Quality, Safety & Experience Committee

Tue 19 December 2023, 14:00 - 17:00

MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcomes & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee held on 28.11.2023

Ceri Phillips

Draft QSE Public Minutes 28.11.2023.pdf (6 pages)

1.5. Action Log from QSE Committee held on 28.11.2023

Ceri Phillips

1.5 Public QSE Action Log.pdf (2 pages)

1.6. Committee Chair's Action

Ceri Phillips

14:05 - 15:30
85 min

2. Items for Review & Assurance

2.1. Mental Health Clinical Board - Assurance Report

30 mins *Mark Doherty*

2.1 - MHCB Assurance Report QSE - Dec 2023.pdf (28 pages)

2.2. Quality Indicators Report

20 mins *Jason Roberts / Meriel Jenney*

2.2 Quality Indicators Report 20231212.pdf (19 pages)

2.3. Learning Committee Update - Verbal

10 mins *Jason Roberts / Meriel Jenney*

2.4. HIW Activity Overview to include HIW Primary Care Contractors

10 mins *Jason Roberts / Meriel Jenney*

2.4 QSE HIW update v2.pdf (12 pages)

2.5. Quality, Safety and Experience Framework - effectiveness review

10 mins *Jason Roberts / Meriel Jenney*

2.6. Research Update

5 mins *Meriel Jenney / Aled Roberts / Sarah Martin*

2.6 QSE Research and Development Update 19.12.2023 _1.pdf (8 pages)

15:30 - 15:30
0 min

3. Items for Approval / Ratification

No items.

15:30 - 15:35
5 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub-Committees

Jason Roberts / Meriel Jenney

4.1 CD&T - Att 1 - Minutes 16.10.23.pdf (12 pages)

4.1.1. WHSSC Patient Safety Minutes

4.1 WHSSC Minutes - Quality Patient Safety Committee Chairs Report.pdf (12 pages)

15:35 - 15:35
0 min

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

No items.

15:35 - 15:35
0 min

6. Agenda for the QSE Private Meeting

Ceri Phillips

i) Private Minutes

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

15:35 - 15:40
5 min

7. Any Other Business

Ceri Phillips

15:40 - 15:40
0 min

8. Review of the Meeting

Ceri Phillips

15:40 - 15:40
0 min

9. Date & Time of Next Meeting

Ceri Phillips

6th February 2pm-5pm

MS Teams

15:40 - 15:40
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 28th November 2023

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Keith Harding	KH	Independent Member - University
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Angela Hughes	AH	Assistant Director of Patient Experience
Claire Beynon	CB	Deputy Director of Public Health
Meriel Jenney	MJ	Executive Medical Director
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
Francesca Thomas	FT	Head of Corporate Governance
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Louise Platt	LP	Director of Operations - Medicine
Jane Murphy	JM	Director of Nursing - Medicine
Sian Rowlands	SR	Head of Quality & Clinical Governance - Medicine
Alun Tomkinson	AT	Clinical Board Director for Surgery
Rebecca Aylward	RA	Deputy Nurse Director (DND)
Matthew McCarthy	MM	Interim Head of Safety, Quality & Organisational Learning
Katherine Prosser	KP	Quality & Governance Lead - Medicine Clinical Board
Richard Skone	RS	Deputy Executive Medical Director
Observers		
Nathan Saunders	NS	Senior Corporate Governance Officer
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Fiona Kinghorn	FK	Executive Director of People & Culture

QSE 23/11/001	**Welcome & Introductions** The Committee Vice Chair (CVC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QSE 23/11/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/11/004	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/11/005	**Minutes of the Committee meeting held on 25.10.23**	

