Public Quality, Safety & Experience Committee

Wed 30 August 2023, 13:00 - 15:00

Agenda

13:00 - 13:10
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 18.07.23

Ceri Phillips

1.4 Draft Public QSE 18.07.2023_cp.pdf (13 pages)

1.5. Action Log – Following the meeting held on 18.07.23

Ceri Phillips

1.5 Action Log 30.08.23.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

13:10 - 13:40
30 min

2. Items for Review & Assurance

2.1. Quality Indicators Report - Verbal Update

20 minutes *Jason Roberts*

2.2. Stroke/Stroke Performance

10 minutes *Paul Bostock*

2.2 Operational Stroke Performance report cover paper -QSE aug 23.pdf (2 pages)
2.2a Public QSE slides on stroke aug 23.pdf (7 pages)

13:40 - 14:00
20 min

3. Items for Approval / Ratification

3.1. Policies:

5 minutes

3.1 Policy Cover Report.pdf (2 pages)

3.1.1. Laser Risk Management Policy and Procedure (UHB 324)

Fiona Jenkins

3.1.1a UHB 324 Laser Risk Management Policy.pdf (2 pages)
3.1.1b UHB 324 Laser Risk Management Procedure.pdf (21 pages)
3.1.1c LASER POLICY EQIA v.2.pdf (10 pages)

3.1.2. Consent to Examination or Treatment Policy (UHB 100)

Meriel Jenney

3.1.2a Consent Policy 2023.pdf (92 pages)
3.1.2b EHIA Consent Policy 2023.pdf (16 pages)

3.2. Childhood Immunisation Update and Plan for 2023/24

10 minutes *Fiona Kinghorn*

3.2 Childhood Immunisation Action Plan_QSE.pdf (4 pages)
3.2a CHILDHOOD IMMUNISATION PLAN.pdf (9 pages)

3.3. Cardiff and Vale of Glamorgan Vaccine Equity Strategy

5 minutes *Fiona Kinghorn*

3.3 Vaccine Equity Strategic Plan_QSE.pdf (3 pages)
3.3a CAV Vaccine Equity Strategic Plan.pdf (18 pages)

14:00 - 14:15
15 min

4. Items for Noting & Information

4.1. Welsh Risk Pool Final Assessment Report

5 minutes *Jason Roberts*

4.1 WRP Final Assessement Report.pdf (4 pages)
4.1a CVUHB WRP Assessment FINAL Report V1.pdf (35 pages)

4.2. Introduction to the Public Health Wales Safeguarding Service, Self-Assessment Safeguarding Maturity Matrix (SMM) for Health Boards and Trusts

10 minutes *Jason Roberts*

4.2 Cover report Safeguarding Maturity Matrix.pdf (2 pages)
4.2a SMM pilot phase 2 final version _.pdf (7 pages)

4.3. Minutes from Clinical Board QSE Sub Committees:

Jason Roberts / Meriel Jenney

1. *Clinical Diagnostics & Therapies – 20.06.2023*
2. *PCIC – 25.07.2023*

4.3.1 CDT Minutes 20.6.23.pdf (13 pages)
4.3.2 PCIC Minutes 25.07.23.pdf (9 pages)

14:15 - 14:15
0 min

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

Ceri Phillips

14:15 - 14:15
0 min

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

i. *Private Minutes*
ii. *Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*

14:15 - 14:15
0 min

7. Any Other Business

Ceri Phillips

14:15 - 14:15
0 min

8. Review of the Meeting

Ceri Phillips

14:15 - 14:15
0 min

9. Date & Time of Next Meeting:

Tuesday 26 September - 2pm via MS Teams

14:15 - 14:15
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 18.07.23

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		
Annette Beasley	AB	Macmillan Lead Cancer Nurse
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
Sarah Lloyd	SL	Interim Director of Operations for Clinical Diagnostics and Therapeutics
Helen Luton	HL	Interim Director of Nursing and Multi-Professional teams – CD&T
Suzanne Rankin	SR	Chief Executive Officer
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety
Jason Roberts	JR	Executive Nurse Director
Paul Rogers	PR	Interim Assistant Director of Therapies and Health Science
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Vicky Stewart	VS	Head of Concerns & Redress
James Quance	JQ	Director of Corporate Governance
Clare Wade	CW	Director of Operations for Patient Flow
Aron White	AW	Nurse Informatics Lead
Oliver Williams	OW	Speciality Registrar in Public Health
Suzanne Wood	SW	Consultant in Public Health Medicine
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 23/07/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh	**Action**
QSE 23/07/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/07/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/07/004	**Minutes of the Committee meeting held on 9 May 2023** The minutes of the Committee meeting held on 9 May 2023 were received. **The Committee resolved that:**	

	a) The minutes of the meeting held on 9 May 2023 were approved as a true and accurate record of the meeting.	
QSE 23/07/005	**Action Log following the Meeting held on 9 May 2023** The Action Log following the Meeting held on 9 May 2023 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 9 May 2023 was noted.	
QSE 23/07/006	**Chair's Actions** No Chair's Actions were raised.	
23/07/007	**CD&T Clinical Board Assurance Report** The CD&T Clinical Board Assurance Report was received. The Interim Director of Nursing and Multi-Professional teams (IDNMPT) advised the Committee that the paper covered the period from the 1st of April 2022 to the 31st of March 2023 and outlined the progress made to improve quality, safety and patient experience in the Clinical, Diagnostics & Therapies (CD&T) Clinical Board, whilst highlighting some of the achievements and innovations undertaken to improve the quality of care for patients. She added that the report also outlined some of the key risks and the mitigations put in place. It was noted that CD&T had a wide range of diagnostic and therapeutic procedures that were provided on a local, regional and sometimes a UK wide level and that the services underpinned some of the core components of almost every aspect of clinical activity undertaken across the Health Board. The IDNMPT shared a Patient Story with the Committee which had been received by the Committee in March 2023 from the Specialist Clinical Board. She added that the story was provided from the CD&T point of view and how each of the CD&T directorates were involved in the patient's journey. The Committee was reminded that that the patient had come off his quad bike at force and the quad bike had landed on him, which required the patient to be air-lifted to the University Hospital of Wales (UHW). The patient's journey was presented which included: • Critical Care – a 2 day stay in ITU • Polytrauma Unit • Staying on Ward West 8 • Being discharged home nearly 12 months later from admission. The CD&T areas that had touched that patient journey included: • Laboratory Medicine – 20 units of blood products were administered which had been managed by the Health Board's blood bank. • Radiology, Medical Physics and Clinical Engineering – The patient's medication was delivered via a medical infusion device, 78 images were taken of the patient during their hospital stay as well as outpatient appointments which included CT, MRI and ultrasound. • Pharmacy – Pharmacists and Pharmacy Technicians were all involved in the patient care and provided a number of services such as smoking cessation advice, diabetes management, wound management and vaccination. • Medical Illustration – Photographs were taken of the patient on 4 occasions for suspected deep tissue injury, pressure ulcer, moisture lesions and to document a rash.	

- Therapies – A large number of therapists provided care to the patient including Psychologists, Dietitians, Rehabilitation Technicians, Physiotherapists and Occupational Therapists.

- Health Records and Outpatients – The patient's hospital stay of almost 12 months created a significant volume of medical records which were collated, managed and stored securely by health records staff.

The Executive Nurse Director (END) advised the Committee that sometimes the CD&T Clinical Board felt quite hidden from the Health Board and that a significant amount of work and support was provided by the Clinical Board which needed to be identified and highlighted to the Committee.

The Interim Director of Operations for Clinical Diagnostics and Therapeutics (IDOCDT) reiterated to the Committee that the Patient had touched every aspect of CD&T and that the information would be taken back to the CD&T Clinical Board's own Quality & Safety meetings within the directorates to bring that message back to the teams.

The CC responded that the intent was certainly conveyed via the Patient Story and thanked the CD&T Clinical Board teams for all of their hard work in relation to the patient's care.

The IDNMPT then pulled out key points from the CD&T Clinical Board assurance report which included:

- Values Based Appraisals – It was noted that the Clinical Board remained committed to delivering the values and behaviours of the Health Board to all staff and that during the last 12 months there had been a particular focus on staff completing a values-based appraisal, with directorates providing trajectories to achieve 85% by July 2023 which had not quite been achieved but that the momentum was still ongoing.

- The Inclusion Agenda – it was noted that the Clinical Board was developing actions to deliver on the inclusion agenda and to create a Safe Space initiative, which would create an environment where colleagues felt free to be supported and to speak up if they had any concerns.

- Regulated and Accredited services – It was noted that a number of inspections and assessments had been undertaken from the CD&T regulatory bodies over the last 12 months and that all of the laboratory services had maintained their ISO accreditation from The United Kingdom Accreditation Service (UKAS).

- HIW Inspection IR(ME)R at University Hospital Llandough (UHL) – It was noted that Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection and had reported that staff had a good awareness of their roles and responsibilities in line with IR(ME)R 2017.

  The IDNMPT added that there was very positive feedback provided from patients about their experiences when attending the department. HIW had requested that action was taken to actively collect patient feedback on their experience of visiting the department and the team had now piloted a questionnaire accessible via QR code and paper copies in the department with a view to a wider roll out across the directorate.

- All Wales Quality Assurance of Aseptic Preparation Services UHL – It was noted that the inspection highlighted issues relating to the facility's age, including general fabrication and the air handling units and the long-term future of the of the unit, which were linked to the regionalisation of aseptic services as part of the Transforming Access to Medicines (TRAMS) programme.

The IDNMPT advised the Committee that a number of the challenges and risks observed by the Clinical Board directly related to the fabric of the estate and some of the ageing equipment, which could impact on regulatory compliance.

She added that a business case for the refurbishment of the Mortuary had been submitted to Welsh Government, which would not only see an improvement in the environment but also increase capacity.

Another risk highlighted to the Committee related to the backlog diagnostics both for radiology and cellular pathology, which had resulted in a potential risk of increased morbidity and mortality due to long turnaround times for results.

The IDNMPT added that there were a number of Nationally Reported Incidents in relation to delays in cellular pathology which had an impact on patient pathways.

She added that backlogs had accrued in all areas within the cellular pathology pathway and that at one point in the system there had been a backlog of over 6000 cases in the microtomy section.

It was noted that there had been significant improvement due to the focused efforts of the team and the introduction of 7-day working which had resulted in the workload being reduced to a manageable operational level of around 100 specimens in the laboratory at any one time.

The IDNMPT concluded the report by highlighting a number of service improvements made by the CD&T teams which included:

- A project called “Kids Med Cymru” which was an initiative that aimed to get children off liquid medication and onto tablets by attending a “pill school”. It was noted that it added both an environmental and financial benefit to the Health Board as well as a benefit to children and their families.

- A Teledermascopy service – introduced by the Medical Illustration Service which had reduced the demand on dermatology by removing the requirement for all referrals to have an initial face to face appointment and redirecting capacity to those patients that really needed to have that face to face appointment

- A Rehabilitation Model and Operating Model - since updating the Rehabilitation Model the service had acted to communicate and embed the model throughout the Health Board and was recognised by the United Kingdom AHA awards 2023 and the team became the winner of the Welsh Government Award for Value based care: making the best use of resources to maximise outcomes.

- Radiology, Medical Physics and Clinical Engineering - During the last 12 months an ambitious programme of installation of new equipment had been undertaken with two new X-ray rooms being installed as part of the fracture clinic move back to the UHW site.

- It was noted that a number of installations and refurbishments had taken place during the programme which included:

    - 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

The CC noted that the report had been summarised very succinctly and thanked the IDNMPT and the wider CD&T Clinical Board teams for all of their hard work.

The Independent Member – Capital & Estates (IMCE) asked what work was being undertaken to mitigate the risk identified where by patients had complaints around the rearranging of appointments.

The IDNMPT responded that it had largely related to physiotherapy appointments held at the Cardiff Royal Infirmary (CRI) where there were significant telecoms issues which had been resolved and so fewer complaints were being received at present.

She added that work was being looked at to automate the system which would mitigate those issues in the future.

The IMCE asked for further information around pathology and the longer-term requirements needed to deal with the backlog identified in the report as well as how sustainable the changes were.

The IDNMPT responded that the 7-day working in pathology was well embedded and positive feedback had been provided by the teams which was sustained.

	She added that the Health Board was one of the few laboratories in Wales that undertook 7-day working and noted that one of the challenges identified was that some reporting required outsourcing. The IDOCDT added that another area being focused on within pathology was technology and newer machines with quicker turnaround times and a future step change to move into a digital system. The Independent Member – Community (IMC) asked what was being done to mitigate the high risk around laboratory medicine. The IDNMPT responded that the large majority of incidents identified within the report were of "no harm" to patients and that the incidents were raised as part of a trigger warning as opposed to an actual incident. She added that the laboratory staff had a really good reporting culture and that the quality managers within the laboratories had a good handle on all of the incidents. The Executive Medical Director (EMD) acknowledged the detail and amount of work being undertaken by the clinical board and provided assurance to the Committee on pathology and noted that there was a strong focus on it. She added that since the report was written, changes had been implemented which had improved the service by way of new machinery and the implementation of the 7-day working. It was noted that there was also an infrastructure issue with the Radiopharmacy which would be discussed in the private session the meeting and then brought back to public at the September meeting. **The QSE Committee resolved that:** a) The progress made by the Clinical Board to date was noted b) The content of the report and the assurance given by the Clinical Diagnostics and Therapeutics Clinical Board was noted.	
QSE 23/07/008	**Quality Indicators Report:** The Quality Indicators Report was received. **Deep Dive into Complaints.** The Assistant Director of Patient Experience (ADPE) presented to the Committee and explained why good complaints handling was important. The key principles of good complaints handling were identified which included: • Accessibility: To ensure the complaints process was easily accessible to all individuals, regardless of their background or circumstances. • Fairness: To treat all complaints fairly, impartially, and without discrimination. • Empathy: Show empathy and understanding towards complainants, acknowledging their experiences and emotions. • Timeliness: Respond promptly to complaints, keeping complainants informed throughout the process. • Transparency: Maintain open communication, providing clear explanations and updates regarding the complaint's progress. • Learning and Improvement: Use complaints as an opportunity for learning, reflection, and continuous improvement.	

The ADPE advised the Committee that the number of concerns and compliments data presented to the Committee was from between October 2021 until June 2023 and noted that a significant raise had been observed.

She added that the majority of concerns and complaints were received by the department via telephone with almost 4500 being received through that method, with the second highest being via email of which 3250 had been received.

The Committee was advised that a dedicated Early Resolution Hub to support timely outcomes to complainants was established and it was noted that between 65 to 80 % of concerns were managed via that hub and that during May and June 202, 69% of all concerns were managed under Early Resolution.

The ADPE advised the Committee that personal contact was made to all complainants on receipt of concerns to agree specific questions for investigation which was recognised good practice by the Welsh Risk Pool (WRP).

The Committee was presented with the concerns received by top 10 primary subjects in the last 12 rolling months and further detail was provided on each area which included:

- Appointments
- Communication issues (including language)
- Clinical Treatment/Assessment
- Attitude and Behaviour
- Patient Care
- Test and Investigation Results
- Referrals
- Medication
- Discharge Issues
- Environment/Facilities

The ADPE advised the Committee that it was important to note what was being doing around the mitigation of concerns and presented the actions undertaken around appointment and communication concerns which included:

- Clinical Boards were adding additional clinics and theatre time where possible as well as using insourcing and outsourcing.
- In order to reduce in patient Cataract waiting times, two new vanguard theatres were installed in the car park and two cataract fellows were appointed.
- Concerns raised regarding numerous cancellations in Neurosurgery resulted in a generic email address being set up so that GPs were easily able to contact the team if there were any concerns between appointments.
- WIFI phones were purchased for the sole purpose of improving communication between patients and relatives.
- Sister Clinics were being piloted in some areas whereby one day a week there would be a dedicated clinic where relatives could book an appointment with the sister to discuss ongoing care which had reduced concerns in that area.

It was noted that another area that communication concerns had increased was around bereavement and it was noted that during COVID the concerns team made a conscious effort to phone anybody who had a bereavement through the bereavement team which had provided helpful mitigations to the concerns raised but the ADPE added that it was difficult to sustain post COVID.

The ADPE concluded that in order to raise awareness of concerns, the concerns team had recently started circulating “Learning from Event” forms with every formal concern to highlight any learning, no matter how small and noted that in some areas the concerns and learning were being summarised and shared to areas so that patient experience and learning could be shared on a wider scale.

The Committee were presented with links to Online Training available in areas which included:

- Putting Things Right
- Breach of Duty
- Learning from Events
- Duty of Candour

The Committee was advised that from 1 September 2023, the concerns team would be collating feedback from people who had used the Concerns (Complaints) Duty of Candour and Redress process to listen and improve services.

The ADPE added that as well as capturing the feedback, the teams would also collect ethnicity data which was important to help the system identify any areas of deprivation.

The Committee was presented with information around redress where it was noted that some concerns could enter the redress process which could include:

- An apology
- Remedial Treatment and/or financial compensation up to the value of £25,000

The ADPE advised the Committee that anything that did go through the redress process could be reimbursed from the Welsh Risk Pool and so over the past 15 months, £109.251.75 had been received.

She concluded that a consultation was being undertaken in October 2023 around Horizon Fixed recoverable costs and that Fixed Recoverable Costs (FRC) was a term used in the legal system to refer to a set of predetermined costs that could be recovered by the winning party from the losing party in certain types of civil cases.

It was noted that FRC aimed to streamline the process of determining legal costs by setting predefined limits on the amount that could be claimed-from April 2024 and that it could impact on the NHS redress process.

The Independent Member – University (IMU) asked if there were any benchmarks in relation to "time to resolution" of issues of concern.

The ADPE responded that the WG target was 75% of concerns to be responded to within 30 working days and that the Health Board was achieving around 79% to 83%.

Wales Cancer Patient Experience Survey

The Macmillan Lead Cancer Nurse (MLCN) presented the latest Wales Cancer Patient Experience Survey to the Committee.

It was noted that it was the third survey undertaken and was conducted by IQVIA on behalf of Macmillan Cancer Support and the Wales Cancer Network in 2021.

The MLCN advised the Committee that the survey was designed to measure and understand the patient experience of cancer care and treatment in Wales to help drive improvements both locally and nationally.

She added that thanks should be noted to all of the people who took part in the survey.

It was noted that 935 questionnaires were returned which gave a response rate of 57.9% which was slightly below the all-Wales response rate of 59.5%.

The Committee was presented with the data around the respondents which included data around:

- The tumour group
- Sex
- Age
- Ethnicity
- Sexuality

It was noted that in terms of the headline results, 92% of respondents for the Health Board rated their overall care a 7 out of 10 or more and that the Health Board were the top scoring Health Board in Wales.

The MLCN provided the Committee with the positive scores which included:

- 90% of patients said they were always treated with dignity and respect whilst in hospital

	• 94% of patients said they were always given enough privacy when being examined or treated • 93% of patients said they were given all the information required about their operation and tests • 92% of patients said that hospital staff had told them who to contact if they were worried about their condition or treatment after leaving hospital. She added that the teams should be congratulated for achieving relatively high results, but added that there were also some les positive scores which required addressing, including: • 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. • 28% of patients said that, after leaving hospital, they were given enough care and help from their GP and 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. The Committee was presented with the next steps for the Wales Cancer Patient Experience Survey and the MLCN noted that the report had been shared with the Health Board's Executive Cancer Board and the report had also been shared with the patient experience team, clinical board triumvirates and the cancer workforce. She added that to facilitate and enable service improvement to strengthen areas in which people with cancer reported fewer positive experiences, engagement would be held with clinical boards and clinicians for their contribution to the action plan and that when completed, the action plan would be presented to the Executive Cancer Board. It was noted that ongoing monitoring of progress would be by the new Person Centered Care in Cancer Board and the Cancer Stakeholder Reference Group. The MLCN concluded that as a means to capture more frequent patient experience and to measure the effectiveness of service improvement, a patient experience questionnaire had been co-produced with the specialist cancer nursing workforce and the patient experience team. She added that the questions focussed on a number of identified themes within the Wales Cancer Patient Experience Survey and that the questionnaire would be used by all site-specific teams. The IMU noted that he had an association with the University Department of Surgery for nearly forty years and could remember discussions held 20 years ago, where it was said that for a University Hospital it should be the exception that patients were not included in clinical trials and noted that there was evidence that there was still more to do to ensure that the Health Board continued to justify its University Health Board status. The EMD noted that she shared the ambition and highlighted to the Committee that a business case was being prepared for the Cardiff Cancer Research Hub specifically for the acceleration of clinical trials, early phased trials and access for patients with cancer to those therapies across South Wales. The Director of Operations for Patient Flow asked if there would be a more up to date feedback mechanism because the survey was dated for 2021/22 which was when the service was running through the Covid-19 pandemic. The MLCN responded that a number of improvements had been reported already and noted that they had worked with the Cancer Clinical Nurse Specialist workforce and taken some areas of questioning from the Wales Cancer Patient Experience Survey and placed onto the CIVICA feedback process which would provide continual service improvement. **The QSE Committee resolved that:** a) The Deep Dive into Complaints presentation was noted b) The Wales Cancer Patient Experience Survey report was noted	
QSE 23/07/009	**MBRRACE – Verbal Update** The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UH (MBRRACE) verbal update was received.	

	The EMD advised the Committee that the report referred to the Health Boards perinatal and stillbirth and neonatal mortality up to 2021. She added that further detail would be provided during the private session of the meeting and that more detail would be brought back to the public forum in the future. It was noted that the maternity services teams were working through a number of actions that had arisen over the last two years with an aim to show improvement, because the Health Board were not where it wanted to be in terms of the national basis for mortality. The EMD concluded that a matrix report would be brought back to the Committee which would outline a number of reports which would include the MBRRACE report. **The QSE Committee resolved that:** a) The MBRRACE update was noted	
QSE 23/07/010	**HIW Activity Report** The HIW Activity Report was received. The Assistant Director of Quality & Patient Safety (ADQPS) advised the Committee that she would take the paper as read and noted that since January 2023, unannounced inspections had been held on the following wards: • Pine ward – Hafan Y Coed • Ash ward – Hafan Y Coed • East 12 ward – University Hospital Llandough (UHL) • East 16 ward – UHL • B5 ward – University Hospital of Wales (UHW) • T5 – UHW • A7 – UHW She added that planned inspection had recently taken place at the University Dental Hospital. It was noted that all of the reports had been published by HIW at the time of writing the report with the exception of the T5, A7 and Dental Hospital reports. The ADQPS advised the Committee that in addition to those HIW inspections a further inspection was undertaken in maternity services on the 27th 28th and 29th March 2023 and several immediate improvements were re-issued and several further immediate assurance issues were identified. She added that a combined report that provided oversight of both inspections and the overarching improvement plan was published on 21st June 2023 and that HIW had found that staff had worked hard to provide patients with a positive experience despite the pressures on the department. It was noted that a full action plan had been developed to support the requisite improvements and internal inspection and an audit was being undertaken on a regular basis to provide assurance that those improvements were being sustained. **The QSE Committee resolved that:** a) The assurance provided by the response to HIW inspections and the actions implemented to address immediate assurance issues where identified were noted.	
QSE 23/07/011	**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 at the May 2023 meeting of the Committee it was agreed that a reporting cycle was required for risks to ensure that the Committee was able to afford sufficient time to discussing each of the risks on a regular basis to fulfil its responsibility to the Board. It was noted that the cycle enabled the Committee assurance to link more closely with the 'deep dive' approach into reporting of quality measures and in order to do so the cycle was not fixed as it would 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 IDCG advised the Committee that the inherent risk was 25 and that after controls it was still maintained at 20 which it had been for some time. **The QSE Committee resolved that:** a) The risk in relation to Patient Safety was reviewed. b) Assurance would be provided to the Board on 27th July 2023 on the management /mitigation of this risk.	
QSE 23/07/012	**Policies & Procedures:** The following policies and procedures were received: • Mental Health Clinical Risk / Risk Mitigation Management Policy (UHB 119) • Clinical Audit Policy (UHB 509) and Procedure for Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group (UHB 510) • Labelling of Specimens submitted to Medical Laboratories Policy (UHB 017) & Labelling of Specimens submitted to Medical Laboratories Procedures (UHB 452) • Nutrition and Catering Policy (UHB 221) & Procedure for Inpatients (UHB 367) The IMCE advised the Committee that the readability of the policies needed a discussion because a number of policies were clinical and had a large volume of information. She asked if a summary could be provided for Committee members on future policy documents. The EMD responded that the policies were received by the Committee for ratification and that they were published for reference. She added that summarising a policy could be challenging on top of the already large amount of work undertaken by policy authors. **The Committee resolved that:** a) The Mental Health Clinical Risk and Risk Mitigation Management Policy (UHB 119) was approved. b) The Clinical Audit Policy (UHB 509) was approved c) The Procedure for Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group (510) was approved. d) The Labelling of Specimens submitted to Medical Laboratories Policy (UHB017) and Labelling of Specimens submitted to Medical Laboratories Procedures (UHB 452) were approved. e) The Nutrition and Catering Policy for Inpatients (UHB 221) and Nutrition and Catering Procedure for Inpatients (UHB 367) were approved.	
QSE 23/07/013	**Cardiff and Vale of Glamorgan Winter Respiratory Vaccination Plan 2023/24** The Cardiff and Vale of Glamorgan Winter Respiratory Vaccination Plan 2023/24 was received. The Executive Director of Public Health (EDPH) advised the Committee that the Winter Respiratory Vaccination Plan was one part of the Health Boards armoury in being able to deal with and mitigate the challenges of winter.	

	The Consultant in Public Health Medicine (CPHM) advised the Committee that the plan would reduce morbidity and mortality and that it would also help to reduce admissions, in particular to the Intensive Care Unit (ICU). She provided the Committee with information around the previous season of 2022/23 where it was noted that the Health Board had maintained excellent levels of uptake amongst citizens aged 65 and over with over 75% vaccinated for flu and 80% vaccinated for Covid-19. It was noted that the overall uptake of flu vaccination for Health Board staff with direct patient contact was 37.9% in 2022/23, which was a decrease of 15% when compared to 2021/22 uptake and it was noted that the pattern was also observed for Covid-19 with uptake being 56.8% for Health Board staff with direct patient contact. The CPHM advised the Committee that inequities remained across the 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). She added that the Public Health team were working hard around inequities and noted that there was significant momentum behind the programme. It was noted that throughout the plan, the 6 domains of quality from the American Institute of Medicine had been included and that those consisted of: • Safety • Effectiveness • Patient-centeredness • Timeliness • Equity • Efficiency The CPHM advised the Committee that a number of stakeholders had been engaged to ensure that all of the seldom heard groups had been reached within the plan and it was noted that the communications around the Winter Respiratory Vaccination Plan 2023/24 would be really important. She concluded that there was an action plan which outlined the key strategic areas that would be covered by the Public Health team. The EDPH advised the Committee that a number of Clinical Boards had responsibilities for the population out in the community and that all Clinical Boards needed to be championing vaccine uptake for Health Board staff. **The Committee resolved that:** a) The progress to date was noted. b) The Winter Respiratory Vaccination Programme Plan 2023/24 was approved c) Leadership and support to the implementation of the Plan was provided.	
QSE 23/07/014	**Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25** The Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25 was received. The EDPH introduced the Speciality Registrar in Public Health (SRPH) and noted that alongside various teams, he had prepared the Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25 to help eliminate hepatitis (B and C) as part of the wider health protection sustainable plan in place. The SRPH presented to the Committee. It was noted that a Welsh Health Circular had been received by the Health Board in January 2023 which outlined the requirement for: • Elimination and prevention of hepatitis (B and C) by 2023 • 13 actions to be addressed for Health Boards • A Joint Recovery Plan to be provided by mid-July 2023.	

	It was noted that high risk groups had been identified from a mapping exercise which outlined a number of groups which included: • Migrants from high prevalence areas • Recipients of blood products • Recipients of tattoos/piercings from unregulated parlours or individuals • People who use drugs The SRPH advised the Board that in terms of the two viruses and their vaccine/treatment it was estimated that just under 20,000 people would require hepatitis B vaccine or treatment and just over 4000 people in Wales would require hepatitis C vaccine or treatment. He added that in March 2023 an Oversight Group was established and that the group had reviewed current structures, processes and outcomes, had identified the challenges and had produced an action plan. A number of actions from that plan were presented to the Committee and it was noted that the action plan provided 37 actions across 5 action areas for the first 2 years and formed part of the Cardiff and Vale of Glamorgan Health Protection Plan. The SRPH added that the 5 main themes included: • Infection prevention • Case Finding and Testing • Treatment • Re-engagement • Data He added that the plan had been received by the Senior Leadership Board the previous week and was now being received by the Committee to view the next steps of the plan which included: • An implementation group would take the work forward which required current services and staff within the system to incorporate additional pieces of work and additional staff and other resources from the WG health protection resource. • Working through how the Health Board could best deploy the people and resources currently in the system to support the health protection action required which included delivery of the hepatitis (B and C) plan. The CC advised the Committee that they had received further detail within the papers which could be read. **The Committee resolved that:** a) The Cardiff and Vale Eliminating Hepatitis (B and C) Joint Recovery Plan 2023-25 for submission to Welsh Government was approved.	
QSE 23/07/015	**Quality, Safety & Experience Terms of Reference** The Quality, Safety & Experience Terms of Reference were received. The EDPH advised the Committee that that small additions made to the terms of reference had enhanced them and made sure that it was clear that reporting of the relevant frameworks would go through the Committee. **The Committee resolved that:** a) The proposed amendments included in the extract of the Quality, Safety and Experience Committee Terms of Reference were reviewed. b) The amendments to the Terms of Reference were ratified c) The Committee Terms of Reference be recommended for approval to the Board on 27th July 2023.	
QSE 23/07/016	**Executive Summary of Child and Adult Practice Reviews**	

	The Executive Summary of Child and Adult Practice Reviews were received. The END advised the Committee that the Health Board undertook a child practice review as part of a multi-agency approach with Police and local authority colleagues and noted that the final reports were received by the Committee along with the recommendations from the findings of the reports. **The Committee resolved that:** a) The summary of recently published Regional Safeguarding Board Child and Adult Practice Reviews were noted.	
QSE 23/07/017	**Clinical Audit Strategy** The Clinical Audit Strategy was received. The EMD advised the Committee that she would take the paper as read and had no further information to add. **The Committee resolved that:** a) The assurance provided by the 2023-2025 clinical audit strategy was noted.	
QSE 23/07/018	**Unpaid Carers Annual Report** The Unpaid Carers Annual Report was received. The ADPE advised the Committee that it would be the last Unpaid Carers Annual Report because there were no longer transitional funds and so it would be held by the regional partnership board in future. **The Committee resolved that:** a) The Unpaid Carers Annual Report was noted	
QSE 23/07/019	**Minutes from Clinical Board QSE Sub Committees:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/07/020	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/07/021	**Agenda for Private QSE Meeting** *i) Private Minutes -* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *iii) MBRRACE Report – Verbal* *iv) Cyber Security Update*	
QSE 23/07/022	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: Tuesday, 30 August 2023 at 1pm via MS Teams.	

Action Log

Quality, Safety & Experience Committee

Update for meeting 30 August 2023
(Following the meeting held on 19 July 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
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	**COMPLETED Updated 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	**COMPLETED Updated on 18 July 2023** Agenda item 2.3
Actions in Progress					
QSE 23/05/007	**Civica "Once for Wales" platform**	To undertake a deep dive into the Civica data via Quality Indicators Report.	**29.08.2023**	Jason Roberts	**Update in August 2023** *To note that a report was received by the Board on 27/07/23*
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 23/03/008	**Looked After Children – Assessment Backlogs**	An update report to be brought back to the Committee in 3-4 months.	**29.08.2023**	Jason Roberts/Catherine Wood	**Update in August 2023**
QSE 23/03/007	**Specialist Clinical Board Assurance Report – re: South**	To update the Committee with regards to the WHSSC funding for South Wales Trauma Network review and associated actions	**26.09.2023**	Jason Roberts/Guy Blackshaw	**Update in September 2023**

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
	Wales Trauma Network				
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**
QSE 23/07/009	**MBRRACE Update**	A matrix report to be provided to the Committee to include the MBRRACE report.	**10.10.2023**	Meriel Jenney / Jason Roberts	**Update in October 2023**
QSE 23/07/014	**Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25**	An update to be provided in 12 months' time.	**July 2024**	Fiona Kinghorn	**Update in July 2024**
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					
AAC 4/7/23/013	**Regulatory Compliance Tracking Report**	Some of the Patient Safety Solutions had been on the tracker for some time and should be taken to a future Quality, Safety & Experience (QSE) Committee meeting to provide assurance.	**26.09.2023**	Aaron Fowler / Matt Phillips	**Update on 28 September 2023**
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	**26.09.2023**	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.	**26.09.2023**	Jason Roberts/Angela Hughes	**Update on 28 September 2023**

Report Title:	Stroke Performace Update				Agenda Item no.	2.2
Meeting:	Quality, Safety and Experience Committee		Public	✔	Meeting Date:	30/08//2023
			Private			
Status *(please tick one only):*	Assurance	✔	Approval		Information	
Lead Executive:	Chief Operating Officer					
Report Author (Title):	Chief Operating Officer and Stroke Service Manager					

Main Report
Background and current situation:

Background and current situation:

The purpose of this report is to brief the QSE committee on the current operational performance of the stroke service as measured against the UK Stroke Sentinel Audit Programme (SSNAP).

The attached slide deck shows where the service has improved and where there are still gaps in the service provision.

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

The latest quarterly SSNAP performance data scored the overall CAV stroke service as a **C**. Whilst this score could be considered average, there are some very low scores across the key performance indicators particularly at the front end of the pathway when interventions are time critical

- Admission to stroke unit within 4 hours – **E**
- Thrombolysis rates – **D**
- Assessment by a stroke specialist – **E**

There are some very good scores once the patients are admitted which brings the overall score up to a C.

A number of actions and improvements have been made to the stroke pathway and 3 internal stroke summits have been made and the improvements are shown in the slides.

However, additional investment is now required to further improve the overall performance and to ensure that mortality stays within the expected range. It is not going to be possible to further improve without the introduction of a new clinical model that provides a consultant delivered service 7/7 08.00 – 22.00.

A business case is being produced for consideration as part of next year's organisational priority setting.

Recommendation:

The Quality, Safety and Experience Committee is asked to **NOTE** the current stroke performance position, the improvements made so far and the next steps regarding a new clinical model.

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

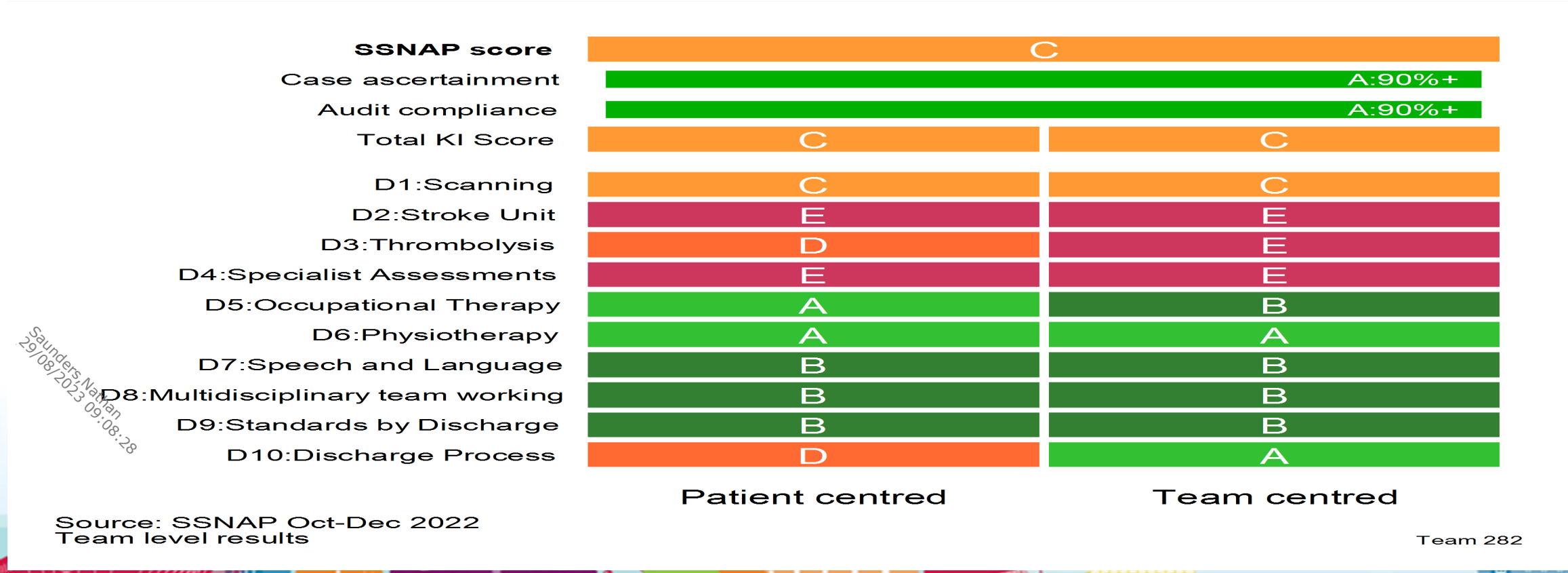
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

QSE
Stroke Performance Update

August 2023

How are we doing?

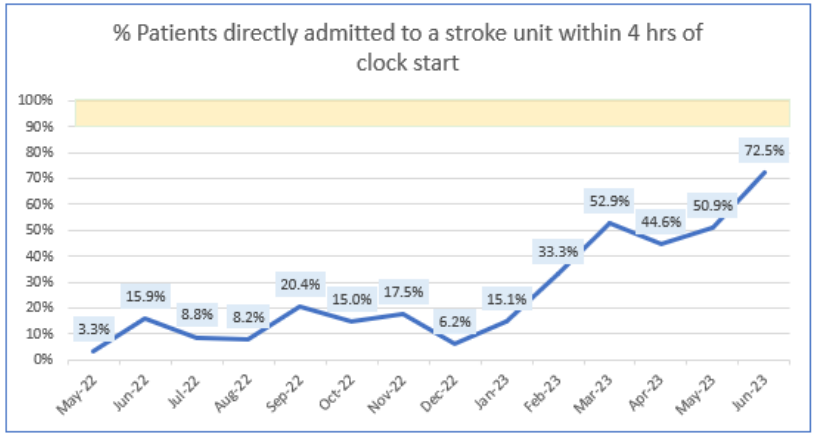
- Stroke performance is measured via UK Stroke Sentinel Audit Programme (SSNAP) on a quarterly basis
- Number of indicators reviewed and scored and an aggregate score given



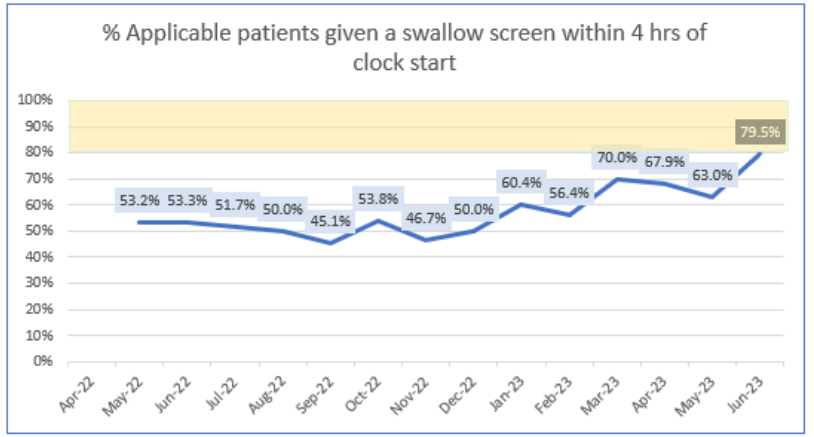
Actions to Improve

- 3 x Internal Stroke summits
  - Organisational support and focus on stroke patients pathways
  - multidisciplinary meetings bringing together medical, nursing and therapy clinicians with operational and senior leaders.
- Stroke Improvement Programme
  - Launched January 23, overseen by dedicated resource of Stroke Service Manager and Clinical Director and reporting to Medicine Clinical Board and Executive Management Team.
  - Collaborative, cross-clinical board workstreams
    - Revision of stroke imaging pathway and emergency stroke assessment pathway in ED - Addressing self-presenting patients and triage challenges, removing delays in the assessment pathway.
    - Workforce review through redesign of the optimal clinical model
    - Implementation of digital solutions supporting the emergency stroke assessment pathway and imaging interpretation

June Operational Performance

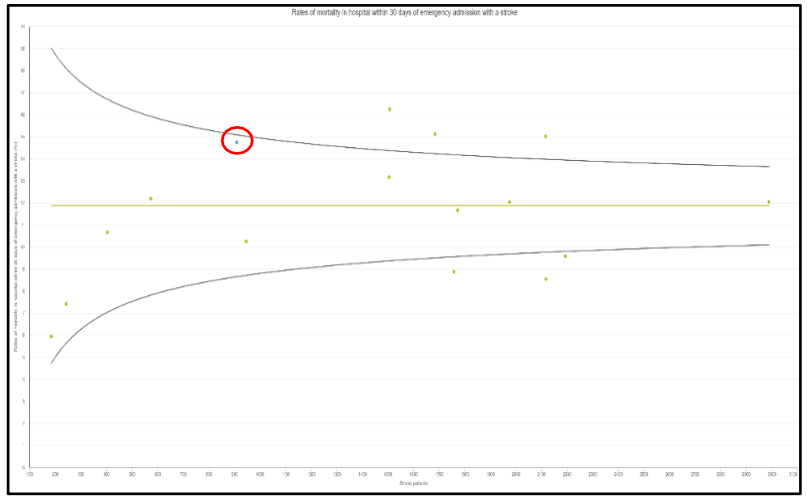


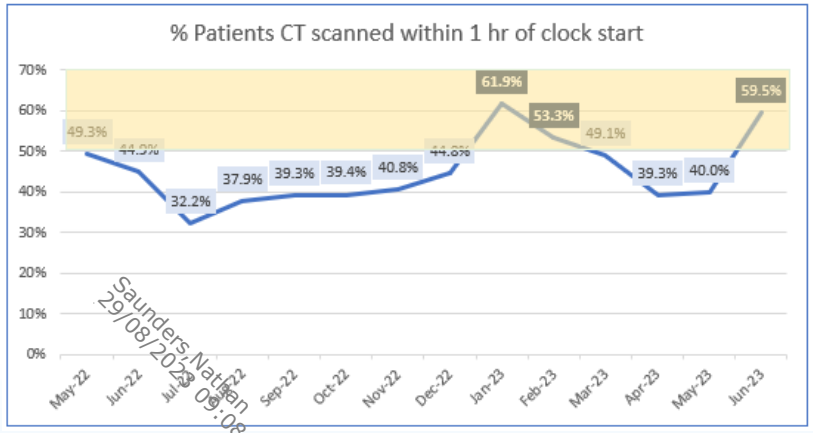
SSNAP A grade: consistent 90% admitted within 4 hours with a median time of <2hr. 90% of patients to spend 90% of their UHW stay on the stroke unit



SSNAP A grade: consistent 80% screened within 4 hours, 80% formal assessment within 72 hours

CHKS Stroke Mortality - September 21- April 23





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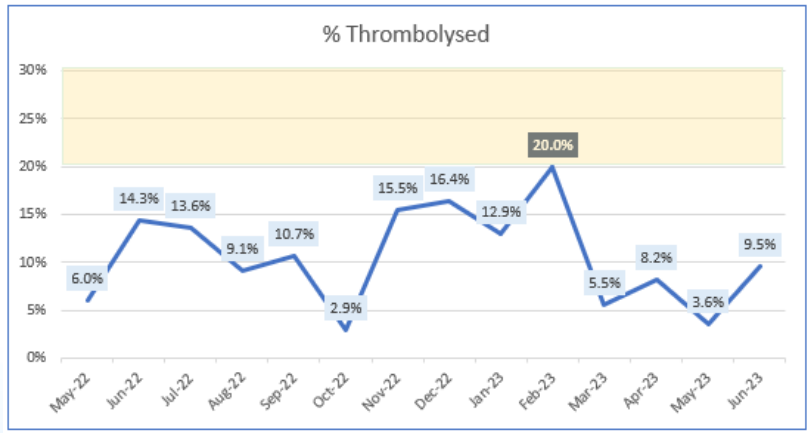
SSNAP A grade: consistent 50% scanned within 1 hour, 95% within 12 hours with a median time of <1hr



SSNAP A grade: consistent 20% thrombolysis rate, 90% of eligible patients thrombolysed. 45 minute QIM (DU) 1 hour standard (SSNAP)

Median time to scan 46 min

1 hour 28 min in May

Median door to ward time

2 hours 25 min

9 hours 30 min in December

4 hours in April and May

Challenges to Stroke Performance

- Delivery of thrombolysis treatment – treatment rates and timely administration
- Provision of senior specialist staff ensuring the optimal patient pathway is delivered consistently
- Consistent scanning within 60m
- Mortality within expected range but only just

Next Steps

- To deliver A SSNAP score requires investment c£1m
  - Business case to be produced for 24/25 consideration
- Clinical Model now agreed in principle that will enable 85% of suspected stroke patients seen by a consultant

ED

- Consultant cover 8am to 10pm 7/7 (stroke and neurology coalition)
- Middle grade doctor 24/7
- Stroke CNS support 24/7 in phased approach with opportunity to progress in ANP / MDT ACP roles

MSDEC Clinic

- Consultant led clinics for TIA and established stroke symptoms >24 hour & acute neurology hot clinic
- Junior doctor support to clinic
- Stroke CNS support to clinic

Summary

- Good progress to improve some of the key metrics
  - Ring fenced beds
  - Organisational oversight and support
  - Neurology and stroke working together
  - Clinical model agreed

- Not going to deliver ‘A’ SSNAP performance without right sizing stroke service
  - Requires additional investment
  - Will need to be considered as part of 24/25 priorities

Report Title:	Policies for Ratification			Agenda Item no.	3.1
Meeting:	Quality & Safety Committee	Public	X	Meeting Date:	10/01/2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Fiona Jenkins, Executive Director of Therapies and Healthcare Sciences. Meriel Jenney, Executive Medical Director				
Report Author (Title):	Nathan Saunders, Senior Corporate Governance Officer				

Main Report
Background and current situation:

The Following Policies and Procedures are for review:

1. Laser Risk Management Policy and Procedure (UHB 324)
2. Consent to Examination or Treatment Policy (UHB 100)

The policies and procedures 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:

Laser Risk Management Policy and Procedure (UHB 324):

No significant changes have been made to the policy and procedure. However, a verbal briefing will be provided in the Quality, Safety Committee for the policy and procedure by the Executive Director of Therapies and Health Sciences.

