Public Quality, Safety & Experience Committee

Wed 25 October 2023, 10:30 - 11:45

MS Teams

Agenda

10:30 - 10:40
10 min

1. Standing Items

1.1. Welcome & Introductions

Rhian Thomas

1.2. Apologies for Absence

Rhian Thomas

1.3. Declarations of Interest

Rhian Thomas

1.4. Minutes of the QSE Committee Meeting held on 26.09.23

Rhian Thomas

1.4 QSE Public Minutes 26.09.2023.pdf (11 pages)

1.5. Action Log – Following the meeting held on 26.09.23

Rhian Thomas

1.5 Public QSE Action Log.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

10:40 - 11:35
55 min

2. Items for Review & Assurance

2.1. Quality Indicators Report to include:

20 minutes *Jason Roberts / Alex Scott*

- HIW Update

2.1 Quality Indicators Report 20231018 pe.pdf (19 pages)

2.2. Children & Women's Waiting List Update

10 minutes *Paul Bostock / Jason Roberts / Andy Jones*

2.2 QSE CYPFHS waiting times Report Board Oct 2023.pdf (6 pages)
2.2 combined ACH and CYP Wating times update for QSE oct 23.pdf (16 pages)

2.3. Maternity Thematic Review

20 minutes *Jason Roberts*

2.3 Maternity Thematic Review Report.pdf (8 pages)

2.4. Specialist Clinical Board Assurance Report – re: South Wales Trauma Network Verbal Update

5 minutes *Paul Bostock*

11:35 - 11:40
5 min

3. Items for Approval / Ratification

3.1. Policies:

Intraoperative Cell Salvage policy and procedure (UHB 403 & 030)

3.1 UHB 403 Intraoperative Cell salvage procedure Cover Report.pdf (2 pages)
3.1a UHB 030 Intraoperative Cell Salvage Policy 2023 (1).pdf (3 pages)
3.1b UHB 403 Intraoperative Cell salvage procedure 2023.pdf (52 pages)

11:40 - 11:40
0 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees:

Jason Roberts / Meriel Jenney

i) Clinical, Diagnostics & Therapies Minutes: 14.07.2023 & 22.09.2023

4.1a CDT QS Minutes 14.7.23.pdf (13 pages)
4.1b CDT QS Minutes 22.9.23.pdf (16 pages)

11:40 - 11:40
0 min

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

Ceri Phillips

11:40 - 11:40
0 min

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

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

11:40 - 11:40
0 min

7. Any Other Business

Ceri Phillips

11:40 - 11:40
0 min

8. Review of the Meeting

Ceri Phillips

11:40 - 11:40
0 min

9. Date & Time of Next Meeting:

Ceri Phillips

Tuesday 28 November 2023

Time – 2pm

Via MS Teams

11:40 - 11:40
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 26.09.2023

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Rhian Thomas	RT	Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Third Sector
In Attendance		
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Emma Cooke	EC	Deputy Director of Therapies and Health Sciences
Gavin Forbes	GF	Consultant Microbiologist
Angela Hughes	AH	Assistant Director of Patient Experience
Andy Jones	AJ	Director of Nursing – Children & Women's Clinical Board
Helen Kemp	HK	Deputy Clinical Board Director - PCIC
Fiona Kinghorn	FK	Executive Director of Public Health
Anna Mogie	AM	Deputy Director of Nursing - PCIC
Dino Motti	DM	Consultant in Public Health Medicine
Matt Phillips	MP	Director of Corporate Governance
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Richard Skone	RS	Deputy Medical Director
Yvonne Hyde	YH	Head of Nursing, Infection Prevention & Control
Clare Wade	CW	Director of Operations for Patient Flow
Observers		
Matthew McCarthy	MM	Interim Head of Safety, Quality and Organisational Learning
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Keith Harding	IM	Independent Member – University
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer

QSE 23/09/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh	**ACTION**
QSE 23/09/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/09/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/09/004	**Minutes of the Committee meeting held on 30.08.23** The minutes of the Committee meeting held on 30.08.23 were received.	

	The Committee resolved that: a) The minutes of the meeting held on 30 August 2023 were approved as a true and accurate record of the meeting.	
QSE 23/09/005	**Action Log following the Meeting held on 30.08.2023** The Action Log following the Meeting held on 30.08.2023 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 30.08.2023 was noted.	
QSE 23/09/006	**Chair's Actions** No Chair's Actions were raised.	
QSE 23/09/007	**PCIC Assurance Report** The PCIC Assurance Report was received. The Deputy Director of Nursing – PCIC (DDNP) advised the Committee that she would take the report as read and noted that she and Deputy Clinical Board Director - PCIC (DCBDP) would raise key points for the Committee which included: • Duty of Candour – it was noted that the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect in April 2023 and had imposed several new duties on all Clinical Boards, including PCIC around the Duty of Candour (DoC) aspects and it was noted that PCIC had not been required to proceed with any DoC declarations to date. • The Medical Examiner Service (MES) – it was noted that with the DoC and the mortality review process, PCIC had been working with independent contractors to make sure that the required support was available in both processes and the Committee were made aware that the PCIC governance team had been working with the lead medical examiner and lead medical examiner officer around the implementation of the mortality review process. • Safe Care: - it was noted that PCIC had no open Nationally Reportable Incidents (NRIs) with 3 being closed over the past 6 months with learning identified from those. - PCIC had reported 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incident to HIW. The incident was investigated which had identified no harm and a full report would be submitted in October 2023 to meet the regulatory requirements. - It was noted that PCIC were good at scrutinising investigations around Pressure Damage with weekly scrutiny panels held in localities where positive feedback was received by care home staff. • Community Pharmacy – it was noted that PCIC had a very close relationship with the community pharmacy service and collaborated well around incident reporting, complaints and responses from an independent contractor perspective. • Infection prevention and control (IP&C) – it was noted that PCIC had identified that support for independent contractors was required on advice around IP&C requirements and noted that work was ongoing with those contractors.	

	• Key Risks for PCIC – it was noted that a number of risks had been identified within PCIC such as the change to medication policy and impact on supporting patients and prison staffing and it was highlighted that action plans had been formed to mitigate the risks with a number of controls put in place. • Developments – it was noted that a PCIC academy had been established and that the expectation of the Academy would be to effectively consider and coordinate training and education for a broad range of professionals working within primary and community services as set out in the Primary Care Model. The DCBDP concluded that a large amount of strategic work was being undertaken by PCIC around the performance list and engagement with other Health Board colleagues around improvements and various strategic programmes. The Independent Member – Capital & Estates (IMCE) asked if it was felt that the Cardiff and Vale population had sufficient access to local pharmacy services. The DCBDP responded that it was their understanding that there was a population needs assessment undertaken which would be referred to around pharmacy access and noted that there was a Primary Care Panel which would reference that. She added that awareness of impact was identified for when electronic prescribing would start within pharmacies and noted that it had been identified as a risk for PCIC. The IMCE noted that the mobile dental units available for the Cardiff and Vale population were not fit for purpose and asked for further context on those. The DDNP responded that the answer would be sought offline from dental colleagues and provided to the IMCE via email which was undertaken the following day upon completion of the meeting. The Executive Director of Public Health (EDPC) noted that staffing around the prison service was a regularly reported risk and asked for further assurance around that. The DDNP responded that a skill-mix review had been undertaken and questions had been asked around recruitment of staff with new roles being introduced to the service. She added that a lot of work was ongoing around recruitment and collaborative work with prison staff and the overall prison regime to ensure that PCIC could meet the core critical service needs. The CC noted that continued pressures in the prison service had been identified within the report received by the Committee and noted that lessons learned were subject to action plans monitored via QS&E meetings held by PCIC. He asked that those action plans be received by the Committee at future meetings. **The Committee resolved that:** a) The current position and also the actions taken since the previous report to strengthen assurance and manage risks within PCIC Clinical Board were noted.	**NS**
QSE 23/09/008	**Quality Indicators Report – Deep Dive: Infection Prevention & Control (IP&C).** The Quality Indicators Report Deep Dive was received. The Head of Nursing, Infection Prevention & Control (HNIPC) advised the Committee that she would take the report as read and noted key elements to highlight to the Committee which included:	

- Staffing – it was noted that extra staff had been provided to the IP&C team over the past 4 years which had allowed them to continue supporting Clinical Boards and the Corporate Team and it was noted that the team was appointing a Band 8a Senior Nurse in IP&C which would free up the Head of Nursing for IP&C to undertake a more strategic role both within the health board and on an all-Wales level.

- Key Outbreaks – it was noted that the IP&C team continued to support Clinical Boards with incident and outbreak management with outbreaks/incidents of infection including:

  - MRSA outbreak in Neonatal Intensive Care
  - MDR Klebsiella pneumoniae in West 8 UHL where a meeting was held in August 2023 to close the W8 MDR Klebsiella outbreak after nearly 4 years,
  - SSI (Surgical Site infection) in Trauma & Orthopaedics,
  - MSSA in Renal
  - COVID19/Influenza/norovirus outbreaks in multiple clinical areas.

- The Welsh Health Circular 2023/031 – it was noted that the Antimicrobial Resistance & Healthcare Associated Infection Improvement Goals for 2023-24 was received by the Health Board in August 2023 which described the current Health Board position with regards to the reportable bacteraemia's outline.

- Improvement Goals – the HNIPC advised the Committee that a number of improvement goals were identified and highlighted goal 7, 8 and 9:

  - Improvement Goal 7, a reduction in the annual incidence of P. aeruginosa and Klebsiella spp. bacteraemia by 10% against 2017-18 figures. It was noted that there had been 9 cases of Pseudomonas bacteraemia to the end of August 2023, a rate of 4.27 cases per 100,000 and that the Health Board was currently on the trajectory to achieve the reduction expectation of 6.38 cases per 100,000 population and to have the third lowest rate in Wales.

  - Improvement Goal 8, a reduction in the annual incidence of C. difficile disease to 25 cases per 100,000 or below where it was noted that the Health Board would achieve that goal and that there had been 49 C'difficile toxin positive cases in the Health Board from April 1st to the end of August 2023, 10 cases less than the equivalent period in 2022/23.

  - Improvement Goal 9, a reduction in the annual incidence of Staphylococcus aureus bacteraemia to 20 cases per 100,000 or below, with zero tolerance of preventable MRSA blood stream infections and a continued drive to reduce cases. It was noted that there had been 5 cases of MRSA in the Health Board from April 1st to the end of August 2023 and MRSA bacteraemia cases had reduced by 2 compared to the equivalent period in 2022/23.

The HNIPC advised the Committee of other key areas identified within the report which included the work done alongside non-clinical teams (Capital, Estates, and Facilities and procurement) and noted that current ongoing work with procurement included:

- Reviewing the cleaning products used to clean clinical areas which had the potential to make an annual saving for the Health Board of almost £29,000 whilst maintaining high standards of cleaning.

- Effective decontamination of Ultrasound probes.

- Working with pharmacy to source appropriate pre-operative skin cleansing solutions due to a national shortage of what was currently in use

	• Collaborative working between IP&C, Surgery Practice Educators and Procurement to promote the "RCN Gloves off Campaign". She concluded that Since April 2023 there had been over 500 audits undertaken by the IP&C nurses which was the most ever undertaken by the team and noted that a clinical quality dashboard was in development to triangulate the staffing, capacity, acute / dependency and IPC data which would give greater intelligence and understanding of the impact of those variables in relation to healthcare associated infection. The Executive Nurse Director (END) advised the Committee that the link of IP&C to the Tendable system enabled staff to do more audits than ever before which was a positive outcome. **The QSE Committee resolved that:** a) The assurance provided by the actions underway to support scrutiny and oversight of bacteremias and to embed improvements in practice was noted.	
QSE 23/09/009	**Looked After Children – Assessment Backlogs** The Looked After Children – Assessment Backlogs was received. The END advised the Committee that a report was received by the Committee approximately 6 months ago which noted that an update would be received approximately 6 months later which was the reason for the update. The Director of Nursing – Children & Women's Clinical Board (DNCW) advised the Committee that Looked After Children (LAC) remained a key area for the Children & Women's Clinical Board as it was clear that LAC had adverse outcomes and so the continued assessment of their needs was vital. It was noted that the paper received by the Committee previously had described the scope of the problem and since March 2023 the Clinical Board, in response to the problem had looked at additional actions to implement to enable the team to meet the statutory health assessments. The DNCW added that there had been a consistent increase in children in care in Cardiff and the Vale of Glamorgan and that there were currently 1,666 children on the database in September 2023 with 399 children who were looked after out of area which left the Health Board with a considerable number of children living across Cardiff and Vale that the CLA team had statutory obligations around the new initial health assessment, and review health assessment. Actions taken were identified which included: • An additional 2.90 Whole Time Equivalent (WTE) nurses had been appointed to increase the nursing workforce to 7.10wte. • Nurses were now undertaking all initial and review health assessments for children over where prior to March 2023 medical staff were undertaking all health assessments for children under 10. It was noted that the above actions demonstrated the increase in Heath Assessments undertaken and the reduction in the backlog of Health Assessments and that whilst there had been a significant improvement in the numbers waiting, meeting the regulations continued to be a challenge.	

	The DNCW advised the Committee that workforce was still the biggest challenge and noted that the demand still exceeded the Clinical Board's capacity. He added that that there were a number of options outlined within the report to bridge the gaps identified and it was noted that the Clinical Board were working through those options to find the best action to take which would hopefully enable the Clinical Board to continue to report a level of improvement to the Committee. The Independent Member – Capital & Estates (IMCE) noted that it was important for the Committee to remain sighted on LAC and asked what relationship was held between the Health Board and the Local Authority (LA) around the LAC context and if there were any issues. The DNCW responded that there were no significant issues held between the Health Board and the LA and noted that some of the solutions to help with LAC could be digital solutions to work across multiple platforms and progression was required on those digital solutions to ensure that the referral process could be smoother. The Independent Member – Community (IMC) asked if the Digital & Health Intelligence Committee could be sighted on the digital restraints as it was important work to progress. The END agreed and asked that the Committee receive a further LAC update in 6 months' time. **The QSE Committee resolved that:** a) The content of the paper and the actions taken to mitigate the risks associated child health assessments was noted.	**JR**
QSE 23/09/010	**Covid Investigation Programme Update** The Covid Investigation Programme Update was received. The Assistant Director of Quality and Patient Safety (ADQPS) reminded the Committee that 18 months ago, a statutory requirement to investigate all potential and confirmed Healthcare acquired cases of Covid-19 was established in Wales with funding allocated to the Health Board to do that which ran until March 2024. She noted that the charts outlined within the report received by the Committee showed that the Covid Investigation programme was exceeding the trajectory with more investigations completed than required at the current time and if the Health Board continue on that trajectory, it would complete the programme early. It was noted that despite the positive trajectory, there were still risks identified with the programme including staffing because a number of the Covid investigation team were on fixed term contracts until March 2023 and so were in the process of looking for new roles. The ADQPS advised the Committee that to date, there were 511 investigations remaining, down from the starting figure of just over 3500 and that of those 511, 49 were completed but were subject to further scrutiny through either the Covid panels or the Covid Scrutiny Clinic to quality assure the investigation. She added that areas of good practice and learning continued to be collated and noted that learning fitted under four broad overarching themes: • Infection, Prevention and Control, • Operational, • Patient/Family Experience • Estates and Environment.	

	It was noted that the development of AMAT (Audit Management & Tracking) software was currently underway to strengthen the sharing of learning whilst ensuring the programme's legacy. The Independent Member – Trade Union (IMTU) asked if the Health Board were in a position to put a contingence in place should the staffing situation worsen. The ADQPS responded that the Health Board had a number of staff working on the bank within the Covid Investigation team and so those could be drawn upon if required. The IMTU asked what the consequences would be if the Health Board were unable to complete the programme. The ADQPS responded that if the programme was not completed in the provided timeframe, it would pose a financial risk to the Health Board as it was duty bound to investigate. She added that assurance could be taken from the good progress mad so far and the fact that the Health Board was ahead. The ADQPS concluded that the biggest risk with the Covid Investigation programme was that a number of cases had been referred to legal and risk and so there was a potential that those cases would not have been resolved by the March 2024 deadline. **The Committee resolved that:** a) The assurance provided by the progress against the framework was noted	
QSE 23/09/011	**Transition to NRFit for Neuraxial Procedures** The Transition to NRFit for Neuraxial Procedures report was received. The ADQPS advised the Committee that medications could be given by a number of routes, including oral, intravenous and neuraxial. It was noted that neuraxial included spinal – into the cerebral spinal fluid, and epidural – into the extradural space and that there was ongoing requirement for the Health Board to plan switching from luer equipment to Neuraxial equipment with an aim to reduce accidental “wrong-route” errors. The Interim Head of Safety, Quality and Organisational Learning (IHSQOL) advised the Committee that the Health Board were 3 weeks away from the switchover and noted that the Health Board were now in a position to purchase enough neuraxial equipment to undertake all of the neuraxial procedures. He added that there was a very well-established task and finish group leading the work who had involved all relevant specialties in the planning for implementation including delivery of training and testing compatibility of the equipment with certain drugs including chemotherapy and that risks had been identified and mitigation put in place to minimise those risks. The Committee was advised of a number of areas that had been planned around the transition to NRFit for neuraxial procedures which included: • Changeover days - it was noted that changeover days were planned to avoid school holidays, winter pressures and rotation of junior medical staff and it was agreed by the local neuraxial task and finish group that the changeover should be implemented rapidly to minimise the period of time during which the Luer	

compatible neuraxial devices remained in circulation after the introduction of NRFit equivalents.

- Stock – it was noted that in order to ensure the safe transition to NRFit, an initial central order of NRFit equipment and consumables had been placed by procurement and that the initial central order had been designed to give approximately 6 weeks usage for theatre and maternity areas, and a minimum of 4 weeks usage for other areas.

- Education and training – it were noted that a comprehensive SharePoint site had been developed with training material and resources, which included educational videos for anaesthesia and all other specialities and that local “NRFit Champions” had been trained in key clinical areas who provided training to theatre staff as part of safety and quality sessions.

The IHSQOL identified the key risks which included:

- Clinical areas missed from changeover – it was noted that a considerable number of different neuraxial procedures were performed within the Health Board by a wide range of clinical teams across many locations and so there was a risk that areas, particularly small areas, with low volumes of neuraxial procedures, would not be aware of the need to change to NRFit compliant equipment.

It was noted that the risk was managed by:

- Ensuring wide engagement with the Task & Finish Group from across clinical specialties.
- Using information from procurement systems to identify areas which currently used Luer neuraxial equipment.
- Engagement with Clinical Boards/Directorates and presenting at relevant meetings.

- Procedure delays due to incompatible equipment- it was noted that there was a risk that if an area was not fully transitioned to NRFit, it could cause delays in procedures.

It was noted that the risk was managed by a number of actions which included:

- Close working with clinical staff and those responsible for ordering stock in clinical areas to ensure that sufficient equipment would be ordered and delivered ahead of changeover.
- Education of staff to check that all the necessary equipment was available and NRFit compatible before starting a procedure.
- A changeover plan that minimised the time that Luer and NRFit neuraxial equipment was in circulation concurrently.

- Insufficient equipment received prior to changeover – it was noted that it was vital that sufficient quantities of NRFit equipment could be received into Health Board stores for delivery to clinical areas.

It was noted that the risk was managed by:

- Early provision of the initial central order (Mid-August 2023) to procurement to allow time for orders to be placed with suppliers and received into stores.
- A planned second order prior to changeover to add additional required items that had been identified since the initial order was placed.

	- Working with supplier representatives to receive early notification of any supply issues and resolving any issues. **The Committee resolved that:** a) The changeover to NRFit for neuraxial procedures on 15th/16th October 2023, subject to sufficient NRFit equipment being received in Health Board stores by 26th September was approved.	
QSE 23/09/012	**Paediatric Intensive Care Unit (PICU) Pressure Damage Update** The PICU Pressure Damage update was received. The END advised the Committee that the Welsh Health Specialised Services Committee (WHSSC) had identified concerns within the PICU which enabled a piece of work to be undertaken by the Health Board and a report was received via the private session of the Committee in May 2023 with an aim to update the Committee in the public session in September 2023. The DNCW advised the Committee that he would take the paper as read and noted that pressure damage remained a concern for the Clinical Board. He added that a retrospective review of pressure damage within the Acute Child Health Directorate was undertaken and identified 44 patient safety incidents relating to pressure damage reported between 1st March 2022 and 15th March 2023, with 24 children affected. It was noted that: • 11 cases related to incidents of moisture associated skin damage associated with incontinence or nappy rash. • 15 incidents related to medical devices including ventilator masks. The Committee was advised that analysis of the incidents evidenced good risk assessment and Tissue Viability Service and Medical Photography involvement for the most complex cases. It was noted that there were however, improvements required in the oversight and management of pressure damage related patient safety incidents and that immediate training was provided to senior and lead nurses to support appropriate management of incidents reporting and management. The DNCW noted that in response to the review, the Acute Child Health Directorate would implement a monthly Pressure Damage Scrutiny Panel to provide senior oversight of all incidents with involvement from the Tissue Viability Service, with the aim to identify areas of learning and improvement and to reduce pressure damage incidence. He added that A new skin integrity pathway was developed to ensure appropriate action was taken to prevent device related tissue damage within the vulnerable patient cohort and complex service area and that the pathway would commence within four hours of admission to PICU and would be reviewed daily. The Committee was advised that In June 2023 the Acute Child Health Directorate launched the use of the Paediatric Purpose-T pressure ulcer risk assessment tool which was being rolled out across Wales and supported proactive identification of risks of developing pressure damage and mitigating actions. The CC thanked the DNCW for the update and noted that the hard work identified within the report demonstrated the improvements and commitment of the Clinical Board.	

	The END added that the paper had also been received by WHSSC for their assurance. **The 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 Children & Women Clinical Board was noted.	
QSE 23/09/013	**Policies:** The Medicines Code 2023 (UHB 389) was received. The Staff Winter Respiratory Vaccination Policy and Procedure (UHB 494) was received. **The Committee resolved that:** a) The Medicines Code 2023 (UHB 389) was reviewed and approved. b) The Staff Winter Respiratory Vaccination Policy and Procedure (UHB 494) was reviewed and approved.	
QSE 23/09/014	**Bi-Annual National Clinical Audit** The Bi-Annual National Clinical Audit was received. **The Committee resolved that:** a) The assurance provided by the national audit results and oversight of the improvements was noted.	
QSE 23/09/015	**NG Tube Patient Safety Notice** The NG Tube Patient Safety Notice was received. **The Committee resolved that:** a) The reporting of compliance with Patient Safety Alert 008 – 'Nasogastric tube misplacement: continuing risk of death and severe harm' was noted.	
QSE 23/09/016	**Radiation Protection Group – Chairs Report** The Radiation Protection Group – Chairs Report was received. **The Committee resolved that:** a) The summary of the key issues from the meeting were noted.	
QSE 23/09/017	**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 23/09/018	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/09/019	**Agenda for Private QSE Meeting**	

	i) Private Minutes - *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
QSE 23/09/020	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: October – tbc - via MS Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 25 October 2023
(Following the meeting held on 26 September 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 23/03/008	**Looked After Children – Assessment Backlogs**	An update report to be brought back to the Committee in 3-4 months.	**26.09.2023**	Jason Roberts/Catherine Wood	**COMPLETED** **Updated in September 2023** *Agenda item 2.3*
QSE 23/04/009	**Pressure Damage**	An update report to be brought back to the Committee in 4-6 months' time.	**25.10.2023**	Jason Roberts	**COMPLETED** **Updated in October 2023** *(Agenda item 2.3)*
Actions in Progress					
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	**25.10.2023**	Jason Roberts	**Update in October 2023** *Agenda item 2.2*
QSE 23/03/007	**Specialist Clinical Board Assurance Report – re: South Wales Trauma Network**	To update the Committee with regards to the WHSSC funding for South Wales Trauma Network review and associated actions	**25.10.2023**	Paul Bostock/Guy Blackshaw	**Update in October 2023** *Agenda item 2.4*
QSE 23/09/007	**PCIC Assurance Report**	Action Plans to be received by the Committee around prison deaths and learning	**28.11.2023**	Jason Roberts / Meriel Jenney	**Update in November 2023**
QSE 23/07/009	**MBRRACE Update**	A matrix report to be provided to the Committee to include the MBRRACE report.	**28.11.2023**	Meriel Jenney / Jason Roberts	**Update in November 2023**
QSE 23/09/009	**Looked After Children –**	A 6-month update to be provided to the Committee	**05.03.2024**	Jason Roberts	**Update in March 2024**

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
	Assessment Backlogs				
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.	**28.11.2023**	Aaron Fowler / Matt Phillips	**Update in November**
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 in November**
UHB 23/03/013	**QSE Chair's Report**	A deep dive with regards to stillbirths to be considered at the QSE Committee.	**30.11.2023**	Jason Roberts/Angela Hughes	**Update to be given to Board on 30 November 2023.** *Deep dive provided to the QSE on 28 November 2023.*

Report Title:	**Quality Indicators Report**			Agenda Item no.	2.1
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	25th october 2023
		Private			
Status *(please tick one only):*	Assurance		Approval		Information
Lead Executive:	Executive Medical Director and Executive Nurse Director				
Report Author (Title):	Assistant Director of Quality and Patient Safety and Assistant Director of Patient Experience				

Main Report Background and current situation:

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

The report provides oversight of data up until the end of September 2023 with details of actions that are being undertaken to drive the requisite improvements.

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

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

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

- Current Klebsiella, Pseudomonous aeruginosa, E. coli, Staphylococcus aureus and Clostridium difficile rates bacteraemia rates are exceeding the required reduction trajectory. The development of a live dashboard is supporting oversight of IP&C compliance rates. Work is underway to gain wider assurance of uptake of Aseptic Non-Touch Technique (ANTT) processes
- A falls prevention and management training programme has been developed and the plot training has been delivered to over 40 members of staff in September and will be subject to a full evaluation
- The development of a Tendable medication administration audit tool will support oversight of omitted doses of medication. The critical time medication task and finish group is progressing and will support a standardised approach to staff education and oversight of critical time medication prescribing and administration.
- The UHB is compliant with all Patient Safety Solutions and work is underway to meet the compliance deadline of 15 December 2023 for PSA016 Calcium Gluconate
- An update of the B5 T5 improvement plan has been provided to HIW with 64 of 67 actions complete and the final three are underway.
- Work to analyse Medical Examiner referrals by Welsh Index of Multiple Deprivation is being scoped to support analysis of care inequities
- Five elements of NICE and HTW guidance have been circulated this month
- Progress with Covid Investigations is exceeding the required trajectory
- The Health Board continues to receive a significant number of concerns and appointments/ waiting times remain the highest reported concern

- Overall satisfaction scores with our services is high-we note those in patients who use the bed side survey whilst lower in number report a lower rate-this is being reviewed and analysed
- Safe Care is now being used systematically to support oversight of acuity and nurse staff in UHW and UHL

Recommendation:

The Board / Committee are requested to: **NOTE** the assurance provided by the quality indicators and the actions underway to drive the necessary improvements.

