW** Advises to discuss within the team as no extra finance is available.	
SCB/QS: 23/36	**4. Date & time of next Meeting** **16th May 2023 8-10am MS Teams**	

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

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
HELD AT 11 AM ON 30TH MAY, 2023, 11 AM
Venue: MS TEAMS

Attendees	
Helen Kemp (HK)	Deputy Clinical Board Director (Chair)
Anna Mogie (AM)	Deputy Director of Nursing
Rachel Armitage (RA)	Quality and Safety Manager
Lisa Waters (LW)	Senior Nurse for Quality and Education
Clare Clement (CC)	Head of Medicines Management
Lynne Topham (LTop)	Locality Manager, South and East Locality
Helen Donovan (HD)	Locality Lead Nurse, North & West Locality
Sarah Griffiths (SG)	Head of Primary Care
Neil Morgan (NM)	Vale Locality Manager
Kate Roberts (KR)	Vale Interim Lead Nurse
Ruth Cann (RC)	Consultant Nurse Older Vulnerable Adults
Victoria Whitchurch (VW)	Head of Operations, Mass Imms
Janice Aspinall (JA)	Health and Safety Representative
Sarah Gray (SG)	Health and Safety Representative
Lorna McCourt (LMc)	Staff Side Trade Union Representative
Ellen Davies (ED)	Clinical Nurse Specialist in Infection Prevention & Control
Louise Thomas (LTho)	Quality & Safety Officer

Apologies	
Anna Lewellin	Director of Nursing
Lisa Dunsford (LD)	Director of Operations

Clare Evans (CE)	Assistant Director Primary Care
Jane Brown (JB)	Head of Dental and Optometry
Deborah Powell (DP)	Safeguarding
Helen Earland (HE)	Clinical Operational Lead, GP Out of Hours
Gneeta Joshi (GJ)	Community Director of Clinical Governance
Andrea Rich (AR)	Lead Nurse, Palliative Care
Carol Preece (CP)	Lead Nurse, South & East Locality
Rhys Davies (RD)	North West Locality Manager
Rebecca Gill (RG)	Senior Nurse

ITEM NO.	TITLE	ACTION
05/23/01	HK welcomed everyone to the meeting.	
05/23/02	Apologies were noted as above.	
05/23/03	No declarations of interest were raised.	
05/23/04	Minutes The minutes of the meeting held on 28th March, 2023 were reviewed; it was agreed that the centralised waiting list referred to in item 03/23/07.7 should be specified as the "dental" centralised waiting list. LTho to amend the minutes to reflect this change. There were no other matters arising.	LTho
05/23/05	Action Log Please refer to item 5.	
05/23/06.1	OOH Business Report There was no representative available. Please refer to item 6.1	
05/23/06.2	N&W Locality Business Report Workforce issues continue with four District Nurses due to commence maternity leave at the end of the summer; the team is doing all it can to fill these future service gaps. There are ongoing parking issues at St David's Hospital. Road works for the new Velindre access road around the North & West locality site continues to cause disruption but are almost complete. There are a few ongoing concerns along with two new ones received this month.	

	The NHS benchmarking audit registration is open for 2023 and involves the CRT working in conjunction with the Regional Partnership Board (RPB). Hilary Hyett is working on this. The recent IG breach has been dealt with via the disciplinary process following on from a member of staff accessing a relative's records. Provider Performance Monitoring (PPN) processes are in place at Dan y Bryn.	
05/23/06.3	<u>Vale Locality Business Report</u> Fluctuating sickness levels have been seen amongst the District Nursing teams but this is beginning to improve. The band 6 District Nurse vacancies remain unfilled; the locality employs District Nurses who are both experienced and inexperienced but there is a lack of Nurses who bridge this spectrum. The area is actively trying to recruit into these roles. Lead nurse post and the cluster lead post is about to be advertised. The locality will also advertise for a band 8A programme manager post to replace Wendy Wade. Difficulties have been experienced recruiting reablement homecare staff, particularly in the VCRS service. There is a constant recruitment drive. It is not uncommon to recruit six new staff and then receive four resignations not long after. Priority will be placed on these roles in the forthcoming recruitment event. The group discussed the utilisation of exit questionnaires; LTop noted that her area does not tend to receive exit questionnaire feedback. HK suggested that these themes should be captured in the Quality and Safety reports. Ongoing parking issues continue along with room issues at St David's Hospital. The bladder and bowel team will participate in the All Wales launch in June. Ann Yates (Director of Continence Services) and Wendy Simmonds (Tissue Viability Specialist Nurse) will be speaking at the event along with the Tissue Viability Nurses. Space in Barry Hospital is becoming an issue; clinical space is in demand. Peter Welsh, General Manager, Barry Hospital is due to retire; NM will have some responsibility as site point of contact following on from this. Meetings and discussions regarding the health and wellbeing Hub for Barry Hospital should begin later this year. Meetings regarding the Penarth Hub have commenced. LMc offered her services to these meeting; NM will inform Rob Wilkinson who will be running the Hubs.	
05/23/06.4	<u>South and East Locality & HMP Business Report</u> Main risks are staffing levels, in particular the GP and Nursing levels in HMP. Everything is being done to fill these vacancies but significant risks remain. DOSH electronic patient records continue to experience glitches on the Milcare system; there have been a few challenges in relation to resolving these issues. LTop anticipates shortlisting a project manager to work on this. A project team will then be created to work on the system. Cluster gaps continue, leading to pressure on the locality management team.	

	The food and fluid policy came through the last QSE meeting and is being implemented by HMP and healthcare staff. Tendable is being used in HMP to help monitor standards. The Senior Nurse Manager in HMP is working on the modifications required to fit with the HMP environment. LMc has been involved in discussions regarding carparking in CRI; car parking spaces will be reduced when the site is redeveloped. Butetown is under pressure due to maternity leave amongst the DN team. A potential disciplinary matter recently came to light; the team is in the early stage of investigation. There has been political interest regarding the restart of the sexual health service in the Vale; work is being carried out looking at the contraception service offered to young people in the area. AM noted the recent HMP IPC audit conducted by Yvonne Hyde (Head of Nursing for Infection Prevention & Control) which highlighted a few significant issues in relation to soap dispensers, etc and advised that the audit is presented at the HMP Quality and Safety meeting. ED will ensure the report has been circulated to the relevant staff. LTho to send AM the Nursing Home QA report to forward to Jason and the Corporate team.	ED LTho
05/23/06.5	<u>Medicines Management</u>. A new risk has been raised regarding Kaleidoscope, a commissioned service that provides substance misuse support for clients in the criminal justice system. The Community Pharmacy team is in the process of compiling a risk assessment form and formally placing the risk on the risk register. A site visit is planned in order to review the service provision and review the work that is being carried out under the controlled drug regulations and to look at the Health Board's powers within the framework. There is a risk surrounding the inability to discharge or delay to discharge which is linked to the regional adult services and medicines support policy. A meeting is diarised with high level stakeholders to progress discussions around investment required and implementation of the policy. The Lead Pharmacist post has been recruited into and a Pharmacy Technician will take up post at the end of July. The Community Pharmacy team has been contacted by three different routes from people asking about the willingness for GPs to prescribe methylphenidate initiated by private providers. The routes in which these queries are entering the Health Board have a suspicious feel to them, especially as they coincided with a television programme (Panorama) that was recently aired. CC noted that she would like to bring this to the group's attention in case any other members receive similar queries, noting that her team will be happy to be involved should the need arise. The Health Board and Community Pharmacy palliative care service is being reviewed in order to move towards a new updated national service for an urgent	

	medicine service, not a palliative care service. This will allow the pharmacy team to stock new non-palliative care medicines if and when needed. The medicines management team carry out a lot of work around antibiotics and is currently focussing on appropriate antibiotic durations. The team is engaging with Microbiology to deliver education through the CD sessions along with piloting a surgery where the computer default is changed.	
05/23/06.6	Palliative Care Please refer to item 6.6 in AR's absence. There were no comments or questions in relation to the report.	
05/23/06.7	Primary Care 8 practices (with a population of approximately 51k patients) were reporting at level 3 and 4, this has dropped to six since the report was produced (5 practices are reporting at level 3, 1 practice is reporting at level 4). There are no closed lists; the practice with a previous closed list in the South West cluster has reopened (the list was closed as a result of the salaried GP leaving the practice, leaving one GP contractor who also left after a number of weeks). Issues have now been rectified. No applications for support via the sustainability framework have been received although the primary care support team are actively supporting a number of practices. The support team has increased in size by 2 GPs (Dr Paul Williams and Dr Laura McKenzie) who are working on patient demand and access. Two mergers are progressing, one in the Vale of Glamorgan, the other in the South West cluster. Two apprentices have been recruited, Patrick is currently working in Radyr and Kim is working in Four Elms Medical Practice. The medical facility in St Athan will close. It looks after approximately 200 patients who will look for alternative GMS services in the local area. The practices are not concerned and we are working with the MOD and the practices to ensure the transition is as smooth as possible. Patients will not be allocated; there is patient choice in the area and patients will be advised of the practices taking on new patients. LMc pointed out that she is happy to visit the staff should they have any queries. SG noted that she will pass any dental or optometry questions to JB; there were no questions raised.	
05/23/06.8	Mass Vaccination Centre (MVC) report No report was available; a verbal update was provided. The spring booster campaign is drawing to a close. The biggest risk regarding the winter vaccination programme is the potential lack of vaccination site. The lease on the modular build in Woodland House expires in August 2023; the MVC team is working with Estates to identify a replacement. Holm View is being utilised in the Vale and space in Barry Hospital has been secured. The team is heavily reliant on temporary staff. There is a risk to the call centre and testing team's 7 day cover due to the potential plans of the possible closure of Woodland House on a Saturday and Sunday.	

	WHO has declared that Covid 19 is no longer a global emergency; work will be undertaken on how the unregistered vaccination workforce is managed going forward without a national protocol. The Human Medications Regulations had allowed an unregistered vaccination workforce to work throughout the pandemic; this protocol no longer exists since the pandemic has been declared over. This is a national problem which is being worked through with WAG. The Delivery Unit has assured the team it should continue with their current working models.	
05/23/07	<u>PCIC QSE Terms of Reference review</u> Item 7 has been circulated for comments. RA thanked HK and CC for their queries. A Public Health representative will be invited to future meetings. RA will organise. HK had suggested adding strategic documents as appendices; RA suggested adding foot notes with links to access the documents in order to make the document as short as possible. The group agreed with this suggestion. Quality standards, Duty of Candour and the Duty of Quality will be added to the ToR. It will be recognised that other Clinical guidelines and procedures will be received via this meeting (Community Pharmacy, etc). Medicines and Community Pharmacy Subgroup no longer exists. RA to remove. AM/LMc/JA to discuss staff side representation with AL. RA to speak with Emma Lewis regarding representation following on from RT's departure. Guidance to be taken from Corporate Governance regarding health pathways.	RA RA RA AM/LMc/ JA/AL RA RA
05/23/08	<u>Risk Register</u> RA has circulated individual risk registers to Business Unit leads requesting them to review. The highest risks are sent to the Corporate team on a bimonthly basis after they have been moderated by the Director of Operations. RA asked the Business Unit leads to ensure they are happy with gradings, etc. A risk register deep dive is scheduled this week. RA thanked the group for engaging with this arduous and complex process.	
05/23/09	<u>Business Continuity</u> The group previously noted a number of business continuity plans developed by business units which are in the process of being reviewed and updated; completion is proving to be a challenge due to operational pressures. The corporate team that issued the template no longer have the resources to continue its update. TB is of the opinion that the template is no longer fit for purpose as it does not reflect the post Covid ways of working. TB is due to look at the template with the emergency preparedness team in order to modify it for PCIC's use instead of utilising the corporate version; she hopes that a PCIC specific template will be available in 6 months' time. TB will continue emailing operational areas requesting to be informed of any updates made to the plan.	

	TB will attend each PCIC QSE meeting in order to keep business continuity at the forefront of the team's minds.	
05/23/10	<u>PCIC Quality report</u> There are 3 open NRIs which are close to closure. LW thanked all who had contributed to the action plans and for all of their hard work. There are 481 open datixes but 296 of these are new incidents. LW explained that incidents remain as 'new' incidents even if the incident manager has simply opened it to look at the detail; this will imply an unknown risk in the area. This is a consequence of the new system; LW will circulate an email informing staff of this change. LW confirmed she is happy to link in with the audit report from an IP&C perspective. Duty of Candour (DoC) now forms part of the Health Board's legislative duty; there is a dedicated team who is happy to attend team meetings. Please refer to the link in the report. It was agreed that DoC will be centrally recorded and attributed to locality. RA will enquire if the Corporate team intend to reset their agendas for meetings across the Health Board due to the new health standards that have come into effect. When this has been confirmed, the group will look at this meeting's agenda followed by Business Unit reports. LW congratulated Amy Worrell who was awarded the Queen's Institute Award for her work within the district nursing service. Amy had received several lovely, touching compliments about the care she has provided. The Education Programme for Patient Coordinators team has also received a lovely compliment.	LW RA
05/23/10a	<u>WHC 2023 017 (National Policy on Patient Safety Incident Reporting)</u> HK encouraged the group to look at item 10a for their information.	
05/23/10b	<u>Update from Medical Examiners Service (MES)</u> Legislation is being reviewed and will be a statutory duty as of April 2024. In preparation, it is advised that PCIC adheres to this legislation as of September 2023. GP colleagues should be aware of this. Regular meetings are held with the Lead Medical Officers.	
05/23/11 & 11a/b/c	<u>IPC update</u> ED ran through the end of year report for reduction expectations. From April 2022 – March 2023 the Clinical Board had a CDiff expectation of less than 20 cases annually; there were 55 cases (an increase of 4 cases upon last year). From April 2023 to date there have been 5 CDiff cases, which is again an increase (of 2) for the same period last year. ED is in discussion with an epidemiologist regarding the collation of data for reporting purposes. The MRSA reduction expectation is zero; there is a zero tolerance but last year there were 4 cases. There have been 0 cases since April 2023 to date. The MSSA reduction expectation is less than 30 cases; PCIC had 46 cases although this was a reduction of 3 cases on the previous year. There have been 5 cases since April 2023 to date.	