Consent to Examination or Treatment Policy (UHB 100):

No significant changes have been made to the policy. Links and references have been updated and slight amendments to terminology. A verbal briefing will be provided in the Quality, Safety Committee for the policy by the Executive Director of Medicine.

Recommendation:

The Committee is requested to:

Approve the following attached policies and procedure: -

(i) Laser Risk Management Policy and Procedure (UHB 324)
(ii) Consent to Examination or Treatment Policy (UHB 100)

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
None
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:

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

Reference Number: UHB 324
Version Number: 3
Date of Next Review: 01/08/2026
Previous Trust/LHB Reference Number: N/A

THE LASER RISK MANAGEMENT POLICY

Policy Statement

To ensure that the Cardiff and Vale UHB delivers its aims, objectives, responsibilities and legal requirements transparently and consistently we will manage the use of medical treatment lasers in a safe manner in order to protect the health and well being of staff working with this equipment and people who may be affected by the work.

The Cardiff and Vale UHB will ensure that risks to patients, staff and the UHB arising from the use of medical treatment laser equipment are minimised, and that UHB consistently delivers the best health and financial outcomes from the use of medical laser equipment.

Policy Commitment

The UHB will:

- Provide a robust framework for the management of medical treatment lasers to ensure that services are safe, and compliant with current legislation, standards and guidelines, in order to protect the UHB, patients, staff and members of the public.
- Ensure that managers and staff recognise their responsibility to safeguard of all persons involved with, or who may be affected by, the use of medical treatment lasers.
- Ensure that measures for the protection of all persons who may be affected by the use of medical treatment lasers on UHB premises are implemented and maintained.
- Demonstrate compliance through record keeping and audit.
- Appoint Laser Safety Advisors.
- Appoint Laser Protection Supervisors.

Supporting Procedures and Written Control Documents

This Policy and the supporting Laser Risk Management Procedure describes the following with regard to laser safety:

- Responsibilities in the management of medical treatment lasers.
- Training requirements
- Procurement and use of medical treatment lasers.
- Maintenance, repair and quality assurance of medical treatment lasers.
- Management of laser controlled areas and protection measures.
- Demonstration of compliance with regulatory requirements.

Scope

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

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed for this policy.
Health Impact Assessment	A Health Impact Assessment is not required for this policy.
Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author	*Dr Kate Bryant (Head of Non Ionising Radiation, Laser Protection Advisor), on behalf of the Radiation Protection Group*

Summary of reviews/amendments

Version Number	Date review approved	Date Published	Summary of amendments
1	28/06/2016	18/06/2016	New Policy
2	18/02/2020	03/03/2020	Updated
3	14/06/2023		Updated

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.

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

Reference Number: UHB 324
Version Number: 3
Date of Next Review: 01/08/26
Previous LHB Reference Number: N/A

THE LASER RISK MANAGEMENT PROCEDURE

Introduction and Aim

The optical radiation emitted by lasers has potentially hazardous effects on patients, equipment users and the public. Hazards from lasers will depend on the type of laser, but potential problems include eye injury, skin burns, fire or explosion and smoke inhalation.

The UHB has a Laser Risk Management Policy whose aim is to ensure that we manage the use of medical treatment lasers, to ensure the health and safety of all staff working with medical treatment lasers, and any person who may be affected by the work.

This Laser Risk Management Procedure supports the Policy and will provide a set of minimum service standards against which all Clinical Services which use medical treatment lasers will comply with, and outlines the identification of organisational and individual responsibilities.

This will ensure that risks to patients, staff and the UHB arising from the use of medical treatment laser equipment are minimised, and that the UHB consistently delivers the best health and financial outcomes from the use of medical laser equipment.

Objectives

The Laser Risk Management Procedure establishes a clear framework within which the UHB can:

- Effectively and actively manage its laser services, so as to reduce risk,
- Meet its legal obligations to comply with legislation,
- Meet its governance obligations, both clinical and financial,
- Adhere to the requirements of the relevant Health and Care Standards,
- Demonstrate that it is taking account of MHRA guidance.

The UHB will achieve these objectives by:

- Providing a framework for service managers to develop services that are safe, effective and compliant with current legislation in order to protect the UHB, the public and staff.
- Providing direction to service managers as regards to procedures, training, documentation and resources that must be in place.
- Outlining the responsibilities of staff working with medical treatment lasers.
- Ensuring that employees, contractors and others are adequately informed of the risk posed from laser use and, where appropriate, ensure they receive adequate training and supervision.
- Ensuring protection measures for all persons on Cardiff and Vale UHB premises from the associated risks of laser radiation are implemented and maintained.
- Ensuring all laser equipment is in good repair, operating correctly and safely, and regularly maintained.
- Appointing a Laser Safety Advisor(s).
- Appointing a Laser Safety Supervisor(s).
- Monitoring and reviewing the effectiveness of the laser policy and procedure and, if necessary, implement improvements.

Scope

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

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

Documents to read alongside this Procedure	Cardiff and Vale UHB Policies: • The Medical Equipment Management Policy • Decontamination of Reusable Medical Devices Policy Regulations, Guidelines and Standards: • Provision and Use of Work Equipment Regulations (PUWER), 1998 • Managing Medical Devices, Guidance for healthcare and social services organisations, MHRA, January 2021. • Lasers, intense light source systems and LEDs – guidance for the safe use in medical, surgical, dental and aesthetic practices. MHRA, Department of Health, September 2015 • The Control of Artificial Optical Radiation at Work Regulations 2010. Statutory Instruments 2010 No. 1140 • The Medical Devices Regulations 2002 • Directive 93/42/EEC on medical devices (EU MDD) • ISO 19818-1:2021 Eye and face protection — Protection against laser radiation — Part 1: Requirements and test methods • BS EN 207:2017 - TC Personal eye-protection equipment. Filters and eyeprotectors against laser radiation (laser eye-protectors) • BS EN 208:2009 Personal eye-protection. Eye-protectors for adjustment work on lasers and laser systems (laser adjustment eyeprotectors) • BS EN 60825-1:2014+A11:2021 Safety of laser products. Equipment classification and requirements • BS EN 60601-1:2006+A2:2021 Medical electrical equipment. General requirements for basic safety and essential performance • BS EN IEC 60601-2-22:2020 Medical electrical equipment. Particular requirements for basic safety and essential performance of surgical, cosmetic, therapeutic and diagnostic laser equipment • BS 5499-10:2014 Guidance for the selection and use of safety signs and fire safety notices

	• ICNIRP Guidelines on limits of exposure to laser radiation of wavelengths between 180 nm and 1,000 µm: Health Physics 105(3):271 295; 2013
Approved by	Quality, Safety and Experience Committee
Accountable Executive	Executive Director of Therapies and Health Science.
Author(s)	*Dr Kate Bryant (Head of Non Ionising Radiation, Laser Protection Advisor), on behalf of the Radiation Protection Group*

Disclaimer

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

Contents

Appendices

1 Definition of terms

Laser
For the purposes of this policy the term laser is used for any piece of equipment that emits light at wavelengths between approximately 100nanometres and 1millimetre, and which is capable of producing accessible levels of harmful optical radiation through the physical mechanism of light amplification by stimulated emission of radiation

Medical Treatment Laser
All Medical Treatment lasers covered by this policy are Class 3B or 4.

Maximum Permissible Exposure (MPE)
The Maximum Permissible Exposure (W/m^2 or J/m^2) is the maximum exposure level for the eyes or skin considered safe

Nominal Ocular Hazard Distance (NOHD)
Distance over which the laser hazard extends.

Laser Controlled Area
A designated area around an item of laser equipment where the accessible level of laser radiation is considered potentially hazardous.

LPA
Laser Protection Adviser

LPS
Laser Protection Supervisor

RPG
Radiation Protection Group

SOP(s)
Standard Operating Procedure(s)

PPE
Personal Protective Equipment

2 Use and Classification of Medical Treatment Lasers

Lasers are classified according to their potential to cause injury. This classification is summarised below. Full classification has been given by the MHRA guidance document [1].

Class 1	Inherently safe – either completely enclosed or very low power.
Class 2	Low power visible.
Class 2M	Low power. Safe for brief exposure with naked eye. Potentially hazardous when exposure occurs with magnifiers for divergent beams or binoculars for large diameter collimated beams.
Class 3R	Low power. Accidental exposure usually not hazardous, but eye injury possible for intentional intra-beam viewing.
Class 3B	Medium power. Exposure of the eye to the direct beam may cause serious eye injuries. Limited skin hazard. Viewing of reflections normally safe.
Class 4	High power. Exposure of the eye to the direct beam and close viewing of reflected beam may lead to serious eye injuries. May cause serious skin hazard. Presents a fire hazard.

All medical treatment lasers covered by this policy are Class 3B or 4. Lower class laser devices e.g. positioning lasers are not covered by this policy.

3 Duties

Responsibility for implementing the Laser Risk management policy and its supporting procedures lies with the UHB as the employer, with the Executive Director of Therapies and Health Science being the responsible officer. This responsibility is fulfilled by assigning the duties described here.

The duties of the Executive Director of Therapies and Health Science include:

- Taking overall responsibility for the management of Laser Safety on behalf of the UHB.
- Providing assurance to the UHB Board that Laser safety is managed in compliance with the UHB's policies and procedures.
- Informing the UHB about issues related to laser safety management.
- Appointing the UHB's Laser Protection Adviser(s) in writing.
- Delegating duties to other managers as appropriate.

The duties of the Clinical Board Heads of Operations and Delivery include:

- Providing assurance to the Executive Director of Therapies and Health Science that laser safety is managed in compliance with the UHB's policies and procedures.
- Reporting instances of non-compliance and other concerns to the Executive Director of Therapies and Health Science.
- Communicating and liaising with relevant Directorate Managers about issues related to laser safety.

The duties of the Chair of the UHB Radiation Protection Group (RPG) include:

- Ensure the review of relevant UHB policies and procedures at least every three years, and ensuring that they are amended and updated as necessary.
- Ensure the review of reports from the Laser Protection Adviser and taking action as necessary.
- Reporting laser safety issues to the Quality and Safety Committee as notified to the Radiation Protection Group
- Recommending relevant, as raised by the LPA, to the Chief Executive via the approved route when necessary.

The duties of the Clinical Director of each directorate include:

- Ensuring compliance with this policy, and the requirements of legislation and guidance relevant to the use of medical treatment lasers.
- Authorising Authorised Users in writing.

- Ensuring that local Standard Operating Procedures (SOPs), Local Rules and risk assessments are written to implement the requirements of this UHB procedure.
- Appointing one or more Laser Protection Supervisor (LPS).
- Ensuing sufficient and suitable personal protective equipment (PPE) is provided for all staff.
- Ensuring that all relevant members of staff including the LPS, authorised users and assisting staff are adequately trained and have the resources to comply with the SOPs and Local Rules.
- Implementing measures to monitor staff compliance with SOPs and Local Rules.
- Maintaining records of staff training.
- Liaising with, and seeking advice from the LPA.
- Making risk assessments and taking mitigating action as necessary.
- Reporting Laser safety issues to the Clinical Board Head of Operations and Delivery.
- Ensuring lasers are regularly serviced and maintained, and subject to adequate quality assurance and safety testing.
- Ensuring adequate records are kept of laser equipment, including servicing, maintenance, electrical safety and quality assurance testing.
- Delegating responsibilities to other managers where appropriate.

The duties of the Service Managers of each laser department include:

- The day-to-day delivery of safe laser services, supported by the LPS(s).

A Laser Protection Advisor (LPA) should be appointed who is knowledgeable in the evaluation of laser hazards. The role profile of the LPA is summarised in Appendix 1. The duties of the Laser Protection Advisor include:

- Advising on compliance with statutory requirements concerning the use of medical lasers.
- Reporting laser safety issues to the Radiation Protection Group.
- Identifying the Laser Controlled Area.
- Advising on the control of hazards.
- Assisting the Laser Protection Supervisor (LPS) in writing Local Rules and SOPs.
- Undertaking a risk assessment in conjunction with the LPS before the laser is brought into operation.
- Providing safety training in line with MHRA guidelines [1] for the LPS, laser operators and assistants, or identify relevant training courses for them to attend.

- Performing an annual safety audit review of all locations where laser equipment is being used.
- Reporting the annual safety audit review results and recommendations to the LPS, and RPG as necessary.
- Liaising with all appropriate LPSs, laser operators and those who assist with medical procedures involving lasers to promote the safe operation of medical lasers.
- Investigating any adverse events, including reporting the incident to the employer.
- Providing advice on equipment purchase, installation planning, and acceptance testing.

A Laser Protection Supervisor (LPS) is an individual within the directorate where the laser is used. The role profile of the LPS is summarised in Appendix 2. The duties of the Laser Protection Supervisor include:

- Understanding the nature of the hazards involved.
- Ensuring they have up to date laser safety training.
- Producing the local rules and SOPs, with assistance and advice from the LPA.
- Undertaking a risk assessment in conjunction with the LPA before the laser is brought into operation.
- LPS to review risk assessments and local rules annually, with advice from the LPA.
- Supervising the work of personnel who operate laser equipment, and those assisting with laser procedures.
- Supervising the laser equipment and controlled area.
- Ensuring all Laser operators (authorised users) and those assisting with the procedures (including trainee doctors, registrars or visiting staff) sign statements to acknowledge they have read and understood the Local Rules, and agree to abide by them.
- Ensuring that the register and signed statements of those authorised to operate and assist with the laser are kept up to date.
- Implementing and ensuring compliance with the Local Rules on a day-today basis.
- Ensuring that only authorised operators use the laser.
- Ensuring that the key for each laser is clearly labelled and is kept in safe custody in a locked key cupboard when the laser is not in use. In addition, the LPS shall ensure that the key for each laser is issued only to a registered authorised operator or assistant.
- Holding an up to date copy of safety training records of all laser operators and those assisting with laser procedures.

- Informing the LPA as soon as possible of any matters which may require the Local Rules or risk assessments to be amended.
- Informing the LPA as soon as possible of any matters which give rise to a potential hazard.
- Informing the LPA as soon as possible of any hazardous event. Verbal communications must be confirmed in writing within 48 hours and include details of the date and time of the event, the nature of the event and a list of those present.
- Seeking assistance from the Laser Protection Adviser on the safety implications of any proposed changes in operating procedure.
- Keeping an inventory of all laser / IPL / optical radiation equipment kept in their department and provide a copy to the LPA.
- Reporting any changes in equipment or environment that may affect laser safety to the LPA.
- Ensuring loan or demonstration equipment complies with, and is covered by the local rules.
- Ensuring that service engineers have followed the correct equipment handover procedures.
- Regularly checking the condition of laser PPE, including protective eyewear (Laser goggles), documenting the check, and taking any action as necessary.
- Regularly checking the condition of warning signs, and equipment such as protective blinds and screens on a regular basis), documenting the check, and taking any action as necessary.
- Liaising with the LPA during LPA safety audits, and acting on any recommendations.

Authorised users are individuals authorised in writing by the clinical director, and named within the local rules, who operates the laser. The duties of Authorised users include:

- The safety of all persons present, including the patient, visitors and themselves, during the operation of the laser.
- Using all personal protective equipment that has been provided.
- Reading, understanding and signing the Local Rules.
- Understanding the nature of the hazards involved.
- Ensuring that all staff present have been adequately instructed about laser hazards.
- Complying with local rules, SOPs, legislation and guidelines.
- Using the laser safely.
- Only using the laser for specific purposes authorised by the Cardiff and Vale UHB, in which they have been trained, in line with the SOPs.

- Using the laser only in compliance with the manufacturer's operating instructions.
- Ensuring they have up to date laser equipment training, including safety training, how to operate the equipment, and how the controls effect treatments.
- Keeping records of all training.
- Ensuring a record of each laser treatment is kept.

The duties of all staff assisting with, or present during laser procedures include:

- Attending laser safety training.
- Attending training in the use of any laser equipment they may use.
- Reading, understanding and signing the Local Rules.
- Understanding the nature of the hazard involved.
- Complying with local rules, SOPs, legislation and guidelines.
- Using all personal protective equipment that has been provided.
- Following instructions from the LPS and authorised user w.r.t laser safety.

The duties of the Director of Medical Physics and Clinical Engineering include:

- The provision of the Laser Protection Advice Service.
- Recommending suitable member(s) of staff to the Executive Director of Therapies and Health Science for appointment as LPA to the UHB.
- The provision of electrical safety testing of medical lasers by suitably trained Medical Physics staff.
- Delegating duties to other managers as appropriate.

4 General arrangements for the management of Laser Safety

4.1 Laser Controlled Areas

The Nominal Ocular Hazard Distance (NOHD) is the distance over which the laser hazard extends. A potential hazard exists where there is a possibility that the Maximum Permissible Exposure (MPE) levels might be exceeded.

Any areas where this possibility exists shall be designated a Laser Controlled Area. The advice of the LPA shall be sought on the designation of areas.

All persons entering a Laser Controlled Area must be controlled under Local Rules. All entry points to the laser controlled area must be appropriately and adequately signed, and access restricted when the laser is in use.

4.2 Risk Assessment

For each activity involving a medical laser a suitable and sufficient risk assessment shall be carried out before first use, and subject to regular review.

4.3 Local Rules

Local Rules shall be issued for each locality where Class 3B or Class 4 medical lasers are to be used. The Local Rules shall be designed to prevent the unauthorised operation of the laser and to control the conditions under which they are used, to minimise the risk to patients, staff and any other persons.

The LPS is responsible for writing the local rules, with assistance from the LPA. Guidance for content of the local rules is given in the MHRA 2015 guidance document [1].

The Local Rules must be read and signed by all laser operators and assistants.

4.4 Laser Protection Supervisors

A Laser Protection Supervisor (LPS) shall be appointed for each locality where Class 3B or Class 4 medical lasers are to be used. The LPS must be appropriately trained and is responsible for ensuring compliance with the Local Rules. The LPS shall be named in the Local Rules. The advice of the LPA shall be sought on the appointment of a LPS and their training requirements.

The LPS is not responsible for the safe operation of the laser equipment – this lies with the operator. The role profile of the LPS is summarised in Appendix 2.

4.5 Clinical Protocols

All work involving medical lasers shall be carried out in accordance with written protocols and standard operating procedures.

4.6 Register of Authorised Operators and Assistants

For each Class 3B, and Class 4 medical laser, a register shall be kept of:
(a) persons authorised to operate that specific laser
(b) persons authorised to assist in the use of that laser

Operators and assistants must be appropriately trained and sign to indicate that they have read and understood the Local Rules and they agree to abide by them. The register and signed statements shall be appended to the Local Rules and the completed document kept by the LPS.

4.7 Personal Protective Equipment (PPE)

All personnel in the Laser Controlled Area shall wear protective eyewear of an approved type and appropriate for the laser in use. For certain medical lasers, the operator may be provided with adequate eye protection by means of a suitable viewing device in which case additional protective eyewear may not be necessary.

4.8 Laser Security Key Protocol

Class 3B and Class 4 medical lasers must incorporate a key-operated master control. The key must be removed by an authorised operator or assistant whenever the laser is unattended. The key must be kept in safe custody by the LPS in a locked cupboard.

A log shall be kept by the LPS of authorised operator /assistants to whom the key can be issued with the date and time of issue and return.

4.9 Adverse Incidents

All adverse incidents including near misses shall be reported and investigated in accordance with the Health Board Incident Reporting and Investigation Procedure.

5 Equipment Management

5.1 Purchase of New or Replaced Equipment

The Health Board policy on the Management of Medical Equipment applies to the purchase of this type of equipment and must be followed.

Prior to the purchase of new or replacement medical laser equipment, the prospective purchaser shall consult with the LPA and LPS to gain advice on matters including the following:

- Equipment safety and suitability
- The proposed location of the equipment
- The necessary amendments to the Local Rules
- The requirements for additional training of professional users and assistants
- The provision of commissioning tests
- The provision of regular maintenance, output testing and safety testing

5.2 Equipment Maintenance, Repair and Quality Assurance (QA)

All medical laser equipment shall be kept in good repair and regularly maintained and safety tested, including electrical safety testing, by authorised personnel, technically competent in the field of work. Arrangements for repair, maintenance and safety testing shall be made in consultation with the LPA.

Procedures and schedule for QA tests shall be established at the time of commissioning, and this information specified in the Local Rules.

All Class 3B and Class 4 medical lasers equipment shall be regularly tested to monitor power/energy output and alignment of main beam and aiming system. All quality assurance and safety tests must be carried out by an authorised person technically competent in the field of work.

5.3 Equipment on Loan, Trial or Hire

Any medical laser equipment received on loan, trial or hire must be assessed for safety before clinical use and the appropriate indemnity

arrangements put in place. All loan, hire or trial lasers must comply with this procedure, and be covered by the local rules, and risk assessments.

5.4 Equipment Modification

Modification, maintenance or repair of medical laser equipment other than by the manufacturer or his appointed agent is not permitted.

Modification of any medical laser equipment should not be carried out, unless by the manufacturer or his appointed agent. If these modifications affect its performance the laser must be examined and, if necessary, reclassified before use. Adequate notification of such modifications must be given to the LPA.

Modification of equipment other than by the manufacturer or his appointed agent will transfer the manufacturer's liability to the person carrying out the modification. The Health Boards insurers (the Welsh Risk Pool) will only provide cover for modifications carried out by the Health Board if a full risk assessment has been carried out.

5.5 Infection Control and Decontamination

There is a risk of cross infection from laser equipment that comes into contact with many staff and patients. All laser equipment, including, laser beam applicators and manipulators, and auxiliary equipment must be cleaned and decontaminated according to the UHB's Infection control and reusable medical equipment decontamination policies.

6 Resources

In order for this policy to be implemented the following resources will be required:

- Applications training provided by the manufacturer or laser supplier is to be included in purchase arrangements for new Lasers.
- Regular Maintenance and servicing arrangements are to be included in purchase arrangements for new Lasers.
- The appointment of local LPS will impact upon their existing role within respective departments if they are to discharge their duties effectively and therefore arrangements must be put in place.
- Appointment of a LPA.
- Procurement of sufficient PPE and engineering controls

7 Training Requirements

7.1 Equipment Based Training

The manufacturer or laser supplier should provide equipment based training at the time of installation.

Further equipment based training may be provided by the LPS, manufacturer/supplier or another designated trainer.

7.2 Safety Training

The LPA should have received advanced, documented training.

All laser operators and those assisting with laser procedures, should attend a 'Core of Knowledge' course as outlined in the MHRA guidance [1], and reattend a Core of Knowledge Course or receive update training every 5 years. The LPS will require additional training as advised by the LPA.

Training will be documented and records held by the LPS. The training will form part of the individual's Knowledge and Skills profile and will be reflected in the individual's personal development plan.

Laser Safety Awareness training may be provided by the LPA, or the LPA should identify relevant training courses.
.

7.3 Procedural Training

- Procedural based training may be provided by the laser manufacturer/supplier.
- The clinician who oversees the procedures may provide the clinical based training to specific staff.

8 Review

The effectiveness of this policy will be reviewed post implementation. The indicators used to monitor the effectiveness of this policy are:

- LPA inspection visits and audits

- Reported incidents involving laser use
- Reports of inspections by HSE.

This policy will be reviewed every three years in collaboration with the RPG. The policy will also be reviewed when there is a significant change in relevant legislation or national guidance for the use on Medical Lasers.

9 Further Information

9.1 Legislation

The legislation controlling the use of medical lasers includes:

- The Health and Safety at Work etc. Act 1974
- The Electricity at Work Regulations 1989
- The Management of Health and Safety at Work Regulations 1999
- The Personal Protective Equipment Regulations 1992 (2002)
- The Provision and User of Work Equipment Regulations 1998
- The Workplace (Health, safety and Welfare) Regulations 1992
- The Control of Artificial Optical Radiation at work Regulations 2010
- The Health and Safety (Safety Signs and Signals) Regulations 1996

9.2 Guidance and standards

Guidance and standards for Safety is given by:

- Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices. MHRA September 2015
- The Control of Artificial Optical Radiation at Work Regulations 2010, 2010 No. 1140
- BS EN 207:2017 - TC Personal eye-protection equipment. Filters and eyeprotectors against laser radiation (laser eye-protectors)
- BS EN 208:2009 Personal eye-protection. Eye-protectors for adjustment work on lasers and laser systems (laser adjustment eyeprotectors)
- BS EN 60825-1:2014+A11:2021 Safety of laser products. Equipment classification and requirements
- BS EN 60601-1:2006+A2:2021 Medical electrical equipment. General requirements for basic safety and essential performance

- BS EN IEC 60601-2-22:2020 Medical electrical equipment. Particular requirements for basic safety and essential performance of surgical, cosmetic, therapeutic and diagnostic laser equipment
- BS 5499-10:2014 Guidance for the selection and use of safety signs and fire safety notices
- ICNIRP Guidelines on limits of exposure to laser radiation of wavelengths between 180 nm and 1,000 µm: Health Physics 105(3):271–295; 2013

10 References

[1] Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices. MHRA September 2015.

Appendix 1

Role profile for Laser Protection Advisor (LPA)

- HCPC Registered Clinical Scientist (Medical Physics)
- Ideally Certificated LPA (RPA 2000)
- Highly knowledgeable and competent on laser safety (documented training)
- Appointed in writing by the Chief Executive / Employer.

Appendix 2

Role profile for Laser Protection Supervisor (LPS)

A Laser Protection Supervisor (LPS) is an individual within the directorate where the laser is used who is responsible for implementing the Local Rules and ensuring that they are adhered to on a day-to-day basis. The duties and responsibilities of the LPS include the following.

1. The LPS should be knowledgeable in laser safety, and maintain up to date, documented laser safety training.
2. Producing the local rules and SOPs, with assistance and advice from the LPA.

3. Undertaking a risk assessment in conjunction with the LPA before the laser is brought into operation.
4. LPS to review risk assessments and local rules annually, with advice from the LPA.
5. To ensure compliance with the Local Rules.
6. To inform the Laser Protection Adviser (LPA) as soon as possible of any matters which may require the Local Rules to be amended.
7. To ensure that the register and signed statements of those authorised to assist with and operate the laser are kept up to date.
8. To ensure that the key for each laser is clearly labelled and is kept in safe custody in a locked key cupboard when the laser is not in use. In addition, the LPS shall ensure that the key for each laser is issued only to a registered operator or assistant.
9. To ensure that only authorised operators use the laser.
10. To bring to the attention of the LPA as soon as possible any matters which give rise to a potential hazard.
11. To inform the LPA as soon as possible of any hazardous event. Verbal communications must be confirmed in writing within 48 hours and include details of the date and time of the event, the nature of the event and a list of those present.
12. To seek assistance from the Laser Protection Adviser on the safety implications of any proposed changes in operating procedure.
13. The LPS should regularly check the condition of laser PPE, including protective eyewear (Laser goggles).
14. The LPS should check the condition of warning signs, protective blinds and screens on a regular basis.
15. Liaise with the LPA during laser inspections or audits, and act upon any recommendations.

Section A: Assessment	
Name of Policy	**THE LASER RISK MANAGEMENT PROCEDURE**
Person/persons conducting this assessment with Contact Details	Kate Bryant Head of Non-Ionising Radiation Kate.bryant@wales.nhs.uk
Date	14/03/2023

1. The Policy
Is this a new or existing policy? *Existing*
What is the purpose of the policy? To ensure that the Cardiff and Vale UHB delivers its aims, objectives, responsibilities and legal requirements transparently and consistently to manage the use of medical treatment lasers in a safe manner in order to protect the health and well being of staff working with this equipment and people who may be affected by the work. To ensure that risks to patients, staff and the UHB arising from the use of medical treatment laser equipment are minimised, and that UHB consistently delivers the best health and financial outcomes from the use of medical laser equipment.

How do the aims of the policy fit in with corporate priorities? i.e. Corporate Plan

This policy fits with the priorities of the integrated medium term plan by 1) managing risks across the UHB (section 11.1) and providing a framework for patient clinical safety and service quality (section 7). It also manages the health and safety of patients, visitors and staff and also ensures regulatory compliance and conformance to health and care standards.

Who will benefit from the policy?

Patients, carers, visitors and staff.

What outcomes are wanted from this policy?

The desired outcome from the implementation of this policy are:

- A robust framework for the management of medical treatment lasers to ensure that services are safe, and compliant with current legislation, standards and guidelines, in order to protect the UHB, patients, staff and members of the public.
- Ensuring that managers and staff recognise their responsibility to safeguard of all persons involved with, or who may be affected by, the use of medical treatment lasers.
- Ensuring that measures for the protection of all persons who may be affected by the use of medical treatment lasers on UHB premises are implemented and maintained.
- Demonstrating compliance through record keeping and audit.

Are there any factors that might prevent outcomes being achieved? (e.g. Training/practice/culture/human or financial resources)

Standardisation of practices may be difficult to achieve as user preference and clinical autonomy are frequently barriers to change. This risk management strategy will be overseen by the Radiation Protection Group. Further spread of managed service contracts will also be encouraged for laser equipment.

The appointment of local laser protection Supervisor (LPS) may impact upon their existing role within respective departments if they are to discharge their duties effectively and therefore arrangements must be put in place.

Financial resources may be needed to ensure regular maintenance and servicing arrangements are in place for laser equipment and that local training and competence frameworks are robust and fit for purpose.

Financial resources may also be needed to ensure sufficient personal protective equipment (PPE) is available to users, and to ensure Regular Maintenance and servicing arrangements are in place for Laser equipment.

Additional training may be needed for laser users or assistants who are not up to date with the Core of knowledge, safety or equipment training requirements.

2. Data Collection

What qualitative data do you have about the policy relating to equalities groups (e.g. monitoring data on proportions of service users compared to proportions in the population)?
What quantitative data do you have on the different groups (e.g. findings from discussion groups, information from comparator authorities)?
Please indicate the source of the data gathered? (e.g. Concerns/Service/Department/Team/Other)
What gaps in data have you identified? (Please put actions to address this in your action plan?)

Please be advised that all the below lists and links are not an exhaustive list of the available evidence and information but provides an indicative summary of the evidence and information applicable to this policy.

Laser safety is a requirement for the safe and effective provision of healthcare no matter what the healthcare setting. The standards established in the policy mirror national best practice guidance and are equally applicable to all patient groups including those patients, carers or service users with a protected characteristic. It is believed that the impact of the implementation of this policy will be overwhelmingly positive. It improves standards and overall quality of service provision for all patients, carers, services users and staff and will not be discriminatory in anyway. It requires that all adult and paediatric diagnostic services are delivered to the same high standard, and to include consistent practice for services assuring parity of service provision regardless of gender.

3. Impact
Please answer the following Consider the information gathered in section 2 above of this assessment form, comparing monitoring information with census data as appropriate (see www.ons.gov.uk Office National Statistics website) and considering any other earlier research or consultation. You should also look at the guidance in Appendix 1 with regard to the protected characteristics **stating the impact and giving the key reasons for your decision.**
Do you think that the policy impacts on people because of their age? (This includes children and young people up to 18 and older people) No
Do you think that the policy impacts on people because of their caring responsibilities? No

Do you think that the policy impacts on people because of their disability? (This includes Visual impairment, hearing impairment, physically disabled, Learning disability, some mental health issues, HIV positive, multiple sclerosis, cancer, diabetes and epilepsy). No
Do you think that the policy impacts on people because of Gender reassignment? (This includes Trans transgender and transvestites) No
Do you think that the policy impacts on people because of their being married or in a civil partnership? No
Do you think that the policy impacts on people because of their being pregnant or just having had a baby? Positively impacts as it assures consistent high quality services compliant with contemporary guidance across all UHB services including Obstetrics and Gynaecology services.
Do you think that the policy impacts on people because of their race? (This includes colour, nationality and citizenship or ethnic or national origin such as Gypsy and Traveller Communities.) No
Do you think that the policy impacts on people because of their religion, belief or non-belief? (Religious groups cover a wide range of groupings the most of which are Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs. Consider these categories individually and collectively when considering impacts) No

Do you think that the policy impacts on men and woman in different ways? No all services will be covered by the same standards.
Do you think that the policy impacts on people because of their sexual orientation? (This includes Gay men, heterosexuals, lesbians and bisexuals) No
Do you think that the policy impacts on people because of their Welsh language? No

4. Summary.
Which equality groups have positive or negative impacts been identified for (i.e. differential impact). Is the policy directly or indirectly discriminatory under the equalities legislation? If the policy is indirectly discriminatory can it be justified under the relevant legislation?
It is believed that the impact of this policy will be overwhelmingly positive for all patients, carers, service users, visitors or staff who provide or receive treatment from services which use laser technologies to care for people or to keep people well.

The revised policy is more inclusive of all care setting and sectors and establishes common standards of care which are seamless for patients across every care pathway where laser technologies are deployed. No negative impact identified.

Section B: Action
5. Please complete your action plan below. Issues you are likely to need to address include •What **consultation** needs to take place with equality groups (bearing in mind any relevant consultation already done and any planned corporate consultation activities?) • What **monitoring**/evaluation will be required to further assess the impact of any changes on equality target groups?

Equalities Impact Assessment Implementation Mitigation/Action Plan

Issue to be addressed	Responsible Officer	Action Required	Timescale for completion	Action Taken	Comments

6. Report, publication and Review **Please record details of the report or file note which records the outcome of the EQIA together with any actions / recommendations being pursued (date, type of report etc)**
Please record details of where and when EQIA results will be published The EQIA will be published on the Cardiff and Vale UHB's intranet site alongside the Laser Risk Management Policy and Procedure.
Please record below when the EQIA will be subject to review. The EQIA will be reviewed in parallel with the Laser Risk Management Policy and Procedure.

Name of person completing	Kate Bryant Non-Ionising Lead
Signed	
Date	14/03/2023

Name of Responsible Executive/Clinical Board Director Authorising Assessment and Action Plan for publication	Fiona Jenkins, Executive Director of Therapies and Health Science.
Signed	
Date	

Executive Summary

The purpose of the Laser Risk Management Procedure is to ensure that Cardiff and Vale UHB provides uniform, laser services which consistently meet as a minimum all national evidence based standards. The Laser Risk Management Procedure will provide a set of minimum service standards to which all Clinical Services which use medical lasers will comply. This will ensure that risks to patients, staff and the UHB arising from the use of laser equipment are minimised and that UHB consistently delivers the best health and financial outcomes from the use of laser equipment.

Background

The procedure was commissioned by the Radiation protection Group to as part of an overarching governance framework to provide consistent standards against which an assessment of service quality and safety could be made in order to provide assurance to the Executive Board.

The scope of the EQIA

The procedure covers the use of laser technologies in all care settings and for all patients, service users, carers, visitors and staff who may be affected by the use of laser devices.

Key findings

It is believed that the impact of this policy will be overwhelmingly positive for all patients, carers, service users, visitors or staff who provide or receive treatment from services which use laser technologies to care for people or to keep people well.

Recommendations

That the procedures have no adverse impact on patients, carers, service users, visitors or staff who have a protected characteristic and the procedure should therefore be adopted immediately.

Reference Number: **Version Number:** 4	**Date of Next Review:** *September 2026* **Previous Trust/LHB Reference Number:** T37

CONSENT TO EXAMINATION OR TREATMENT POLICY

Policy Statement

To ensure that Cardiff and Vale University Health Board (the UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will

- Formally ratify this model All-Wales Policy
- Ensure that all clinicians are made aware of this policy
- Ensure that clinicians are aware of the support and advice they can access in the UHB
- Ensure that consent training is available to clinicians

We recognise that to undertake assessment, imaging, examination, investigation, treatment, care or research without consent, or outwith statute law, could amount to a criminal offence and/or lead to a civil claim (such as for trespass to the person/ negligence).

Policy Commitment

We are committed to ensuring that the legal framework that governs the provision of treatment and care to patients is understood and adhered to by our staff.

We support staff in this by

- Publishing this policy and keeping it updated
- Providing intranet pages containing useful information on consent and capacity issues
- Providing training for staff on consent and capacity
- Providing support to staff with queries on consent and capacity issues

Supporting Procedures and Written Control Documents

This policy and the supporting procedures describe the following with regard to consent

- The legal framework which governs the provision of treatment and care to patients

Other supporting documents are:

- Consent to Examination or Treatment Under the Mental Health Act 1983 (UHB 491)
- Independent Mental Capacity Advocacy Procedure (Mental Capacity Act 2005), UHB 186

- Lasting Power of Attorney and Court Appointed Deputy Procedure (Mental Capacity Act 2005) UHB 113
- Mental Capacity Act 2005 Code of Practice
- Research Consent and Capacity: Standard Operating Procedure, UHB 147
- *Accessing Legal Advice Procedure UHB 469*

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 this found there to be a positive impact. Key actions have been identified and these can be found in the EHIA.

Policy Approved by	
Group with authority to approve procedures written to explain how this policy will be implemented	
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	Approved by Quality and Safety Committee 21/02/2012		Revised document
1.1	Quality, Safety and Experience Committee 21/05/2015		Front page amended to confirm that policy is still current whilst review is underway.
2	Quality Safety and Experience Committee 23/02/2016	28/04/2016	7.2 Availability of forms 8.6 Parental Responsibility 9.3 Inclusion of *Montgomery* 19.3 Transition period

			Titles, organisations and bodies updated where necessary Weblinks amended where appropriate
3		17/12/2019	Revised All-Wales Model Policy for Consent to Examination or Treatment
4	Quality, Safety and Experience Committee 30/08/2023	tbc	Updated links, references and amendments to terminology

CONTENTS

Appendix A **Link to current consent forms in use in the UHB**

Appendix B **Useful contact/link details**

Appendix C **How to obtain legal advice**

Appendix D **Assessing *Gillick* competence in under 16s**

Appendix E **About the consent form: information for patients**

Glossary

ADRT	**Advance Decision to Refuse Treatment**
BMA	**British Medical Association**
BNF	**British National Formulary (Supplementary guidance only)**
CAD	**Court Appointed Deputy**
CANH	**Clinically Assisted Nutrition and Hydration**
CoP	**Court of Protection**
DBD	**Donation after brainstem death**
DCD	**Donation after circulatory death**
DNA	**Deoxyribonucleic Acid**
DNACPR	**Do Not Attempt Cardiopulmonary Resuscitation**
ECT	**Electroconvulsive Therapy**
EPO	**Emergency Protection Order**
GMC	**General Medical Council**
HFEA 1990	**Human Fertilisation and Embryology Act 1990**
HFEA	**Human Fertilisation and Embryology Authority**
HIW	**Healthcare Inspectorate Wales (Supplementary guidance only)**
HRA	**Human Rights Act 1998**
HTA 2004	**Human Tissue Act 2004**
HTA	**Human Tissue Authority**
HTA 2013	**Human Transplantation (Wales) Act 2013**
IMCA	**Independent Mental Capacity Advocate**

ICSI	**Intracytoplasmic sperm injection**
IVF	**In vitro fertilisation**
LPA	**Lasting Power of Attorney**
MCA	**Mental Capacity Act 2005**
MHA	**Mental Health Act 1983**
MCS	**Minimally Conscious State**
Montgomery	**Montgomery v Lanarkshire NHS Health Board**
OPG	**Office of the Public Guardian**
PPO	**Police Protection Order**
PDOC	**Prolonged Disorder of Consciousness**
PVS	**Persistent Vegetative State**
WHC	**Welsh Health Circular**

Executive summary

What is consent?

- Consent is a patient's ongoing agreement to treatment or care
- It is a process – not a one-off event
- For consent to be valid –
    - the patient must have the mental capacity to make the relevant decision about their treatment or care
    - consent must be given voluntarily
    - he or she must be properly informed about the proposed intervention
- Compliance, where a patient is not able to make an informed decision, is not "consent"

What information should be provided?

- Patients must be provided with all the information they require, in a format and language they can understand, so that they can make an informed decision about what treatment, if any, they want to receive. The following should be discussed with the patient:
    - All reasonable treatment options
    - All of the intended benefits and material risks, including the risks/benefits of doing nothing
    - Any requirement to take and retain tissue samples, photographs etc
    - The presence of any trainees or students
    - The use of any experimental techniques
    - Any requests for further information or clarification should be met
    - Outside an emergency setting, patients should be given adequate time to consider all of the relevant information

What is a material risk?

The test of materiality is whether, in the circumstances of the particular case:

- a reasonable person in the patient's position would be likely to attach significance to the risk; or
- the clinician is, or should be, reasonably aware that the particular patient would be likely to attach significance to it

What are the exceptions to the duty to disclose all relevant information?

- Where the patient has made it clear that they do not want to know the risks involved; or
- Where treatment is required urgently, but the patient is unconscious or unable to make the decision for any reason (treatment is provided on the grounds of necessity); or
- Where advising the patient of the risks would be seriously detrimental to their health (this 'therapeutic exception' is limited and should not be abused)

When do healthcare professionals need to obtain consent?

- Before any kind of treatment or care is provided, if the patient has capacity to consent

Who is the right person to seek consent?

- The healthcare professional providing the intervention
- Seeking consent can be delegated to an appropriately trained colleague
- If you have been asked to obtain consent but don't feel competent to do so, you must refuse

How does a patient give consent?

- Consent is given through an ongoing dialogue between the patient and healthcare professional
- Consent will normally be given verbally or in writing, but consent may also be implied in certain circumstances (be very cautious about relying on implied consent)
- The consent form is a record of the patient's decision, along with the record of any related discussions in a patient's medical or nursing notes
- A signature on a consent form does not prove that valid consent has been obtained
- This consent policy explains when you should obtain written consent

Can children (aged under 16 years) give consent for themselves?

- Children under 16 years who are *Gillick* competent can give consent
- Where a child is not *Gillick* competent, someone with parental responsibility must give consent on their behalf, unless the situation is an emergency and they cannot be contacted
- If a competent child consents to treatment, a parent **cannot** over-ride that consent
- If a competent child refuses necessary treatment, legal advice should be sought

- Not all parents have parental responsibility for their children (e.g. unmarried fathers do not automatically have such responsibility)
- If you doubt whether a person has parental responsibility for a child, you must check

What about patients (aged 16 years and over) who lack capacity to give consent?

- Patients (aged 16 years and over) are presumed to have mental capacity unless demonstrated otherwise. A patient lacks capacity to make a specific decision if:

    - They have an impairment or disturbance that affects the way their mind or brain works; and
    - That impairment or disturbance causes them to be unable to make a specific decision at the time it needs to be made

- An assessment of a patient's capacity must be based upon their ability to make a specific decision at the time it needs to be made. A patient with an "impairment or disturbance" is unable to make a decision if they cannot do one or more of the following:

    - **Understand** the information relevant to the decision
    - **Retain** the information long enough to make a decision
    - **Use or weigh up** the information as part of a decision-making process
    - **Communicate the decision** – this could be by talking or using sign language and includes simple muscle movements such as blinking or squeezing a hand

  A patient is not to be treated as unable to make a decision unless all practicable steps to help the patient do so have been taken without success. A patient can only be said to be unable to communicate when all forms of communication have been explored.