	The minutes of the Committee meeting held on 25.10.23 were received. **The Committee resolved that:** a) The minutes of the meeting held on 25th October 2023 were approved as a true and accurate record of the meeting.	
QSE 23/11/006	**Action Log following the Meeting held on 25.10.2023** The Action Log following the Meeting held on 25.10.2023 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 25.10.2023 was noted.	
QSE 23/11/007	**Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QSE 23/11/008	**Medicine Clinical Board – Assurance Report** The DO-M introduced the patient story about a 95-year-old lady to demonstrate the positive impact that digital technology and AI can have on a patient's journey, and summarised that: - CVUHB was the first Health Board to pilot the technology VISIONABLE (which started on 04.09.2023) in collaboration with WAST – the paramedic could contact the stroke consultant on call to discuss a patient - A 95-year-old lady with a suspected stroke was taken through the VISIONABLE app – it was determined that she had had a waking stroke, where they were unsure when she had had her stroke. - The paramedic was advised to take the patient through the A&E department into recess and CT scanned. - A waking stroke patient would not usually be thrombolysed - However, because of the new Perfusion CT scan (which Brainomix formed a part of), the Consultant received the scan on his phone to review, and they could make the decision whether to thrombolyse or not. - In this case they made the decision to thrombolyse the patient – she had since been discharged home. The IM-C asked if there was a specific type of phone required to use the technology. The CBD-S explained that the images were high-resolution and that most modern phones could support these images. He added that consultants on-call at home could still receive the images and advise on the care of a patient. The CBD-S commented that their thrombolysis and thrombectomy rates had improved significantly over the previous 2 months. The DO-M noted that to date they were at 23.5% for thrombolysis, and their thrombectomy was at 7.8%. The CBD-S noted that this technology was life-changing, as the patients otherwise would have very prolonged length of stays and complicated discharge packages, and in some cases the patients would not have survived. The EMD asked how patients got referred, and whether it was available to only C&V patients. The DO-M responded that both VISIONABLE and Brainomix were only available at present within CVUHB. The EMD asked whether there were plans to widen this in the long-term.	

The DO-M responded that SBUHB and BCUHB had gone live in the middle of November, and that CTMUHB and ABUHB would follow shortly.

The END highlighted that this technology was life-changing, and that if they got the stroke pathway right, it could have a huge impact on patient experience and quality.

The EDTHS provided congratulations to the whole team.

The IM-U informed the Committee that he was a stroke survivor himself, and he commended the care he had received in the stroke unit the previous January.

The CC noted that an underlying principle of the Committee was to aspire to excellence, and to achieve an A standard rating in SSNAP would demonstrate this.

The DN-M introduced the Assurance Report, and provided the following summaries:

National Reportable Incidents:

The DN-M highlighted that:

- Medicine had a high number of NRIs
- It was important to review these and feedback to the families in a timely manner - the main aim was to ensure that the NRIs did not become overdue
- The NRI's were cross clinical board and were very complex, however some would be downgraded after fact-finding
- They currently had 4 overdue, and 2 were near submission.
- Another risk was that they had an increasing gastro NRIs regarding delay of treatment, surveillance and cancer diagnosis – all of which was a large piece of work being undertaken by the Medicine Clinical Board to put plans in place
- They had managed 4-5 COVID potential healthcare acquired deaths, which had previously been managed by the COVID team
- Whilst they were concerned about the rise of NRIs, they did not have a high proportion overdue - they hoped to keep to 3 minimal
- They provided assurance that they were investigating and learning – they had started to use AmAt.

The END provided assurance that this had been discussed in great detail in their Executive Review the previous week, and that all of the Executives were aware of the NRIs. He noted concern over the increase in the number of overdue NRIs, as at the end of an NRI investigation was a family waiting for answers.

Staffing:

The DN-M highlighted that:

- Their nursing and retention plan contained 12 specific actions to maximise opportunities to recruit and retain staff.
- They had issues over the previous year's validation of vacancies – each directorate had undertaken a large piece of work to track their vacancies.
- New roles had been introduced over the previous year (specifically the Assistant Practitioner Band 4 role) – in some areas, they had received good results although it was still in the early stages.
- In response to the HIW report in EADU the previous year – the lead nurse had led a specific piece of work around recruitment and retention, and they had received excellent results. They had invested in the Senior Nurse for Education who focused on staff training and obtained feedback from new starters and staff.
- In October 2022 their turnover in ED was 16.31%, and this year it was 8.32%
- The Preceptorship Programme started 18 months ago with 12 nurses – all staff had been retained, and a second programme was underway at present
- They had also trained AMPs to aid with succession planning.