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

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

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

Prevention		Long term		Integration		Collaboration		Involvement	

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

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

October 2023 Quality Indicators Report

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

Quality Indicators Report

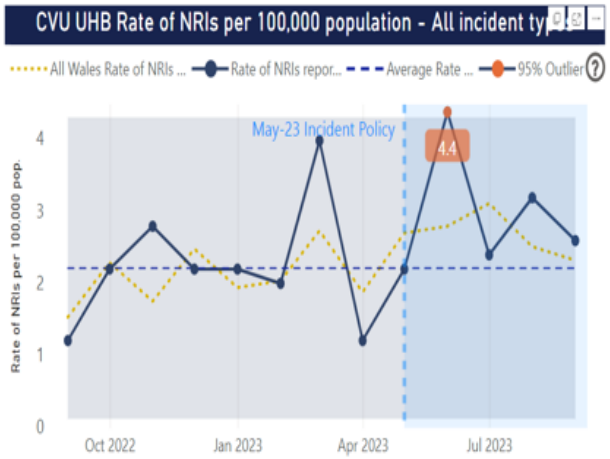
Quality Safety and Experience Committee

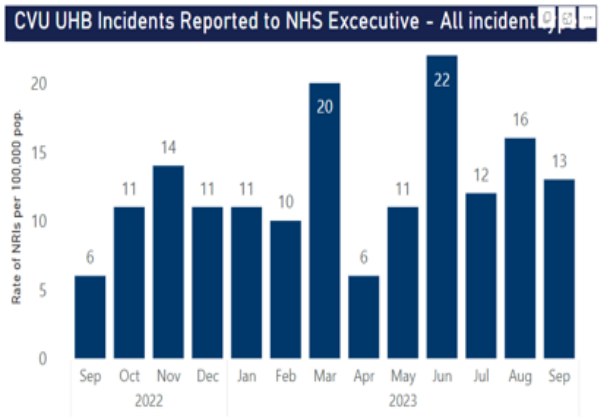
October 2023

October 2023 Quality Indicators Report

Safe Care

National Reportable Incidents and Never Events

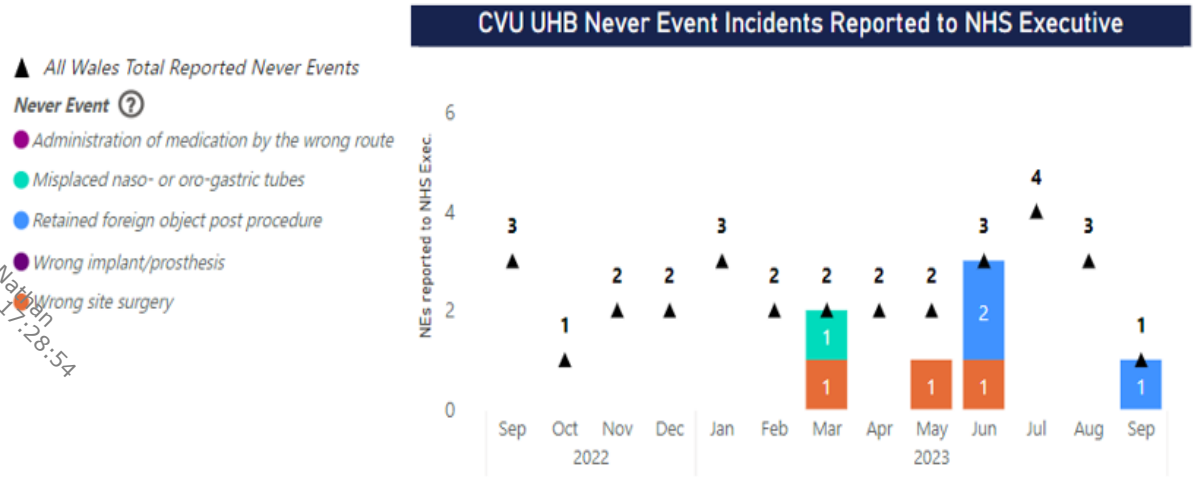




Thirteen NRIs reported In September

Six Never Events reported this year

- ❑ wrong cataract
- ❑ wrong finger
- ❑ Retained drain tip
- ❑ wrong site block
- ❑ Retained swab
- ❑ Retained dental Swab



Actions

Five Steps to Safer Surgery

- ❑ Retrospective Five Steps audit of all theatres in UHL UHW and CHFW using AMaT
- ❑ Recirculated the Five Steps SOP to all theatre staff
- ❑ Communication to all staff from the Clinical Board Director
- ❑ Presentation of retrospective audit results to perioperative QSE and Surgical CB QSE
- ❑ Focus on sign in and sign out as new additions to Theatreman
- ❑ Planned re audit
- ❑ Monthly scrutiny of Theatreman data

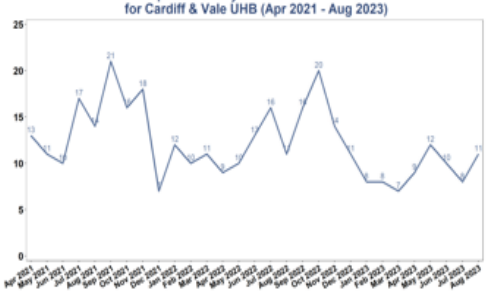
October 2023 Quality Indicators Report

Diogel Safe

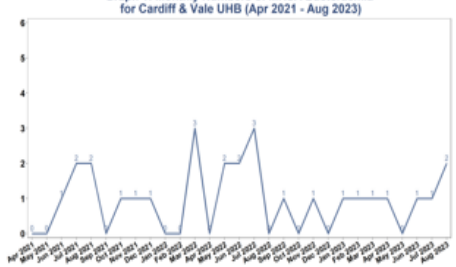
Safe Care

Infection Prevention and Control

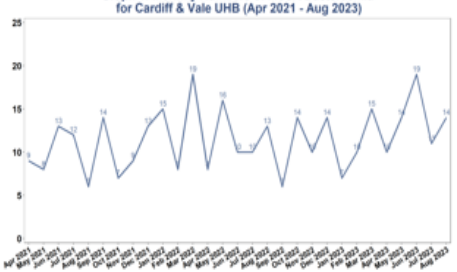
Graph 1: Monthly Numbers of C. difficile for Cardiff & Vale UHB (Apr 2021 - Aug 2023)



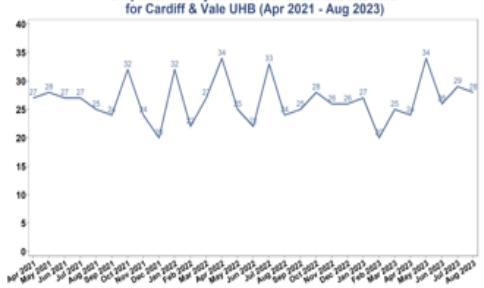
Graph 1: Monthly Numbers of MRSA Bacteraemia for Cardiff & Vale UHB (Apr 2021 - Aug 2023)



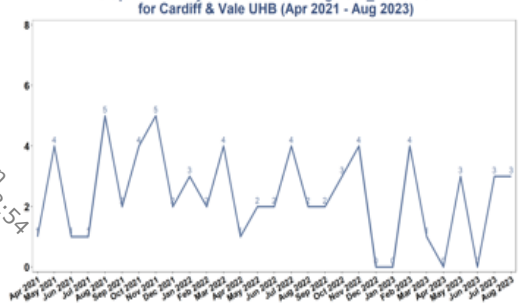
Graph 1: Monthly Numbers of MSSA Bacteraemia for Cardiff & Vale UHB (Apr 2021 - Aug 2023)



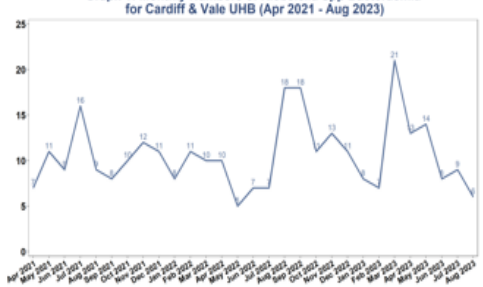
Graph 1: Monthly Numbers of E. coli Bacteraemia for Cardiff & Vale UHB (Apr 2021 - Aug 2023)



Graph 1: Monthly Numbers of P.Aeruginosa_Bacteraemia for Cardiff & Vale UHB (Apr 2021 - Aug 2023)



Graph 1: Monthly Numbers of Klebsiella Spp Bacteraemia for Cardiff & Vale UHB (Apr 2021 - Aug 2023)



- Between April 23 and September 23, there were 58 cases of ***Klebsiella spp*** **bacteraemia** 24 over the reduction expectation.
- There were 13 cases of ***P. aeruginosa*** **bacteraemia,** 50 over the reduction expectation.
- There were 174 cases of **E. coli bacteraemia** 50 over the reduction expectation.
- There were 83 cases of **S. aureus bacteraemia** 44 over the reduction expectation.
- There were 58 cases of **C. difficile** 19 over the reduction expectation

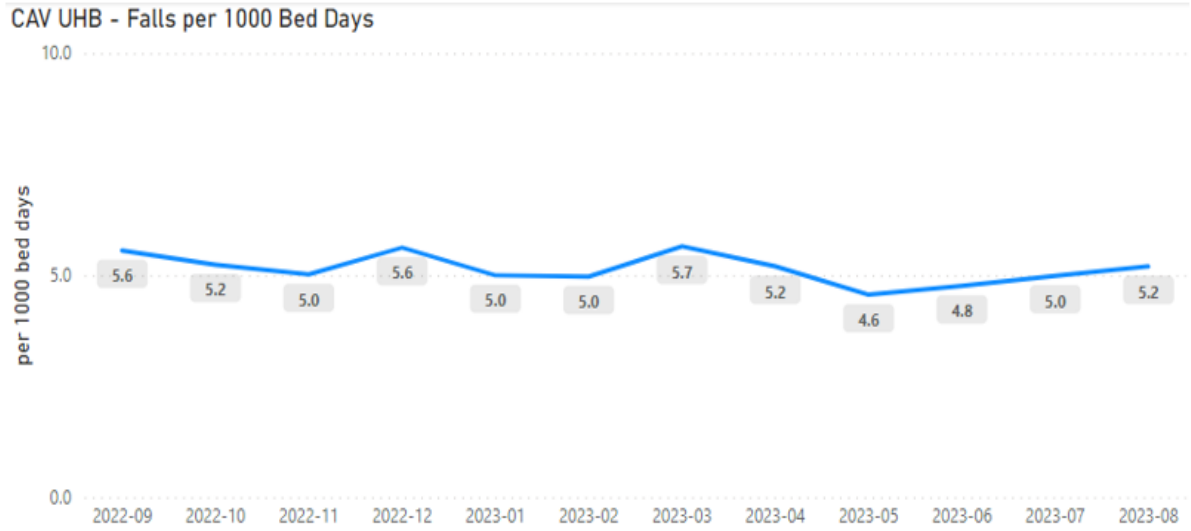
Improvements

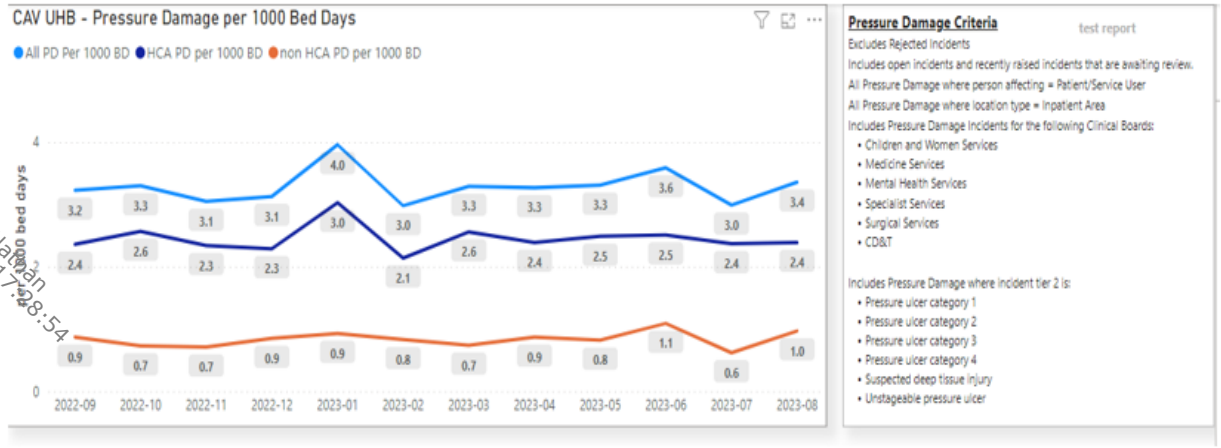
- Use of Tendable to monitor IP&C, ward and Senior / Lead nurse audits
- Able to compare performance between independent IP&C audits and self audit of performance
- Live dashboard released in September 2023 to show IP&C compliance rates across locations
- Meeting held in October 2023 to support gain wider assurance about Aseptic Non Touch Technique (ANTT) processes

October 2023 Quality Indicators Report

Safe Care

Falls and Pressure Damage





Falls

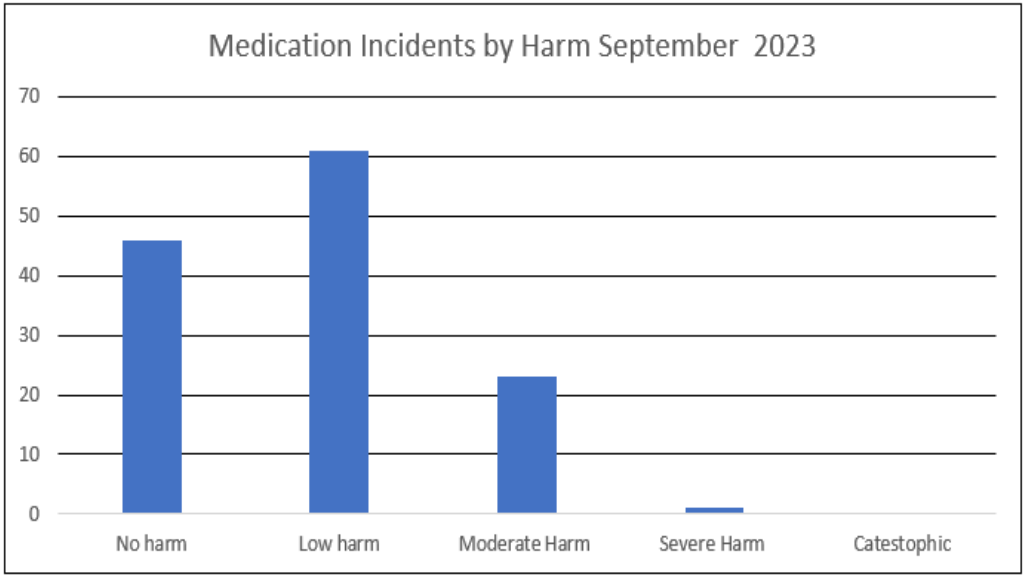
The UHB Falls prevention and management training programme commenced in was launched in September 2023 with a pilot training programme delivered to over 40 members of staff on Ward E7 and E8. A full evaluation is being undertaken and falls occurrence will be monitored in these ward to establish if there is a reduction. The Multi Factorial Risk Assessment will be re-audited to establish if there has been an improvement in consideration of risk and mitigation.

Pressure Damage

The UHB Pressure Ulcer Collaborative continues will re convene in October 2023 to provide governance and oversight of pressure damage related incidents.

Safe Care

Medication Incidents



Failure to administer a prescribed Intravenous Teicoplanin 400mg administered to a patient post operatively.

Improvements

Tendable Development

Development of a medication audit which will include omitted doses.

Critical Time Medications Task and Finish Group

Ongoing work to strengthen to prescribing and administration of critical time medications.

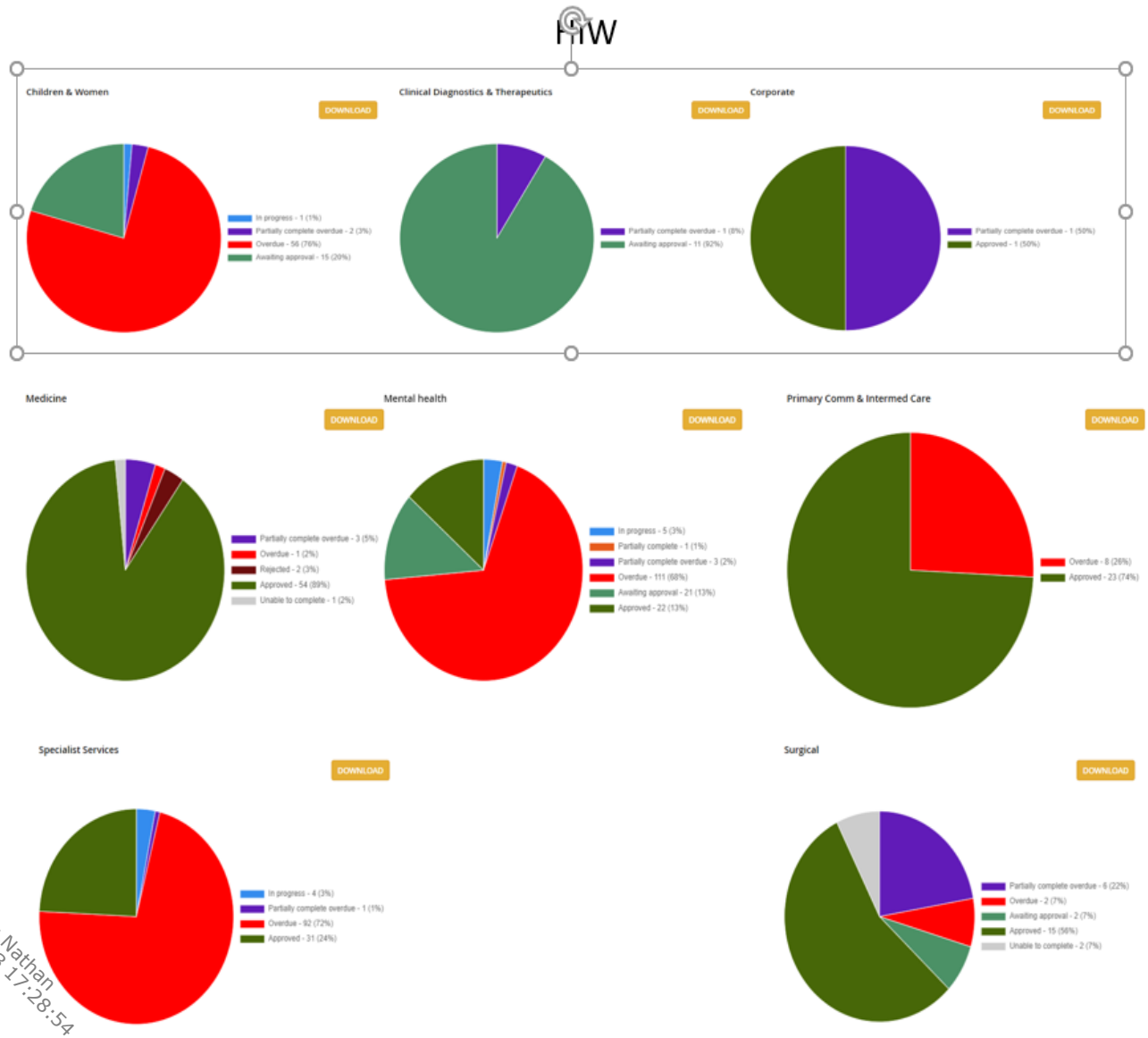
- Staff education
- Patient Information
- Policy oversight
- Prescribing safety measures until EPMA is implemented
- Self administration of medications

Implementation of the Valproate Pregnancy Prevention Programme.

- 2021 Valproate working group established to support the safe prescribing of sodium valproate to individual of child bearing potential that agreed that prescribing for this patent group should occur within specialities which commenced in February 23.
- Development of a database of individuals prescribed Valproate
- Valproate was changed to Hospital only for this patient cohort on the UHB formulary.
- National Safer prescribing of Sodium Valproate – short life working group

October 2023 Quality Indicators Report

Safe Care



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B5 and T5 Improvement Plan update

B5 and T5 were subject to HIW inspection in March 2023. An update of the improvement plan has been provided this Month.

- 64 Improvements are now complete with ongoing monitoring
- Funding to develop the quiet room and to update furniture and decorations is being sourced
- Joint walk around with estates in October to review ward storage

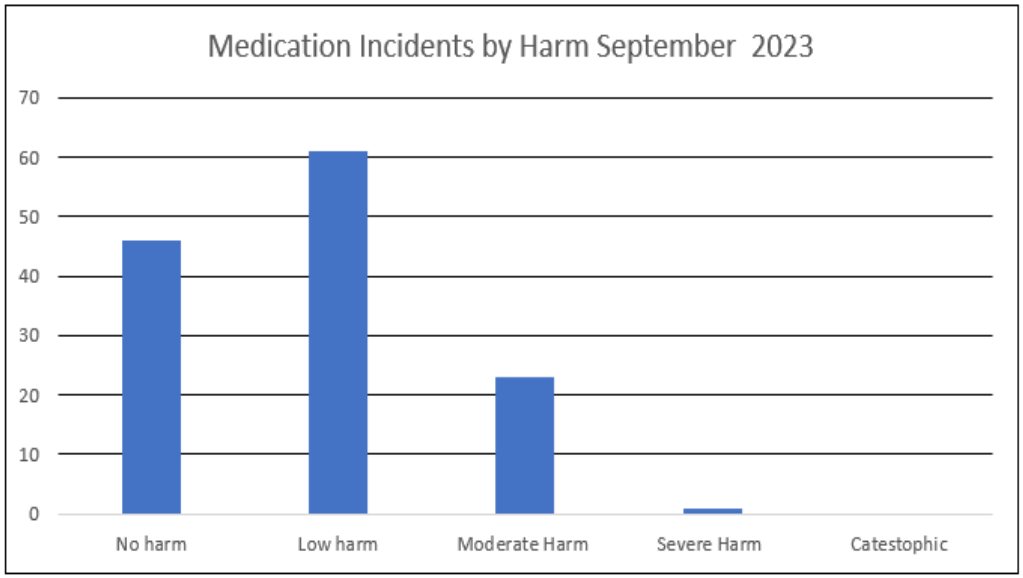
Improvements

An exercise to upload all historical actions onto the AMaT system is currently underway. This will support ongoing monitoring of progress and sustainability.

The Pie chart represent HIW actions by clinical board, a reconciliation exercise will be undertaken between October and December 2023 to review all open and overdue improvements to provide an accurate and up to date picture of improvements.

Safe Care

Medication Incidents



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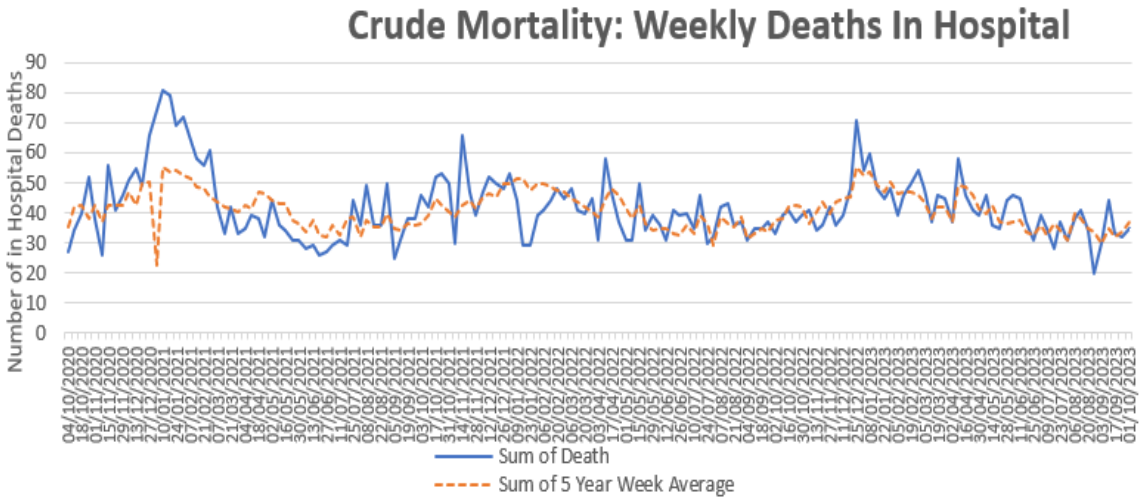
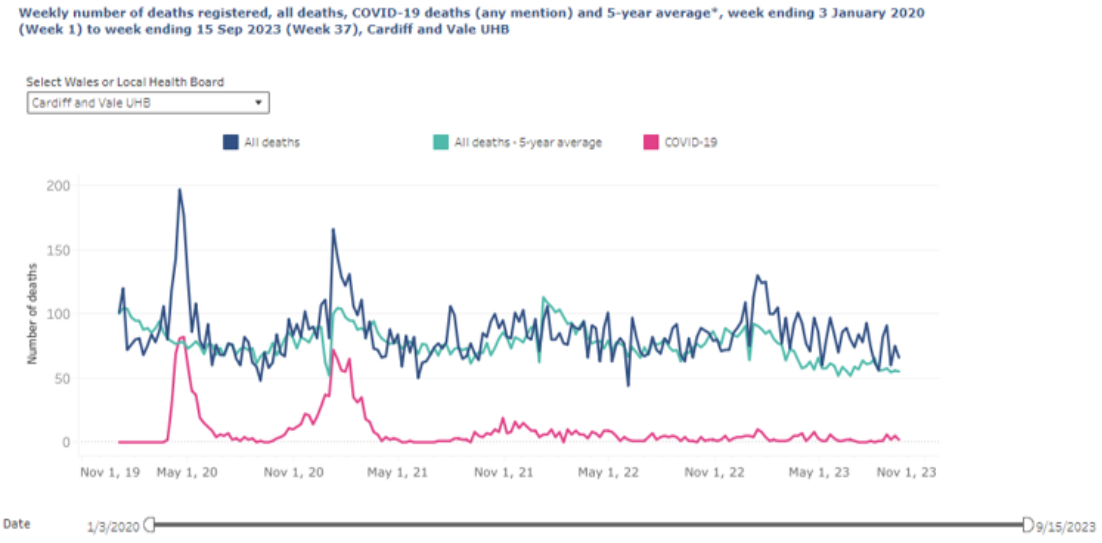
Effeithiol
Effective

Effective Care

Mortality





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- The Crude Inpatient Mortality chart demonstrates the numbers of inpatient deaths that occur in the Health Board on a weekly basis and demonstrates that the rate is comparable to the five year average for the same period.

- Crude all-cause mortality, demonstrates the weekly number of deaths registered in Cardiff and the Vale of Glamorgan, regardless of where they occurred. An increase above the five year average has been noted across wales since April 2023 with a similar increase noted in Cardiff and Vale UHB with five year average crude mortality in week 28 being recorded as 76 compared with 63.6 for the previous five year average.
- Work will be undertaken to explore the cause of death and to understand emergent themes.
- Work to analyse Medical examiner referrals and correlate with welsh Multiple Index of Deprivation is being scoped to explore inequities in care and patient experience.

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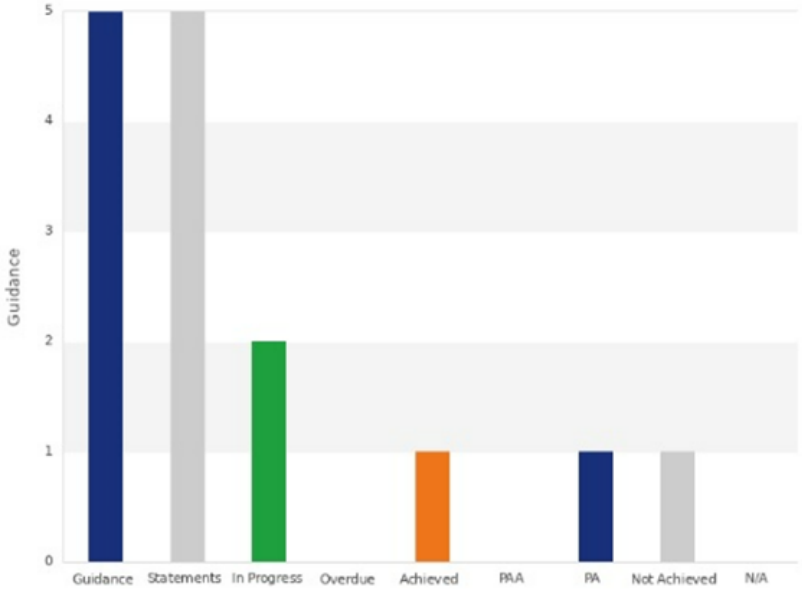
Effective Care

Clinical Effectiveness

Guidance overview



- **Guidance (5)** - total number of guidance (that may contain one or more statements)
- **Statements (5)** - total of 'In Progress', 'Achieved', 'Partially Achieved', and 'Not Achieved' bars
- **In Progress (2)** - number of the trust's Guidance Statement entries that do not currently have a status
- **Overdue (0)** - number of the trust's Guidance Statement entries that are overdue
- **Achieved (1)** - number of the trust's Guidance Statement entries that have this status value
- **PAA (0)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Acceptable' status value
- **PA (1)** - number of the trust's Guidance Statement entries that have 'Partially Achieved' status value
- **Not Achieved (1)** - number of the trust's Guidance Statement entries that have 'Not Achieved' status value
- **Not Applicable (0)** - number of the trust's Guidance Statement entries that have 'Not Applicable' value

Circulated Guidance

- Covid 19 rapid guideline: haematopoietic stem cell transplantation
- Caesarean birth (replacing NICE guidelines CG132)
- Intrapartum care (replaces NICE guideines CG190)
- Semaglutide for managing overweight and obesity
- Mavacamten for treating symptomatic obstructive hypertrophic cardiomyopathy.

October 2023 Quality Indicators Report

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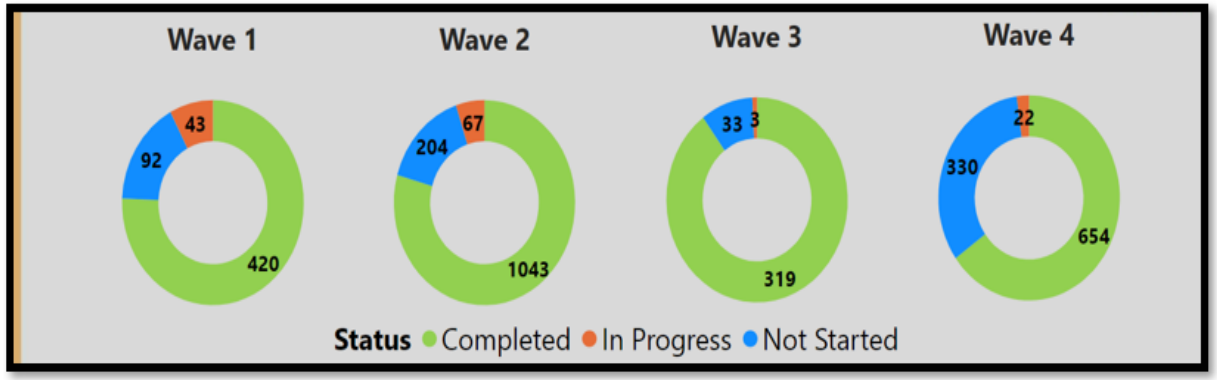
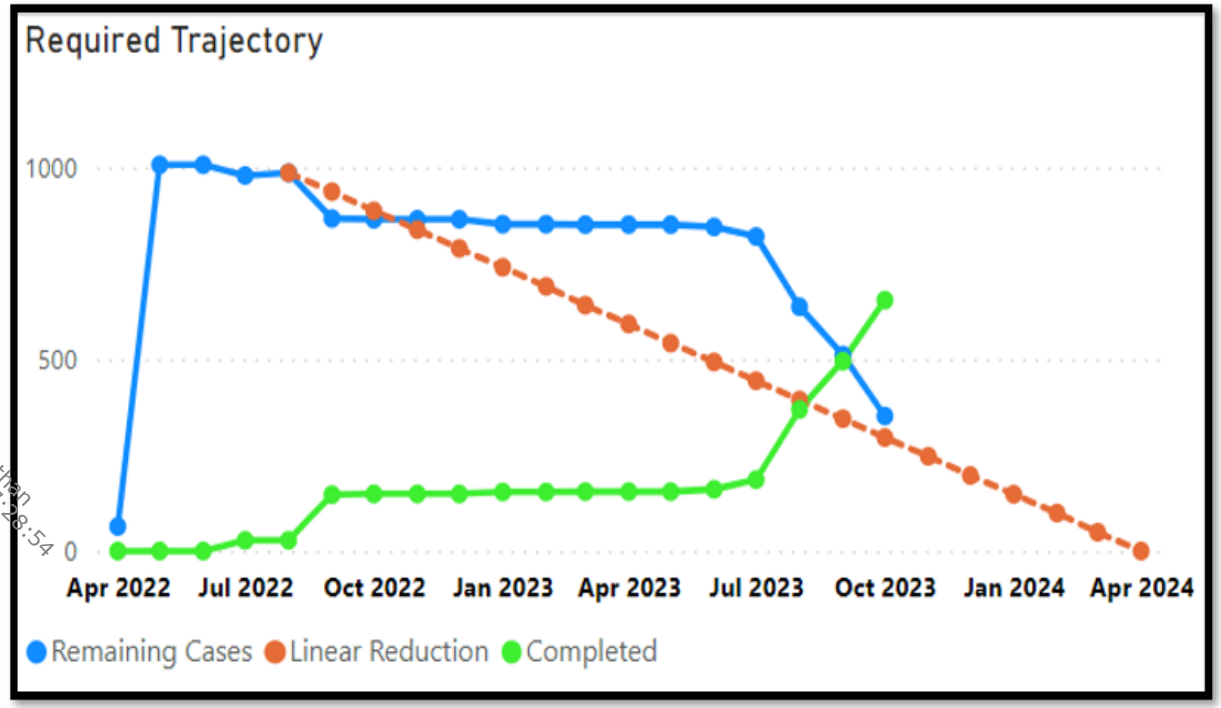
Effective

Effective Care

Covid Investigations





The covid-19 investigation programme is making good progress across all four waves and completed investigations currently exceed the required trajectory.

October 2023 Quality Indicators Report

Person Centred Care

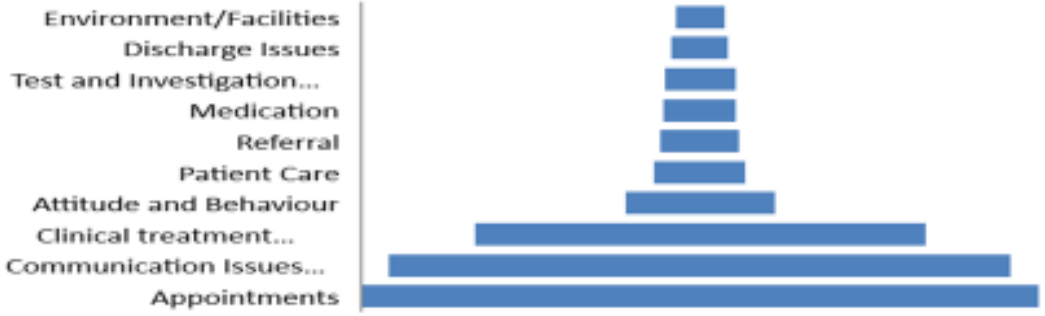
Patient Experience

CONCERNS

As a Health Board we are committed to listening to people who use our services, resolving their concerns where possible in a proportionate and empathetic manner. We aim to provide an effective and timely process for responding to concerns, which enables the Health Board to improve services based on lessons learnt, with the aim of achieving high quality, compassionate and effective care for all service users, whether in provided or commissioned services.