	The E. coli reduction expectation is less than 144 cases but there were 173 cases. Last year there were 185 cases. There have been 12 cases since April 2023 to date. ED will attend next week's LMC meeting. ED noted that the IPC team look for any potential sources by reviewing cases and looking at patient history and any possible triggers. Her team will look if these patients had any health care interventions prior to their positive blood culture/test result. RA suggested linking in with Rebecca Gill, Senior Nurse, who has connections with the practice nursing community. RA pointed out that GPs are no longer contracted to reply to RCA requests and commended GPs for engaging in the process.	
05/23/12	<u>Llais (new CHC)</u> Stephen Allen was unable to present at today's meeting; he will be invited to present at the next meeting scheduled in July 2023.	LTho
05/23/13	<u>Safeguarding</u> No representative was available. The nursing home quality report will be brought to the next meeting. RA noted that the governance team sends supportive documents to GP practices when they are notified of an unexpected death in childhood.	
05/23/14	<u>Interim learning report – National Nosocomial COVID-19 programme</u> Please note item 14 regarding the Covid 19 programme which was established in April 2022 to support NHS Wales organisations to conduct proportionate investigations into Covid patient safety incidents which occurred between March 2020 and April 2022.	
05/23/15	<u>Monthly Clinical Board Video Consultation Report April 2023</u> Please note item 15 for information.	
05/23/16	<u>Any Other Business</u> There is planned industrial action on 6th and 7th June 2023. The team is working in conjunction with the RCN; services such as the MVC and certain DOSH clinics will be stood down in order to plan critical services. Patient stories will be reintroduced to these meetings; LW will compile a rota.	LW
PART 2	The Group noted the papers submitted for information.	
Date and time of next meeting: 25th July, 2023 at 11.00 am.		

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee
Held on 23rd January 2023
Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Director of Nursing CD&T/Multi Professional Teams
Suzanne Rees	SR	Lead Nurse, CD&T
Jo Fleming	JF	Quality Lead, Radiology
Kim Atkinson	KA	Head of Occupational Therapy
Jenna Walker	JW	Pharmacist, Pharmacy
Robert Bracchi	RB	Medical Advisor to AWTTC
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer
Seetal Sall	SS	Point of Care Testing Manager
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Jonathan Davies	JD	Health and Safety Adviser
Sian Jones	SJ	Directorate Manager, Laboratory Services
Paul Williams	PW	Clinical Scientist, Medical Physics
Louise Long	LL	Public Health Wales Microbiology
Rhys Morris	RM	CD&T R&D Lead
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Christopher Tetley	CT	Head of Clinical Photography, Medical Illustration
Samantha Davies	SD	Radiographer, Radiology
Kate Bishop	KB	UHB MCA and Consent Lead
Secretariat:		
Helen Jenkins	HJ	Clinical Board Secretary
Apologies:		
Sandeep Hemmadi	SH	Clinical Board Director
Becca Jos	BJ	Deputy Director of Operations
Matthew Temby	MT	Clinical Board Director of Operations
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Lesley Harris	LH	Head of Radiography UHL
Bolette Jones	BoJ	Head of Medical Illustration
Jamie Williams	JWi	Senior Nurse, Radiology
Alun Roderick	AR	Laboratory Service Manager, Haematology
Tracy Wooster	TW	Sister, Outpatients
Catherine Evans	CE	Patient Safety Facilitator
Marie Glyn-Jones	MG-J	Deputy General Manager, Radiology & Medical Physics/ Clinical Engineering
Timothy Banner	TB	Clinical Director, Pharmacy

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 23/001	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 23/002	**Apologies for Absence** **The Group resolved that:** a) The apologies for absence were noted.	
CDTQSE 23/003	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting held on 24th November 2022 were accepted as an accurate record.	
CDTQSE 23/004	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 22/158 NICE guidance relating to rehab following a traumatic injury* HL to ensure there is specific reference in the risk register in relation to workforce around this issue. *CDTQSE 22/243 Lift in Toxicology* During the last servicing of the lift, it was advised that at the next service, there is a possibility that the lift will be condemned. Numerous attempts have been made to contact Estates but no response has been received. Helen Luton will follow up with Estates. The risk is on the Clinical Board risk register. Helen Luton will share with RB for him to review the risk. In Biochemistry there is a risk as when the lifts are out of order staff need to carry helium cylinders up to the department on the 4th floor. A business case was submitted to the Clinical Board with a mitigation option to convert the analysers to piped-in hydrogen. This was agreed by the Clinical Board. *CDTQSE 22/247 SBAR for Therapies Relating to Estates Issues* This is in progress. KA is collating the risks and placing them in order of priority.	**HL** **HL** **HL/ RB** **KA**

	CDTQSE 22/247 Clinical Board Risk Register HL to add the risk register to Teams. *CDTQSE 22/264 Digital Therapies* MK and SO will present at the next meeting. *CDTQSE 22/358 Dementia* KA reported that the newly appointed Strategic Lead Occupational Therapist is a real expert on dementia. She previously worked in Public Health Wales having developed the Dementia Charter and will be a great resource for the Health Board. *CDTQSE 22/362 Scanning Options in Clinical Engineering* EC noted that the option of offsite storage incurred a very small cost and was therefore agreed as the preferred option. **The Group resolved that:** a) The update on the actions from the previous meeting were noted.	**HL** **MK/SO**
6 DOMAINS OF QUALITY		
CDTQSE 23/005	The Duty of Quality Statutory Guidance 2023 The statutory guidance comes into force from 1st April 2023 and was shared for information. The agenda of this meeting has been changed slightly to incorporate the 6 Domains of Quality. Key points within the document are: - The strategic and policy context of placing quality and safety as the priority above all else. - Integrate improvement into everyday working - A focus on prevention, health improvement and inequality. From the perspective of this agenda, health services need to be: Safe Timely Effective Efficient Person Centred. A PowerPoint presentation is available summarising the key elements of the document and Helen Luton will circulate this. **The Group resolved that:**	**HL**

	a) The Duty of Quality Statutory Guidance 2023 was noted and thought will be given to any future agenda items that are currently not discussed that fit within this guidance.	
SAFE		
CDTQSE 23/006	**Concerns and Compliments Report** Most of the concerns received by the Clinical Board are for early resolution. The key theme relates to difficulties in patients arranging and cancelling appointments via booking lines. There is 1 formal concern currently open relating to queries around the care of a patient stay on Glan Ely Ward. **The Group resolved that:** a) The Concerns dashboard was received and noted.	
CDTQSE 23/007	**National Reportable Incidents – NRI report** The Clinical Board currently has 4 open NRIs: Incident No 5670 related to a delay in a patient receiving a CT Thorax. This incident is now closed. There was learning identified from this incident in terms of identifying which patients are fast tracked where they have a suspected cancer. There are also lessons around the referral from the GP which the patient was keen for the Clinical Board to look into. Incident No 13127 relates to a patient under the care of Cardiology pertaining to their discharge medication advice letter. This incident will be shared at a future meeting for shared learning. Incident No 21070 relates to an MRI scan. The initial meeting has not yet been held to determine the terms of reference. Incident No 22207 relates to medication not being dispensed from Pharmacy for a paediatric patient with epilepsy. The initial meeting has not yet held to determine the terms of reference. Incident No 14687 relates to a delay in diagnosing a malignant melanoma. The investigation is underway. **The Group resolved that:** a) Learning from the incidents will be discussed at future meetings when the investigations have been completed and the incidents are closed.	
CDTQSE 23/008	**New NRIs** **The Group resolved that:** a) There were no further new incidents to report.	

CDTQSE 23/009	**Risk Register** Helen Luton asked directorates to consider the best mechanism for reviewing their risk registers and submitting their updates for the Clinical Board risk register. Kim Atkinson advised that Therapies could provide an automatic feed from their risk register directly into the Clinical Board risk register with their updates. If this works it could be replicated across the other directorates. KA and HL will look into how this can be implemented. Radiology hold quarterly reviews of the risk register and will invite HL to the meetings. AWTTC submit their updated risk register following their Board meetings. **The Group resolved that:** a) Directorates will consider how best to submit their updates and how frequently they review their risk registers.	**All** **KA/HL** **JF**
FCDTQSE 23/010	**Patient Safety Alerts** **The Group resolved that:** a) No patient safety alerts have been received.	
CDTQSE 23/011	**Medical Device/Equipment Risks** EC presented an SBAR from Paediatric Occupational Therapy to undertake a mobile seating base trial. There are a number of different mobile seating bases in use across all UHB sites and it would be advantageous to standardise on a single mobile base unit, suitable for mounting the prescribed seating systems required across the service. EC is content and recommends that approval is given for the trial. KA suggested that approval is also needed from Children and Women's Clinical Board as the services sits within their remit. EC will contact the Medical Device Safety Officer for Children and Women's Clinical Board. An Executive Patient Safety Walkround was held at the equipment library. This was a positive visit. The need for a larger room and the constraints around the current room were noted. An action was agreed that general communication is needed with all Health Board staff to remind them that some pieces of equipment are more expensive than they appear which may not be appreciated. A newsletter is being produced for wide circulation.	**EC**

	Seetal Sall noted that Point of Care Testing utilise the library and endorsed her support for the department to be allocated a larger room which would also benefit the wider UHB. As discussed at the last meeting an Internal Audit was undertaken in Clinical Engineering. Reasonable assurance was provided. Recommendations relate to: • To publicise the recommended list of medical equipment and devices. EC has a catalogue of equipment that can be shared across the Health Board. • Undertake an audit of items not seen for over 10 years. • Management of loaned medical equipment. This is difficult for Clinical Engineering to manage as it does not have an overview of everything within the Health Board. It is therefore important that all staff keep a record of on what basis is the equipment loaned, terms of the contract etc. • A centralised system for training records is needed. Clinical Engineering hold records of training that they have provided however, wards or departments should have records of equipment training and relevant people responsible for maintaining staff competency are aware they exist. The Medical Equipment Group and Director of Therapies and Health Sciences need to discuss this. An Internal Safety Notice was issued around Transillumination devices in December. An Internal Safety Notice has been issued in England but not yet in Wales around the safe use of oxygen sensors. EC noted that CD cylinders are in short supply and asked if there are cylinders in departments not being used if they could be sent back to the cylinder store as they are needed in the Emergency Unit. Sion O'Keefe advised that the Medical Gas Committee will be undertaking a pilot at UHL around the tracking of CD cylinders. **The Group resolved that:** a) EC will contact the Medical Device Safety Officer for Children and Women's Clinical Board and share the SBAR for the trial. It was agreed that the trial can proceed if this acceptable by the Children and Women's Clinical Board. Feedback on the trial will be captured. b) A Clinical Engineering Newsletter is being produced for publication and wide circulation. c) Actions from the Internal Audit in Clinical Engineering were noted.	

	d) The request was noted for CD cylinders not needed within departments, to be sent back to the cylinder store so they can be used in the Emergency Unit.	
CDTQSE 23/012	**Point of Care Testing** Seetal Sall reported that there was a problem with an inline blood gas machine in Cardiothoracic Surgery resulting in the potential of stopping all of the Cardiothoracic bypass surgery if they could not source a replacement machine. Clinical Engineering and Point of Care Testing were not aware of the existence of this machine. She wanted to acknowledged the efforts of the Biochemistry team and Point of Care Testing team for quickly identifying and implementing a blood gas machine at significant pace. Helen Luton commented that the Point of Care Testing Governance Group and Medical Equipment Group will be a mechanism of sharing the learning from cases such as this and raising the issues that can arise when departments have purchased equipment without consultation with Clinical Engineering or Point of Care Testing. The sharing of the catalogue of equipment will also help departments in procuring the right equipment and understand what equipment is suitable and approved. There was a blood gas clinical incident relating to glucose results from a blood gas report in Theatres. The Point of Care Testing team are working with the Patient Safety Team to address some of the issues and put mitigation in place to prevent a reoccurrence. **The Group resolved that:** a) The Point of Care Testing Update was noted.	
CDTQSE 23/013	**IP&C/ Decontamination Issues** The UHB Decontamination Group and IP&C Committee has not met since the previous meeting. Helen Luton reminded members that the flu and Covid vaccinations are still available for staff. **The Group resolved that:** a) Going forward, the minutes of UHB Decontamination Group will be shared at this meeting.	
CDTQSE 23/014	**Safeguarding Update** Kate Bishop, Mental Capacity and Consent Lead for the UHB was welcomed to the meeting.	

	A lot of work is being undertaken around mental capacity and consent, focusing on how to expand the delivery of training and identifying what are the barriers to accessing training. **The Group resolved that:** a) Members will make contact if they require any training or have any issues to raise.	
CDTQSE 23/015	**Health and Safety Issues** A RIDDOR reportable incident occurred this week involving a member of staff slipping on the ice. A further RIDDOR occurred on Glan Ely Ward involving a member of staff that slipped on water. **The Group resolved that:** a) The health and safety update was noted.	
CDTQSE 23/016	**Regulatory Compliance** **Mortuary position in relation to HTA compliance and the Fuller Enquiry** SG reported that the mortuary position has been exceptionally challenging since the beginning of December with limited capacity. Funeral Directors are currently experiencing significant occupancy levels. The directorate have worked with estates colleagues to expand capacity on a temporary basis to address current challenges. Being mindful of the recommendations following the Fuller Enquiry, Welsh Government submitted a letter to the Chief Executive asking for assurance around conformance with the HTA standards. A gap analysis was therefore undertaken against the updated standards. There are some actions required in respect of the alarm system and the security cameras. The UHB also needs to be clear on how it uses its augmented capacity as the Act is very clear around the care pathway for deceased patients. The UHB has full traceability of its patients. It is imperative that flow continues to be managed and support is being provided by the Bereavement team. In all circumstances the UHB is working to ensure the dignity of all the deceased patients within its care is a priority.	