Patient Experience

The DN-M highlighted that:

- The Civica system was praised as it provided live feedback, and it had been used to triangulate data and undertake diagnostic reviews on wards
- A good action plan had been uploaded onto AmAt which was being worked through.

The CC commended the emphasis on learning and improvement which had been evident throughout the report. He asked to what extent they had engaged with the Improvement Team.

The DO-M responded that they had worked with the Improvement Team in a number of areas – notably around A1 and A2.

The END stated that they had a positive discussion around quality and safety in the previous Executive Review.

The ADQPS highlighted the learning around the NRIs, and that they used a thematic approach to investigation and reviewing them to find commonality. They used this information to look at similar issues across the Welsh Health Boards.

The EMD commented that this work aligned with Mortality work, which would be discussed later in the meeting.

Regarding IPC and how increased lengths of stay impact upon increased infection rates, the CC asked what Clinical Boards were doing to address these issues.

The DN-M responded that there had been notable issues within the University Hospital of Llandough (UHL) due to the layout of the wards (Nightingale Wards).

The END noted that he had reported to the Board around healthcare acquired infections across the organisation, where there had been mixed progress. Through 2024 there would be a focus on a zero-tolerance approach for any infection.

Mortality and Clinical Audits

The HQCG-M highlighted that:

- The analysis of the mortality data was crucial, and it was important to ensure it was accessible to all clinicians and staff
- In conjunction with BIS colleagues, a dashboard had been developed which provided more information on mortality data within EU and ward areas.
- By the following committee, they hoped to share some data.

The CC noted that there had been a degree of fiction around mortality rates due to the lack of data.

The Committee resolved that:

a) The assurance provided by the Medicine Clinical Board in this report and the steps being taken to improve quality, safety and patient experience across Medicine were noted.

QSE 23/11/009

Quality Indicators Report – Deep Dive on Mortality

The AMD-CES presented the report which set out the key sources of mortality information and how it was used to ensure the safety of the services provided by the Health Board. The report is available to view in detail alongside the papers received for the Public QSE Committee on the 28/11/2023 for Agenda item 2.2.1.

The EMD added that:

	- They were proactively providing Executive oversight to ensure that any action plans were in place and completed. - Over the previous few years, all in-hospital deaths had been reviewed to further learning - this was a step change in the service provided across Wales so there was better scrutiny at local level. The CC asked how they planned on getting into the space of being better than average. The EMD responded that the COO had led on a number of summits which looked in detail at the pathways of care for some of the most vulnerable patients. They were undertaking deep dives and overviews to improve mortality data/outcomes in 2 years' time. The AMD-CES agreed with the EMD's comments and added that a lot of data was collected internally. The IHSQO Interim Head of Safety, Quality & Organisational Learning commented that the medical examiners valued feedback from families around their end of life care and treatment. The CC noted that they were in a good place to work proactively rather than reactively. **The QSE Committee resolved that:** a) The assurance provided by the UHB mortality rates reported were noted.	
QSE 23/11/010	**Outstanding Actions from the Ombudsman's Annual Letter** The ADPE presented the report which provided a summary of the outstanding actions which came from the Ombudsman's annual letter. The report is available to view in detail alongside the papers received for the Public QSE Committee on the 28/11/2023 for Agenda item 2.3. The CC thanked the team for the thorough report. **The QSE Committee resolved that:** a) The contents of the report was noted.	
	Items for Approval / Ratification	
QSE 23/11/011	**Healthy Eating Standards for Hospital Restaurant and Retail Outlets** The DDPH introduced the report and summarised the following: - Since 2016, C&V had a 75% healthy eating offer in the restaurants and retail outlets the UHB had control over for visitors and staff. - The report detailed the robust audit conducted over the previous years - In 2023 their compliance had dipped below the 75% - colleagues in the Capital, Estates & Facilities team had found compliance challenging due to staffing difficulties and the inability to pay it proper attention. - The proposal agreed was that for a 12-month period, they would reduce the compliance level to 60%. The IM-CE acknowledged that the team were being pragmatic in the context of the current climate. She asked what discussions had been had with their suppliers in terms of their pricing mechanisms. The DDPH recognised this was a challenge, and conversations were ongoing with the suppliers and those who manage the tills to provide them with more detailed information and ensure this was automated going forward. She added that their ambition was to get back to the 75% compliance level. **The QSE Committee resolved that:**	