Concerns received by month - last 12 complete months

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



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We currently have 333 active concerns. As anticipated, we noted a reduction in concerns during the summer period, however, we still receive an average of 350 Concerns a month. Surgery and Medicine Clinical Boards consistently receive the highest number of concerns, the high volumes of concerns received in Medicine and Surgery Clinical Board is in line with the number of patient contacts and complex care both Clinical Board's provide. The number of necessary cancellations and delays due to Covid or Industrial Action and the significant increase and demand on services like EU.

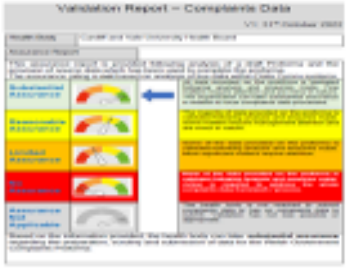
The second chart demonstrates the 10 main themes noted in Concerns.

Communication and Clinical treatment have historically been noted as the primary subject in concerns, however, concerns regarding cancellations of appointments have increased and are now a theme throughout our concerns with Communication and Clinical Concerns following closely behind. Environment and Attitudes and behaviors are continuing to be recorded as a theme and increasingly statistically significant in number.

- Welsh Government target for responding to concerns is 75% within 30 working days
- During August and September 2023, the Health Board received :706 Concerns
- 77 % closed within 30 working days (including Early Resolution)
- 63 % managed under Early Resolution

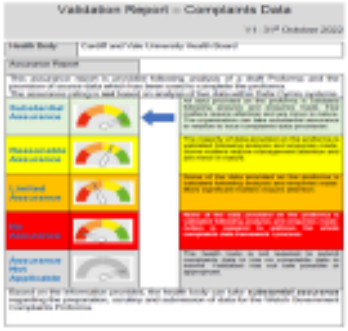
Person Centred Care

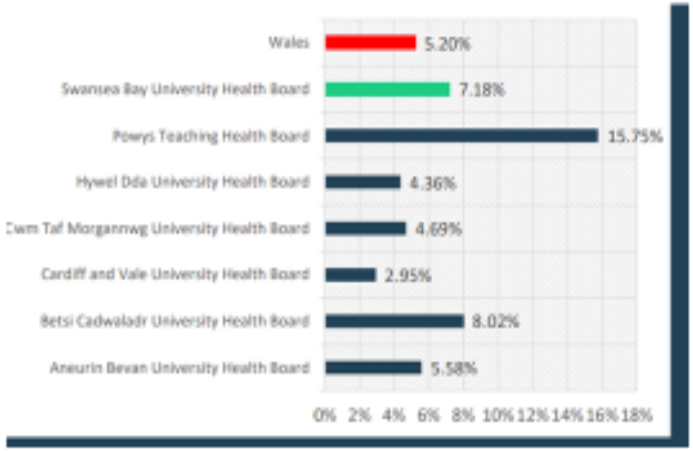
Patient Experience Concerns Assurance



The Welsh Risk Pool, at the request of Welsh Government, have undertaken a validation exercise of the 2022-23 Q2 and 3 quarterly complaints data prepared for submission by each health body.

The Welsh Risk Pool have also shared their assessment report (to be shared in QSE) where we were pleased to receive the highest level of assurance in Complaints, Redress , Claims, Learning from Events and the Reimbursement process





This graph the volume of complaints received by PSOW about Welsh Health Boards in 22/23, as a proportion of all the complaints they closed

The validation exercise was intended to provide support to each health body in relation to the assurance of local processes for the application of the requirements of the Putting Thing Right regulations, published definitions and guidance and the maintenance of accurate and consistent information within the Datix Cymru system.

The validation exercise consisted of verifying source

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

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.

PSOW-Public Service Ombudsman for Wales –despite having a high number of concerns received the referral rate to the Ombudsman by complainants is the lowest in Wales

October 2023 Quality Indicators Report

Person Centred Care

Patient Experience - CIVICA

From 1 August to 30 September 2023

Tell Us in 2 survey

SMS sent: 19108

Survey responses: 3532

Response rate: 19%

89% were satisfied with their overall experience.

Tell Us in 2 survey Bedside

Survey responses: 113

51% were satisfied with their overall experience.

Emergency Unit Survey

SMS sent: 7503

Surveys responses: 1079

Response rate: 14%

71% were satisfied with their overall experience.

Combined results:

Based on 3771 partial/full survey completions.

- Whilst in our care did you feel safe? 83% of respondents answered 'Always'.
- Were staff kind and caring? 82% of respondents answered 'Always'.
- Did you feel involved, when decisions were made about your care and/or treatment? 68% of respondents answered 'Always'.
- 88% were satisfied with their overall experience.

Currently:

- Accessibility – Feedback surveys are currently available in four languages, English, Welsh and in BSL English and Welsh, our Feedback Lead is currently working implementation the top 10 languages used in Cardiff and the Vale
- We continue to randomly select across all Clinical Boards 600 people who have used a variety of our services on a daily basis for feedback via text message.
- As of August 2023 an all Wales Emergency Unit survey was implemented within the Health Board, the system randomly selects 200 people who have visited our Emergency Unit for feedback via text message on a daily basis.
- On the 05th of October the Volunteer Service Team welcomed 100 Cardiff University first year pharmacy students who on a weekly basis will be providing a face-to-face service supporting with obtaining patient experience feedback. This rolling project runs every Tuesday afternoon between October 2023 and March 2024
- Recruitment of Feedback Volunteers to support bespoke feedback surveys in specialised areas and areas where feedback is negative.

Person Centred Care

Patient Experience - CIVICA

SMS

Tell Us in 2 survey

SMS sent: 19108

Survey responses: 3532

Response rate: 19%

89% were satisfied with their overall experience.

- Whilst in our care did you feel safe? 84% of respondents answered 'Always'.
- Were staff kind and caring? 83% of respondents answered 'Always'.
- Did you feel involved, when decisions were made about your care and/or treatment? 69% of respondents answered 'Always'.
- 89% were satisfied with their overall experience.

The word cloud is based on the comments received in our feedback from our Tell us in 2 survey. The green highlights positive sentiments and the red highlights negative sentiments.

To alleviate people feeling anxious and stressed as highlighted opposite, the PE Team have introduced mobile loaning library trolleys stocked with books, magazines and patient activity packs for all levels of cognitive impairments to provide distraction.

Personal radios and DVD players and DVDs are also available from the trolleys for patients to loan while on our wards to take their minds away from their problems.

The Voluntary Services Team are assembling a task and finish group comprising of the Dementia learning and development and Chaplaincy teams to identify appropriate items of spiritual and religious items as well as information and guidance for volunteers in distributing these items sensitively. All of these items will be inclusive, audio format, large print and in different languages. The inclusion calendar will be used to promote spiritual, religious and national awareness days.

Person Centred Care

Patient Experience - CIVICA

Tell Us in 2 survey Bedside

Survey responses: 113

51% were satisfied with their overall experience.

- Whilst in our care did you feel safe? 52% of respondents answered 'Always'.
- Were staff kind and caring? 54% of respondents answered 'Always'.
- Did you feel involved, when decisions were made about your care and/or treatment? 38% of respondents answered 'Always'.
- 51% were satisfied with their overall experience.

The word cloud is based on the comments received in our feedback from our Tell us in 2 survey taken at the patients bedside.

The green highlights positive sentiments and the red highlights negative sentiments.

In addition to the trolley service, new ward befrienders have been recruited to interact with patients and help with a friendly chat, hopefully alleviating some patient anxieties and nervousness with a friendly face.

Future:

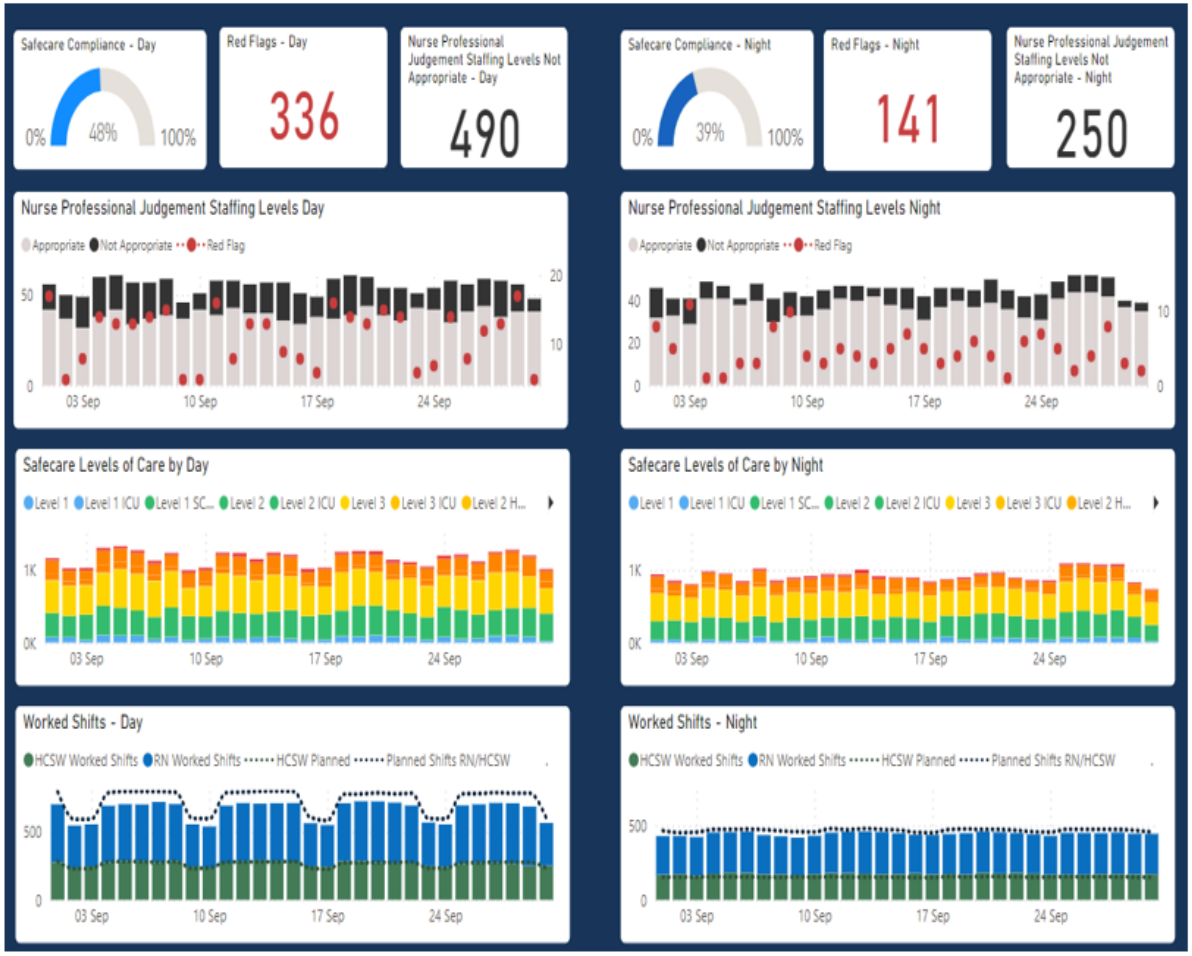
- During November 2023 Mental Health Services will be included in the daily selection via Civica, we will be randomly selecting 200 mental health service users who have recently been discharged or have attended as an outpatient each day by text message
- In the coming month 10 new feedback kiosks that will be launched across our hospital sites.
- Digital Story Platform within Civica - Version 8 to be released in the coming months which will include the Civica Once for Wales Digital Story Platform. Our Digital Lead will be working to facilitate this alongside other Health Boards in Wales

October 2023 Quality Indicators Report

Effeithlon
Efficient

Efficient Care

Safe Care



The dashboard displayed contains information obtained from the digital systems SafeCare and Health Roster. The dashboard is updated monthly and provides a crucial opportunity to review themes and trends at a UHB and directorate level, with the ability to probe into the details at ward level. Actual nurse staffing levels compared with the agreed nursing establishment can be seen within the dashboard and this is accompanied with patient acuity information measured using the Welsh Levels of Care acuity tool. Further information contained in the dashboard relates to the professional judgement of the nursing team relating to the appropriateness of nurse staffing levels during their shift and any red flags raised.

Report Title:	Report on updated position regarding the volume of waiting lists within the Children & Women Clinical Board			Agenda Item no.	2.2
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	25/10/2023
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	General Manager, Children, Young People and Family Health Services				

Main Report Background and current situation:

The purpose of this report is to provide Committee Members will an updated position regarding the volume of waiting lists within the Children & Women Clinical Board, and specifically within the Children, Young People and Family Health Services (CYPFHS) Directorate.

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

The CYPFHS Directorate have a number of services with growing demand which has led to increased waiting list volumes.

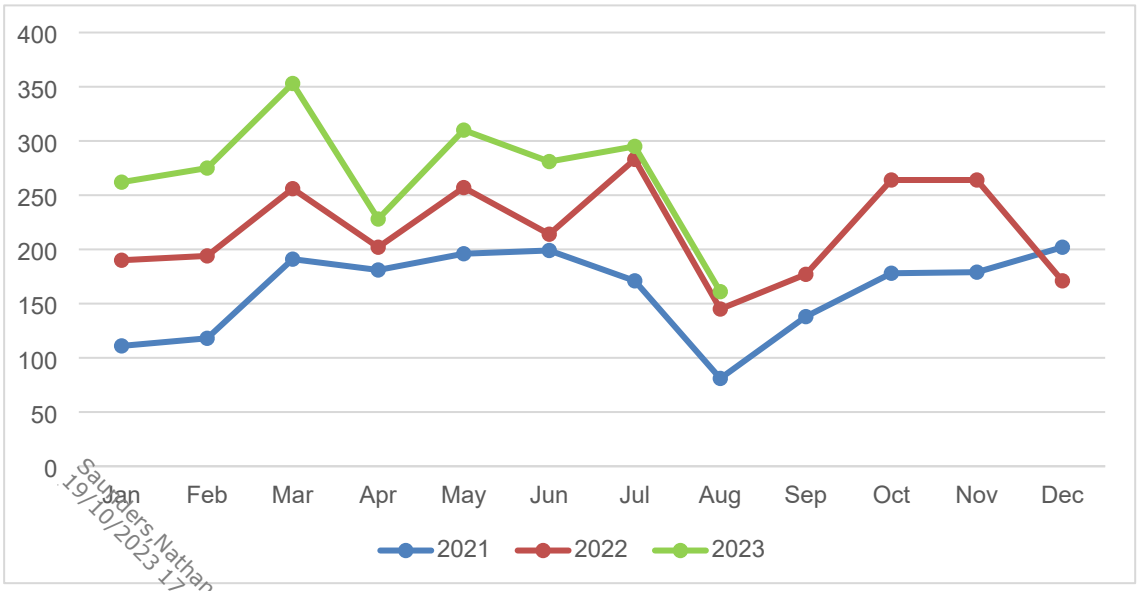
This report describes the current risks, actions and progress around Neurodevelopment, Children Looked after and Eating Disorders.

Neurodevelopment

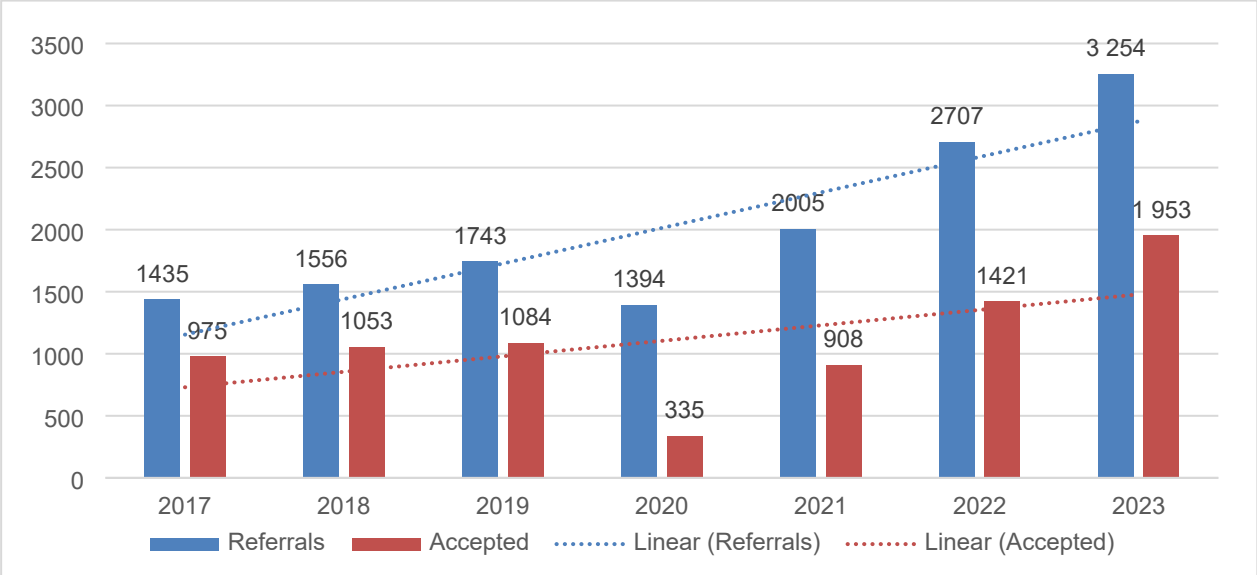
The most significant risk within CYPFHS is the growing waiting list and waiting times for children waiting a Neurodevelopment assessment.

The service has seen a significant increase in referrals since pre COVID. There was a 55% to 2022, with a further 20% predicted in 2023 based on referrals to date, as demonstrated on the graphs below.

Graph 1 – Neurodevelopment referral rates 2021 to date



Graph 2 – Neurodevelopment referral and acceptance per annum 2017 to 2023 (predicted)

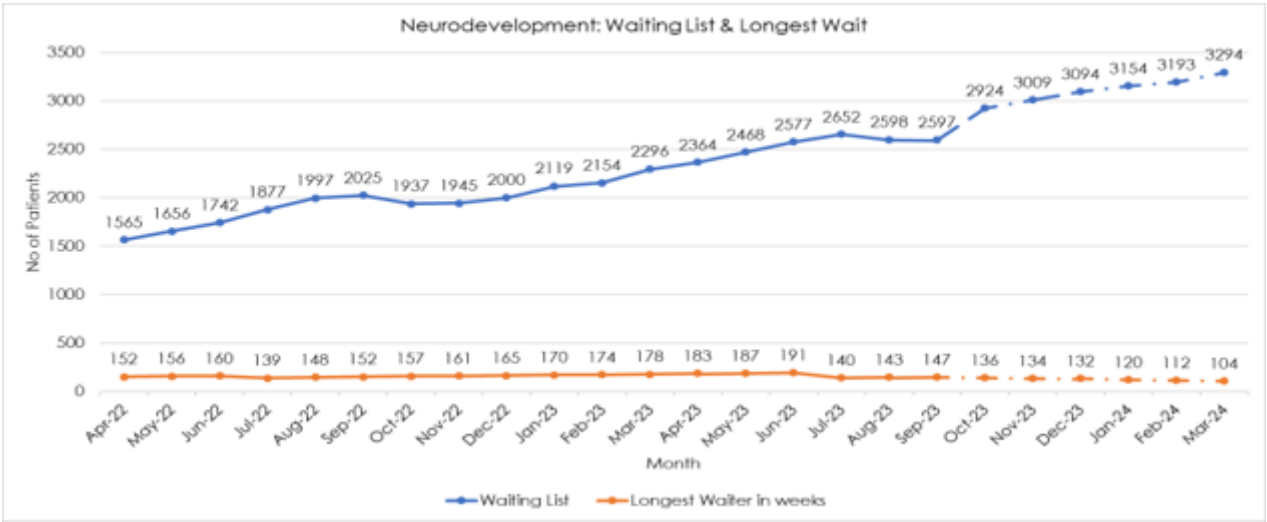


Conversion rates have been consistently between 50% and 60%, with the current conversion being 60% of referrals added to list.

This increase in referral have had a significant impact on waiting list volumes and waiting times. We currently have c. 2,500 on the list with a wait of over 2 ½ years.

The graphs below demonstrate the impact on this increase in referrals on the waiting list.

Graph x - ND waiting list times and trajectory to March 2024



There are a number of actions to address the waiting list volume and waiting times.

- Secured some additional funding to expand the team which we are anticipating will directly impact on the waiting times, but will not address the growing demand and capacity gaps.
- Launch of an E referral form to improve timeliness and information capture. Shared with all referrers and has had positive feedback.
- Reviewing the triage process, as currently triaged by Consultant. We have appointed a triage practitioner to support the process and allow us to divert Consultants to see & assess the children.

- Reviewing the clinical pathways, through joint assessments to enable a quicker outcome where appropriate, and fast track assessment based on a model in the Integrated Autism Triage clinic model.

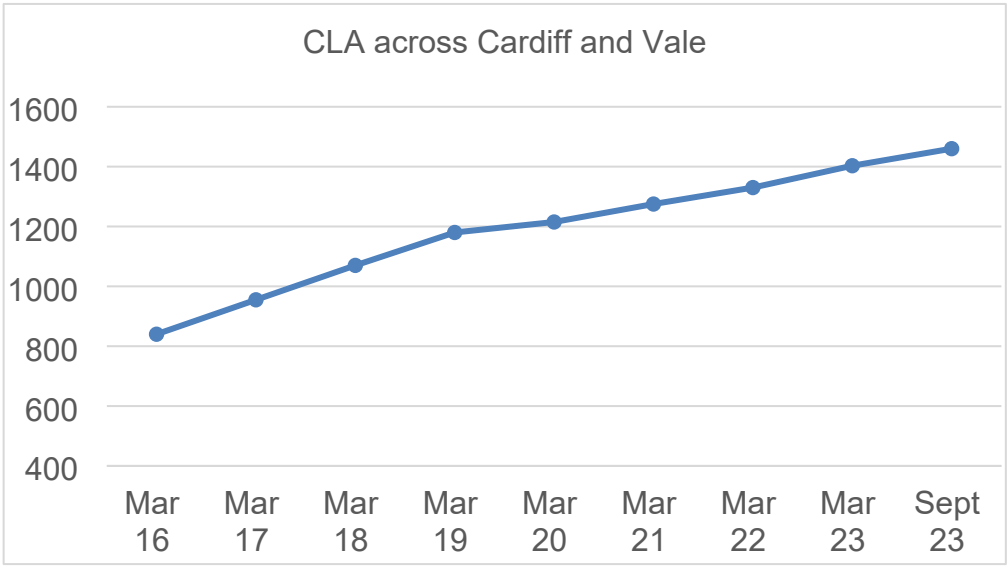
- Through Early Years Pathway, development of Community Connectors to work with children and families on the ND waiting list.

- Development of ND website, similar to the Emotional Wellbeing and Mental Health website developed.

- Engagement with Silvercloud, who have developed a Supporting a Child with ADHD programme. This is currently in review by the NHS Wales clinical project team for consideration and appropriateness.

CLA

There has been a consistent growth in the number of Children Looked After across Cardiff and Vale. There are currently 1,400 across the region compared to 1,280 pre COVID.



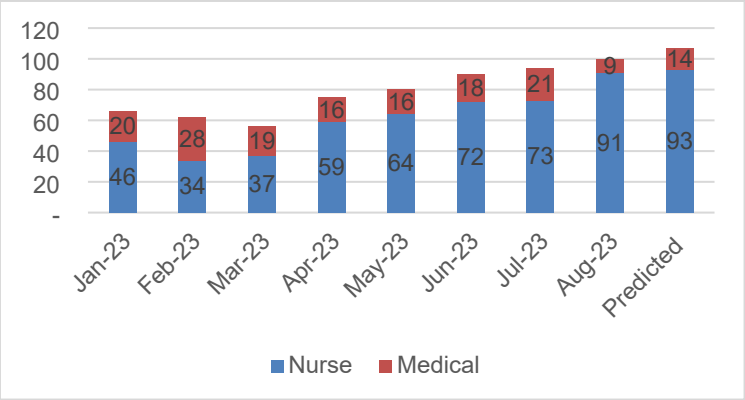
Statutory regulations stipulate that within 28 days of a child being accommodated by the local authority they should have a holistic health assessment. For children under the age of 5 years a review health assessment should be undertaken every 6 months, for those aged 5+ years this should be completed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

The increase in numbers of Looked after have a significant impact on the number of Initial & review Health Assessments required each year.

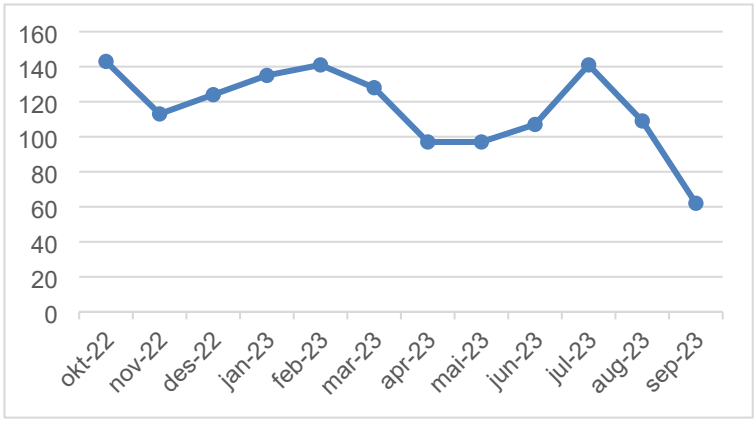
An additional 2.90 WTE nurses have been appointed to increase the nursing workforce to 7.10wte. Nurses are now undertaking all initial and review health assessments for children over 5. Prior to March 2023 medical staff were undertaking all health assessments for children under 10.

The graphs below demonstrate the increase in Heath Assessments undertaken and the reduction in the backlog of Health Assessments.

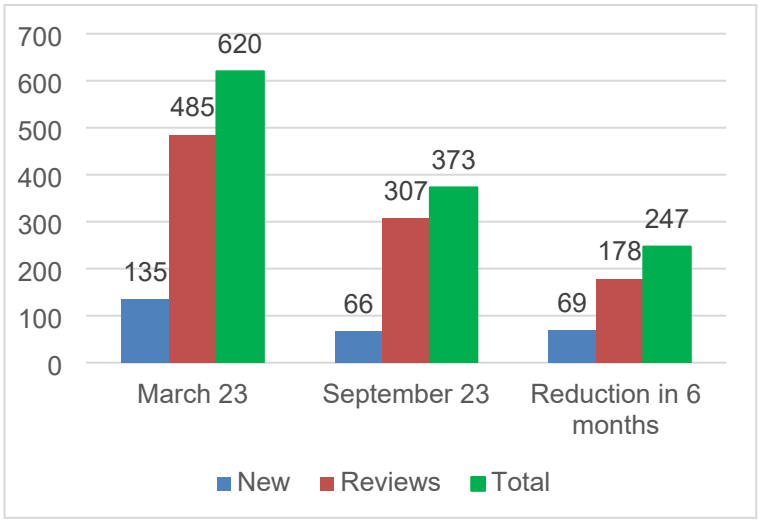
Graph x - Number of Health Assessments undertaken



Graph x - Number of Initial Health Assessments outstanding



Graph 3 – Backlog of Health Assessments – reduction March 2023 to September 2023



Whilst there has been a significant improvement in the numbers waiting, meeting these regulations continues to be a challenge within the current workforce, specifically in respect of under 5s.

Alternative staffing models have been explored to consider options to address the backlog, meet current demand and also to manage caseload in line with recommendations.

- Immediate review of role of trainee doctors and their contribution to health assessments for under 5s.
- Review of completion of under 5s. These children require 2 health assessments per annum, currently undertaken by Medics. Consideration is being given to the nurse / health visiting completing one of the two annual assessments.

- Further nurse recruitment to consider Health Visiting roles, in addition to traditional Clinical Nurse Specialist roles.
- Review of outcomes from an Audit of quality of Health Assessments and information sharing. The audit will look at the quality and how differences information shared has an impact of the time the assessment takes, which will have a direct impact on the number of assessments that can be completed.

Eating Disorders

In November 2021, the Eating Disorder Team was established to address the long waits for children and young people to be seen for Eating Disorders.

The specialist team is led by a Clinical Psychologist, to work closely with children and young people with severe eating disorder presentations. The service is able to offer a holistic wraparound provision , providing both assessment and treatment for Eating Disorders using the Maudsley model.

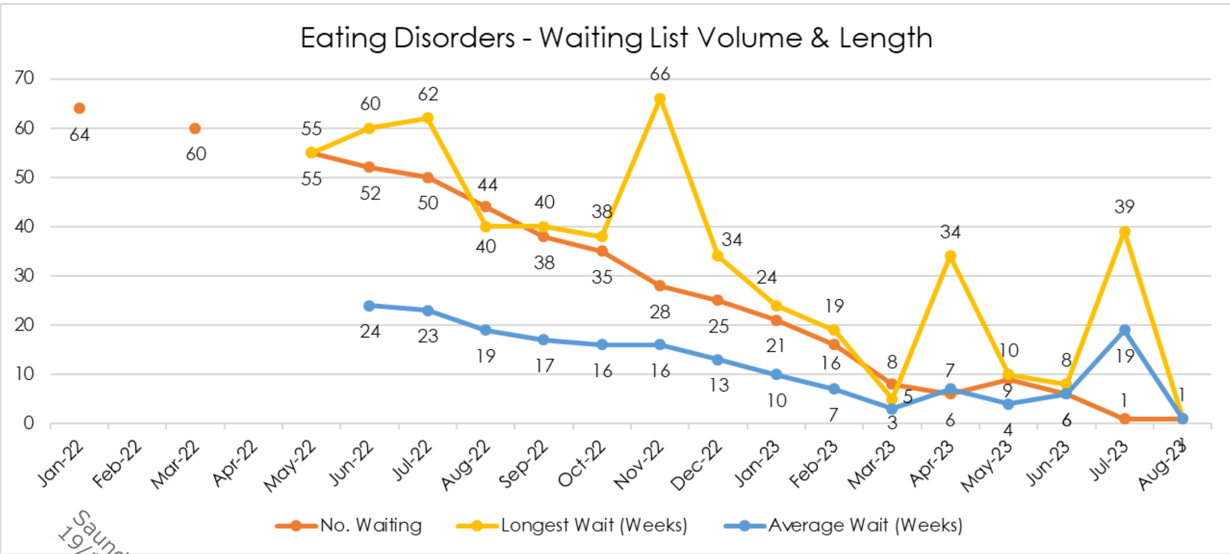
The multidisciplinary team consists of psychology, family therapy, nursing, psychiatry, dietician, support worker, and substantive Consultant Paediatrician. The team have also recruited transition workers to support young people who require onward support in adult services.

The team work closely with the Core team, Community Intensive Therapy Team and the Intensive Home Treatment team. They also work closely with our local Eating Disorder transition service for 16-25, and all Wales Tier 4 Eating Disorder Outreach Service.

Children and young people are now able to have an appointment within a week of referral.

	Jun 22	Sept 22	Dec 22	Mar 23	Jun 23	Sept 23
No. on waiting list	52	38	25	8	6	1
Longest wait	60	40	34	5	8	1
Average wait		17	13	3	6	1

Graph x – Eating disorders waiting list and volumes



As the waiting list has now reduced, the team are now able to support the wider health system both within the Health Board and across partners. The team will offer support to our Assessment Team with joint assessment work to help develop their skills in recognising Eating Disorders, and provide additional support in our Single Point of Access who offer consultation to professionals Monday to Friday between the hours of 10:00-14:00. This will support a more robust referral process and collaboration with Primary Care and other referrers.

Additionally, the team are thinking about how they can engage more with education and provide psycho-education around food as part of an early intervention offer.