	HL commented that she had not appreciated that the cost of living crisis is also having an impact, with families affected by the crisis trying to fundraise to pay for funerals. **The Group resolved that:** a) The issue will remain on the agenda for the next few months to monitor the position.	
TIMELY		
CDTQSE 23/017	**Initiatives to Improve Access to Services** **The Group resolved that:** a) This agenda item will be an opportunity for directorates to share any initiatives they have implemented that has improved access to their services.	
CDTQSE 23/018	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** At end of December there were 2023 patients waiting 8 weeks or more diagnostics. This was a significant increase of 708 from the previous month. This was due to supporting service pressures during the industrial action days and prioritising inpatient imaging. Patients waiting 14 weeks or more for Therapies in December were 433 down 9 from the previous month. Further impact is expected from the further planned industrial action days. **The Group resolved that:** a) The waiting times performance for Diagnostics and Therapies was noted.	
EFFECTIVE		
CDTQSE 23/019	**Feedback from UHB QSE Committee** The minutes of the meeting held on 29th November 2022 were received. It was noted that the Tendable platform has been implemented in inpatient ward areas and has scope to be utilised in outpatient settings. Tendable provides patient feedback as well as audit information and KPIs around issues such as hand hygiene and infection, prevention and control. SR utilised the platform for a nurse audit on Glan Ely Ward. The plan is for all areas to be issued with tablets to undertake the audits whilst walking round the areas whilst inputting the data. The system has a dashboard where service leads can look at what audits have been undertaken. At present this is only in use	

	on the wards but there will be scope for this to be implemented in areas such as Outpatients and Radiology. JJ noted that she would be keen for this to be implemented in Radiology and asked if clinical staff other than nurses will have access to the system. SR will enquire on the status of other healthcare practitioners. The meeting also discussed the UHB IP&C position, noting that if C-diff, E-Coli, MRSA and MSSA infections are grouped together there has been no in-year improvement against the 2018-19 baseline. It was noted that for all C-diff infections, a root cause analysis is undertaken and the meetings with the Executive Nurse Director and Medical Director have been reinstated. HIW activity was also discussed. Visits have been held to Cardiothoracics UHL, Stroke Services, Maternity and Nuclear Medicine UHL. HL commented that Therapies are key to the Cardiothoracics and Stroke teams but it was noted that KA had not received any feedback. The risk register was reviewed and it was noted that a risk within Haematology had been on the register since 2010. HL noted that there are a number of risks within this Clinical Board that have been on the register for a number of years and asked directorates to ensure these are being reviewed along with the mitigation and are being updated. **The group resolved that:** a) The minutes of the QSE Committee were noted.	**SR**
CDTQSE 23/020	**NICE Guidance** **The Group resolved that:** a) There was no NICE guidance to discuss.	
CDTQSE 23/021	**Research and Development** RM reported that the Clinical Board Research and Development Group met last week and was well attended. Discussions were held around funding proposals and research work ongoing. There are currently no representatives on the Group for Laboratory Medicine and Pharmacy. Pharmacy are in the process of identifying a nomination. Laboratory Medicine will discuss at their management team meeting, A clinical academic meeting was held last week between the UHB and the University to consider how the two institutions can collaborate more closely on research. It was very much focused on medics and RM was concerned that research work being undertaken by non-medics is undervalued. This Clinical Board	

	has a role in reminding consultant colleagues that other non-medical professions also undertake research. The Clinical Board Research Forum was also held last week and there was reasonable attendance. The intention is to try to secure engagement from the broader Health Board for the next session. **The Group resolved that:** a) The R&D update was noted.	
CDTQSE 23/022	**Service Improvement Initiatives** SO provided an update on General Practice Test Requesting and Electronic Test Requesting. Cardiff and Vale achieved the GPTR 90% target set for all Health Boards across Wales. This is being sustained. Electronic test requests in the Health Board have hit the 1m mark. A weekly Phlebotomy Governance Group has been set up to try and improve the picture across the Health Board for patients who need to have bloods taken and for clinicians that need to take decisions based upon this. There is representation from different staff groups with the majority in Secondary Care and this is being worked through into Primary Care and there has been good engagement. The aim is to link this work to the Reset Week and support ongoing pressures in the Emergency Unit. An audio presentation has been shared and there is good engagement with Phlebotomists and they are being supported in the ask for them to work differently. Improvement Practitioner training has been impacted on and this will be followed up in a few months' time. **The Group resolved that:** a) It was noted communications to share the GPTR and ETR good news story is being developed.	
CDTQSE 23/023	**Information Governance/Data Quality** SO reported that around a year ago, a data breach occurred with records stored with a company in Crickhowell. There was severe flooding of the unit and the Information Governance Team ensured the salvaged records were placed into alternative storage and specialist storage to prevent further damage. There is a need for the records being stored to be reviewed by services and will require site visits. SO will pass on the information to the relevant services. Health Records was subject to internal leaks during the recent severe rain and there was damage to a number of records. These are in the process of being dried out and whilst there	**SO**

	might be some compromise to them it is unlikely they will require destruction. **The Group resolved that:** a) The update on information governance and data quality was noted.	
CDTQSE 23/024	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** **The Group resolved that:** a) The HIW visits were discussed earlier in the meeting. There were no other inspections to report.	
EFFICIENT		
CDTQSE 23/025	**Exception Reports from Directorates** **The Group resolved that:** a) There were no exceptions to report.	
CDTQSE 23/026	**Clinical/Internal Audits** SO reported that an internal audit was undertaken into medical records tracking. A lot of recommendations were not just related to medical records but UHB wide. The response has been submitted to the Audit Committee for review. Work is needed within the UHB to address gaps in governance. There is also a local action plan to be taken forward within Health Records. Other elements linked to digital strategies and management of records outside the remit of Health Records will require organisational support. **The Group resolved that:** a)	
CDTQSE 23/027	**Therapies Digital** KA reported there are issues around the posts that were leading on digital within Therapies. MK will provide an update at the next meeting. **The Group resolved that:** a) An update will be provided at the next meeting.	**MK**
CDTQSE 23/028	**Waste and Sustainability** SJ thanked the departments that are attending the CD&T Green Group, particularly noting the good coverage from within the Therapies department. The meeting last week discussed the	

	small and achievable sustainability changes that can be made to start off the New Year. At forthcoming meetings a dietitian will be presenting and AWTTC will be sharing the work they have undertaken. **The Group resolved that:** a) Directorates to contact HJ or SJ with the names of any individuals who would like to participate in the Group.	
EQUITABLE		
CDTQSE 23/029	**Feedback from Clinical Board Inclusion Ambassadors Group** Work is being undertaking to develop an Inclusion Plan linked to the UHB's Anti-Racist Plan. It was noted that there has been very little direct information being fed back from staff suggesting there is a lack of awareness or trust in divulging information. To help address this, the Clinical Board are learning from Partnership colleagues who have set up a Safe Space initiative where staff can offload. They have also set up an exercise providing an alternative exit interview to the one in place in the Health Board which is more detailed and is anonymised. The plan is for the Clinical Board to receive this information without compromising the identity of the staff member. Staff will be aware that information may be shared in a generic fashion but they will also be given the opportunity to speak to the Clinical Board should they wish. **The Group resolved that:** a) The Clinical Board will refresh its Inclusion Ambassador contacts and consider a re-launch and engage with directorate teams.	
CDTQSE 23/030	**Equality and Diversity Issues** KA reported that the Welsh Allied Health Professions Committee is setting up an Equality, Inclusion and Belonging Group and looking at attracting a wider representation of our communities into the professions, as individuals with Protected Characteristics are poorly represented. **The Group resolved that:** a) More training opportunities on equality and diversity within the Health Board would be welcomed. It would also be useful to identify staff who have received this type of training.	
PERSON CENTRED		

CDTQSE 23/031	**Patient Story** **The Group resolved that:** a) Medical Illustration will present at the next meeting.	**BoJ**
CDTQSE 23/032	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 23/033	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/034	**National User Experience Framework/Feedback from Patient and Service User Surveys** Jo Fleming reported that patient surveys have recently commenced in the Emergency Unit relating to the Radiographer Led Discharge Service. This is predominantly in the paediatric service and for patients attending through Minor Injuries. This week a pilot is also starting on a Radiology survey in the Nuclear Medicine Department. This will then be refined and rolled out across Radiology. **The Group resolved that:** a) Feedback from the Radiology surveys will be discussed at the next meeting.	**JF**
CDTQSE 23/035	**Staff Awards and Recognition** Jess Leonard, Clinical Photographer was successful in 2 National Awards. The Clinical Board congratulated her on her success. **The Group resolved that:** a) Directorates to inform the Clinical Board of their staff achievements or their staff that are working above and beyond.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 23/036	**The Group resolved that:** a) There were no items to receive.	

ANY OTHER BUSINESS		
CDTQSE 23/037	NR reported that there has been a shortage of paediatric blood tubes and Biochemistry have been working with Paediatrics to provide them with advice on how to maintain stock supplies. He also reported that there have been supply issues with Radiometer syringes. An alternative supplier has been identified and it has been recommended to Procurement that this supplier is used and are added to the managed service contract.	
CDTQSE 23/038	**Date & time of next Meeting** 22nd February 2023 at 10am via Teams	

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee
Held on 20th March 2023

Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Interim Director of Nursing/Multi Professional Teams
Adam Christian	AdC	Clinical Board Director
Alun Roderick	AR	Laboratory Service Manager, Haematology
Robert Bracchi	RB	Medical Advisor to AWTTC
Rhys Morris	RM	CD&T R&D Lead
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer
Suzanne Rees	SR	Lead Nurse
Jo Fleming	JF	Quality Lead, Radiology
Bolette Jones	BoJ	Head of Medical Illustration
Seetal Sall	SS	Point of Care Testing Manager
Jonathan Davies	JD	Health and Safety Adviser
Sian Jones	SJ	Directorate Manager, Laboratory Services
Claire Constantinou	CC	Representing Dietetics (For Helen Nicholls)
Catherine Evans	CE	Patient Safety Facilitator
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
In Attendance:		
Linda Hughes-Jones	LH-J	Head of Safeguarding
Sarah Phillips	SP	Safeguarding Team
Robert Gordon	RG	Senior Finance Business Partner
Suzanne Brushett	SB	Secretary to Head of Podiatry
Secretariat:		
Helen Jenkins	HJ	Clinical Board Secretary
Apologies:		
Sandeep Hemmadi	SH	Clinical Board Director
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Matthew Temby	MT	Director of Operations
Becca Jos	BJ	Deputy Director of Operations
Mathew King	MK	Head of Podiatry
Lesley Harris	LH	Head of Radiography UHL
Paul Williams	PW	Clinical Scientist, Medical Physics
Louise Long	LL	Public Health Wales Microbiology
Jamie Williams	JWi	Senior Nurse, Radiology
Tracy Wooster	TW	Sister, Outpatients
Timothy Banner	TB	Clinical Director, Pharmacy
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Helen Nicholls	HN	Head of Podiatry

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 23/039	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 23/040	**Apologies for Absence** **The Group resolved that:** a) The apologies for absence were noted.	
CDTQSE 23/041	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting held on 23rd January 2023 were accepted as an accurate record.	
CDTQSE 23/042	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 22/243 Lift in Toxicology* HL has reviewed the risk register to reflect the issues with the lift in Toxicology at UHL. HL will follow up on progress with Estates. *CDTQSE 22/264 Therapies Digital* SO and MK will present the Therapies digital work at a future meeting. *CDTQSE 23/019 Tendable* Aaron White, the UHB Lead for the Tendable system has agreed to present on the Tendable system at a future meeting. HJ to send him dates of forthcoming meetings. *CDTQSE 23/023 Offsite Storage* Records that are being stored in the off site facilities following the flood at Crickhowell will need to be reviewed by relevant services. Sion O'Keefe will pass on the information to the relevant services. **The Group resolved that:** a) The update on the actions from the previous meeting were noted.	**HL** **SO/MK** **HJ** **SO**

6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 23/044	**Concerns and Compliments Report** The Clinical Board is reporting an amber status for concerns received in February 2023. It received 42 concerns with 1 breach in response times. 67% of concerns were informal and 9 compliments were received. The key theme related to difficulties in patients contacting booking lines to arrange or cancel appointments. **The Group resolved that:** a) The Concerns dashboard was received and noted.	
CDTQSE 23/045	**National Reportable Incidents – NRI report** The Clinical Board currently has 5 open NRIs: Incident No 13127 relates to a patient under the care of Cardiology pertaining to their discharge medication advice letter. This incident will be shared at a future meeting for wider learning. Incident No 21070 relates to a miss on an MRI scan. Incident No 22207 relates to medication not being dispensed from Pharmacy for a paediatric patient with epilepsy. Incident No 16847 relates to a delay in diagnosing a malignant melanoma. The investigation is underway. Incident No 25423 relates to a delay in a histology report. **The Group resolved that:** a) All the incidents are currently at the stage of investigation.	
CDTQSE 23/046	**New NRIs** **The Group resolved that:** a) There were no further new incidents to report.	
CDTQSE 23/047	**Risk Register** The risk register has recently been updated and submitted to the Corporate Team. **The Group resolved that:** a) Directorates will submit their risk registers bi monthly and timely to the submission of the Clinical Board risk register to the Corporate Governance Team.	

FCDTQSE 23/048	**Patient Safety Alerts** **ISN 2023/Feb/001b BD Bodyguard Microsets – Update** The updated alert was circulated across the Clinical Board for information. **The Group resolved that:** a) This alert was not applicable to this Clinical Board.	
CDTQSE 23/049	**Medical Device/Equipment Risks** EC reported that feedback was received from Kings Hospital in London that there have been incidences of nursing staff trapping their fingers in the bed sides of Medstron solo beds. It was noted that this was a local issue with 3 incidents were reported from that Trust. A letter has been circulated to Health Boards advising that if any incidents occur, to contact Medstron. EC will share the letter. Following the safety alert circulated previously relating to Belmont Rapid Infusers, this issue has now been resolved. **The Group resolved that:** a) The update on the medical device and equipment risks was noted.	**EC**
CDTQSE 23/050	**Point of Care Testing** SS reported that Welsh Government will be taking a decision from April on whether they will fund any further Covid testing kits. Sites will be required to take responsibility for the purchasing of kits and Clinical Boards have been informed. Feedback has been received that Maternity are considering whether they will continue to test, and the EU will decrease the numbers of tests that they are taking. Surgical areas will continue for the present time. **The Group resolved that:** a) The update relating to Covid testing kits was noted.	
CDTQSE 23/051	**IP&C/ Decontamination Issues** SR reported that in terms of decontamination, water coolers across the UHB are an issue. The IPC Committee held a discussion around the high counts of legionella at UHL. It was emphasised that weekly flushing regimes need to be documented. C-Diff reduction is off target.	