- A person who has authority under a Health and Welfare Lasting Power of Attorney (LPA) or a Court Appointed Deputy (CAD) with appropriate authority can give consent when the patient lacks capacity

- In the absence of a person with authority under a Health and Welfare LPA or CAD, or a valid and applicable advance decision to refuse treatment, you must determine the patient's best interests in accordance with Mental Capacity Act 2005 (MCA)

- 'Best interests' includes past and present wishes, feelings, beliefs and values of the patient lacking capacity and any other factors which they

would take into account if they were able to do so. (It is not the same as "medical best interests").

- You must, where practical and reasonable, consult people who care for, or have an interest in the welfare of the patient, about the patient's wishes and beliefs

- Where there is nobody with whom you can consult, apart from paid staff, an Independent Mental Capacity Advocate (IMCA) **MUST** be instructed where decisions are needed about serious medical treatment (including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders). The only exception to this duty occurs when an urgent decision is required e.g. to save the patient's life. IMCAs will not make a decision for the patient, but healthcare professionals have a legal duty to consider their views.

What about refusal of treatment?

- Adults with capacity are entitled to refuse treatment or withdraw consent for any reason, at any time, no matter how unwise this may seem. The exception is where the treatment is for mental disorder and the patient is detained under the Mental Health Act 1983 (MHA)

- A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to the health of the foetus. If a woman in labour refuses treatment seek urgent legal advice

- If an *un-sedated* patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately and the event recorded in the notes

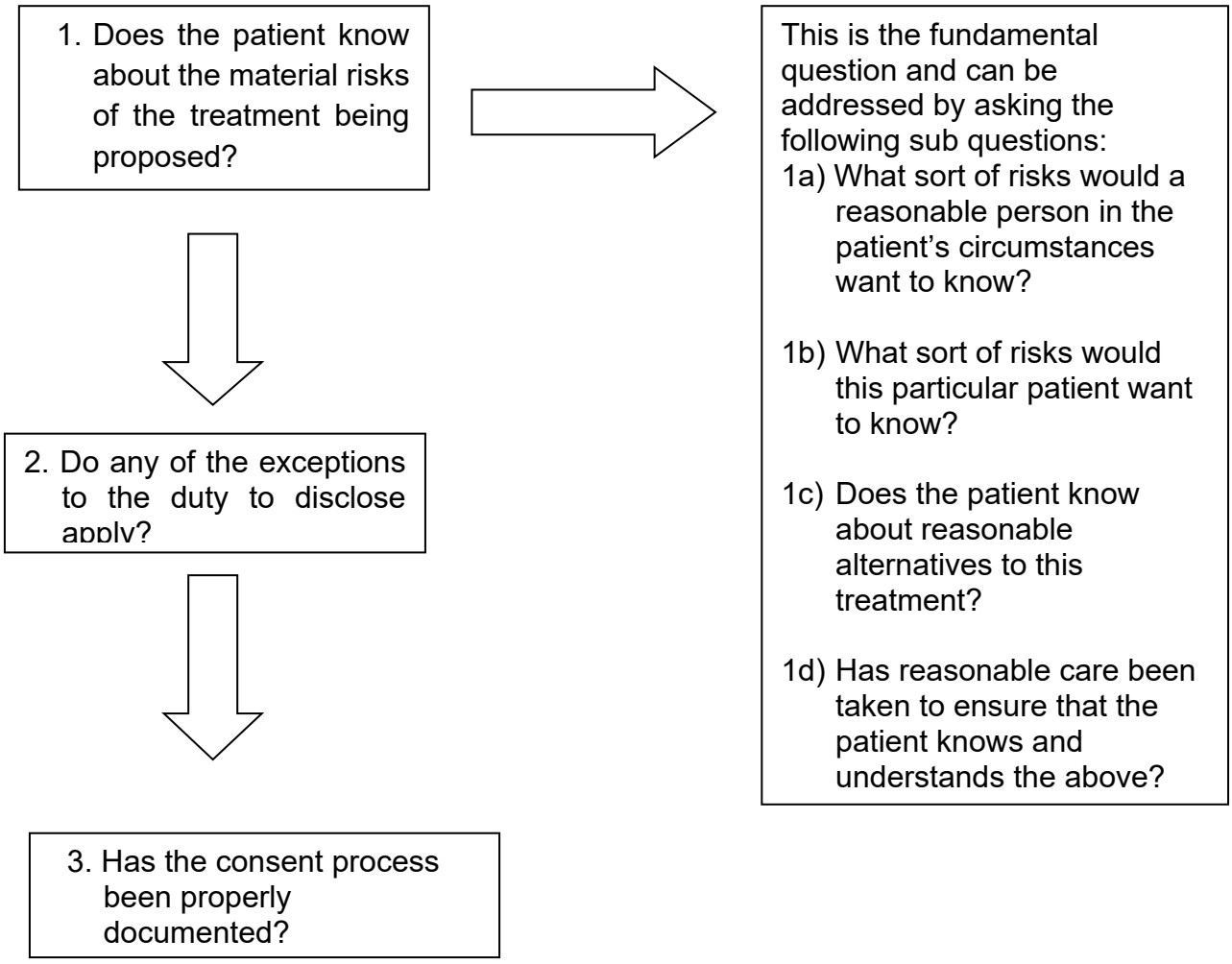
- If a patient lacks capacity but has clearly indicated in the past, while competent, that they would refuse treatment in specified circumstances (an advance decision), and those circumstances arise, you must abide by that decision if it is **valid** and **applicable**

- Advance decisions (made by patients with capacity aged 18 years or over) about life-sustaining treatment **must be** made in writing and contain a statement that the advance decision is to apply even if their life is at risk. The document must be signed by the patient (or by someone appointed by them), in the presence of a witness, who must also sign the document.

Informed Consent Flowchart

If a patient has capacity they are entitled to decide which, if any, of the available treatments to undergo and their consent must be obtained before treatment.

In order to obtain and document informed consent the three questions below, together with the sub-questions, should be addressed:



CORE POLICY

1. Introduction

About this policy

1.1 Cardiff and Vale UHB recognises that people have a fundamental legal and ethical right to determine what happens to their own bodies and this is reflected in this policy. Valid consent to treatment is absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is not only a legal obligation but also a matter of common courtesy between healthcare staff and patients. Both the UHB and healthcare staff may be liable to legal action if valid consent is not obtained.

1.2 Doctors, Nurses and Allied Health Professionals must at all times follow professional standards as set out in GMC, NMC, HCPC and other regulatory guidance. The Welsh Government's revised Welsh Health Circular (WHC) 2017/036: Guide to Consent for Examination or Treatment (the Guide) - sets out the legal framework for consent and can be found on the Welsh Government's revised Welsh Health Circular (WHC) 2017/036: Guide to Consent for Examination or Treatment. The Supreme Court ruling in Montgomery v Lanarkshire NHS Health Board, has fundamentally changed the legal framework for consent to examination and treatment, enshrining the concepts of **informed consent** and **material risk** in UK law (discussed later in chapter 3), bringing the law on consent in line with existing regulatory guidance. Healthcare staff in this UHB must comply with the standards and procedures in this policy, which should be applied in conjunction with the principles set out in the Guide.

1.3 While this policy is primarily concerned with healthcare and refers to healthcare staff in all NHS settings, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

1.4 A patient may either be an adult or a child. Reference in this policy to an adult means a patient of 18 years or above and a child is a patient who is under the age of 16. Reference in this policy to a young person means a child aged 16 or 17 years.

What consent is – and isn't

1.5 Consent is a patient's ongoing agreement for healthcare staff to provide care or treatment. Before providing care or treatment, healthcare staff

should be satisfied that the patient has given his or her **consent**. Consent will only be valid if:

- the patient has capacity to give consent
- it is given freely and not under duress
- the patient has been properly informed

1.6 Consent can be given in writing, verbally or even indicated non-verbally (for example by presenting an arm for a pulse to be taken). In all cases it is essential that an adequate record of the consent is maintained for future reference.

1.7 The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of advice from a healthcare professional. In some cases, the healthcare professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the healthcare staff will help the patient to decide between the available options.

The relevant questions to consider

1.8 In seeking to obtain valid consent, healthcare staff should ask themselves a series of questions, as follows.

Is there reason to doubt the patient's capacity to give consent?

1.9 In determining whether an adult or young person lacks the mental capacity (either temporarily or permanently) to give or withhold consent, healthcare professionals must act in accordance with the MCA and the MCA *Code of Practice*. It is important to remember that nobody can give consent on behalf of an adult, unless they are an appointed attorney with authority under a Health and Welfare LPA or Court Appointed Deputy. A patient who lacks capacity can, however, be given treatment if it is in their best interests in accordance with the MCA, unless there is a valid and applicable advance decision refusing treatment (advance decisions are valid only for adult patients).

1.10 When treating patients who may lack capacity, healthcare professionals should give careful consideration to chapter 8 of this policy and the Guide, particularly the paragraphs set out below.

Is the consent given freely?

1.11 Pressure to agree to a particular treatment can be intentionally or unintentionally applied by family, friends or healthcare professionals.

Professionals should be alert to this possibility, and where appropriate, arrange to review the patient on their own to establish that the decision is autonomous.

1.12 When patients are seen and treated in environments where involuntary detention may be an issue, such as prisons and mental health hospitals, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent and care must be taken to ensure that the patient makes a decision freely. Coercion should be distinguished from providing the patient with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for their health. However, threats such as withdrawal of any privileges or loss of remission of sentence for refusing consent, or using such matters to induce the patient to give consent are not acceptable. Consent will not be valid in these circumstances.

Is the patient aware of all of the material risks and benefits of the proposed treatment and or any alternatives, including no treatment?

1.13 The healthcare professional must inform the patient about all the material risks, benefits and available alternatives, including no treatment. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, ‘seeking consent’ is better described as ‘joint decision-making’: the patient and healthcare professional need to come to an agreement on the best way forward, based on the patient’s values and preferences and the healthcare professional’s clinical knowledge.

1.14 The informed person may either be the patient or someone with parental responsibility. Where a patient lacks capacity to give consent to the specified treatment, the decision should be made in the patient’s best interests in accordance with MCA. It is important that a person acting under a Health and Welfare LPA or a CAD for health and welfare decisions is also aware of all material risks, benefits and available alternatives, including no treatment.

Cultural issues

1.15 Cultural diversity issues should be actively considered whilst obtaining patient’s consent. Members of some religious faiths, for example, are extremely modest in relation to exposure of parts of the body and may only consent to examination or treatment if it is undertaken by someone of the same sex.

1.16 If there is any doubt or uncertainty in relation to particular

consent/capacity issues, contact the Mental Capacity Team.

2. Documentation

2.1 Healthcare professionals must clearly document the information provided to a patient and any related discussions during the consent process. This may be recorded on a consent form (with further detail in the patient's medical note as necessary) or within an entry in the patient's medical notes. (See chapter 3).

2.2 Where the signing of a consent form is not required, healthcare professionals must document the consent process followed with an entry in the patient's medical notes, including details of any information provided or related discussions.

Valid forms of consent

2.3 It will not usually be necessary to obtain a patient's written consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be advisable to do so.

2.4 It is rarely a legal requirement to seek written consent[1], but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some healthcare professionals would describe as 'side-effects' or 'complications');
- the procedure involves general/regional anaesthesia or sedation;
- providing clinical care is not the primary purpose of the procedure;
- there may be significant consequences for the patient's employment or personal life;
- the treatment is part of a project or programme of research approved by this UHB (see chapter 15 of this policy).

2.5 If you are in doubt about whether a procedure requires written consent, then the safest course of action is to complete an appropriate consent form.

[1]The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances

2.6 It is important to note that the place in which the treatment or procedure is to be carried out e.g. outpatients / theatre / clinic / in the patient's home, etc. should not affect the type of consent taken. The nature of the consent (i.e. written, verbal or implied) should be appropriate to the procedure concerned.

2.7 Abbreviations should never be used on consent forms.

2.8 Completed forms should be kept with the patient's medical notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and the relevant healthcare professional.

2.9 A patient's signature on a consent form does not prove that valid consent has been provided. If a patient has made a decision on the basis of inadequate information, or has not had sufficient time to make a decision, consent may not be valid. Conversely, if a patient has given valid verbal consent, the fact that they have not signed a consent form does not mean that consent is not valid. Patients may withdraw consent after they have signed a form; it is not a binding contract.

Standard consent forms – Consent Forms 1 and 2

2.10 There are two versions of the standard consent form:

- **Consent Form 1** for adults, young people or *Gillick* competent children
- **Consent Form 2** for parental consent for a child under 16 who is not *Gillick* competent

2.11 The consent forms have been designed to allow the patient to be given a copy in either Welsh or English. It is essential that the original top copy, which is in English, is the one filed in the patient's medical notes. See appendix A.

Form for patients aged 16 years and over who are unable to consent for themselves – Form 4

2.12 The standard consent forms (**Consent Forms 1 and 2**) should never be used for adult patients and young people who are unable to consent for themselves. Where an adult patient or young person does not have the capacity to give or withhold consent to a significant intervention, this should be documented in **Form 4** - Treatment in best interests: form for patients aged 16 years and over who lack capacity to consent to examination and treatment. See appendix A.

2.13 Although Form 4 is referred to as a consent form, it should be noted that no-one, other than a person who has authority under a Health and Welfare LPA or a CAD for health and welfare decisions can give consent on behalf of an adult patient. If a person who has authority under a LPA or a CAD is giving consent then they should sign the appropriate section of Form 4. A copy of Form 4 should be offered to this person.

2.14 Form 4 requires healthcare professionals to document why the patient lacks the capacity to make this particular healthcare decision, and why the proposed treatment would be in his or her best interests, in accordance with the Mental Capacity Act 2005. Where the patient's family and friends have been consulted about the patient's wishes and feelings (in order to inform the determination of what is in the patient's best interests) the details of this discussion must also be recorded on the form. For further information regarding patients who lack mental capacity to give or withhold consent, see chapter 8 of this policy. For more minor interventions, this information should be entered in the patient's medical notes.

Patient information leaflet

2.15 Patients may find consent forms daunting or confusing and an explanatory leaflet "**About the consent form**" is available for patients with questions or concerns (Appendix E).

Availability of forms

2.16 Consent Forms 1 and 2 and Form 4 can be ordered via the 'Oracle' system.

Procedure/condition specific consent forms

2.17 Procedure specific consent forms may offer advantages for clinical practice and service organisations, providing standardised information about significant risks, benefits and alternative treatment(s). Space must be provided on these forms so that any additional material risks, which are specific to individual patients, can be recorded. The forms should also meet Welsh language requirements in line with the Welsh Language Standards.

2.18 Where Clinical Boards determine that a customised consent form is necessary (e.g. for particular high volume procedures), they must abide by the following -

- Take responsibility for the design of the forms and paying for them. Use the procedure specific consent form template (Appendix ?) and follow the guidance outlined in the Principles and Framework for the Development of UHB Procedure Specific Consent Forms.
- Before the forms are printed, they must be sent to the Mental Capacity Team for review and approval
- The customised forms must then be formally approved at the Clinical Board's Quality, Safety and Experience meeting
- In the event of any dispute about the information on the forms, the Medical Director will arbitrate

3. When should consent be sought?

3.1 Outside an urgent setting, it is good practice to seek the patient's consent to the proposed procedure well in advance, so that there is time to respond to questions and provide adequate information for the individual patient to make a fully informed decision. Seeking consent should be viewed as a process rather than a one off event, reflecting a dialogue between the individual patient and the healthcare professional. The provision of information and related discussion are components of the shared decision-making process.

3.2 This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness and/or urgency of the situation. Healthcare professionals should take reasonable care to ensure that patients are made aware of all of the intended benefits, material risks and alternatives to the proposed treatment.

What is a "material risk"?

3.3 The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the healthcare professional is or should be reasonably aware that the particular patient would be likely to attach significance to it.

3.4 All clinical staff should have regard to the ruling in the case of Montgomery v Lanarkshire Health Board[2] given on 11th March 2015.

3.5 Following this Supreme Court ruling, healthcare professionals are reminded of their professional responsibility to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."

3.6 This standard of consent is similar to that required in GMC Guidance – *Good Medical Practice* 2013 – namely, work in partnership with patients. Listen to, and respond to their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patients' right to reach decisions with you about their treatment and care[3].

3.7 Healthcare professionals must be satisfied that:

[2] https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf
[3] http://www.gmc-uk.org/guidance/good_medical_practice.asp

- The patient knows and understands all the material risks of the proposed treatment
- The patient is aware of all reasonable alternatives
- He/she has taken reasonable care to ensure that the patient understands all of the relevant information
- Valid exceptions to the duty to disclose apply

3.8 The three exceptions to the duty to disclose are:

- The patient tells the healthcare professional that he or she prefers not to know the risks
- The healthcare professional reasonably considers that telling the patient something would cause serious harm to the patient's health and wellbeing
- Consent is not required as the patient lacks capacity and urgent treatment is required

3.9 The Informed Consent Flowchart set out at the beginning of this document provides a useful reference guide for staff on the practical implications of the Montgomery case and is also available online[4].

Single stage process

3.10 In many cases, it will be appropriate for a healthcare professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient gives their consent, the procedure can go ahead immediately. Verbal consent will often be provided in this situation. This should be recorded in the patient's medical notes.

3.11 If a proposed procedure/treatment involves significant and important material risks for the patient concerned, it may be appropriate to seek written consent. Healthcare professionals should also consider whether the patient has had sufficient opportunity or time to process the information required for them to make the relevant decision.

Two or more stage process

3.12 In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure. This may be on just one occasion or it might be over a whole series of

[4] http://howis.wales.nhs.uk/sitesplus/documents/861/Legal%20and%20Risk%20-%20Montgomery%20flowchart.pdf

consultations with a number of different healthcare professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (verbal) decision, and the second being confirmation that the patient still wants to go ahead[5]. A careful record of the information provided and the related discussion with the patient should be detailed in the patient's medical notes. The consent form may be used as a means of recording the information stage(s), as well as the confirmation stage.

3.13 Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the consent form documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. However, if a form is signed before patients arrive for treatment, a member of the healthcare team (for example a nurse admitting the patient for an elective procedure) **must** check with the patient at this point whether they understand the procedure and the risks involved, whether they have any further questions or further concerns and whether their condition has changed. This is particularly important where:

- there has been a significant lapse of time between the form being signed and the procedure
- new information becomes available regarding the proposed intervention (for example, new evidence of risks or new treatment options)
- the patient's condition has changed significantly in the intervening period
- the patient's responsible clinician has changed since the form was signed

3.14 Similarly, if a patient is returning on multiple occasions for a course of treatment, a member of the healthcare team must check with the patient on each occasion that they still consent to the procedure. This confirmation of consent should be recorded on the consent form, or, if insufficient space, in the patient's medical notes.

3.15 When confirming the patient's consent and understanding, it is

[5] https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/consent/

advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with “tell me what you’re expecting to happen”, rather than “is everything all right?”

3.16 It should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient’s condition.

Postal consent

3.17 The patient’s consent may be obtained by post, as this may give the patient time to read and reflect on the consent form and information provided. However, any person carrying out a procedure must ensure, at the earliest opportunity following admission, that the patient has understood the information and that they still give their consent. If the patient has queries or concerns he or she must be given time to consider any additional information. It is important to remember that, whether a patient does or does not have capacity to consent, no relative or carer can sign on his or her behalf (unless in accordance with the MCA – see chapter 8 of this policy, or under parental responsibility, if the competent child or young person wishes the parent to take the decision for them).

3.18 Patients should not be given pre-operative sedation before being asked for their consent to proceed with treatment (although women in labour can consent to a caesarean section even if they have received sedation – see paragraph 17.2 of this policy). If a situation arises where a change to the consent form is required after the patient has received sedation, this should only be done if the doctor responsible for the patient’s care is clearly able to demonstrate that the patient still has capacity to be involved in the decision to make the required change. This must be documented in the patient’s medical notes. The outcome of the assessment, any changes made to the consent form and the reasons for the changes must also be clearly documented in the patient’s medical notes. If the patient does not have capacity due to the administration of sedation, any changes to the consent form should be delayed until capacity is regained (i.e. the effects of the sedation have worn off). If the urgency of the situation is such that a delay in undertaking the procedure would lead to harm to the patient, any decision that is made about continuing has to be made in the best interests of the patient. Best interests decisions and the reasons for them should be documented in the patient’s medical notes. Chapter 8 of this policy provides further guidance on assessing capacity and making best interests decisions.

Seeking consent for anaesthesia

3.19 Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and significant or material risks with the patient. In an elective setting it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient may not be able to make a considered decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in an outpatient setting, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is recorded in the anaesthetic record, the patient's medical notes or on the consent form. Where the healthcare professional providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

3.20 Where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has been provided all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

Emergencies

3.21 Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) may follow straight on from each other, and it may often be appropriate to use the patient's medical notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality and should still include benefits, significant and important (material) risks and alternatives relevant to the individual circumstances of the patient.

Treatment of children and young people

3.22 When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law and consider carefully whether the child or young person is competent to give his or her consent to the treatment. Chapter 7 of this policy provides further information.

Withdrawal of consent

3.23 A patient with capacity is entitled to withdraw consent at any time. Where a patient does object during treatment, it is good practice for the healthcare professional, if at all possible, to stop the procedure, establish the patient's concerns, and explain the consequences of not completing the procedure. If the patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately.

3.24 The healthcare professional should try to establish whether at that time the patient has capacity to withdraw consent. This is particularly important if the patient has been given sedation. If a patient lacks capacity, it may be justified to continue in the patient's best interests in accordance with the MCA.

3.25 If a sedated patient or one who otherwise lacks mental capacity to consent begins to struggle or resists treatment either verbally or physically, it is the responsibility of the healthcare professional to act in the patient's best interests. If this event occurs at a crucial time, which will have an impact on a successful outcome, then it would be wise to pause, attempt to regain co-operation and complete, perhaps with additional sedation. If the situation deteriorates, is irretrievable, and patient safety is likely to become compromised, then termination of the procedure is recommended. This must be recorded in the patient's medical notes.

3.26 For issues relating to withdrawal of consent by patients being treated in accordance with sections 57, 58 or 58A of the Mental Health Act, please refer to the *Mental Health Act 1983 Code of Practice for Wales*.

4. Provision of information

4.1 The provision of information is central to the consent process. Before patients can make an informed decision about their treatment, they need comprehensible information about their condition and any reasonable treatment options and their risks and benefits (including the risks/benefits of doing nothing). Patients also need to know the scope of the intended treatment and whether additional procedures are likely to be necessary, for example - blood transfusion or the removal of particular tissue.

4.2 Patients will differ in how much information they want about a proposed treatment. Some patients will want as much detail as possible, including details of rare risks, while others will ask healthcare professionals to make decisions for them. In such circumstances, the healthcare professional should explain the importance of understanding the significant risks and benefits of a recommended treatment, and making an informed decision. The *presumption* must be that the patient wishes to be well informed about the material risks and benefits of the various treatment options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented and the patient may be asked to sign the record to confirm their decision. It must be made clear to the patient that they can change their mind and have more information at any time.

Has the patient received sufficient information?

4.3 To give valid consent the patient needs to be provided with sufficient information to understand in broad terms the nature and purpose of the procedure. Information about any significant and material risks and benefits of the proposed treatment and any alternative options should be provided, including the option of no treatment. Any misrepresentation of these elements will invalidate consent. Where relevant, information about anaesthesia must be given (see paragraph 3.19 above) as well as information about the procedure itself.

4.4 The information provided should be tailored to the individual patient.

4.5 The use of patient information leaflets can help healthcare professionals to provide patients with the information they need, in order to arrive at an informed decision. Wherever possible patients should be sent information prior to their appointment so that they have time to read and absorb it, and can consider what questions they would like to ask when they meet with the relevant healthcare professional. This will help to ensure that they fully understand the treatment being

proposed and can make an informed decision regarding consent. However, the use of leaflets does not remove the healthcare professional's responsibility to provide a verbal explanation of often much the same information. In this context, the use of patient information leaflets is considered to be an example of best practice. The use and provision of the patient information leaflet should be documented on the consent form or in the patient's health records. A copy of the patient information leaflet should be inserted into the patient's health record. If an EIDO information leaflet has been used, its name, number and date can be documented.

4.6 Patient information in different formats and languages must be made available.

Communication Issues

4.7 A patient must not be assessed as lacking capacity to consent to the particular investigation, treatment or care merely because they have a limited ability to communicate. Care should be taken not to underestimate the ability of a patient to communicate, whatever their condition. Healthcare professionals should take all reasonable steps to facilitate communication with the patient, using communication aids as appropriate. Particular consideration should be given to the way in which information is presented to the patient. Drawings, diagrams and models may be useful for example. In emergency situations, taking these steps may not be possible, but good practice would be to record the reasons for this in the patient's medical notes.

4.8 Where appropriate those who know the patient well, including their family, friends, carers or staff from professional or voluntary support services, may be able to advise on the best ways to communicate with the patient.

Provision for Welsh speaking patients

4.9

The Welsh Language (Wales) Measure 2011 has given the Welsh language official status in Wales by placing Welsh Language Standards on organisations – [insert link to the Health Board / Trust's Welsh Language Standards Document]. The duties deriving from the standards mean that the Health Board / Trust and its staff should not treat the Welsh language less favourably than the English language. In line with the Welsh Language Standards, the language preference of the patient must be offered, established, recorded, acted upon and relayed to others within the [Health Board / Trust]. Welsh speaking

healthcare professionals should ideally obtain consent from patients whose preferred language is Welsh. If the relevant healthcare professional is not Welsh speaking, consent should be obtained with the support of Welsh speaking colleagues or simultaneous translation.

For further information about the provision of Welsh language support, please see the Translation and Interpreter Services page of the intranet.

4.10 The All Wales consent forms (see chapter 2 of this policy) have been designed bilingually so that the patient can be given a copy in either English or Welsh. It is essential that the top copy, which is in English, is completed and added to the patient's medical notes. Availability of bilingual consent forms ensures that:

- Welsh and English versions of consent forms are equally accessible to patients
- both the patient and healthcare professional are clear about what is being agreed to in circumstances where a non-Welsh speaking healthcare professional is dealing with a Welsh speaking patient, and
- the needs of mixed-language families, other mixed-language audiences and Welsh learners are met

Provision for patients whose first language is not English or Welsh

4.11 This UHB is committed to ensuring that patients whose first language is not English or Welsh receive the information they need and are able to communicate appropriately with healthcare staff. This includes British Sign Language (BSL). In order to safeguard the consent process, unless the healthcare professional is fluent in the patient's language, an interpreter should always be used when seeking consent from the patient (except for minor, routine procedures).

4.12 It is not appropriate to use children or family members to interpret for patients who do not speak English.

For further information about the provision of language/communication support, please see the Translation and Interpreter Services page of the intranet.

Access to more detailed or specialist information

4.13 Patients may sometimes request more detailed information about their condition or a proposed treatment than that provided in general leaflets

and every effort must be made to accommodate such a request.

Access to healthcare professionals between formal appointments

4.14 After an appointment with a healthcare professional, patients will often think of further questions which they would like answered before making a decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or wait until the date of an elective procedure, by which time it is too late for the patient to reflect upon the information. Patients should be provided with appropriate contact details at the time of their appointment.

4.15 The provision of advice over the telephone needs to be undertaken by suitably qualified staff and must follow agreed guidelines, policies and procedures. Advice given must be evidence based and up to date. A record of the information given must be kept in the patient's medical notes. Where advice deviates from accepted guidance, the advice given must be clearly documented and the reasons for such deviation stated.

Open access clinics

4.16 Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need to give their consent before proceeding with an investigation or treatment.

Consent and inpatients

4.17 Irrespective of whether the patient is an inpatient or outpatient, the process of seeking consent must be adhered to. Just because a patient is already in a hospital bed, consent for examination and treatment cannot be assumed. As stated previously, the patient needs to be provided with sufficient time and information to understand in broad terms the nature and purpose of the procedure.

5. Who is responsible for seeking consent?

5.1 The healthcare professional carrying out the procedure is ultimately responsible for ensuring that the patient has given valid consent for the proposed treatment or procedure. He or she will be held responsible in law if the validity of consent is subsequently challenged.

5.2 Where verbal or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the healthcare professional responsible. However, team work is a crucial part of the way the NHS operates and, where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent e.g. providing information about the treatment or procedure.

Competence of those seeking consent

5.3 Consent must be obtained by a healthcare professional who is competent either because they themselves carry out the procedure or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit. Inappropriate delegation (e.g. where the healthcare professional seeking consent has inadequate knowledge of the procedure) may mean that the consent is not valid.

5.4 It is a healthcare professional's own responsibility:

- to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
- to work within their own competence and not to agree to perform tasks which exceed that competence

5.5 If you feel that you are being pressurised to seek consent when you do not feel competent to do so, please discuss this with your manager/supervisor/educational lead or the Patient Safety Team.

5.6 The Wales Deanery and the Welsh Government have made it clear that F1 doctors can only take consent in specific clinical situations where they have undertaken formal training and their competency has been assessed. Healthcare professionals are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary.

Completing consent forms

5.7 The standard consent form provides space for a healthcare professional to provide information to patients and to sign confirming that they have done so. The healthcare professional providing the information must be competent to do so.

5.8 If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a healthcare professional involved in their care on the day should sign 'Confirmation of Consent' section of the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

Attendance by students and trainees (i.e. pre-registration clinicians from any discipline)

5.9 Where a student or trainee healthcare professional is undertaking examination or treatment of the patient where the procedure will further the patient's care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the patient that the healthcare professional is a student, although it would always be good practice to do so and consent in the usual way will still be required.

5.10 In contrast, where a student proposes to conduct a physical examination which is not part of the patient's care, then it is essential to explain that the purpose of the examination is to further the student's training and to seek consent for that to take place. Verbal consent must be obtained and a record made in the patient's medical notes.

5.11 A patient's consent should be obtained when a student is going to be present during an examination or treatment purely as an observer. Patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment. Written consent must be obtained if students or trainees are going to be present during examination or treatment using sedation or anaesthetic.

5.12 Patients must be informed that they have the right to refuse consent to being observed, attended to or examined by students without any detrimental effect on their treatment.

5.13 It is essential that appropriate supervision of students is carried out in all of the above situations and that, where consent is required, the supervisor is reassured that valid consent has been obtained.

Attendance by company representatives

5.14 On occasions when company representatives need to be present for a procedure/treatment (e.g. where equipment is being used for the first time and the representative is there to assist with its use), written consent from the patient must be obtained.

6. Adults with capacity – refusal of treatment

Right to refuse treatment

6.1 An adult patient who has capacity can refuse any treatment, except in certain circumstances governed by the Mental Health Act 1983 (see chapter 14 of this policy). The following paragraphs apply primarily to adults. In determining whether a patient has capacity to make this decision the MCA must be applied. See chapter 8 of this policy.

6.2 An adult with capacity may make a decision which is based on their religious belief (e.g. Jehovah's Witnesses) or value system. Even if it is perceived by others that the decision is unwise or irrational, the patient may still make that decision if he or she has capacity to do so and it is a voluntary and informed decision. Any attempt to treat that patient against his or her wishes could amount to a criminal offence. It is the right of an adult patient with capacity to refuse treatment even if that refusal might result in their death. However in cases of doubt, healthcare professionals should always seek legal advice.

6.3 If, after discussion of possible treatment options, a patient refuses treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, the healthcare professional (and where possible the patient) should note this on the 'Patient has withdrawn consent' section of the consent form.

6.4 Where a patient has refused a particular intervention, the healthcare professional must ensure that he or she continues to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

6.5 If a patient consents to a particular procedure but refuses certain aspects of the intervention, the healthcare professional must explain to the patient the possible consequences of their partial refusal. If the healthcare professional genuinely believes that the procedure cannot be safely carried out under the patient's stipulated conditions, he or she is not obliged to perform it. They must, however, continue to provide any other appropriate care. Where another healthcare professional believes that the treatment can be safely carried out under the conditions specified by the patient, he or she must on request be prepared to transfer the patient's care to that healthcare professional.

6.6 Whilst a patient has the right to refuse treatment this does not mean

that they have the right to require a particular course of treatment.

Self harm and attempted suicide

6.7 Cases of self harm present a particular difficulty for healthcare professionals but the same law and guidance, as set out above, applies to treatment of these cases. Where the patient is able to communicate, an assessment of their mental capacity should be made as a matter of urgency.

6.8 If the patient is judged not to have capacity, decisions about their physical health treatment need to be made in accordance with the MCA (see chapter 8 of this policy). If treatment is required for their mental health, the MHA will apply. If a patient has attempted suicide and is unconscious, and there is insufficient time to undertake the usual best interests decision making process then he or she should be given emergency treatment unless the healthcare professional is satisfied that an advance decision to refuse treatment exists which is valid and applicable to the life-sustaining treatment in these circumstances.

6.9 Adult patients with capacity do have the right to refuse life-sustaining treatment, both at the time it is offered and in the future even if the healthcare professional believes that the patient's decision is unwise. If a patient with capacity has harmed themselves and refuses treatment, it may be appropriate to consider obtaining a psychiatric assessment. Unless the adult patient with capacity is detained under the Mental Health Act 1983 and the treatment is for, or a symptom of, a mental disorder, then their refusal must be respected although attempts should be made to encourage him or her to accept help and healthcare professionals should consult legal advisers.

Patients who refuse blood or blood components (e.g. Jehovah's Witnesses)

6.10 The same legal principles apply to any patient who refuses treatment whether they do so out of religious convictions or otherwise. No patient should be considered to be likely to refuse blood products merely on the basis of their religion. Every patient needs to be asked and informed individually.

Further information on Jehovah's Witness Patients

6.11 It is important to remember that not all Jehovah's Witnesses refuse blood products. Most practising Jehovah's Witnesses who do will carry with them a clear, signed and witnessed advance decision card prohibiting blood transfusions and releasing clinicians from any liability

arising from this refusal. If an applicable and valid advance decision is produced, then this should be acted upon. If the patient does not have capacity and a valid and applicable advance decision cannot be produced, the clinical judgement of a doctor should take precedence over the opinion of relatives or associates.

6.12 Further information can be found at the following:

- Royal College of Surgeons (2016) Caring for patients who refuse blood: a guide to good practice for the surgical management of Jehovah's Witnesses and other patients who decline transfusion
- Association of Anaesthetists of Great Britain and Ireland, 2nd Edition, (2005) *Management of Anaesthesia for Jehovah's Witnesses*
- Hospital Information Services for Jehovah's Witnesses (2005) *Care plan for women in labour refusing a blood transfusion*
- UK Blood Transfusion and Tissue Transplantation Services (http://www.transfusionguidelines.org.uk/index.asp?Publication=BBT&Section=22&pageid=510 *Better Blood Transfusion Toolkit: Appropriate Use of Blood: Pre-operative Assessment – Jehovah's Witnesses*
- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee chapter 12: Management of patients who do not accept transfusion

6.13 Further information or advice on the clinical management of this group of patients can be obtained from:

- A Consultant Haematologist within the UHB
- The local Hospital Liaison Committee for Jehovah's Witnesses

7. Treatment of children and young people

7.1 When treating or caring for children and young people, healthcare professionals should take account of chapter 5 of the Guide.

Children or young people with capacity to consent to treatment

7.2 When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law.

7.3 Careful consideration should be given to whether the child is competent to give his or her consent to the specified treatment. A child under the age of 16, who has sufficient maturity and intelligence to be capable of understanding the treatment and making a decision based on the information provided (*Gillick* competent) will have capacity to consent to treatment and care. If a competent child consents to treatment a parent cannot over-ride that consent. As with adults, consent will only be valid if it is given voluntarily by an appropriately informed patient who has capacity to consent to the particular treatment.

7.4 Young people aged 16 or 17 with capacity are assumed in law to be competent and can give consent for their own treatment. If a 16 or 17 year old consents to treatment a parent cannot over-ride that consent. This applies equally to young people with capacity who are to be admitted (informally) to hospital for treatment for a mental disorder.

7.5 It is not a legal requirement but it is advisable to include the child/young person's family in discussions regarding treatment. However, this can only be done with the consent of the child/young person.

See Appendix D for guidance on assessing whether a child is *Gillick* competent.

Children who are not competent to consent to treatment

7.6 If the child is not competent to give consent, then the healthcare professional may give treatment on the basis of parental consent. Parental consent may be given by any person who has parental responsibility for the child, provided that person has capacity to give such consent. This may not necessarily be the parents but, for convenience, "parents" in this policy means all persons with parental responsibility.

7.7 Healthcare professionals need to make reasonable enquiries as to who

holds parental responsibility for the child. Every effort should be made to include all those with parental responsibility in discussions regarding treatment options.

7.8 Not all parents have parental responsibility for their children. For example, unmarried fathers do not automatically have such responsibility - but they can acquire it. If you have any doubt about whether the person with the child has parental responsibility for that child, you must check. The Children Act 1989 (which applies to both children and young people) sets out the persons who may have responsibility for a child.

7.9 Parental responsibility is vested in:

- the mother automatically on the birth of the child
- the father if his name has been registered on the child's birth certificate (this only applies to births from 1st December 2003)
- the father/partner when he/she is married to the mother at the time of the birth
- an unmarried father can acquire parental responsibility in the following ways:-
    - by jointly registering the birth with the mother (only applies to births from 1st December 2003)
    - by entering into a Parental Responsibility Agreement with the mother
    - by applying to the courts for a Parental Responsibility Order
    - by being appointed as guardian either by the mother or the court (although he will usually only assume parental responsibility upon the mother's death)
    - by obtaining a residence order
    - by marrying the mother and agreeing with her that he will assume parental responsibility
    - marrying the mother and upon his application to the court
    - by adopting the child
- legally appointed guardian
- a person who has been granted a residence order in respect of the child
- a step-parent who has entered into a Parental Responsibility Agreement with the mother

- a local authority in whose favour a care order has been made[6]
- a person who has been granted an emergency protection order
- an adopter of a child in accordance with section 46 of Adoption and Children Act 2002
- a husband and wife in whose favour a parental order has been made under section 30 of the Human Fertilisation and Embryology Act 1990
- an adoption agency in accordance with section 25 of the Adoption and Children Act 2002
- the court in wardship procedures
- some same-sex partners in certain situations

7.10 If you are in any doubt about whether a person has parental responsibility or whether a parent is acting in the best interests of the child you should seek legal advice.

7.11 Consent is usually only needed from one person holding parental responsibility. However there have been legal cases where the Court has advised that all parties with parental responsibility must give consent; if consent cannot be agreed an order from the Family Division of the High Court must be obtained. Those cases have included:

- sterilisation for contraceptive purposes
- non-therapeutic male circumcision
- hotly contested issues of immunization

7.12 Where consent is being given on behalf of a child who is not competent to consent, the healthcare professionals, the child and the person with parental responsibility must meet to discuss and consider treatment options. This is particularly important if more than one person has parental responsibility for a child.

7.13 When children who are not competent to give consent are being cared for in hospital, it may not seem practicable to seek the consent of the parents on every occasion for every routine intervention such as blood or urine tests or X-rays. However, healthcare professionals should remember that, in law, such consent is required, although consent may be given in advance. Where a child is admitted, the healthcare professional should discuss with the parents what routine procedures

[6]Care should be sought as a Local Authority has the power to restrict the parental responsibility of the parents in relation to health care. It should always be established who has parental responsibility when an order is made and in what circumstances the parental responsibility can be exercised.

will be necessary, and, if it is not practicable to seek consent for every intervention, they may ask the parents if they are content to give their consent in advance for these routine procedures. If the parents are not content to give their consent, then consent should be obtained on every occasion. The parents may specify that they wish to be asked before particular procedures are initiated. You must then do so, unless the delay involved in contacting them would put the child's health at risk.

7.14 It is important to be aware that neither an Emergency Protection Order (EPO) nor a Police Protection Order (PPO) confers the consent for examination. If the person who has parental responsibility is not available, consent with directions, must be obtained from the Family Division of the High Court.

7.15 A healthcare professional must not rely on the consent of a parent if he or she has any doubts about whether the parent is acting in the best interests of the child. In order to consent on behalf of a child, the person with parental responsibility must also have mental capacity themselves.

7.16 For forensic examinations different rules may apply.

Young people (age 16 and 17 years) without capacity to consent to treatment

7.17 Healthcare professionals must follow the Mental Capacity Act when the young person lacks capacity to decide about treatment.

Children who are competent or young people (aged 16 or 17) with capacity who refuse treatment

7.18 Healthcare professionals should be very careful in cases where a young person or child refuses treatment. Such cases can be controversial and raise complex legal issues. Healthcare professionals should have particular regard to chapter 3 of the Guide. Please contact the Mental Capacity Act Manager/Patient Safety Team in the first instance.

7.19 Where a young person of 16 or 17 who has capacity, or a child under 16 who has been assessed as *Gillick* competent, refuses treatment, a person with parental responsibility for the child / young person or the Courts can be used as alternative sources of consent. In such circumstances legal advice should be sought[7]. See Appendix C.

[7] NHS Trust v X (In the matter of X (A Child) (No 2)) [2021] EWHC 65 (Fam) (18 January 2021) (bailii.org)

7.20 Where a child has refused treatment, and a decision is made to give treatment on the basis of parental consent, it must be exercised on the grounds that the welfare of the child is paramount. The psychological effect on the child of having their decision over-ruled must also be considered.

7.21 Where a young person aged 16-17 who has capacity is to be admitted to hospital for treatment for a mental disorder, the MHA provides that where that person refuses to be admitted to hospital for treatment for a mental disorder, a person with parental responsibility for that person cannot overrule that refusal. The MHA should be used where appropriate.

Person with parental responsibility refusing treatment

7.22 If consent for treatment is refused by one or more of those with parental responsibility, or where an agreement cannot be reached between the persons with parental responsibility, seek legal advice. See Appendix C.

Young people aged 16 and 17 who refuse life-sustaining treatment

7.23 Where a young person aged 16 or 17 refuses life-sustaining treatment (e.g. a blood transfusion on the basis of their religious conviction) healthcare professionals should exercise extreme caution. In these circumstances, legal advice should be sought and, if necessary, the matter should be referred to the court. See Appendix C

7.24 The management of a young person in an emergency situation, who is likely to die or suffer serious permanent harm without immediate treatment, is viewed in law in a different light. There may not even be time for emergency application to the court. Senior clinicians may decide to treat without consulting the court. Parents may not prevent clinicians from administering treatment to their children if their child's life or health is in imminent danger. This includes cases where the parents wish to refuse blood products for their child on religious grounds. Staff may rely on the support of the courts to endorse decisions that are taken in good faith and in the best interests of the young person concerned. It is important, however that two doctors of consultant status should make an unambiguous, signed and dated entry in the patient's medical notes that the treatment is essential to save life or prevent serious permanent harm. The doctor who stands by and allows a 'minor' patient to die in circumstances where treatment might have avoided death may be vulnerable to criminal prosecution.

7.25 The courts have often commented that such a situation does not

detract from the loving and responsible reputation of the parents involved, and they have stressed the need for parents to be fully informed of the clinical developments regarding their child and of the intended action by clinicians.

7.26 When treating children or young people in these circumstances, healthcare professionals should consider carefully the guidance in chapter 5 of the Guide.

Parents refusing life-sustaining treatment for a child

7.27 Where a parent or parents intend to refuse life-sustaining treatment for a child under the age of 16, staff must always seek legal advice (see Appendix C). The well-being of the child is paramount and, if the parents refuse to give permission for the treatment, it may be necessary to apply for a court order to administer the treatment lawfully. Healthcare professionals should note that a court order can be obtained out of hours when necessary.

Emergency treatment

7.28 A life threatening emergency may arise in connection with a child when consultation with either a person with parental responsibility or the court is impossible, or the persons with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of that child. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health.

8. Patients who lack capacity to give or withhold consent

8.1 In determining whether a patient aged 16 years and over lacks the mental capacity - either temporarily or permanently - to give or withhold consent for themselves, healthcare professionals must act in accordance with the Mental Capacity Act 2005. A patient who lacks capacity can be given treatment if it is in their best interests, as long as the patient (when aged 18 years and over) has not made a valid and applicable advance decision refusing that specific treatment.

8.2 When treating patients who may lack capacity, healthcare professionals must have due regard for the MCA Code of Practice.

Does the patient have capacity?

8.3 The MCA applies in relation to determining whether a patient has capacity to give their consent. It is a key principle of the MCA that a patient is assumed to have capacity to make decisions for themselves unless it is established on the balance of probabilities that they do not.