	1) The temporary changes to the Standards and the plan to be back up to the original compliance of 75% by December 2024 was noted; 2) The revised Standards (in the Appendix) was approved.	
	Items for Noting & Information	
QSE 23/11/012	**Minutes from Clinical Board QSE Sub Committees** The END noted the minutes for PCIC (26.09.2023), Children & Women's (26.09.2023), and Specialist (02.10.2023) were available for the Committee members to view. **The QSE Committee resolved that:** 1) The minutes from the Clinical Board QSE Sub-Committees were noted.	
23/11/013	**Child Practice Review Report** The END introduced the report and summarised the following: - The lengthy report followed the sad death of a 17-year-old looked after child in C&V - The report was already in the public arena and press - For assurance, any child and adult practice reviews were brought to QSE - There was no action or requirements for the UHB. **The QSE Committee resolved that:** 1) The contents of the report was noted.	
QSE 23/11/014	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/11/015	**Agenda for Private QSE Meeting** *i) Private Minutes* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *iii) Prison (Confidential Discussion)*	
QSE 23/11/016	**Any Other Business** The CC thanked Keith Harding for his work as he was leaving at the end of the month. The CC informed the Committee that due to the schedule of the meetings, the preparation of the papers had become problematic. From 2024, the meetings would move to a 6-week schedule.	
	Date & Time of Next Meeting: 19th December - 2pm-5pm - via MS Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 19 December 2023
(Following the meeting held on 28 November 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
UHB 23/05/015	**Integrated Performance Report: QSE**	For mortality data assurance to be provided to the Board at a Board Development session following a deep dive at the QSE Committee meeting in November.	**28.11.2023**	Meriel Jenney	**COMPLETED** Update was provided in the 28.11.2023 QSE Committee.
Actions in Progress					
QSE 23/07/009	**MBRRACE Update**	For a matrix report to be provided to the Committee to include the MBRRACE report.	**09.01.2024**	Meriel Jenney / Jason Roberts	**Update in January 2024**
QSE 23/09/009	**Looked After Children – Assessment Backlogs**	For a 6-month update on the Assessment Backlogs for Looked After Children to be provided to the Committee.	**05.03.2024**	Jason Roberts	**Update in March 2024**
QSE 23/07/014	**Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25**	For an update on the Hep B & C Joint Recovery Plan 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					

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
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**	Jason Roberts	**Update in December**