	Work is being undertaken to address line related infections acquired in the community. MRSA cases increased in January. **The Group resolved that:** a) HL will circulate the minutes when available.	**HL**
CDTQSE 23/052	**Safeguarding Update** SP reported that the UHB has appointed a new Child IDVA, based in A&E who is working on a project around health relationships for 11 to 16-year olds. It was agreed to invite her to present at the August meeting. In relation to safeguarding training, the Clinical Board is reporting: Adult level 2 training - 70.4% compliance Child level 2 - 70.11% VOWDA (Violence Against Women and Domestic Abuse) Group 1 -76.4% VOWDA Group 2 has recently been made mandatory. Sessions are fully booked up until September. In the event of a member of staff requiring attendance at this training to comply with requirements in relation to their pay progression, to contact SP Staff are reminded to review safeguarding case notes on Paris regularly for any updates. MASH are now taking on strategy meetings for the Vale. The team are also involved in national referral mechanism meetings, high risk panel meetings and CSE safeguarding meetings. Group supervision is being undertaken the team are offering supervision to Paeds physiotherapy staff. **Single Unified Safeguarding Review** LH-J reported that this is an All Wales initiative to create a single review process with a multidisciplinary approach incorporating a number of different reviews that previously were undertaken individually, into one single review. The purpose is to avoid duplication of reviews. This has been challenging to implement and the UHB is undertaking a pilot involving a domestic homicide review. WG have not yet published the guidance for the SUSR, but there is a consultancy with stakeholders around Wales over the new few months and the formal publication will be issued following this. A Safeguarding Nurse Advisor is required to sit on the panel and gather all of the health information, including information from	**HJ**

	GPs to share with the multi-agency forum. This will have resource implications for the safeguarding team. As thee is a mental health element to the review, a lead nurse from the Mental Health Team will also sit on the panel. WG is looking to set up a repository for all reviews undertaken and will be available to the public. **Change in Legislation with the Removal of Physical Chastisement Defence** It is now a criminal offence to hit a child. If this occurs the police should be notified if there is an immediate risk. If not, a multi-agency referral form should be submitted via the Safeguarding Team. **Maturity Change Matrix** Each Health Board is required to undertake a self-assessment on 5 topics. This will be discussed at the UHB Safeguarding Group this month. **Training** The national training agreement has set a mandatory training target of 85%. However, the Nurse Director has advised that 75% is a more realistic training compliance target for Clinical Boards against safeguarding mandatory training modules. **The Group resolved that:** a) The Safeguarding Team will attend twice a year with updates**.**	
CDTQSE 23/053	**Health and Safety Issues** JD reported that the Head of Health and Safety is meeting with Clinical Boards to discuss Riddors. 18 staff incidents were reported across the UHB this month, 15 of which were of low or no harm. JF asked if there is any update on guidance with staff not in work due to long Covid. HL will seek advice from People and Culture colleagues. JF to provide HL with the specific details of a particular case and HL will seek advice from the People and Culture Team. HL referred to incidents relating to industrial injuries being reported on Datix and requested that as much detail as possible is provided. **The Group resolved that:** a) The health and safety update was noted.	**JF/HL**

CDTQSE 23/054	**Regulatory Compliance** HL reported from the Regulatory Compliance Group that for most departments the metrics are on track. the Blood Transfusion department have made good progress in addressing their metrics. A departmental shutdown is currently underway in SMPU, which will temporarily affect the improvement in their metrics. Haematology will be subject to a UKAS inspection in April. **The Group resolved that:** a) The update from the Regulatory Compliance Group was noted.	
TIMELY		
CDTQSE 23/055	**Initiatives to Improve Access to Services** Nothing to report. **The Group resolved that:** a) This agenda item will be an opportunity for directorates to share any initiatives they have implemented that has improved access to their services.	
CDTQSE 23/056	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** **The Group resolved that:** a) The updated waiting times position was not available.	
EFFECTIVE		
CDTQSE 23/057	**Feedback from UHB QSE Committee** The minutes of the meeting held on 10th January 2023 were received. The Duty of Candour legislation is coming into force from 1st April and the Patient Experience Team are leading on the rollout. Any incidents graded moderate or above will trigger duty of candour, which involves contact with the family and establishing the confirmed level of harm to the patient. There are a lot of incidents marked as moderate and guidance will be circulated to help staff grade incidents appropriately going forward. SR provided an update on the open Datix incidents in the Clinical Board. Laboratory Medicine are reporting the highest number within the Clinical Board. Overall there are 274 open incidents.	

	A large proportion of these incidents are no harm. These need to be investigated and closed down quite quickly. Catherine Evans issued a reminder not to close incidents until the management review has been completed. Some directorates still do not have enough members of staff trained on Datix. Training is now online and can be done at staff's own convenience. NR commented that there are some departments that have not completed the training and therefore managers cannot reassign incidents to them for them to investigate. Incidents are then left on the Datix system with departments that cannot investigate the incident. HL suggested that any manager having difficulty finding an individual outside of their department to reassign an incident to, to inform SR, who will then seek support from the Patient Experience Team to find an appropriate individual. EC noted that Clinical Engineering are allocated incidents to investigate on behalf of lots of different owners of incidents. He asked if the national team could make the equipment field mandatory, as often minimal details are provided on the equipment being reported which results in a lot of work for the team to look through records to find the relevant piece of equipment. **The group resolved that:** a) The minutes of the QSE Committee were noted. b) A process was agreed to help managers reassign an incident to a department that has no trained manager on Datix. c) The request for equipment to be made a mandatory field on Datix was noted.	
CDTQSE 23/058	**NICE Guidance** **The Group resolved that:** a) There was no NICE guidance to discuss.	
CDTQSE 23/059	**Research and Development** RM reported that the Clinical Board R&D meeting was held last week. R&D Leads are still to be identified in Laboratory Medicine and Pharmacy. RM is seeking volunteers to present at the Clinical Board R&D Forum. **The Group resolved that:**	

	a) The R&D update was noted.	
CDTQSE 23/060	**Service Improvement Initiatives** EL was not in attendance to present the Kidzmeds project. **The Group resolved that:** a) HL will ask her to present at a future meeting.	**EL**
CDTQSE 23/061	**Information Governance/Data Quality** **The Group resolved that:** a) The update on information governance and data quality was noted.	
CDTQSE 23/062	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** It was reported that the CHC is changing its structure across Wales and will be changing to Citizens Voice Bodies as opposed to CHCs. The new name is Llais, which is voice in Welsh. The function will not change. Any posters or leaflets referencing CHC need to be removed from departments. New posters will be issued. **The Group resolved that:** a) There have been no inspections in this Clinical Board since the last meeting. b) Any posters or leaflets referencing the CHC will be removed.	**All**
EFFICIENT		
CDTQSE 23/063	**Exception Reports from Directorates** **The Group resolved that:** a) There were no exceptions to report.	
CDTQSE 23/064	**Clinical/Internal Audits** **The Group resolved that:** a) There were no internal audits to report.	
CDTQSE 23/065	**Therapies Digital** **The Group resolved that:** a) MK and SO will present at a future meeting. SB and HJ will find a suitable date.	**MK**

CDTQSE 23/066	**Waste and Sustainability** SJ reported that the Clinical Board Green Group was held earlier this week. A presentation was provided from Physiotherapy which included an update on their walking aid amnesty. Laboratory Medicine are hosting an open session to share the learning of their Leaf Accreditation project. It was also noted that the UHB Green Group has been reinstated. **The Group resolved that:** a) Directorates and their staff are encouraged to attend the Clinical Board Green Group.	
EQUITABLE		
CDTQSE 23/067	**Feedback from Clinical Board Inclusion Ambassadors Group** The Inclusion Ambassadors met earlier today and Dawn Ward, Chair of Staff Side was in attendance. Discussions were held around the implementation of the UHB Race Equality Plan and SO will be meeting with the UHB Equality Adviser to discuss how this can be taken forward within this Clinical Board. Due to changes in the Clinical Board management team, the roles of the Inclusion Ambassadors need to be reallocated. Anyone interested in taking on a role to contact Helen Jenkins. **The Group resolved that:** a) The Clinical Board will be refreshing its Inclusion Ambassador contacts and consider a re-launch and engage with directorate teams.	
CDTQSE 23/068	**Equality and Diversity Issues** HL reported that the People and Culture team are requesting that staff are encouraged to update their demographic details on ESR so that the data in the system reflects the staffing profile of the UHB. **The Group resolved that:** a) Staff to be encouraged to update their demographics on ESR.	**All**
PERSON CENTRED		
CDTQSE 23/069	**Patient Story** Bolette Jones presented on the Teledermoscopy Service that has commenced in Medical Illustration. There is a high demand	

for patient appointments in Dermatology, with a significant waiting list and backlog due to the pandemic. The demand significantly outweighs capacity and results in long waits for patients to be seen.

The referrals for dermatology are all received electronically from GPs with photographs attached, however the quality of the photographs is variable.

In 2021, a pilot study was undertaken where dermatologists identified suitable patients that have been referred by the GP with high quality photographs combined with Dermoscopy images.

Dermoscopy is a non-invasive technique that visualises the epidermal and dermal layers of the skin. It removes the reflection from the skin surface allowing greater clarity of sub-surface structures, and can identify features that are not evident to the naked eye. This makes it a useful diagnostic technique in differentiating between benign and malignant skin lesions, and predominantly used to evaluate pigmented lesions.

Th pilot study results highlighted that where there were higher resolution images together with the Dermoscopy images, this improved the Dermatologists' confidence in diagnosing the skin lesions. They identified that approximately 70% of referrals could be returned to the GP with advice on diagnosis and management and this would release clinic capacity and clinic time.

An application was submitted to the Outpatients and Eye Care Transformation Fund in 2022 to fund the implementation of a local teledermoscopy service. The objective was to reduce demand and ensure appointments were offered to those that need to be seen in an outpatient setting by a dermatologist.

Funding was awarded for 2 years including 2 band 5 photographers, 5 dedicated consultant sessions and camera equipment. The second year of the funding is dependent on a formal review at the end of Year 1. The service must demonstrate that there has been a reduction in waiting times for patients and a reduction in the number of patients breaching 26 weeks.

The service operates with GP referrals screened by the Dermatologist and those that are deemed appropriate forwarded to Medical Illustration who coordinate the appointments. Patients attend an appointment at UHW presently and images are taken. These are stored in the UHB image database. Photoweb and the dermatologists review the images and the patients are either discharged from the service and managed in the community or are offered an outpatient appointment.

	The benefits of the service are that it reduces waiting times for patients by removing the requirement for all referrals to have an initial face to face appointment where clinically appropriate. 70% of patients are being discharged and capacity is redirected to those with greater health needs. Currently the service is focused on new referrals only and not addressing the backlog of the waiting list. As the service expands, this will be offered to patients in more locations. **The Group resolved that:** a) It would be keen to receive an update on this service at a future meeting as it progresses.	
CDTQSE 23/070	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** HJ reported that the Clinical Board Managers Resilience Surgeries are still taking place on Friday mornings. **The Group resolved that:** a) Managers are encouraged to attend.	
CDTQSE 23/071	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/072	**National User Experience Framework/Feedback from Patient and Service User Surveys** Patient feedback from the Civica system was received. Positive comments were received from patients using physiotherapy and phlebotomy services in particular**.** JF provided feedback from the Radiographer Led Discharge (RLD) pilot service which relates to patients attending A&E. Where patients fall within the scope of the service, they will have their x-rays taken and these will be discussed with the patients directly followed by a discussion on their treatment. Overall, the rating of the care received for RLD patients was better than patients not referred to the service with an average satisfaction score reported of 9.7/10 for RLD patients. 98% of RLD patients felt that the explanation of their results was clear and easy to understand.	

	Overall the feedback received was very good with positive comments received on the efficiency, clarity of diagnosis, compassionate care and professionalism of the service. The pilot is coming to an end, however in the meantime the service will continue. There is a plan to take this forward as a full-time service. **The Group resolved that:** a) The CIVICA report is received weekly and HL will circulate when available. b) JF to send HL the PowerPoint slides of the RLD presentation.	 **HL** **JF**
CDTQSE 23/073	**Staff Awards and Recognition** HL encouraged nominations into the Clinical Board Staff Recognition Scheme. HJ will circulate the nomination forms received from the latest category as an example of the good work ongoing in the Clinical Board. **The Group resolved that:** a) Directorates to consider nominating their staff for their achievements and where they are working above and beyond.	 **HJ**
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 23/074	**The Group resolved that:** a) There were no items to receive.	
ANY OTHER BUSINESS		
CDTQSE 23/075	There were no further items to report.	
CDTQSE 23/076	**Date & time of next Meeting** 12th April 2023 at 2pm via Teams.	

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee

Held on 12th April 2023 Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Interim Director of Nursing/Multi Professional Teams
Sarah Lloyd	SL	Director of Operations
Suzanne Rees	SR	Lead Nurse
Amelia Jukes	AJ	Representing Dietetics
Robert Bracchi	RB	Medical Advisor to AWTTC
Rhys Morris	RM	CD&T R&D Lead
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Jo Fleming	JF	Quality Lead, Radiology
Bolette Jones	BoJ	Head of Medical Illustration
Stephen Coombs	SC	Professional Lead Podiatrist Representing Therapies
Jonathan Davies	JD	Health and Safety Adviser
Sian Jones	SJ	Directorate Manager, Laboratory Services
Louise Long	LL	Public Health Wales Microbiology
Saul Harris	SH	Representing Medical Device Officer
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
In Attendance:		
Katherine Gallagher	KG	Parenteral Nutrition CNS
Debbie Jones	DJ	Deputy Head of Quality, Assurance and Clinical Effectiveness, Patient Safety and Quality Team
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Adam Christian	AdC	Interim Clinical Board Director
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Becca Jos	BJ	Deputy Director of Operations
Alun Roderick	AR	Laboratory Service Manager, Haematology
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer
Seetal Sall	SS	Point of Care Testing Manager
Mathew King	MK	Head of Podiatry
Lesley Harris	LH	Head of Radiography UHL
Paul Williams	PW	Clinical Scientist, Medical Physics
Jamie Williams	JWi	Senior Nurse, Radiology
Tracy Wooster	TW	Sister, Outpatients
Timothy Banner	TB	Clinical Director, Pharmacy
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Helen Nicholls	HN	Head of Podiatry
Catherine Evans	CE	Patient Safety Facilitator
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Jenna Walker	JW	Quality Lead, Pharmacy

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 23/077	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 23/078	**Apologies for Absence** **The Group resolved that:** a) The apologies for absence were noted.	
CDTQSE 23/079	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting held on 20th March 2023 were accepted as an accurate record.	
CDTQSE 23/080	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 22/243 Maintenance to lift in Toxicology* HL has received a response from Estates and it was noted that Paul George will be meeting with AWTTC. HL advised that the issue has been placed on the Clinical Board risk register. RB to feedback at the next meeting following the discussion with Estates. *CDTQSE 22/264 Therapies Digital Work* MK will be presenting on this work at the meeting in September. *CDTQSE 23/051 Minutes of IP&C Committee* HL will circulate the minutes when they become available. *CDTQSE 23/053 Long Covid Case Being classed as an Industrial injury* HL to follow up on this specific case with the People and Culture Team. **The Group resolved that:** a) The update on the actions from the previous meeting were noted.	**RB** **HL** **HL**

6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 23/081	**Concerns and Compliments Report** In March 2023, the Clinical Board received 54 concerns, 80% of which were informal concerns and 9 compliments. There were no breaches in response times. The key themes relate to difficulties in patients getting through to appointment booking lines and patient experience concerns relating to bereavement documentation. Issues with telephone lines are being reported in Health Records, Radiology and Physiotherapy. Alternative mechanisms to telephone lines are being explored that will enable patients to contact departments relating to their appointment bookings. **The Group resolved that:** a) The Concerns metrics were received and noted.	
CDTQSE 23/082	**National Reportable Incidents – NRI report** The Clinical Board currently has 5 open NRIs: Incident No 21070 relates to the reporting of a Neuroradiology case. Incident No 13127 relates to a patient under the care of Cardiology pertaining to their discharge medication advice letter. This incident will be shared at a future meeting for wider learning. Incident No 21070 relates to a miss on an MRI scan. Incident No 22207 relates to medication not being dispensed from Pharmacy for a paediatric patient with epilepsy. Incident No 16847 relates to a delay in diagnosing a malignant melanoma. The investigation is underway. Incident No 25423 relates to a delay in a histology report. **The Group resolved that:** a) All the incidents are currently at the stage of investigation. Learning will be shared from the Pathology incidents that are due to be closed this month, to the next meeting.	**SR**
CDTQSE 23/083	**New NRIs** **The Group resolved that:** a) There were no new NRI's reported.	