Recommendation:

The Board / Committee are requested to note the content of the paper and the actions taken to mitigate the risks associated child health assessments.

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

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.

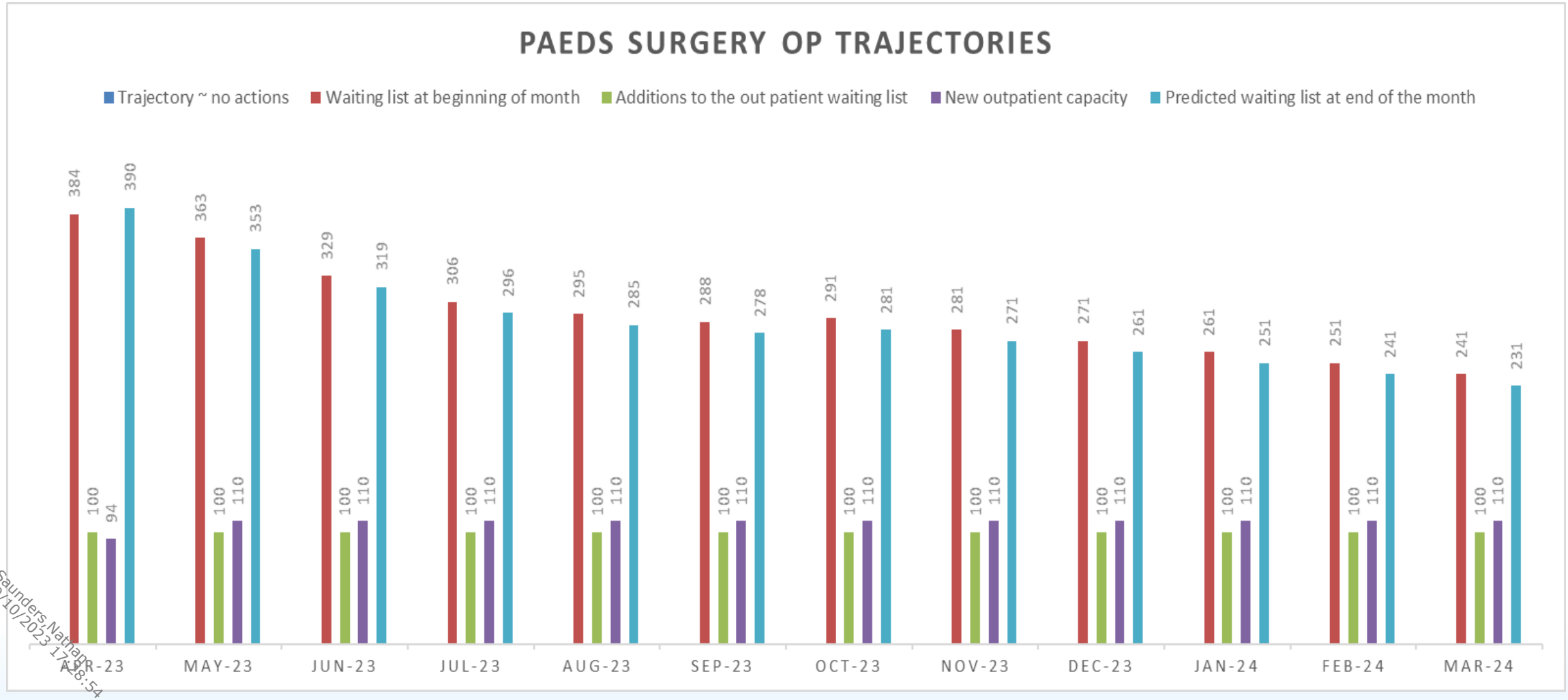
Risk: Yes
This has been risk assessed and entered onto the Risk Register
Safety: Yes
In the main body of the report
Financial: Yes
Immediate financial risk has been mitigated by redirecting resource to CLA service due to risk being held.
Workforce: Yes
Detailed in body of the report
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation:No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Acute Child Health
Update on Paediatric Surgery Waiting Times

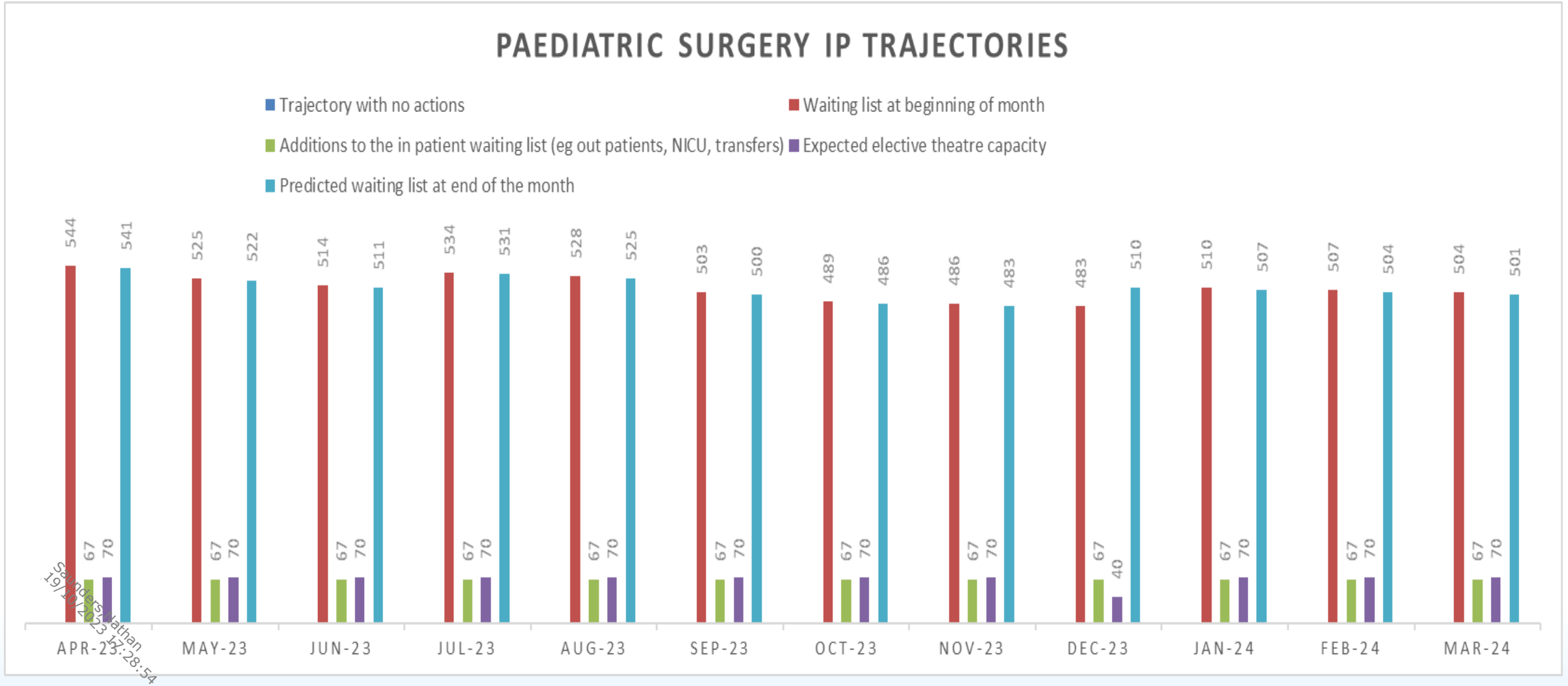
Paediatric Surgery OP WL



Paediatric Surgery OP WL

- The paediatric surgery OP WL is predicted to reduce by the end of March 24.
- On average looking at the referral rate 100 patients are being added to the list each month
- The service is treating approximately 110 new patients per month

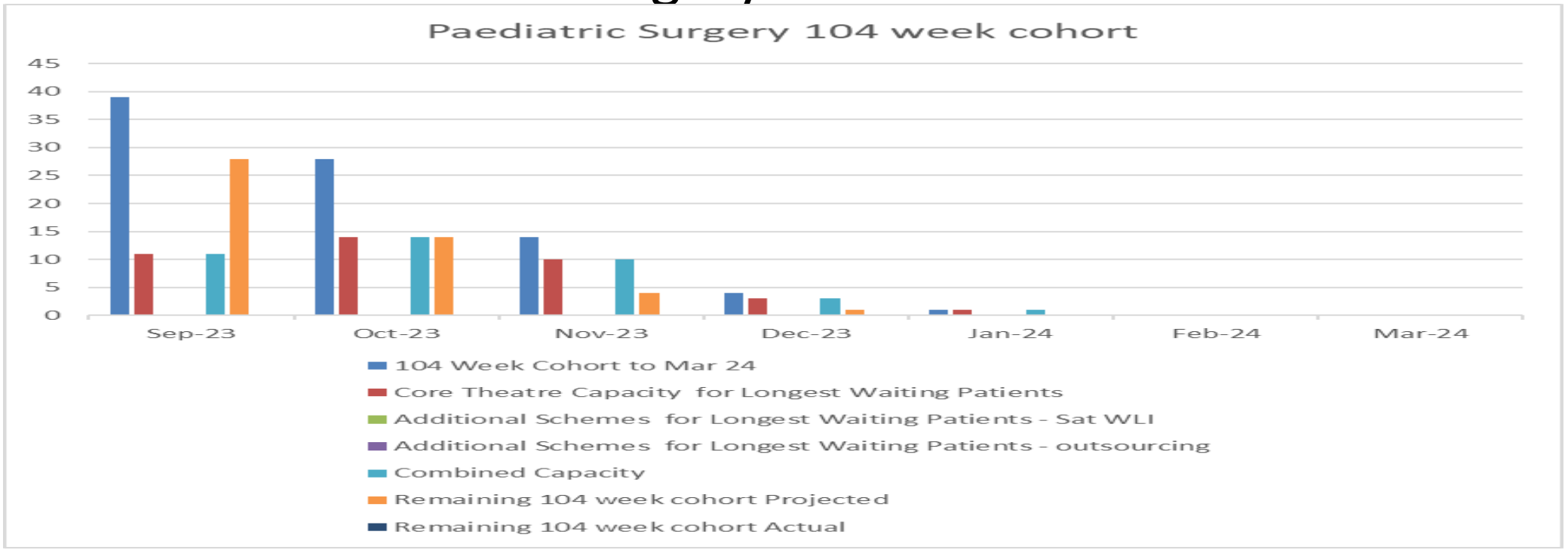
Paediatric Surgery IP WL



Paediatric Surgery IP WL

- We are currently scheduling approximately 75 elective cases each month and with cancellations taken into consideration treating around 70 cases. This is based on our current theatre capacity.
- WHSSC LTA is set at 87 elective patients to be treated each month. Our current theatre capacity does not allow for this.
- Additional theatre capacity is being explored
- We are on average seeing 67 patients added to the list each month.

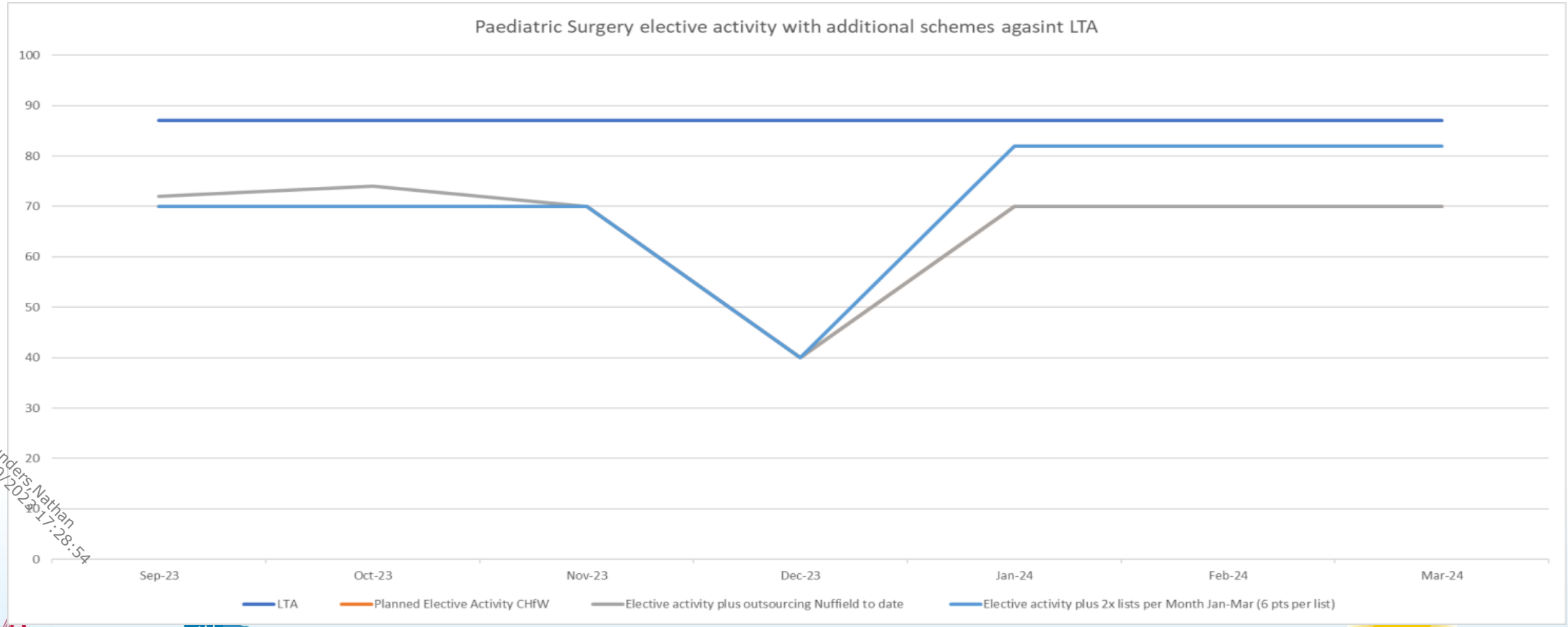
Paediatric Surgery IP 104 Week Cohort



We are currently on track to deliver 0 104 week waits for paediatric surgery by end of March as part of planned care.

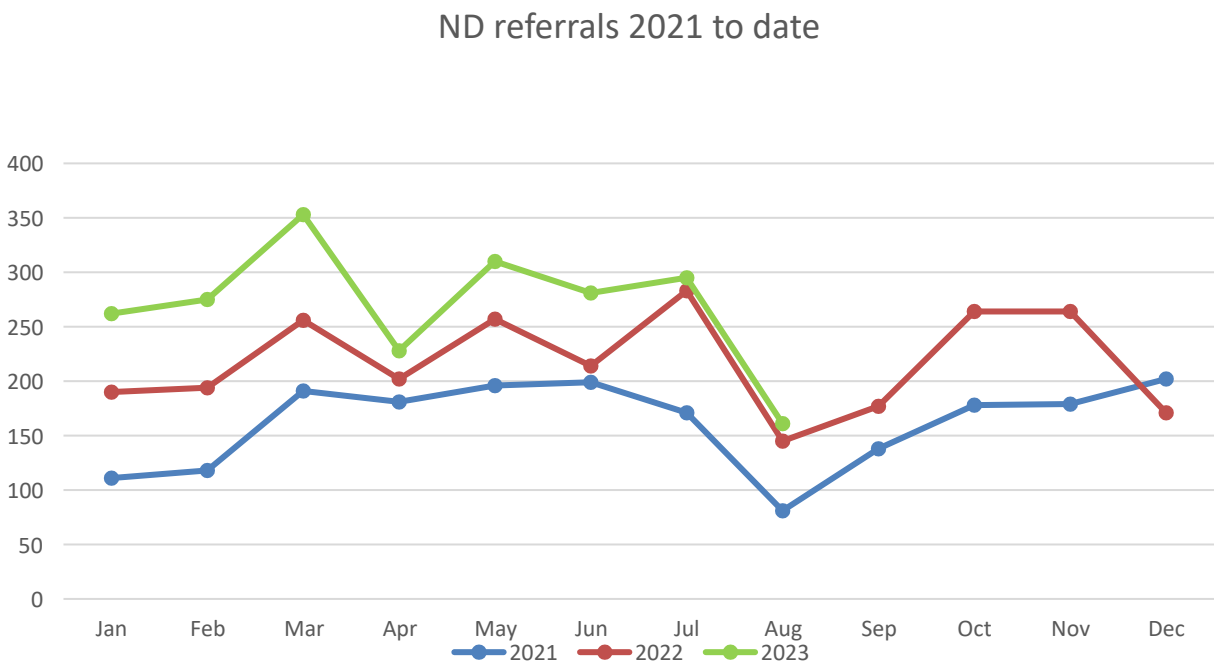
Paediatric Surgery Revised Trajectory with Additional Activity

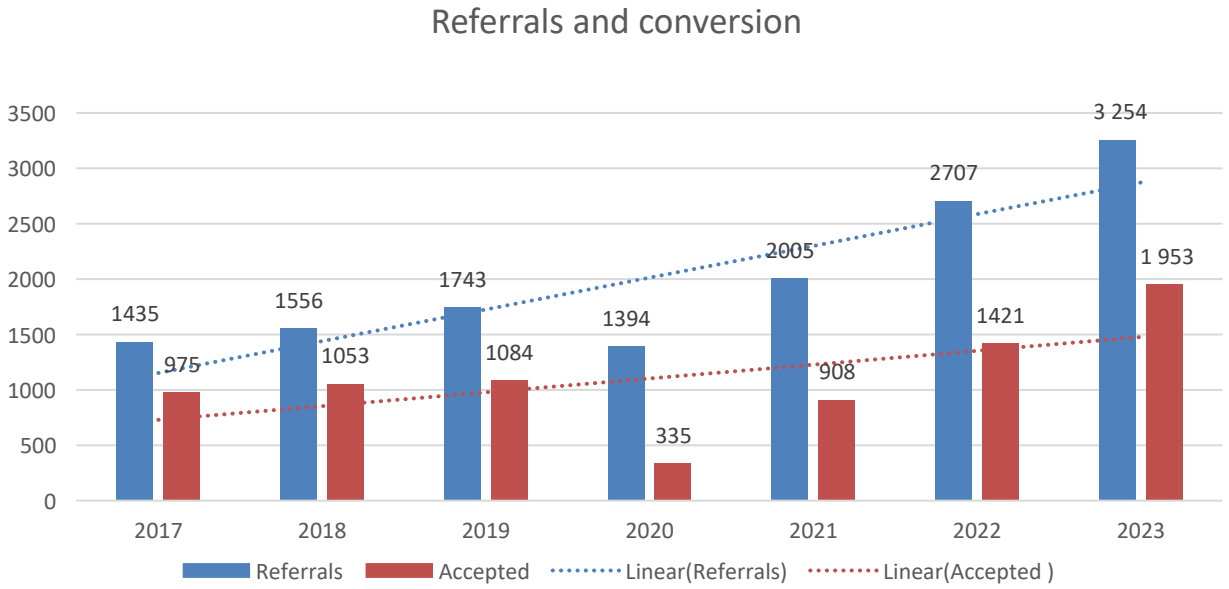
A revised trajectory has been set based on an additional 2 all day theatre lists a month from January 2024 to get monthly activity up to 82 patients against the WHSSC LTA.



CYPFHS
Update on waiting times

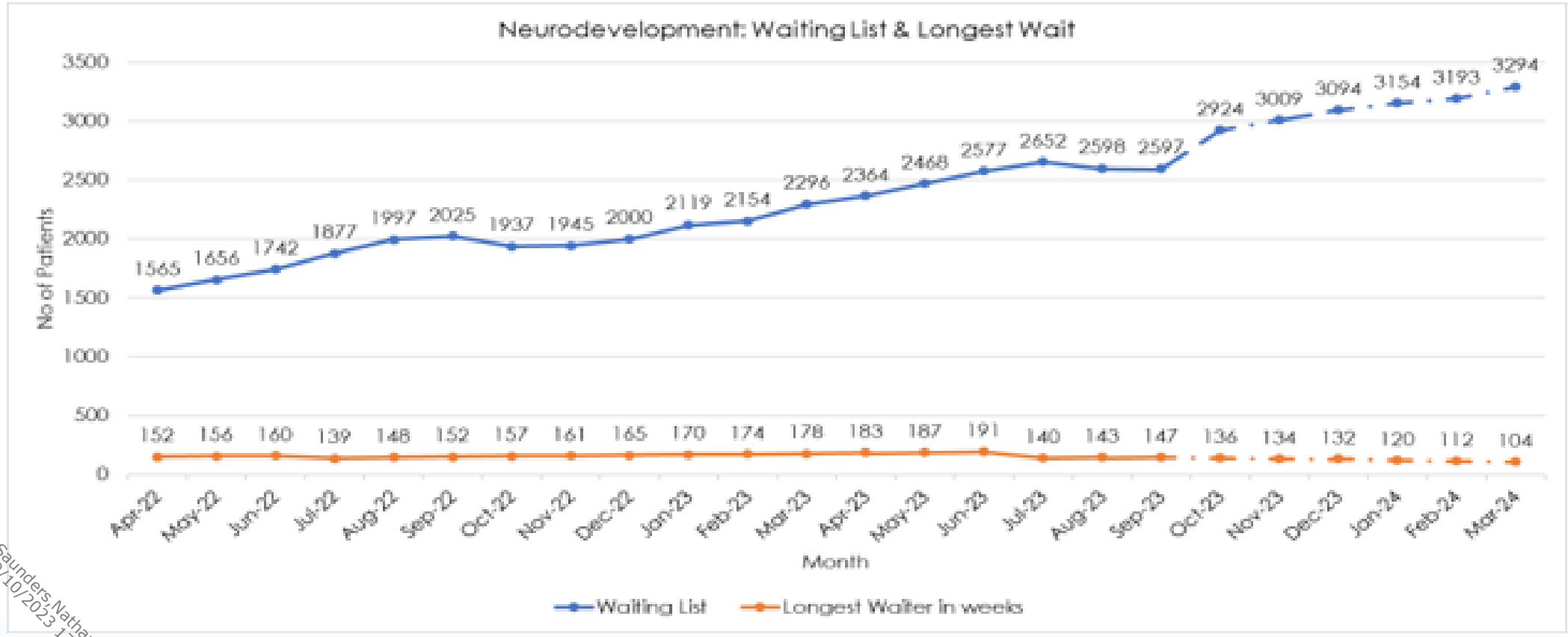
Neurodevelopment





- **Referrals** -significant increase in referrals since 2019. 55% 2019 to 2022 with a further 20% predicted in 2023.
- **Conversion** – currently 60% of referrals added to list

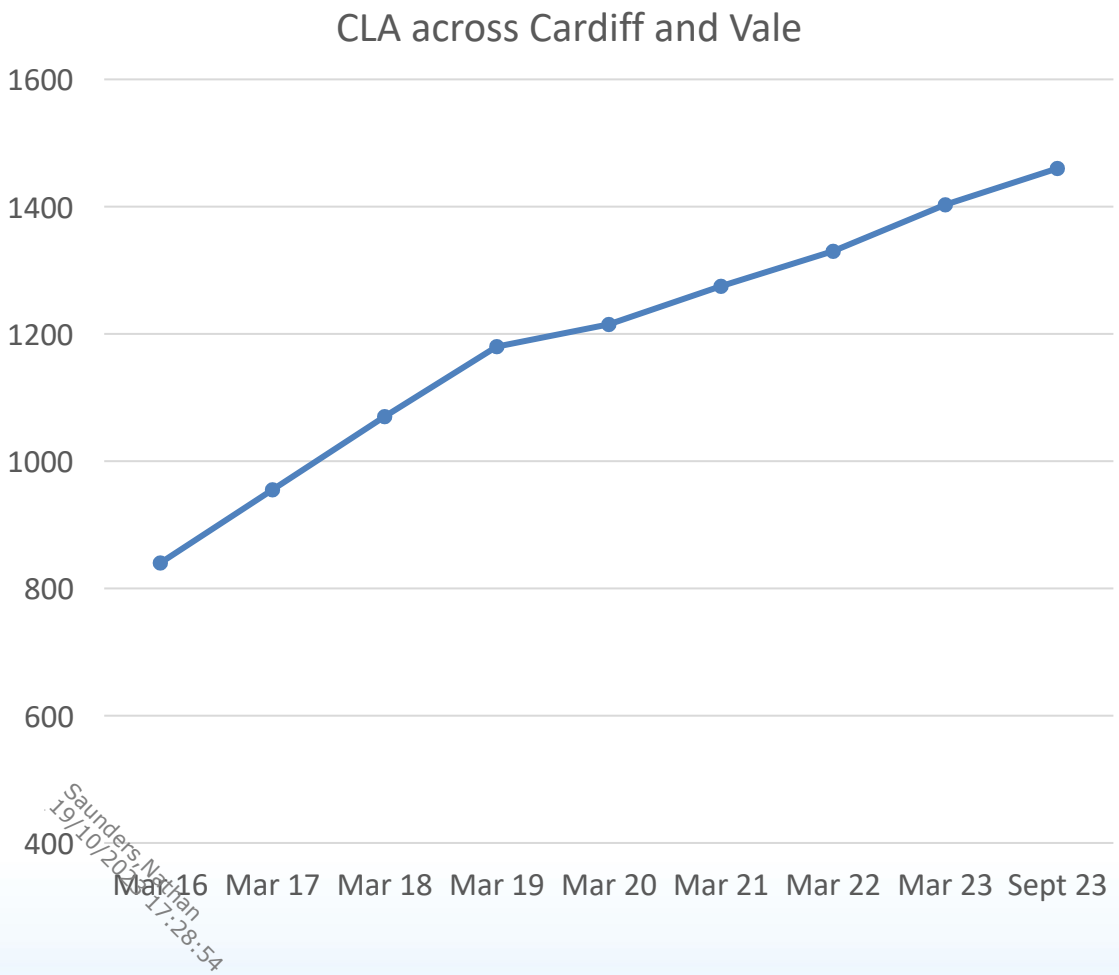
Neurodevelopment – waiting times



Neurodevelopment – actions

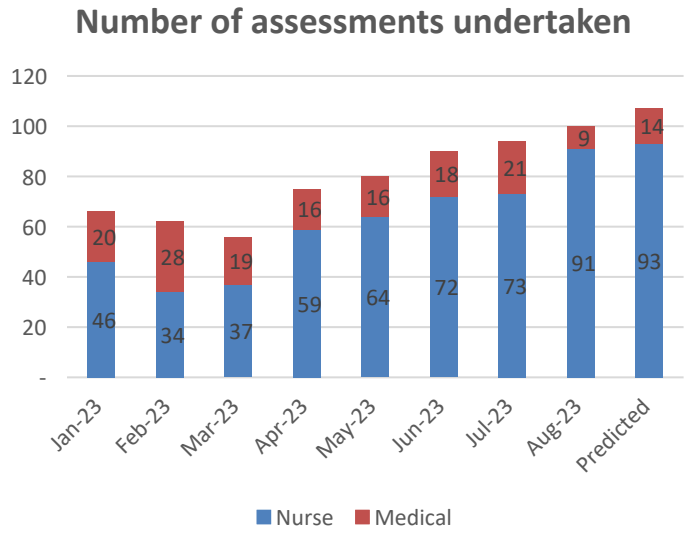
- Recruitment – additional investment
- E referral form launched
- Review triage process
- Health Pathways
- Community Connectors
- Website
- Silvercloud

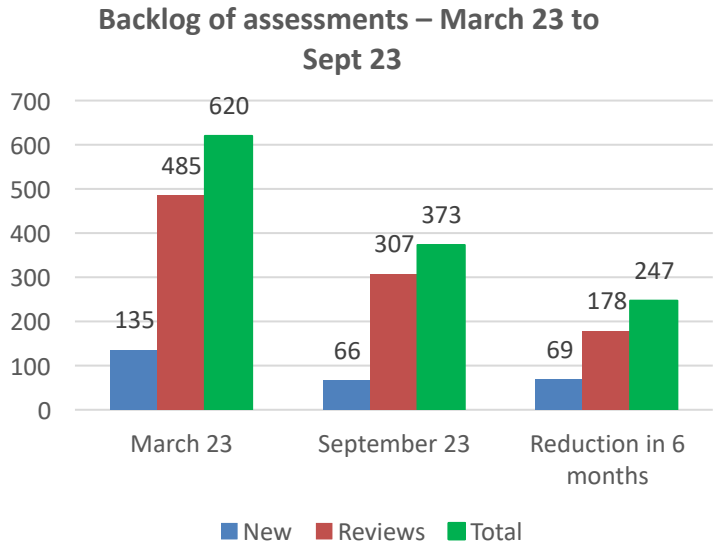
Children Looked After

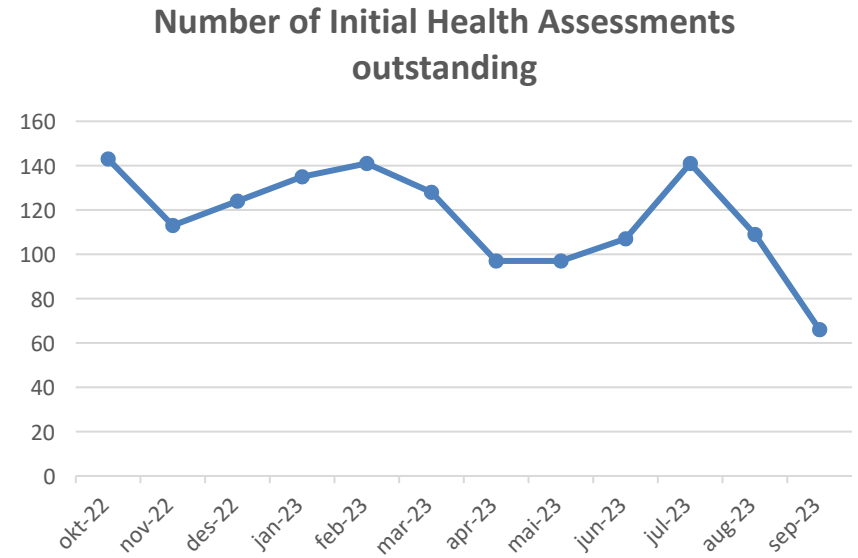


- Significant growth in the number of children Looked After in Cardiff and Vale.
- Statutory regulations stipulate that within 28 days of a child being accommodated by the local authority they should have a holistic health assessment. For children under the age of 5 years a review health assessment should be undertaken every 6 months, for those aged 5+ years this should be completed annually.
- The increase in numbers of Looked after have a significant impact on the number of Initial & review Health Assessments required each year.
- Additional nurses have been appointed, and expand role to undertake all initial and review health assessments for children over 5. Prior to March 2023 medical staff were undertaking all health assessments for children under 10.

Children Looked After – impact of recruitment







- Increase in assessments undertaken – 66% increase since Jan 23
- Impact on backlog – focus in initial health assessments and urgent reviews
- Whilst there has been a significant improvement in the numbers waiting, meeting these regulations continues to be a challenge within the current workforce, specifically in respect of under 5s.

Children Looked After - actions

Alternative staffing models have been explored to consider options to address the backlog, meet current demand and also to manage caseload in line with recommendations.

- Immediate review of role of trainee doctors and their contribution to health assessments for under 5s.
- Review of completion of under 5s. These children require 2 health assessments per annum, currently undertaken by Medics. Consideration is being given to the nurse / health visiting completing one of the two annual assessments.
- Further nurse recruitment to consider Health Visiting roles, in addition to traditional Clinical Nurse Specialist roles.
- Review of outcomes from an Audit of quality of Health Assessments and information sharing. The audit will look at the quality and how differences information shared has an impact of the time the assessment takes, which will have a direct impact on the number of assessments that can be completed.