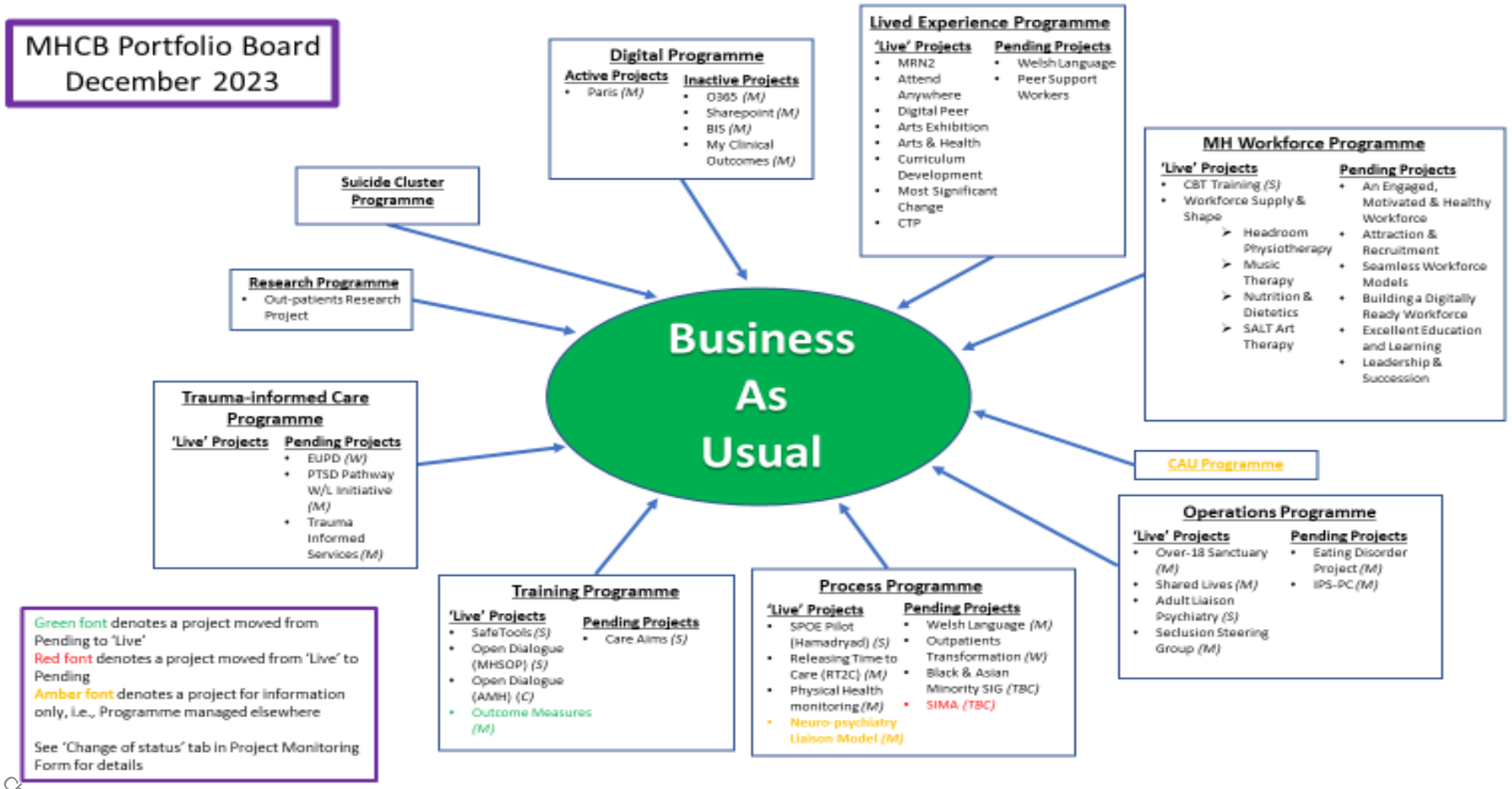
Report Title:	Mental Health Clinical Board Assurance Report			Agenda Item no.	
Meeting:	Executive Board QSE Assurance Meeting	Public		Meeting Date:	
		Private			
Status *(please tick one only):*	Assurance		Approval	Information	
Lead Executive:	Neil Jones Clinical Board Director, Mark Doherty, Director of Nursing, and Dan Crossland Director of Operations for Mental Health Clinical Board				
Report Author (Title):	Mark Doherty, Director of Nursing, Mental Health Clinical Board				

Main Report
Background and current situation:

This report has been prepared to provide assurance to the Quality, Safety and Patient Experience Committee. It aims to demonstrate that quality, safety and patient experience is at the heart of the delivery of services to the mental health service users within Cardiff and Vale University Health Board