CDTQSE 23/084	**Risk Register** Podiatry have reviewed their risk register and escalated the risks that they are unable to progress without support: Implementation of foot assessments for inpatients with diabetes during hospitalisation. The main issue is the difficulty in establishing ownership for undertaking this task, Hywel Dda Health Board have developed a form that is being piloted that fits within the nursing electronic notes and if effective could be implemented across all Health Boards. Medicine have developed a tool but this has not been embedded due to training issues. On 20th April 2023 the UHB is undergoing a teams site visit for a diabetes inpatient accreditation pilot. One of the quality standards is the clinical effectiveness with foot assessments being undertaken within 24 hours of being requested. To achieve this standard this risk needs to be resolved. The other risk to escalate also relates to diabetes. This involves the increase in aspects of care and clinical decisions outside of scope of practice of the podiatrist, as the frequency of MDT is inadequate for demand. There is only access to one MDT session monthly and poor attendance from consultants in other services has been noted. There is also sometimes a problem with delays in requests for prescriptions of antibiotics being prescribed by GPs and GPs refusing to prescribe antibiotics on behalf of podiatrists. There is also a lack of community support services in terms of Phlebotomy at CRI and Radiology at the CRI on Fridays which delays appropriate diagnostics and impacts on timely management. HL will escalate the risk around inpatient diabetes during hospitalisation with the Nurse Director/ Directors of Nursing and establish a way forward. SC to provide Helen Luton with the documentation on the quality standards. The standards may result in addressing the risk relating to MDT sessions. **The Group resolved that:** a) Directorates will submit their risk registers bi monthly and timely to the submission of the Clinical Board risk register to the Corporate Governance Team.	**HL** **SC**
FCDTQSE 23/085	**Patient Safety Alerts** SH referred to a manufacturer's alert affecting Radiology which has been received relating to Phillips x-ray diagnostic machines. If a monitor is turned off there is no sound alert to indicate that a dose is being given. JF has also received the alert direct from Phillips and she noted that it specifically relates to new equipment received in A&E and action has been taken.	

	Nigel Roberts reported on a patient information system issue which has not yet been circulated as an alert. The DCHW turned on a patient merging system on 30th March 2023. There was a flaw in the system and it incorrectly merged 4000 patients on the Welsh Clinical Portal. DHCW are in the process of taking action to rectify this, which will take up to 14 days to rectify. Radiology and Pharmacy are aware of this issue. 282 patients in Cardiff and Vale are affected. 24 of these patients are category 1 patients that are within the Health Board now or have an episode of care forthcoming. A banner advising of the issue has been placed on the WCP. Communications with clearer actions will be circulated later today. The Cardiff and Vale IT team are looking to flag on the system the patients in Cardiff and Vale that are affected. **The Group resolved that:** a) The manufacturer alert relating to Radiology has been received by the department and action taken. b) Further communications on the WCP patient information issue will be shared when received.	
CDTQSE 23/086	**Medical Device/Equipment Risks** **The Group resolved that:** a) Aside from the alert relating to Radiology there are no other medical device or equipment risks to report.	
CDTQSE 23/087	**Point of Care Testing** **The Group resolved that:** a) There were no Point of Care Testing issues to discuss.	
CDTQSE 23/088	**IP&C/ Decontamination Issues** HL reported that Covid cases within the UHB are on the decline. Updated guidance has been issued on mask wearing, testing of staff and managing sickness. A number of queries have been raised by managers in this Clinical Board seeking further clarity on the guidance. SR provided feedback from the Water Safety Group. The purchase of water coolers will need to be submitted to this group for a decision. Flushing compliance is low across the UHB, particularly in UHL where 25% compliance is reported. SR will circulate the minutes from the Water Safety Group.	**SR**

	The Group resolved that: a) The responses to the queries raised relating to the new Covid-19 guidance will be circulated when received. b) Any departments that have taps or water outlets that are not being used to consider whether these should be capped off by Estates.	
CDTQSE 23/089	**Safeguarding Update** **The Group resolved that:** a) There were no safeguarding issues to report.	
CDTQSE 23/090	**Health and Safety Issues** JD reported that in the last month for CD&T Clinical Board, 10 staff incidents have been reported of low or no harm. 0 Riddor incidents were reported this month. **The Group resolved that:** a) The health and safety update was noted.	
CDTQSE 23/091	**Regulatory Compliance** SMPU and Blood Transfusion have taken actions to improve their metrics. A HTA Inspection will be held in Stem Cell in August The next Haematology UKAS inspection will be held on 25th April. Cellular Pathology have a split assessment scheduled to take place 19th and 28th June. **The Group resolved that:** a) Helen Jenkins will circulate the minutes from the Regulatory Compliance Group for information.	**HJ**
TIMELY		
CDTQSE 23/092	**Initiatives to Improve Access to Services** A business case is being written to take forward the Radiographer Led Discharge project. **The Group resolved that:** a) This agenda item will be an opportunity for directorates to share any initiatives they have implemented that has improved access to their services.	

CDTQSE 23/093	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** **The Group resolved that:** a) There was no update to report on the waiting times in Diagnostics and Therapies.	
EFFECTIVE		
CDTQSE 23/094	**Feedback from UHB QSE Committee** The minutes of the meeting held on 7th March 2023 were received. Specialist Clinical Board presented their annual report. Duty of Quality and Duty of Candour went live on 1st April. The UHB has a team reviewing incidents and regrading the level of harm where necessary. Their aim is to feedback to reporters that are incorrectly grading incidents. C-Diff rates remain high. This is across the UK and not unique to Cardiff and Vale. It was reported that the Civica return rate from patients is low at 18%. The number of overdue NRIs have reduced in the Health Board by 41% since September. An increase in number of concerns across the UHB has been noted. **The group resolved that:** a) The minutes of the QSE Committee were noted. b) HL suggested for an agenda item to be scheduled at this meeting every 3 months to establish how many Duty of Candour cases relate to this Clinical Board starting from May. c) Angela Hughes will be presenting on Duty of Candour at the next meeting.	**HJ**
CDTQSE 23/095	**NICE Guidance** **The Group resolved that:** a) There was no NICE guidance to discuss.	
CDTQSE 23/096	**Research and Development** RM reported that nominations for R&D Leads are needed from Laboratory Medicine and Pharmacy. SJ to seek a nomination in	

	Laboratory Medicine and HL will ask TB for a nomination from Pharmacy. RM advised that he will be scheduling in the next Clinical Board R&D forum in the next 2 months. **The Group resolved that:** a) The R&D update was noted.	
CDTQSE 23/097	**Service Improvement Initiatives** **The Group resolved that:** a) There were no service improvement initiatives to report.	
CDTQSE 23/098	**Information Governance/Data Quality** **The Group resolved that:** a) There were no information governance issues to report.	
CDTQSE 23/099	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** **The Group resolved that:** **a)** There have been no inspections in this Clinical Board.	
CDTQSE 23/100	**Policies and Procedures** **Parenteral Nutrition Line Procedures** AJ and KG presented the nursing procedures that dictate ANTT practice for patients that require PN via central lines. The procedures were originally ratified in 2019 by the Nursing and Midwifery Board and are due for review. The main updates relate to manufacturing of device for example needle free devices. The service now also undertakes parenteral nutrition via peripherally inserted central lines that Radiology place and a protocol for this has been incorporated into the procedures. HL commented that the Accountable Executive should be amended to Jason Roberts. She also commented that the actual procedures are clear. SR will review and advise AJ of any further updates. HL will advise AJ of the date of the next Nursing Midwifery Board and will arrange for the document to be placed on the agenda She requested that AJ present at the meeting.	**SR** **HL**

	The Group resolved that: **a)** Subject to the amendment to the Accountable Executive and any final comments from SR, the Group approved for the procedures to be submitted to the Nursing and Midwifery Board for ratification.	
EFFICIENT		
CDTQSE 23/101	**Exception Reports from Directorates** **The Group resolved that:** **a)** There were no exceptions to report.	
CDTQSE 23/102	**Clinical/Internal Audits** **Presentation on AMAT system** Debbie Jones advised that every Health Board in Wales has procured the AMAT system for audit tracking. All staff can access the system if they have a Cardiff and Vale email address. All Clinical Audit projects are to be registered in the blue module of the system. 182 projects are currently registered. Projects highlighted in green are completed. It was noted that all inpatient ward areas are using the Tendable system to capture standard IPC and ward audits. All guidance i.e. NICE will all be disseminated through AMAT. Debbie Jones happy to support staff that are requested to provide comments. All guidance is hyperlinked. The inspections and recommendations module is used for HIW work. This module is also useful for NRIs in terms of completing action plans and identifying those that are overdue. This is also being used for LFERs for Welsh Risk Pool. The Quality Improvement Projects module links to colleagues in Innovation and Improvement Team and they can offer support. The system has received a good response across the Health Board. Feedback on the system is welcomed from users. SL asked if there has been contact with audit leads in the Clinical Board. DJ responded that she attends audit leads sessions. SL asked if there are any introduction to AMAT notes and guidance on how to request access. DL placed a link in the Teams channel. HL asked if inspections module could be used for reportable incidents as well as inspections. DJ confirmed that the recommendations and list of actions relating to this can be allocated to individuals. A due date needs to be set and the	

	individual will receive notifications weekly until the action is completed. **The Group resolved that:** a) Radiology will trial the inspections module when it is next subject to a HIW inspection. b) It was agreed that from a laboratory perspective, the Q-Pulse system will still need to be utilised for their regulatory inspections.	
CDTQSE 23/103	**Waste and Sustainability** The CD&T Green Group is being held tomorrow. The theme is information on Earth Day 22nd April 2023. **The Group resolved that:** a) All staff within the Clinical Board are welcome to attend.	
EQUITABLE		
CDTQSE 23/104	**Feedback from Clinical Board Inclusion Ambassadors Group** **The Group resolved that:** a) The Clinical Board will be refreshing its Inclusion Ambassador contacts.	
CDTQSE 23/105	**Equality and Diversity Issues** **The Group resolved that:** a) There were no issues to report.	
PERSON CENTRED		
CDTQSE 23/106	**Patient Story** **The Group resolved that:** a) The patient story due to be presented from Dietetics has been deferred to the next meeting.	
CDTQSE 23/107	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 23/108	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:**	

	a) There were no initiatives to report.	
CDTQSE 22/109	**National User Experience Framework/Feedback from Patient and Service User Surveys** JF reported that Radiology had undertaken patient surveys at UHL and is awaiting the results. The results will inform whether any changes need to be made to the process before implementing this wider across Radiology. **The Group resolved that:** a) The update from Radiology was noted.	
CDTQSE 23/110	**Staff Awards and Recognition** The Clinical Board monthly staff recognition scheme is ongoing. HL encouraged nominations from all directorates. **The Group resolved that:** a) All directorates to consider nominating their staff for their achievements and where they are working above and beyond.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 23/111	**The Group resolved that:** a) The minutes of the Clinical Board Health and Safety Group and R&D Group were received and noted.	
ANY OTHER BUSINESS		
CDTQSE 23/112	There were no further items to report.	
CDTQSE 23/113	**Date & time of next Meeting** 12th May 2023 at 10am via Teams	

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee

Held on 12th May 2023 Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Interim Director of Nursing/Multi Professional Teams
Adam Christian	AdC	Interim Clinical Board Director
Suzanne Rees	SR	Lead Nurse
Sian Jones	SJ	Directorate Manager, Laboratory Services
Jonathan Davies	JD	Health and Safety Adviser
Robert Bracchi	RB	Medical Advisor to AWTTC
Louise Long	LL	Public Health Wales Microbiology
Susan Beer	SB	Public Health Wales Microbiology
Rhys Morris	RM	CD&T R&D Lead
Seetal Sall	SS	Point of Care Testing Manager
Jenna Walker	JW	Quality Lead, Pharmacy
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Jo Fleming	JF	Quality Lead, Radiology
Bolette Jones	BoJ	Head of Medical Illustration
Stephen Coombs	SC	Professional Lead Podiatrist Representing Therapies
Catherine Evans	CE	Patient Safety Facilitator
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Saul Harris	SH	Representing Medical Device Officer
Jamie Williams	JWi	Senior Nurse, Radiology
Jacqueline Sharp	JS	Head of Physiotherapy
Elaine Lewis	EL	General Manager, Pharmacy
In Attendance:		
Clara Danielsen	CD	Directorate Pharmacist for Children's Hospital
Hapria Bhogal	HB	Pharmacy
Aron White	AW	Nursing Informatics Lead
Charlotte Dowd	ChD	Nutrition and Dietetics
Claire Constantinou	CC	Nutrition and Dietetics
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Sarah Lloyd	SL	Director of Operations
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Becca Jos	BJ	Deputy Director of Operations
Alun Roderick	AR	Laboratory Service Manager, Haematology
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer
Lesley Harris	LH	Head of Radiography UHL
Paul Williams	PW	Clinical Scientist, Medical Physics
Tracy Wooster	TW	Sister, Outpatients

Timothy Banner	TB	Clinical Director, Pharmacy
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Helen Nicholls	HN	Head of Dietetics

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 23/114	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 23/115	**Apologies for Absence** **The Group resolved that:** a) The apologies for absence were noted.	
CDTQSE 23/116	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting held on 12th April 2023 were accepted as an accurate record.	
CDTQSE 23/117	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 22/243 Toxicology Lift* Estates have advised that there are no plans to replace the lift. It is serviced in correct intervals and is inspected in line with legislation for use. AWTTC Board felt that it was important to review the original engineer's report to ensure there is no risk of catastrophic failure. The original report in March 2022 suggested that the lift was irreparable. It was agreed that HL will be sent a copy of the report and she will discuss with Estates colleagues on what the next steps should be. *CDTQSE 23/084 Inpatient Diabetes During Hospitalisation* HL discussed the foot assessment with the other Directors of Nursing. She has not yet received the documentation from Podiatry but will take this forward when received. *CDTQSE 23/094 Duty of Candour* This item will be added to the agenda every 3 months and will be discussed at the next meeting in June.	**HL** **HJ**