8.4 In ascertaining a patient's capacity, the healthcare professional must not make a judgment on the basis of the patient's age, appearance, assumptions about their condition or any other aspect of his or her behaviour. It is important to take all possible steps to try and help the patient make a decision for themselves (see chapter 3 of the MCA Code of Practice). Where there is doubt about a patient's capacity, an assessment must be carried out and the healthcare professional must be able to justify their conclusions.

8.5 It is the healthcare professional proposing treatment or examination who should assess the patient's capacity to consent. More complex decisions are likely to need more formal assessments, which may include a professional opinion (for example from a speech and language therapist/psychologist), but the final decision about the patient's capacity must be made by the person intending to carry out the action.

8.6 Healthcare professionals who carry out actions related to the care and treatment of patients who lack capacity to consent to them at that time may be protected from liability if they reasonably believe (having assessed the patient's capacity where there is doubt) that the patient lacks capacity to make that particular decision at the time it needs to be made and the action is in the patient's best interests. (For further guidance see chapter 6 of the MCA Code of Practice and note that the

MCA imposes limitations on acts which can be carried out with protection from liability – including where there is inappropriate use of restraint or where the patient who lacks capacity is deprived of their liberty).

8.7 A patient lacks capacity if he or she is unable to make a specific decision for themselves in relation to a matter at the time it needs to be made because they have an impairment or disturbance of the mind or brain. This impairment or disturbance can either be temporary or permanent.

8.8 The MCA provides that a patient with an "impairment or disturbance" is unable to make a decision if they are unable to do one or more of the following:

a) understand the information relevant to the decision; or
b) retain that information; or
c) use or weigh that information as part of the process of making the decision; or
d) communicate his or her decision, whether by talking, using sign language or any other means

8.9 If a patient cannot do one or more of these as a result of their impairment they will be treated as being unable to make the decision. Point d) only applies in situations where the patient cannot communicate their decisions in any way.

8.10 The British Medical Association has published advice on the assessment of capacity - www.bma.org.uk/

8.11 Capacity should not be confused with a healthcare professional's assessment of the reasonableness of the patient's decision. The patient is entitled to make a decision which is based on their own religious belief or value system, even if it is perceived by others to be unwise or irrational.

8.12 Where there is any doubt about a patient's capacity to make a particular decision, after support has been provided without success, an assessment must be carried out. This should be done in accordance with the requirements of the MCA and the assessment must be recorded e.g. using Form 4.

8.13 An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. The healthcare professional undertaking the assessment of capacity is required by the MCA to take all practicable steps to help the patient make the decision, therefore they should involve appropriate

colleagues, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal formats where appropriate.

Advance decisions to refuse treatment (ADRT)

8.14 In accordance with the MCA, a person who is 18 or over and has capacity can make an ADRT. An ADRT may be withdrawn or altered at any time whilst the person has capacity.

8.15 Any ADRT that is valid and applicable to the treatment that is proposed is legally binding. A healthcare professional must follow a valid and applicable ADRT. If they do not, they could face criminal prosecution and or civil liability.

8.16 A valid and applicable ADRT that is made after a Health and Welfare LPA overrules the decision of any Attorney.

8.17 If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder, a healthcare professional may still give that treatment to the patient if he or she has authority to do so under Part 4 and 4A of the MHA and consent is not required. Informal patients are not covered by Part 4 of the MHA and their advance decisions refusing treatment are enforceable if valid and applicable.

Validity of an ADRT

8.18 An ADRT is valid if made voluntarily by an appropriately informed adult (aged 18 years or over) with capacity.

8.19 An ADRT is **not** valid if the individual:

a) was under 18 years of age when it was drawn up; or
b) did not have capacity when the decision was made; or
c) was acting under duress; or
d) has withdrawn the advance decision (verbally or in writing) at a time when he/she had capacity to do so; or
e) has done anything else clearly inconsistent with the ADRT remaining his fixed decision; or
f) creates a LPA after the date when the ADRT was made, conferring authority on the attorney to give or refuse consent to the treatment to which the ADRT relates.

8.20 Healthcare professionals should ensure that the ADRT that is being considered has been regularly reviewed and updated. However, ADRTs made long in advance of incapacity are not necessarily invalid unless, for example, there are reasonable grounds for believing that circumstances have since arisen which mean the patient would have changed their mind if they still had capacity. For example, there may be a medical advancement which the patient was unaware of at the time he or she made the advance decision, which could significantly improve their condition.

8.21 There are no specific legal requirements concerning the format of an ADRT (unless it involves life-sustaining treatment – see below). It may be a written document, a witnessed verbal statement, a signed printed card, a smart card, or a note of discussion recorded in a patient's health record. Although there is no legal requirement, if possible patients should be encouraged to put their ADRT in writing so that there is a clear record of their wishes.

8.22 If an ADRT relates to refusal of life-sustaining treatment, it will only be valid if it is in writing, contains the words 'even if life is at risk' (or words to that effect) and is signed, dated and witnessed.

Applicability of an ADRT

8.23 An ADRT must clearly specify the treatment that is being refused and in what specific circumstances it applies. It must be unambiguous and applicable to present circumstances. If the decision to be made falls outside of the scope of the ADRT, it will not be applicable.

8.24 An ADRT cannot authorize anyone to do anything which is unlawful (for example assist an individual in committing suicide), or make anyone carry out a particular treatment.

Responsibility of healthcare professionals

8.25 It is the responsibility of the person making the ADRT to ensure that it will be drawn to the attention of healthcare professionals when it is needed. However, healthcare professionals are also responsible for asking patients or their representatives about the existence of ADRT.

8.26 If a healthcare professional knows or has reasonable grounds to believe that an ADRT exists, and time permits, then they should make reasonable enquiries regarding its existence and content. Emergency treatment should not be delayed in order to look for an ADRT if there is no clear indication that one exists.

8.27 If an ADRT relates to refusal of life-sustaining treatment, then the healthcare professional must see a written, signed and witnessed ADRT which contains the words 'even if life is at risk' (or similar).

8.28 A healthcare professional will not be acting unlawfully if he or she treats a patient and is genuinely unaware of the existence of an ADRT. Similarly they will not act unlawfully if they act in accordance with an ADRT that they believe is valid and applicable at the time but is later proved to be invalid/ not applicable.

8.29 If there is any doubt about the validity or applicability of an ADRT it may be necessary to refer the matter to the Court of Protection (CoP). In this situation, healthcare professionals may provide life-sustaining treatment or treatment that prevents serious deterioration in the patient's condition whilst the decision of the court is awaited.

8.30 If an ADRT is not valid and applicable, it should still be noted as an expression of the patient's feelings and wishes about what should happen to them, and should be taken into account in deciding what is in their best interests.

Advance statements

8.31 An advance statement is different to an advance decision to refuse treatment in that it generally outlines a patient's wishes or preferences in relation to care or treatment that they want to have, as opposed to being a refusal of treatment. Although an advance statement is not legally binding it should be noted as an expression of the patient's feelings and wishes about what should happen to them if they lack capacity to decide for themselves, and should be taken into account in deciding what is in their best interests.

8.32 Some advance statements will express the patient's wishes that a particular course of action should be taken or that they should receive a particular type of treatment in the event that they no longer have capacity. The healthcare professional is not under a legal obligation to provide treatment because the patient demands it. The decision to treat is ultimately a matter for his or her professional judgment acting in the context of a best interests decision. In making that decision the healthcare professional will, however, be required to take into account the patient's wishes as expressed in determining what is in his or her best interests.

8.33 Further information about ADRT is available in chapter 9 of the MCA *Code of Practice*.

Decisions made in the patient's best interests

8.34 In determining what is in the patient's best interests, the healthcare professional must look at the patient's circumstances as a whole and not just at what is in the patient's best medical interests. They must try to work out what the patient would have wanted if he or she had capacity, rather than what that professional believes to be in his or her best interests. The healthcare professional must make all reasonable efforts to ascertain:

- the patient's past and present wishes and feelings
- any beliefs and values that would be likely to influence the patient's decision, and
- any other factors that the patient would be likely to consider if they were making the decision

8.35 Lack of capacity to make the decision in question will not automatically mean that the patient is unable to participate in the decision making process, and every assistance should be given to enable him or her to do so.

8.36 A healthcare professional must not make assumptions about someone's best interests simply on their age, appearance, condition or behaviour. They should also consider whether the patient is likely to regain capacity and if so whether the decision can be deferred.

8.37 They must also, so far as is practicable, consult representatives of the patient to see if they have any information about the patient's wishes, feelings, beliefs and values. In particular, they should try to consult:

- any unpaid person who is named by the patient as a person who should be consulted on such matters
- anyone engaged in caring for the patient or interested in his welfare
- any person who has been granted a LPA by the patient; and
- any deputy appointed for the patient by the CoP to make decisions for that patient

8.38 The purpose of consulting is to ascertain what the patient would have wanted if they had capacity, not what the persons consulted believe should happen. Where a patient has made a Health and Welfare LPA or a deputy of the CoP (for personal welfare) has been appointed, and if it is within their authority, it will be for the attorney or deputy to make the decision on the patient's behalf. However, they too must act in the patient's best interests and, where practicable and appropriate, consult the people indicated above.

8.39 If a patient has no one who can be consulted, healthcare professionals must consider whether the circumstances are such that an Independent Mental Capacity Advocate (IMCA) should be instructed (see below).

8.40 If the patient has made an advance statement (other than a valid and applicable ADRT), then the healthcare professional should still take that statement into account in deciding what is in the patient's best interests, as it is a reflection of the patient's wishes and feelings. However, if it is the healthcare professional's judgment that to act in accordance with the advance statement would not be appropriate and not in the patient's best interests, he or she is not bound to do so.

Temporary incapacity

8.41 Patients may suffer a temporary loss of capacity, for example, where they are under a general anaesthetic or sedation, or unconscious after a road accident. As with any other situation, an assessment of that patient's capacity must only examine their capacity to make a particular decision when it needs to be made. Unless the patient has made a valid and applicable ADRT of which you are aware, then they may be treated insofar as is reasonably required in their best interests pending recovery of capacity. This will include, but is not limited to, routine procedures such as washing and assistance with feeding. If a medical intervention is thought to be in the patient's best interests but can be delayed until the patient recovers capacity and is able to consent to (or refuse) the intervention, it must be delayed.

Fluctuating capacity

8.42 It is possible for a patient's capacity to fluctuate. In such cases, it is good practice to establish whilst the patient has capacity their views about any clinical intervention that may be necessary during a period of incapacity and to record these views. The patient may wish to make an advance decision to refuse certain types of treatment (see paragraphs 8.14 to 8.30). If the person does not make a relevant ADRT, the patient's treatment when incapacitated should accord with the principles for treating the temporarily incapacitated (see above).

Lasting Power of Attorney (LPA)

8.43 LPA was introduced by the MCA. An LPA may be executed by any person of 18 years or over whilst they have capacity and takes effect when they no longer have capacity. A Health and Welfare LPA appoints a person to act as an attorney to make decisions about a

person's welfare and medical treatment when that person lacks the capacity to make that particular decision. The attorney acting under a Health and Welfare LPA must make the decision in the person's best interests. The LPA must be registered with the Office of the Public Guardian (OPG) before it can be used and it is essential that healthcare professionals see the sealed (OPG stamp) LPA document to confirm that it has been registered, and to assure themselves of the authority that it confers on Attorney(s). An LPA does not authorise an attorney to refuse or give consent to life-sustaining treatment unless this is explicitly stated in the LPA. If two or more people have been appointed as attorneys, they may either be appointed to act jointly or jointly and severally. If they are acting jointly, any decision must be made by consensus. However if they are acting jointly or severally, then either of the attorneys can make a decision independently of the other.

8.44 If the patient has made a valid and applicable ADRT to refuse treatment, then this can be overridden by an attorney providing that the LPA was made after the advance decision and his or her authority under the LPA extends to making decisions about treatment that is the subject of the advance decision. An attorney, like any person who is making a decision on behalf of a patient who lacks capacity, must act in accordance with the MCA and must have regard to the MCA *Code of Practice*.

8.45 When acting on the basis of a decision by an attorney, a healthcare professional should, so far as is reasonable, try to ensure that the attorney is acting within their authority. Any disputes between a healthcare professional and an attorney that cannot be resolved, or cases where there are grounds for believing that the attorney is not making decisions that are in the best interests of the patient, should be referred to the CoP.

Court Appointed Deputies (CAD)

8.46 Whilst a decision made by the Court is always preferred, the MCA now provides that the Court can appoint deputies to make decisions on its behalf. This may be necessary if there are a number of difficult decisions to be made in relation to the patient. The CAD will normally be a family member, partner, friend or person who is well known to the patient. Healthcare professionals must always ensure that they see a sealed (CoP stamp) copy of the deputyship order so that they are clear what authority the CAD holds.

8.47 As with attorneys appointed under a LPA, a CAD may only make decisions where they have reasonable grounds to believe that the

person they are acting for does not have capacity, and any decisions they take will be strictly limited to the terms specified by the Court and in accordance with the MCA. A CAD is also subject to a number of restrictions in the exercising of their powers. For example, a CAD cannot refuse consent to the carrying out or continuation of life-sustaining treatment for the patient, nor can he or she direct a person responsible for the patient's healthcare to allow a different person to take over that responsibility**.** A deputy cannot restrict a named person from having access to the patient.

8.48 Healthcare professionals should co-operate with the CAD with the aim of doing what is best for the patient. Where a CAD acting within their authority makes a decision that a treatment (that is not life-sustaining) should be withheld or withdrawn the healthcare professional must act in accordance with those instructions. However a CAD cannot require a healthcare professional to give a particular type of treatment, as this is a matter of clinical judgement. In such cases where a healthcare professional has declined to give treatment, then it is good practice to seek a second opinion, although the CAD cannot insist that the healthcare professional steps aside to allow another professional to take over the case. A CAD is supervised by the OPG, and where a healthcare professional suspects that a deputy is not acting in the best interests of the patient, he or she should refer the matter to the Public Guardian.

8.49 A valid and applicable ADRT overrules the decision of the CAD.

Independent Mental Capacity Advocates (IMCA)

8.50 If a patient aged 16 years or older who lacks capacity is to receive serious medical treatment, and that patient has no one else to consult and support them other than paid or professional staff, then unless a decision has to be made urgently (e.g. to save the person's life), an IMCA must be instructed. The duty to instruct rests with the Health Board in the case of treatment provided in hospital. (Note that there are other situations when an IMCA must be instructed – e.g. decisions about whether to place people into accommodation (for example, a care home or a long stay hospital and under the Deprivation of Liberty Safeguards.)

8.51 The role of the IMCA is to represent and support the patient. They will not make decisions on the patient's behalf. Such decisions will still be made by the healthcare professional on the basis of what is in the patient's best interests. However the IMCA will speak to the patient and, so far as possible, try to engage them in the decision process. They will assist in determining what is in the patient's best interests and

the healthcare professional must take into account the views of the IMCA in deciding what actions to take. The IMCA is entitled to information about the patient and to see his or her relevant health records.

8.52 Where serious medical treatment is proposed, they will discuss with the professional the proposed course of treatment or action and any alternative treatment that may be available and may, if they consider it necessary, ask for a second medical opinion.

8.53 Serious medical treatment for this purpose means treatment which involves providing, withdrawing or withholding treatment in circumstances:

- where there is a fine balance between the benefits and burdens the treatment would have on the patient and taking into account the likely risks, or
- where there is a choice of treatments, a decision as to which one to use is finely balanced, or
- what is proposed would be likely to involve serious consequences for the patient

Referral to the Court of Protection

8.54 Where there are difficult or complex decisions to make on behalf of a patient who lacks capacity, the matter must be referred to the Court of Protection if all other options for making the decision or resolving differences have been exhausted.

8.55 The Court of Protection can deal with any matters covered by the Mental Capacity Act 2005, such as:

- whether the patient has capacity to make a particular decision
- whether an ADRT is valid and applicable
- what course of action/decision would be in a patient's best interests
- where there is a dispute between healthcare professionals, members of the family, partners, carers or any other interested persons such as an Independent Mental Capacity Advocate or the attorney of a Lasting Power of Attorney about what is in the patient's best interests
- where there is doubt about whether the patient lacks capacity to make a decision for themselves and is not likely to regain capacity in the short term
- where treatment of an experimental nature is proposed

8.56 Where a patient lacks capacity then ***a referral to the Court must be made*** in the following circumstances:

- where it is proposed that the patient should undergo non-therapeutic sterilisation (e.g. for contraceptive purposes)
- cases involving organ or bone marrow donation by a patient who lacks capacity to consent
- where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and, for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests, or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both persistent vegetative state (PVS) and minimally conscious state (MCS)
- where there are doubts or a dispute about whether a particular treatment would be in the best interests of the patient

This is not an exhaustive list and the courts may extend the list of procedures that should always be referred. Legal advice should be sought.

8.57 In cases of PDOC, if

- the MCA, MCA *Code of Practice* and regulatory framework are observed correctly
- there is agreement as to what is in the patient's best interests
- a second independent clinical opinion is available which supports the best interests decision and that the clinical decision to withdraw Clinically Assisted Nutrition and Hydration (CANH) is reasonable in the circumstances, given the diagnosis

then life sustaining treatment (including CANH) can be withdrawn /withheld without the need to make an application to the Court. The second clinical opinion should be sought from a consultant with experience of PDOC, who has not been involved in the patient's care and who should, so far as reasonably practical, be external to the UHB. The consultant should examine the patient and review the patient's medical notes and the information that has been collected. Healthcare professionals should make a very detailed entry/record in the medical notes, outlining any relevant discussions or meetings that have taken place and the reasons for the opinion that has been provided. Legal advice can be sought to support the decision.

8.58 The Court has held that therapeutic abortion and sterilisation where there is a medical necessity does not automatically require a referral,

although such procedures can give rise to special concern about the best interests and rights of a patient who lacks capacity. In the case of a patient with learning disabilities, it is good practice to involve a learning disability consultant psychiatrist, the multidisciplinary team and the patient's family/partner as part of the decision-making process and to document their involvement. Less invasive or reversible options should always be considered before permanent sterilisation.

8.59 Appendix C provides advice for healthcare professionals who need legal advice when they are faced with a situation that may require the intervention of the Court of Protection. Guidance on referring matters to the Court of Protection has also been issued by the General Medical Council and the BMA.

http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp
https://www.bma.org.uk/advice/employment/ethics/mental-capacity/mental-capacity-toolkit/12-court-of-protection-and-court-appointed-deputies

8.60 Where an adult or young person has been assessed to lack the capacity to give or withhold consent to a significant intervention, this fact should be documented on Form 4: Treatment in best interests (see chapter 2 of this policy) along with full details of the assessment of capacity and best interests.

9. Human Tissue

Removal, storage and use of human tissue

9.1 The Human Tissue Act 2004 (HTA 2004) makes consent the fundamental principle underpinning the lawful retention and use of body parts, organs and tissue from the living or deceased for specified health related purposes and public display. Human tissue is defined as material which has come from a human body and consists of, or includes human cells. Live gametes and embryos are excluded as they are regulated under the Human Fertilisation and Embryology Act 1990 (HFEA).

9.2 *The Human Tissue Act Codes of Practice and Standards* issued by the Human Tissue Authority (HTA) contain detailed provisions on consent to the storage and use of relevant material from the living and the deceased. The Codes and Standards can be found on the following link: https://archive.hta.gov.uk/hta-codes-practice-and-standards-0

9.3 The HTA 2004 creates an offence of DNA theft. It is unlawful to obtain and store human tissue with the intention of its DNA being analysed, without consent of the patient from whom the tissue was obtained.

9.4 The HTA 2004 allows material taken from the living to be stored and used without consent for the following scheduled purposes on the basis that these are bound up with the general provision of clinical and diagnostic services:

- clinical audit
- education or training relating to human health
- performance assessment
- public health monitoring and
- quality assurance

9.5 However, if a patient actively objects to the use of their samples for such purposes, then that objection should be complied with. The Act and the Code contain a complex set of rules around the need for consent being required for the above purposes if the tissue is removed after death. There is also a set of rules about relevant material taken from a patient in their lifetime continues to be treated as such after death. It is the point at which the material is removed that determines how it is affected by the Act. The Code refers to concepts such as nominated representatives and qualifying relationships for the purpose of consent. It is too detailed to quote fully here and it should be consulted where relevant decisions need to be made.

9.6 Consent is required to store and use tissue removed from the living for:

- obtaining scientific or medical information about a patient which may be relevant to any other person (now or in the future)
- public display
- research into disorders, or the functioning of the human body and
- transplantation

9.7 The system must be well-publicised and transparent, making provision for patients to record their consent or objection to the use of such tissue and for this to be notified to the laboratory. Patients must also be able to record any objections to particular uses or use of particular tissues.

9.8 Written consent must be obtained from the patient either at the time of their procedure, or retrospectively, to indicate whether or not they give their consent to the use of removed tissue for a specific research project.

Consent to post mortem examinations

9.9 The Bereavement Intranet Page should be referred to for necessary details.

9.10 If a post mortem examination is ordered by the coroner, the consent of relatives is not required.

9.11 Other post-mortem examinations are hospital post-mortem examinations which are usually carried out at the request of doctors who have been caring for the patient or, sometimes, at the request of close relatives wishing to find out more about how a patient died. In some circumstances it may be appropriate to limit the examination to a particular region of the body.

9.12 All post mortems are carried out under an HTA licence held by the Health Board. It is a requirement of the HTA 2004 that appropriate consent is taken before a post-mortem can be carried out or any other tissue removed from the body of a deceased person. This consent must be obtained from a person in a "qualifying relationship" (see also above). The request for a hospital post-mortem should be made by the clinician who, after discussions, will liaise with the appropriate persons to ensure all statutory requirements are met.

9.13 For further information on post mortems the *Human Tissue Authority Code of Practice – Post Mortem Examination (Code B, 2012)* should be consulted. For further information on retention of tissues, organs

and body fluids, please seek advice from the pathologist.

Transplantation - living Donation

9.14 The HTA is responsible for the regulation, through a system of approvals, of the donation from living people of solid organs, bone marrow and peripheral stem cells for transplantation into others. Information on the legal requirements is available - https://www.hta.gov.uk/

Transplantation - deceased organ donation

9.15 Consent to organ donation in Wales is governed by the Human Transplantation (Wales) Act 2013. There is an associated Code of Practice - https://bts.org.uk/wp-content/uploads/2018/01/HTA_CoP_on_Human_Transplantation_Wales_Act_2013_-_Final_-_May_2014.pdf.

This system operates on the basis of deemed consent; it is assumed that the individual had no objection to organ donation unless they have registered or expressed a decision not to donate their organs following their death. Patient representatives should be consulted to obtain any evidence that a patient did not wish to be an organ donor.

9.16 Express consent to organ donation is required where a patient has not been an ordinary resident in Wales for more than 12 months before dying.

10. Clinical photography, video recordings and audio recordings

Making and using visual or audio recordings of patients

10.1 This chapter focuses on the consent aspect of making photographic, video or audio recordings of patients. 'Recordings' in this chapter means originals or copies of audio recordings, photographs and other visual images of patients that may be made using any recording device e.g. video.

10.2 Visual and audio recordings of patients may be made for any of the following reasons:

- As part of assessment, investigation or treatment of a patient, to be kept in the patient's medical notes
- For use in teaching, training or assessment of fellow healthcare professionals and students or other appropriate groups e.g. at a conference
- For use in clinical research
- For publication e.g. in a book, a journal, a patient information leaflet, on a poster or in publicity material, any of which may also be accessible on the internet
- As potential evidence e.g. following injuries sustained as the result of an accident or an assault or where there is suspected non-accidental injury

10.3 Because it is sometimes possible for people to be identified by tattoos or other distinguishing marks or features, or from the sound of their voice in an audio recording, it is the Health Board's policy that written consent must always be obtained prior to making a visual or audio recording of a patient (or part of a patient) for any of the purposes described in paragraph 10.2 (for exceptions see paragraph 10.9 below).

10.4 Healthcare professionals should always ensure that they ask for a patient's written consent in advance if any photographic, video or audio recording will result from a procedure (unless the patient is temporarily unconscious – see paragraph 10.18).

10.5 If you only obtain consent for use of photographic, video or audio recordings as part of treating or assessing a patient you must not use them for any purpose other than the patient's care or the audit of that care, without obtaining further consent from the patient.

General Principles

10.6 When making or using recordings you must respect the patient's privacy and dignity and their right to make or participate in decisions that affect them. The following general principles apply to most photographic, video and audio recordings:

- seek permission to make the recording and get consent for any use or disclosure
- give patients adequate information about the purpose of the recording when seeking their permission
- make recordings only when you have appropriate consent or other valid authority for doing so
- ensure that patients are under no pressure to give their permission for the recording to be made
- stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment
- do not participate in any recording made against a patient's wishes
- eyes or faces must not be blacked out in an attempt to conceal identity after the recording has been made. Every effort must be made to conceal the identity of the patient whilst the recording is being taken. You must ensure that the patient is informed if their face will be visible in the recording
- ensure that the recording does not compromise patients' privacy and dignity
- do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent
- make appropriate secure arrangements for storage of recordings

10.7 Before the photograph, video or audio recording is made, healthcare professionals must ensure that patients:

- understand the purpose of the recording, who will be allowed to see/hear it, the circumstances in which it will be shown/played, that copies are likely to be made if the recording is for educational purposes, and that the recording will be stored securely within the Health Board / Trust
- understand that, in the case of publication, they will not be able to withdraw their consent or control future use of the material, once the recording is in the public domain
- understand that withholding permission for the recording to be made, or withdrawing permission during the recording, will not affect the quality of care they receive
- are given time to read explanatory material and to consider the implications of giving their written permission. Explanatory material should not imply that permission is expected. It should

be written in language that is easily understood. If necessary, translations should be provided
- have completed and signed consent form which is broken down into granular statements for the various purposes, clearly indicating which statements they consent to and which ones they don't.

10.8 After the recording, the healthcare professional must ensure that:

- patients are asked if they want to vary or withdraw their consent to the use of the recording
- recordings are used only for the purpose for which patients have given consent
- patients are given the chance, if they wish, to see the recording in the form in which it will be shown
- recordings are given the same level of protection as with patient's medical notes against improper disclosure
- if a patient withdraws or fails to confirm consent for the use of the recording, the recording is not used and is erased as soon as possible

Recordings for which consent is not required

10.9 Permission and consent is not needed to make or use the recordings listed below, provided that, before use, they are effectively anonymised by the removal of any identifying marks (writing in the margins of an x-ray, for example):

- Images taken from pathology slides
- X-rays
- Laparoscopic or endoscopic images
- Images of internal organs (however, it is best practice to obtain written consent if the recording is to be used in education or publication and will be accompanied by verbal or written information which may enable inadvertent identification of the patient)
- Recordings of organ functions
- Ultrasound images

Children and young people

10.10 Where children lack the understanding to give their permission to photographic, video or audio recordings, healthcare professionals must get permission to record from the person with parental responsibility. Children under 16 who have the competence to give permission for a recording may sign the consent form themselves. Healthcare

professionals should make a note of the factors taken into account in assessing the child's competence. Young people are assumed in law to be competent and can give permission to recordings themselves, unless they lack capacity.

10.11 In cases of suspected non-accidental injury of a child, photographs may be taken without parental consent if necessary. However, these photographs must only be used as part of the clinical record, or as potential evidence. They must not be used for education, publication or research without written consent. If written consent is given for use in education, publication or research, it is recommended that images are not used for these purposes before or during likely legal proceedings.

Vulnerable adults

10.12 In the case of suspected non-accidental injury of a vulnerable adult, efforts should be made to obtain written consent to the taking and use of photographs as potential evidence.

10.13 If the patient is unwilling for recordings to be made for evidential purposes, then the patient should still be asked for consent to photographs being taken for their clinical record, if it is a valid addition to the record, or if it is not appropriate to seek their consent for evidential purposes at that time e.g. if the alleged perpetrator is present. Photographs taken for the clinical record cannot be used as evidence, unless, at a later date, the patient changes their mind. In this case the consent form can be modified at this later date, and these modifications must be signed and dated by the patient.

Foetal loss, stillbirth and neonatal death

10.14 Photographs taken solely for the purpose of giving them to the bereaved parents do not qualify as clinical photographs and therefore do not come under the auspices of this policy. Photographs taken on behalf of the bereaved must not be used for any other purpose without written consent from the person with parental responsibility.

10.15 If photographs are required for any other purpose (except during the course of a post mortem examination) the written consent of those with parental responsibility must be obtained.

Adults and young people who lack the capacity to consent for themselves

10.16 When adults or young people lack capacity to make a decision about an audio or visual recording for themselves, any decision must be made in accordance with the MCA.

10.17 As a general principle you should not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

10.18 The situation may sometimes arise where the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

Adults and young people who lack capacity - recordings made as part of clinical care, or as potential evidence

10.19 If it can be demonstrated that it is in the patient's best interests, then photographs, video and audio recordings can be made as part of the patient's clinical care, or as potential evidence. If someone holds a Health and Welfare LPA or is a CAD, they should be asked to consent on behalf of the patient. Otherwise the healthcare professional making the recording must confirm that they have assessed capacity and are acting in the patient's best interests.

Adults and young people who lack capacity - recordings made for education and publication

10.20 If adults or young people lack capacity to make a decision about photographs, video or audio recordings for themselves, then recordings can only be taken and used for education or publication if it has been determined to be in the patient's best interests.

Patients who have capacity but are unable to sign the consent form

10.21 Physical inability to sign a consent form does not detract from an individual's ability to give consent. Patients can indicate their consent verbally or non-verbally, in the presence of a witness, who should then sign the consent form to confirm that the patient's consent was given. Recordings can then be used in the same way as if the patient had signed the consent form.

Withdrawal of consent

10.22 Patients have the right to withdraw consent for the use of their audio or visual records at any time. This should be documented on the consent form and the form, or the appropriate section of the form, should be scored through. In the case of publication, it is particularly important to make it clear to patients, when consent is originally obtained, that once the recording is in the public domain there is no opportunity for effective withdrawal of consent.

Further information

10.23 The above information is drawn from the GMC guidance: *Making and using visual and audio recordings of patients* (2011), which gives further detailed advice in the use of recordings when treating or assessing patients.

Telemedicine

10.24 Telemedicine should be viewed as a form of examination, and valid consent should be obtained in the same way as in any other examination, not just to the recording and exchange of information but to the process of telemedicine. The patient should understand that:

- it is not the same as seeing a healthcare professional in a face-to-face meeting
- the information/diagnosis received may be compromised by the technology
- they have a right to decline review via telemedicine

Healthcare professionals must abide by their IT Security Policy and Data Protection Policies in the handling of all images/recordings and data

11. Consent to specific procedures

Consent to screening

11.1 Healthcare professionals must ensure that anyone considering whether to consent to screening can make a properly informed decision. As far as possible, they should ensure that screening would not be contrary to the individual's interest. Particular attention must be paid to ensuring that the information the patient wants or ought to have is identified and provided. Those taking consent should be careful to explain clearly:

- the purpose of the screening
- the likelihood of positive/negative findings and possibility of false positive/negative results
- whether there are any reasonable alternatives
- the uncertainties and material risks attached to the screening process
- any significant medical, social or financial implications of screening for the particular condition or predisposition
- follow up plans, including availability of counselling and support services

11.2 If healthcare professionals are considering the possibility of screening adults and young people who do not have capacity to consent to the screening they must act in accordance with the MCA and ensure that decisions made are in the patient's best interests. In appropriate cases, account must be taken of the guidance issued by bodies such as the Advisory Committee on Genetic Testing.

Consent to cosmetic treatments (surgical and non-surgical)

11.3 From **1 June 2016** new GMC guidance for Doctors applies to both surgical (such as breast augmentation) and non-surgical (such as Botox) procedures. A link to this guidance can be found here: http://www.gmc-uk.org/static/documents/content/Guidance_for_doctors_who_offer_cosmetic_interventions_080416.pdf

12. Seeking consent for genetic investigations (or investigations likely to reveal the diagnosis as being a genetic disorder)

12.1 Consent to genetic investigations is a particularly complex and controversial area.

Information and likely implications

232. 12.2 When obtaining consent for investigations which may reveal genetic disorders, it is important that patients have been given full information about the likely implications of the test. . There are points to note about the types of result that might come from a diagnostic genetic investigation, and which should be understood by the person giving consent:

- a clear explanation of the patient's problems or features
- no relevant findings, even if the problem has a genetic cause
- a variant of uncertain significance (VUS) (on chromosomal microarray or on the DNA sequencing of a gene, a panel of genes, the exome or the whole genome). It may become possible to clarify the interpretation of such a VUS at some point in the future, so a reinterpretation after a few years might be appropriate
- an incidental finding may emerge of no relevance to why the test was performed, but is still of some possible clinical importance to the patient and perhaps to other members of the family. For example, a test may be performed to investigate neurodevelopmental difficulties. The results may or may not explain those problems, but the test might find some other variant that indicates a serious risk of an inherited cancer or of cardiac disease or late-onset dementia etc.
- as understanding of genetics improves rapidly, the result may be subject to reinterpretation in the future. Regard must be given to many results issued now being somewhat provisional.

12.3 If healthcare professionals are considering the possibility of performing investigations on adults and young people who do not have capacity to consent to the investigation, they must act in accordance with the MCA and ensure that they make decisions in the patient's best interests.

12.4 It is recommended that reference should be made to specialist guidelines such as guidance issued by the Joint Committee on Medical Genetics: https://www.bsgm.org.uk/healthcare-professionals/confidentiality-and-genetic-information/

13. Withholding or withdrawing life – sustaining treatment

General

13.1 The GMC guidance *Treatment and care towards the end of life: good practice in decision making* (2010) provides detailed guidance on withdrawing and withholding life - sustaining treatment.

13.2 A competent patient should always be consulted when making a decision to withhold or withdraw life-sustaining treatment unless the healthcare professional forms a view that involvement will actually 'harm' the patient. Recent case law has underlined the extent of the duty of the healthcare professionals to consult a competent patient[8] or those with an interest in the welfare of the patient, where that patient lacks mental capacity[9] to be involved in the decision.

13.3 Any valid and applicable ADRT is legally binding and must be respected unless a patient has subsequently made a Health and Welfare LPA giving the attorney authority to make decisions regarding the provision of life-sustaining treatment.

13.4 Where the patient lacks capacity to be involved in the decisions, and the patient has not made a Health and Welfare LPA giving an attorney appropriate authority, the healthcare professional must consult the patient's relatives, friends, or carers and other professionals involved in their care when making a best interests decision about the withholding or withdrawal of life-sustaining treatment. If there is no-one other than paid staff to consult with, an IMCA must be instructed. Where an urgent decision is required and a patient's representatives cannot be contacted, the reasons for this must be carefully recorded in the patient's medical notes. See paragraphs 8.34 – 8.40 above.

13.5 There is an important distinction between withdrawing or withholding treatment which is of no clinical benefit to the patient or is not in the patient's best interests, and taking a deliberate action to end the patient's life. A deliberate action which is intended to cause death is unlawful. Equally, there is no lawful justification for continuing treatment which is not in a patient's best interests.

13.6 Once a decision has been reached to withhold or withdraw life-prolonging treatment, the basis of the decision and the details of any discussions with the patient and/or their representatives must be

[8] Tracey v Cambridge University Hospital NHS FoundationTrust & Ors
[9] Elaine Winspear v City Hospitals Sunderland NHS Foundation Trust

recorded in the medical notes. Decisions to withhold or withdraw life-prolonging treatment should be reviewed periodically and following any relevant change in a patient's circumstances.

Prolonged disorder of consciousness (PDOC)

13.7 If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a second independent clinical opinion is available which supports the best interests decision, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. For more detail see paragraphs 8.56 and 8.57.

13.8 Additional information is available from:

- RCP, BMA (2018) Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent
- GMC (2010) Treatment and care towards the end of life: good practice in decision making

14. Medical treatment of patients with a mental disorder

Basic principles

14.1 This chapter provides information regarding consent issues relating to the medical treatment of patients with a mental disorder. It should not be read in isolation from the rest of this policy, since the principles contained throughout this document apply to all patients from whom consent is sought, irrespective of whether or not they have a mental disorder.

14.2 The principle of self-determination and autonomy of the individual, described in chapter 1 of this policy, applies equally to those who are suffering from mental disorder; a key distinction being that, in the circumstances authorised by the Mental Health Act 1983 (referred to as the MHA), treatment for a mental disorder may be given in the absence of the recipient's consent. Nevertheless, consensual treatment should always be sought in line with the principle of provision within the least restrictive context.

14.3 Part 4 of the MHA is concerned with consent to treatment. The reader should also refer to the MHA 1983 Code of Practice for Wales, 2016 generally and particularly chapters 24 and 25 for further information about consent and the Mental Health Act 1983.

14.4 Patients suffering from mental disorder, including those detained under the MHA are not necessarily incapable of giving valid consent and each patient's capacity to consent has to be judged individually in the light of the decision required and the patient's mental state at the time. Lack of capacity can be permanent or temporary and can also vary over time. Assessment of capacity should follow the principles described in the Mental Capacity Act 2005 (see chapter 8 of this policy).

14.5 The approved clinician in charge of the treatment has a duty to ensure that the patient is provided with sufficient information to enable him/her to understand:

- the nature, purpose, likely and intended effects of the treatment
- their right to withdraw consent at any time, and
- how and when treatment can be given without their consent, including the legal authority for the treatment

14.6 A record of the discussion at which consent is obtained or sought must be fully recorded in the health records.

14.7 Inpatients in Wales, whether detained or informal, and those subject to conditional discharge, a community treatment order, or guardianship are eligible for an independent mental health advocate (IMHA). All patients being considered for s57 type treatments (i.e. psychosurgery or implantation of hormones to reduce male sex drive) and children under 16 years being considered for ECT are also eligible. The only exception is a patient detained in a place of safety under s135 or s136 of the MHA. Further information about the role of the IMHA may be found in chapter 6 of the MHA Code of Practice for Wales, 2016.

Medical treatment for mental disorder

14.8 Psychiatric in-patients may be classified into three groups when considering consent to treatment for their mental disorder:

a) patients detained under the Mental Health Act 1983
b) informal patients who possess capacity to consent to treatment, and
c) informal patients who lack capacity to consent to treatment

a. Patients detained under the Mental Health Act 1983

14.9 Where a patient is capable of giving consent and refuses, non-consensual treatment may only be given if it is for a mental disorder and the healthcare professional has the legal authority in accordance with the provisions of the MHA and the necessary certification requirements. Medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation and rehabilitation and care the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.

14.10 Medical treatment for mental disorder (except treatments under s. 57 i.e. psychosurgery and implantation of hormones to reduce male sexual drive) may be lawfully administered without the patient's consent provided:

- the patient is detained under the Mental Health Act 1983 (excluding patients detained under ss. 4(4)(a), 5(2), 5(4), 35, 135, 136, 37(4)), and
- the proposed medical treatment falls within the provisions of
  - s58 (a second opinion is required for patients who are refusing or incapable of consenting after three months of treatment)
  - s62 (urgent treatment), or
  - s63 (treatment for the first three months of detention) of the MHA

b. Informal patients who possess capacity to consent to treatment

14.11 Where informal patients possess the required capacity to give valid consent to medical treatment for mental disorder or to a plan of treatment, then their consent must be obtained. Where appropriate, this should be written consent. Where informal patients with capacity refuse treatment for their mental disorder consideration may be given to detaining the patient under the provisions of the MHA.

c. Informal patients who lack the capacity to consent to treatment

14.12 An assessment of capacity should be undertaken in accordance with the MCA. If a patient is found to lack capacity to consent to treatment then a determination of their best interests must be undertaken before any treatment is provided. In assessing someone's best interests it is essential to consult people who are close to the patient.

14.13 Section 5 of the Mental Capacity Act 2005 (MCA) provides that treatment may be given to a patient who lacks capacity to consent provided that it is in his or her best interests to do so. Section 6 of the MCA provides that a patient may only be restrained to give care or treatment if it is necessary to prevent harm and it is a proportionate response to the likelihood and severity of that harm – provided that it in in his/her best interests.

14.14 If a patient who lacks capacity to consent to treatment appears to be objecting to treatment, then consideration should be given to detaining the patient under the MHA.

Patients detained under the Mental Health Act 1983 requiring treatment for a physical disorder

14.15 Part IV of the MHA is concerned with medical treatment for mental disorder. The MHA cannot be used to enforce treatment for a physical disorder, which is unrelated to a mental disorder, where a patient refuses consent. For patients who lack capacity to consent to medical treatment for a physical illness the provisions of the MCA would be engaged.

14.16 The patient's mental disorder may affect their capacity to consent. This should be assessed as a priority in line with the MCA, as treatment for the physical disorder might proceed in the patient's best interests. However, it should not be assumed that the patient lacks capacity simply because they have a mental disorder.

14.17 Section 63 of the MHA may allow for the treatment of a physical disorder, without the patient's consent, where it is 'ancillary to the

treatment of the mental disorder' for example:

- Naso-gastric feeding a patient with anorexia nervosa (*Re KB (Adult)* (1994))
- Taking blood for patients on clozapine
- Treating self-inflicted wounds

14.18 The term 'medical treatment' in section 63 of the MHA refers to treatment which, taken as a whole, is calculated to alleviate or prevent a deterioration of the mental disorder from which the patient is suffering. This includes a range of acts ancillary to the core treatment including those which prevent the patient from harming herself or those which alleviate the symptoms of the disorder (B v Croydon HA [1995])

14.19 If uncertainty exists as to a patient's capacity to consent to treatment, or whether the physical disorder may be treated as a symptom of the mental disorder, legal advice should be sought. See appendix C.

15. Consent to research and innovative treatment

Research

15.1 Any research undertaken within the Health Board must be registered with the Health Board's Research & Development Office, from where additional advice can be obtained. All research and development must be approved before it can be commenced. Please visit the Research and Development Department's intranet page

15.2 Consent to clinical trials is covered by the *Medicines for Human Use Regulations* (2004)

15.3 The same legal principles apply when seeking consent from a patient for research purposes. GMC guidance states that patients 'should be told how the proposed treatment differs from usual methods, why it is being offered, and if there are any additional risks or uncertainties'.

15.4 Where the proposed treatment is of an experimental nature, but not part of a research trial, this fact must be clearly outlined to the patient along standard alternatives – including no treatment – during the consent process.

Patients who lack capacity to consent to being involved in research

15.5 There are strict rules within the MCA concerning the involvement of people who lack capacity in research. (See MCA *Code of Practice* and Welsh Government's *Guide to Consent for Examination and Treatment*). In determining whether the patient should participate in the proposed research, the patient's wishes and feelings about being involved in research should be respected. It should be stressed that many research studies are non-therapeutic, i.e. they will not benefit the research participants personally. Carers or other persons who have an interest in the patient's welfare must be consulted. If there is no one who can be consulted, then a person who is unconnected with the research project must be appointed to advise on whether the patient should take part in the research. If at any time during the research it appears that the patient is upset or unhappy, it must cease immediately. Please see the Research, Consent and Capacity: Standard operating procedure

15.6 Where a patient lacks capacity, experimental/innovative treatment cannot be given unless it is in their best interests. Where there is no alternative treatment available, it may be reasonable to consider an experimental treatment, with unknown risks and benefits, where

treatment may benefit the patient.

Consent to research and innovative treatment in children

15.7 The legal approach to consent to therapeutic research in children is similar to any other proposed examination or treatment: the treatment must be in the child's best interests.

15.8 UHB staff should contact the R&D Department for further advice on obtaining consent for children aged under 16 years. The approach will differ depending on whether the study is a clinical trial or not, and whether or not the proposed research will take place in an emergency setting.

16. Training

The following types of training are available to staff:

- Mental Capacity Level 1 (ESR) (covers consent to treatment)
- Mental Capacity Level 2 (ESR)
- Face-to-face training on both MCA and Consent provided by the Mental Capacity Team (both levels)

Mental Capacity Act training is mandatory for all staff who have contact with patients.

Supplementary Guidance

17. Consent in obstetrics and gynaecology

Pregnant women

17.1 A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to herself and/or her foetus(es). Any treatment involving the foetus will require maternal consent. However, it should be stressed that maternal refusal of treatment thought to benefit one or both parties is a rarity.

Caesarean section (including refusal)

17.2 If a caesarean birth is required, the standard Consent Form 1 must be used. Women in labour can consent to a caesarean birth even if they have received sedation.