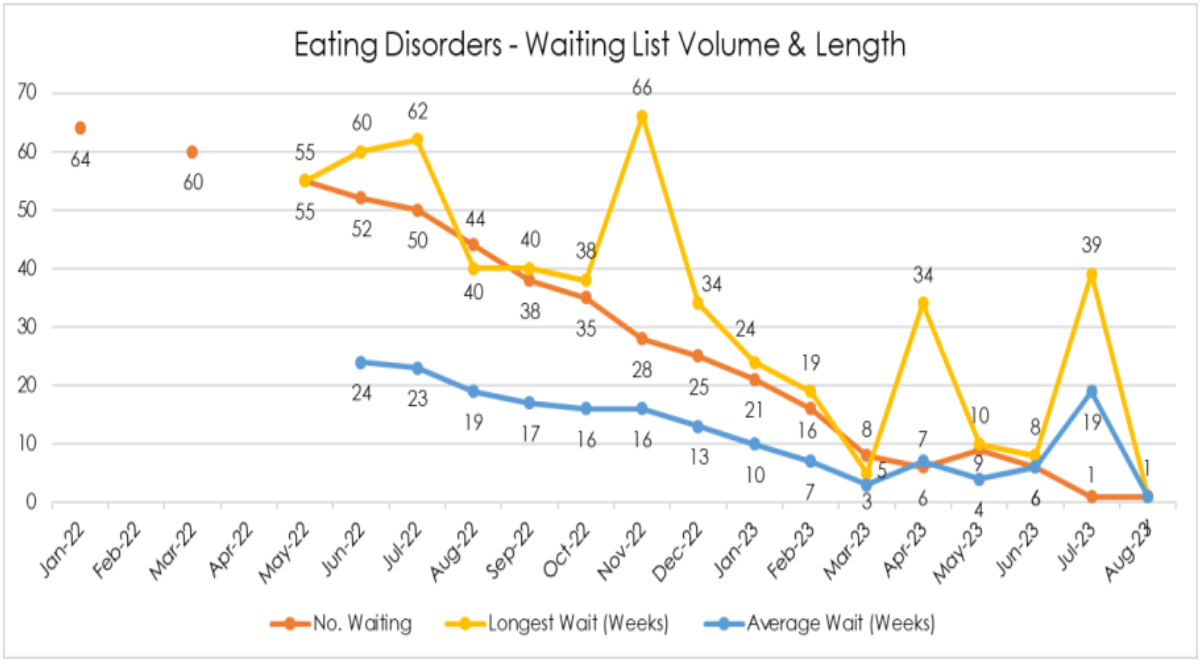
Paediatric Eating Disorders

- Specialist Eating Disorder Team was established to address the long waits for children and young people to be seen for Eating Disorders.

- Provides a holistic wraparound provision, providing both assessment and treatment for Eating Disorders using the Maudsley model.

- Multidisciplinary team, led by a Clinical Psychologist.

- The team work closely with the Core team, Community Intensive Therapy Team and the Intensive Home Treatment team, local Eating Disorder transition service for 16-25, and all Wales Tier 4 Eating Disorder Outreach Service.



- **Children and young people are now able to have an appointment within a week of referral.**

Paediatric Eating Disorders – next steps

As the waiting list has now reduced, the team are now able to support the wider health system both within the Health Board and across partners.

- The team will offer support to our Assessment Team with joint assessment work to help develop their skills in recognising Eating Disorders

- The team will provide additional support in our Single Point of Access who offer consultation to professionals Monday to Friday between the hours of 10:00-14:00. This will support a more robust referral process and collaboration with Primary Care and other referrers.

- Additionally, the team are thinking about how they can engage more with education and provide psycho-education around food as part of an early intervention offer.

Report Title:	Maternity thematic review				Agenda Item no.	2.3	
Meeting:	Public QSE		Public	X	Meeting Date:	25.10.2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Jason Roberts Executive Nurse Director						
Report Author (Title):	Abigail Holmes, Director of Midwifery and Neonatal Service						

Main Report
Background and current situation:

In March 2022 the second and final report by Donna Ockenden into the Maternity Services at Shrewsbury and Telford NHS Trust was published. This report outlined systemic failings within Maternity and Neonatal services that resulted in avoidable harm to mothers and babies within their care. The report outlined 89 recommendations that all Trusts /Health Boards in the UK should adhere to, to improve the quality of maternity and neonatal services. Following its publication an immediate self-assessment of the Cardiff and Vale Maternity and Neonatal services was undertaken against the Ockenden recommendations, concluding that 45 of the recommendations were already met, 27 partially met, and 17 not met at all.

In November 2022 Health Inspectorate Wales (HIW) attended the Maternity Unit at the University Hospital Wales for an unannounced inspection. The investigation team were present within the maternity unit for two days. During their inspection they meet with staff and families, reviewed all clinical areas and reviewed evidence relating to workforce, risk and governance structures and patient outcomes. Following the review, the service was given eight immediate assurances addressing; quality of patient experience, delivery of safe and effective care, education and training, workforce and quality of leadership and management. A secondary unannounced inspection was performed in March 2023 finding significant and sustained improvements to the Maternity services at Cardiff and Vale University Health Board with the combined inspection report published in June 2023. Further assurance was provided to HIW in September 2023 with all actions in the improvement plan set to be completed by January 2024, remaining actions include;

- The implementation of Purpose T risk assessment tool for pressure damage prevention,
- Recruitment to the psychologist post for staff and patient wellbeing
- Obstetric theatre staffing model (business case prepared)
- Non-clinical midwifery escalation rota audit
- Relocation of the senior midwifery leadership team to the clinical areas

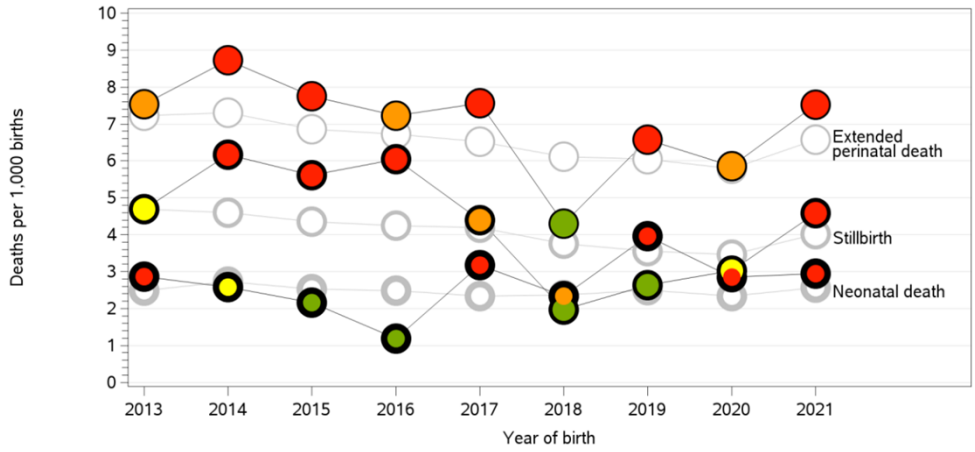
In July 2023 the Maternity and Neonatal Safety Support Programme (MatNeoSSP) Wales published its first report into Maternity and Neonatal Services across Wales. The report outlined 16 priority areas with 110 recommendations. A further gap analysis was performed within Cardiff and Vale Maternity Services Identifying 31 unmet recommendations from the MatNeoSSP. A mapping exercise has been undertaken to track the recommendations from Ockenden, HIW and MatNeoSSP.

In August 2023 the Cardiff and Vale MBBRACE report identified a small but sustained increase in both rates of stillbirth and Neonatal Deaths with Cardiff and Vale University Health Board. The MBBRACE relates to birth up to 2021 as outlined in the infographics below.

Crude mortality by year of birth (all deaths)

Crude mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

Due to updates to the data, these results might differ slightly from those in previous reports.



Perinatal mortality (all deaths)

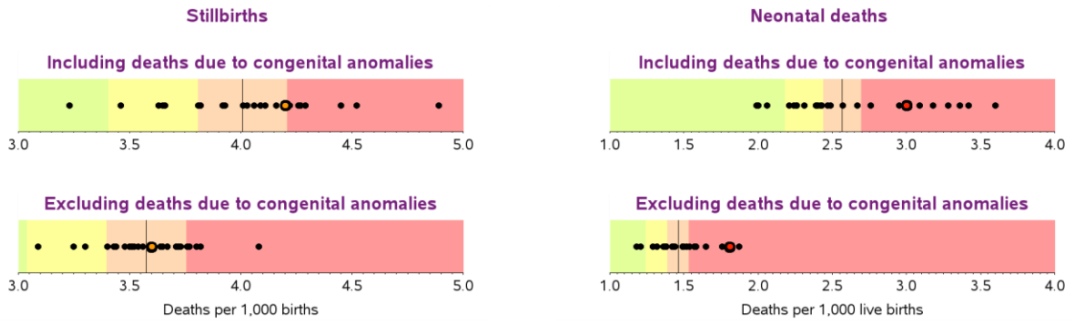
Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	25	4.59	4.20	(3.23 to 5.39)	Up to 5% higher or up to 5% lower
Neonatal	16	2.95	3.00	(2.05 to 4.43)	More than 5% higher
Extended perinatal	41	7.52	7.17	(6.16 to 9.24)	More than 5% higher

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	20	3.68	3.60	(2.94 to 4.40)	Up to 5% higher or up to 5% lower
Neonatal	12	2.21	1.81	(1.11 to 2.88)	More than 5% higher
Extended perinatal	32	5.88	5.37	(4.59 to 6.79)	More than 5% higher

Comparisons with similar Trusts, Health Boards and the UK average

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a circle:



- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group

Trusts and Health Boards whose mortality rates are marked ● or ● should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

The Ockenden report, HIW inspection report and MatNeoSSP report have been cross referenced identifying four common themes;

- Workforce
- Patient safety, Quality and Experience
- Training and Education
- Leadership and Team Working

In response to these emerging themes and to ensure services are aligned with all recommendations the Health Board agreed investment into the Maternity and Neonatal services of £2.7million. The areas for improvement identified within each theme are described below.

Workforce

The most recent BirthRate+ assessment was undertaken in November 2022 identifying a midwifery shortfall of 11 whole time equivalent midwives (WTE). The investment into maternity services has seen the funded midwifery establishment increased from April 2023 to reflect the November 2022 BirthRate+ assessment. The MatNeoSSP, HIW and Ockenden all sited workforce as fundamental to safe care, making recommendations for recruitment and retention, skill mix, succession planning and workforce development.

During the summer of 2022 it was recognised that significant midwifery workforce shortages were impacting on patient care and staff wellbeing as described in the HIW inspection immediate actions November (2022). Midwifery recruitment is limited to one output a year of newly qualified midwives (NQM). In October each Health Board in Wales employs NQM's based on University commissioning numbers. Discussions are currently ongoing with our University partners and Welsh Government regarding the feasibility of two midwifery outputs each year to support and maintain the midwifery workforce.

In October 2022 26wte NQM joined the Health Board, the impact of this was reflected in the March (2023) HIW inspection, and was realised through a reduction in clinical delays in care, and reported clinical incidents (via Datix Cymru) improved staff wellbeing, reduced levels of sickness.

In August 2023 the Health Board was offered the opportunity to increase the number of NQM's employed from the October output above our commissioned numbers due to the increased number of newly qualified midwives requesting to work within Cardiff and Vale and in October 2023 35wte midwives have joined the organisation, this has enabled all midwifery vacancies to be filled as we approach the end of 2023.

Within the maternity unit there is a 16 bedded neonatal transitional care unit, this unit is staffed with midwives and nursery nurses (band 4). Ockenden recognised the requirement for transitional care units to be staffed in partnership with Midwives and Neonatal nurses. The investment into the services has seen the recruitment of 6 band 5 neonatal nurses to support the TC unit. This is the recognised optimal standard of care model by the British Association of Perinatal Medicine (BAPM) and supports keeping families together (MatNeoSSP, Ockenden) by utilising models of best practice.

Both the Ockenden and MatNeoSSP report recognised the need for minimum staffing levels that must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave. An All Wales approach is required to develop maternity services uplift for midwifery staffing levels. Maternity leave does not currently inform the Save Staffing act (2016) uplift of 26.9%. Within Children and Womens clinical board the current rate of maternity leave is 4.2% of the workforce.

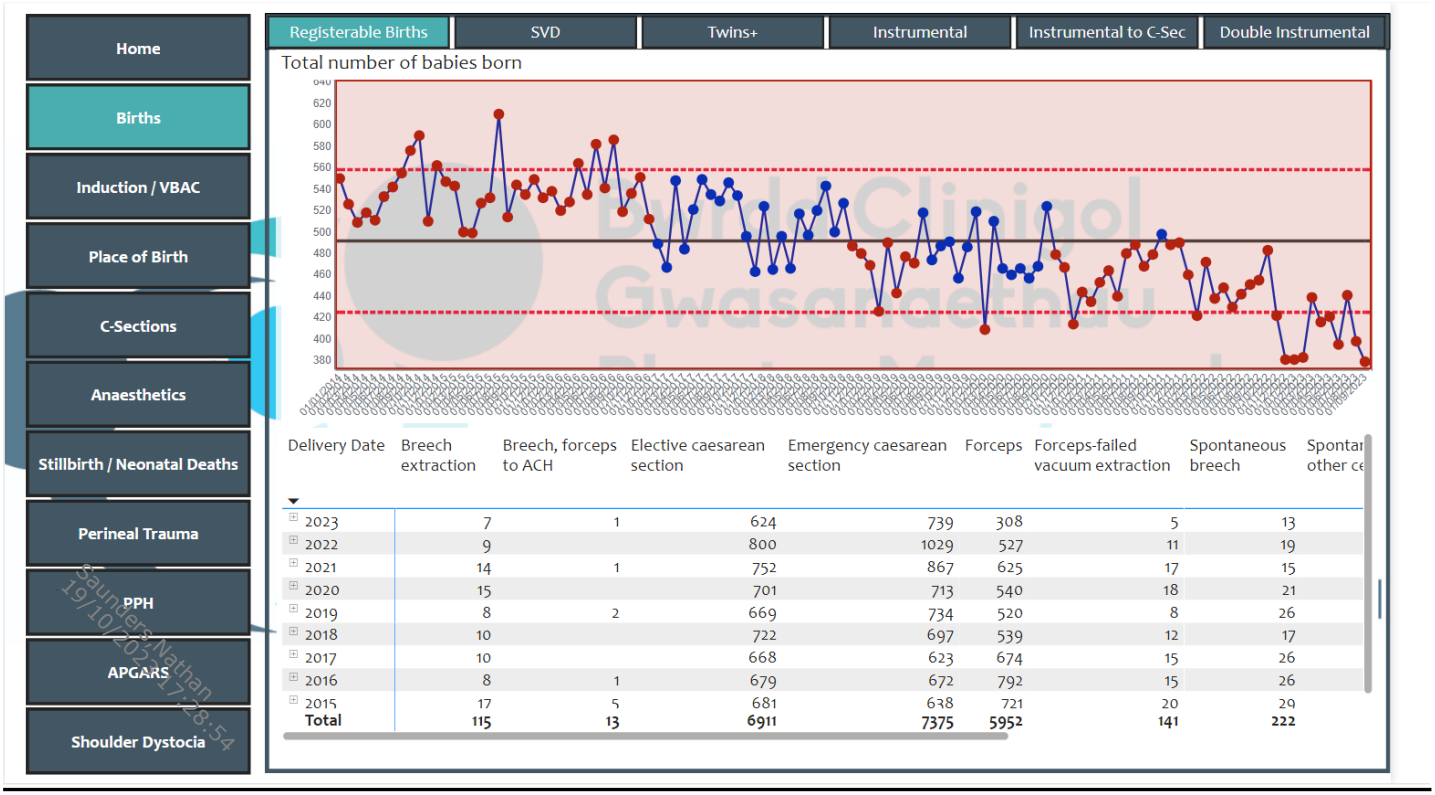
Patient Safety, Quality and Experience

Following the publication of the Ockenden report a maternity and neonatal oversight panel was established with executive membership to ensure oversight of the quality and performance of maternity and neonatal services. The Executive team also have daily oversight of the maternity and neonatal services through Sitrep reporting, with floor to board escalation pathways embedded in practice. Cardiff and Vale maternity services will move to Safe Care by the end of the year to ensure clear reporting pathways for red flag events and at-risk areas of the service.

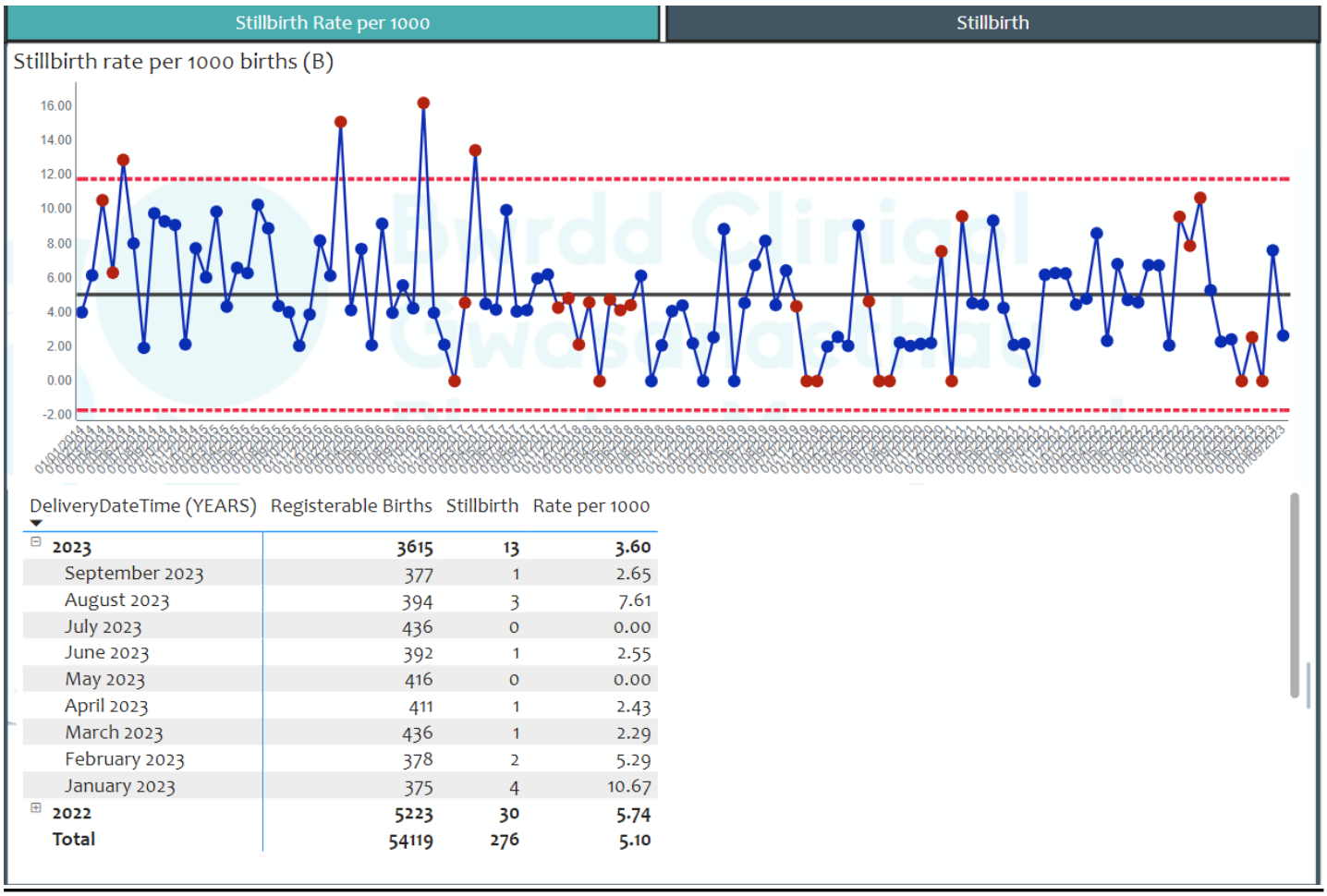
The HIW inspection sited concerns with pathways of care with the mixing of antenatal (pregnant) women and women that had recently given birth, it was felt that this impacted on the ability of midwives to provided individualised care to women that resulted in delays in care. To resolve this the maternity ward has been reconfigured to ensure single rooms are available in all areas to maintain the privacy and dignity for women.

Both the Ockenden and MatNeoSSP recommendations are clear that incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner, The HIW inspection findings raised concerns that clinical incidents where not reviewed in a timely manner resulting in delays in identifying learning. The Investment into maternity and neonatal services has enabled to review of our governance structures, both maternity and neonatal services have appointed a senior Nurse/Midwife for patient safety and governance to ensure robust reporting mechanisms are in place to facilitate thematic analysis, learning and improvement. A datix Cymru lead for maternity services has been appointed to ensure all reported clinical incidents are reviewed within 24 hours and the appropriate action taken.

In January 2023 the maternity dashboard with created to ensure oversight and ownership for all maternity and neonatal; outcome data, below is an example of the data collected. The dashboard enables trends in the data to be identified and action taken when deviations from a normal range are identified.

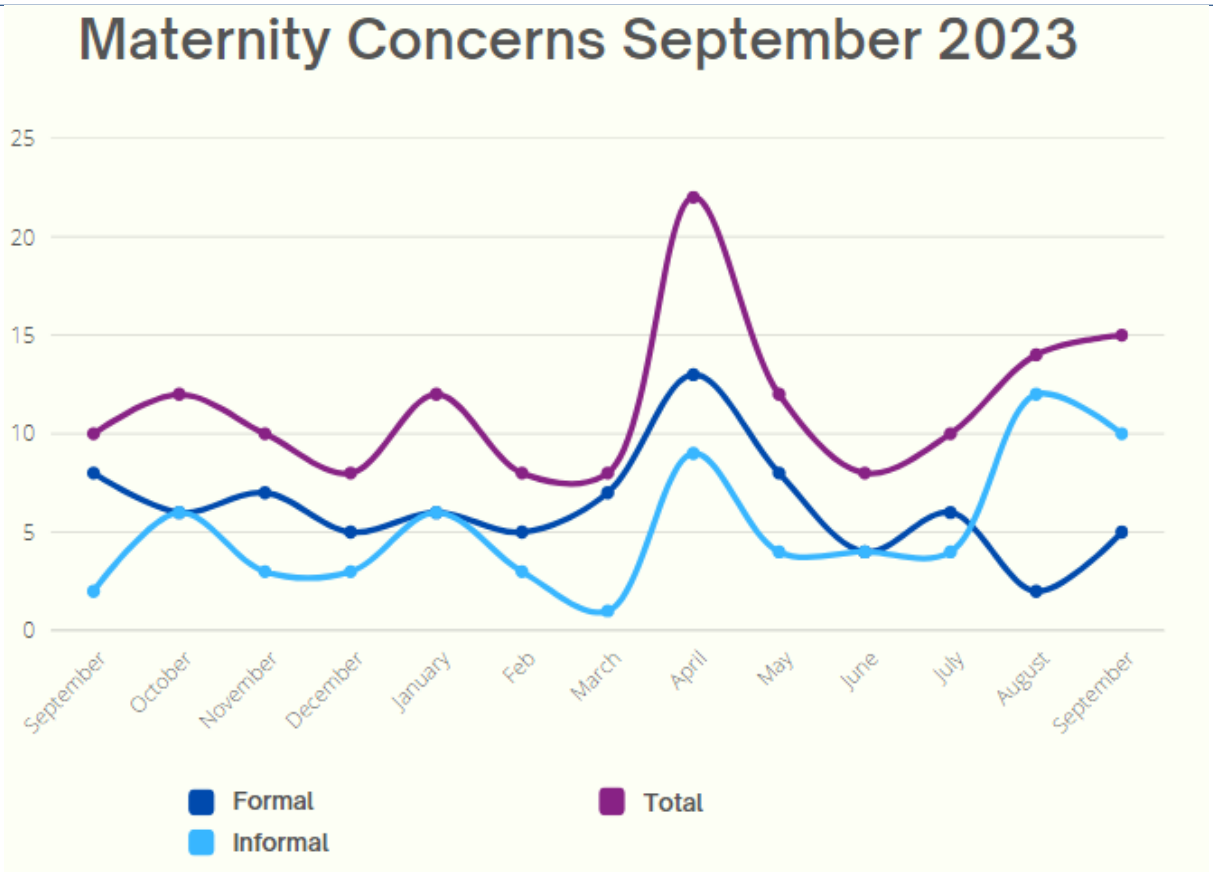


The dashboard data demonstrates a significant downward trajectory the stillbirth rate for 2023 (crude unadjusted rates).



DeliveryDateTime (YEARS)	Registerable Births	Stillbirth	Rate per 1000
2023	**3615**	**13**	**3.60**
September 2023	377	1	2.65
August 2023	394	3	7.61
July 2023	436	0	0.00
June 2023	392	1	2.55
May 2023	416	0	0.00
April 2023	411	1	2.43
March 2023	436	1	2.29
February 2023	378	2	5.29
January 2023	375	4	10.67
2022	**5223**	**30**	**5.74**
Total	**54119**	**276**	**5.10**

Patient experience data is captured via our Experience Midwife, compliments and concerns is collated every month and share with staff to inform learning and service development. Civica data is also captured monthly and used to inform service improvements. The HIW inspection observed many examples of staff being compassionate and kind, however privacy and dignity was a concern in some areas on the maternity ward. Due to the layout and design of the ward women are often in bays during the induction of labour care. Work has been completed to establish three single rooms on the antenatal area of the ward (nine induction of labour beds are on the ward) women are assessed to ensure those with additional needs are offered single rooms, birth partners are also able to remain on the ward throughout the induction of labour process. Below is our concerns data for 2023. Both Ockenden and MatNeoSSP prioritise psychological needs of staff so that teams are able to deliver kind compassionate and safe care.



Training and Education

Following the publication of the Ockenden report all health boards were required to ensure that robust preceptorship programs for newly qualified midwives were in place. Following the HIW inspection it was recognised that the Cardiff and Vale induction program was not sufficient with NQM's stating they did not feel supported during their supernumerary period. For 2023 the induction program has been redesigned with the appointment of a band 7 preceptorship led midwife (first in Wales) who will supported the NQM's through their first year of practice.

Both Ockenden and MatNeoSSP recognised the importance of human factors training, labour ward leaders' education and specialist midwifery skills, stating that all Trusts / Health Board must mandate annual human factor training for all staff working in a maternity setting. The HIW inspection found staff felt unable to escalate, as pathways of escalation were unclear. To resolve this all escalation pathways have been rewritten and shared with staff. Wider escalation to senior and executive teams happens four times a day through Sitrep reporting mechanisms. In September 2023 Cardiff and Vale commissioned the human factors training from baby lifeline for all band 7 midwives and consultant Obstetricians, this included the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. Cardiff and Vale has also developed an in house (first in Wales) High dependency training (HDU) training for midwives to meet the requirement that All trusts / Health Hoards must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.

During the November (2023) HIW it was recognised that both midwifery and obstetric mandatory training for fetal surveillance and Practical Obstetric Multi-Professional Training (PROMPT) compliance was not of an acceptable standard. During the Summer of 2022 a number of study days

were canceled due to clinical activity. All study days have been reinstated with compliance rates increasing to 87.5% for PROMPT and 87.7% for Fetal Surveillance.

Leadership and Team Working

The HIW report inspection report found that there was no assurance that there was supportive culture in place and that the leadership and management team were not sufficiently focused and robust. Ockenden and MatNeoSSP both support a Director of Midwifery for each health Board. In June 2023 a Director of Midwifery was appointed. Monthly Executive walk rounds have been taking place since April 2023 and will continue. A member of the senior midwifery leadership team attends the central delivery suite handover daily. Monthly communication sessions are held for all staff to attend either in person or virtually. Weekly written communication is shared with all staff and Director of Midwifery VLOG are shared.

Multi-disciplinary (MDT) Safety huddles take place daily with, midwifery, obstetric, neonatal and anaesthetics in attendance. All mandatory training is MDT. Monthly MDT audit days take place. The Senior midwifery leadership team are in the process of moving office space so that they can be co-located in the clinical areas to provided ongoing support to staff. All senior midwifery managers work clinically at least once a month to maintain their clinical skills and to promote team working alongside all grades of staff.

In April 2024 a 3 year programme of work lead by the maternity and neonatal network in partnership with NHS Executive to set to priority work maternity and neonatal services from the MatNeoSSP.This work will shape the Maternity and Neonatal Services for Cardiff and Vale.

Recommendation:

The Committee is requested to:

Continue to have oversight of maternity and neonatal services and note the report.

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

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

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

Prevention	X	Long term	X	Integration		Collaboration		Involvement	X

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.	
Risk: Yes/No	
n/a	
Safety: Yes/No	
n/a	
Financial: Yes/No	
Workforce: Yes/No	
n/a	
Legal: Yes/No	
n/a	
Reputational: Yes/No	
n/a	
Socio Economic: Yes/No	
n/a	
Equality and Health: Yes/No	
n/a	
Decarbonisation: Yes/No	
n/a	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
19/10/2023 17:28:54

Report Title:	**Intraoperative Cell Salvage policy and procedure**			Agenda Item no.	3.1
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	25.10.2023
		Private			
Status *(please tick one only)*:	Assurance		Approval	X	Information	
Lead Executive:	**Executive Medical Director**				
Report Author (Title):	**Dr Simon Logan, Consultant Anaesthetist** **Barbara Jones, Perioperative Care Directorate Education Lead**				

Main Report

Background and current situation:

Whilst allogeneic (donated) blood is an essential adjunct to health care, it is a limited resource (subject to the threat of future shortages), increasingly expensive and can present a source of risk for patients, in particular the risk of "wrong blood" incidents as reported by the Serious Hazards of Transfusion (SHOT) 2023.

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that cell salvage is used safely and appropriately in order to avoid the risks of unnecessary autologous transfusion in our patients. Utilising appropriate alternatives to blood transfusion is cost-effective and complies with clinical governance requirements. The collection and re-infusion of autologous red blood cells provides an important contribution to reducing the demand for allogeneic blood. However, it is only one aspect of a strategic approach to safe and Appropriate transfusion practice. This policy is based on and fulfills all standards of Wales Intraoperative Cell Salvage Standards published by the Blood Health National oversight group (BHNOG) ICS workstream.

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

This is an existing policy and procedure that required a review and update of content.

Recommendation:

The Committee is requested to:

- **APPROVE** the Intraoperative Cell Policy and Procedure
- **APPROVE** the full publication of the Intraoperative Cell Salvage Policy and Procedure in accordance with the UHB Publication Scheme

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:

Saunders,Nathan
19/10/2023 17:28:54

Reference Number: UHB 030 **Version Number:** 3	**Date of Next Review:** **Previous Trust/LHB Reference Number:**

PROVISION OF INTRAOPERATIVE CELL SALVAGE POLICY

Policy Statement

Whilst allogeneic (donated) blood is an essential adjunct to health care, it is a limited resource (subject to the threat of future shortages), increasingly expensive and can present a source of risk for patients, in particular the risk of “wrong blood” incidents as reported by the Serious Hazards of Transfusion (SHOT) 2023.