	CDTQSE 23/1200 Parenteral Nutrition Procedures SR reviewed the procedures and they were submitted to Nursing and Midwifery Board this week. **The Group resolved that:** a) The update on the actions from the previous meeting were noted.	
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 23/118	**Concerns and Compliments Report** For April 2023, 28 concerns were received, 4 of which were formal and 24 early resolution. 9 compliments were received. The main themes of concerns were difficulties arranging and cancelling appointments and waiting times for test results/scan reports. There has been an increase in concerns relating to staff attitude this month. **The Group resolved that:** a) The concerns metrics including a breakdown for each department, were received and noted.	
CDTQSE 23/119	**National Reportable Incidents – NRI report** The Clinical Board has the same open NRIs as reported last month. SR provided feedback on a Pathology incident that she investigated. A 35-year-old man with a non-eventful past medical history presented to his GP initially with a lesion on his arm in 2020. He sent a photograph to his GP and was treated conservatively and advised to apply antibiotic cream. He was advised to return to his GP if this did not improve. In June 2022 the lesion had changed significantly. He was seen by his GP and the GP anticipated that it was a non-typical squamous cell carcinoma and an urgent USC referral was made. The referral was not sent for 7 days. In July his referral was reviewed in Dermatology and he was prioritised for an appointment with a Dermatologist and a CNS. At that appointment the legion was excised and a metastasis was noted on his arm. The sample was sent off to Dermatopathology as needing urgent review. At this time there were significant capacity and demand issues in Dermatopathology at this time and an outsourcing company was	

	being used. When the sample was prepared in August it was sent out to the outsourcing company. In September , the Dermatology secretaries chased up the sample as the result had not been received back. The result was retrieved and a cancer diagnosis was confirmed but the result received from the outsourcing company was not indicative of the clinical information that was supplied on the referral form. The patient was advised of his initial results and was advised that the result was to be sent off for further analysis and the inhouse teams were notified that result was not complete and an MDT was undertaken. The patient was seen on that same day and had a wide local excision of the area, which is the definitive treatment, and he exited the cancer pathway 106 days after attending his GP. The aim for the single cancer pathway is for everything to be completed within 67 days. The initial Datix was raised by the Clinical Nurse Specialist in Dermatology, who identified that here had been significant delays and an incomplete report when his results came back to Dermatology. There were referrals to Velindre and the patient eventually started a juvant immunotherapy on Day 201. The findings of the investigation highlighted demand and capacity issues within Dermatopathology and a shortage of Dermatopathologists. There was a large backlog of samples that required the use of outsourcing. The processes around the following up of samples was not clear. There was no digital method of clinicians knowing there are outstanding results. Incomplete results held up the confirmation of the diagnosis. The investigation also highlighted there were areas of good practice. The support to the patient from the Dermatology CNS was very good and the CNS was able to explain the situation to the patient one the issues with the initial results were noted. When the incomplete result was identified, it was dealt with appropriately. There was a prompt turnaround time in the reporting locally when the error from the outsourcing company had been identified. The recommendations from the investigation were that Primary Care should ensure that there is a system in place to ensure prompt onward referrals for all urgent suspected cancer referrals.	

	Cellular Pathology should ensure that they have a robust process in place to track and monitor the journey of samples both inhouse and to outsourcing companies. Cellular Pathology should manage high risk cases inhouse. Cellular Pathology should also aim ot improve demand and capacity within the laboratory. Outsourcing to external companies should be limited. Dermatology should have an effective flag system to highlight missing results. The Health Board should have an electronic flagging system to highlight there is a need to review a significant urgent or suspected cancer result that has been reported on. In terms of an update on the patient, he has had no further disease progression and he is continuing with his immunotherapy treatment with regular follow ups and CT scans. One of the questions within the terms of reference for this investigation was to identify the impact of the delay on the patient's diagnosis. At present this is difficult for the clinicians to ascertain. A lot of change has been implemented since this case. 7-day working has been implemented in Cellular Pathology. Review of dermatology tracking of results and process is in place. Cellular Pathology have reviewed the tracking of samples. There has been a change in outsourcing company with improved turnaround times and limited use in high risk samples. **The Group resolved that:** a) The investigation into the NRI reflects the true position of what happened and the changes that have been implemented.	
CDTQSE 23/120	**New NRIs** **The Group resolved that:** a) There were no new NRI's reported.	
CDTQSE 23/121	**Risk Register** Radiology have identified a significant new risk relating to the replacement required of the IR rooms and equipment in Radiology. 3 new risks have been added to the AWTTC risk register **The Group resolved that:**	

	a) Directorates will submit their risk registers bi monthly and timely to the submission of the Clinical Board risk register to the Corporate Governance Team.	
FCDTQSE 23/122	**Patient Safety Alerts** No new patient safety alerts have been circulated. It was noted that there are an increasing number of medical devices delivering medicine which is resulting in an overlap in terms of who is leading on safety alerts. **The Group resolved that:** a) JW and SH will discuss outside of the meeting and consider developing links from a Pharmacy and Clinical Engineering perspective.	**JW/SH**
CDTQSE 23/123	**Medical Device/Equipment Risks** V60 Phillips ventilator issues are ongoing nationally. Governance issues are being discussed around the introduction of AI systems. SS stated that an evaluation is in process for an AI based full blood count and is concerned around the lack of governance around this and the requirements that need to be met are not clear. JF noted that AI software for stroke imaging that would outsource images externally and then an AI report would come back with an analysis of the imaging. This is being undertaken on an All Wales level. Bristol are already using the software. SH noted that in England they are required to follow the GC BO 160 Standard. **The Group resolved that:** a) It was agreed that there will be challenges setting up the standards for AI as this is a new development.	
CDTQSE 23/124	**Point of Care Testing** **The Group resolved that:** a) There were no other Point of Care Testing issues to discuss.	
CDTQSE 23/125	**IP&C/ Decontamination Issues** The UHB IPC Group and Decontamination Group have not met this month.	

	The Group resolved that: a) There were no IPC and Decontamination issues to report.	
CDTQSE 23/126	**Safeguarding Update** HL issued a reminder that mandatory training modules relating to safeguarding are available online. **The Group resolved that:** a) Overall the Clinical Board's mandatory training compliance in relation to safeguarding modules is in a reasonable position.	
CDTQSE 23/127	**Health and Safety Issues** JD reported that for this Clinical Board 17 staff incidents have been reported with 13 of low harm. A Riddor was reported in Pharmacy relating to a member of staff that stripped over a bucket and slipped on steps. HL noted that a meeting was held with Estates and Health and Safety to discuss the generator testing in Haematology following health concerns raised by laboratory staff. Gaps where pipe work was entering the building have since been filled and gas monitoring will be undertaking to ensure there are no issues. JF reported that one of the vascular labs is currently out of use for interventional procedures, in particular steroid procedures. The sinks are blocked and there is a challenge to identify an individual with confined space training to complete the works. A second lab is also at risk as the air handling unit is not functioning properly and the temperature is fluctuating. The superintendents are producing a risk assessment. The issues have been escalated and there have been numerous meetings held with Estates, who are reliant on replacement parts and outside contractors. There is potential risk that procedures of the lowest priority will need to be cancelled to prioritise emergency work. **The Group resolved that:** a) The health and safety update was noted.	
CDTQSE 23/128	**Regulatory Compliance** HL thanked all the teams involved in the preparation for the recent HSE, UKAS and MHRA inspections. Good feedback was received from the inspections. **The Group resolved that:** a) The minutes of the Regulatory Compliance Group were received and noted.	

TIMELY		
CDTQSE 23/129	**Initiatives to Improve Access to Services** Nothing to report. **The Group resolved that:** a) This agenda item will be an opportunity for directorates to share any initiatives they have implemented that has improved access to their services.	
CDTQSE 23/130	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** SO reported that the number of patients waiting 14 weeks or more for Therapies is 72. An increase of 12 from the previous month. The waiting times figures for diagnostics are not yet available. Indicative diagnostic figures for patients waiting over 8 weeks is showing a significant increase. This is related to issues with scanners, workforce issues and there has been demand on the service to support with operational flow. The Bank Holidays also impact on activity. AC noted that the UHB has instructed the department to focus on cancer patients and to quantify the detriment this has on the 8-week performance data. **The Group resolved that:** a) There was no update to report on the waiting times in Diagnostics and Therapies.	
EFFECTIVE		
CDTQSE 23/131	**Feedback from UHB QSE Committee** This Clinical Board will be presenting its annual report to the next QSE Committee in June. HL will contact directorates for contributions. **The group resolved that:** a) The minutes of the UHB QSE Committee held in May were received and noted.	
CDTQSE 23/132	**NICE Guidance** **The Group resolved that:** a) There was no NICE guidance to discuss.	
CDTQSE 23/133	**Research and Development** RM reported that there are still no R&D Leads identified for Laboratory Medicine and Pharmacy.	

	The Clinical Board R&D Forum will be held on 29th June. Radiology and Pharmacy will be presenting. The Clinical Board R&D Performance Review is due to be held with the Medical Director. The Clinical Board has been requested to provide information for the annual performance reports and publications. **The Group resolved that:** a) JW to discuss the requirement for a nomination for an R&D Representative from Pharmacy with Tim Banner and Elaine Lewis.	**JW**
CDTQSE 23/134	**Service Improvement Initiatives** Clara Danielson, Directorate Pharmacist for Children's Hospital, presented the KidzMedz Cymru Project. The aim of the project is to teach children how to swallow tablets and capsules in a safe way and to switch patients from liquid and sachet medicines. Once the training is established, the plan is to prescribe to children potentially before they start treatment and start them off on tablets or capsules from the outset. The plan is to teach 400 children to swallow tablets and capsules in the first year and to reduce prescribing of liquid medicine by 20% over the first year. This project has been trialled in other hospitals in England with a lot of success**.** It is important that for children with chronic conditions who will be taking medicines from a young age, to develop this life skill. Also, there are children who are well and do not have chronic conditions that may not need to take medicines until they reach their teenage years, and will not realise until then that they do not have good skills for swallowing tablets. Children will be taught how to take tablets before they reach the stage of swallowing a tablet which half dissolves in their mouth and tastes unpleasant. In terms of safety, there is an increased amount of errors associated with liquid medicines. There are different strengths available and they might be prescribed in mls rather than milligrams. There are also a lot of unlicensed liquid medicines on the market and are significantly more expensive, as unlicensed medicines do not have a drug tariff price. This project also has a positive effect in terms of sustainability. Liquid medicines have a more significant environmental impact with increased packaging and excess wastage due to expiry dates. The project will entail to identify the number of patients that have switched to tablets. Permission will be sought from parents to access GP records at regular intervals to review if the child has remained with tablets or reverted back to liquids. Comparisons	

	will be made between the number of prescribed liquid medicines versus tablets and capsules. In the other Trusts that have implemented this project significant savings were also identified. An audit will also be undertaken to identify how much liquid medicines potentially lead to medication errors or near misses within the hospital. The project is supported by the Cardiff and Vale Youth Council and has received funding from the Staff Lottery. The project will be launched on 8th June. Feedback will be sought from parents on their experiences. Packs have been designed to include as many children as possible e.g. vegetarians, vegans, gluten free, dairy free. Once established in Secondary Care, the plan is to roll this out to Primary Care. Other Health Boards are also keen to taken on this project and it is hoped that this will be implemented across Wales. **The Group resolved that:** a) The service improvement initiatives were noted.	
CDTQSE 23/135	**Information Governance/Data Quality** SO provided an update following the tracking of medical records audit. The improvement plan is still in place and part of the recommendations were to bolster governance arrangements not just within this Clinical Board but UHB wide and changes are imminent. The process for addressing concerns around staff accessing records inappropriately is in place and managers are receiving reports. Advice is being sent out to ensure that staff are aware of responsibilities and processes for when they need to access family/ acquaintances records for business reasons. If they do not have consent and have accessed records for reasons not business related they are likely to be subjected to an investigation. **The Group resolved that:** a) The update on information governance issues were noted.	
CDTQSE 23/136	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** **The Group resolved that:** a) There have been no inspections in this Clinical Board.	
CDTQSE 23/137	**Policies and Procedures** **The Group resolved that:**	

	a) Policies currently out to consultation can be access from the UHB SharePoint site.	
EFFICIENT		
CDTQSE 23/138	**Exception Reports from Directorates** **The Group resolved that:** a) There were no exceptions to report.	
CDTQSE 23/139	**Clinical/Internal Audits** **Tendable System Presentation** Aron White, Nursing Informatics Lead, was welcomed to the meeting to provide an update on the Tendable system and whether this can be applied to non-ward based areas. The Tendable system has been rolled out across inpatients and is now being implemented in Pharmacy and Outpatients. There are currently 4 options available for undertaking audits; on paper, on Excel, the AMAT system or the Tendable system. Tendable works on both desktop and mobile devices. An overview was provided of inputting onto the system and the analytics information that is available. SS would like a domain set up for Point of Care Testing and will link in with Aron White and Helen Bonello. AC asked where would it be expected to use Tendable versus AMAT and also if departments can create their own audits in Tendable or whether they are preset. It was noted that AMAT is preferable where there are national standards that need to be followed and audits relating to this are infrequent, or if departments plan on undertaking an annual audit. If there is a core data set to be checked monthly, Tendable will have advantages. Tendable is more user friendly. JF commented that a lot of audits are undertaken in Radiology that do not necessarily sit within a ward environment but are straightforward audits. She asked if Tendable would be a suitable platform for this work. AW advised that Tendable could be used but there is a caveat that no patient identifiable information or photographs of patients are uploaded onto the system. Therefore if patient identifiable information is part of the audits than AMAT would be more suitable. Tendable could be used for IPC audits, environmental audits, radiation checks and equipment checks. SO asked if Tendable links to other reports and systems. It was noted that it only links into the BIS system. SH asked if barcodes can be built into the photo element of the system. AR stated that it is part of the plan for Tendable for 2024 to create equipment lists for wards that can be scanned.	

	The Group resolved that: a) Any queries relating to whether Tendable or AMAT would be the most appropriate system to contact AW and Helen Bonello.	
CDTQSE 23/140	**Waste and Sustainability** At the May CD&T Green Group meeting, feedback was provided on the Bevan Commission Let's Not Waste event. AWTTC also provided a presentation on their best practice work around inhalers. **The Group resolved that:** a) A request was made for directorates to encourage attendance from their teams to share learning around sustainability issues and provide any support to projects if needed.	**All**
EQUITABLE		
CDTQSE 23/141	**Feedback from Clinical Board Inclusion Ambassadors Group** The Health Board is launching its Anti-Racist Action Plan. Thoughts are being considered as to how this can translate to the other Protected Characteristics. SO has been working with Dawn Ward and Steve Gauci to introduce a Safe Space where staff can raise concerns anonymously as an alternative route to the other formal mechanisms in the Health Board. **The Group resolved that:** The Clinical Board is engaging with the People and Culture Team to ensure this route does not by-pass these other mechanisms.	
CDTQSE 23/142	**Equality and Diversity Issues** **The Group resolved that:** a) There were no equality, diversity and inclusion issues to escalate.	
PERSON CENTRED		
CDTQSE 23/143	**Patient Story** Charlotte Dowd, Dietitian specialising in gastroenterology was welcomed to the meeting to present the patient story. The patient was a 55-year old female with a background of chronic pancreatitis and gastroparesis and also a type 2 diabetic.	