17.3 It is important to ensure that all pregnant women have a good understanding of the different ways in which they may give birth and the associated benefits and material risks. This will include information about the circumstances in which a caesarean birth will be offered. A pregnant woman with capacity may refuse a caesarean birth, even if "the consequence may be the death or serious handicap of the child she bears, or her own death" (Court of Appeal Re MB). In other words a mentally competent woman in labour has the same right under common law to consent to or refuse consent to treatment as any other patient. United Kingdom law does not currently grant the foetus any legal rights, therefore a caesarean birth cannot be authorised by a Court against a competent woman's will and action cannot be taken in the best interests of the pregnant woman or the foetus. In this situation all advice given to the woman should be recorded in her notes. Unequivocal assurances should be obtained from the woman (and recorded in writing) that the refusal represents an informed decision: that is, that she understands the nature of and reasons for the proposed treatment and the risks and the likely prognosis involved in the decision to refuse or accept it. It is good practice to ask the woman to sign the written indication of her refusal. It is also good practice to involve another senior colleague to indicate that a body of senior medical opinion considers caesarean birth to be the most appropriate course and that the patient has refused consent for a caesarean birth.

17.4 If the woman is unwilling to sign a written indication of this refusal, this too should be recorded in the notes. Such a written indication is merely a record for evidential purposes. It should not be confused with or regarded as a disclaimer.

17.5 There have been a number of cases where doubts have arisen, for various reasons, as to a woman's capacity to make a valid decision

about a caesarean birth. Temporary factors such as fear, shock, fatigue, pain or drugs may affect capacity. If there is reason to doubt capacity, support should be provided to help the woman make a decision. If that fails, a capacity assessment must be undertaken.

17.6 Where there is any doubt about a woman's capacity and/or where a refusal would lead to serious consequences for the pregnant woman or her unborn child, then legal advice should be obtained. If a pregnant woman refuses a caesarean birth (or any other intervention) and it has been demonstrated (in line with the MCA) that she lacks the capacity to make such a decision, an application to the CoP will be required to decide whether or not such treatment can be carried out Please see Appendix C for details of how to obtain legal advice. In the case of Re S, the Court of Appeal laid down general principles that should be applied in future cases. If the mother lacks capacity, avoiding the foetus' death may be seen by the Court as being in the best interests of the mother.

17.7 Where a pregnant woman lacks capacity due to unconsciousness and so is incapable of giving consent, the caesarean birth may be carried out if it is in her best interests, unless a valid and applicable advance decision to refuse treatment exists. The most usual form of advance decision used by pregnant women is the birth plan. However, if there is reason to doubt the reliability of the advance decision (e.g. it might sensibly be thought not to apply to the circumstances which have arisen – see chapter 8 of this policy) then legal advice should be sought. See Appendix C.

Sterilisation

17.8 Men and women requesting sterilisation should be given information about alternative long-term reversible methods of contraception. This should include information on the risks, benefits and relative failure rates of each method. Non-operative methods of long-term contraception should have been specifically rejected by the patient before a decision is taken to proceed with sterilisation.

17.9 Both vasectomy and tubal occlusion should be discussed with all men and women requesting sterilisation. Women in particular should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancy and there is less risk related to the procedure when compared with female sterilisation.

17.10 Patients should be told that the procedure is intended to be permanent, but should also be given the success rates of reversal procedures. They should be informed that the reversal operations of in vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI) are rarely

provided by the NHS.

17.11 People requesting sterilisation should be informed that tubal occlusion and vasectomy can be unsuccessful and that pregnancies can occur several years after the procedure.

17.12 Written consent must be obtained for vasectomy, and the man should be advised to take other contraceptive precautions until there have been two consecutive negative semen analyses. It is important that the possibility of late failure is explained to the patient and his partner before vasectomy, so they can make informed decision about additional contraceptive methods.

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17.13 Non therapeutic sterilisation of someone who lacks the capacity to give their consent must be referred to the Court of Protection. The individual's capacity and best interests must be thoroughly assessed in line with the Mental Capacity Act and legal advice should be sought at all times. (See chapter 8 and Appendix C).

Fertility

17.14 It is a legal requirement under the HFEA 1990, as amended, that consent to the storage and use of gametes must be given in writing after the patient has received such relevant information as is proper and had an opportunity to receive counselling. Where these requirements are not satisfied, it is unlawful to store or use the patient's gametes. Healthcare professionals should ensure that written consent to storage exists before retrieving gametes.

17.15 Outside specialist infertility practice, these requirements may be relevant to healthcare professionals whose patients are about to undergo treatment which may render them sterile (such as chemotherapy or radiotherapy) where a patient may wish to have gametes, or ovarian or testicular tissue, stored prior to the procedure. Healthcare professionals may also receive requests to remove gametes from a patient unable to give consent.

17.16 The HFEA 1990, as amended, makes provision to address cases where the taking of gametes is in the patient's best interests but the patient is unable to give written consent or lacks capacity to consent to the storage of the gametes.

17.17 Further guidance is available from the Human Fertilisation and Embryology Authority.

Termination of pregnancy

17.18 The termination of a pregnancy may only take place with the informed consent of the pregnant woman. Prior to obtaining written consent, discussion must take place concerning the type of procedure (medical or surgical) and the risk of complications. Written information should be given to support verbal information. The husband or putative father's authority is not legally required.

17.219 If a woman opts for a medical termination of pregnancy then a realistic description should be given of the process, the number of visits necessary and the need for a health care professional to see products of conception or to perform a subsequent scan to ensure the termination is complete. It should be pointed out that there is a small risk of heavy bleeding at home before returning to hospital for the second part of the procedure, and that there is a high chance of miscarriage if the patient changes her mind between the first and second stages of the procedure.

17.20 If cervical ripening agents are to be used before surgical termination of pregnancy, the patient should understand that there is a high chance of miscarriage if she changes her mind before completing the procedure.

17.21 Prior to taking consent for termination of pregnancy, the senior doctor (Registrar or above) must sign Certificate A (Abortion Act, 1967) to indicate that he is in agreement with the need for the termination. The woman will receive counselling in advance of the procedure and will then be scanned to assess gestational age. If the procedure is to be undertaken, Consent Form 1 must be used.

17.22 Clinicians are advised to seek legal advice (see Appendix C) where:

- a woman lacks the mental capacity to understand and appreciate the nature or consequences of a termination of her pregnancy; or
- a woman is in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy
- a partner wishes to over-rule a decision to terminate a pregnancy

Histological examination and disposal of non-viable foetal products

17.24 Consent should always be obtained with regard to the histological examination and disposal of non-viable foetal products up to the age of 24 weeks gestation.

Appendix A - Link to current consent forms in use in this organisation – Link update

Copies of the All-Wales consent forms can be found here – All Wales Consent Forms: Patient Consent to Examination or Treatment - NHS Wales Shared Services Partnership
The forms must be purchased through the ORACLE system.

The forms are –

Form 1 for patients aged 16 years and over with mental capacity and also for *Gillick* competent children

Form 2 for parental consent for a child who is not competent

Form 4 for patients aged 16 years and over who lack capacity to consent to examination or treatment

Appendix B - Useful contact / link details

Mental Capacity Team (for both consent and MCA queries), Tel. 029 2183 2001

Head of Risk and Regulation, Tel. 029 2183 6012 (for accessing legal advice)

Executive Medical Director, Tel. 029 2183 6001 (Executive Lead)

Out of hours advice/guidance in emergencies, via the on-call Senior Manager rota, including obtaining legal advice

Appendix C – How to obtain legal advice

If you need advice about a consent/capacity issue and/or you think a court application may be required, you should in the first instance contact the Mental Capacity Team/Head of Risk and Regulation who will be able to advise whether you need to access a Solicitor.

The UHB's How to access Legal Advice Procedure can be found here: ..\..\LPS\LPS Training\Email docs for Training\UHB 469 Accessing Legal Advice Procedure Clean (1).docx

If you need urgent legal advice out of hours, access to a Legal and Risk Solicitor can be obtained via the on-call Senior Manager rota.

You should ensure that you have all the relevant information about the case to hand so that you can brief the MCA Team/ on-call Senior Manager/ Solicitor appropriately.

You should keep a clear record of the legal advice you have been given by the Solicitor and you should follow that advice.

There may be occasions when the situation may be so urgent, and the consequences so desperate, that it is impractical to attempt to comply with these guidelines. Where delay may itself cause serious damage to the patient's health, or put their life at risk, then rigid compliance with these guidelines would be inappropriate.

The Court of Protection deals with serious decisions affecting personal welfare matters, including health care. Cases involving any of the following decisions should be regarded as serious medical treatment, and should be brought to the court:

a) cases involving organ or bone marrow donation by a patient who lacks capacity to consent
b) cases involving non-therapeutic sterilisation of a patient who lacks capacity to consent
c) where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests, or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both persistent vegetative state (PVS) and minimally conscious state

(MCS)

d) all other cases where there is dispute about whether a particular treatment will be in a patient's best interests (including cases involving ethical dilemmas in untested areas).

Appendix D - Assessing and documenting *Gillick* Competence in Under 16s

Assessment of *Gillick* competence should document the following[10]:

- The age of the child
- The intervention being offered
- The child's ability to understand that there is a choice and that choices have consequences, both risks and benefits
- The child's understanding of the nature and purpose of the proposed intervention
- The child's understanding of the proposed intervention's risks and side effects, both in the short and long term
- The child's understanding of any alternatives to the proposed intervention, and the risks and benefits attached to them
- The child's ability to weigh the information and arrive at a decision
- The child's willingness to make a choice (including the choice that someone else should make the decision)
- An estimate of the child's freedom from undue pressure

[10] BMA - Children and Young People Toolkit

Appendix E - About the consent form: information for patients

Before a doctor or other healthcare professional examines or treats you, they need your consent – in other words, your agreement. Sometimes you can simply tell them whether you agree with their suggestions. However, sometimes a written record of your decision is helpful – for example, if your treatment involves sedation or general anaesthesia. In this case, you will be asked to sign a consent form. If you later change your mind about having the treatment, you are entitled to withdraw consent – even after signing the form.

What should I know before deciding?

Healthcare professionals must ensure you know enough to enable you to decide about treatment. They will write information on the consent form and offer you a copy to keep (in either Welsh, English or both languages) as well as discussing the choices of treatment with you. Although they may well recommend a particular option, you do not have to accept that option. People's attitudes vary to things like the amount of risk or pain they are prepared to accept. That goes for the amount of information, too. The person who is treating you will encourage you to listen to all of the information about your treatment but if you would rather not know about certain aspects, discuss your worries with them.

Should I ask questions?

Healthcare professionals will encourage you to ask questions and you should always ask anything you want. As a reminder, you can write your questions down. The person you ask should do his or her best to answer, but if they don't know they should find someone else who is able to discuss your concerns. To support you and prompt questions, you might like to bring a friend or relative. Ask if you would like someone independent to speak up for you.

Is there anything I should tell people?

If there is any procedure or treatment you **don't** want, you should tell the people treating you. It is also important for them to know about anything that is particularly important to you and any illnesses or allergies which you may have or have suffered from in the past.

Who is treating me?

Amongst the healthcare professionals treating you may be a "doctor in training" – medically qualified, but now doing more specialist training. They range from recently qualified doctors to doctors almost ready to be consultants. They will only carry out procedures for which they have been

appropriately trained. Someone senior will supervise – either in person accompanying a less experienced doctor in training or available to advise someone more experienced. Other healthcare professionals such as nurses and therapists may also provide you with treatment.

What about anaesthesia?

If your treatment involves general or regional anaesthesia (where more than a small part of your body is being anaesthetised), you will be given general information about it in advance. You will also have an opportunity to talk with the anaesthetist when he or she assesses your state of health shortly before treatment. For some procedures, you will be invited to a pre-assessment clinic which will provide you with the chance to discuss things a few weeks earlier.

Will samples be taken?

Some kinds of operation involve removing a part of the body (such as a gall bladder or a tooth). You would always be told about this in advance. Other operations may mean taking samples as part of your care. These samples may be of blood or small sections of tissue, for example of an unexplained lump. Such samples may be further checked by other healthcare professionals to ensure the best possible standards. Again, you should be told in advance if samples are likely to be taken.

Sometimes samples taken during operations may also be used for teaching, research or public health monitoring in the future interests of all NHS patients. If a healthcare professional wishes to use your samples for research purposes they will ask for your written consent.

Students

One of the ways that student doctors, nurses or other healthcare professionals learn is by watching care or treatment being given. If the healthcare professional treating you would like a student to watch your examination or treatment, then they have to ask your permission first. If you are having sedation or an anaesthetic during your treatment, then they need your written consent for a student to watch your procedure. This is why there is a section on the consent form for you to say whether or not you agree to students being present. If you are happy for the student to be present, they will be supervised by a qualified member of staff at all times. Your care will not be affected in any way if you decide that you prefer not to have students in the room during your procedure.

Advance decision to refuse treatment (ADRT)

Some people chose to make an ADRT refusing certain care or treatment (sometimes referred to as “living wills” or “advance directives”). If you have

made, or wish to make an advance decision refusing a treatment or procedure which may become necessary during the course of your care or treatment, then you must tell the healthcare professional caring for you. This will make sure that your decisions are followed, for example, whilst you are under anaesthetic. This is why there is a section on the consent form for you to say whether or not you have made a relevant advance decision.

Photographs, videos and audio recordings

As part of your treatment it is sometimes helpful for a photographic, video or audio recording to be made – for example, to record changes to a skin lesion. You will always be told if this is going to happen. The use of photographs and recordings is also extremely important for other NHS work, such as teaching or medical research. If the healthcare professional would like to take photographs, video or audio recordings, then you will be asked to sign a consent form giving your permission. The photograph / video / audio recording will be kept with your notes and will be held in confidence as part of your medical record. This means that it will normally be seen only by those involved in providing you with care or those who need to check the quality of care you have received, unless you have given permission for it to be used in other ways e.g. teaching, publication, research. We will not use the photograph / recording in a way that might allow you to be identified or recognised without your express permission.

What if things don’t go as expected?

Amongst the 25,000 operations taking place every day, sometimes things don’t go as they should. Although the doctor involved should inform you and your family, often the patient is the first to notice something amiss. If you are worried – for example, about the after-effects of an operation continuing much longer than you were told to expect – tell a healthcare professional right away. Speak to your GP, or contact your clinic - the phone number should be on your appointment card, letter or consent form copy.

What do I need to know?

You should be made aware of all of the significant risks (including important (material) risks to you), benefits and alternative treatments (including no treatment) of what is being proposed by the healthcare professional, so that you can make an informed decision

What are the key things to remember?

It’s your decision! It is up to you to choose whether or not to consent to what is being proposed. Ask as many questions as you like, and remember to tell the team about anything that concerns you or about any medication, allergies or past history which might affect your general health.

Can I find out more about giving consent?

This Health Board has a policy on patient consent to examination or treatment, which will be made available to you on request. The Welsh Government has also issued a *Guide to Consent for Examination or Treatment* which can be accessed at: http://www.wales.nhs.uk/governance-emanual/patient-consent/

Questions to ask healthcare professionals

As well as giving you information healthcare professionals must listen and do their best to answer your questions. Before your next appointment, you can write some down.

You may want to ask questions about the **treatment itself**, for example:

- What are the main treatment options?
- What are the benefits of each of the options?
- What are the risks, if any, of each option?
- What are the success rates for different options (nationally, for this unit or for the surgeon)?
- Why do you think an operation (if suggested) is necessary?
- What are the risks if I decide to do nothing for the time being?
- How can I expect to feel after the procedure?
- When am I likely to be able to get back to work?

You may also want to ask questions about how the treatment might affect your future state of health or lifestyle, for example:

- Will I need long-term care?
- Will my mobility be affected?
- Will I still be able to drive?
- Will it affect the kind of work I do?
- Will it affect my personal/sexual relationships?
- Will I be able to take part in my favourite sport/exercises?
- Will I be able to follow my usual diet?

Health care professionals should welcome your views and discuss any issues so they can work in partnership with you for the best outcome.

Unacceptable behaviour

Our staff deserve the right to do their jobs without being verbally or physically abused. Most of our patients and visitors respect this right. Thank you for being one of them. We will work with the police to prosecute those who abuse our staff.

Complaints and compliments

We would like to hear your views about your experience of our services. Our aim is to provide you with the highest standards of care at all times, but we recognise that things can sometimes go wrong. If you have any concerns, speak to the senior staff member on duty or the appropriate ward, hospital or community manager, who will be able to assist and, hopefully, resolve matters to your satisfaction. Where this is not successful, ask for our leaflet *Putting Things Right – Raising a concern about the NHS in Wales*. This advises you how to make a formal complaint and the various stages of the procedure.

In making a complaint, advice and assistance is available to you from your local Community Health Council, which represents the interests of patients and the public in the NHS. The Community Health Councils are skilled in handling complaints. Their Complaints Advocates can provide a range of support during the process of your complaint.

Llais

Pro-Copy Business Centre (Rear)
Parc Ty Glas
Llanishen
CARDIFF
CF14 5DU

Tel. 029 2075 0112

Email. SouthGlam.chiefofficer@waleschc.org.uk

Data Protection Act/General Data Protection Regulations (2016) or any subsequent legislation having the same effect

Under current Data Protection legislation, we are committed to protecting the privacy of patient information. If you require an explanation of why information is needed, or how you can access information or your health records, please contact

Health Records Manager

Legal Services Section
Medical Records Department
University Hospital of Wales
Heath Park
CARDIFF
CF14 4XW

Tel. 029 2074 6500

You are entitled to see your health records but if you wish to receive a copy note that a charge will usually be made. You should also be aware that in certain circumstances your right to see some details in your health records may be limited in your own interest or for other reasons.

APPENDIX 1

Equality & Health Impact Assessment for

CONSENT TO EXAMINATION OR TREATMENT POLICY

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
- 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	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	LPS Project Lead, Tel. 029 2183 2001 Safeguarding, Corporate Nursing
3.	Objectives of strategy/ policy/ plan/ procedure/ service	This policy sets out the legal framework that governs the provision of treatment and care to patients. The legal framework comprises the common law on consent; the Mental Capacity Act 2005; and the Mental Health Act 1983.

		There is also some particular legislation for specialist issues – e.g. research and organ donation. The policy applies to all the UHB's patients. Clinicians who do not comply with this policy are likely to be acting unlawfully.
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[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	• This Policy applies to all patients being treated and cared for by the UHB and sets out the law regarding the provision of health care and treatment. If the Policy is not followed, staff will be treating and caring for patients unlawfully. As the Policy applies to all patients, there is no question of the Policy having a negative effect on any of the equalities groups. There are positive impacts which the policy includes – see the impact section below. • The EHIA completed for the previous version of this Policy found there to be no adverse impact on any of the equalities groups. As the law on consent and capacity has not substantially changed since then, it is most unlikely that the effect of this Policy on any of the equalities groups will have changed. There are positive impacts which the policy includes – see the impact section below.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	UHB staff and patients.

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

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	In the case of a patient under 16 years of age, consent may be given either by the patient, if they are *Gillick* competent, or by someone with parental responsibility for them. For patients who are 16 years and over, treatment and care may be lawfully provided either with the patient's consent, or through the Mental Capacity Act 2005. Patients of any age may be treated under Mental Health Act 1983. The Policy therefore has a positive impact, because patients of all ages are reflected in the policy.		
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	For patients under 16 years of age who have a disability, consent may be given either by the patient, if they are *Gillick* competent, or by someone with parental responsibility for them. For patients who are 16 years and over, treatment and care may be lawfully provided either with the patient's consent, or through the Mental Capacity Act 2005. Patients of any age may be treated under Mental Health Act 1983.		

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
	For treatment and care to be provided lawfully, it is essential that patients are able to both receive information and communicate in the medium of their choice, as the Consent Policy makes clear. So, for example, it is essential that UHB staff access BSL interpreters, where appropriate. The Mental Capacity Act 2005 has as one of its principles the provision of support to help people make their own decisions. The Consent Policy includes the need to provide information to patients in different languages and media and to comply with the Mental Capacity Act 2005 where appropriate. The Mental Capacity Act 2005 Code of Practice gives examples of the kinds of support that could be provided. The Policy therefore has a positive impact, because it sets out the legal requirements to provide patients with information that they can understand and to support them to make their own decisions.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment	No evidence. All UHB patients must be treated in compliance with the law, regardless of their gender.		

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
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			
6.4 People who are married or who have a civil partner.	No evidence. All UHB patients must be treated in compliance with the law, regardless of their marriage or civil partnership status.		
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 evidence. All UHB patients must be treated in compliance with the law, regardless of whether or not they are pregnant or have just had a baby, or are breast-feeding.		

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	All UHB patients must be treated in compliance with the law, regardless of their race. For treatment and care to be provided lawfully, it is essential that patients are able to both receive information and communicate in the language of their choice. If patients cannot understand the information about the treatment they are being offered, then any "consent" will be invalid and the treatment will be unlawful. The Policy reflects that patients must be given information and communicate in the language/method of their choice. The Policy may therefore have a positive impact.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Whether patients have a religious faith or not, they cannot be treated without their consent, or outwith the Mental Capacity Act 2005 or the Mental Health Act 1983. The law is clear that people who have the mental capacity to do so, may refuse any treatment on any grounds, including religious beliefs, or for no clear reason. The Policy, in setting out the law, may have a positive impact.		
6.8 People who are attracted to other people of:	No evidence. All UHB patients must be treated in compliance with the law, regardless of their sexual orientation.		

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 opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)			
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	All UHB patients must be treated in compliance with the law, regardless of their being Welsh speakers or speakers of any other language. If patients are unable to understand the information they are given about possible treatments, because of language differences, then any "consent" gained will be invalid and any treatment may well be unlawful. The policy reflects the requirement to ensure that patients are able to receive information and communicate in the language/manner of their choice. The Policy may therefore have a positive impact.		
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 evidence. All UHB patients must be treated in compliance with the law, regardless of their income.		

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
6.11 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 evidence. All UHB patients must be treated in compliance with the law, regardless of where they live.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	No evidence.		

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	No impact		
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	No impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
impact on 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	No impact		
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	No impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
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	No impact		

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 Policy applies to all of the UHB's patients. It sets out the law regarding consent to treatment and mental capacity. If the Policy is not followed then the patient is at risk of unlawful treatment/care, regardless of whether or not they are protected by equalities legislation. The policy may have a positive impact on the following equalities groups – age; disability; race; religion and Welsh language. There is no evidence that the Consent Policy adversely affects any of the equalities groups and it is neither directly nor indirectly discriminatory under the equalities legislation.

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?	Remind Clinical Boards to report any Consent Policy Equality issues to Mental Capacity Team	LPS Project Lead	After adoption of updated Consent Policy	

	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?	No.			

	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:
  ○ continues unchanged as there are no significant negative impacts
  ○ adjusts to account for the negative impacts
  ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)
  ○ stops.
• Have your strategy, policy, plan, procedure and/or service proposal approved
• Publish your report of this impact assessment
• Monitor and review
	Submit to Quality, Safety and Experience Committee for approval	Medical Director	July 2023	

Report Title:	Cardiff and Vale of Glamorgan Childhood Immunisation Action Plan			Agenda Item no.	3.2
Meeting:	Quality, Safety and Experience Committee	Public	X	Meeting Date:	30 August 2023
		Private			
Status *(please tick one only):*	Assurance		Approval X	Information	
Lead Executive:	Executive Director of Public Health				
Report Author (Title):	Consultant in Public Health Medicine/Principal Public Health Practitioner				

Main Report
Background and current situation:

Background

Vaccination is a life-saving intervention, which prevents disease and outbreaks in our communities. Vaccination needs to be embraced from the pre-conception period onwards, and normalised as a part of our life course. The childhood vaccination schedule is important to be adhered to; however, locally and nationally, childhood vaccination rates have been decreasing in recent years, and even more so since the COVID-19 pandemic. This Cardiff and Vale of Glamorgan Childhood Immunisation Action Plan aims to increase the uptake of childhood vaccinations, whilst simultaneously redressing the inequities that we also see by socio-economic status and ethnicity.

Reasons for not being vaccinated are varied and complex, and vaccine hesitancy (the delay or refusal to have a vaccine) is not evenly distributed across the population. Vaccine hesitancy is common amongst particular population groups including: some ethnic minority communities, certain religious communities, Gypsy and Traveller communities, migrants and asylum seekers, children from large families, people living in areas of high deprivation and people from non-English speaking families.

The three 'C's' behind vaccine hesitancy need to be addressed throughout the development of interventions designed to increase uptake:

- Complacency – the low perception of risk
- Convenience – the availability and accessibility of vaccines; health literacy; language barriers and cultural context
- Confidence – trust in vaccine safety and effectiveness and in policy makers and programmes

The reasons behind Cardiff and Vale of Glamorgan Health Board area having low uptake of childhood vaccinations were explored in a Cardiff Metropolitan University research report in 2022, with recommendations made around evidence-based interventions to improve uptake within the local context. The population of Cardiff and Vale includes many of the groups listed above who are known to have low vaccine uptake, including people living in deprivation, high numbers of ethnic minority communities, high numbers of Gypsy and Traveller families, and high numbers of refugees and asylum seekers.

Recommendations for interventions to increase uptake and address the inequities included:

1. Utilising multiple channels for communication of messages, in multiple languages
2. Accessible vaccination locations, with appointments outside working hours and easy booking systems
3. Provide opportunities for children who missed vaccinations at school due to being home schooled or travelling etc to catch up, utilising community venues as far as possible
4. Engage children in the decision-making process, provide them with learning opportunities and the chance to speak to health professionals about vaccination

5. Specific actions for ethnic minority communities should be locally designed according to need and insights, and multi-factorial, addressing accessibility, communication and education.

Current situation

Currently, the uptake of routine childhood vaccinations (4 in 1, Hib/MenC and MMR 2nd dose) by age 4 in Cardiff and Vale is below the Welsh Government target of 95%, at 80.5% (for year 2022/23), and the lowest Health Board in Wales (Wales uptake rate was 84.5%). This is also a reduction from 84.2% in the previous year (2021/22), according to COVER data. Over the same time period, Powys Health Board achieved 90.3% uptake, the highest uptake Health Board in Wales during 2022/23. The uptake of flu vaccine for 2 and 3 year old's in 2022/23 ranged from 62.0% in Cardiff West cluster to 30.1% in Cardiff East.

Analysis by disadvantage shows that based on 2021/22 figures for Cardiff and Vale, being up-to-date with vaccinations at age 4 has a lower uptake in the most deprived quintile at 77.0%; whereas the least deprived quintile achieved 89.8%; a difference of 12.8%. During 2022/23, uptake in City and South cluster was 63.3% for being up-to-date with age 4 vaccinations. This compares to 90.3% uptake in Eastern Vale (the highest uptake cluster), a difference of 27.0%. City and South cluster have a very ethnically diverse population, and is also an area with some of the highest levels disadvantage in Cardiff and Vale of Glamorgan.

A range of interventions and actions to reduce the inequities in vaccine uptake have been implemented by the UHB and partners including GP practices in the last year, utilising the recommendations from local and national research and evidence. This includes:

1. Work with primary care clusters in areas of lowest uptake, including development of quality improvement projects to assess effectiveness of invitation mechanisms for children missing vaccines; utilising call handlers to contact families of children missing vaccines to encourage them to attend appointments; offering support to practices in areas with high ethnic minority populations from the multi-cultural link workers and provision of templates and a range of communication materials to practices in key languages
2. Targeted communications campaigns in areas of low uptake, using social media channels, physical materials on buses and phone booths, and the creation of animations providing information about 3 vaccines, again in a range of languages.
3. Focused work to enable children missing school-based vaccines to catch up, through appointment-based clinics and walk-in sessions.
4. Immunisation Coordinators supporting individual GP practices to data cleanse records, and support practices with resources to help them encourage families to attend their appointments.
5. Work to enable refugees and asylum seekers to ensure children are up to date with vaccinations, through CAVHIS.
6. Initiating work with schools in areas of low uptake to pilot projects with parents around education, and develop teaching materials for teachers around vaccination in the new curriculum.

The Cardiff and Vale of Glamorgan Immunisation Action Plan aims to continue to work to improve uptake and reduce health inequities for vaccination in childhood, building upon previous improvement actions and insights work. It has 5 key themes:

1. A data-informed approach
2. A behavioural sciences approach
3. Stakeholder engagement
4. Communication
5. Evaluation and continuous improvement

The work will be overseen by the Childhood Immunisation Steering Group to drive forward the actions and implementation of innovative programmes.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:
1. The uptake for childhood vaccinations at age 4 (being up-to-date) is the lowest in Wales and is decreasing. 2. Health inequities exist in terms of uptake for childhood immunisations. 3. The Cardiff and Vale of Glamorgan Immunisation Action Plan aims to increase uptake and reduce health inequities.

Recommendation:
The Quality, Safety and Experience Committee are requested to: 1. **NOTE** the progress to date 2. **ENDORSE AND SUPPORT** the Childhood Immunisation Plan

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		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:
Strategic Leadership Board	26 July 2023
Quality, Safety and Experience	30 August 2023

Cardiff and Vale of Glamorgan

Childhood Immunisation Action Plan

July 2023

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

Introduction

Childhood vaccination is an important health intervention to protect children and young people from serious illness and disease. The uptake of childhood vaccinations in Cardiff and Vale UHB is for most vaccines the lowest in Wales, and some areas and population groups have particularly low levels of uptake. The reasons for low uptake are complex and varied, and can include accessibility, lack of information or education, mistrust in health authorities or vaccine hesitancy due to safety or ingredient concerns for example.

Our Purpose and Vision

The purpose and vision of this plan mirror those in the Cardiff and Vale Vaccine Equity Strategic Plan, but with a focus on the provision and uptake of childhood vaccinations.

The vision for childhood vaccinations is that everyone who wishes to have their child vaccinated, or get vaccinations themselves (if they are a young person), has the opportunity, the capability and the motivation to do so. There are substantial inequalities amongst population groups in Cardiff and Vale in relation to vaccination uptake, and this plan aims to address these.

Our Purpose

To effectively protect our local population against vaccine-preventable diseases.

Our Vision

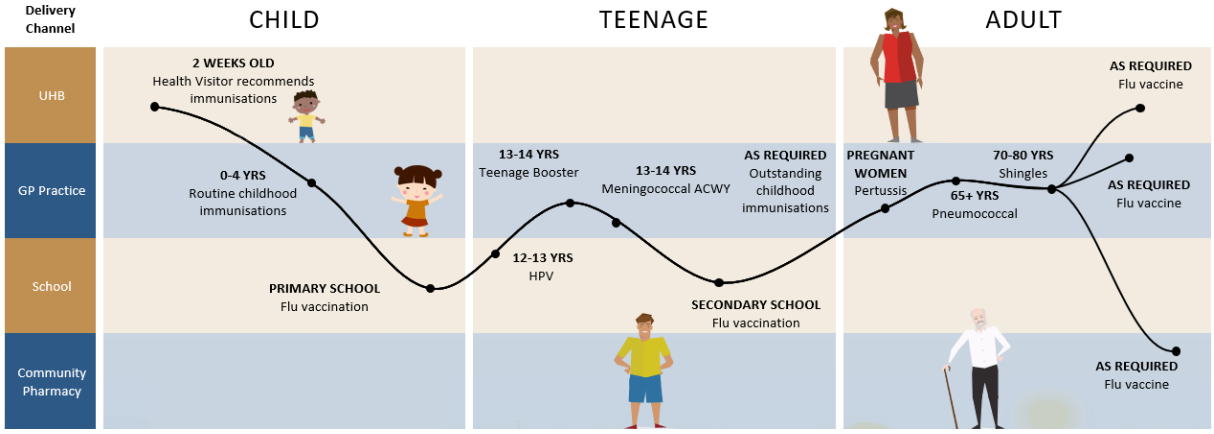
Protecting our local population through equitable, safe, innovative, timely, and person-centred immunisation delivery, maximising uptake in the process.

Background and Context

The aim of this plan is to outline actions to address the low uptake of childhood vaccinations in Cardiff and Vale UHB area, ensuring that specific focus is upon the areas and population groups where there are barriers to uptake and vaccine hesitancy. The objectives are to:

- Provide vaccination at accessible and appropriate locations
- Ensure that information is available and accessible to increase awareness and knowledge
- Promote uptake of vaccination in a targeted way, tailored to the needs of specific communities
- Improve knowledge of vaccine hesitancy and barriers amongst seldom heard groups
- Educate children and families about vaccination

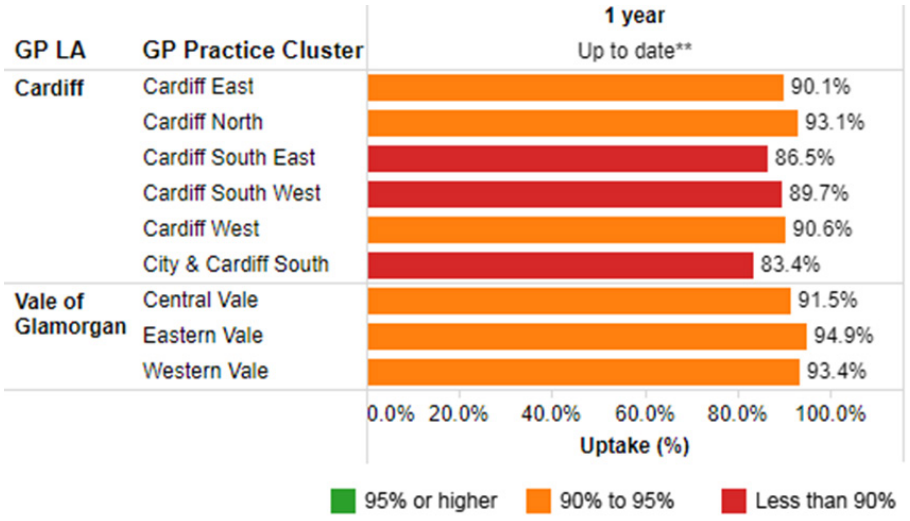
Current vaccination delivery channels throughout the life-course (as at 2022):



Inequity in vaccine uptake

Within Cardiff and Vale, there is inequity in the uptake of vaccinations, both geographically and amongst specific population groups. The data in figure 1 highlights the clusters with the lowest uptake for 1 and 4 year olds, and Figure 2 illustrates the trend of lower levels of uptake amongst the most deprived communities for children age 5 years. The clusters in Cardiff and Vale with the lowest uptake are those in the areas of deprivation.

Figure 1: Children up to date with vaccinations at age 1 and 4 by primary care cluster (April 2022 - March 2023)



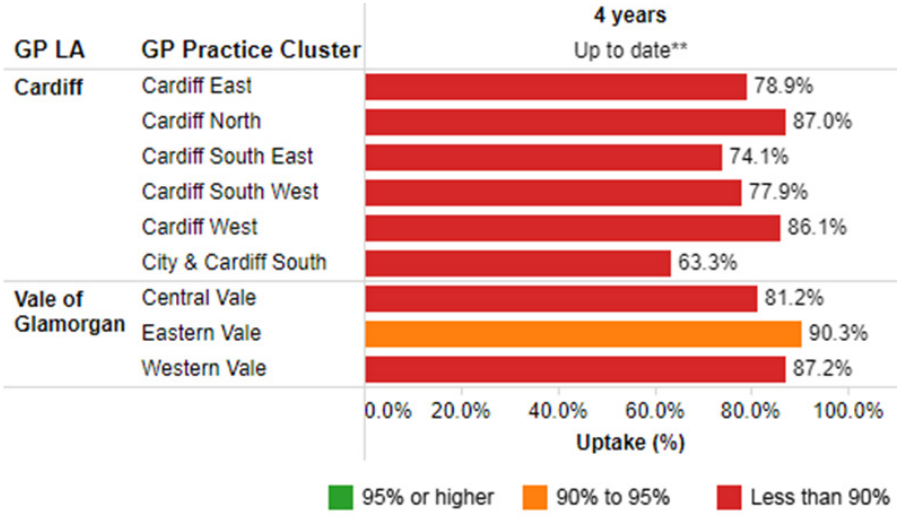
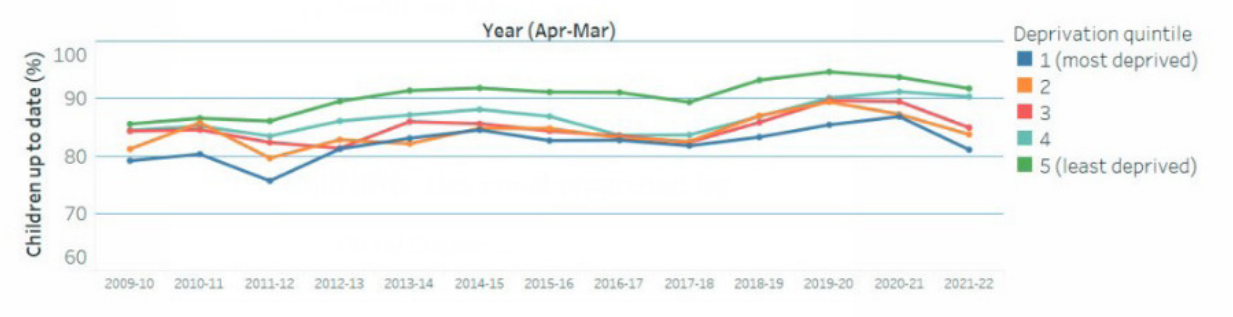


Figure 2: Proportion of children up to date with routine vaccinations by 5 years of age by deprivation quintile in Cardiff and Vale UHB up to 2021-22



In addition to the geographical areas of low uptake, there are a number of 'seldom heard' members of our community, and those with protected characteristics, identified in the Cardiff & Vale Vaccine Equity Strategic Plan that this plan will aim to target to reduce inequity. This plan will align with these principles:

- ✓ **Provision for identifying groups with low vaccination uptake**
- ✓ **Provision for determining barriers to uptake**
- ✓ **Partnership working and meaningful engagement with community champions, trusted voices and third sector organisations**
- ✓ **Co-production of tailored interventions**
- ✓ **Evaluation of actions and interventions**

Vaccine uptake drivers

Trust is a key driver for vaccine uptake – in health professionals and policy makers, the process, and in the vaccine itself. Building and maintaining trust is a crucial element of increasing uptake amongst the groups we need to target. Behavioural and social drivers impact upon vaccine acceptability, beliefs and experiences can make people more or less likely to get children vaccinated.

Vaccine hesitancy

Vaccine hesitancy describes a wide range of beliefs and barriers to vaccination, and it is not evenly distributed across the population. Hesitancy is influenced by the 3 'C's', and these factors need to be considered throughout actions to increase uptake:

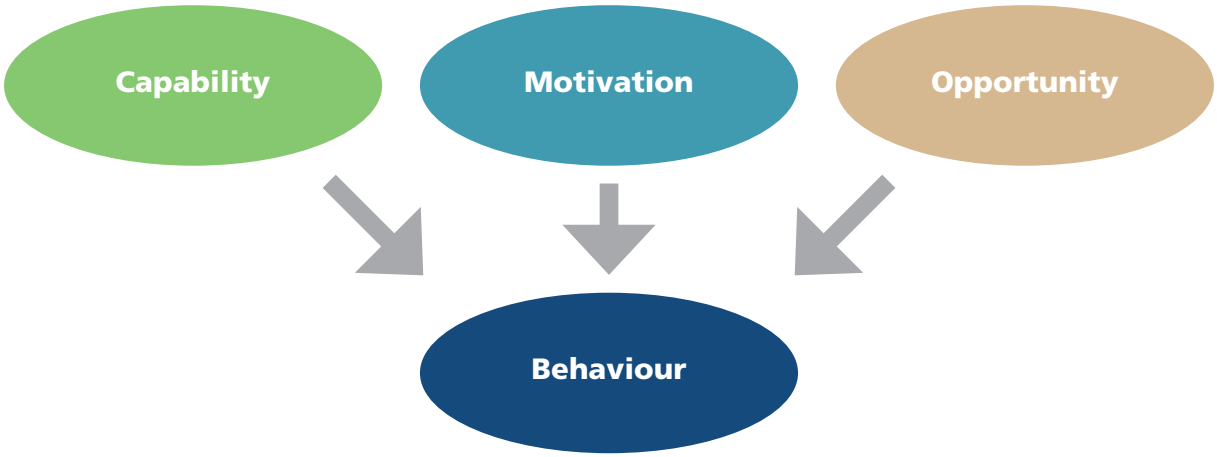
Complacency: low perception of risk

Convenience: availability and accessibility of vaccines; health literacy; language barriers; cultural context

Confidence: trust in vaccine safety and effectiveness, policy makers, and delivery programmes. Misinformation reduces vaccine acceptance.

Increasing uptake

In order to change behaviour and increase uptake, we need to utilise the COM-B model of behaviour change. This model addresses the 3 factors of capability, motivation and opportunity in order to change behaviour.



This plan will implement a partnership approach to reducing inequities in childhood vaccination across Cardiff and Vale, through the strategic themes identified in the Vaccine Equity Strategic Plan, and take into account the principles, evidence base, data and drivers described above.

The plan includes a range of actions for delivery in 2023/24, and will target the geographical areas and population groups with the lowest uptake of childhood vaccinations. Actions will be framed around the COM-B model, be multi-component and align to the needs of the community. Actions will focus on families, children and young people themselves, and key stakeholders including professionals working with the target groups.

Successful childhood immunisation starts before birth, so to increase childhood vaccination uptake, especially in those seldom heard groups already experiencing health inequities, we need to also focus on future parents and pregnant people. The plan aims to identify opportunities to build trust and educate early before birth about the benefits of vaccination. This can be part of community outreach, antenatal care, pregnancy planning pathways or alongside maternal vaccination efforts for Flu, COVID and Pertussis. Focusing on pregnancy can help us identify early the communities and the individuals with the most need and tailor approaches that, with cultural humility, continuity of care and of carer, are most likely to achieve optimal outcomes.

Actions for delivery in 2023/24

Vaccine Equity Strategic Theme	Objective	Actions
A data-informed approach	To use national and local data to agree a targeted approach to tackling inequity to inform future effective delivery	Encourage and support GP Practices to undertake data cleansing to improve data accuracy and quality through development of an education and training pathway (for Primary Care and Child Health) for data input/entry
		Use uptake data to plan targeted and tailored interventions
		Commission bespoke data analysis where needed
A behavioural insights approach	Address the 3 drivers of behaviour (capability, opportunity, motivation) and barriers to uptake which address vaccine hesitancy (complacency, confidence, convenience)	Provide community-based vaccination provision (eg pharmacies or outreach) to improve accessibility and ensure target seldom heard groups
		Work to understand low uptake of vaccination amongst seldom heard groups and gather insights from population groups and monitor this regularly within the UHB Imms Ops Board
		Leverage support from community and religious leaders to address vaccine hesitancy
		Tailor vaccination information and provision according to identified needs amongst community groups
Stakeholder engagement	Engaging and co-producing with communities and settings to address barriers	Engage with stakeholders and community representatives to understand needs, issues and most appropriate ways of ensuring needs are met - Hold community events/ education sessions with specific groups
		Work with schools (including special schools) in areas of low up-take to educate children and parents about vaccination: - Lessons to pupils - Parent education sessions
		Support GP practices to engage families and overcome barriers to vaccination - Offer bespoke support from ICs - Templates and planning tools from PH - Comms materials - Provision of data - Explore incentives for practices to increase uptake by the hardest to reach Implement recommendations from Stakeholder Research report
Communication	Ensuring that communications, education and training and engagement are culturally and linguistically appropriate	Develop and cascade comms and info resources in a variety of formats - Produce new culturally appropriate video content - Utilise PHW materials as they are cascaded - Develop comms plan for child imms
		Offer MECC training to staff who have contact with communities with low uptake, particularly those working with ethnic minority groups
Evaluation and continuous improvement	Ensure that evaluation and lessons learnt are taken into account in future planning and programmes focus on vaccine equity	Undertake monitoring and evaluation on all projects and programmes and feed back regularly to the UHB Imms Operational Board

Report Title:	Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan			Agenda Item no.	3.3
Meeting:	Quality, Safety and Experience Committee	Public	X	Meeting Date:	30 August 2023
		Private			
Status *(please tick one only):*	Assurance		Approval X	Information	
Lead Executive:	Executive Director of Public Health				
Report Author (Title):	Consultant in Public Health Medicine/Principal Public Health Practitioner				

Main Report
Background and current situation:

Background

Vaccination is a life-saving intervention, which prevents disease and outbreaks in our communities. Despite being an effective intervention, uptake of vaccinations is not equitable locally, nationally or globally. The reasons for this are multi-factorial and complex. Our Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan aims to redress this inequity locally.