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that cell salvage is used safely and appropriately in order to avoid the risks of unnecessary autologous transfusion in our patients. Utilising appropriate alternatives to blood transfusion is cost-effective and complies with clinical governance requirements. The collection and re-infusion of autologous red blood cells provides an important contribution to reducing the demand for allogeneic blood. However, it is only one aspect of a strategic approach to safe and Appropriate transfusion practice. This policy is based on and fulfills all standards of Wales Intraoperative Cell Salvage Standards published by the Blood Health National oversight group (BHNOG) ICS workstream.

Policy Commitment

By adhering to the accompanying Intraoperative Cell Salvage (ICS) Policy and Procedure we will ensure the UHB

- Promotes safer transfusion as part of clinical governance responsibilities
- Utilises ICS in a safe and effective manner
- Safely identifies suitable patients undergoing surgical procedures where ICS could be used
- Delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, by the lawful, safe and appropriate administration of blood/components according to current law, national guidelines and regulatory requirements, and to the maintenance of patient information in accordance with the Data Protection Act 1998.

Supporting Procedures and Written Control Documents

This Intraoperative Cell Salvage Policy and supporting Procedure describe the following with regard to Intraoperative Cell Salvage:

- Responsibilities
- Training
- Indications and contraindications for selection
- Conditions for using ICS
- Resources
- Implementation
- Governance

Other supporting documents are:

List all documents the reader needs to be aware of alongside / in support of this document

- UHB 068 - Blood Component Policy
- UHB 348 - Blood Component Procedure
- UHB – 282 Decontamination of Reusable Medical Devices Policy and Procedure
- UHB 100 - Consent to Examination or Treatment Policy
- UHB 186 - Independent Mental Capacity Advocacy Procedure (Mental Capacity Act 2005),
- UHB 113 - Lasting Power of Attorney and Court Appointed Deputy Procedure (Mental Capacity Act 2005),
- Reference Guide for Consent to Examination or Treatment, WHC (2008) 10
- Good Practice in Consent Implementation Guidance: consent to examination or treatment, WHC (2008) 36
- Mental Capacity Act 2005 Code of Practice
- ANTT all- Wales policy http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/ANTT%20IPC%20Policy%20FINAL%20May%202017%20V1pdf.pdf
- UHB 138 – Incident, Hazard and near miss reporting policy and procedure

Scope

This policy has been written to support the implementation and use of intraoperative cell salvage in the intraoperative/surgical setting within the Cardiff and Vale University Health Board (UHB). It may also be applicable when intraoperative cell salvage devices are used in the pre and/or postoperative environment (e.g. Accident and Emergency, recovery, ward etc) and for devices specifically designed for Intra and Postoperative Cell Salvage.

This policy **does not** relate to the use of unwashed postoperative autologous wound drains.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive impact. No additional key actions have been identified.

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Perioperative Care Directorate Governance forum, quality & safety forum. Surgery Clinical Board Quality & Safety Forum

Accountable Executive or Clinical Board Director	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	22/02/11	02/03/11	Ne document
2	12/06/18	13/06/18	V1 of the policy also included the procedure. These are now two separate documents. The content of the procedure remains unchanged.
3			The Blood, Health, National Oversight Group standards, 2023 incorporated to reflect current guidelines

Reference Number: UHB 403 **Version Number** 2	**Date of Next Review:** **Previous Trust/LHB Reference Number:** UHB 030

Intraoperative Cell Salvage Procedure

Introduction and Aim

This procedure is supporting the Intraoperative Cell Salvage Policy.

The Welsh Health Circular (WHC), "Better Blood Transfusion: Appropriate Use of blood", recommends that in order to make transfusion safer, to provide better information for patients relating to transfusion and to avoid the unnecessary use of blood in clinical practice, blood transfusion must be an integral part of care and clinical governance responsibilities. The Blood Health National Oversight group (BHNOG) have published (2023) cell salvage standards and key performance indicators.

The aim of this procedure is to support a safe, effective, efficient, lawful, timely, equitable, patient centred and prudent approach to using ICS.

Objectives

- To promote safer transfusion as part of clinical governance responsibilities
- To ensure that ICS is used by adequately trained staff, is simple, safe and cost-effective method of reducing allogeneic transfusion.
- To assist clinical staff in the identification of patients and procedures considered suitable for ICS and outlining the indications and contraindications.
- To assist clinical staff to provide appropriate advice on options for treatment, particularly where patients are anxious about risks associated with, or prefer not to receive, allogeneic blood.
- To provide clear written information about the risks and benefits of autologous transfusions from blood salvaged intraoperatively.
- To assist clinical staff to minimise avoidable / potential risks of autologous transfusions from blood salvaged intraoperatively.
- To ensure that any treatment is given lawfully

Scope

This procedure has been written to support the implementation and use of intraoperative cell salvage in the intraoperative / surgical setting within the Cardiff and Vale University Health Board (UHB). It may also be applicable when intraoperative cell salvage devices are used in the pre and /or postoperative environment (e.g. Emergency Unit, recovery, ward etc.) and for devices specifically designed for Intra and Post-operative Cell Salvage.

Equality and Health	An Equality and Health Impact Assessment (EHIA) has been

Impact Assessment	complete and this found there to be a positive impact. Key actions have been identified and these can be found within this procedure.
Documents to read alongside this Procedure	UHB 030 - Cell Salvage Policy UHB 068 - Blood Component Policy UHB 348 - Blood Component Procedure UHB 282 - Decontamination of Reusable Medical Devices Policy and Procedure UHB 100 - Consent to Examination or Treatment Policy UHB 186 - Independent Mental Capacity Advocacy Procedure (Mental Capacity Act 2005), UHB 113 - Lasting Power of Attorney and Court Appointed Deputy Procedure (Mental Capacity Act 2005), Welsh Government Guide to Consent for Examination or Treatment (July 2017) Mental Capacity Act 2005 Code of Practice ANTT all- Wales policy http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/ANTT%20IPC%20Policy%20FINAL%20May%202017%20V1pdf.pdf UHB 138 – Incident, Hazard and near miss reporting policy and procedure
Approved by	Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	*Medical Director*
Author(s)	*Dr Simon Logan (Consultant Anaesthetist) and Babs Jones (Education Lead, Perioperative Care Directorate).*

Disclaimer

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

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	12/06/18	13/06/18	Previous policy is now split into a policy and procedure. Welsh Government Guide to Consent for Examination or Treatment (July 2017) and Mental Capacity Act Code of Practice 2005 referred to.
2			The Blood, Health, National Oversight Group standards, 2023 incorporated to reflect current guidelines

Contents

ROLES AND RESPONSIBILITIES

The UHB

The UHB is responsible for

- Ensuring that there is a Clinical Lead for Cell Salvage. The organisation's Clinical Lead for ICS is currently a Consultant Anaesthetist.
- Providing a member of the theatre management team to be the Operational Manager, responsible for ensuring overall management and facilitation of the ICS service. The Senior Nurse for Theatres is currently in this role. The Operational Manager will be supported by a number of Cell Salvage Coordinators.
- Ensuring that all cell salvage operators have been trained and achieved their cell salvage competencies.
- Ensuring that competent personnel in sufficient numbers are available to provide the ICS service, including for out of hours cases if applicable.

The Clinical Lead

The Clinical Lead is responsible for

- Identifying members of staff who will take on the role of coordinating the cell salvage service.
- Being involved in the purchase of equipment and service contracts.
- Liaising with the Lead ICS clinician to produce and implement local protocols and guidelines.

The Cell Salvage Co-ordinators

The Cell Salvage Co-ordinators are responsible for

- Delivering and recording of training and competency assessment.
- Arranging for cell salvage to be available at the clinician's request.

If the service is not available this should be reported to the lead ICS Manager and Clinician

- Ensuring audit is complete
- Regular Quality Control of machines

These roles are carried out as extended roles by named theatre staff.

Prescribing Responsibilities

Salvaged blood for reinfusion will be appropriately prescribed by the responsible clinician on the designated documentation. The responsible

clinician must also ensure that valid consent for transfusion is obtained, or where there is reason to doubt a patient's mental capacity to provide consent, the Mental Capacity Act 2005 is followed.

Labelling Responsibilities

The reinfusion bag must be labelled as soon as is reasonably practical (i.e. When the patient is in theatre or as soon as the processing set is loaded if a "collect only" system has been used initially). The patient details should be handwritten and include the following:

- Full name
- Date of birth
- Hospital number
- Collection start date and time
- Expiry date and time

Addressograph labels **should not** be used because of the known associated risks.

Individual Responsibilities

The cell salvage Operators will ensure that they are adequately trained and competent in the safe use of the ICS system in each of the specialties they work in. All individuals involved in the care of patients undergoing cell salvage will ensure that they are adequately trained in the safe use, including the indications and contraindications, of cell salvage i.e. operator, anaesthetic, surgical, scrub, recovery and ward staff.

Documentation responsibilities

Staff must ensure that documentation (including all appropriate labelling) accurately reflect the ICS process, the documentation record should include:

- The ICS audit form (Appendix 1). Audit of use enables future service planning and quality assurance.
- The autologous transfusion label which must be fully completed and attached to the reinfusion bag.
- At the time of reinfusion of the salvaged blood, the peel out section on the autologous transfusion label must be completed and attached in the appropriate place in the patients' clinical records or equivalent as specified in the Blood Component Transfusion Procedure
- There must be appropriate labelling of anticoagulant used e.g. Heparin Saline with confirmation of appropriate dose by lead Anaesthetist at the start of the procedure. (See appendix 10). Guidance on prescribing will be attached to each of the machines.
- Bedside pre-transfusion checks and patient observations should be performed and recorded during the autologous blood reinfusion in the

same way as for the transfusion of allogeneic blood. Refer to the UHB 068 Blood Component transfusion policy and UHB 348 Blood component transfusion procedure. The minimum observations required are pre-transfusion, 15 minutes into the transfusion and on completion of the transfusion. Additional observations are at the discretion of the clinical staff based on an individual patient assessment.

- Adverse incidents should be documented in the patients' clinical records

TRAINING

Training is provided in accordance with the Joint United Kingdom Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC). A UK Cell Salvage Action Group was established in 2006 to help support wider implementation of cell salvage as an alternative to donor blood https://www.transfusionguidelines.org/transfusion-practice/uk-cell-salvage-action-group

Individual staff must receive training in the indications, contraindications and technical differences specific to their specialty /specialties. If a member of staff moves from one specialty to another, it is essential that training needs are identified and addressed prior to the staff member using ICS in their new clinical environment.

Theoretical and practical training must be undertaken and staff must be competency assessed before they set up or operate ICS equipment without supervision. This must include Aseptic Non-Touch Technique (ANTT) training and assessment

Staff carrying out ICS for patients with particular religious or other requirements must have received training and have been competency assessed in preparing the equipment and blood for reinfusion in accordance with the patients' requirements prior to carrying out the procedure.

An ICS Competency Assessment Workbook is available via the Better Blood Transfusion Toolkit https://www.transfusionguidelines.org/transfusion-practice/uk-cell-salvage-action-group/cell-salvage-competency-workbooks . All members of staff carrying out ICS will hold this workbook and once assessed as competent will keep an ongoing log (as in the ICS Competency Assessment Workbook) of all the ICS procedures they carry out.

Update training is recommended under the following circumstances:

- Any reasonable length of time without practical use of the ICS device
- A learning need is identified by an individual member of staff or supervisor
- Changes in the product from the manufacturer or a change in the product due to the organisation trialing/purchasing new products
- Changes to national and/or local guidelines relating to any aspect of autologous transfusion (which could include changes to the Blood Component Transfusion policy

To ensure that trained personnel are available to operate the cell saver, for elective cases the Consultant Surgeon must give at least two weeks' notice to the Clinical Lead in anaesthesia.

INDICATIONS AND PATIENT SELECTION

ICS systems may be used in elective and/or emergency surgical procedures where the surgical field is not contaminated by faecal or infective matter and where no other contraindications exist (see next section).

Patient selection for ICS is considered via the clinical decision-making processes of the surgeon and anaesthetist responsible for the patient. Providing that none of the contraindication listed in the next section exist, patients to be considered for ICS include

- Adult and paediatric patients undergoing elective or emergency surgical procedures where the anticipated blood loss in greater than 20% of the patient's estimated blood volume
- Cases fitting the criteria that are undertaken locally regularly include:
  - Cardiac surgery
  - Scoliosis surgery
  - Revision hip replacements
  - Major gynaecological surgery
  - Abdominal Aortic Aneurysm
  - Cystectomy
  - Nephrectomy
  - Liver resection
  - Pancreatic transplantations
  - Caesarian sections at high risk of bleeding greater than 20% total blood volume
  - Postpartum haemorrhage
  - Meningioma

- Major trauma where blood loss likely to be greater than 20% total blood volume
- Any procedure where blood loss is higher than expected and likely to exceed 20% total blood volume
- Adult and paediatric patients undergoing elective or emergency surgical procedures who have risk factors for bleeding or low preoperative Haemoglobin levels
- Patients who have rare blood groups or multiple antibodies for whom it may be difficult to obtain allogeneic blood

CONTRAINDICATION AND WARNINGS

The risk benefit ratio of ICS should be assessed for each individual patient by the surgeon and anaesthetist responsible for the patient's care.

Contraindications

ICS should not be used in the following situations:

- Bowel contents in the surgical field
- Heparin induced thrombocytopenia or Antithrombin III Deficiency when heparin is the anticoagulant of choice (a citrate containing anticoagulant solution may be used instead) See appendix 10)

Warnings

ICS should be temporarily discontinued when substances not licensed for Intravenous (IV) use are used within the surgical field and could potentially be aspirated into the collection reservoir. The standard theatre suction must be used to aspirate the surgical field and the wound should be irrigated with copious 0.9% IV Sodium Chloride before resuming ICS.

Examples of non-IV materials that should not be aspirated into the ICS system include:

- Antibiotics not licensed for IV use
- Iodine
- Topical Clotting Agents
- Orthopaedic cement of debris
- The use of ICS in the presence of **infection** may result in bacterial contamination of the salvaged blood. The aspiration of blood from an infected site should be avoided and antibiotics should be given as appropriate.

- **Gastric/pancreatic** secretions should not be aspirated into the system as they may cause enzymatic haemolysis and are not reliably removed by the washing procedure.
- **Pleural effusions** should not be aspirated and should be drained prior to cell salvage. However, blood which subsequently accumulates in the pleural space may be aspirated.
- There are concerns relating to the use of ICS in patients with **sickle cell disease**. The use of ICS in patients with abnormal red cell disorders should be made on a clinical, individual patient basis.
- **Amniotic fluid** shouldn't be aspirated into the system due to theoretical concerns related to Amniotic Fluid Embolism. See Appendix III for obstetric ICS usage.
- The use of ICS in patients undergoing surgery for **malignant disease** is not recommended by the manufacturers of ICS devices. This is due to concern about the possibility of malignant cells being reinfused and giving rise to metastases. It is vital that the clinicians remain up to date with the latest evidence relating to this. However, there are now a number of reports in the literature of the use of ICS in cancer surgery without obviously leading to early metastasis and some hospitals now use ICS routinely during surgery for malignant disease. Aspiration of blood from around the tumour site should be avoided to minimise decontamination of salvaged blood with malignant cells and the salvaged blood should be reinfused through a leucocyte reduction filter to minimise the reinfusion of any malignant cells which may have been aspirated into the collection reservoir. The decision to use ICS in the presence of malignant disease should be made by the surgeon and anaesthetist in consultation with the patient and duly documented in the medical records
- As there is no evidence to support the use of cell salvage in **paediatric malignancy** surgery the local paediatric oncologists have advised against its use. In cases where it is felt that benefit may outweigh the risk. Obtain the agreement of the paediatric oncologist prior to proceeding

Cautions

- The use of Hartmann's Solution will inhibit the action of citrate based anticoagulants (e.g. ACD) if used as an irrigant or wash solutions.
- Air will be present in the primary reinfusion bag when it is still connected to the cell saver or when it has been disconnected but air has not been evacuated. Where possible, all air should be evacuated from the primary reinfusion bag prior to reinfusion. Manufacturers advise not to use a pressure cuff as there is a risk of air embolus and

some devices may also detect a back pressure if the reinfusion line is open.

- Manual node – it is recommended the ICS devices are not run in manual mode as this may lead to reduced quality, insufficient washing of the final red blood cell product and the possible reinfusion of potentially harmful contaminants e.g. heparin. Machines should be run in automatic mode and manual mode should only be used when the benefits of doing so outweigh the risks e.g. emergency situations where the need to reinfuse the red cells quickly outweighs the risks associated with running the machine in manual mode.

PATIENT INFORMATION AND CONSENT ISSUES

Patients considered likely to have ICS during planned surgery must receive information about ICS before their operation. The process must be discussed with the patient pre-operatively whenever possible. Written information should be given to the patient wherever possible – for example the Patient Information Leaflet "Cell Salvage" (Appendix 5.1).

The patient must be given comprehensive information, in a format that they are likely to be able to understand, about ICS. They must also be advised of any specific risk's peculiar to them that this procedure might involve. They must also be told of any alternatives to ICS (i.e. allogeneic blood). The patient's consent must be obtained and documented.

Where the patient is aged under 16 years, a person with parental responsibility must give consent if the patient is not *Gillick* competent.

If there is reason to doubt the patient's mental capacity to consent to ICS and the patient is aged 16 years and over, then the Mental Capacity Act 2005 must be followed.

In an emergency, in the absence of a valid Advance Decision to Refuse Treatment or an attorney of a personal welfare Lasting Power of Attorney, the clinician should decide how to proceed using the information they have available and their clinical experience.

For further information about consent and capacity issues, please see the UHB's Consent to Examination or Treatment Policy

CONDITIONS FOR USING ICS

Use of ICS Equipment

- The ICS system should be used in accordance with the manufacturer's guidelines (Appendix 5).
- All procedures should be carried out in accordance with this and other relevant policy /procedural documents including infection control, management of sharps, decontamination and blood components transfusion.
- The ICS system should be routinely run in automatic mode (see Cautions in the precious section).
- Contraindications should be considered as identified in the previous section
- All staff who set up or operate ICS systems should receive theoretical and practical training and should have completed the ICS Competency Assessment Workbook (Appendix 2).
- Aseptic non-touch technique (ANTT) should be used as appropriate, to reduce the risk of infection.

Anticoagulant

- The type of anticoagulant and dose used should be documented on the cell salvage record and anaesthetic chart for each case (Appendix 1 and Appendix 10).
- Anticoagulant prepared by the operator (e.g. heparin saline) **must** be labelled clearly to avoid error

Wash Solution

- 0.9% IV Grade Saline should be used as the wash solution.
- The minimum wash volume, as outlined in the manufacturer's guidelines (Appendix 5) for the size of the centrifuge bowl in use and the type of surgical procedure should be used in all but the most urgent situations.

Labelling

- All salvaged blood **must** be labelled.
- Labels should be hand written. Pre-printed "addressograph" labels **should not** be used.
- Labelling information should include
  - full name
  - date of birth
  - hospital number
  - collection start date and time
  - expiry date and time

- the statement “Untested Blood – For Autologous Use Only”

- To avoid errors in patient identification an autologous transfusion label such as that in appendix 6 should be completed at the patient’s side, when the patient has arrived in theatre i.e. the reinfusion bag should not be pre-labelled prior to the patent’s arrival in theatre or labelled after the patient has left theatre. The patient details should be taken from their identification band and not from any clinical records or charts that may be present in the operating theatre. All fields on the label should be completed in full.
- If the system has been set up as a “collect only” system (collection reservoir and aspiration and anticoagulant line only), the collection reservoir should be labelled in accordance with the above instruction for labelling a reinfusion bag. If a processing set is subsequently loaded into the machine, the autologous label on the collection reservoir should be transferred onto the reinfusion bag immediately or a new label completed (as above).

Re-infusion

Prescribing responsibilities: Salvaged blood reinfusion should be prescribed by the responsible clinician on the blood transfusion documentation record.

- ICS may be set up as a “closed-circuit” system. Blood is aspirated from the surgical field, processed and transferred to a reinfusion bag. The reinfusion bag is simultaneously connected to the patient’s IV cannula via an appropriate filter (see below). The person administering the reinfusion adjusts the rate at which the red cells are reinfused using a clamp on the administration set and by adjusting the height of the reinfusion bag. A pressure cuff **should not** be applied to increase the flow rate because of the risk of air embolism. The same reinfusion bag may fill and empty many times during an operation.
- Alternatively, ICS mat be set up without simultaneous connection of the reinfusion bag to the patient (as above). In this case, the reinfusion bag is disconnected from the ICS device when it is full or at the end of the surgical procedure and is subsequently connected and reinfused to the patient as in the “closed-circuit” system.
- A filter, appropriate to the type of surgery, should be used for reinfusion. In most cases this will be a 200-micron filter found in a standard blood administration set. In certain circumstances (e.g. obstetrics and malignancy) a leukocyte depletion filter may be indicated. A 40-micron microaggregate filter or a 40-micron lipid depleting filter is suggested for orthopaedic surgery where there is a risk of contamination of fat embolism respectively.
- The reinfusion bag should be kept beside the patient at all times.

- The reinfusion bag **should not** be placed into a refrigerator.
- Reinfusion of the salvaged blood should follow standard blood transfusion practice as described in the Blood Components Transfusion Policy.
- The responsible clinician should prescribe salvaged blood for reinfusion in the same manner as for allogeneic blood.
- The patient details on the reinfusion bag must be carefully checked against the details on the identification band attached to the patient before connecting the reinfusion bag to the patient.
- The reinfusion of salvaged blood should be documented appropriately on the blood transfusion documentation record. The autologous transfusion label, as in Appendix 6, contains a peel out section which should be completed at the time of reinfusion and can be used for this purpose.

Expiry

- The collection, processing and reinfusion of salvaged blood should be completed within the timeframes as recommended by the manufacturer. This should be in accordance with guidance from the American Association of Blood Banks (AABB) and the Blood Components Transfusion Policy and Procedure.

The AABB Guidelines state the reinfusion times for cell salvaged blood as follows:

- Intraoperative Cell Salvage: 4 hours from the completion of processing.
- Postoperative Cell Salvage: 6 hours from the start of collection (applicable when Intra-operative Cell Salvage devices are used to salvage blood postoperatively).

Any blood that has not been transfused within the timeframe specified in the guidelines must be disposed of in accordance with local policy for dealing with liquid bio hazardous waste (see Disposal below).

Documentation

- The collection and reinfusion of salvaged blood should be accurately documented on form https://bhnog.wales.nhs.uk/wp-content/uploads/2023/05/ICS-Data-Collection-Form.pdf in Appendix 1.
- The use of a generic autologous transfusion label is recommended (Appendix 6) – the peel out section of the label is completed and attached to the patient's clinical record upon reinfusion of the salvaged blood.
- Adverse incidents, near misses and hazards should be documented and reported according to the Adverse Event section of this procedure

and in accordance with the Incident, hazard and near miss reporting policy and procedure

- Bedside pre-transfusion checks and patients' observations should be performed and recorded during autologous blood reinfusion in the same way as transfusion of allogeneic blood – in accordance with the Blood Components Procedure. Additional observations are at the discretion of the clinical staff based on an individual patient assessment.
- The organisation should ensure that adequate records are retained in all cases where ICS is used.

Disposal of used ICS equipment

- Following use, all ICS disposable equipment should be disposed of in accordance with local requirements. The UHB Waste Management Department requires cell salvage associated waste to be disposed of in containers appropriate for incineration.

Cleaning and Disinfection of ICS Machines

- Following use, the cell salvage machine should be cleaned in accordance with the manufacturer's guidance and the Decontamination of reusable medical devises policy and procedure including procedures for cleaning equipment following high risk cases.
- Following contamination of the equipment internally, the equipment should be removed from use, identified as a potential biohazard and referred to the manufacturer.

Maintenance of Equipment

- All ICS equipment should be serviced regularly in accordance with the manufacturers' recommendations. A maintenance record and fault log (Appendix 7) should be kept for each machine.

MANAGEMENT OF MASSIVE REINFUSION

As with the transfusion of large volumes of allogeneic red cells, the return of large volumes of salvaged red blood cells will coincide with the depletion of platelets and clotting factors associated with massive blood loss.

In the event of a massive reinfusion of salvaged red blood cells, it is vital to consider the need for additional appropriate transfusion support e.g. platelets, fresh frozen plasma and cryoprecipitate.

Staff should be alert to a large blood loss into the collection reservoir and report the to the surgeon and/or anaesthetist.

Quality Assurance

It is necessary to maintain a comprehensive quality assurance system to ensure the provision of a safe, high quality ICS service.

Personnel

The UHB has identified a single individual responsible for ensuring that a safe and effective ICS service is provided. The organisation's Clinical Lead for ICS is currently a Consultant Anaesthetist. The Lead is responsible for ensuring that quality assurance systems are fully implemented.

The organisation will ensure that competent personnel in sufficient numbers are available to provide the ICS serviced, including for out of hours cases if applicable. Personnel involved in ICS will have undergone appropriated training (see section 6) and competency assessment (Appendix 2). Training Records will be maintained for all staff involved in the ICS process and it is highly recommended that individuals maintain a case log of all procedures in their own portfolios.

Equipment

All ICS equipment must be appropriately maintained. Maintenance should include both an operator maintenance programme and regular manufacturer maintenance visits. Operator maintenance programmes should include the implementation of a documented cleaning and minor checking system and the use of a machine specific fault log (Appendix 7). Manufacturer maintenance visits must be carried out by an authorised service engineer who will perform a series of documented maintenance controls and fine tune the device for maximum performance.

Product Quality

A Quality Control procedure will be performed on each machine every 2 months at both UHL and UHW sites. The QC log is to be checked by the operator prior to each case, and samples taken if the last QC was performed more than two months ago. This involves taking 2 samples from salvaged blood prior to return to the patients.

A full blood count is requested on 1 sample to assess Haematocrit. An acceptable level to be obtained is above 45%.

An anti-factor Xa assay is requested on the 2nd sample to assess heparin contamination. A result of (less than) <0.05U/ml is reported as the lower limit of detection of the anti-factor Xa assay.

The QC results will be returned to the clinical lead who will record this data in the QC logbook for each machine.

If results are outside the acceptable range further management will be discussed with haematology, and the manufacturers.

ADVERSE EVENT REPORTING

- Technical problems with ICS should be reported to the manufacture. It is advisable to discuss any action suggested by the manufacturer with Clinical Engineering.
- Serious Adverse Events must be reported to the Clinical Lead for ICS and the Transfusion Practitioner. Any adverse events relating to the ICS device must be reported in accordance with the UHB Incident, hazard and near miss reporting policy and procedure. Additionally, where appropriate reporting to the relevant external bodies should be undertaken e.g. Serious Hazards of Transfusion (SHOT), Medicine and Healthcare products Regulatory Agency (MHRA), especially if the incident has led to or, were it to occur again, could lead to death, life-threatening illness or injury.
- Other minor safety or quality incidents should also be reported as these can help demonstrate trends or highlight inadequate manufacturing or supply systems, or inadequate instructions and / or training.
- Adverse incidents, near misses and hazards should be documented and reported in accordance with the Incident, hazard and near miss reporting policy and procedure.

Examples of Adverse Events include:

- Severe reaction on reinfusion of salvaged blood
- Non-labelling / incorrect labelling of salvaged blood
- Equipment malfunction
- Communication failure leading to inappropriate reinfusion of the salvaged blood where contamination occurred within the surgical field and this was not communicated to the operator/anaesthetist.

AUDIT

Appropriate audit activity will be co-ordinated via the Cell Salvage Working Group Refer also to Appendix 1.

RESOURCES

The UHB will ensure adequate resources for the formal, documented training of all staff who set up of operate the equipment and for the regular maintenance and prompt repair of all ICS equipment.

Welsh Blood Service provides a substantial amount of funding for Intra-operative and Postoperative Cell Salvage, however, funding is capped and the UHB makes up the shortfall. In order to recue costs, the reservoir for collection only is set up in the first instance. Processing is only to occur if adequate volumes are obtained and a decision is made to process and reinfuse collected blood to the patient.

Evidence of cell salvage activity and consumable use must be provided to the WBS to enable reimbursement to the organisation.

EQUALITY

The UHB is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its staff reflects their individual needs and does not discriminate against individuals or groups. An Equality and Health Impact Assessment has been undertaken for this policy and procedure. The assessment found that ICS has a positive impact.

IMPLEMENTATION

This procedure document will be circulated to all relevant personnel and implemented in all areas which may be involved in ICS. This will include:

- Consultant Lead for Transfusion
- Clinical Lead for ICS
- Manager for Theatres
- Transfusion Practitioner
- Jehovah's Witness Hospital Liaison Committee
- Senior Nurse / Theatre Managers
- Relevant surgical specialities
- Obstetrics and Gynaecology

It will also be available via the UHB Intranet. Members of the public will be able to access it via the website of the UHB with hard copies being provided on request.

Guidance on and queries relating to the procedure should be addressed to the organisation's Clinical Lead for ICS.

REVIEW

The procedure will be reviewed at timely intervals when new information becomes available that needs to be incorporated or every 3 years.

APPENDIX 1 – All Wales Cell Salvage (ICS) data collection form

The intraoperative Cell Salvage data collection form which should be completed for every ICS procedure even if not processed is available through the Blood Health National Oversight group (BHNOG) website at:

https://bhnog.wales.nhs.uk/wp-content/uploads/2023/05/ICS-Data-Collection-Form.pdf

APPENDIX 2 – Intraoperative Cell Salvage in Obstetrics

ICS is being increasingly used in the UK in obstetrics for women at risk from post-Partum haemorrhage during caesarean section as evidence grows in support of it.
The use of ICS in obstetrics has been endorsed by:

- The Confidential Enquiry into Maternal and Child Health
- Joint Association of Anaesthetists of Great Britain and Ireland/Obstetric Anaesthetists Association Guidelines

- National Institute Health and Care Excellence

Any healthcare professional involved with obstetric ICS should be familiar with these guidelines.

Patient Selection and Preparation
Wherever possible, the advantages and risks of ICS and allogeneic blood transfusion should be discussed with the patient prior to undergoing an obstetric surgical procedure. In a pre-planned case this can be during the pregnancy. It is recommended that patients receive the NHS Blood and Transplant information leaflet entitled "Will I need a blood transfusion?" (Appendix VIII) which contains an "Alternatives to blood transfusion" section in the Intraoperative Cell Salvage Patient Information Leaflet (Appendix IV).

The NICE guidance "Intraoperative blood cell salvage in obstetrics recommends that whenever possible, the woman understands what is involved and the theoretical risks, and agrees (consents) to have the procedure. When obtaining formal consent for a caesarean section, the obstetrician or anaesthetist should discuss the advantages and risks of ICS with the patient and document clearly the agreement of the patient to undertake the procedure. Such detailed consent may not be practicable in an emergency, as for allogeneic transfusion.

Indications for ICS
Patient selection for ICS is at the discretion of the obstetrician and anaesthetist caring for the patient who should be involved in the decision. The type of obstetric cases that should be considered for selection include:

- Emergency situations
  - Ruptured ectopic pregnancy
  - Post –partum haemorrhage

- Elective situations
  - Patient with an anticipated blood loss of (more than) >1000 mls e.g. placenta accrete, large uterine fibroids, and other predictable causes of MOH.

- Other situations
  - Patients who for religious or other reasons refuse allogeneic blood and have consented to the use of ICS in elective or emergency bleeding situations of in significant anaemia.