She was prescribed a pancreatic enzyme replacement and also placed on a water tablet.

The patient had multiple admissions to hospital and presented in multiple ways i.e. surgical related issues, presentations at A&E and on medical wards due to endocrine problems with poorly controlled diabetes and gastro wards due to poorly controlled bowels and diarrhoea.

On her most recent admission, she was admitted for pneumonia and she had a new diagnosis of decompensated liver disease. At this point she had a weight of 38 kg and her BMI was 16.4 which placed her in the underweight category.

She had a social history of previous alcohol excess but was no longer drinking alcohol. She lived with her husband and was independent, but had limitations as she was frail due to her low body weight. She was working but not always able to attend work due to bowel problems which was significantly impacting on her quality of life.

She was referred to a gastro specialist dietitian. During this clinic an adjustment was recommended to the pancreatic enzymes and anti-diarrhoea medication was introduced along with nutritional supplements. She was issued with hypo advice and an urgent diabetes review.

The patient was also referred due to her incontinence by the GP to the ECAS service. A few months later the consultant who saw her at the ECAS Service wrote to advise that the patient had previously been opening her bowels 8 to 9 times a day and following input from the gastro specialist dietitian and altering her medications, opened her bowels once a day with no incontinence. Her appetite was much improved and although her weight had not increased, the patient was managing to eat more. Unfortunately, the patient still had poor diabetic control and was due to see the Diabetic Specialist Nurses.

The patient sadly passed away later on that year but the interventions did have a profound impact on her quality of life in her last few months.

The learning from this story is that patients with chronic pancreatic disease are extremely complex and this can have a debilitating effect on their quality of life. Evidence suggests that this impacts on survival and MDT management is vital.

CC noted that this cohort of patients fall through a gap and live with their conditions for a long time before they start to receive specialist intervention. It demonstrates the need for a robust MDT to be set up in Cardiff and Vale, as many specialties need to come together to manage these patients. Whilst there is a

	focus around cancer patients, there are patient populations wider than this that also experience similar pain and discomfort and poor quality of life. The pathway for these patients both before and after treatment for surgery is also extremely important. **The Group resolved that:** a) The patient story was noted.	
CDTQSE 23/144	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** JW noted that Pharmacy have active wellbeing champions who are supporting colleagues and have produced a monthly wellbeing newsletter, signpost staff to useful resources and organised wellbeing walks. **The Group resolved that:** a) JW will share the newsletter with Helen Luton.	**JW**
CDTQSE 23/145	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/146	**National User Experience Framework/Feedback from Patient and Service User Surveys** Patient experience feedback is collated from users of Nuclear Medicine at UHL. **The Group resolved that:** a) JF will share the feedback at the next meeting.	**JF**
CDTQSE 23/147	**Staff Awards and Recognition** JW advised that a Paediatric Pharmacist received an Inspirational Member Award from the Children's Cancer and Leukaemia Group. **The Group resolved that:** a) All directorates to consider nominating their staff for their achievements in the Clinical Board Staff Recognition Scheme, where they are working above and beyond. b) HL asked to be informed where any staff have been recognised wider than the Clinical Board.	**All**

ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 23/148	Clinical Board Regulatory Compliance Group Minutes May 2023	
ANY OTHER BUSINESS		
CDTQSE 23/149	There were no further items to report.	
CDTQSE 23/150	**Date & time of next Meeting** 20th June 2023 at 9am via Teams	

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

MENTAL HEALTH CLINICAL BOARD
Quality, Safety & Experience Committee

Thursday 16th February 2023 at 9:30am
MS Teams Meeting
Minutes

Attendees:		
Tara Robinson (Chair)	Deputy Director of Nursing, MHCB	TR
Alexander Bridgeman	Recovery, Operations	AB
Alison Lewis	Patient Quality and Safety Department	AL
Andrea Sullivan	Senior Nurse for Patient Safety, Quality and Experience	AS
David Seward	Mental Health Act Manager	DS
Heather Hancock	Directorate Manager, Adult MH	HH
Jayne Bell	Consultant Nurse, MHCB	JB
Joanne Wilson	Directorate Manager, MHSOP	JW
Katja Empson	EU Consultant	KE
Lisa Walters	Lead Nurse, Adult MH	LW
Neil Jones	Clinical Director, MHCB	NJ
Rob Kidd	Clinical Lead, P&PT	RK
Sue Tapper	Admin Manager, MHSOP	ST
Suzie Cheesman	Patient Quality and Safety Department	SC
Teresa Delaney	Directorate Manager, P&PT	TD
Tracey Skyrme	Head of Inquests, Patient Experience	TS
Apologies:		
Andrew Vidgen	Deputy Clinical Director, Adult MH	AV
Jenny Pinkerton	Occupational Therapy Clinical Lead MHSOP	JP
Mark Doherty	Director of Nursing, MHCB	MD
Marianne Seabright	Lead Nurse, MHSOP	MS
Nicola Evans	Head of People and Culture	NE
Norman Young	Consultant Nurse, MHCB	NY
Rachel Rushforth	Senior Nurse for Quality, Safety and Education	RR
Rebecca Marsh	Deputy Head of People's Services	RM
Victoria Gimson	Pharmacy Lead	VG

Part 1:	**PRELIMINARIES**
1.1	**Welcome and Introductions** TR welcomed all and introductions were made.

1.2	**Apologies** Apologies were given as noted above.
1.3	**Minutes** The minutes for the meeting on 20/10/2022 have previously been approved by MD.  Minutes MHCB QSE 20th October 2022 (1)
1.4	**Action Log** The action log was discussed and updated.  MHCB QSE Action Log.xlsx

Presentation

KE and AB presented the 'Six Goals Framework'. This is a national programme across Wales to support organisations to transform emergency and unscheduled care. There are some areas in which Mental Health Provision is a key part.


Six Goals Programme - How we move forwa

Part 2:	**GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY**
2.1	**UHB QS&E Committee** Not discussed.
2.2	**Regulatory Compliance** Not discussed.
2.3	**Risk Register** The risk register was discussed and reviewed.
2.4	**Escalation Reports and Escalation of Key QSE Issues from Directorate QSE Groups** **Adult Mental Health – Dated 12/01/2023** LW discussed the recent Adult QSE Meeting. There have been issues with people breaking into Pendine's garden. Ongoing discussions about frosting windows looking into courtyard in HYC. Recruitment and retention are ongoing issues. Estates issues include leaks and damp in walls, a toilet leak above MHA office and ongoing issues in Headroom. Focus has been on pushing consistent fire safety checks, and identifying MHA Champions in the ward. Work has been done with the retention of staff to try to accommodate them on their preferred wards. Changes to Elm ward were discussed, the ward will be moving back to low-secure in the future. HH noted that she has requested an updated quote for Britplas fences, and this item is linked to the larger piece of work around open-door discussions and Metrasens machines.

AMH QSE Minutes January.docx

MHSOP
JW discussed the latest QSE minutes. MHSOP have set up a care and treatment plan subgroup to look at pathways. There are major staffing gaps across the wards and community teams. Using agency staff, moving staff around and planning promotional events to attract staff.

Will be introducing MHSOP and neuropsychiatry areas to the 'Keeping You Well' website. Occupational are increasing activities off the wards. The MHSOP 2a Business Case is due to be heard at the end of March. There are several different schemes being developed by Physical Health in MHSOP. There are ongoing issues with the lifts used for deliveries.

MHSOP are trialling a new primary nurse model, where each primary nurse is linked with an associate nurse. The reporting of observation levels is being reviewed. REACT have very low staffing levels, looking at long-term solutions. An audit is being completed regarding pathways e-referrals on AMAT. Open dialogue training is being held at the end of March.

MHSOP Q S Minutes 5.12.22.doc

Psychology and Psychological Therapies
RK discussed the latest psychology QSE meeting. A guest speaker from the Public Health department attended, who discussed the demographics of the CAV footprint and services in relation to this. A discussion was held around recent Stonewall Cymru training. In the February meeting, RK had official Welsh Government slides with information about duty of quality and candour. There is a move to 'Domains of Quality'. Professor Neil Roberts joined the February meeting and discussed the Trauma Informed Wales Framework. Discussed the 'Trace Tool' which is being trialled within P&PT.

TR and NJ requested to invite Professor Neil Roberts to the next QSE meeting, and to add the Trauma Informed Framework as an agenda item. CQ mentioned that the framework needed to be co-produced, and questioned if the implementation of this framework would sit across the organisation or within the Clinical Board. NJ happy to discuss in the next QSE meeting and then take this to Executive level.

P&PT QS Minutes and Action log 07.12.2

Pharmacy
Unable to attend – update attached.

MH Medicines Management Group M

MH ACT
Two Welsh Minister referrals have been completed as rights had not been read in the first 14 days. DS received an email from the Senior Medical Officer from the Welsh Government,

	as this wasn't the first incidence. DS hopes that the Mental Health Act champions will help with this. The MHA office have lost some staff so are very busy at the moment. **MHIPC** Not available for discussion. **SUI Steering Group** Main topic of discussion was the Reducing Restrictive Practices Framework. Health boards have been asked to evidence how they are measuring their work against the new framework. RK discussed the connection with the trauma informed framework. JB mentioned that there is a lot of work to be done around understanding the framework prior to the response, the Clinical Board are expected to present progress at the next SUI meeting in approximately 2.5 months.  Jayne Bell - Notes on SUI SG.docx
2.5	**Controlled Document Oversight Group** TR discussed the new Teams Channel and the terms of reference. Any comments to be sent to NH. CAV_MH Policies and Procedures Teams Channel  TOR CDOG.docx  2.5b Meeting Notes CDOG 27-01-23.docx
Part 3:	**HEALTH PROMOTION PROTECTION AND IMPROVEMENT**
3.1	LW discussed the Reflective Practice that has been facilitated externally for Cedar and Alder wards. The developing themes include; personality disorders, mentorships and preceptorships, debriefs, lack of understanding around the role/function of Cedar Ward (LW linked to operational policy), staffing levels on nights and ILS training. The senior team will be meeting to discuss this. TR noted that the trauma informed approach was discussed with the practitioner. Attendance is going well, difficulty to release staff for meetings, keen. RK discussed facilitating Schwartz Round – AS will be evaluating the engagement and value of the reflective practice sessions to staff. There was discussion around who will be trained to be Schwartz facilitators. CQ discussed the need to a multi-professional and service approach to this across the clinical board.
Part 4:	**SAFE CARE**
4.1a	**Patient Safety Incidents** A number of improvement plans have now been uploaded onto AMAT. There is hope this will help the CB to monitor their process against the improvement plans. Themes developed from the improvement plans have helped to develop an overarching improvement plan for the mental health clinical board. JW requested that improvement plans are available for all to view. TR and AS requested supporting input to ensure the plans are robust and meaningful. AS discussed that the improvement plan is broken down into 7 recommendations, with a number of actions for each recommendation. These actions need to be allocated to an individual. This is helpful to keep track of actions, and is a good source of evidence for

	outside organisations. Themes have been collected from significant incidents over the last couple of years. JW discussed how access to the improvement plans could be opened up. AS to find this out. AS talked through each recommendation and what actions there were for each one. MHCB Draft Overarching Improv MH-MHSOP-GK154 260-action plan.pdf MHSOP GT - Action plan.pdf MHSOP JD 8356 - Action plan.pdf MHSOP MC- 7403 - Action plan.pdf
4.1b	**Tendable Update** This will be discussed in the following meeting with Casey Keegans and Marianne Seabright.
4.1c	**WG Closure Form Status** Not discussed – attachment enclosed. Mental Health CB Open NRIs and closur
4.2	**Patient Safety Alerts** pH Strips - Code change.pdf PSA015 Oxygen cylinder FINAL.pdf Guidance Sensitive Oxygen Cylinder FIN ISN 2022 Dec 004 Transillumination li ISN 2022 Dec 006 - ZOLL Defibrillator Cl PSN065 Safe use of ultrasound gel Dec Flowchart_ultrasou nd infection preven Safety Critical Complex NatPSA UK
4.3	**Key Patient Safety Risks** Crash call put out on Alder ward following a patient suffering from post-injection syndrome following an Olanzapine depot injection. Patient was very unwell. The immediate response was fantastic and there were no concerns relating to this. There was a discussion about the use of these depots in the community – patients are advised to wait for the monitoring period but often decline. Quality Standards: Primary care | Resuscitation Council UK
Part 5:	**EFFECTIVE CARE**
5.1	**Monitoring of CB Clinical Audit Plan** Not discussed – attachment enclosed. Developing Clinical Audit Plans Guidanc
5.2	**Implementation of Key NICE Guidance**

	NJ discussed the new guidance that Esketamine is not to be used in treatment resistant depression. Doesn't believe anyone is using this currently. NJ also discussed the attached standards around the transition from CAHMS to Adult mental health care. Overview | Esketamine nasal spray for treatment-resistant depression | Guidance | NICE Overview | Delirium: prevention, diagnosis and management in hospital and long-term care | Guidance | NICE –  ps03_22 Delivering better outcomes for
5.3	**QNWA Standards** NJ discussed ongoing work on 1:1's in the inpatient space. A small pilot study has led NJ to continue with concerns relating to medical 1:1's. Most inpatients will be seen once per week by their consultant, NJ is working towards an additional 1:1 outside of ward rounds. This was discussed with MD concerning 1:1 work with other staffing groups like nursing. NJ also discussed care plans, most patients do not have this in place in terms of a holistic document which includes multidisciplinary input and is shared with the patient and updated on a weekly basis. Moving forward, NJ would like to be clear about expectations of 1:1's and care plans and agree how the Clinical Board will monitor and audit against the QNWA standards. There are also NICE quality and safety standards which has quite stringent criteria and NJ would like the Clinical Board to state their position in relation to these. There was a discussion about ensuring additional 1:1 time adds value, and how this would be monitored. NJ is aiming for clarity around the standards, to enable them to be monitored. This is to be included in care plans to ensure patients know what they can expect. The standards will be across Adult and MHSOP. TD mentioned that this could be an opportunity to formalise and focus work that is being done informally. Potential of producing a template e.g. categorising patients as red/amber/green. TR will invite TD to QNWA discussion. The standards could be monitored on Tendable or AMAT. TR mentioned that the Clinical Board are working towards SIRAN accreditation and have been allocated funds for this. NJ discussed the upcoming Royal College of Psychiatry invited review. This will be taking place in March, they will be visiting and interviewing staff. Notes relating to incidents will be being uploaded to them. A review document will be received in approximately 4 months, and there will be a visit 6 months after this to follow up on the recommendations.  QNWA Standards.xlsx
5.4	**POMH Update** Unable to attend.
5.5	**Research and Development** Not discussed – attachment enclosed.