Current situation

The National Immunisation Framework (NIF) for Wales (https://www.gov.wales/national-immunisation-framework-wales) has six areas of focus for design arrangements, of which vaccination equity is one area. Our local Vaccine Equity Strategic Plan considers the findings from the NIF. Building equity into our vaccination programmes will ensure that unfair differences in vaccination uptake will decrease. For example, during 2022/23 uptake in City and South cluster was 63.3% for being up-to-date with age 4 childhood vaccinations. This compares to 90.3% uptake in Eastern Vale (the highest uptake cluster), a difference of 27.0%. City and South cluster has a very ethnically diverse population, and is also an area of disadvantage. Based on 2021/22 figures for Cardiff and Vale, being up-to-date with vaccinations at age 4 has a lower uptake in the most deprived quintile at 77.0%; whereas the least deprived quintile achieved 89.8%; a difference of 12.8%. Welsh data on COVID-19 Spring 2023 booster shows that as at 5 June 2023, the uptake in the eligible Black population was 21.8%; whereas it was 59.3% in the White population; a difference of 37.5%.

The reasons for these differences include structural issues such as access and convenience of vaccination services, as well as vaccine hesitancy (the delay in acceptance or refusal to receive a vaccine). Vaccine hesitancy is bound in social and cultural norms as well as personal belief systems.

In order to redress these differences, the Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan sets out five strategic themes:

1. A data informed approach
2. A behavioural insights approach
3. Stakeholder engagement
4. Communication
5. Evaluation and continuous improvement

This then frames a ten-point action plan for 2023/24 to deliver equity in our communities (see Appendix). The approach requires a multi-agency response, and builds on the successful programme delivered during the COVID-19 pandemic.

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

1. Unfair differences in vaccination uptake exist in our communities, particularly in our more disadvantaged and ethnically diverse communities.
2. We need to adopt a flexible, innovative and evidence-based approach to redress this need, working differently with some of our local communities to better meet their needs.
3. Our response needs to be multi-agency in nature, be data-driven, utilise a behavioural insights approach, engage stakeholders, create appropriate communications and continuously evaluate what is working.

Recommendation:

The Quality, Safety and Experience Committee are requested to:

1. **NOTE** the content of the Vaccine Equity Strategic Plan
2. **APPROVE AND SUPPORT** the Vaccine Equity Strategic Plan

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

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		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:
Strategic Leadership Board	26 July 2023
Quality, Safety and Experience	30 August 2023

Cardiff and Vale of Glamorgan

Vaccine Equity Strategic Plan

June 2023

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

Introduction

According to the World Health Organisation, vaccination is an excellent health intervention, saving millions of lives. Vaccination can also reduce inequalities, increase access to health services in general and reduce poverty. However, although Cardiff and Vale UHB alongside other Health Boards in Wales generally have high uptake of vaccinations overall, there continue to be many children and adults who are not fully protected against vaccine-preventable diseases. The reasons for this are complex and multi-faceted including a lack of accessible information, locations for vaccinations that are not convenient or accessible, concerns about the safety of vaccines, or lack of trust in health authorities.

This plan builds on work we have undertaken locally to understand the barriers to vaccination amongst population groups with suboptimal vaccination coverage. It sets out a framework for action designed to support, motivate and enable people to get vaccinated. It also builds on national and international evidence - such as from the World Health Organisation - with the overall aim of ensuring that all population groups – regardless of income, education, age, geography, ethnicity, religion or beliefs – are vaccinated to the highest levels possible.

Our Purpose and Vision

During 2021/22, a review was undertaken to consider how we could improve and develop a future model for immunisation building on the successful delivery of the Covid-19 mass vaccination programme. Throughout the review process, extensive consultation was undertaken with a variety of Stakeholders across the Health Board and beyond, primarily in the form of a Design Group (comprising UHB Executive & Senior Strategic and Operational roles) and an Operations Team (comprising roles from across Primary Care, Child Health, Occupational Health, Digital, Patient Experience, School Health, Mass Vaccinations and Local Authorities). The Design Group was focused on strategic direction, and the Operations Team looked at operational details, implication and feasibility of proposed priority areas. As a result of this process, the following purpose and vision for a future immunisation service were agreed.

Our Purpose

To effectively protect our local population against vaccine-preventable diseases.

Our Vision

Protecting our local population through equitable, safe, innovative, timely, and person-centred immunisation delivery, maximising uptake in the process.

This means:

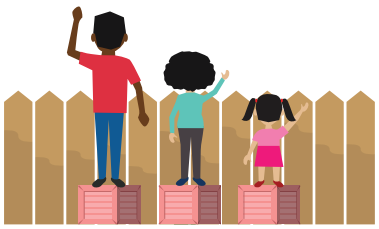
- **Effective:** **Government uptake targets** are consistently achieved and, where possible, exceeded. The result is that the **spread of vaccine preventable diseases is minimised**, and any **outbreaks are swiftly mitigated**.
- **Safe:** **Clinically-led** delivery of immunisations, with public safety at the heart of what we do.
- **Innovative:** Consistently striving to improve the way we **deliver, process & track** immunisations.
- **Timely:** Ensuring every person has access to immunisation **at a clinically appropriate time**, and the system has the ability to **flex delivery** to effectively target outbreaks. We will endeavour to **make every contact count**, removing barriers to opportunistic vaccination where possible.
- **Person-centred:** Ensuring each immunisation is delivered with individual experience in mind, ensuring service is **as close to home as practicable** and with the highest standards of care.
- **Equitable:** **Actively monitoring** equity of information and advice about immunisation, accessibility and delivery across demographics including age, race, socio-economic background, gender, sexual orientation, disability, and multi-faith/no faith. With **proactive interventions** in the community to benefit health.

Background and Context

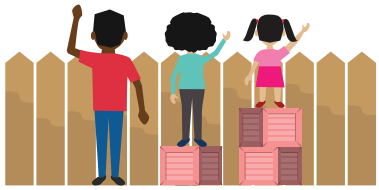
Vaccination equity is at the core of Cardiff and the Vale's vision and purpose for delivering an effective and safe vaccination service. The Covid-19 vaccination programme has demonstrated that when we have timely data available and work closely with community representatives to identify barriers and what works for them we can ensure that seldom heard groups can make an informed choice about the vaccinations they obtain and access them at the right time, and in the right place for them as an individual. Key to the Covid-19 programme has been the issue of accessibility. We have seen that traditionally seldom heard communities have come forward for vaccination if they receive the appropriate information, in the most appropriate format and we offer a choice about where to obtain a vaccination. Our multi-model of delivery encompassing mass vaccination centres, GP Practices, Community Pharmacies, mobile vehicles, outreach teams and pop-up clinics have provided flexibility and choice, often overcoming the barriers to accessibility that our insight work with communities continues to highlight.

1. Inequality and Inequity

Inequalities in health are gaps in health status between different groups, for example those who live in different areas, or of different ethnicity or socioeconomic status; such differences can be caused by a variety of factors, not all of which are possible to change e.g. inherited characteristics or geographical location. However, health inequity is a difference in health that is unnecessary, avoidable or unjust; such difference are amenable to action and is therefore the term used in this strategy.



EQUALITY



EQUITY

Examples of an equitable vaccination service might include:

- Uptake levels that are comparable across a range of ethnically diverse groups and geographical areas.
- Vaccination available at different locations, in the heart of communities.
- Information available in a variety of languages and formats, and accessible through a variety of channels, catering to different cultural needs.
- Vaccines available that are acceptable to different cultures and faith groups.

2. The National Immunisation Framework for Wales

The National Immunisation Framework aims for vaccination transformation which will deliver world-leading outcomes in vaccine preventable diseases. The vision for the future of immunisation in Wales is high uptake of a sustainably delivered, effective vaccine, at the right time, to reduce morbidity and mortality. At the core of this framework is a focus on reducing health inequalities and improving health outcomes.

The Framework identifies six areas of focus so that design arrangements that are fit for the future:

Vaccination Equity	**Digitally Enabled Vaccination**	**Eligibility**
Public Vaccination Literacy	**Deployment**	**Governance**

Equity is at the core of Wales' approach to vaccination. The remaining five key areas of focus will drive towards ensuring an equitable approach to vaccination across the vaccination programmes. For example, digital improvements will improve accessibility to vaccinations across our communities as well as flexible deployment approaches will ensure people are able to access vaccinations in the most appropriate place, and at the right time for them.

Equitable uptake of vaccination is needed across all sections of society within Wales so that individuals, families, and their communities are protected from the harms of vaccine preventable disease. This requires a proactive approach to 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.

In response, Health Boards are asked to develop a Vaccine Equity Strategy and programme of work with dedicated public health input, adopting the principles summarised in Figure 1:

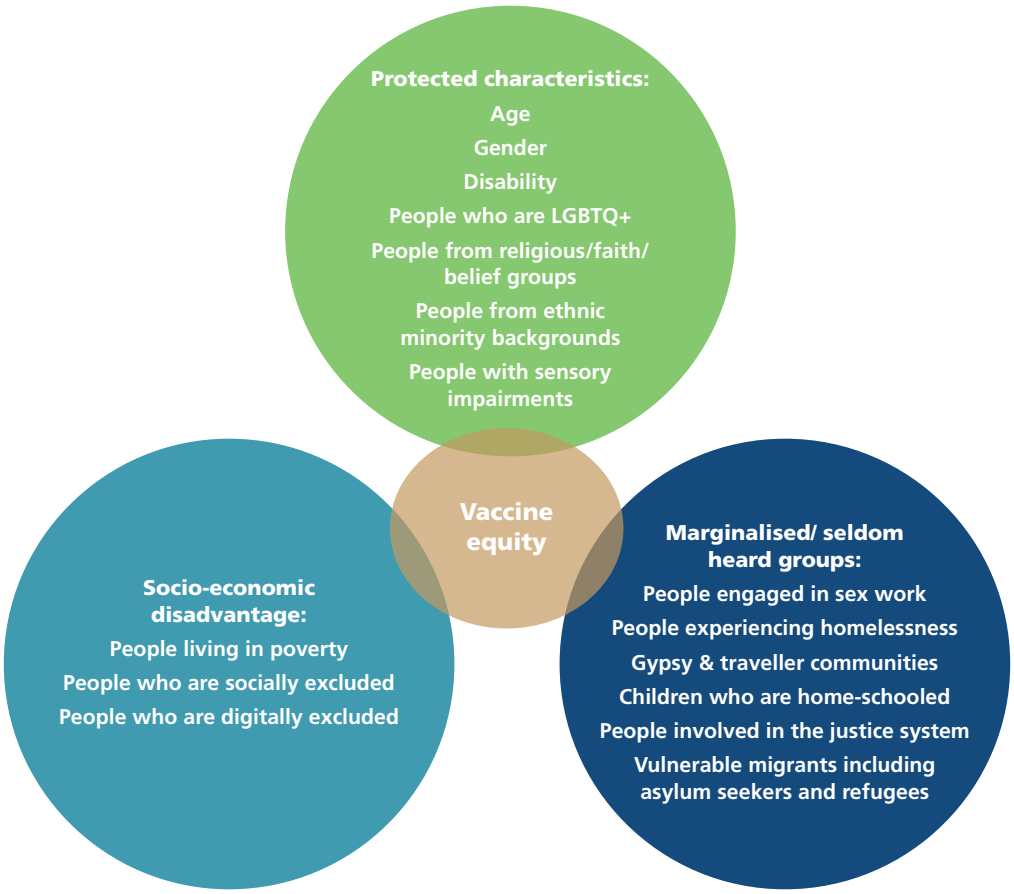
Figure 1: Vaccine Equity Strategic Principles checklist

3. The scope of the Health Board's approach to vaccine equity

Targeted action for an equitable vaccination service can be considered across three interlinked dimensions (figure 2):

- 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.

Figure 2: Groups included in our vaccine equity approach

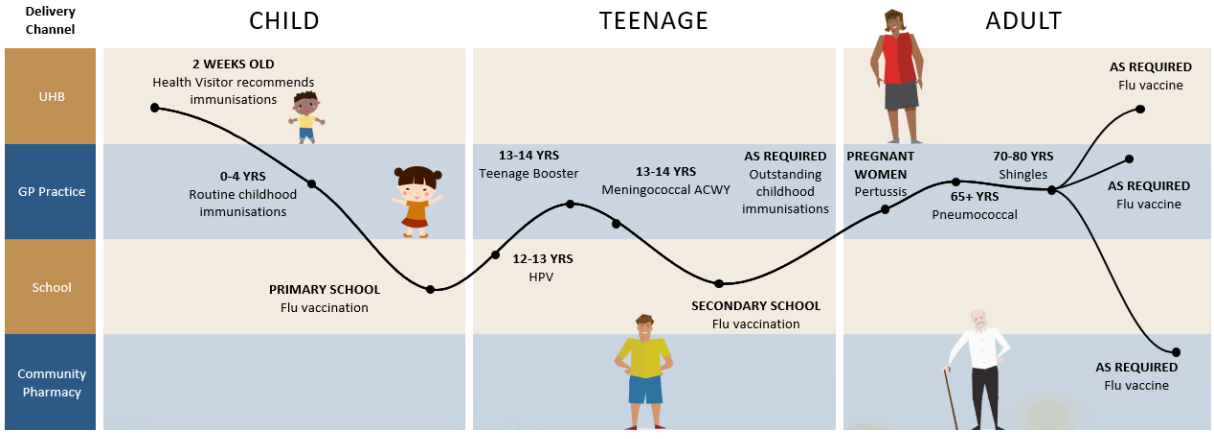


There are many existing vaccination programmes across the life course of citizens (Figure 3). These vary in scope from routine, targeted, selective (e.g. additional vaccines for individuals with underlying health conditions) and travel vaccinations. There is a routine immunisation schedule which summarises who is eligible for which vaccine and when each vaccine should be offered and administered. In addition, the Covid-19 vaccination programme has been in place since 2020, with the JCVI and Welsh Government setting out the recommendations based on the evolving epidemiological landscape for Covid-19 prevalence and risk factors. Similarly, there are vaccination programmes required in response to infectious disease outbreaks, where a vaccine might be available to reduce risk or the spread of infection, such as monkey pox or meningococcal disease.

Vaccinations are also administered through a variety of delivery channels throughout a person's life-course. The channel that a vaccination is administered through depends on the individuals' age, the type of vaccination, and sometimes their profession. An equitable approach to vaccination will need to consider the variety of delivery channels and their flexibility as this will often determine acceptability, accessibility and uptake of vaccinations.

The scope of the Health Board's approach to vaccine equity will span the entirety of the vaccination programmes and should be data driven wherever possible and feasible.

Figure 3: Vaccination delivery channels throughout the life-course (as at 2022)



Data on vaccine inequities in Cardiff and Vale UHB

1. National (UK) trends:

National data shows that reported vaccine uptake has been lower in areas with a higher proportion of people from an ethnic minority background, for example:

- Black African and Black Caribbean population groups are less likely to be vaccinated compared to White groups
- For new vaccines (post-2013), adults in minority ethnic groups are less likely to have received the vaccine compared to those in White Groups.

Gypsy, Roma and Traveller communities, people experiencing homelessness and asylum seeker, refugee and migrant populations may need additional routes to access the vaccine.

Income and socio-economic circumstances correlate with lower levels of uptake in areas of higher deprivation.

2. Local trends:

Figures 4 to 7 illustrate the inequities currently observed by geographical area and deprivation quintiles in Cardiff and the Vale of Glamorgan. In particular, we experience lower 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 4: Children aged 4 up to date with all vaccines in Cardiff and Vale Primary Care clusters (April 2022 - March 2023)

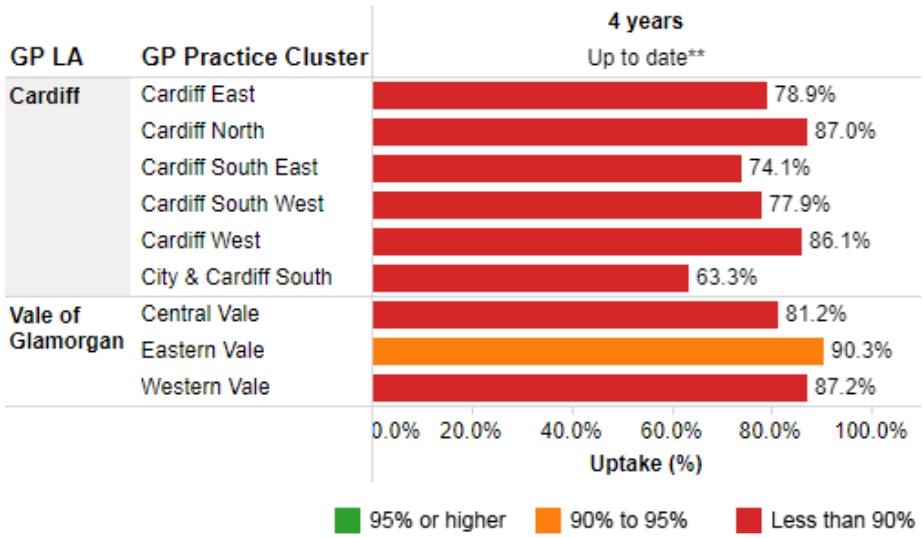


Figure 5: Proportion of children up to date with routine immunisations by four years of age, by quintile of deprivation of the LSOA in which they reside. Vaccine uptake across Wales is presented for children reaching their fourth birthday between 01/04/2021 and 31/03/2022, and resident in their respective Health Board area on 31/03/2022

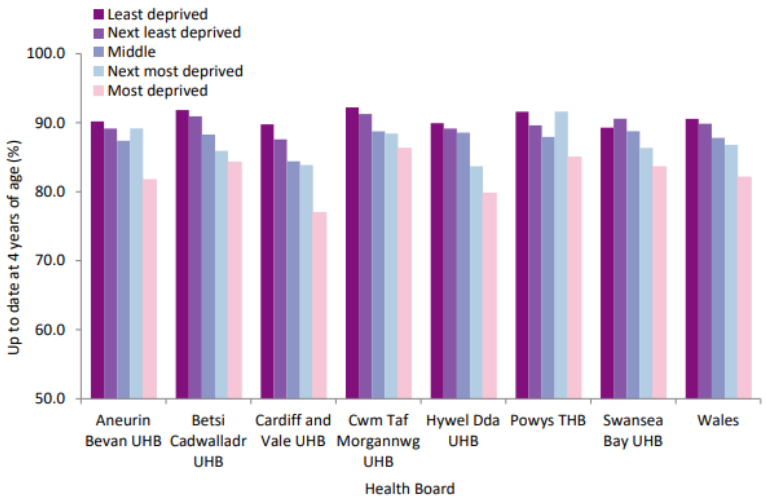


Figure 6: Proportion (%) of children up to date with routine vaccinations by 5 years of age in Cardiff and Vale UHB, from 2009-10 to 2021-22

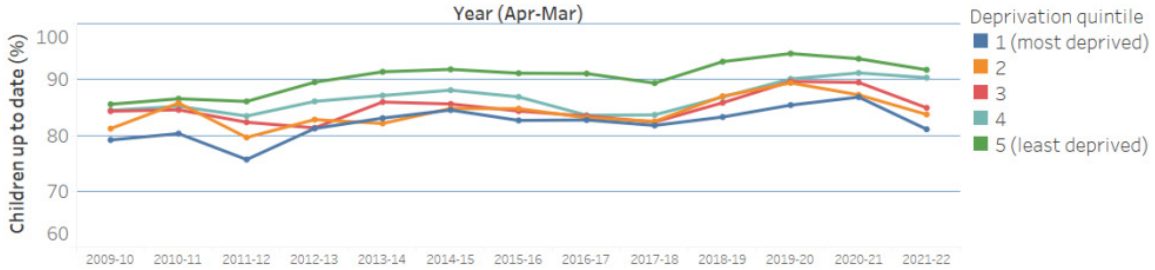


Figure 7: Coverage of 2022 Covid-19 autumn boosters in eligible groups by ethnicity in Cardiff and Vale UHB (at 08/12/2022)

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	3,300	31.1	(30.4-33)
	Mixed	1,400	20.0	(19.4-21.8)
	Other	900	19.4	(18.4-22.8)
	Unknown	10,100	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)

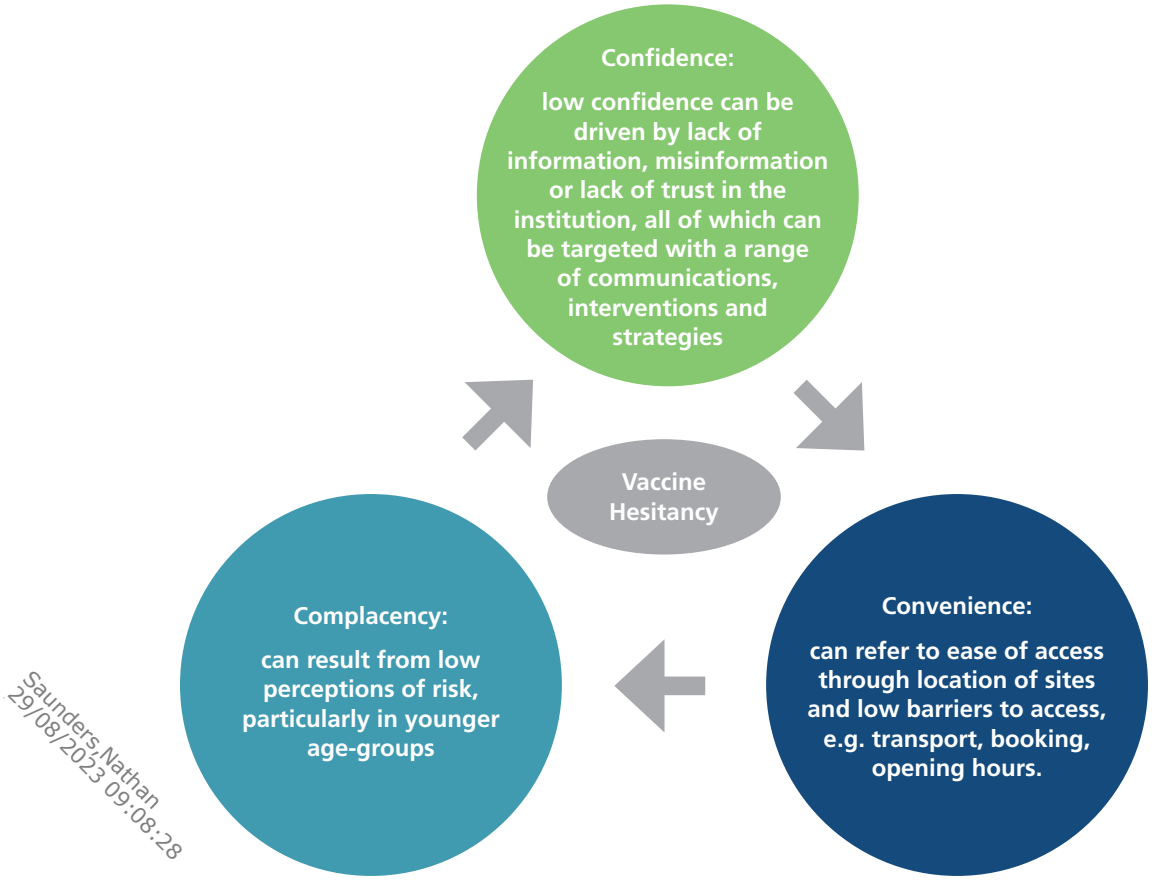
An evidence-based approach to vaccine equity

1. Vaccine hesitancy:

Vaccine hesitancy describes the delay in acceptance or refusal to receive a vaccination. This can be a rejection of all vaccinations, acceptance of some vaccinations but rejection of others or the acceptance of vaccinations but with a concern or reluctance (WHO, 2014). Factors that lead to vaccine hesitancy, are complex and context specific spanning all aspects of availability, accessibility and acceptability. They can reflect personal values and beliefs, social and cultural norms within communities and wider society in addition to structural issues such as access and convenience of vaccination services.

Underpinned by the three root causes of vaccine hesitancy identified by the World Health Organisation in Figure 8.

Figure 8: WHO root causes of vaccine hesitancy



World Health Organisation (2014) Strategies for addressing vaccine hesitancy - a systematic review (Microsoft Word - 3_ SAGE WG \226 Strategies for addressing vaccine hesitancy \226 Final copy_17Oct 2014.docx) (who.int)

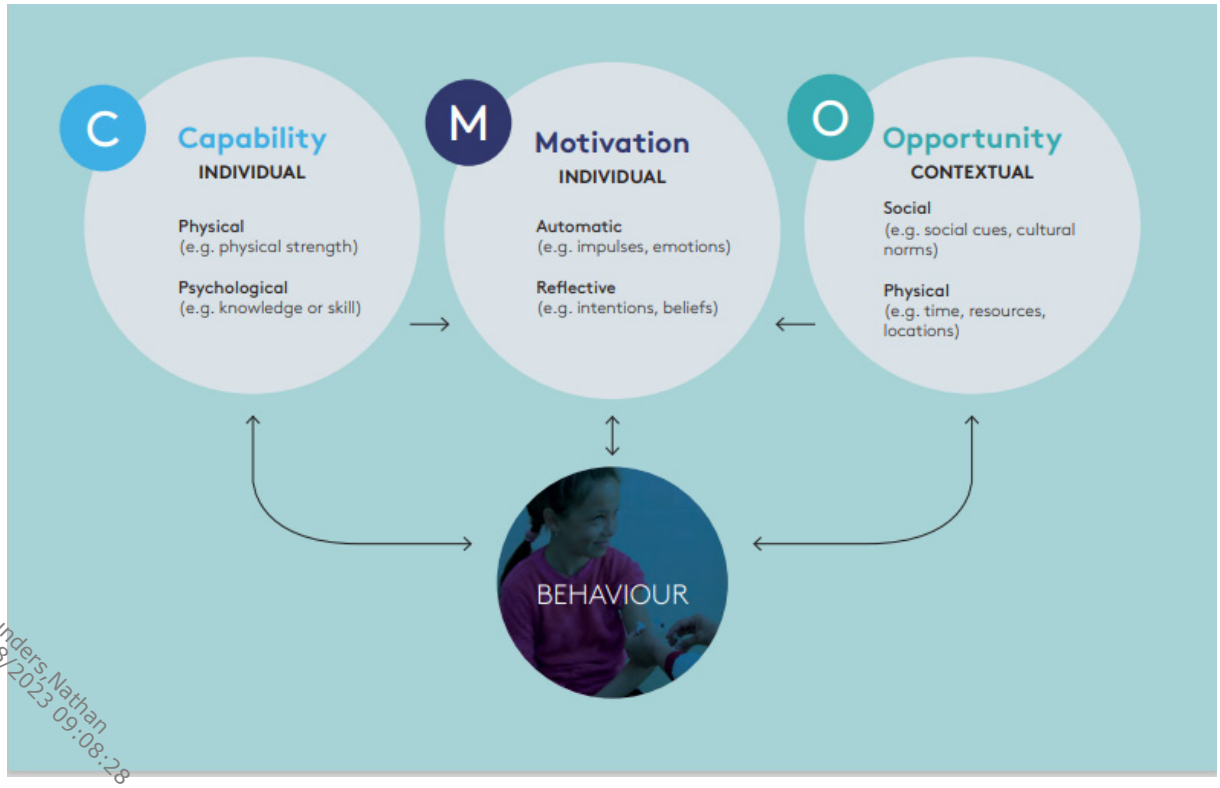
2. A theoretical model for action: COM-B

The WHO Tailoring Immunization Programmes (TIP) is underpinned by evidence from behavioural science, which aims to define and understand which factors are necessary for behaviours to take place, and which factors increase the probability that a behaviour will occur (drivers) or decrease probability (barriers). The theoretical model and framework used in the TIP approach is based on the COM-B model and the Behavioural Change Wheel framework.

The Cardiff and Vale UHB approach will utilise the COM-B model as it takes a comprehensive approach through focusing on a broad range of individual and contextual issues affecting health behaviours.

At the centre of the model are three overall factors, capability, opportunity and motivation (COM) that need to be in place for any health behaviour (B) to occur. Capability and motivation relate to the individual; opportunity relates to the context. The factors interact: capability and opportunity both influence motivation; and all three factors influence behaviour. Conversely, behaviour influences all three factors. Each of the three factors has two subcomponents (Figure 9).

Figure 9: The COM-B Model

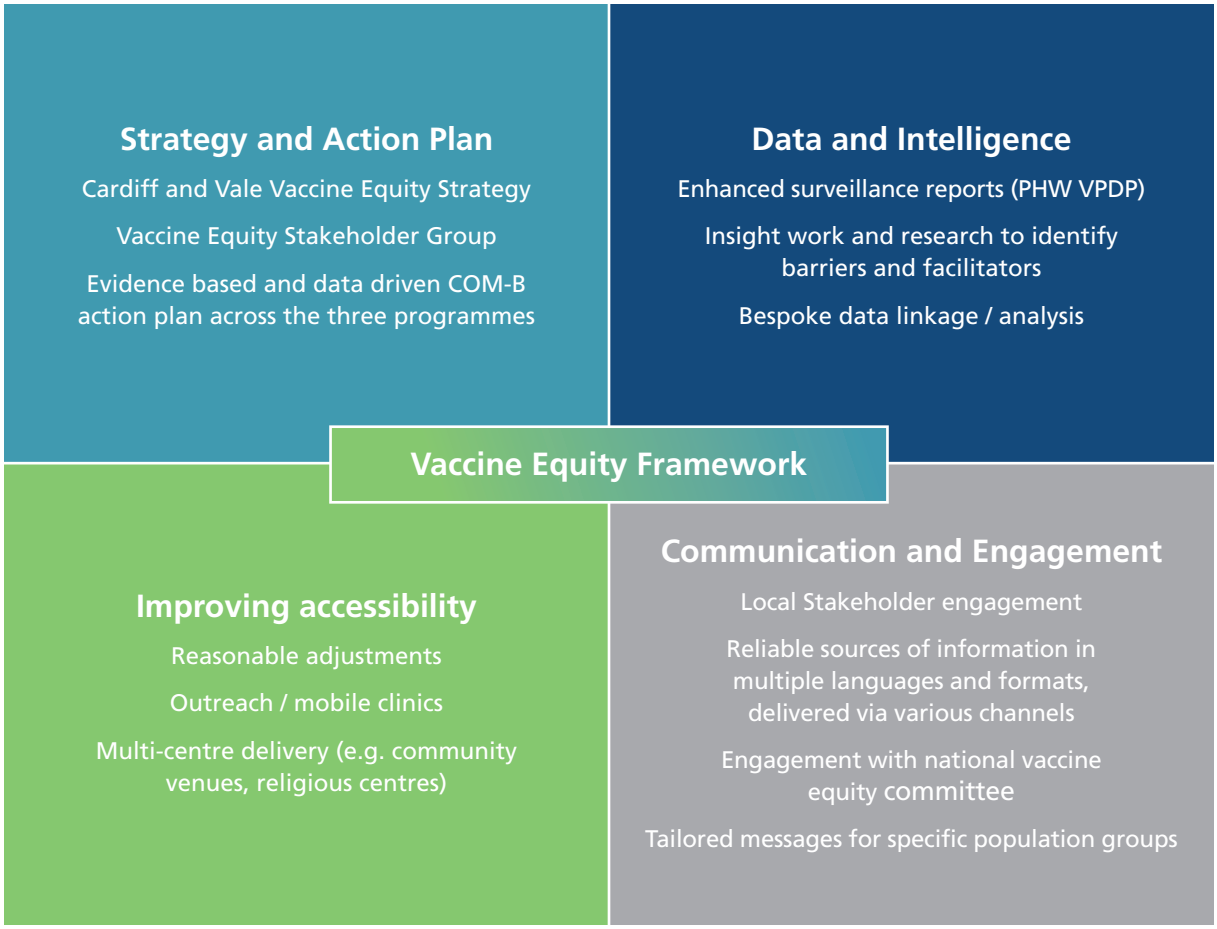


World Health Organisation (2019) Tailoring Immunisation Programmes TIP: tailoring immunization programmes (who.int)

3. A framework for vaccine equity

Based on Covid-19 Vaccine Equity Strategy for Wales, figure 10 describes the components which should underpin and provide the Governance structure for actions which specifically address issues of vaccine inequity, underpinned by the COM-B model of behaviour change:

Figure 10: Cardiff and Vale Vaccine Equity Strategic Plan



Strategic Themes for an equitable vaccination service in Cardiff and the Vale of Glamorgan during 2023/24

Strategic Themes

During 2023/24, we will implement a partnership approach to reducing inequities in access to and uptake of vaccinations across Cardiff and the Vale of Glamorgan through the implementation of:

1. **A data informed approach:** using national and local data to agree a targeted approach to tackling inequity within defined populations to inform future effective delivery
2. **A Behavioural insights approach:** to address the three drivers of behaviour (Capability, Opportunity, Motivation) and barriers to uptake which address the root causes of vaccine hesitancy (Complacency, Confidence, Convenience) including improving access
3. **Stakeholder engagement:** engaging and co-producing with communities and settings (e.g. schools) to address barriers
4. **Communication:** ensuring that communications, education and training and engagement are culturally and linguistically appropriate and accessible
5. **Evaluation and Continuous Improvement:** learn by doing and sharing intelligence of what works.

Our Top 10 actions for delivery during 2023/24

Strategic Theme	Action	Vaccination Programme (Childhood/ Flu/Covid-19)
A data-informed approach	1. Undertake a regular schedule of data cleansing across Primary Care Clusters to improve data accuracy and quality supported by an education & training pathway (for Primary Care & Child Health) for data input / entry.	Childhood
	2. Use Primary Care Collaboratives and GP Practices uptake data (COVER and IVOR) to plan targeted and tailored support and interventions.	Childhood and Flu
	3. Commission bespoke data analysis / linkage where information on inequities is not routinely or readily available (e.g. uptake by ethnic group).	All
A Behavioural Insights Approach	4. Provide community-based vaccination provision (e.g. community pharmacies and outreach clinics) to improve accessibility & to ensure we are offering to groups who find us hard to reach.	All
	5. Undertake continued work to understand low uptake of vaccinations amongst seldom heard groups and gather insight from population groups (including ethnic minority groups and other groups with other protected characteristics) and monitor this regularly within the UHB Immunisation Operational Board.	All
	6. Leverage support from community and religious leaders to address issues relating to vaccine hesitancy.	All
Stakeholder Engagement	7. Maintain strong links with the UHB patient experience team to ensure that patient experience forms part of service evaluation and aids learning across all vaccination programmes.	All
	8. Engage with stakeholders and community representatives (e.g. via the Ethnic Minority Sub-Group and UHB-employed culturally diverse link workers) to understand needs, issues of vaccine hesitancy and the most appropriate ways to ensure needs are met.	All
Communication	9. Develop and cascade communication and information resources in a variety of formats that are culturally and linguistically appropriate across all vaccination programmes.	All
Evaluation and Continuous Improvement	10. Undertake an annual evaluation / lessons learnt exercise for Winter Respiratory Vaccination programmes with a focus on vaccine equity.	Flu and Covid-19

Data and Monitoring

A suite of high level indicators will be developed to allow a data driven approach to be adopted and progress to be measured.

Governance

The Vaccine Equity Strategic Plan will be owned by the Immunisation Operational Board with strategic oversight by the Consultant in Public Health-lead for immunisations.

Report Title:	Welsh Risk Pool final Assessment Report			Agenda Item no.	*4.1*
Meeting:	QSE	Public	✓	Meeting Date:	30/08/23
		Private			
Status *(please tick one only):*	Assurance		Approval		Information ✓
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Assistant Director of Patient Experience				

Main Report

Background and current situation:

This report provides findings for the health body following a review conducted by an independent assessment team from the Welsh Risk Pool.

We developed an action plan which addresses the findings and supports the implementation of the recommendations

A copy of the organisation's action plan is included in the final report to enable tracking of information and to support future reviews.

Outline of Review

1.1 The Welsh Risk Pool undertakes assessments of member organisations' policies, procedures, and practice as part of its oversight duties – with the aim of gathering assurance on local processes for the Welsh Risk Pool Committee and Welsh Government, and to provide recommendations to support organisations in continuous improvement in this area.

1.2 The WRP Assessment is used by the Welsh Risk Pool Committee when determining members' contributions to the fund as part of the risk sharing agreement. For the 2022-23 Programme of assessments, the outputs will be advisory in nature and will not affect the individual contributions already established for the 2023-24 financial year.

1.3 The WRP Assessment process provides a framework for the analysis of an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and other national policies & procedures related to the Putting Things Right sector.

1.4 The review involves analysis of individual case management against both legal requirements and policy criteria. It also examines compliance with the application of the Once for Wales Concerns Management System workflows and essential data fields.

1.5 The review further facilitates analysis of the efficacy of the Learning from Events process within the organisation and examines how a health body shares and implements good practice between organisations.

1.6 The methodology for assessment has evolved during the last few years in line with national policies. The approach is focused on peer-review, with senior leaders within the Putting Things Right sector in other organisations joining staff from the Welsh Risk Pool in conducting the assessment.

Specialist advisors, in legal specialists, join the assessment team as required. This approach is considered to promote sharing of best practice and enable the assessment team to recognise the application of the areas for assessment in operational practice

7 For each area for assessment, the Assessment Team consider the available evidence and report assurance to the organisation using the NHS Wales Internal Audit Assurance Framework. Details of the framework are shown in

6.0 Assurance Summary

Cardiff & Vale University Health Board		
Management of Concerns (Incidents)	REASONABLE ASSURANCE	
Management of Concerns (Complaints & Enquiries)	SUBSTANTIAL ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	
NOTES		

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

There were areas of good practice noted in Concerns and Redress

Areas of Good Practice

The Assessment Team found excellent practice with the production of training videos for staff on PTR together with a Newsletter with useful hints and tips. These should be shared as examples of good practice with other NHS Wales organisations.

The Concerns SOP is considered to be an exemplar and should be shared as good practice with other NHS Wales organisations

Recommendation:

The Committee are requested to: **Note** the content of the report and the improvement 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: Yes

Failure to identify learning from themes will lead to increased harm and litigation.

Safety: Yes

failure to identify recurring themes and taking mitigative and improvement actions can lead to harm

financial: yes

failure to complete Ifer's has a financial risk

Workforce: No

Legal: Yes

We need to adhere to the relevant legislation.

Reputational: Yes

There is media interest in QSE.

Socio Economic: Yes/No
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 indicators when reviewed in detail demonstrate equality and health inequalities.
Decarbonisation: No

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

Cardiff & Vale University Health Board

Final Report July 2023

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

July 2023

About this Report

This report is intended to support health bodies within NHS Wales to continuously improve the operation of its Putting Things Right processes and provide assurance in relation to current policies, procedures, and practice.

This report provides findings for the health body following a review conducted by an independent assessment team. It has previously been circulated for comments and factual accuracy considerations.

The report identifies a number of recommendations. Each organisation has been asked to develop an action plan which addresses the findings and supports the prioritisation of improvement activity in this area. A copy of the organisation's action plan is included in the final report to enable tracking of information and to support future reviews.

In addition to the report, the health body has been provided with a summary of the fieldwork analysis of the matters scrutinised. This enables the organisation to consider the comments in the context of the information that the reviewers analysed.

Assessment Visits	Nov 2022
Draft Findings shared	May 2023
Action Plans Received	Jun 2023
Final Report Published	Jul 2023

Version
Cardiff & Vale WRP Concerns Assessment Report V1

WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

July 2023

CONTENTS

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1.7 For each area for assessment, the Assessment Team consider the available evidence and report assurance to the organisation using the NHS Wales Internal Audit Assurance Framework. Details of the framework are shown in Appendix 1.

2.0 Scope of Review

2.1 The review considers a number of areas for assessment, each focussed on a different aspect of the Putting Things Right process.

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management
- Claims Case Management
- Learning from Events
- WRP Reimbursement Process

2.2 The period used for the assessment related to policies and procedures in force and matters opened, under investigation, or closed between 1st January 2022 to 31st March 2022. This period was selected and agreed with senior leaders from the Putting Things Right sector, as it is considered that cases would be sufficiently progressed from initial report and commencement of investigations to facilitate a thorough review. This period was selected for all organisations to allow a fair comparison between organisations where the outputs of the assessment are used as part of the risk sharing agreement. Where an organisation had not commenced live use of the Once for Wales Concerns Management System during the intended period, the first three months of live use of the system was selected as an alternative period.

2.3 The clinical specialities selected as an area for focus in organisations which provide acute care were chosen as they represent the greatest proportion of the litigation profile across NHS Wales. The clinical specialties selected for the focus of the assessment in acute organisations were:

- Maternity Services
- Emergency Department Care
- Orthopaedics

3.0 Assessment Team

3.1 The WRP Assessments are conducted by a small group of specialist practitioners who are drawn from the Putting Things Right sector.

3.2 The Coordinator for each Assessment is a member of the Welsh Risk Pool team, with the Chair of the Assessment Team drawn from a member of the Heads of Patient Experience Safety & Learning Network – providing realistic advice on the practicalities in achieving the standards in practice.

3.3 To ensure compliance with the legislation, a lawyer from the Legal & Risk Service is included in the Assessment Team and this colleague focusses on compliance with redress case handling and legal compliance in relation to claims.

3.4 As the assessment process focussing greatly on the use of the Datix Cymru system, a member of the Once for Wales Concerns Management System central team is included in the Assessment Team.

3.4 The Assessment Sponsor coordinates the formation of fieldwork teams and oversees any queries which arise along with signing off the Assessment Report.

3.5 The Assessment Team for this review was:

Sponsor: Jonathan Webb, Head of Safety & Learning
Welsh Risk Pool

Field Work: Zoe Ashman, Assistant Director Quality & Safety
Powys Teaching Health Board

Gemma Cooper, Senior Solicitor
Legal & Risk Services

Christine Buckland, Safety & Learning Advisor
Once for Wales Concerns Management System Team

Katherine Houlston Jones, Corporate Concerns Officer
Betsi Cadwaladr University Health Board

Eleri Wright, Safety & Learning Advisor
Welsh Risk Pool

4.0 Review Findings

4.1 Management of Concerns (Incidents)

4.1.1 The Assessment Team noted that there were 5852 incidents reported in the period 1st March 2022 to 31st May 2022.

4.1.2 In considering the application of policy, the Assessment Team found that there was good evidence of clear incident and nationally reportable incident management within the Health Board. There is a Health Board Incident Management Policy in place which covers the requirements as set out in the PTR guidance and is in the process of being reviewed and updated in light of the recently published policy from the NHS Wales Delivery Unit, and this revised policy was currently at the consultation phase.

4.1.3 There is a corporate Incident Team who oversee the management of incidents across the organisation. The Assessment Team were showed template documents and the Incident Team advised that improvements are to be made to the investigation and Root Cause Analysis template - which the assessment team consider will further enhance the quality of investigations.

4.1.4 Cardiff & Vale University Health Board is a large organisation, with corporate services operating across the entire health body and Clinical Boards which focus on health care in specific specialties or locations. The Assessment Team were pleased to note that there are clear and established links between the corporate services and Clinical Boards, with further local internal incident management processes. This structure ensures clear lines of escalation and reporting to the Executive Team. Weekly meetings are held with Executive Directors to provide progress updates on cases and to report any significant issues. There is also a monthly report submitted to the Executive Team on the current status of incident management across all Clinical Boards.

4.1.5 Whilst reviewing the cases provided to the Assessment Team noted some gaps in the completion of outcomes on Datix Cymru however following discussion with the Health Board and in preparation for the implementation of the Duty of Candour, there is an increased awareness of the need to accurately record investigation outcomes. The Incident Team are aware of this and are taking steps to improve practice within their current system.

4.1.6 It is important that incidents are reported in a timely manner in order to facilitate appropriate safety measures to be implemented. The Assessment Team scrutinised the detail of fourteen incident records within the Datix Cymru system and found that the timescale between the incident occurring and it being reported within the system was reasonable in a number of cases. Where the time between index events and incident reporting was longer than expected, the Assessment Team were pleased to see that this was noted as part of the investigation process. However, there were some cases where it was not clear if the dates recorded were correct and explanation was not provided for a significant delay between the incident and report date.

4.1.7 From the moderate cases reviewed by the Assessment Team there was concern noted that there was no evidence of further discussion or investigation with regards to qualifying liability on the Investigation outcome.

4.1.8 The Assessment Team also noted that the findings of investigation all refer to 'Progress Notes' but would recommend that the Investigation section be completed for accurate reporting purposes. The Assessment Team would recommend that a KPI is introduced for incident reporting and a review process for ensuring cases are closed appropriately as several stated awaiting closure despite being some months post investigation.

Management of Concerns (Incidents)		
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

4.2 Management of Concerns (Complaint and Enquiries)

4.2.1 The Assessment Team noted that there were 1182 complaints reported in the period 1st January 2022 to 31st March 2022.

4.2.2 The Assessment Team reviewed the current Policy in place which was in date and is planned for review later in 2023. The Policy will be ratified by the Quality, Safety and Experience Committee, which is a suitable forum for this purpose. In addition to the Policy there is also a Concerns Standard Operating Procedure in place dated August 2022 which assists the process on a day-to-day basis. The SOP is an excellent resource and it is recommended that it is shared widely among other NHS Wales bodies.