Additional measures necessary in obstetrics ICS:

Amniotic fluid and use of Leukocyte Depletion Filter
Amniotic fluid should ideally not be aspirated into the ICS collection reservoir, but should be removed by separate suction prior to starting cell salvage. This recommendation will reduce the initial contamination, but it should be noted that the *in vitro* evidence is that the ICS process can effectively remove plasma phase elements of amniotic fluid whatever the initial load, therefore, in life-threatening haemorrhage, a clinical decision to use ICS from the start of the procedure could be carefully considered.

After processing, a Pall RS filter (LeucoGuard® RS Leukocyte Reduction Filter, Pall Biomedical Products Co., East Hills, NY) should be used to reinfuse ICS blood. This is the only filter proved to effectively eliminate residual particulate elements of amniotic fluid. It should be remembered that prior to 2000 this filter was not available, over 250 obstetric cases worldwide safely received ICS blood without a problem prior to the availability of the filter. Therefore, in life-threatening haemorrhage a clinical decision to reinfuse ICS blood without this filter could be carefully considered.

8 Rh immunisation and Kleihauer testing
In any pregnancy involving a Rh-negative mother and Rh positive foetus there's a danger of Rh immunisation of the maternal circulation is exposed to foetal red cells.

Kleihauer testing is required to establish the amount of foetal red cell exposure and ensures that the mother receives and appropriate dose of Anti-D immunoglobulin (usually 125 iu/ml of foetal blood). Depending on the results of the Kleihauer, a minimum of 500 is Anti-D will be offered in the post-partum period to Rh negative mothers with Rh positive babies.

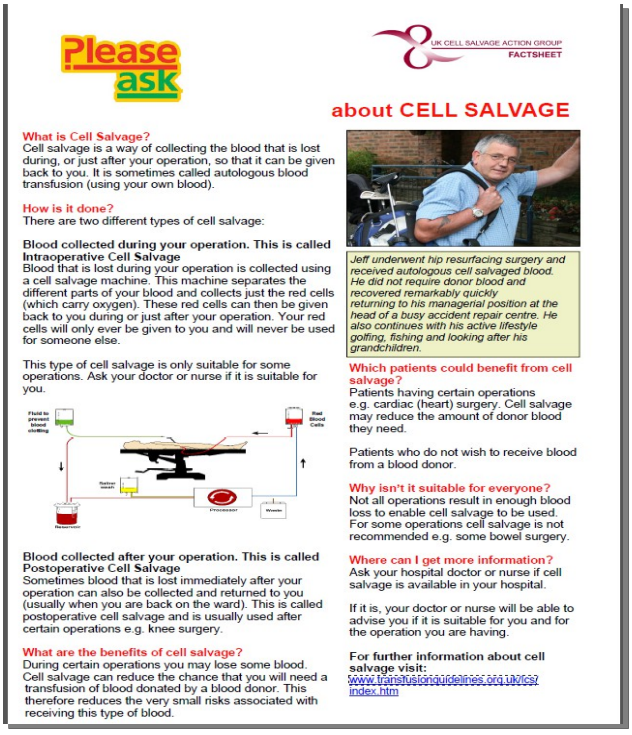
The same protocol should be followed for Rh negative mothers who have undergone reinfusion of ICS blood. The presence of foetal red cells in the ICS blood is likely because the ICS device cannot distinguish foetal from maternal red cells. Depending on the test results it may b that higher doses of Anti-D will need to be administered.

The sample for Kleihauer testing should be taken after the reinfusion of ICS blood and administration of Anti-D should occur within 48-72 hours of delivery.

Patient factsheets – Information about Cell Salvage when you have your baby is available here https://www.transfusionguidelines.org/transfusion-practice/uk-cell-salvage-action-group/patient-factsheet

APPENDIX 3 – Cell Salvage Patient Information Leaflet

The Cell Salvage patient information leaflet can be downloaded from
http://www.npsa.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=28445



Please ask

UK CELL SALVAGE ACTION GROUP FACTSHEET

about CELL SALVAGE

What is Cell Salvage?
Cell salvage is a way of collecting the blood that is lost during, or just after your operation, so that it can be given back to you. It is sometimes called autologous blood transfusion (using your own blood).

How is it done?
There are two different types of cell salvage:

Blood collected during your operation. This is called Intraoperative Cell Salvage
Blood that is lost during your operation is collected using a cell salvage machine. This machine separates the different parts of your blood and collects just the red cells (which carry oxygen). These red cells can then be given back to you during or just after your operation. Your red cells will only ever be given to you and will never be used for someone else.

This type of cell salvage is only suitable for some operations. Ask your doctor or nurse if it is suitable for you.

Blood collected after your operation. This is called Postoperative Cell Salvage
Sometimes blood that is lost immediately after your operation can also be collected and returned to you (usually when you are back on the ward). This is called postoperative cell salvage and is usually used after certain operations e.g. knee surgery.

What are the benefits of cell salvage?
During certain operations you may lose some blood. Cell salvage can reduce the chance that you will need a transfusion of blood donated by a blood donor. This therefore reduces the very small risks associated with receiving this type of blood.

Jeff underwent hip resurfacing surgery and received autologous cell salvaged blood. He did not require donor blood and recovered remarkably quickly returning to his managerial position at the head of a busy accident repair centre. He also continues with his active lifestyle golfing, fishing and looking after his grandchildren.

Which patients could benefit from cell salvage?
Patients having certain operations e.g. cardiac (heart) surgery. Cell salvage may reduce the amount of donor blood they need.

Patients who do not wish to receive blood from a blood donor.

Why isn't it suitable for everyone?
Not all operations result in enough blood loss to enable cell salvage to be used. For some operations cell salvage is not recommended e.g. some bowel surgery.

Where can I get more information?
Ask your hospital doctor or nurse if cell salvage is available in your hospital.

If it is, your doctor or nurse will be able to advise you if it is suitable for you and for the operation you are having.

For further information about cell salvage visit:
www.transfusionguidelines.org.uk/ics/index.htm

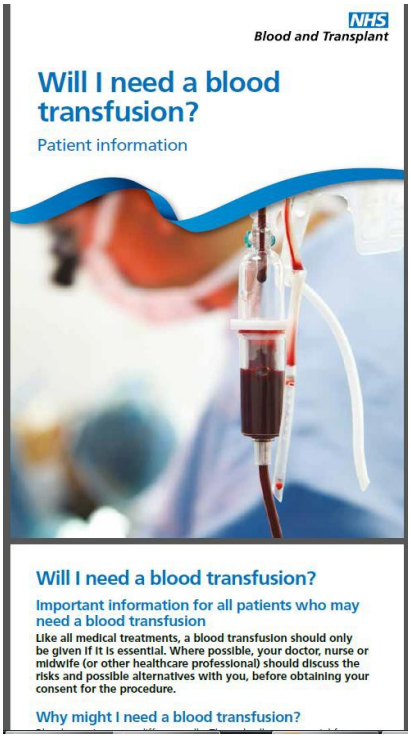
APPENDIX 4 – Manufacturers' Guidelines

These are held centrally by the Clinical Lead for ICS

APPENDIX 5 – Autologous Transfusion Label

These are held centrally by the Clinical Lead for ICS

APPENDIX 6 – NHS Blood and transplant information leaflet entitle "Will I need a blood transfusion"



An order form for the NHS Blood and Transplant information leaflet “Will I need a blood transfusion” can be downloaded at:

https://hospital.nhsbtleaflets.co.uk/Home.html

Alternatively the leaflet can be downloaded at:
http://hospital.blood.co.uk/media/28307/160511-27360-will-i-need-a-blood-transfusion-final.pdf

The leaflet is available in a number of other languages (Welsh, Albanian, Arabic, Bengali, Chinese, Croatian, Farsi, French, Greek, Gujarati, Pashto, Polish, Punjabi, Serbian, Somali, Sorani, Turkish, Urdu, and Vietnamese) at:

http://hospital.blood.co.uk/library/patient_information_leaflets/leaflets/index.asp

APPENDIX 7 – Blood loss calculation

At the end of the procedure, when all of the blood from the collection reservoir has been processed, an estimate of the volume of blood the patient has lost during procedure can be made using a simple calculation.

The information required is:

Fluid in volume (Machine read out) – Total volume of fluid processed by machine, includes: blood aspirated from surgical field, anticoagulant and irrigation frim surgical field.

Irrigation fluid – Volume of sterile irrigation fluid used within surgical field and aspirated into the ICS collection reservoir.

Anticoagulant used – An estimate of volume used

Swab wash – Volume of IV normal saline (0.9% NaCl) or equivalent used to wash swabs

Theatre suction

Wet-dry weight of swabs – compensates for blood and saline swab wash retained on swabs and allows them to be weighed outside of the sterile field after washing.

Blood Loss Calculation:

Blood loss = fluid in volume plus theatre suction plus (wet-dry weight of swabs) minus irrigation fluid minus anticoagulant used minus swab wash

APPENDIX 8 - Heparin Concentration

Heparin Saline

In usual circumstances, 30,000 iu of Heparin is added to 1,000ml of intravenous (IV) normal saline (0.9% NaCl) and labelled clearly with an appropriate “drugs added label”.

Some manufacturers recommend that 60,000 iu of Heparin should be added to 1,000ml of IV normal saline for **neurosurgical** procedures. This should be confirmed with the manufacturer.

The Heparin Saline anticoagulant concentration should be checked by the Lead Anaesthetist at the start of the procedure and documented on the Welsh Blood Service audit form. **Under no circumstances** should the heparin used for preparation of anticoagulant for cell salvage purposes be prescribed on an inpatient drug chart. This is to reduce the risk of inappropriate administration of heparin saline outside of the theatre environment.

A pre-prepared citrate-based anticoagulant should be used for patients with antithrombin III deficiency.

Equality & Health Impact Assessment for

Intraoperative Cell Salvage Policy and Procedure

Please note:

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

Please answer all questions: -

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Intraoperative Cell Salvage Procedure
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Surgery Clinical Board

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

3.	Objectives of strategy/ policy/ plan/ procedure/ service	• To promote safer transfusion as part of clinical governance responsibilities • To ensure that ICS is used by adequately trained staff, is simple, safe and cost-effective method of reducing allogeneic transfusion. • To assist clinical staff in the identification of patients and procedures considered suitable for ICS and outlining the indications and contraindications. • To assist clinical staff to provide appropriate advice on options for treatment, particularly where patients are anxious about risks associated with, or prefer not to receive, allogeneic blood. • To provide clear written information about the risks and benefits of autologous transfusions from blood salvaged intraoperatively. • To assist clinical staff to minimise avoidable / potential risks of autologous transfusions from blood salvaged intraoperatively. • To ensure that patients are treated lawfully
4.	Evidence and background information considered. For example • population data • staff and service user's data, as applicable • needs assessment • engagement and involvement findings • research	**REFERENCES** 1. Serious Hazards of Transfusion (SHOT) Report 2005. http://www.shotuk.org/SHOT%20report%202005.pdf 2. Better Blood Transfusion: The Appropriate Use of Blood (2002) HSC 2002/009 3. Murphy GJ, Rogers CS, Lansdowne WB, Channon I, Alwair H, Cohen A, Caputo M and Angelini GD (2005) Safety, efficacy, and cost of intraoperative cell salvage and autotransfusion after off-pump coronary artery bypass surgery: a randomized trial. *J Thorac Cardiovasc Surg*; 130(1); 20-8 4. James V (2004) A National Blood Conservation Strategy for the NBTC and NBS

	• good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=26734&Rendition=Web 5. Policy for the provision of Intraoperative Cell Salvage. http://www.transfusionguidelines.org.uk/docs/misc/bbt-03_icsag-policy-v11.doc 6. British Committee for Standards in Haematology Blood Transfusion Task Force (1999). The administration of blood and blood components and the management of transfused patients. *Transfusion Medicine*; 9; 227-238. British Committee for Standards in Haematology Blood Transfusion Task Force (1997) Guidelines for Autologous Transfusion II. Perioperative Haemodilution and Cell Salvage. *British Journal for Anaesthesia*; 78; 768-771. 8. Gray CL, Amling CL, Polston GR, Powell CR and Kane CJ (2001) Intraoperative cell salvage in radical retropubic prostatectomy. *Urology*; 58(5); 740-5. 9. Nieder AM, Carmack AJ, Sved PD, Kimm SS, Manoharan M and Soloway MS (2005) Intraoperative cell salvage during radical prostatectomy is not associated with greater biochemical recurrence rate. *Urology*; 65(4); 730-4. 10. Nieder AM, Manoharan M, Yang Y and Soloway MS (2007) Intraoperative Cell Salvage during radical cystectomy does not affect long term survival. *Urology*; 69(5); 881-4. 11. American Association of Blood Banks (AABB) (2005) Standards for Perioperative Autologous Blood Collection and Administration (2nd Edition) 12. Cardiff and Vale NHS Trust Incident Reporting and

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

		Investigation Procedure, May 2007 13. http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/POLICY_PAGEGROUP/LIBRARY/RISK%20MANAGEMENT%20POLICY.PDFMedicines and Healthcare products Regulatory Authority (MHRA) (2007) Device Bulletin: Reporting adverse incidents and disseminating medical device alerts. http://www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dDocName=CON2025834&RevisionSelectionMethod=LatestReleased Roberts, M.M. (2006) Procedure for Post-operative Autologous Blood Transfusion Drainage Systems in Adult and Paediatric Patients. *Cardiff and Vale NHS Trust*. 15. Kelleher, A.A. (2004) Policy for the Provision of Perioperative Red Cell Salvage. *Royal Brompton and Harefield NHS Trust*. 16. Obstetric Intra-operative Cell Salvage Guidelines (Draft 1). *St Mary's NHS Trust* 2006.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Patients who for clinical and/or personal reasons would benefit from the appropriate use of autologous blood transfusion techniques such as Intraoperative Cell Salvage (ICS). Staff who must be adequately trained to undertake the procedure.

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	Where the patient is aged under 16 years, a person with parental responsibility must give consent if the patient is not *Gillick* competent. If there is reason to doubt the patient's mental capacity to consent to ICS and the patient is aged 16 years and over, then the Mental Capacity Act 2005 must be followed.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 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	The policy and procedure lists supporting documents to ensure appropriate consent to treatment and to affirm the rights of patients and their autonomy without discrimination. The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good management practice. **Note -** the Arial font size 14 recommendation is aimed at communication and information needs for	Staff must be familiar with the list of documents associated with informed consent.	Mandatory training compliance. Evidence of clinical audit.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	patients. We are aware that we may need to amend/provide the format of our communication in line with the appropriate All Wales Sensory Loss Standards and legislation.		

7. 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	Where the patient is aged under 16 years, a person with parental responsibility must give consent if the patient is not *Gillick* competent. If there is reason to doubt the patient's mental capacity to consent to ICS and the patient is aged 16 years and over, then the Mental Capacity Act 2005 must be followed.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 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	The policy and procedure lists supporting documents to ensure appropriate consent to treatment and to affirm the rights of patients and their autonomy without discrimination. The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good management practice. **Note -** the Arial font size 14 recommendation is aimed at communication and information needs for	Staff must be familiar with the list of documents associated with informed consent.	Mandatory training compliance. Evidence of clinical audit.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	patients. We are aware that we may need to amend/provide the format of our communication in line with the appropriate All Wales Sensory Loss Standards and legislation.		

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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
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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	patients. We are aware that we may need to amend/provide the format of our communication in line with the appropriate All Wales Sensory Loss Standards and legislation.		
6.3 People of different genders: **Consider men, women, people undergoing gender reassignment** **NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without**	There is no current evidence of positive or negative impact on staff or patients associated with gender though we are aware that it is widely known that there are differences between men and women in the incidence and prevalence of most health conditions.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	There is no current evidence of positive or negative impact on staff or patients associated with this protected characteristic	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There is a specific section for obstetric patients who may be considered for Intraoperative Cell Salvage	Staff must be familiar with specific section.	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Patient information leaflets are available in multiple languages from the NHS Blood and Transplant site. Elective surgery patients being considered for Intraoperative Cell Salvage will have access to an interpreter where appropriate	Staff to be familiar with interpreter booking system	Support interpreter service.
6.7 People with a religion or belief or with no religion or belief. **The term 'religion' includes a religious or philosophical belief**	This is a positive impact for patients for who, for moral, religious or other reasons, are unwilling to receive allogeneic blood and have given their consent to	Staff to be familiar with aspects of the policy and procedure and receive regular updates and training	Provide training where appropriate.

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
	receiving autologous blood collected using ICS (all such decisions should be documented).		
6.8 People who are attracted to other people of: • **the opposite sex (heterosexual);** • **the same sex (lesbian or gay);** • **both sexes (bisexual**	There appears not to be any impact on staff or patients in terms of sexual orientation.	N/A	N/A
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	Bilingual information leaflets are available for patients. This is in line with our current Welsh Language Scheme and the future Welsh Language Standards.	Staff to be familiar on how to access welsh speaking colleagues to support the patient. Information should be available in Welsh.	Provide welsh language training

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
Well-being Goal – A Wales of vibrant culture and thriving Welsh language		Service to encourage Welsh language 'active offer' to those receiving the procedure.	
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**	Minimal Impact is anticipated The procedure aims to deliver an achievable equitable service regardless of an individual's income. Any decisions are clinically made.	N/A	N/A

6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Minimal Impact is anticipated The procedure aims to deliver an achievable equitable service regardless of an individual's income. Any decisions are clinically made.	N/A	N/A
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are anticipated positive impacts for adult and paediatric patients undergoing elective or emergency surgical procedures who have risk factors for bleeding or low preoperative Haemoglobin levels; patients who have rare blood groups or multiple antibodies for whom it may be difficult to obtain allogeneic blood and adult and paediatric patients undergoing elective or emergency surgical procedures where the anticipated blood loss in greater than 20% of the patient's estimated blood volume. The procedure lists contraindications	Staff to be familiar with aspects of the policy and procedure and receive regular updates and training	Provide training where appropriate.

9. 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	People will be consulted regarding ICS dependent on the surgical procedure being undertaken and their own preferences. Geographical location will have no impact on the decision.	N/A	N/A
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including	Indirectly associated with this procedure – patients listed for elective surgery will have the opportunity to improve their wellbeing with healthcare professional support pre-operatively.	N/A	N/A

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
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	Positive impact by ensuring staff are appropriately trained for their roles associated with cell salvage in order to maintain safe practice and thus job security. Aseptic Non-Touch Technique processes (ANTT) has been introduced as an all-Wales approach to reducing healthcare associated infection. The PADR process supports further development appropriate to role and future employment ambitions.	Ensure all staff involved with aseptic techniques associated with ICS are trained and assessed in ANTT	Enable the trained ANTT facilitators to continue rolling out ANTT in accordance with the all-Wales approach
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of	N/A	N/A	N/A

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
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	If a patient has a carer or parent/guardian we will ensure they receive the appropriate information.	N/A	N/A
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic	Intraoperative Cell Salvage has the potential for a positive impact in terms of supporting the prudent use of donated blood in accordance with the Welsh Health Circular (WHC),	N/A	N/A

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
development; biological diversity; climate Well-being Goal – A globally responsible Wales	“Better Blood Transfusion: Appropriate Use of blood”.		

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	Intraoperative cell salvage has a positive impact by providing an alternative to allogeneic blood transfusion in accordance with the Welsh Health Circular (WHC), "Better Blood Transfusion: Appropriate Use of blood". The policy and procedure promote safe and effective practice that is consistent with people's beliefs and values.

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?	All staff should be trained and assessed in line with the all-Wales use of ANTT. This should be embedded in ongoing training for ICS. http://howis.wales.nhs.uk/sitesplus/888/page/64404 There are no additional new actions identified as a result of updating the policy and procedure.	Lead Nurse and Education Lead for the directorate.	Immediate and ongoing	Enable relevant staff to access the eLearning and have a practical assessment by a trained ANTT facilitator within the UHB

	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?	As part of its implementation this procedure document will be circulated to all relevant personnel and implemented in all areas which may be involved in ICS. This will include: • Consultant Lead for Transfusion • Clinical Lead for ICS • Manager for Theatres • Transfusion Practitioner • Jehovah's Witness Hospital Liaison Committee • Senior Nurse / Theatre Managers • Relevant surgical specialities • Obstetrics and Gynaecology It will also be available via the UHB Intranet. Members of the public will be able to access it via the website of the UHB with hard copies being provided on request. Guidance on and queries relating to the procedure should be addressed to the organisation's Clinical Lead for ICS.	N/A	N/A	N/A

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions: - • Decide whether the strate 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) • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Continue unchanged as there are no significant negative impacts. EHIA will be placed on the intranet once approved Adherence to the policy will be monitored through Perioperative Care Directorate governance forums When this policy is reviewed, this EHIA will form pa of that consultation exercise and publication. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).	Lead Nurse and Education Lead for the directorate.	Ongoing	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

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

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board Quality, Safety and Patient Experience Sub-Committee

Held on 14th July 2023 Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Director of Nursing/Multi Professional Teams
Adam Christian	AdC	Clinical Board Director
Jamie Williams	JW	Senior Nurse, Radiology
Seetal Sall	SS	Point of Care Testing Manager
Sian Jones	SJ	Directorate Manager, Laboratory Services
Robert Bracchi	RB	Medical Advisor to AWTTC
Alison Borwick	AB	Quality Manager, Biochemistry
Jonathan Davies	JD	Health and Safety Adviser
Jo Fleming	JF	Quality Lead, Radiology
Suzanne Rees	SR	Lead Nurse
Melissa Melling	MM	Head of Medical Illustration
Tracy Wooster	TW	Sister, Outpatients
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Susan Beer	SB	Public Health Wales Representative
Meurig Francis	MF	Graduate Trainee
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Rhys Morris	RM	CD&T R&D Lead
Sarah Lloyd	SL	Director of Operations
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Jenna Walker	JW	Quality Lead, Pharmacy
Alana Adams	AA	Principal Pharmacist Medicines Information and Advice
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
Alun Roderick	AR	Laboratory Service Manager, Haematology
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

Item No	**Agenda Item**	**Action**
PRELIMINARIES		
CDTQSE 23/190	**Welcome & Introductions** HL welcomed everyone to the meeting.	

CDTQSE 23/191	**Apologies for Absence** The apologies for absence were noted.	
CDTQSE 23/192	**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 20th June 2023 were accepted as an accurate record.	
CDTQSE 23/193	**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* Helen Luton is still awaiting the engineer's report of the Toxicology lift. She will follow this up. *CDTQSE 23/122 Safety Alerts* JW and SH to consider how Pharmacy and Clinical Engineering can link up in terms of where safety alerts overlap between the two departments, such as where medical devices deliver medicine. *CDTQSE 23/133 R&D Lead for Pharmacy* HL will check with RM if a nomination has been received for an R&D Lead for Pharmacy. *CDTQSE 23/156 NRI in Pharmacy* HL has asked Caroline Sutton to present the NRI in Pharmacy that she investigated to the next meeting. *CDTQSE 23/163 ANTT Training* Suzanne Rees has escalated the difficulties Radiographers are having in accessing ANTT training to the UHB IPC Group. *CDTQSE 23/177 Health and Care Quality Discussion* The Health and Care Quality discussion will be deferred to the next meeting. *CDTQSE 23/179 Gloves Off Campaign*	**HL** **JW/SH** **HL** **HL**

	Helen Luton has been advised that Rhian Cottrell is the lead. Helen Jenkins will ask her to present to the Clinical Board Green Group. **The Group resolved that:** a) The update on the actions from the previous meeting were noted.	**HJ**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 23/194	**Concerns and Compliments Report** In June 2023, the Clinical Board received 39 concerns; 6 formal and 33 early resolution concerns. It received 13 compliments. The themes for concerns received are wide ranging. The top 3 main themes relate to: • Difficulties cancelling and arranging appointments (25%) • Waiting time for test results/scan reports (15%) • Communication issues (15%) **The Group resolved that:** a) The concerns metrics including a breakdown for each department, were received and noted. b) The theme of difficulties with arranging and cancelling appointments almost doubled this month compared to last month. Directorates were asked to feedback if there were any specific issues in their areas last month.	
CDTQSE 23/195	**National Reportable Incidents – NRI report** The Clinical Board is reporting 3 NRIs, one of which has been closed. HJ to ask AA to present the Radiology and Neuro case she investigated to a future meeting. **The Group resolved that:** a) The NRI report was received and noted.	**HJ**
CDTQSE 23/196	**New NRIs** There are no new NRIs to report. A case has been reported involving a number of Clinical Boards that relates to a clinical trial. This case involves Radiology, Pharmacy, Neuro, Anaesthetics and Cardiff University. This is	

	not an NRI, however a local review is being undertaken, led by the corporate safety leads for shared learning. A similar local review is also being undertaken in relation to a potential delay in a lymphoma diagnosis. It emerged that the patient did not actually have a lymphoma but the Clinical Board is working with the corporate team around how best to investigate this case. **The Group resolved that:** a) Learning from the local reviews will be shared across the Health Board.	
CDTQSE 23/197	**Duty of Candour Cases** The Clinical Board is reporting duty of candour case. This involved a patient receiving care from Podiatry and District Nursing. This is a complicated process as the case involves pressure damage which is also a reportable incident and the 2 processes are not aligned. The case is also part of the redress process. It was noted that JF is in discussions with the Duty of Candour team to determine whether a case in Radiology is part of this process. This relates to a case where an inpatient attended for a video fluoroscopy study and had no record of any allergies on the referral form. For this procedure a barium product is used which contains a strawberry flavouring and the patient was allergic to strawberries. The patient was not checked for any allergies prior to being given the contract to drink and the patient developed a rash and heavy breathing. JF will provide a further update next month. SO reported that an investigation is being undertaken into a data breach and part of this is assessing whether or not one of the patients would be informed that their records are being accessed without their consent, as there is a risk of putting the staff member who was involved at risk. Support is being provided from the People and Culture and Information Governance Teams. There is ambiguity around which process this case should be dealt under. HL suggested that this case is more likely to fall under information governance/data protection processes as opposed to Duty of Candour. HL referred to a case in Radiology involving a claim and it was agreed that JF will present this case at the next meeting. **The Group resolved that:** a) The Duty of Candour cases were noted. b) The outcome and decision of the information governance case will help inform the process for any similar circumstances.	**JF** **JF**

	c) The case involving a claim will be presented at the next meeting.	
CDTQSE 23/198	**Risk Register** Aaron Fowler and Glynis Mulford were in attendance to offer to provide advice to directorates to ensure there is a unified approach to undertaking risk assessments and completing risk registers. A number of policy documents and presentation slides shave been produced and they have been uploaded into the Group's Teams Channel for information. Helen Luton referred to risks that have been on the register for a number of years and asked if there is anything more can be done, particularly risks that relate to the estate. Aaron Fowler stated that the risks may not have changed but should be updated with any mitigation taken. The scorings should be reviewed to reflect where mitigation has been taken, and also updated if the scoring has increased in terms of regulatory compliance and reputational risks. Seetal Sall enquired on whether there is any training available for new quality staff. JD advised the Health and Safety team provide a half day practical course on a monthly basis. Aaron Fowler also offered to support individuals to work through specific issues. Helen Luton asked how best to manage a risk where there is cross reference with other Clinical Boards. Aaron Fowler advised that the risk is recorded locally and highlighted to the corporate governance team to follow up with the other relevant areas. **The Group resolved that:** a) The support that can be provided from the corporate governance team was noted.	
FCDTQSE 23/199	**Patient Safety Alerts** **ISN 2023 004 Defibrillator Replacement Pads** The alert has been circulated across the Clinical Board and the compliance form will be submitted to the Patient Safety Team noting the actions taken. An Internal Safety Memo was received in Clinical Engineering relating to oxygen therapy equipment and flow meters has been circulated to relevant to departments. A Field Safety Notice was also received in Clinical Engineering around Oxylog Transport Ventilators that could fail to run on mains once they have run on batteries. Clinical Engineering are looking into a software update.	

	The Group resolved that: a) The safety alerts have been circulated across the Clinical Board for awareness.	
CDTQSE 23/200	**Medical Device/Equipment Risks** Ed Chapman was not present but presented a written report with accompanying documents. They will be circulated to the group. An SBAR is being submitted to establish a clinical safety officer that would link in with Digital Team on AI and would be similar to the MDSO model that is in place for medical devices. An internal audit was undertaken on training records in departments for medical devices. HL and SR will link in with other DONs in the first instance to ensure there is a central record of training. A replacement fleet vehicle procurement is creating a risk to the clinical engineering service in terms of an admin burden and risk of companies repossessing or terminating leases. An external audit was undertaken by the BSI in the mechanical section, looking at their QMS systems. This was a positive audit with some minor findings. **The Group resolved that:** a) The report and papers sent by Ed Chapman will be shared for information.	**HJ**
CDTQSE 23/201	**Point of Care Testing** Across the Health Board there are 2 different platforms for testing pregnancy. One is a connected system that is generally used in high throughput, high risk services such as ED and SSSU. The remainder is the visual pregnancy testing cassette. The kit is delivered into Pharmacy and they have highlighted there is a supply issue from the company. he supplier has been contacted and has advised that deliveries will resume on 31st July. In the interim the mitigation recommended is a blood sample is taken and submitted to Biochemistry. Surgery Clinical Board has been notified. An official communication has not yet been produced but needs to go out across the Health Board. SS will forward the detail to HL and HL will arrange for a comms to go out wider. **The Group resolved that:** a) The update on Point of Care Testing was noted.	**SS/HL**

CDTQSE 23/202	**IP&C/ Decontamination Issues** SR noted that the UHB Decontamination Group has not been held since the update given at the last meeting. She provided feedback from the Water Safety Group noting that any requests for water coolers need to be submitted to her direct. There is a robust process and stringent criteria that needs to be met. The Physiotherapy pool at UHW is due to be reopened in July. There has been an outbreak in MSSA bacteria in renal lines, some of which have been put in within Interventional Radiology. A meeting was held and it was reported that there has been an increase over the last 3 months. A deep dive is therefore being undertaken on cases from over the last 18 months. The mean time for the line infections has been around 6 months after they were inserted. IP&C arrangements in Radiology are being reviewed. The risk with non-compliance with ANNT in Radiology has been escalated several times and work is now underway with Yvonne Hyde and Jo Fleming to produce an action plan to improve training compliance and also look at replicating checklists used on wards within Interventional Radiology. SR also reported that areas within this Clinical Board are being added to Tendable for IPC audits. SR is collating a list of link persons in each area for IPC and will be requesting exception reports from them to feed into the IP&C Committee. Jason Roberts has asked Clinical Boards to ensure that IP&C is on their agendas. HL has provided assurance that IP&C is a standing agenda item at this meeting. **The Group resolved that:** a) When the Tendable system is implemented within this Clinical Board, the reports will be discussed at this group.	
CDTQSE 23/203	**Safeguarding Update** HL will share a paper around the procedural response to unexpected deaths in childhood. This sets out the minimum standard for the response expected for an unexpected death in infancy and childhood and describes the process of communication that is required. **The Group resolved that:** a) The Safeguarding update was noted.	**HL**

CDTQSE 23/204	**Health and Safety Issues** 15 staff incidents have been reported since the previous meeting. 5 incidents were rated moderate or above and these are being investigated. Indicative findings from the diesel monitoring in Haematology laboratory suggest the levels are not of significant concern. SJ asked what mitigation or recommendations can be put in place in terms of the emissions, as there is a member of staff with asthma that has previously attended EU due to the fumes. JD noted that he has asked for recommendations to be made and will liaise with estates on mitigation. The UHB has set up monthly meetings with Clinical Boards to discuss serious or Riddor reportable incidents. AB reported an incident that occurred involving 2 members of staff relating to exposure to saline in a bag due to inappropriate waste disposal. An investigation is in progress. **The Group resolved that:** a) The report on the diesel monitoring in Haematology Laboratories will be shared with the laboratory when received.	**JD**
CDTQSE 23/205	**Regulatory Compliance** Cellpath maintained their accreditation following their UKAS assessment. Positive comments were received on the culture in the laboratories and the skills and knowledge of the staff. The findings reported were not unexpected to the department. The MHRA inspection at Pharmacy UHL. There were 3 major findings; 1 relating to the estate, 1 to the recall procedure and 1 relating to updating the QMS. The estate issue is a particular challenge. Stem Cell will be inspected by the HTA at the end of the month. Radiopharmacy Routine microbiology testing in Radiopharmacy identified fungal growth on plates which has resulted in a closure of the unit. The team are working through mitigation and actions to reopen the unit as soon as safely possible. This is likely to take a few weeks. Similar growths were identified in the aseptic unit at UHL and in units in other neighbouring Health Boards. It is likely that the hot and wet weather is a contributing factor to fungal spores in the environment.	