	Developing Clinical Audit Plans Guidance MHCB_Newsletter_1DECEMBER_2022(1) (
Part 6:	**DIGNIFIED CARE**
6.1	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** LW gave an overview of the recent HIW visit to Pine Ward. Immediate and outstanding actions were discussed. No concerns regarding staff practice, good verbal feedback was received. JW discussed the recent HIW visit to Ash Ward. There was one immediate assurance relating to staff being trained in SIMA. Staff who were out of compliance have now been booked in. The floor of Ash treatment room is an outstanding action, JW will chase this up. Draft HIW reponse Ash Ward Jan 2023 (
6.2	**Equality, Diversity and Access** TR noted that the recording of ethnicity on Paris is low in some areas, Rehab are doing well in filling this out. JW requested that Ethnicity be made a mandatory field, and TD requested an update of the ethnicities available due to limited options and duplication. RK spoke about other personal characteristics which are a big part of an individual. Mentioned the importance of improving ability to have conversations around this as part of quality improvements around person centred care. Queried whether Stonewall training would be useful for additional staff. RK will discuss with directorates. 6.2 Inpatient Ethnicity.docx
Part 7:	**TIMELY CARE**
7.1	**Initiatives to improve access to services** Not discussed.
Part 8:	**INDIVIDUAL CARE**
8.1	**Compliments, Complaints, Trends** RK congratulated Dave Hitt and Rhiain Lewis for achieving Agored accreditation for one of their training modules. Compliment 29.12.22.pdf
Part 9:	**STAFF AND RESOURCES**
9.1	**Staffing levels, Streamline nurses, Staffing Establishments, Temporary Staffing** Agency HCSW will be ending on the 1st April 2023, TR requested that the Directorate Leads discuss and plan for filling the gaps created by this.

	Recruitment Update_.pptx Agency HCSW.pdf
9.2	**Staff Surveys** Not discussed.
9.3	**Self-Harm and Suicide Prevention Conference** TR directed attendees to the information in the pack. Booking Link Conference Speakers 2023.jpg
Sub – group reports	
Part 10:	**ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE:**
10.1	**PPE Audit** Not discussed.
Part 11:	**AOB**
	Nothing discussed.
Part 12:	**DATE & TIME OF NEXT MH CLINICAL BOARD QSE MEETING:** **Thursday 20th April 2023 at 09:30am** **DATE & TIME OF NEXT MH CLINICAL BOARD LESSONS LEARNED MEETING:** **Thursday 23rd February 2023 at 9.30am**

Minutes of the Specialist Services Clinical Board
Quality, Safety and Experience Committee

Held Thursday 16 February 2023 at 9:30am

Via MS Teams

Chair:		
Claire Main	CMain	Interim Director of Nursing, Specialist Services CB
Present:		
Aaron Fowler	AaF	Head of Risk and Regulation
Alannah Foote	AF	Directorate Support Manager, Nephrology & Transplant
Alex Scott	AS	Assistant Director of Quality and Patient Safety
Beverley Oughton	BOu	Senior Nurse, Cardiac Services
Catherine Evans	CE	Patient Safety Facilitator
Debbie Jones	DJ	Deputy Head of Quality Assurance & Clinical Effectiveness Lead
Fiona Davies	FD	PaRT Nurse Practitioner
Guy Blackshaw	GB	Clinical Board Director, Specialist Services
Hayley Valentine	HV	Quality Lead for Critical Care
Helen Thomas	HT	Lead Pharmacist for Specialist Services Clinical Board
Jo Clements	JC	Lead Nurse, Critical Care
Jordan Wilmer	JW	Service Manager for Non-malignant Haematology, Immunology and Metabolic Medicine
Keith Wilson	KW	Consultant Haematologist
Kirsty Britton		Senior Nurse, Nephrology & Transplant
Laszlo Szabo	LSz	Consultant Transplant Surgeon
Mat Davies	MD	Consultant Nephrologist, Quality and Safety Lead SSCB
Rachael Sykes	RS	Assistant Head of Health and Safety
Richard Parry	RP	Q&S Facilitator
Sarah Lloyd	SL	Interim Director of Operations, Specialist Services CB
Steven Fernandez	SF	Interim Senior Nurse, Cardiac Services
Secretariat		
Mandy McGee		
Apologies:		
Bethan Ingram		Senior Nurse, Teenage Cancer Trust
Caroline Burford		Consultant in Critical Care
Claire Mahoney		CNS Infection Prevention & Control
Colin Gibson		Consultant Clinical Scientist, ALAS
Jane Morris		Senior Nurse, PaRT
Rachel Long		Directorate Manager for Nephrology & Transplant
Sian Williams		Senior Nurse, Cardiac Services
Tom West		Critical Care Consultant
Tracey Skyrme		Head of Inquests

Item No	Agenda Item	Action
1.1	**Welcome & Introduction** CMain welcomed all to the meeting.	
1.2	**Apologies for Absence** **The Committee resolved that:** a) The apologies given were noted.	
1.3	**Minutes of the Meeting Held 24 November 2022** Point 2.2 the word "plural" should read "pleural". **The Committee resolved that:** With the amendment made the minutes were recorded as a true and accurate record.	
1.4	**AMat Update** CMain introduced Debbie Jones, Deputy Head of Quality Assurance & Clinical Effectiveness Lead who presented an update of the audit management and tracking system, which was originally piloted with the Children & Women CB and went live across the UHB from November- Discussions were held around the presentation. Debbie said that she was happy to have further conversations with people outside of this forum if they would like extra support using the system. CMain thanked Debbie for her presentation.	
1.5	**Professional Standards** GB gave background to the new set of Guidelines on Professional Standards and Behaviours being issued by the UHB with the aim of providing guidance on what staff should do when on-call and how referrals should flow through the system. The document will be presented to Clinical Board Directors later today and will be disseminated to all within the next two weeks. GB asked all to help disseminate this information through the DMT's.	
	Safe Care	
2.1	**Open Nationally Reportable Incidents** RP reported that there are ten NRI's in progress at the moment, of these four have documents that are completed or very near to completion and are expected to close very soon. There are some new NRI's which will be reported here after the first meetings. CE suggested that it may be beneficial to see the closure forms which contain a summary of the incident and recommendations along with learning from the event rather than the closure report which only provides numbers.	.

	Potential NRI's Nothing to report **The GROUP resolved:** It was agreed to continue reviewing all complex cases following the NRI structure in order to share learning **Open Inquests** Nothing to report **The GROUP resolved:** a) To review inquest information as appropriate	
2.2	**Closure Forms** RP reported on the findings for the Investigation of Concerns in Care of MG L066988L, the case of a 25year-old pregnant lady who was found dead at her home by her mother. RP said that there is a second similar case which will be reported on in a future meeting. MD commented that there were a large number of inquests in the report sent out and noted that some date back to Summer of 2021 which would make it difficult to get closure for both the families and medical professionals involved. He asked if this was usual or something which has worsened following the pandemic. CE replied that the situation has worsened, MD said that he would follow this up with Tracey Skyrme outside of this meeting. AS replied that inquests have been subject to the same pressures experienced by the HB as a result of Covid, all face to face inquests ceased at the onset of Covid and it took some time to move to virtual inquests resulting in a significant backlog nationally. RP reported that there are also significant delays in receiving post mortem results which causes significant delays with investigations. MD replied that the pathologists are extremely understaffed at present and experiencing difficulties in being allowed to recruit to these university posts due to financial constraints.	
2.3	**Alerts / Patients Safety Notices** The following notices which have been disseminated to the Group, to share as appropriate: • CPhO MedsLet 2023 002 - Norditropin (somatropin) Flexpro solution for injection pre-filled pens (002) • 23-01-11 - CMO letter providing update on TB services (vA83349546) • PSA015 Oxygen cylinder FINAL • Guidance Sensitive Oxygen Cylinder FINAL1 Wales	

	• SBAR aspHirate PH testing strips Potential batch issue • CAV Antimicrobial Management Group SSTF audit report **The GROUP resolved:** • All documents shared at this meeting to be shared within the Directorates. The antimicrobial audit report will be brought back to the next meeting for further discussion.	
2.4	**Healthcare Associated Infections** No report received CMain reported that she was unaware of any significant infection issues across the area. There are a number of respiratory and Covid issues generally across the HB which are being worked through on an individual basis.	
2.5	**Health Care Standard 2.9 Medical Devices** Nothing to report	
2.6	**Health and Safety** CMain introduced Rachael Sykes from the H&S Team, she will be covering in the interim period as Caroline Murch has moved to a new role. Rachael and Claire will be meeting to discuss H&S within the CB 17 February.	
2.7	**Vaccination Update** KB reported that uptake has not been as successful as previously but this may be due in part of problems in data capture with staff receiving their vaccinations from outside the HB. It is hoped to have a more accurate picture later this month.	
	Governance, Leadership and Accountability	
3.1	**Feedback from UHB QSE** AS reported that there was nothing significant to report. The 2 main topics are the Duty of Quality and the Duty of Candour. AS would like to present on the Duty of Quality at the next meeting and explained that there is a significant process to be implemented by the beginning of April in order to meet our statutory duty with regards to the Duty of Candour. The main principles of Duty of Quality require the improvement of governance across the HB in relation to how Clinical Governance groups interlink with the CB's in order to share lessons learned. It is expected that standard agendas will be amended to include quality in the broader sense using the 6 domains of quality. More information will be provided in March. It is expected that a quality summit will be arranged for later in the year.	

	The GROUP resolved: To invite AS to present overview of Duty of Quality at the next meeting	
3.2	**Mortality Review** CMain asked everyone consider the recent email sent out by Caz Burford looking at the Mortality Review Group and the triggers for enhance mortality review. There has been a recognition that parameters in certain departments are more concerning than others and that there are some nuanced specialty-related outcomes within Specialist Services. CB had asked for representatives from each directorate to look at any opinions on hard triggers for stage 2 mortality reviews that would be recommended to specialities to support the process. Replies by end of February in order for CB to present at the next Mortality Review Group meeting. AS informed that a Learning from Death Framework Is being developed across the HB and added that within the next couple of months all in-patient deaths will be reviewed.	
3.3	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** <u>Nephrology and Transplant</u> Nothing to report <u>Haematology</u> KW reported that the key issue affecting the Department is staffing, both Nursing and Medical. The Department is currently not running at a safe level which is having a significant impact o staff morale and retention. The new lead nurse is currently drawing up action plans to try and resolve the situation. The estate situation is long standing, there is a plan in place to improve facilities but tangible progress has yet to be made. JACIE accreditation is due 2024, KW expressed his concern that the deficits found in the previous inspections remain. MD asked if there were any obvious blockages to recruitment which could be addressed. KW replied that most of the problem is due to the high level of training staff require to work within the Department. CMain informed the Group that there is a very in-depth plan around both spreading the skill mix we have and using the entire workforce and working very differently within the Directorate, this is something that a lot of the other Directorates have already done. The staffing is reviewed on a daily basis and through a new system, SafeCare, the safety of all wards is reviewed and mitigation is put in place in those areas which may not be working at the establishments the are designed to be. CMain has met with the staff from B4 to talk through the specific issues they are experiencing and with them an action plan has been put together which comes into effect immediately in terms of how	

	they can work differently, prioritise workloads and work with different teams. There is a lot of work being undertaken to help ensure that there is a robust plan to grow the Haematology Service back to where it needs to be but there an investment and training period that needs to be undertaken before we can get the staff up to the competency that has been lost due to retirement, people changing priorities and work being undertaken differently. It is anticipated that there will be significant changes seen in terms of day to day practice and the staff feel supported and have a different view on how they can also support themselves through this period. CMain added that further details will be shared with the Team at the next Directorate Performance meeting. SL reported on the plans around the infrastructure issues, it is planned for a strategic outline case to be presented to the Senior Leadership Board in March. This will then go to the Executive Board in May for sign off and from there it will go to Welsh Government. It is hoped that at the time of the JACIE inspection there will be an approved strategic outline case and work will be on-going on a full business case. SL shared KW's concerns around the JACIE inspection and added that it is hoped that the next few months are key in terms of receiving assurance that WG are committed to working with the UHB on this. <u>Critical Care</u> HV reported recurrent problems in getting APTT results back and asked if others were experiencing the same problem. She also informed that a large number of staff are unable to carry out blood sugar testing as the POCT clearance seems to be lapsing with no explanation. POCT are unable to resolve this problem. HV an update on the Critical Care Topic of the Month initiative where incidents on Datix are reviewed and collated into common themes in order to feedback to the staff using a multidisciplinary approach on a monthly basis. CMain thanked HV and the Team for their work in developing this and asked that it be presented to this Group. MD asked for an update on the current staffing levels in CC, HV and JC replied that the situation has greatly improved since the end of last year, department are currently at establishment overall with an over-establishment of Band 5 nurses and under on Band 6 nurses. Throughout all of the winter pressures there was no doubling up nor working with reduced zone leaders. However, it is anticipated that this number may reduce as a lot of the overseas nurses have indicated that they are looking to move to Australia. AS asked if HV would be happy to meet with her to discuss promoting the Topic of the Month initiative across the HB. CE reported that it has been 12 months since the weekly Pressure Damage Scrutiny Panel was set up, at the time there were approximately 55 cases but this has significantly reduced to 18. This is going to be entered in the HSJ Patient Safety Awards as Pilot Project of the Year.	

	Cardiac Services BO reported that an issue was raised at the Cardiac Services Q&S meeting around the emergency transfer of patients from the Cath Lab over to Llandough, this is going to be investigated further. MTC Nothing to report Neurosciences Nothing to report PaRT FD reported that the Management of the Deteriorating Patient study days have been very well received with every one fully booked. The Team are looking to add further dates. ALAS Nothing to report	
	Items to be Recorded as Received and Noted for Information by the Committee	
4.1	Fire Safety – Computers on Wheels Fire Risk	
4.2	Medication Safety – Briefing for Healthcare Professionals	
4.3	Fire Safety Drop-In Session Dates	
5.1	**Any Urgent Business**	
	KW informed the Group that 1 March 2023 will be the 40th anniversary of the first transplant in Wales, a Patient and Family day to celebrate this is planned for later in the year. The annual meetings to benchmark UHW results against other organisations is planned along with one and all who are interested are invited. The Haematology Department have been successful in 3 separate research bids for increased funding. KW announced that he has resigned for his Q&S Medical Lead role with effect from 1 April 2023. AJ reported that as of 17 February there will be standardisation of ZoI defibrillators across the HB.	
6.1	**Date & time of Next Meeting**	
	Monday 6 February 2023 9:30am via Teams	