4.2.3 The Assessment Team scrutinised the detail of eleven complaint records within the Datix Cymru system and found that there was a clear structure in place to receive, manage and respond to concerns. The Assessment Team also noted excellent practice in place in terms of setting out the scope of the investigation within the acknowledgment letter and reaching an agreement with complainants. Concerns are led at a Clinical Board level but they are supported excellently with draft templates to ensure KPI's are met and there is a clear process of escalation in place to ensure compliance.

4.2.4 There is evidence of clear information and advice in relation to PTR and redress being sent to complainants when a complaint is opened and when a complaint is closed a template is in place to arrange a meeting which includes clarity of purpose confirming a list of questions to be asked and addressed. A weekly meeting is held with the Executive Nurse Director to provide progress updates on cases.

Management of Concerns (Complaints & Enquiries)		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

4.3 Redress Case Management

4.3.1 The Assessors noted that the Health Board has a good structure in place to manage redress cases with minimal input required from Legal & Risk Services. There is a clear process for complaints to move to the Redress Team however there is a slightly less defined process with regards to incidents. The Health Board assured the Assessment Team that this is being considered and they are aware of the need to strengthen this process.

4.3.2 The Assessment Team noted there is evidence of good use of a Health Board Redress Clinic and the organisation also has a Redress Panel in place to ensure there is an efficient process to review cases and decisions. This also provides evidence of good governance around the consideration of qualifying liability and offers to be made as part of the PTR Process. The Assessment Team were provided with examples of the Redress Panel Submissions and Minutes however these were not always uploaded onto Datix to provide an audit trail of the decision-making process.

4.3.3 The Assessment Team scrutinised the detail of seven redress records within the Datix Cymru system and noted that the PTR responses reviewed were well written and tailored specifically to the cases and the issues raised within them. The cases reviewed were generally progressed in a timely manner however some delays were evident particularly in relation to Obstetrics & Gynaecology concerns, but this can be explained by the complex nature of the cases considered and is not considered to represent a specific risk.

4.3.4 The Assessment Team considered the process for initial assessment of the likely value of a concern (and whether it exceeds £25,000), as it is important to ensure only appropriate cases are considered in relation to qualifying liability. The Health Board confirmed that the Assistant Director reviews all cases at or near to the outset of the matter and this could be incorporated into the SOP.

4.3.5 The wording for the explanation of the breach of duty (Bolam) test in the responses was found to be technically inaccurate, although the intention was valid. This was discussed with the responsible team at the time of the review and the team have agreed to use a revised wording within the responses.

4.3.6 There is evidence of good practice seen in the form of Breach of Duty and Causation training videos which were shared in September 2022. Clinical Boards

have praised the Department for the training videos as they have allowed staff to view them at their own convenience and they are able to access them as education and reference material when reviewing concerns. The training videos have been shared with Directors of Nursing and all Clinical Boards. The Team have also developed a Newsletter which will provide top tips and FAQ's to assist staff and which they will able to access along with the training videos when convenient for them and will act as useful guides to aid response writing.

4.3.7 The Assessment Team were assured that weekly meetings are held with Executive Nurse Directors to provide progress updates on cases and to advise of any significant issues.

Redress Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

4.4 Claims Case Management

4.4.1 The Assessment Team noted that there were 176 claims opened in the period 1st January 2022 to 31st March 2022.

4.4.2 There was good evidence of clear claims management processes in place for both Clinical Negligence and Personal Injury Claims. The Assessment Team reviewed evidence of a flowchart which is in place however following discussion it was agreed that a Standard Operating Procedure would be beneficial especially for new staff and this was something the Team agreed would be considered.

4.4.3 The Assessment Team were assured that there was a Claims Policy in place and had recently been updated.

4.4.4 Training for staff is in place but on an ad hoc basis as and when requested by Clinical Boards.

4.4.5 Claims are discussed as part of the weekly meeting held with the Executive Team where any significant cases or issues are discussed and highlighted to the team.

4.4.6 The Assessment Team were assured to see evidence of close working relationships with the Clinical Boards.

4.4.7 The Assessment Team scrutinised the detail of nineteen claims records within the Datix Cymru system and noted that there had been an improvement in file management since the introduction of Datix Cymru. The Assessment Team saw evidence of good practice in file management but would recommend that consideration is given to a standard naming convention which would assist when searching for documents.

4.48 The Assessment Team also believe that improved and increased use of Datix Cymru would benefit the management of Claims as it would assist in recording the LFER approval process and submission deadlines.

4.4.9 The Health Board delegates its responsibilities to the Concerns, Claims and Compliments assurance group, the duly authorised committee. The group will receive and review quarterly progress reports on the management and status of claims against the Health Board, in the format specified by WHC (97)17. The special losses panel routinely report the value and incidence of Claims payments to the Audit Committee. The Clinical Director and Consultant responsible for the

patient are informed about the claim by way of notice, with relevant documents attached.

4.4.10 The Health Board were provided with Substantial Assurance in April 2022 by their Internal Audit of WRP Claims and a report was provided to the Assessment Team. The Claims Team discussed the finance process with the Assessment Team and explained that invoices are raised in batches and saved on a central file.

4.4.11 However, when the Team asked to see evidence of a certain payment it was unable to be located and it was not clear that the payment had been made with the date of payment difficult to confirm. Following the assessment, the team were able to view the financial returns submitted to Welsh Government, which identified there are strong financial controls as found in the internal audit report.

4.4.12 The Assessment Team requested information with regards to the delegated limits of the authorised signatories, but the document was not able to be located.

4.4.13 The Assessment Team noted that the Access to Health Records Department deal with all disclosure matters including potential claims. The Assessment Team have recommended to the Welsh Risk Pool that a review of the disclosure arrangements is undertaken within the Health Board.

4.4.14 When reviewing Personal Injury Cases, the Assessment Team noted that the Personal Injury Portal compliance times were low which appeared to be due to both staff working part time on the same days. Failure to comply with the portal timescales places potential financial risks which are ultimately borne by the WRP and it is recommended that these arrangements are reviewed.

Claims Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

4.5 Learning from Events

4.5.1 The Health Board explained that they have a central folder where evidence of lessons learned is stored. Evidence of a patient story presented at a Quality and Safety Meeting was provided confirming appropriate action taken and learning disseminated to relevant staff. This was evidence of regular good practice ensuring relevant staff are made aware of claims and action taken as a result of issues raised.

4.5.2 The Claims Team draft the LFER's and sometimes complete the issues and actions sections for the Clinical Boards to sign. This is believed to be more efficient. The Clinical Directors and Directors of Nursing sign and agree the learning within LFER's which assured the Assessment Team that learning from claims is a priority to the Health Board. Personal Injury LFER's are sent to Health and Safety Meetings where current themes, or trends are highlighted and discussed and a member of the claims team attends as and when is necessary.

4.5.3 The Assessment Team acknowledge that in some cases the Learning from Events Reports, and the information requested by a Learning Assurance Panel, has been delayed. The Assessment Team were shown the process that is followed and were assured to see a tracking process in place to monitor progress with capturing, validating and presenting learning information.

Learning from Events		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

4.6 Reimbursement Process

4.6.1 The Assessment Team were assured that there is a close working relationship with the Finance Department who support the reimbursement process and provide lists of Case Management Report's and timescales to the Claims Team to assist in ensuring cases are submitted in a timely manner. Finance staff prepare the U1 and submit to WRP, but it has the Claims Team signature on it. It would be beneficial for this process be revised to ensure that the U1 is reviewed prior to signature by the Claims Team.

4.6.2 All staff also have their own spreadsheet for monitoring cases and submission deadlines. The Assessment Team would recommend that Datix Cymru is utilised for the LFER and CMR trigger dates to enable a report to be run for the monitoring of cases.

4.6.3 The number of U5 request for reimbursement in closed matters, which would be an indicator or poor case and payment tracking, was noted to be very low and therefore a very good exemplar for other organisations to follow.

Reimbursement Process		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

5.0 Main Themes

5.1 Good evidence of clear incident management structure, with a need to enhance action when a case needs to transition to a redress matter.

5.2 Good communication links between corporate services and Clinical Boards, with excellent records of requests and responses and escalation procedures where required.

5.3 There is a clear, documented, structure in place to manage and respond to concerns raised by service users or their representatives.

5.4 Clear evidence of good advice given to complainants, with records of discussions and correspondence stored in an accessible format.

5.5 Effective communication channels with Executive Team to maintain awareness and provide escalation where necessary.

5.6 Well established process in place for redress management, with an SOP in place, although the terminology associated with the bolam test requires amending to ensure technical accuracy.

5.7 Good Claims management structure in place and this would be further enhanced by the introduced of a documented SOP similar to that seen with Redress matters.

5.8 Regular and close working relationship with Health Board Finance teams to ensure that Welsh Risk Pool and Welsh Government periodic returns align to the case records held corporately.

Areas of Good Practice

The Assessment Team found excellent practice with the production of training videos for staff on PTR together with a Newsletter with useful hints and tips. These should be shared as examples of good practice with other NHS Wales organisations.

The Concerns SOP is considered to be an exemplar and should be shared as good practice with other NHS Wales organisations.

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Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	
NOTES		

7.0 Recommendations

R01 CVUHB should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru.

R02 CVUHB should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary.

R03 CVUHB should ensure that there is evidence of further discussion and / or investigation outcomes with regards to breach of duty (if relevant) in incident records in cases where evidence of harm has been identified.

R04 CVUHB should ensure that the explanation relation to Breach of Duty is updated in all responses to be technically correct (advice can be sought from Legal & Risk Services as required).

R05 CVUHB should uploaded evidence of decision making from Redress Panels is onto Datix Cymru.

R06 CVUHB should record details of payments made on individual cases within the Datix Cymru system.

R07 CVUHB should review the process for the management of the HMCTS Claims Portal to ensure compliance with timescales.

R08 CVUHB should map out the process for transition of an incident into a redress case and consider introducing an SOP to support practice in this area.

R09 CVUHB should consider documenting the process used to ensure the early review of the £25k threshold is undertaken in a timely way as part of concerns handling.

R10 CVUHB should consider development of an SOP for claims management to build on the good process seen and ensure consistency in operational practice.

R11 CVUHB should consider the introduction of a naming convention for files related to claims management.

R12 CVUHB should review its arrangements for delegated authority limits within claims management and publish this in a readily accessible location.

8.0 Health Body Action Plan

Cardiff & Vale University Health Board has developed an action which addresses the recommendations made in this report. The action plan was received by the Welsh Risk Pool on 14th June 2023.

Bwrdd Iechyd Prifysgol
Cardiff and Vale
University Health Board

WRP Concerns Assessment

14th June 2023

Generated with AMaT
Audit Management and Tracking

Table of contents

Inspection details

Title: **WRP Concerns Assessment**

Inspection type: **New**

Inspection origin: **Welsh Risk Pool**

Date of inspection: **01/05/2023**

Next review date: **01/07/2023**

Link to external inspectors: **Welsh Risk Pool**

Inspection lead: **Welsh Risk Pool Assessors**

Inspection team

Internal inspection team: **Angela Hughes**

Recommendations

Ref	Priority	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
MD1	Must do	MD3 MD6 MD8 MD11	TRUSTWIDE	TRUSTWIDE	Putting Things Right	NO	Compliance	R02 CVUHB should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary	1	In progress
MD2	Must do	MD3 MD6 MD8 MD11	TRUSTWIDE	TRUSTWIDE	Putting Things Right Regulations	NO		R01 CVUHB should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru.	1	In progress

Ref	Priority	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
MD3	Must do	MD1 MD2 MD6 MD8 MD11	TRUSTWIDE	TRUSTWIDE	Putting Things Right Regulations	NO	Compliance	CVUHB should ensure that there is evidence of further discussion and / or investigation outcomes with regards to breach of duty (if relevant) in incident records in cases where evidence of harm has been identified	1	In progress
MD4	Must do	MD6 MD8 MD11	TRUSTWIDE	TRUSTWIDE	Putting Things Right	NO	Compliance	CVUHB should ensure that the explanation relation to Breach of Duty is updated in all responses to be technically correct (advice can be sought from Legal & Risk Services as required).	1	All Fully Complete
MD5	Must do	MD6 MD8 MD11	TRUSTWIDE	TRUSTWIDE		NO	Compliance	CVUHB should uploaded evidence of decision making from Redress Panels is onto Datix Cymru.	1	All Fully Complete
MD6	Must do	MD1 MD2 MD3 MD4 MD5 MD11	TRUSTWIDE	TRUSTWIDE		NO	Compliance	CVUHB should record details of payments made on individual cases within the Datix Cymru system.	1	In progress
MD7	Must do	MD11	TRUSTWIDE	TRUSTWIDE	Civil Procedural Rules	NO	Compliance	R07 CVUHB should review the process for the management of the HMCTS Claims Portal to ensure compliance with timescales.	1	In progress
MD8	Must do	MD1 MD2 MD3 MD4 MD5 MD11	TRUSTWIDE	TRUSTWIDE	Putting Things Right Regulations	NO	Compliance	R08 CVUHB should map out the process for transition of an incident into a redress case and consider introducing an SOP to support practice in this area.	1	In progress

Ref	Priority	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
MD9	Must do	MD11	TRUSTWIDE	TRUSTWIDE	Putting Things Right Regulations	NO	Compliance	R09 CVUHB should consider documenting the process used to ensure the early review of the £25k threshold is undertaken in a timely way as part of concerns handling	1	All Fully Complete
MD10	Must do	MD11	TRUSTWIDE	TRUSTWIDE	Putting Things Right Regulations	NO	Compliance	R10 CVUHB should consider development of an SOP for claims management to build on the good process seen and ensure consistency in operational practice	1	In progress
MD11	Must do	MD1 MD2 MD3 MD4 MD5 MD6 MD7 MD8 MD9 MD10	TRUSTWIDE	TRUSTWIDE		NO	Communication	R11 CVUHB should consider the introduction of a naming convention for files related to claims management.	1	In progress
MD12	Must do		TRUSTWIDE	TRUSTWIDE		NO	Compliance	R12 CVUHB should review its arrangements for delegated authority limits within claims management and publish this in a readily accessible location.	1	In progress

Actions

Saunders,Nathan
29/08/2023 09:08:28

Reference	Action	Site	Service	Responsibility	Date raised	Due date	Approval board	Progress status
MD1/1	To work with Clinical Boards and Patient Safety Team to develop the KPI's and Monitor timely closure	TRUSTWIDE	TRUSTWIDE	Mrs Alex Scott	12/06/2023	01/09/2023	QSE Committee	In progress
MD2/1	An Audit needs to be developed and checked weekly that all closed incidents have a recorded outcome	TRUSTWIDE	TRUSTWIDE	Mrs Alex Scott	12/06/2023	01/09/2023	QSE Committee	In progress
MD3/1	All Investigations require a decision regarding Qualifying liability with a pathway into redress	TRUSTWIDE	TRUSTWIDE	Ms Angela Hughes	12/06/2023	01/09/2023	QSE Committee	In progress
MD4/1	Agreed wording-shared with legal and risk	TRUSTWIDE	TRUSTWIDE	Ms Angela Hughes	12/06/2023	12/06/2023	QSE Committee	Fully complete (Approved)
MD5/1	all discussions uploaded to Datix following each redress meeting	TRUSTWIDE	TRUSTWIDE	Ms Angela Hughes	12/06/2023	12/06/2023	QSE Committee	Fully complete (Approved)
MD6/1	Both Heads of Claims will develop a weekly audit to check compliance	TRUSTWIDE	TRUSTWIDE	Mrs Suzanne Wicks	12/06/2023	01/09/2023	QSE Committee	In progress
MD7/1	To review the reasons for the delays and action	TRUSTWIDE	TRUSTWIDE	Ms Angela Hughes	12/06/2023	01/08/2023	QSE Committee	In progress
MD8/1	Agree the Sop and the pathway into redress with roles and responsibilities outlined	TRUSTWIDE	TRUSTWIDE	Ms Angela Hughes	12/06/2023	01/08/2023	QSE Committee	In progress
MD9/1	All Concerns are reviewed by the Assistant Director of Patient Experience and front sheet has been modified to agree where if qualifying liability was accepted claim would be in excess of redress threshold	TRUSTWIDE	TRUSTWIDE	Ms Angela Hughes	12/06/2023	12/06/2023		Fully complete (Approved)

Reference	Action	Site	Service	Responsibility	Date raised	Due date	Approval board	Progress status
MD10/1	To develop a Sop for CLINICAL negligence and Personal Injury claims	TRUSTWIDE	TRUSTWIDE	Mrs Suzanne Wicks	12/06/2023	01/08/2023	QSE Committee	In progress
MD11/1	To agree naming convention for key documents across all modules	TRUSTWIDE	TRUSTWIDE	Ms Vicky Stuart	12/06/2023	01/08/2023	QSE Committee	In progress
MD12/1	To develop the agreed delegated authority limits within claims management	TRUSTWIDE	TRUSTWIDE	Ms Angela Hughes	12/06/2023	01/09/2023	QSE Committee	In progress

Notes

No notes found.

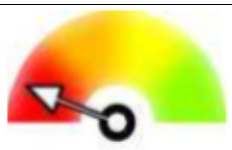
List of Uploaded Files

Name	File Type	Usage	Uploaded By	Uploaded Date
0044fdb1c17c1ffe973fdfaa	PDF	Inspection report (System Generated)	Angela Hughes	14/06/2023

Appendix 1

NHS Wales Assurance Framework

The WRP Assessment Programme utilises the NHS Wales Internal Audit Framework for Assurance:

SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.
NO ASSURANCE		The organisation has **no assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.

Appendix 2

WRP Concerns Assessment – Areas for Assessment

The WRP Assessment Programme uses a series of Areas for Assessment to guide the Assessment Team in the aspects and criteria to be examined. These cover the areas of activity which directly impact on matters which may cause a request for reimbursement from the Welsh Risk Pool.

The Areas for Assessment provide a framework for the Assessment Team to gather information, evidence and collate data to support the identification of findings and the establishment of recommendations.

Assessment Criterion

AREA FOR ASSESSMENT	
A	Management of Concerns (Incidents)
B	Management of Concerns (Complaint and Enquiries)
C	Redress Case Management
D	Claims Case Management
E	Lessons Learned
F	Reimbursement Process

Area for Assessment A: Management of Concerns (Incidents)	
A1-01	Is the timescale between index events and incident reporting reasonable?
A1-02	Did the incident have an initial review, where appropriate?
A1-03	Is the timescale between reporting and initial review, where appropriate, reasonable?
A1-04	Did the incident have a management review completed, where appropriate?
A1-05	Did the incident have a proportionate investigation completed, where appropriate
A1-06	Is the timescale between reporting and investigations reasonable?
A1-07	Have all the essential data fields been completed correctly on Datix Cymru?
A1-08	Was the incident record closed within 30 days? Where this is not possible, is there information to explain the reason for any delays or actions being taken?
A1-09	Was the incident reportable as a Nationally Reportable Incident? Was the timeliness of any notifications reasonable?
A1-10	Was the there a consideration whether the incident met the requirements for a Qualifying Liabilty?

Policy and Procedure	
A2-01	Is there a policy or procedure in place for Incident Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
A2-02	Does the policy or procedure cover the requirements as set out in PTR guidance and associated national policy?

Information, Reporting & Governance Arrangements	
A3-01	Are there effective governance arrangements for the management of incidents?
A3-02	Is there a screening process in place for monitoring accuracy of information submitted in incident reports? Is it timely?
A3-03	How are incidents reported within the Health Body and to what meetings or committees are they reported? Are they reported at Board level or Sub-Committee? Are these arrangements proportionate?
A3-04	Is there training in place for staff for reporting incidents?
A3-05	Is there training in place for staff for investigating incidents?

Area for Assessment B: Management of Concerns (Complaint and Enquiries)	
B1-01	Is the complaint record complete? Is all correspondence, advice and supporting information available for review?
B1-02	Does the complaint investigation consider all relevant points raised in the complaint received?
B1-03	Does the complaint response comply with the content requirement as set out within the guidance?
B1-04	Did the concern conclude with the final response? If not why? How was the concern resolved if not with the final response?
B1-05	Are the essential data fields in Datix Cymru completed accurately and up to date?
B1-06	Has a response been prepared for every concern notified and investigated?
B1-07	Has a report been provided to the person notifying the concern within 30 days
B1-08	Where it has not been possible to provide the report within 30 days, has the person notifying the concern been advised within 30 working days, and an explanation provided, and proposed timescale agreed?
B1-09	Where a complaint is dealt with 'on the spot' / via early resolution, is this recorded appropriately? Is the timescale for early resolution matters recorded accurately and is it appropriate?
B1-10	How many concerns were answered within the 30 day period?

Area for Assessment B:	
Policy and Procedure	
B2-01	Is there a policy or procedure in place for Complaint Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?

Information, Reporting & Governance Arrangements	
B3-01	What are the governance arrangements for the management of complaints and enquiries?
B3-02	How are complaints reported and monitored within the Health Body and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
B3-03	Is there a training package in place for staff for complaints handling?

Area for Assessment C: Redress Case Management	
C1-01	Is there an appropriate process for determining when a matter should be handled by Redress specialists? Is there a clear process for transition from incident teams and complaints teams?
C1-02	Is the redress record complete? Is all correspondence, advice and supporting information available for review?
C1-03	Has an interim report (Reg 26 letter) for the concern reviewed and investigated been prepared where the Health Body considers there may be a Qualifying Liabillity?
C1-04	Has the interim report been provided to the person notifying the concern within 30 days?
C1-05	Does the response letter comply with the content requirement set out in the Regulations & associated Guidance? E.g., explaining QL, advice re Solicitors, addresses all concerns raised etc
C1-06	Has a Reg 24 response been prepared for the concern reviewed which has been investigated and in respect of which the Responsible Body considers there is no QL in tort?
C1-07	Has a Reg 24 been prepared for the concern which has been investigated and in respect of which the Health Board considers the claim to be over £25,000 in value?
C1-08	Has a Reg 24 letter been provided to the person notifying the concern within 30 days?
C1-09	Where it has not been possible to provide the Reg 24 letter within 30 days, has the person notifying the concern been advised within 30 working days, with an explanation provided and proposed timescale agreed?

C1-10	Does the Reg 24 letter comply with the requirements as set out in the guidance? Eg no reference to BOD and QL if considered over £25,000 and advice re Solicitors etc?
C1-11	In circumstances where a Reg 26 interim response was provided, have independent experts been instructed? Has this been done in line with the requirements in the Regulations (ie jointly) and appropriately?
C1-12	Has a Regulation 33 report been sent for every concern reviewed and investigated in respect of which the Responsible Body has not sent a Regulation 24 response?
C1-13	Has the Regulation 33 report been provided within a maximum of 12 months of the concern being notified to it?
C1-14	Does the Regulation 33 Response comply with the requirements of the Guidance? Eg clearly sets out the basis for the final decision as to QL and the offer made.
C1-15	Where financial compensation has been paid, has an appropriate contract been entered into between the recipient of the financial compensation and the Organisation?
C1-16	Has Legal and Risk Advice been requested? Was this request proportionate?
C1-17	Who authorised QL and on what basis? Was this appropriate?
C1-18	Have all essential data fields been completed correctly within the case management record?
C1-19	How many LFER's submitted in relevant period?
C1-20	How many requests for reimbursement submitted to WRP?
C1-21	What is the performance for WRP submission deadlines?
C1-22	How may extensions were requested for submission to WRP?
C1-23	How many cases were approved at the first Learning Advisory Panel?

Policy and Procedure	
C2-01	Is there a policy or procedure in place for Redress Case Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
C2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?
C2-03	Is there a process in place to review admission/denial decisions?

Area for Assessment C: Redress Case Management	
Information, Reporting & Governance Arrangements	
C3-01	What are the governance arrangements for the management of redress cases?
C3-02	How are they reported within the Health Board and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
C3-03	Is there a training package in place for staff?
C3-04	There is a system for learning lessons from events including concerns (incidents, complaints, claims under redress) compensation claims, claims reviews etc which are used to improve services

Area for Assessment D:	
Claims Case Management	
D1-01	Is there an effective process for receiving and processing requests for disclosure of medical records in matters where a claim is being considered against the health body?
D1-02	Where disclosure of records is requested, is there a process to ensure appropriate release of information is managed and redaction of relevant information undertaken as required?
D1-03	Is there an effective process for the oversight of disclosure of information in matters where a claim is being considered against the health body?
D1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of claims to Legal & Risk appropriate?
D1-05	Is there a clear process for receipt of advice in a matter and analysis of requests for instructions? Are the timescales for receiving advice and providing instructions appropriate and proportionate?

Area for Assessment D:	
Policy and Procedure	
D2-01	Is there a policy or procedure in place for Claims Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
D2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?

Area for Assessment D:	
Information, Reporting & Governance Arrangements	
D3-01	What are the governance arrangements for the management of claims cases?
D3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
D3-03	Are they reported at Board level or Sub-Committee?
D3-04	Is there a training package in place for staff responsible for managing claims?

Area for Assessment E:	
Lessons Learned	
E1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and demonstrates practically how it learns lessons from events?
E1-02	Is there a clear process relating to the approval of Learning from Events Reports prior to submission to WRP
E1-03	Is there an assurance process relating to lessons learned from the Operational level to Board level? E.g. Flowchart, Terms of Reference for meetings, Reports?
E1-04	What proportion of LFER reports were submitted in accordance with the WRP Reimbursement Procedures? E.g. timeless, completeness, extension requirements?
E1-05	What proportion of LFER reports were approved by the Learning Advisory Panel?

Area for Assessment F:	
Reimbursement Process	
F1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and provides assurance for the accounting of losses & special payments which are subject to WRP Reimbursement?
F1-02	Does the Health Body have a process for tracking and ensuring submission to WRP for reimbursement? E.g. timeliness?
F1-03	Does the Health Body have a process for identifying and submitting post-closure reimbursement requests in a timely manner?

Report Title:	Introduction to the Public Health Wales Safeguarding Service, Self- Assessment Safeguarding Maturity Matrix (SMM) for Health Boards and Trusts			Agenda Item no.	4.2
Meeting:	Executive QSE	Public	X	Meeting Date:	August 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:

Public Health Wales Safeguarding Service has worked with Health Boards and Trusts since 2015 to standardize safeguarding arrangements for children, adults at risk and staff within organizations across Wales to ensure a consistent approach to safeguarding that demonstrates leadership, support for practitioners, person centered services, shared learning, multi-agency partnership working and consideration of business continuity plans being in place. The Self- Assessment tool has changed this year following a successful pilot undertaken within Wales.

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

The self-assessment tool is completed by the Head of Safeguarding in partnership with Clinical Board Directors of Nursing and service groups such as Patient Safety, Patient Experience, Equality Lead and People's Services. Information from each area is collated and shared within the assessment to determine a scoring of where we are as a UHB and where we need to be in the coming year. An improvement plan for the University Health Board (UHB) is considered that will determine specific audits, learning and additional improvements that are required to increase the ability of the UHB to provide good quality care which is provided in an environment that is supportive and demonstrates that safeguarding is considered for the prevention and protection of our patient's and the UHB workforce. The scoring system has a traffic light approach to consider if actions are on track through to action not started. There are six domains that cover the assessment consideration, these are:

- An organization which is "well led" There are 7 indicators and examples scored as one red and seven green
- Has a "confident and competent workforce" one amber and seven green
- Is "person centred" four amber and six green
- Has a "learning culture" two amber and three green
- Demonstrates "Multi-agency partnership working" five green
- Is "responsive, purposeful and agile" two red and three green

The self-assessment has been agreed by the Executive and Deputy Nurse Director with assistance from the Head of Safeguarding, the completed tool has been discussed and shared at the UHB Safeguarding Steering Group. The overall assessment demonstrates and provides reasonable assurance to the Executive Board that the UHB is on target and able to provide effective, innovative and safe care to service users in an environment that aims to minimize the safeguarding risk to people living and working within the UHB region. The completed self- assessment has been shared with Public Health Wales Safeguarding Service; a peer review process will be organized to share learning, compare, contrast and critique submissions from other Health Boards and Trusts. An Annual Report will be completed by Public Health Wales and shared in the coming year demonstrating themes, identifying good practice, learning and gaps in safeguarding care.

Recommendation:

The improvement plan identifies where there are areas of progress required. Areas scored as red- *action not on track* will be prioritised, this includes participating with Public Health Wales (PHW) to complete a whole Wales safeguarding strategy, consider audit of virtual assessments/ appointments and completion of a safeguarding business continuity plan. In addition, the introduction of Clinical Board self-assessments will be introduced to feed in to the overall UHB Safeguarding Maturity Matrix for the coming year. This will capture a wider breadth of good practice across the UHB that could be transferred and implemented in other service areas.

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

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

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

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

SMM Revision Phase Two 2022

The Safeguarding Maturity Matrix (SMM) is a self assesment quality assurance tool completed by the seven Health Boards and three Trusts that form NHS Wales. The SMM is completed on an annual basis reporting on activity for the previous year.
The SMM annual submission aims to demonstrate improvements and risks in the organisations. The SMM also promotes horizon scanning, allowing organisations and the wider NHS Wales Safeguarding Network to understand safeguarding priorities for the following year.

This phase 2 revision has been collaboratively developed by the NHS Wales Safeguarding Network SMM subgroup.
The revision will be piloted by all organisations in 2023.

Safeguarding is the protection of both adults at risk and children's rights to live in safety, and free from abuse and neglect (Social Services and Wellbeing Act (Wales) 2014). NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need to promote positive outcomes for a healthy, safer and fairer Wales.

The NHS in Wales is committed to protecting and safeguarding the welfare of adults at risk and children. Measuring the effectiveness of health services in the contribution to safeguarding children and vulnerable adults is important. The SMM is an independent assurance tool that enables the Heath Boards and Trusts in Wales to evidence safeguarding quality.

The SMM is important as it gives an opportunity to examine effectiveness, innovation and risk in safeguarding. It also has a unique function in giving opportunity to share learning across Wales, avoiding silo working, repetition and promoting good practice.

The SMM process includes an annual SMM submission (reporting on the year prior) that is submitted in summer each year. The submission is guided by a template where each quality standard is explored by the organisation. The organisational strengths and areas for improvement are reported though this document, and the plans are collated by the National Safeguarding Team (NST). The annual SMM submission forms the basis for a final report, and also the collaborative NHS Wales Safeguarding Network Work Plan.

As part of the SMM process a Peer Review event is held each year. The Peer Review aims to provide a constructive arena for Heads of Safeguarding from the Health Boards and Trusts to compare, contrast and critique the SMM submissions. The event is unanimously enjoyed and appreciated by all who attend and is a real asset to the SMM process.

The SMM Annual Report collates the information shared via the SMM submissions and through Peer Review. It will group themes from the submissions and will identify best practice, learning and gaps in safeguarding care that can be addressed by NHS Wales in the coming year.

Well Led	Confident and Competent Workforce	Person Centred	Learning Culture	Multiagency Partnership Working	Responsive, Purposeful and Agile
Safeguarding is well led and governed in the organisation with evidence of visible and approachable leadership, that is structured at every level. There is a clear safeguarding strategy with well defined quality objectives that evidences areas of strength and risk, and is underpinned by feedback from team members and people who use the services.	There is evidence of a confident and competent workforce that are safe to work with vulnerable people. DBS's are completed and monitored. Safeguarding training and supervision is in place. Individuals know how to report and escalate safeguarding concerns, and also concerns about safe practice.	Safeguarding is focused around the needs of individuals and the local community, and safeguarding activity data can be used to help demonstrate the needs of the community. There is evidence of policy, process and partnership working for safeguarding issues such as mental capacity, domestic abuse, FGM. There is a lifespan approach for vulnerable people where their needs are personalised as they progress through health services as they grow older. This includes being ACE and trauma informed throughout child and adult services. There is a range of services offered using digital approaches and in a variety of languages and formats.	There is evidence of a culture that promotes candour, learning and avoids blame. This is supported by a reporting system for safeguarding concerns, incidents and litigation where they can be monitored, addressed and trends understood. There is evidence of learning from safeguarding incidents and Practice Reviews that reaches frontline team members. Multi agency learning is promoted to share knowledge across the safeguarding community. Feedback from those who use services is used to shape and improve the quality of service provision.	There is a safeguarding strategy that is aligned to local plans in the wider health and social care economy, and services are planned to meet the needs of the relevant population. The organisation actively contributes to the multi agency approaches to safeguarding issues. There is appropriate participation in the Regional Safeguarding Boards and involvement in processes such as MARAC and MAPPA. There is evidence of strong connections and referral mechanisms with local services that can prevent harm, support and protect vulnerable people.	There is evidence that the organisation is agile and has business continuity plans for safeguarding to ensure children and adults-at-risk remain safe and supported in times of national/local crisis. The impact of changed working practices such as remote working must be evaluated and undertaken in line with local protocols to ensure there is no delay in the identification of risk, harm, need and vulnerability.

Standard	Indicators	Examples (this list is not exhaustive and own examples are expected to be provided)	Score at point of 1st review (RAGG)	Highlight of good practice, inovation and Quality Improvement initiatives	Organisational Plan where the need for Improvements have been identified	Trend	Legislation, Statutory Guidance and other national drivers to support the SMM
1. Well Led - Effective Leadership & Governance	1.1. Evidence that safeguarding leaders in all directorates/areas are visible, approachable and accessible and can be communicated with through different channel	Safeguarding governance and leadership flowcharts and contact details held on intranet/internet other non-digital platforms available to staff and patients	Green	All CBS and Corporate to send flow chart to safeguarding.	Assurance required that details are visible on intranet/ internet.		• Royal College of Nursing (2019). Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. • NHS Improvement (2018). Well Led Framework Assessment. • Welsh Government (2019). A Healthier Wales: our Plan for Health and Social Care. • NHS Improvement (2018). Well Led Framework Assessment. • NHS Wales (2021). Quality and Safety Framework: A Learning Health and Care System. • Health and Social Care (Quality and Engagement) (Wales) Act 2020. • NHS Wales National Succession Strategy 2017 - 2027. • NHS Wales (2021). Annual Planning Framework 2021- 2022. • Welsh Government (2015). Well-Being of Future Generations (Wales) Act (2015). • Welsh Government (2021). National Clinical Framework: A Learning Health and Care System. • Social Services and Well-being (Wales) Act 2014. • NHS Wales (2020). Putting Things Right. • NHS Wales (2015). Health and Care Standards. • Welsh Government (2014) Social Services and Well-being (Wales) Act - Working Together to Safeguard People Vol 3 – Adult Practice Reviews • Welsh Government (2014) Social Services and Well-being (Wales) Act - Working Together to Safeguard People Vol 2 – Child Practice Reviews
	1.2. Evidence that there is leadership capacity and capability to deliver high quality, sustainable care in safeguarding E.g. avoidance of single point of failure, succession planning, recruitment, levels of leadership - including leadership at Board Level	Single points of failure in safeguarding are acknowledged and avoided, upskilling junior members of the team for succession planning	Green	Risk Register in respect of priorities and areas of safeguarding which are unachievable to manage. Regular supervision and VBAs undertaken which address staff progression and future promotion within the safeguarding team. Supervision provided to other staff groups which enhances skill set and understanding to join the safeguarding team. Health Lead Practitioners available in each Clinical Board to undertake adult safeguarding which improves understanding of the process. Succession planning is in place within the CORPORATE Safeguarding Team	Work underway to upskill junior team members although there is limited capacity to do this due to resources		
	1.3. Evidence of a robust and realistic safeguarding strategy with well-defined objectives that are achievable and relevant, which are communicated in annual reports, policy and assurance structures	Safeguarding strategy statement is published online and forms introduction of local policies and training	Red	Safeguarding Training Strategy completed. Annual report to be completed and shared at SSG in July.	PHW Safeguarding strategy statement required. Work currently in place to complete the UHB strategy Shaping Our Future 2023-33		
	1.4. Evidence that safeguarding strategies are aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population	Safeguarding strategies are formed and aligned with organisational strategies and purpose and shared with other public services auch as local partnership forums and Regional Boards	Green	Aligned through participation in RSB/ Community Partnership and Public Safety Board strategies. Patient Safety/ Patient Experience Team have shared presentations around Duty of Care & Candour.	Patient Safety & Quality: Duty of Care/ Duty of candour/ Duty of Culture		
	1.5. Evidence that strategic planning takes into account the need to safeguard and promotes the welfare of citizens	Quality Impact Assessments and Equality Impact Assessments should ensure that safeguarding vulnerable people is considered in any plans to start, change or discontinue any element of service delivery.	Green	Strong ties with Strategic Planning through PREVENT referrals and training. Information regarding our EHIAs can be found on our website	As per the Equality Act 2010, the Health Board completes Equality Health Impact Assessments to ensure that the impact of decisions and strategies on diverse communities are taken into consideration. The EHIA considers the impact on those with different protected characteristics, those from different socio-economic background, and the Welsh language. Having the EHIAs in place enables us to safeguard vulnerable people by ensuring they form part of the decision-making process, where we identify risks and mitigate any negative impacts as much as possible.		
	1.6 Evidence that that learning from audits, incidents, practice reviews is embedded into practice and horizon scanning and service area planning. Evidence that learning from audits, incidents, practice reviews reaches all relevant colleagues, particularly hard to reach frontline practitioners	Systems for learning, delegating and monitoring actions across organisations.	Green	Presentations provided at Child Health Forum and HV supervision for Child Practice Reviews locally and out of area.	Information shared with DONs for dissemination at CB Q&S meetings. Annual assurance required from each CB that learning from SSG is shared.		
	1.7 Evidence that the organisations safeguarding structure has clear responsibilities, roles and systems of accountability to support good safeguarding governance and management	Safeguarding flowcharts that are applicable to all directorates	Green	All safeguarding flow charts are applicable to all CBs although differences may be seen in child health and adult services.			
	1.8 The organisations executive board has strategic oversight providing scrutiny of organisational safeguarding risks and safeguarding assurance	Safeguarding is a standing agenda item at executive meetings and the corporate risk register is shared there. Safeguarding is a standard item on CB Quality Assurance meetings	Green	Professional Concerns Meetings with DONs.	VAWDASV Group 6 training presented to Executive Board. Safeguarding Annual Report s shared at the Executive Board meeting.		
2. Confident and Competent Workforce	2.1 There is evidence that services commissioned by the HB or Trust are monitored and are compliant with all relevant safeguarding legislation, policies and guidance. (Where this is local and not a National commissioning contract)	Evidence of collaborative working between commissioning units and safeguarding teams	Amber	Concerns and data shared with Executive Team and safeguarding regarding commissioning within Primary Care/ Care Homes.	Additional information and monitoring required from MH services relating to patients placed outside of Wales. Need to consider LD patients also.		• HM Government (1989). Children Act. • HM Government (2004). Children Act. • Welsh Government (2006). Safeguarding Children: Working Together Under the Children Act 2004. • NHS Wales (2020). Putting Things Right. • All Wales Raising Concerns (Whistleblowing) Policy NHS Wales (2020). • Welsh Government (2019). Wales Safeguarding Procedures. • NHS Wales (2015). Health and Care Standards. • Royal College of Nursing (2019). Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. NHS Wales (2021). • Royal College of Nursing (2018). Adult Safeguarding: Roles and Competencies for Health Care Staff. • Quality and Safety Framework: A Learning Health and Care
	2.2 Evidence of policy/ procedure for safer recruitment that ensures Disclosure and Barring Services (DBS) are utilised	DBS policy in place and HR partnerships in place	Green	All Wales process in place through Shared Services and TRAC.			
	2.3 Evidence of policy/ procedure for colleagues to report concerns/ allegations regarding practitioners	In addition to the duty to report concerns about practitioners, are raised to the corporate safeguarding team and recorded on the concerns management system/internal management system	Green	Policy is in place within the UHB. Robust process in place involving all CBs through the DONs and HR.	Development of a staff questionnaire to raise awareness of impact on individual		
	2.4 Evidence that safeguarding training compliance is able to be monitored for new starters, existing staff, bank & agency staff, independent contractors and volunteers? Outsourced or visiting professionals.	ESR reporting in place and in line with Intercollegiate documents and it includes safeguarding training for medical and dental practitioners. Target for all training compliance is 85% as per Welsh National safeguarding training, learning and development standards	Green	Training is monitored on a monthly basis which incorporates all training for staff working in any capacity within the UHB. Due to current staffing difficulties the target aim within the UHB is 75% compliance. Mandatory training is discussed at VBA.	Continual training monitoring required. CBs to take ownership of services and departments in their own CB		

	2.5 Evidence that risk in safeguarding training compliance is managed and action plans are in place to address non compliance	Risk register for training compliance	Green	There is no current risk register for UHB training compliance.	Agreed compliance within the UHB		System. • NHS Wales (2019). Core skills training framework NHS Wales. • NHS Wales (2015). Health and Care Standards. • Social Services and Well-being (Wales) Act 2014. • Together for Mental Health Delivery Plan: 2019-22 • Home Office and Safe Lives (2019). Responding to colleagues experiencing domestic abuse. • Equality and Human Right Commission and Chartered Institute of Personnel and Development (2020). Managing And Supporting Employees Experiencing Domestic Abuse. • National safeguarding training, learning and development standards 2022 • HM Government (2006). Safeguarding Vulnerable Groups Act • Domestic Abuse Act 2021
	2.6 Evidence of safeguarding supervision arrangements, including policy, training and schedules for safeguarding supervision	Safeguarding supervision risks/ exceptions are brought to directorate and executive meetings	Green	Robust supervision is provided on a regular 3 monthly basis for service groups such as Midwifery, HV, school nursing. Many other groups receive regular supervision on a quarterly basis. Supervision is mainly provided as group supervision with 1:1 supervision provided as required.			
	2.7 Policies and processes in place for colleagues to raise concerns about safeguarding issues pertaining to themselves or their colleagues e.g. domestic abuse, mental health	Staff wellbing support widely available and includes safeguarding issues	Green	EWB and Occupational Health referrals considered in each circumstance. Advice to contact GP also given. HR will also provide support and advice to staff. Staff evaluation questionnaire to be completed and implemented across the UHB	Health IDVAs employed within the UHB		
	2.8 Evidence that information regarding new legislation, policy and guidance is cascaded across the organisation	Awareness raising of the new offence of non-fatal strangulation or suffocation of another person.	Green	All updated information is shared at SSG and directly with DONs for dissemination. The new offence of non-fatal strangulation or suffocation is included in the Group 2 training.			
3. Person Centred	3.1. There is evidence that safeguarding training reflects the Social Services Well-being (Wales) Act (2014) and has significant reference to person centered planning and patient involvement	A training programme that is relevant and up to date	Green	The training programme is continually updated and monitored for new/ additional information. A training schedule is shared at SSG with 6 Level 3 full-day training sessions available with safeguarding facilitating the training.	Continue to monitor and update safeguarding training. Level 3 Study days to be monitored and consider numbers attending		• Social Services Well-being (Wales) Act (2014). • Welsh Government (2019). Wales Safeguarding Procedures. • NHS Wales (2015). Health and Care Standards. • Welsh Government (2015). Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act. • Welsh Government (1993). Welsh Language Act • Taking Wales Forward (Welsh Government) 2016-2021. • Public Health Wales (2015). Adverse Childhood Experiences and their impact on health-harming behaviours. • National Strategy on Violence against Women. • Domestic Abuse and Sexual Violence 2016 - 2021. • Domestic Abuse Act 2022 England & Wales. • Mental Capacity Act (2005). • Mental Capacity Act 2005 Code of Practice. • Mental Capacity (Amendment) Act 2019. • NHS Wales (2021). Quality and Safety Framework: A Learning Health and Care System. • Welsh Government (2021). National Clinical Framework: A Learning Health and Care System. • Health and Social Care (Quality and Engagement) (Wales) Act 2020. • Welsh Government (2015). Well-Being of Future Generations (Wales) Act (2015). • The Transition and Handover Guidance (Welsh Government) 2022. • Welsh Government (2021). Health and Social Care in Wales: Covid-19 Looking Forward. • The Children Act 1989. • The Children Act 2004 • Violence against women, domestic abuse and sexual violence: strategy 2022 to 2026
	3.2. There are mechanisms to monitor safeguarding reports in order to audit quality, numbers, trends and themes of safeguarding data	Evidence of dashboards or scorecards to understand and monitor safeguarding activity, themes and outcomes.	Amber	Safeguarding activity is monitored and discussed at SSG meeting. MARFs and AS1s are picked up ad hoc by administration staff and safeguarding nurse advisors if the quality of the of information is sparse.	There are no score cards available, this has been requested and is on the workplan. Audit to be commenced in 2023/24. Consider monthly safeguarding theme as part of tenable digital audit undertaken in clinical areas.		
	3.3. Evidence that organisations are aware of Adverse Childhood Experiences and can demonstrate examples of trauma informed care delivery	ACE awareness is included in safeguarding training	Green	ACE information and awareness is available through safeguarding training. Staff training opportunities are shared when they arise.			
	3.4. Evidence that the VAWDASV Wales National Strategy is embedded into care provision through policy, process, training and audit	HB or Trust VAWDASV policy available on intranet/internet (for staff, volunteers and the public) and is embedded into training.	Green	The strategy is embedded within the domestic abuse training at all group levels. The updated regional strategy has been submitted and will be shared when finalised and signed off by WG.			
	3.5. Evidence that there is policy, procedure and horizon scanning pertaining to Mental Capacity Amendment Act and Liberty Protection Safeguards	MCA is standing agenda item on safeguarding executive level meeting, it has a designated operational, managerial and exec lead	Green	This work is in progress and is strengthened by the newly developed team structure. The MCA and Consent team are now placed under the safeguarding umbrella.	Additional team members recruited as MCA practitioners and Capacity Lead recruited.		
	3.6. Evidence that feedback from people who use services is used to monitor and improve the quality of services	Evaluations are planned in areas e.g. for looked after children to assess how they have found health assessments and feedback from service users such as complaints and compliments in used to improve service delivery.	Green	NHS Survey scheduled for 2023. Survey development for staff involved in the Professional Concern/ Allegation process. Discuss with Mitchell and Patient Experience. Any surveys in CBs? Contact CLA team Tenable audits are undertaken across all in patient clinical areas and capture patient experience and monitor standards of care delivery Safe care has been implemented across all in patient clinical areas and is a daily monitoring tool to ensure safe staffing levels and proactively manage patient safety and experience based on patient acuity and available staff resource and skill mix Civica – QR codes are clearly visible in clinical areas and also at patient bedside for live patient experience feedback.	The Health Board undertakes an annual survey of the experiences of our LGBTQ+ workforce through our submission to Stonewall's Workplace Equality Index. Tenable audits looking at the experiences of our Welsh speaking patients is scheduled to commence in September 2023. The audit will measure our ability to deliver a Welsh language service. PowerPoint slides available from Patient Experience.		
	3.7. Evidence that there is all language inclusion (including Welsh and British Sign Language) in safeguarding for persons where English is not their first language	There is a policy/practice guidance/SOP available to staff to access translation services such as Language Line or in person translation services	Amber	The organisation has approved a Welsh Language Policy which ensures that patients and staff have access and support to use and develop their Welsh Language skills. This will result in them being able to provide services in Welsh for patients and service users. A Clinical Consultation Plan has also been approved which sets out how the organisation will improve the level of services offered to patients and service users in Welsh over the next five years. The Health Board is also currently drafting a Welsh Language In-Patient Policy which will ensure that patients are asked if Welsh is their preferred language which will form an integral part of their treatment.	Scrutiny required around Language Line use		