	The Group resolved that: a) An update on the root causes of the fungal growth will be provided at the next meeting.	
TIMELY		
CDTQSE 23/206	**Initiatives to Improve Access to Services** SO reported on a service initiative within the Appointments Booking Centre based at UHL, supporting acute appointments. There have been recruitment challenges and difficulties managing the level of calls being received. A programme of work including technical changes to the call queues has been undertaken to make improvements. Also, the potential option of a booking system for Phlebotomy patients to book their own appointments is being explored. The aim is to enable greater use of email and Microsoft forms to reduce the number of calls and increase the number of communication channels. **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 23/207	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** Patients waiting 8 weeks or more for diagnostics was 5120 in June increase from May of 471. The key reason is work was undertaken to prioritise cancer patients for CT and there has been a focus on urgent inpatients which has impacted on routine patients. Patients waiting 14 weeks or more for Therapies increased to 55. The main area affected is in Dietetics. **The Group resolved that:** a) The waiting time performance information was noted.	
EFFECTIVE		
CDTQSE 23/208	**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 23/209	**NICE Guidance** **The Group resolved that:** a) There was no NICE guidance to discuss.	
CDTQSE 23/210	**Research and Development** RM was not present. **The Group resolved that:** a) The next meeting will be held on 20th July.	
CDTQSE 23/211	**Service Improvement Initiatives** SO reported that the UHB T is revitalising patient participation booking, a combination of new acute appointments made in the PMS system that are auto-booked six weeks prior to appointment. Patients will have the opportunity to see their appointment letter digitally and rearrange their booking. If patients cannot view their letters digitally they will receive a paper letter. This process reduces the number of DNAs. The system was previously in place but has now been enhanced with many benefits such as it allows patient appointments to be brought forward earlier than the 6 weeks. The system allows for clinics to be refilled where there are cancellations and short notice appointments can be offered. The plan is to go live from 29th August to end of September for all new acute appointment specialties. The plan for the future is to bring in other specialties that use different systems such as Therapies and Radiology. SO also reported that the first Digital Advisory Board has been implemented. A key aim of this group is to prioritise the digital resources available in the UHB. There is good representation from this Clinical Board on this group. The Clinical Board has met with its Change Business Partner, Katherine Blowers. A meeting is being held next week to discuss the support she is able to provide to this Clinical Board. **The Group resolved that:** a) Patient Participation Booking is a challenging initiative but with support can be delivered.	
CDTQSE 23/212	**Information Governance/Data Quality** SO reported that it has been identified that paper results are still being sent out across the Health Board. The protocol needs to be updated to reflect that electronic results is the mandate and paper results are sent out by exception only.	

	SJ and CE will produce an SBAR and submit to the Clinical Board Senior Management Team to present to Information Governance. **The Group resolved that:** a) The Information Governance Team are supportive of this approach.	**SJ/CE**
CDTQSE 23/213	**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 23/214	**Policies and Procedures** There are no policies or procedures for this group to review. **The Group resolved that:** a) Any policies out for consultation are available on the UHB SharePoint site.	
EFFICIENT		
CDTQSE 23/215	**Exception Reports from Directorates** HL stated that this Sub-Committee needs oversight of issues discussed at directorate Quality and Safety Groups and a template has been produced for directorates to complete summarising discussions held at their QSE meetings. SR requested that a heading for IPC is included on the template and it was also requested for a heading to be included for new risks. HJ to update the template and circulate to the group. **The Group resolved that:** a) Directorates will trial the exception report for the next meeting.	**HJ**
CDTQSE 23/216	**Health and Care Quality Standards** **The Group resolved that:** a) This item will be deferred for a focused discussion at the next meeting.	
CDTQSE 23/217	**Clinical/Internal Audits** A BSI audit was held in Clinical Engineering. **The Group resolved that:** a) The report will be circulated to the Group.	

CDTQSE 23/218	**Waste and Sustainability** The next Clinical Board Waste and Sustainability Group will be held on 20th July. **The Group resolved that:** a) Attendance was encouraged from directorates.	
EQUITABLE		
CDTQSE 23/219	**Feedback from Clinical Board Inclusion Ambassadors Group** SO reported that the UHB Anti-Racist action plan has been signed off by the UHB This will inform a local plan for this Clinical Board. The intent is to use the template and key principles of the action plan and replicate this for the other Protected Characteristics without taking focus from the Anti-Racist agenda. The work on Safe Space is still ongoing in partnership with Staff Side. The plan is to host a combined Safe Space with the Clinical Board and Staff Side and work through how to gain insight around the discussions. The Clinical Board will also need to ensure that this does not impact on the formal UHB processes for staff to raise concerns but is seen as an alternative process. **The Group resolved that:** a) The update from the Inclusion Ambassadors Group was noted.	
CDTQSE 23/220	**Equality and Diversity Issues** The One Voice Network attended Combined Formal Board meeting this week. They noted that ethnic minority staff have raised concerns around discrimination. HL is meeting with the Network to understand the issues they have raised and how to ensure ethnic minority staff can be developed in their roles. **The Group resolved that:** a) The update was noted.	
PERSON CENTRED		
CDTQSE 23/221	**Patient Story** **The Group resolved that:** a) The patient story from Pharmacy has been deferred to the next meeting	

CDTQSE 23/222	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 23/223	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/224	**National User Experience Framework/Feedback from Patient and Service User Surveys** HL will share the Civica data, however she noted that there are comments included in the report that relate to services outside of this Clinical Board. She will be linking with the patient experience team to consider how comments attributed to Therapists on wards can be provided to this Clinical Board. SO reported that there are plans in Phlebotomy to undertake a local survey from patients on where they have had to travel from just to receive their bloods. The plan is to react to the information received. **The Group resolved that:** a) The Civica data will be circulated. b) Feedback will be provided at a future meeting on the Phlebotomy survey results.	
CDTQSE 23/225	**Staff Awards and Recognition** HL reminded directorates to consider nominating staff in the monthly Clinical Board Staff Recognition Scheme. **The Group resolved that:** a) Directorates to advise where any staff have been recognised wider than the Clinical Board.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 23/226	There were no items to receive.	
ANY OTHER BUSINESS		
CDTQSE 23/227	There were no further items to report.	
CDTQSE 23/228	**Date & time of next Meeting** 23rd August 2023 at 11am via Teams	

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board Quality, Safety and Patient Experience Sub-Committee

Held on 22nd September 2023 Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Director of Nursing/Multi Professional Teams
Sarah Lloyd	SL	Director of Operations
Becca Jos	BJ	Deputy Director of Operations
Suzanne Rees	SR	Lead Nurse
Alana Adams	AA	Principal Pharmacist Medicines Information and Advice
Robert Bracchi	RB	Medical Advisor to AWTTC
Jamie Williams	JW	Senior Nurse, Radiology
Alun Roderick	AR	Laboratory Service Manager, Haematology
Paul Williams	PW	Clinical Scientist, Medical Physics
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Jo Fleming	JF	Quality Lead, Radiology
Melissa Melling	MM	Head of Medical Illustration
Tracy Wooster	TW	Sister, Outpatients
Rhys Morris	RM	CD&T R&D Lead
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer
In attendance:		
Julie Postle	JP	Pharmacy
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Adam Christian	AdC	Clinical Board Director
Seetal Sall	SS	Point of Care Testing Manager
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Sian Jones	SJ	Directorate Manager, Laboratory Services
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Timothy Banner	TB	Clinical Director, Pharmacy
Jonathan Davies	JD	Health and Safety Adviser
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Susan Beer	SB	Public Health Wales Representative
Elaine Lewis	EL	General Manager, Pharmacy

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 23/229	**Welcome & Introductions** HL welcomed everyone to the meeting.	

CDTQSE 23/230	**Apologies for Absence** The apologies for absence were noted.	
CDTQSE 23/231	**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 14th July 2023 were accepted as an accurate record.	
CDTQSE 23/232	**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* IHL has not received the engineer's report and will try to obtain a copy. *CDTQSE 23/122 Medical Devices* Links have been made between the Pharmacy and Clinical Engineering departments to consider the overlap around safety alerts involving medical devices that deliver medicines. The departments are also linking in with the Patient Safety Team. *CDTQSE 23/133 R&D Lead in Pharmacy* RM noted that there is no R&D Lead in Pharmacy. AA will feedback to the directorate that a nomination is needed. *CDTQSE 23/212 SBAR on Paper Results* BJ is in discussion with Biochemistry for a letter to be drafted for circulation. An update will be fed back at the next meeting. **The Group resolved that:** a) The update on the actions from the previous meeting were noted.	**HL** **AA** **BJ/NR**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 23/233	**Concerns and Compliments Report** In August 2023, the Clinical Board received 22 concerns; 1 formal and 21 early resolution concerns. There was 1 breach in response times. 8 compliments were received.	

	The 2 main themes of concerns received in August related to: • Difficulties cancelling/arranging appointments – 50% • Communication issues – 14% Workforce challenges within appointments booking teams are exacerbating the situation and despite best efforts from staff to manage the demand, there are telephone calls that are unable to be answered, resulting in patients raising concerns. KA noted that the Corporate Vacancy Scrutiny Panel have asked for further information to be submitted relating to appointment booking vacancies in Physiotherapy. Further justification for the post will be submitted and HJ will provide KA with the numbers of concerns received to help support the case. Helen Luton noted that the UHB is considering implementing a new process around the management of early resolution concerns, whereby if concerns are not resolved within 2 working days, then a written response may need to be provided. **The Group resolved that:** a) The concerns metrics report, which included a breakdown for each department, was received and noted.	**HJ**
CDTQSE 23/234	**National Reportable Incidents** Caroline Sutton will present the NRI in Pharmacy at the next meeting. The Clinical Board is reporting 1 open NRI and is on track for this to be closed within the timeframe. The redress process is completed for the EU investigation. AA was the Investigating Officer and provided feedback on the investigation. A 49-year-old gentleman with multiple sclerosis was prescribed Natalizumab, known as Tysabri as the brand name. This is an effective treatment for multiple sclerosis however this drug can cause a serious and sometimes fatal condition called progressive multifocal leukoencephalopathy known as PML. Patients on this drug are carefully monitored for any symptoms associated with that condition, in particular with regular MRI scans. This patient was of particular high risk having a positive JCV, (John Cunningham Virus) which causes this condition. The patient also had a previous history of immunosuppressant medication which put him at increased risk. Throughout his course of treatment he was fairly stable for the first few years and in April 2022 his JCV level increased. To mitigate against this, the dose interval was extended from monthly to six weekly. He had a regular MRI schedule scan and	

	in April this stated that he had no evidence of PML and it was also reported that he did have a new hyperintense lesion. This would raise suspicion of PML but can also relate to flare ups of their multiple sclerosis, so it is difficult to differentiate between the two. He continued with his treatment and in his June appointment the issue of his lesion and his increased JCV was raised by the nursing team who administered his medication, but was reassured to continue to administer the medication and his case would be discussed at the next MDT meeting. The case was discussed at MDT on 6th July and it was agreed that the patient was too high risk to continue and should be switched to an alternative agent. Following some delays both justified and not justified, on 13th July the patient was presented with alternative options and was given the option to go away and consider which option is the most suitable, as there are considerations with these treatments such as side effects, the schedule of administration etc. On 1st August the patient reported back that he had decided to switch to Ocrelizumab, known as Ocrevus. The problem with this drug is that it requires the patient to have pre-treatment bloods. It is much longer acting than Tysabri and requires a 2-dose regimen at the start of treatment then 6 monthly thereafter. The benefit of this agent was that there is less risk of it causing PML. On 10th August the patient received a follow up MRI scan and did not identify any new lesions. The opportunity was missed to consent him for the new treatment and perform the pre-treatment bloods. On 9th September the patient received assurance that the August scan was stable and he could switch to Ocrevus. The patient received his last dose of Tysabri on 21st September. At this point his bloods were taken for the Ocrevus and a separate appointment was made for him to have the consent undertaken. On 8th November he received the first dose of Ocrevus. On 21st November he developed new symptoms, facial weakness and left sided weakness and left sided facial drop with reduce left sided coordination. This was explained as a relapse of his MS due to the gap between the last dose of his former medication and the first dose of the new one. The patient was treated with intravenous steroids for 5 days and this he received is second dose of Ocrevus on 22nd November. The patient deteriorated and was brought in on 13th December . A repeat MRI scan was performed which showed there was evidence of PML on both the April and August scans. Despite best efforts of treatment, the patient passed away on 12th January.	

	The investigation into this case raised a number of issues. The scan undertaken in April, although reported the new lesion, suggested there was no evidence of PML. There should have been more suspicion of PML at that point. The manufacturer suggests that if there is any evidence of new lesions with this medicine, this should be investigated further before continuing treatment with that agent. The patient continued to receive Tysabri for 2 further doses, which was a considerable amount of time. Once the decision had been made by MDT to switch treatment, there should have been more pace in the process, given the patient was such high risk. PML was not considered as a reason for the patient's symptoms in November. It was automatically assumed to be a relapse and was not investigated further. If the patient had an MRI scan at that point in time, a second dose of Ocrevus could have been avoided. An improvement plan is in place where it is suggested that MRI scans should be scheduled prior to switching patients to a long acting preparation. Written communications need to be strengthened between Neurology and Neuroradiology for these high-risk patients. All healthcare professionals, patients and caregivers need to understand the significance of identifying those symptoms in patients on these treatments, and also for 6 months after discontinuation of treatment. The case was presented to Redress Panel. It was perceived that because of the issues raised in terms of the care received, that this is above the value for Redress Panel and the family are advised to seek legal advice. **Claim Investigation Report** The report was received relating to a member of staff who submitted a claim following an injury sustained on a ward. The improvement plan reminds staff working on wards, that wards have tight bed spaces and for staff to be aware of equipment and furnishings around them. Incident managers are reminded that managers need to report staff injuries on Datix timely and if the incident results in staff absence for 7 days or more this needs to be recorded as a Riddor. Managers are encouraged to take photographs if possible. **The Group resolved that:** a) The NRI report was received and noted.	

CDTQSE 23/235	**New NRIs** **The Group resolved that:** a) There are no New NRIs to report.	
CDTQSE 23/236	**Duty of Candour Cases** There were no new cases to report. **Radiology Claims Cases** A 30-year-old female presented to her GP with a history of pain in the right buttock. A Pelvis x-ray in March and a CT in May 2017 reported a large calcified mass in the right groin. The patient was subsequently referred to Orthopaedics and discussed in MDT with a likely diagnosis of tumoral calcinosis secondary to a traumatic bleed in the adductor muscle. The mass was excised in October 2017 which was confirmed benign. Following this the symptoms began to improve. The patient was diagnosed with hip dysplasia in April 2019 following persistent and worsening symptoms and an orthopaedic review was undertaken. At this stage given the presence of degenerative change in the right hip, hip preservation surgery was deemed unlikely to be successful and the patient required a total hip replacement. Following expert review, it was concluded that the hip dysplasia was present on both the x-ray and CT from 2017. The x-ray was reported by a body Radiologist, not musculoskeletal and there were mixed opinions regarding whether this should have been identified at this point. It was confirmed that the hip dysphasia should definitely have been diagnosed on the CT from 2017 and this was a breach of duty. The case was discussed at the Radiology Events and Learning Meeting, where the majority of non-MSK Radiologists did not spot the dysplasia on the x-ray. Learning points were discussed and shared following the meeting. An 80-year-old woman attended her GP in August 2016 suffering with a cough and intermittent vomiting. She had a chest x-ray followed by a CT scan of the thorax, abdomen and pelvis in September 2016 and an abdominal ultrasound in November 2016. The CT identified kidney and liver cysts that were not concerning. The Claimant had a further CT scan in November 2016 which reported 'no abnormality associated with the abdominal aorta, pancreas, kidneys or spleen'. In December 2019, the Claimant attended her GP with deteriorating symptoms. An urgent CT scan was arranged	

	which reported a malignant looking 7.7cm mass in the left kidney. The Urological Surgeon reviewed the 2016 imaging and confirmed, with the benefit of hindsight, there was evidence of a 3cm tumour which had been slowly developing over the years. She was subsequently diagnosed with renal cell carcinoma. The Claimant was deemed to be too frail for surgical intervention and was treated palliatively until she passed away in December 2020. Although expert opinion was that 20-40% of Radiologists would also have missed the tumour, 50% would have identified it. The Health Board denied causation on the basis she was too frail for curative treatment in 2016 but agreed to settle the case. The case was shared at the Radiology Events and Learning Meeting for wider learning. **The Group resolved that:** a) The claims cases were noted for learning purposes.	
CDTQSE 23/237	**Risk Register** HL has been meeting with individual departments to review their directorate risk registers. It was noted that the Medical Physics team are reviewing their risks and submit their register following the review **The Group resolved that:** a) Directorates to provide any updates to their risk registers to HJ to incorporate into the Clinical Board risk register	**All**
CDTQSE 23/238	**Patient Safety Alerts** A safety alert relating to Medstron Solo bed side rails has been circulated in the Health Board but did not enter via the usual communication route. KA noted that work is being undertaken by Occupational Therapy with the Joint Equipment store and the Local Authority as there are around 6000 pieces of equipment across Cardiff and Vale that could be affected. AR reported that there is a Blue Alert from the Welsh Blood Service for O negative blood. This has been shared with weekend planning. HL will follow up with the Communications Team for this to be circulated. Phillips have released a safety alert relating to potential safety issues with the wireless footswitch used with the Phillips Allura Xper and Azurion systems. This equipment is used in Vascular 3. The issues can include loss of Bluetooth connection, battery issues, damage in the charger/cable.	**HL**

	The Group resolved that: a) In terms of the Medstron alert, EC has informed the Patient Safety Team of the alert and suggested that a task and finish group is set up to address the issues within the alert. b) Following receipt of the Phillips alert, Radiology advised it will use a wired foot switch in the interim and have put a risk assessment in place.	
CDTQSE 23/239	**Medical Device/Equipment Risks** Ed Chapman also referred to the Medstron safety alert advising that where the bed rail sides have a locking function, it is recommended one hand is used to lower the bed side as it is causing trapping of hands and causing injury. There is a diagram to show users how to operate the sides. If the equipment is stiff, this needs to be reported to Medstron and do not continue with its use. Medstron Representatives are visiting affected areas. A Memo has been received relating to oxygen flow meters and the risk of them stopping flow at flow rates of 2 litres or less. This is due to a faulty control in the flow valve. Clinical Engineering will replace them but is awaiting on stock of the components. HL thanked the Clinical Engineering Team for supporting the suction replacement at UHL. EC noted that Operation POET was generally successful and he acknowledged the amount of work that was undertaken in preparation for this event. **The Group resolved that:** a) The Safety Alerts will be circulated following the meeting.	**EC/HJ**
CDTQSE 23/240	**Point of Care Testing** **The Group resolved that:** a) There were no issues to report.	
CDTQSE 23/241	**IP&C/ Decontamination Issues** SR attended the UHB IP&C Group and there was discussion around the MSSA line infections in Radiology. A deep dive is being undertaken and there are no links in terms of any significant harm caused by direct line insertions in Radiology. There are issues around processes and all the SOPs need to be realigned as different procedures are being followed. ANNTT compliance has been reviewed and Radiology have worked hard to improve their compliance. There are a limited number of	

	assessors within this Clinical Board and the aim is to work on this with other directorates that have a lot more practice development nursing posts that are able to provide cascade training. SR is also starting work with Podiatry on ANTT compliance. The Radiopharmacy unit is now back up and running following the issues with fungal growths on places, which are now resolved. Glan Ely Ward is still currently part of this Clinical Board and it has been noted that Covid cases are increasing. Vaccine Champions have been contacted in the Clinical Board and will be attending training to start supplementing the mass vaccination campaign. Interested staff can still sign up as a Vaccine Champion. JF reported that she is working with the IPC Team on cleaning products that can be used on some of the equipment within Radiology. There is a challenge as Actichlor cannot be used and a HPV clean is also not suitable. This may be a risk for the risk register if appropriate cleaning products cannot be used on the equipment without causing damage. **The Group resolved that:** a) JF to provide an update at the next meeting.	**JF**
CDTQSE 23/242	**Safeguarding Update** The following papers have been circulated: NHS Safeguarding Network Bulletin Safeguarding Statement within All Wales Contract of Employments 10 Step Guide to Sharing Information to Safeguard Children Introduction from ICO Sharing Information to Safeguard Children **The Group resolved that:** a) The papers were noted for information.	
CDTQSE 23/243	**Health and Safety Issues** **The Group resolved that:** a) There were no Health and Safety issues to escalate.	

CDTQSE 23/244	**Regulatory Compliance** The Radiopharmacy unit is back up and running. There are outstanding estates issues to be finalised. Fungal growth outbreaks were reported in other manufacturing sites within the Clinical Board and these have also been resolved. Air handling unit issues in Biochemistry were resolved with a temporary solution. A more suitable, alternative temporary fix is now being put in place but NR raised concerns that a permanent solution must remain on the agenda and there is risk of the water in the cooling unit freezing in the Winter period. SL provided assurance that the Executives are sighted on this issue and the Director of Therapies and Healthcare Sciences is very supportive of resolving this issue. Given the current financial situation options are being considered how to progress this. HL advised that this issue has also been highlighted on the Clinical Board risk register as a separate risk to the other air handling issues that are a risk within this Clinical Board. The HTA will be carrying out an inspection of the Mortuary at the end of October and as part of this they will undertake an advisory visit of the temporary body store at UHL. SG to provide an update on feedback at the November meeting. HIW are inspecting Radiology in UHW in November. In terms of regulatory compliance, the metrics are stable. Haematology has improved its compliance. **The Group resolved that:** a) The update on regulatory compliance was noted.	**SG**
TIMELY		
CDTQSE 23/245	**Initiatives to Improve Access to Services** There were no initiatives to report. **The Group resolved that:** a) At the next meeting, SO to present on the initiatives in Health Records around appointment booking.	**SO**
CDTQSE 23/246	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** BJ reported that the number of patients waiting 8 weeks or more for diagnostics in Radiology are now in excess of 7000 patients. This is a consequence of increased demand and focus on prioritising cancer patients and inpatients. Plans are in place to start addressing the issue with an interim mobile solution in UHL in November.	

	Therapies are in general performing well against the 14-week target. Dietetics is area of concern due to increased demand in weight management services. The August position for the median turnaround times for cancer patients in Cellpath was 14 days. The expectation is to achieve a 10-day turnaround time and an improvement plan is in place. With regards to the 10-day turnaround time ambition for cancer patients for CT and MRI, the average turnaround times are 13.8 days for CT and 18.8 days for MRI. **The Group resolved that:** a) The waiting time performance information was noted.	
EFFECTIVE		
CDTQSE 23/247	**Feedback from UHB QSE Committee** **The group resolved that:** a) The minutes of the meeting held on 30th August 2023 are not yet available.	
CDTQSE 23/248	**NICE Guidance** The Wegovy weight loss drug has been approved. **The Group resolved that:** a) This will have major implications for Pharmacy and also particularly for Dietetics, where the challenge will be managing demand and patients' expectations.	
CDTQSE 23/249	**Research and Development** RM reported that the R&D Forum was held this week and was well attended. A presentation was provided from Podiatry on the Quick Change project, which relates to providing exercise routines in Primary Schools. They also shared their experiences on the RfPPB application process. There are plans to hold another forum in November/ December and RM requested presentations from any staff who would like to share a project or their experience of working on a project. The Clinical Board R&D Group also met this week. Concerns were raised that there are no R&D Leads in Laboratory Medicine, Therapies and Pharmacy. The Clinical Board will be presenting its annual R&D presentation to the R&D Performance Review and Group reviewed the presentation slides.	

	The Group resolved that: a) The Clinical Board will follow up on the gaps in R&D Leads within directorates.	
CDTQSE 23/250	**Service Improvement Initiatives** There were no service improvement initiatives to be shared. **The Group resolved that:** a) The update on the digital work in Therapies to be rearranged to a forthcoming meeting.	**MK**
CDTQSE 23/251	**Information Governance/Data Quality** **The Group resolved that:** a) There were no information governance/data quality issues to report.	
CDTQSE 23/252	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** As discussed earlier, HIW will be inspecting Radiology in November. **The Group resolved that:** a) Feedback following the inspection will be shared.	
CDTQSE 23/253	**Policies and Procedures** There are no policies or procedures for this group to review. **The Group resolved that:** a) Any policies out for consultation are available on the UHB SharePoint site.	
EFFICIENT		
CDTQSE 23/254	**Exception Reports from Directorates** MM advised there is a nationwide software issue with Imagenet, which consultants use to view images within Ophthalmology. This is impacting on waits and clinics. IT are aware but this is a manufacturer issue. Advice has been sought from the IPC Team relating to allergy issues with the carpet in the Medical Illustration department that could potentially have health implications. HL will discuss with MM outside of the meeting. MM raised concerns that the guidance relating to staff with respiratory symptoms could cause staffing shortages. BJ noted	

	that is often interpreted that if staff have any respiratory symptoms that they should not come to work, however the guidance actually states that if staff are unwell not to come to work which is an important distinction. HL noted that she has followed up on her conversation with MM on the issue with version control of documents with the Executive Director of Nursing, who will take this forward with the digital leads around WNCR. PW reported an incident which occurred in Med Physics where a Dexa patient having a bone scan suffered a cardiac arrest. Due to the swift action from staff providing chest compressions and using an automatic defibrillator, they managed to revive the patient. The patient was then attended by the Cardiac Arrest team and taken to Recess and had a positive outcome. This incident has not occurred previously in the department and was a stressful situation for staff. HL stated that this is an example where the life support training that all staff receive becomes beneficial. The Clinical Board acknowledged the efforts of the staff involved and HL advised that if the team would like a debrief with the Recess team that this can be arranged. KA stated that she will ensure there are defibrillators within Therapy areas. She reported on the poor quality of workmanship relating to the kitchen at Riverside Health Centre, which was stripped out to resolve a problem and put back in place. Photographs have been taken. There is an issue with 3 Band 3 staff working in EU with no registrant resource to support them. An SBAR has been produced around accommodation space for therapies, particularly dietetics, SLT and OT. The fire officer has raised issues with overcrowding. A temperature issue occurred in the Physiotherapy Hydropool, the day prior to its planned reopening. KA thanked the Estates team for their swift action to avoid delaying the re-opening. **The Group resolved that:** a) Directorates will trial using the exception report template to feedback a brief overview of the key issues that are discussed in their QSE meetings. Members are asked to feedback if there are concerns that this is unsustainable as it is adding to workloads are causing duplication.	
CDTQSE 23/255	**Health and Care Quality Standards** **The Group resolved that:** a) This item will be deferred to the next meeting.	

CDTQSE 23/256	**Clinical/Internal Audits** Pharmacy are preparing for an inspection as part of an application for a Home Office licence to allow the department to supply control drugs. As part of this work, all the control drug processes are being strengthened, part of this includes auditing balances and ensuring they are up to date and accurate. The plan is to use the Tendable system for this work. **The Group resolved that:** a) The update on clinical/internal audits was noted.	
CDTQSE 23/257	**Waste and Sustainability** KA noted that Therapies have developed a sustainability plan and this has been submitted to the Health Board Sustainability Group. The next Clinical Board Waste and Sustainability Group will be held next week where an overview will be given on the new Green Health Wales website. **The Group resolved that:** a) All staff within CD&T Clinical Board are welcome to attend the CD&T Waste and Sustainability Group.	
EQUITABLE		
CDTQSE 23/258	**Feedback from Clinical Board Inclusion Ambassadors Group** **The Group resolved that:** a) There was no feedback to report.	
CDTQSE 23/259	**Equality and Diversity Issues** JF noted that the department has a hearing loop that needs repair. It was suggested that she contact EC. On the Equality, Diversity and Inclusion calendar, next month is Black History Month. **The Group resolved that:** a) The update was noted.	
PERSON CENTRED		
CDTQSE 23/260	**Patient Story** Julie Postle was welcomed to the meeting to present a dispensing error. A patient brought a prescription to Outpatients for Isosorbide Mononitrate 10mg tablets. The prescription was checked and issued to the patient, however	

	Isotretinoin was dispensed in error. The department received a call from the extremely upset patient who could not understand why they were prescribed the wrong drug. The patient was concerned that there may have been a mix up with a prescription for a pregnant patient, as there is a warning on the label that the medication is not suitable for taking during pregnancy. A visit was made to the patient's home with the correct medication but the patient was still anxious and upset. The patient was therefore followed up the next day with a telephone call. The patient was also concerned that the member of staff that made the error should not be disciplined and following this conversation they were more reassured. The error was investigated and the person who made the error was new in post and training issues were highlighted in terms of the labelling system. Also, that day a dermatology clinic had taken place, where a lot of prescriptions were submitted for Isotretinoin which influenced the checking of the medication. Good reflections were undertaken as part of the investigation which also raised learning for the team as a whole in terms of checking drugs. **The Group resolved that:** a) A delay in communication with patients can increase their anxiety and early, open and transparent communication with patients when mistakes are made and learning from this can provide assurance.	
CDTQSE 23/261	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 23/262	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/263	**National User Experience Framework/Feedback from Patient and Service User Surveys** JF advised that patient experience surveys are being undertaken in Radiology outpatients. The Podiatry team are keen to implement patient surveys and JF will share any learning with Podiatry. HL has raised issues with the Patient Experience Team around obtaining relevant data for this Clinical Board from the Civica surveys.	**JF**

	The Group resolved that: a) Results from patient experience surveys will be shared at this meeting.	
CDTQSE 23/264	**Staff Awards and Recognition** The CD&T Clinical Board Staff Recognition Award for September is the Green/Sustainability Award. The Radiographer Led Discharge service have been shortlisted in the Advancing Healthcare Cymru Awards for the new ways of working category. Therapies staff are also nominated in the Advancing Healthcare Awards and the Innovate Awards. There will be recognition in the Clinical Board for the following national professions days: National Pharmacist Day next week. National Pharmacy Technician Day next month National Podiatrist Day next month Radiography Day 8th November. **The Group resolved that:** a) Directorates to advise where any staff have been recognised wider than the Clinical Board. b) Directorates to advise of any national professions days.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 23/265	Regulatory Compliance Group Minutes August 2023	
ANY OTHER BUSINESS		
CDTQSE 23/266	BJ noted that the CD&T Sharepoint site has a database for departments to advertise items that are no longer needed in their teams that others can use, or list any wanted items.	
CDTQSE 23/267	**Date & time of next Meeting** 16th October 2023 at 1pm via Teams	