	3.8. Evidence that safeguarding is considered in the use of face to face and digital approaches to support transformative models of care	There is a policy/practice guidance/SOP available to staff to support them in their safeguarding duties whilst utilising new technologies e.g. digital consultations	Amber	All areas within the UHB use a digital safeguarding referrals. The UHB is able to evidence that both acute and community services provide digital consultations.	To check with other HBs and Trusts if a document is available for sharing.		
	3.9. The voice of the victim/ survivor and the voice of children is clear in safeguarding policy, process and training	Survivor stories are used to inform current policies, practice and training	Green	Evidenced in SSG Minutes			
	3.10 There is evidence that systems are in place to help children, young people and their carers have a positive experience of transitioning and handover to adults services	That every child and young person transferring from children to adult services will have a documented Transition and Handover Plan (THP), or equivalent.	Amber	Good Practice in specified specialised areas such as Teenage Cancer Trust	Further information and exploring is required with Children & Women		
4. Learning Culture	4.1. Evidence that safeguarding policies are aligned to national guidance, are up to date and have been formally agreed by the Board and are updated to reflect continued learning from reviews etc.	VAWDASV policies are reviewed to meet any updates to the review of the National Training Framework (VAWDASV) & Domestic Abuse Act 2022 England & Wales. RSB procedures.	Green	Evidenced through participation and NTF plan. PCIC - Multiagency escalating concerns process signed off at RPB, SSG and UHB and CB QS&E			• Welsh Government (2014). Social Services Well-being (Wales) Act (2014). • NHS Wales (2020). All Wales Raising Concerns (Whistleblowing) Policy. • NHS Wales (2021). Quality and Safety Framework: A Learning Health and Care System. • NHS Wales (2015). Health and Care Standards.
	4.2. Evidence that the All Wales Raising Concerns policy is embedded in the organisation to report concerns about safe practice and the organisations culture promoting honesty, openness and candour	RL DATIX and/or relevant concerns management system is regularly audited to highlight any safeguarding concerns that are being raised via "Raising Concerns"	Green	Tenable Digital Audit asks this question across all in patient clinical areas.	Patient Safety update: Ensure a safe culture and promote psychological safety for staff to feel able to report concerns and safety issues. Embedded QSE Framework. RCA tool recently changed with refreshed terms to move away a non-punitive approach and focus on learning.		
	4.3. Evidence of clear and effective processes for managing safeguarding risks, complaints, litigation and incidents and that they are recorded, reported and investigated	RL DATIX and/or relevant concerns management system is used to report and reports are run quarterly to include in safeguarding board/committee meetings	Amber	Information collated within safeguarding, not shared in SSG- to be considered	Consider DATIX data for safeguarding being shared at SSG. This is work in progress		
	4.4. Evidence that trends, strengths or risk identified from safeguarding data e.g. increase in domestic abuse is incorporated into HB / Trust safeguarding strategies	Safeguarding data is shared at safeguarding board meetings	Green	Evidenced through SSG minutes			
	4.5 There is evidence of the dissemination of learning to front line team members identified through safeguarding incidents, practice reviews, etc.	Newsletters, bulletins, briefings etc	Amber	Ad hoc bespoke presentations of published CPR/ APR. Supervision. L3 study day arranged for 2023.	Safeguarding Newsletter needs to be re-commenced.		
5. Multi Agency Partnerships	5.1. Evidence of appropriate participation in Regional Safeguarding Boards and Subgroups and that participation generates continuous improvements in service delivery and practice across the safeguarding community	Inclusion in multiagency action trackers following Practice Review	Green	Evidenced through RSB. PCIC - Participation and leading of multiagency escalating concerns processes	Evidenced through RSB		• Welsh Government (2014). Social Services Well-being (Wales) Act (2014). Section 134. • NHS Wales (2015). Health and Care Standards. • Home Office - Criminal Exploitation of children and vulnerable adults: County Lines guidance 2018 • The legal and policy framework for Contextual Safeguarding approaches 2018. • Female Genital Mutilation Act 2003. • Modern Slavery Act 2015. • Safeguarding Children and Young People from Sexual Exploitation • Working Together Under The Children Act 2004. • Welsh Government (2015). Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act. • Welsh Government (2015). Well-Being of Future Generations (Wales) Act (2015). • NHS Wales (2021). Annual Planning Framework 2021- 2022. • NHS Wales (2021). Emerging Drivers of Vulnerability to Health Inequity in the Context of COVID-19: Perspectives and response from the Voluntary and Community Sector in Wales. • NHS Wales (2021). Annual Planning Framework 2021- 2022. • Welsh Government (2019). A Healthier Wales: our Plan for Health and Social Care. • Welsh Government (2019). National Action Plan Preventing and Responding to Child Sexual Abuse
	5.2. Evidence that the organisation actively engages in the responsibilities of Multi Agency Public Protection Arrangements (MAPPA) and Multi Agency Risk Assessment Conferences (MARAC)	MARAC process in place and Health are actively engaged in MARAC's routinely, including input from and feedback to G.P.s	Green	100% attendance at both MARAC meetings for Cardiff and VOG. C&V region information is shared with GPs by the MARAC coordinators.			
	5.3. Evidence of meaningful partnership working with third sector partners and advocacy services? E.g. charities, independent providers, IMCA	There is evidence of collaboration with advocacy services e.g. IMCA, IDVA	Green	Stonewll Charity. Race Equality First (Board Development Sessions). Diversity Champion programme. Diverse Cymru all Wales group. Llais (community health council and advocacy).	Evidenced through health IDVA team. MH consider use of IMCA. All Wales contract agreement in place and signed by UHB		
	5.4. Evidence that the organisation actively contributes to local and national multi-agency approaches such as VAWDASV, Modern Slavery, PREVENT, Honour Based Abuse	Safeguarding colleagues attend and input into the regional VAWDSASV steering group	Green	Evidenced through attendance at meetings and partnership working with the strategy. PCIC - Participation and leading of multiagency escalating concerns processes			
	5.5 There is evidence that the organisation is working towards protecting people of all ages from exploitation	Exploitation is included into training packages	Green	Evidenced in the training slides. Health VPT, participation in MASH/NRM/ Cardiff LA SAFE meetings			
6. Responsive, Resilient and Purposeful	6.1. Evidence that changes in safeguarding activity & practice due to NHS pressures/cost of living crisis/covid legacy are being evaluated to evidence improvements and guide service delivery changes in the future	Where people have received Health Assessments/virtual appointments, an audit is planned to evaluate the effectiveness and preference of the people involved to inform future care provision	Red	This would need to be considered for this coming year. All CBs to consid	Audit. This would need to be considered for this coming year.		

	6.2. There are robust Business Continuity Plans in place relating to safeguarding activity and delivery in the event of future extraordinary events e.g. pandemic	Business Continuity Plans have been developed and signed off by the executive board in consultation with the corporate safeguarding team	Red	This is not in process at the moment in safeguarding. Safeguarding COVID NEWSLETTER shared internally and externally.	This is not in process at the moment in safeguarding. All CBs to consider. Discussion with Strategic Planning required, Business Continuity plan shared.		• Welsh Government (2015). Well-Being of Future Generations (Wales) Act (2015). • NHS Wales (2021). Annual Planning Framework 2021- 2022. • NHS Wales (2021). Quality and Safety Framework: A Learning Health and Care System. • Welsh Government (2021). Together for Mental Health. • Welsh Government (2015). Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act. • Welsh Government (2021). Health and Social Care in Wales: Covid-19 Looking Forward • Welsh Government (2019). A Healthier Wales: our Plan for Health and Social Care.
	6.3. Evidence of planning to address hidden harms that have occurred due to the pandemic legacy and/or the cost of living crisis e.g. domestic abuse, sexual abuse, ACEs	Training has been adapted to highlight the importance of professional curiosity and the impact of the cost of living crisis on abuse and hidden harms	Green	Evidenced in both VAWDASV training and safeguarding training			
	6.4. Evidence of policy/ process for safeguarding training for colleagues and support staff such as volunteers, that may not usually see persons at risk to recognise signs of abuse and fulfil their duty to report	Capacity and consent awareness training is in place for volunteers working with at risk adults to ensure that their best interests are protected	Green	This is in place	Safeguarding training available to volunteers		
	6.5. Evidence that any harm from an 'overwhelmed NHS and social care system' is considered in safeguarding processes such as supervision, debriefs and post incident support	An evidence based method of responding and supporting colleagues following a significant incident is in place.	Green	Standard supervision is in place for staff within the safeguarding team. Evidence of COVID updates shared during COVID. Clinical supervision in place within the CBs. PCIC - Multiagency debrief/sharing of lessons learned is a key part of the process when a home/agency closes			

Complete Columns D E F G in the **Improvement Plan Tab** and submit by 31st July 2023

Completion Guide	
Scoring System	
Colour	**Meaning**
Red	Action not on track - major issues
Amber	Action mainly on track - minor issues
Green	Action on track or completed
Grey	Action not started/Not applicable/No data
Trend	
Arrow	**Meaning**
↑	Quality improvement from previous reporting
→	No change in quality from previous reporting
↓	Quality decline from previous reporting

To remove any of the above on your **Improvement Plan** press delete in the cell

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee

Held on 20th June 2023 Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Director of Nursing/Multi Professional Teams
Adam Christian	AdC	Interim Clinical Board Director
Sarah Lloyd	SL	Interim Director of Operations
Seetal Sall	SS	Point of Care Testing Manager
Sian Jones	SJ	Directorate Manager, Laboratory Services
Jonathan Davies	JD	Health and Safety Adviser
Robert Bracchi	RB	Medical Advisor to AWTTC
Jo Fleming	JF	Quality Lead, Radiology
Rhys Morris	RM	CD&T R&D Lead
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Alun Roderick	AR	Laboratory Service Manager, Haematology
Tracy Wooster	TW	Sister, Outpatients
Meurig Francis	MF	Graduate Trainee
Becca Jos	BJ	Deputy Director of Operations
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Paul Williams	PW	Clinical Scientist, Medical Physics
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Elaine Lewis	EL	General Manager, Pharmacy
In Attendance:		
Angela Hughes/ Rose Lewis	AH	Patient Experience Team
Huw Davies	HD	AHP, Community Lead Rehab, Physiotherapy
Carol Evans	CE	Laboratory Director, Biochemistry
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Suzanne Rees	SR	Lead Nurse
Jenna Walker	JW	Quality Lead, Pharmacy
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer
Timothy Banner	TB	Clinical Director, Pharmacy

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 23/151	**Welcome & Introductions** HL welcomed everyone to the meeting.	

CDTQSE 23/152	**Apologies for Absence** The apologies for absence were noted.	
CDTQSE 23/153	**Minutes of the previous meeting** The minutes of the previous meeting were received. **The Group resolved that:** a) The minutes of the previous meeting held on 12th May 2023 were accepted as an accurate record.	
CDTQSE 23/154	**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* HL has requested the engineers report from Estates but not yet received it. *CDTQSE 23/122 Safety Alerts* JW and SH to consider how Clinical Engineering and Pharmacy can link up in terms of safety alerts where medical devices deliver medicine. *CDTQSE 23/133 Pharmacy R&D Lead* HL to check with RM if Pharmacy have nominated an R&D lead. **The Group resolved that:** a) The update on the actions from the previous meeting were noted.	**HL** **JW/SH** **HL/RM**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 23/155	**Concerns and Compliments Report** In May 2023, the Clinical Board received 29 concerns; 7 formal and 22 early resolution concerns. It received 11 compliments. There was a breach in response times within Dietetics. This was due to ongoing dialogue with the complainant to help bring the concern to a resolution. A formal response has now been submitted. The themes for concerns received are wide ranging. The top 3 main themes relate to:	

	• Difficulties cancelling and arranging appointments (22%) • Waiting list times (17%) • Waiting time for test results/scan reports (14%) **The Group resolved that:** a) The concerns metrics including a breakdown for each department, were received and noted.	
CDTQSE 23/156	**National Reportable Incidents – NRI report** HL will ask Caroline Sutton to attend the next meeting to present the NRI in Pharmacy for shared learning. **The Group resolved that:** a) The NRI report was received and noted.	**HL**
CDTQSE 23/157	**New NRIs** There are 2 potential new NRIs within Cellular Pathology; 1 case relates to Dermatology and the other case relates to a possible lymphoma diagnosis. This is a complicated case involving a number of Clinical Boards. **The Group resolved that:** a) Initial meetings have been arranged.	
DTQSE 23/158	**Duty of Candour** AH and RL from the Patient Experience Team attended the meeting to provide information on Duty of Candour. Duty of Candour will only occur if there is an unintended and unexpected consequence that has caused harm or will cause future harm. Harm must be at a level that is more than moderate to trigger a Duty of Candour. If healthcare is not an issue, then this would be classed as no harm. In terms of a transfusion error, it would need to be assured that this is unexpected and not a known side effect or complication. The UHB has created a culture of incident reporting. Many of the incidents reported will still fall under near misses as they do not actually cause harm or they cause very low harm. 40% of incidents are presently being downgraded where the duty of candour threshold has not been met. Most cases that are moderate harm would have a pathway through to Redress. In the Health Board since April 2023, only 1 case has triggered Duty of Candour. The majority of cases sit in the low harm threshold.	

	If Duty of Candour is triggered and is a moderate threshold, where harm was caused and healthcare was the causative factor, this will need a pathway to redress, which is an apology, remedial treatment or it can be financial compensation to the value of £25k. The clinician would need to have a conversation with the individual . An acknowledgement letter would need to be sent out within 5 working days. An investigation would then need to be undertaken and the outcome would be shared. Duty of Candour applies across all healthcare settings including the Primary Care setting. **The Group resolved that:** a) If any support or advice is required in relation to a case, to contact AH and RL.	
CDTQSE 23/159	**Risk Register** NR escalated a risk in Biochemistry where a major piece of equipment has reached end of life and has started to fail. A £30k capital bid is being submitted. The risk scoring on the risk register has been increased. JF reported a battery issue in detectors in the General Radiology rooms which resulted in patients requiring repeat imaging. A risk assessment is being completed. Work is being undertaken on the Pharmacy risk register. The MHRA report for the PSU in UHL is a major risk. The recent high temperatures are impacting on equipment within the Clinical Board. The high temperatures are affecting the laboratories in terms of temperature control and the directorate is linking in with the Estates Team. Medical Illustration are experiencing issues with their camera equipment in Outpatients due to lack of ventilation. There was a breakdown of 2 MRI scanners yesterday where due to the high temperatures the water coming from from the water cooler on the roof was too warm to run the scanners. **The Group resolved that:** a) The corporate governance team will be attending the next meeting to discuss refreshing risk registers. b) Risks relating to the high temperatures will be raised at the Clinical Board Executive Performance Review. c) The next Clinical Board risk register submission is 3rd July. Directorates to submit any updates by Friday.	
FCDTQSE 23/160	**Patient Safety Alerts**	

	ISN 2023 002 Fentanyl with Bupivacaine Bags This is a Pharmacy related safety notice. **Field Safety Notice: Phillips MobileDiagnost wDR** This safety notice affected equipment in Radiology. The issue is now resolved. **ISN 2023 003 Shortage of GlucaGen 1mg Hypokit Glucagen** This safety notice is also related to Pharmacy. **The Group resolved that:** a) The safety alerts have been circulated across the Clinical Board for awareness.	
CDTQSE 23/161	**Medical Device/Equipment Risks** **The Group resolved that:** a) There were no risks to report.	
CDTQSE 23/162	**Point of Care Testing** The Point of Care Testing Team are looking to progress with refresher implementation for some POCT connectivity devices for pregnancy testing. Risks relating to blood gas testing have been highlighted on the risk register. **The Group resolved that:** a) The update on Point of Care Testing was noted.	
CDTQSE 23/163	**IP&C/ Decontamination Issues** SR attended the UHB IP&C Group meeting. A discussion was held on ANTT training for AHP colleagues. The primary focus was with nursing staff and this is now extending to AHP staff. Helen Luton suggested Podiatry should be a priority area. JF noted that there are difficulties in identifying how Radiographers can access ANTT training. SR to feedback this to the next IP&C Group. It was noted that the Needlestick Policy is under review. An All Wales Probe Cleaning Guidance document is being produced. SR to circulate when available.	**SR** **SR**

	HL attended the UHB Decontamination Group. There was in issue raised in Speech and Language Therapy whereby a nasendoscope has been procured for a swallow assessment and clarification was needed on the decontamination requirements for this device. **The Group resolved that:** a) ANTT training for AHPs and Radiographers will be followed up with the IP&C Group. b) The update from the UHB Decontamination Group was noted.	
CDTQSE 23/164	**Safeguarding Update** HL noted that there is an outstanding case within Glan Ely Ward relating to a patient who raised concerns around being discharged home. **The Group resolved that:** a) The Safeguarding update was noted.	
CDTQSE 23/165	**Health and Safety Issues** JD reported that the UHB Operational Health and Safety Group was held last week. Concerns were raised around safety implications in the tunnels at UHW and a working group has been reinstated. Work is underway around planning for the power outage for the whole of the UHW site in September. Concerns were raised that there are a high number of staff that are not attending health and safety training sessions that they have booked onto. Contractor management issues were raised. This Clinical Board is reporting 21 staff health and safety incidents and 0 RIDDOR incidents JD also reported that issues have been raised by staff in the Haematology laboratory around fumes entering their work area when the generator is tested weekly. An external company will be attending on site tomorrow to undertake monitoring in the department. Staff will be asked to wear monitoring devices and devices will also be placed on desks. He also noted that manual handling advice has been provided to the Stem Cell laboratory staff. **The Group resolved that:**	

	a) The health and safety update was noted.	
CDTQSE 23/166	**Regulatory Compliance** HL reported that UKAS have undertaken an inspection in Cellpath last week and will visiting again for three days next week. **The Group resolved that:** a) The minutes of the Regulatory Compliance Group were received and noted.	
TIMELY		
CDTQSE 23/167	**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 23/168	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** BJ reported that Therapies are minimising breaches in their 14 weeks' waiting times. There were 13 breaches in Adult dietetics in May. Speech and Language Therapy have reduced their breaches to 38. Physiotherapy, Podiatry and OT are reporting 0 breaches. Patients waiting over 8 weeks for diagnostics are increasing. The instruction for Radiology to prioritise cancer patients and inpatients has impacted on their routine waiting lists. **The Group resolved that:** a) The waiting time performance information was noted.	
EFFECTIVE		
CDTQSE 23/169	**Feedback from UHB QSE Committee** The next meeting is due to be held on 18th July 2023. **The group resolved that:** a) The Clinical Board will be presenting at this meeting and a patient story will be shared.	

CDTQSE 23/170	**NICE Guidance** **The Group resolved that:** a) There was no NICE guidance to discuss.	
CDTQSE 23/171	**Research and Development** RM has organised an R&D Forum on 29th June at 12. This is open to anyone in the Clinical Board interested in R&D. RM has submitted an SBAR document relating to protecting CPD time for non-medical staff to undertake research and development opportunities. **The Group resolved that:** a) The update on Research and Development was noted.	
CDTQSE 23/172	**Service Improvement Initiatives** The service improvements relating to Electronic Test Requesting are presented in today's Patient Story. **The Group resolved that:** a) There were no other service improvement initiatives to report.	
CDTQSE 23/173	**Information Governance/Data Quality** **The Group resolved that:** a) There were no information governance or data quality issues to report.	
CDTQSE 23/174	**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 23/175	**Policies and Procedures** The Labelling of Specimens Submitted to Medical Laboratories Policy and Procedure documents have been reviewed. There were no content changes required to the documents. **The Group resolved that:** a) Any comments on the policy and procedure to be submitted To Alison Borwick by the end of the week. The policies will then be submitted to the Corporate team.	

	b) Clarification is needed on the process for signing off review of policies.	
EFFICIENT		
CDTQSE 23/176	**Exception Reports from Directorates** **The Group resolved that:** a) There were no exceptions to report.	
CDTQSE 23/177	**Health and Care Quality Standards** A document was received outlining the framework and the different domains. **The Group resolved that:** b) Further discussion will be held at the next meeting in terms of how the standards should be applied within this Clinical Board.	**HL**
CDTQSE 23/178	**Clinical/Internal Audits** **The Group resolved that:** a) There was no information relating to audits to report.	
CDTQSE 23/179	**Waste and Sustainability** The CD&T Sustainability Group received a presentation on the UHB Decarbonisation Strategy/Action Plan. The UHB Green Group was also promoted which takes place every third Friday of the month. At the next meeting, SJ will provide an update on Leaf Accreditation. HL suggested linking in with Surgery on their work on the RCN Gloves Off campaign. She will enquire with Catherine Twamley on who to approach in Surgery to arrange a presentation. **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.	**HL**
EQUITABLE		
CDTQSE 23/180	**Feedback from Clinical Board Inclusion Ambassadors Group** SO has been working with the Clinical Board Staff Lead Representative and Chair of Staff Side around creating a 'Safe Space' where staff can raise concerns specific to them anonymously/confidentially.	

	The Group resolved that: a) Further discussion on this work will be held at the next Clinical Board Partnership Forum.	
CDTQSE 23/181	**Equality and Diversity Issues** HL will check if the UHB anti-racist action plan has been ratified. **The Group resolved that:** a) When available the UHB anti-racist action plan will be shared with the Group.	**HL**
PERSON CENTRED		
CDTQSE 23/182	**Patient Story** Dr Carol Evans, Laboratory Director for Biochemistry gave a presentation on the other quality enhancements Electronic Test Requesting (ETR) has brought to Cardiff and Vale. The major improvements of ETR are: Clinicians can focus on the clinical question and request only the tests that need to be done to answer that question. This allows for focus on getting the right answer for the patient rather than the right test. It reduces the possibility of a relevant test being missed. It makes requesting faster and simpler and improves adherence to NICE and other guidance. ETR provides information for patients and requesters. It allows for leaflets for patients to be readily available and provides pop up instructions which advises the clinician on any other information and advice they may need to share with the patient such as dietary advice before taking a urine sample. ETR has realised improvement in the laboratory workflow. The quality of samples is much improved. The electronic test request form has reduced the amount of paper coming into the laboratories. The paper requesting process involved 9 steps and ETR has reduced to a 3-step receipt process. ETR optimises use of automation. The exact time from samples being taken by the Phlebotomist to arriving and being centrifuged and made fit for analysis is now identifiable. The data shows the number of samples that arrive in the department after 6 hours. This helps identify if there are problems in specimen reception area or which surgeries have delays in their samples coming in. The next piece of work is to work with Primary Care to improve transport and logistical issues. Samples that are received and processed for patients earlier in the day, eliminates the need to call the Out of Hours service with critical patients' results.	

	CE thanked all the staff involved in supporting the improvement work and embracing the change. **The Group resolved that:** a) The significant benefits of electronic test requesting were noted.	
CDTQSE 23/183	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 23/184	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/185	**National User Experience Framework/Feedback from Patient and Service User Surveys** Huw Davies, AHP Lead for Community Neuro was in attendance to discuss the digital methods for collecting patient information within Therapies. He noted that he has undertaken a lot of work with the Live Well Team on the digital collection of PROMs data, feedback from patients and referrals. Microsoft Forms is the platform used for creating surveys. The form has the functionality to invite others to respond and see real time results as they are submitted. MS Forms allows numerous options for completing a survey such as creating a QR code, a web link to the form, or produce a paper copy. The forms can be tailored to individuals' responses to keep the flow of the questions applicable to the survey user. All the data collected links to other Microsoft packages i.e. email and SharePoint lists and results can be transferred onto an Excel spreadsheet to undertake an analysis. It was noted that a data protection impact assessment has been completed for this work. KA noted the improved quality of the data using this platform as well as the efficiency savings this work has realised in terms of time and finances. HL commented that this is a good opportunity to capture patient's feedback on CD&T services and obtain data that is more meaningful for services.	

	HD offered to provide advice to any directorates looking to implement MS forms in their areas. SL noted that there are training resources available on the UHB intranet. Link below: https://nhswales365.sharepoint.com/sites/CAV_O365%20Programme/SitePages/M365-Applications.aspx?Mode=Edit It was that there are many applications where MS forms are useful i.e. for gaining staff feedback, as part of gaining feedback for VBAs using a QR code. HL thanked HD for attending the meeting. Jo Fleming provided an update on the patient feedback collated in Nuclear Medicine UHL and noted that feedback is also being collated in the CT service in UHL. She liaised with the Patient Experience Team to produce the surveys which consisted of 9 questions. Feedback was obtained over a 3-week period and 24 surveys were completed on tablets provided to patients whilst in the department. the feedback was collated via MS forms. From the feedback received it was noted that: 22 out of 24 felt they have received sufficient information prior to their examination relating to their procedure. Appointment letters are being reviewed to identify if any further information should be included. 3 out of 24 felt they were not informed of when they would obtain their results. Patients were asked what could be improved. Most responses were that there were no improvements to be made. Good feedback was provided relating to the attitude of staff and felt that the staff were supportive and signposted them to other services. A tablet is on loan from the Patient Experience Team for obtaining feedback but the period of the loan is unclear. The plan is to use QR codes in the future. It was noted that the Clinical Board has tablets available that could support this work. **The Group resolved that:** a) Services will consider how MS forms can be used in their areas.	
CDTQSE 23/186	**Staff Awards and Recognition** Podiatry staff were awarded a Making it Better Award in December and they received their award at their study day earlier this month.	

	A member of the Physiotherapy Team in UHL was awarded the Living Our Vales Award. **The Group resolved that:** a) All directorates to consider nominating their staff for their achievements in the Clinical Board Staff Recognition Scheme. b) Directorates to advise where any staff have been recognised wider than the Clinical Board.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 23/187	Regulatory Compliance Group Minutes June 2023 Clinical Board Health and Safety Minutes June 2023	
ANY OTHER BUSINESS		
CDTQSE 23/188	There were no further items to report.	
CDTQSE 23/189	**Date & time of next Meeting** 14th July 2023 at 11am via Teams	

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 25TH JULY, 2023, 11 AM
Venue: MS TEAMS

Attendees	
Anna Mogie (AM)	Deputy Director of Nursing (Chair)
Helen Kemp (HK)	Deputy Clinical Board Director (Chair)
Clare Evans (CE)	Assistant Director Primary Care
Sarah Griffiths (SG)	Head of Primary Care
Gneeta Joshi (GJ)	Community Director of Clinical Governance
Rachel Armitage (RA)	Quality and Safety Manager
Lisa Waters (LW)	Senior Nurse for Quality and Education
Clare Clement (CC)	Head of Medicines Management
Helen Donovan (HD)	Locality Lead Nurse, North & West Locality
Neil Morgan (NM)	Vale Locality Manager
Kate Roberts (KR)	Vale Interim Lead Nurse
Carol Preece (CP)	Lead Nurse, South & East Locality
Helen Earland (HE)	Clinical Operational Lead, GP Out of Hours
Andrea Rich (AR)	Lead Nurse, Palliative Care
Ruth Cann (RC)	Consultant Nurse Older Vulnerable Adults
Sian Griffiths (SGri)	Consultant in Public Health Medicine
Victoria Whitchurch (VW)	Head of Operations, Mass Imms
Lorna McCourt (LMc)	Staff Side Trade Union Representative
Ellen Davies (ED)	Clinical Nurse Specialist in Infection Prevention & Control
Nicola Robinson (NR)	Head of People and Culture
Robert Parr (RP)	PCIC Organisational Development Manager

Theresa Blackwell (TB)	PCIC Business Manager
Louise Thomas (LTho)	Quality & Safety Officer

Apologies	
Anna Llewellin	Director of Nursing
Lisa Dunsford (LD)	Director of Operations
Jane Brown (JB)	Head of Dental and Optometry
Lynne Topham (LTop)	Locality Manager, South and East Locality
Rhys Davies (RD)	North West Locality Manager

ITEM NO.	TITLE	ACTION
07/23/01	AM welcomed everyone to the meeting.	
07/23/02	Apologies of absence were noted as above.	
07/23/03	No declarations of interest were raised.	
07/23/04	<u>Minutes</u> The minutes of the meeting held on 30th May, 2023 were reviewed; it was agreed that item 05/23/06.5 should read "The **Medicines Management** team is in the process of compiling a risk assessment form and formally placing the risk on the risk register", not the "**Community Pharmacy**" team. It was also noted that TB should be added to the attendees list. LTho to update the minutes of the last meeting. There were no other matters arising.	LTho
07/23/05	<u>Action Log</u> Please refer to item 5.	
07/23/06	<u>Patient story</u> CP informed the group of feedback received by her team regarding the Education for Patient Programme (EPP). The team was looking to support individuals with chaotic lifestyles and linked in with the Adam Street homeless hostel to deliver a mindfulness programme. The Activity Officer for Cardiff Council has since contacted CP to thank the team and let them know that the initiative was successful and had impacted positively on several of the individuals at the hostel. Very few attendees were at the initial meeting with just one individual who engaged with the entire session. The group weren't listening until the course deliverer opened up about her own life experiences which were relatable to the group. One particular individual did not believe she would get much out of the session but as the course provider was so approachable and willing to provide a safe space for the group to try new things, she felt welcome and became involved from the first breathing	

	exercise. She discovered that the exercise was easy to perform and worked for her. The session ended with a visualisation technique, which she seemed to like the most. Following on from this, this individual created her own personalised visualisation script to use in her own counselling session. She recommended the session to a further individual who engaged and utilised the skills learnt to help him sleep instead of taking medication. A further individual with ADHD did not initially engage until he read the first engager's visual aid and was then able to relax and engage himself. These three complex individuals enquire when the next session will be held and are cascading information and recommending the sessions to their peers.	
07/23/07.1	<u>OOH Business Report</u> There are ongoing workforce issues with 111 press 2. Peer review has taken place where the national team advised that use of agency staff if available, to support the roll out and expansion would be centrally funded to support. The new Salas system can be utilised from November 2023. However, the Adastra contract expired at the end of May 2023 and a new three year contract had to be purchased. An additional £30k must be sought to pay for the new Adastra contract to cover the overlap period. The issue is noted on the risk register.	
07/23/07.2	<u>N&W Locality Business Report</u> There are still vacancies across the DN teams but recruitment has been more successful lately. Parking issues at St David's Hospital have been raised at the Executive Review meeting; the Executive Medical Director has sent an email confirming that the issue is being followed up. CRT continues to experience low step down referrals from hospitals. A new electronic traffic system has been installed in Crystal Glenn and is impacting on several community staff who have received fixed penalty notices when visiting patients in the area. Concessions were not made for community nursing and community teams and the Council has advised to appeal the fines. This is not appropriate for staff who repeatedly visit these patients. Colin McMillan, Head of Transport and Sustainability is aware. HK queried if a template can be produced for staff to send to the Council in the interim period. HD will check if Maxine Gronow has produced a template to share. RA queried if this could be brought to the attention of the Integrated Health and Social Care Regional Partnership Board.	HD
07/23/07.3	<u>Vale Locality Business Report</u> There are vacancies across all teams. A recruitment evening is scheduled on the evening of 26th July, 2023 in Barry Memorial Hall. St David's Hospital bladder and bowel health wound care specialist teams continue to experience issues in relation to office space.	

	Advanced Nurse Practitioners are working on the escalation procedure for the acutely deteriorated individual, particularly in relation to support and nursing homes. This is part of the safe care collaborative working. AR suggested linking in with the palliative team.	
07/23/07.4	South and East Locality & HMP Business Report HMP staffing remains the highest critical risk area. An incident occurred on 24th July at the CAVHIS service when an unwell gentleman was discovered to be concealing a knife. Partner agencies were informed of the incident. CP's team will draw up a risk assessment and look at how to manage moving forward, ensuring that robust safety and security measures are in place. AM noted the issue with cameras and where they sit on the detection system. It was also noted that the Datix alert system for incidents with high impact did not flag the incident to the Clinical Board management team. It has since been confirmed that this is because only high impact incidents involving patients are flagged in this way. It has been discussed with patient safety whether this can be widened out to incidents involving staff. There are also issues with Datix reporting in HMP Cardiff as they do not sit under our organisational structure because of IT issues. This has been escalated and is being followed up by RA in liaison with the Datix implementation lead.	
07/23/07.5	Medicines Management. Following on from the last meeting, it has been confirmed that the concerns in relation to the Kaleidoscope service and controlled drugs regulations risk lies with the Area Planning Board (which commissions services on behalf of Welsh Government), not PCIC. The PCIC team has investigated the issue due to the responsibility they do have with the controlled drug regulation. A service visit was carried out (report attached to item 7.5). No risks were identified when the Community Pharmacy team carried out a planned visit. A future unannounced visit will be conducted by the Health Board's Responsible Officer. PGD policies and procedures are being reviewed. AM noted that they do not need to be signed off by this group but the group needs to be consulted on the process operationally and for awareness.	
07/23/07.6	Palliative Care There is an increase in short term sickness within the hospital CNS team; many episodes relate to the increased stress experienced by the team. A huge number of referrals were received last year compared to usual numbers. The team usually receives approximately 1100 referrals a year; last year approximately 1600 referrals were received. AM noted that a huge spike has been seen in end of life care and a case for increasing the team establishment due to the increased workload is being considered by SMT.	

	AR believes this increase is likely to become a trend rather than the causation of late diagnosis during Covid. AM noted that the end of life dashboard will be a useful resource to refer to for workforce planning when the statistics are available.	
07/23/07.7	<u>Primary Care</u> The biggest risk for the team is sustainability of General Medical Services (GMS). Issues regarding premises are causing the most concern and is the area that the team is probably least equipped to deal with. The team's opportunities to solve some of these issues is limited due to the way in which the contract is set up and how purchased premises are managed by contractors in terms of their responsibilities. City and South is bearing the consequences of a practice closure along with significant population growth. SG noted that this issue needs to be escalated further (it is also being escalated via Primary Care Directors). It was noted that there is an SLA in place with the Shared Services Partnership for specialist estates advice. Specialist Estate colleagues have arranged a national information session but SG noted that this is just one part of the problem. A further contributory factor is the team's inability to influence decisions made; decisions for high profile developments and schemes are made at Board level. The GMS team's profile is to ensure GMS services are provided to the population so can sometimes feel like a 'catch 22' situation. There are other technical issues surrounding the way in which rent is calculated and how it is reviewed and further specialist advice and estates advice is required. SG would like to make the group aware of these issues that could potentially contribute to contract termination. SG referred to the recent letter circulated by the local public health teams to clinical colleagues urging those who have not received their MMR or measles vaccination to do so in light of the recent outbreak. SGri believes that Public Health Wales is planning a campaign aimed at students about to start university. RA referred to item 7.7 which refers to an optometrist who has applied to join the performers list and needs two references. She enquired if the optometrist could be provisionally included with the provision being that he/she obtains references within the next three months. If they do not, they will be removed from the list. SG agreed to pass this information to JB in her absence. RA encouraged the PC team to link in with the Governance team if they have any queries in relation to performers lists, etc.	SG
07/23/07.8	<u>Mass Vaccination Centre (MVC) report</u> The biggest risk for the immunisations team is the uncertainty of a base to deliver their service in terms of autumn/winter planning for Covid and flu. A few potential sites have been identified; timescales will be very tight in readiness for autumn/winter planning and delivery. VW explained that winter planning is difficult as the Covid situation is unclear and national direction is awaited, which will impact on planning and delivery. The team is therefore unable to make any formal offers to Primary Care which will obviously also impact upon their ability to plan and deliver. As an aside, RA thanked those who had responded to the audit plans and would be grateful if the group could send her details of any ongoing audits. HK noted that the Health Board's preferred tool for logging audits is AMaT. AR has utilised	

	the system and recognised what a useful tool it will be. New audits should be recorded on AMaT; the Patient Safety team will be happy to assist.	
07/23/08	Risk Register RA is planning to move the risk register to SharePoint with the help of Emma Lewis. A set of rules regarding its use will be established but this will not be completed for quite some time given workload pressures.	
07/23/09	Business Continuity TB has met with Simon Dring, Emergency Preparedness Business Manager; they are due to meet again in August. TB requested that the group reviews their Business Continuity plans on an annual basis and reupload them whenever a change is made. The plans will be moved to SharePoint in August of this year. All teams have been asked to update their documents in the on call folder as these will be the first items moved over to SharePoint.	
07/23/10	PCIC Quality report LW highlighted the lovely compliments received across the Clinical Board, one for the North and West palliative care nursing team from a patient's family saying that they felt comfortable in the knowledge that their father received the best possible care along with further compliments for the dental team and MVC as noted in item 10A. The group referred to the graph on page 4 of item 10A "All medication incidents PCIC 1st May to 30th June 2023" noting that Community Pharmacy now report their incidents via Datix, hence the perceived graph distortion. CC noted that Community Pharmacy incidents have been referred to as Medicine Management incidents; LW explained that this is the way in which Datix pulls the information through. CC will feed this back to the Datix team. RA would like to commend the Pharmacy/Medicines Management team on not receiving more incidents than they do when considering the amount of medication dealt with across our Clinical Board in all settings and the stringencies of pharmaceutical pharmacies having to report in the way in which they do. The Duty of Candour (DoC) legislation is now a legal obligation. No declarations have been received to date. HK noted that 33% of DoCs have been regraded from moderate harm to low harm. The DoC team is happy to be contacted should anyone have any queries. LW shared item 10B on screen, "NRI outcomes and action plans" and will add the document to the Teams channel. A number of NRIs have been closed in recent months and she thanked all who have been involved in the investigations, noting the challenging process and the amount of time this takes. The NRIs include ID 5388 which relates to a child who was seen by a trained clinician in a GP practice, but despite medical intervention, passed away. A post mortem examination highlighted a rare life-threatening infectious disease called Lemiere's syndrome that led to the unexpected rapid deterioration and death. An improvement plan was developed by the GP practice focusing on communication and record keeping. It would have been impossible to predict the outcome due to the rare infectious disease.	CC

	ID 5396 relates to a retrospective NRI which was a very complicated case. A diabetic patient sadly lost her sight following diabetic complications despite urgent surgical intervention in 2019. There were prolonged challenges of non-compliant diabetic management, mental health issues and mental capacity issues. The case highlighted the importance of ensuring that staff are aware of what specialist advice and support is available. An extensive improvement plan was developed that spanned across three clinical boards. Learning has focussed on communication, education and MDT working. ID 6537 relates to a prisoner in HMP Cardiff who died unexpectedly. He was found in his cell having ligatured from the cell window using a bed sheet. The findings of the investigation report were shared with HMP Cardiff via the regional safety team to address communication processes with South Wales Police and the Probation Service to ensure robust process are in place. ID 2599 is a retrospective NRI relating to a death in HMP. A prisoner was found unresponsive in his prison cell and despite resuscitation attempts the patient was pronounced dead. The Coroner concluded that there were significant missed opportunities in the care provided to the prisoner, inadequate and ineffective communication and reporting of information and unsuitable and inappropriate advice by the prison GP. An extensive action plan was completed which highlighted the changes in practice since the prisoner's death in 2019. Learning focused on recognition of the deteriorating patient, safety briefings, communication and escalation. ID0692 relates to a diabetic patient who was diagnosed with type 2 diabetes in 2000; he was not able to tolerate oral diabetic medication and was non-compliant with his insulin regimen. He was started on a once-a-week injection to allow greater compliance and easy of patient use but sadly died of Diabetic Ketoacidosis. Learning has focused on safety netting, patient information, clinical staff education and management of non-compliant patients within the GP practice. The report also refers to 7 pressure damage NRIs: • ID30909 • ID26602 • ID24617 • ID22643 • ID12613 • ID10718 • ID24796 LW will ensure the report is uploaded to Teams for the group's reference.	LW/LTho
07/23/11 Saunders,Nathan 29/08/2023 09:08:28	<u>Information Governance (IG)</u> IG meetings are not currently being held in the absence of a Deputy Director of Operations. RA has asked Business Unit leads to incorporate any IG issues in their reports. There is nothing to note at this meeting and no notifications have been received for distribution. VW noted that she has carried out a piece of work in relation to IG when staff leave the service.	

07/23/12	IPC update IPC training sessions for patient facing staff have been carried out/booked; 10 PCIC staff attended training at UHW. Training at UHL and Llanedeyrn has also been scheduled. ED ran through the PCIC C.difficile RCAs for April 2022 – March 2023 explaining that 55 cases were encountered in PCIC during this period. Out of these 55, 26 Route Cause Analysis (RCA) forms were returned by GP surgeries, 29 RCAs were not returned. This included 2 cases where patients were treated with alternative medication without consulting microbiology. 73% of cases involved patients aged 65 years and over, 19% of these patients were prescribed laxatives. CC noted that NICE guidance regarding the change to vancomycin was promoted and Microguide was updated accordingly. However, this was done during Covid. She agreed to link in with the CD sessions to provide education directly to prescribers and will look at setting up a default to ensure the correct medication is prescribed. ED will liaise with Maria Dyban with regard to health pathways. There has been a huge improvement in the way in which RCAs have been completed this year; more comprehensive results are anticipated next year should this trend continue. RA noted that GPs are not under contractual obligation to return RCAs and commended the practices who have responded. ED confirmed she is pleased with the return rate and quality of these forms. ED will circulate her presentation.	CC ED ED
07/23/13	Llais (new CHC) Stephen Allen was unable to present at today's meeting; he will be invited to present at the next meeting scheduled in September 2023.	LTho
07/23/14	Safeguarding No representative was available. There was nothing to report.	
07/23/15	Patient Safety Incident Reporting There have been some slight amendments to the process; a Welsh Health Circular has been circulated reminding staff of the changes. Patient safety incidents are now reported to the Delivery Unit. Please refer to item 15.	
07/23/16	New option for end of life patients/families calling 111 This item was previously discussed under item 7.1.	
07/23/17	Care Home QA report May 2023 Item 16 is included for noting. AM will take the report to Safeguarding for noting.	AM
07/23/18	The application of the scheme for GMPI where there are ambulance delays in the community Please ensure this document is circulated appropriately. The recent pharmacy case highlights that the issue of ambulance delays in the community is not unique to GPs.	
07/23/19	Any Other Business There was no other business to discuss.	

PART 2	The Group noted the papers submitted for information.	
Date and time of next meeting: 26th September, 2023 at 11.00 am.		