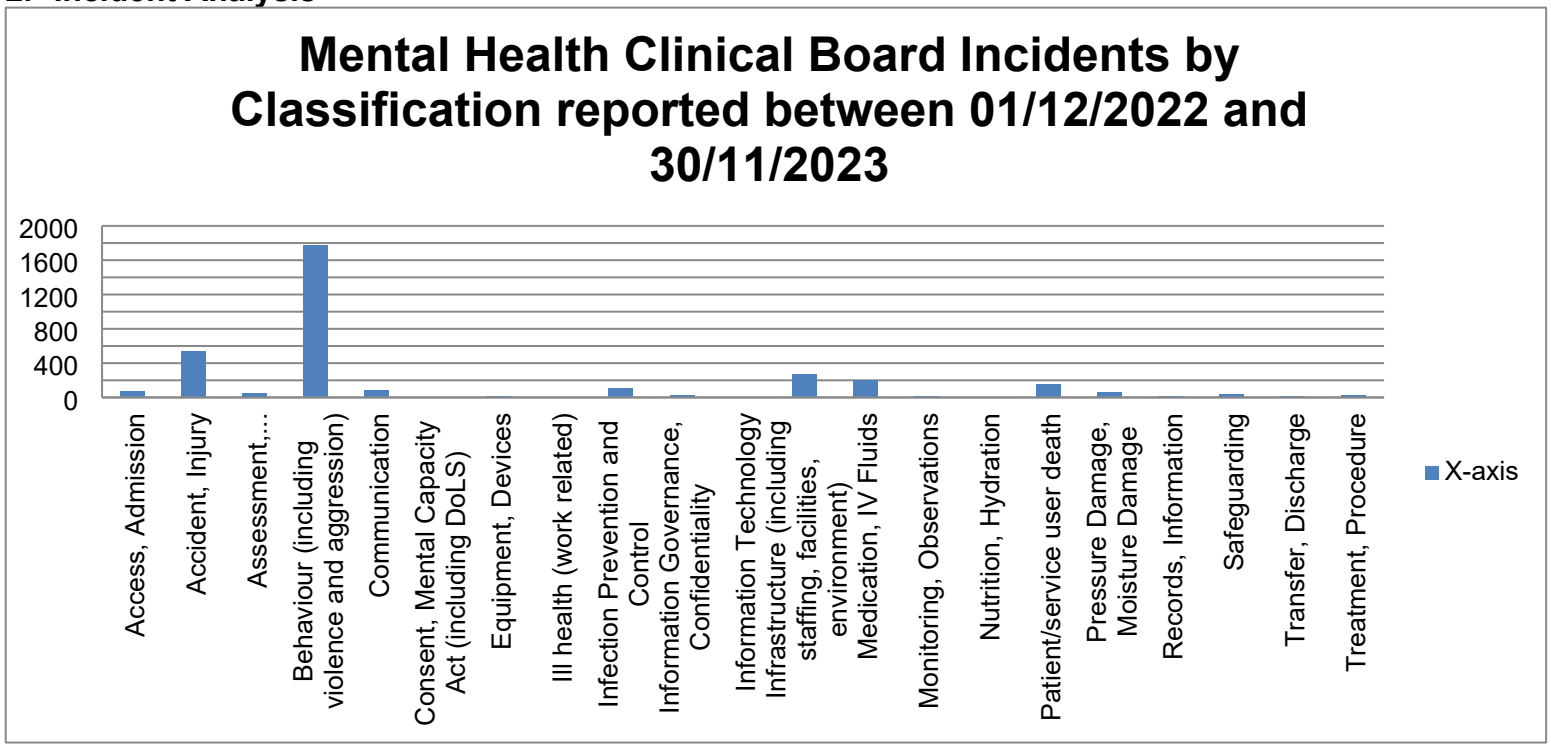
The Mental Health Clinical Board is continuously trying to improve quality within a positive risk management culture to promote recovery. The Clinical Board will seek to ensure that risks, untoward incidents and mistakes are identified quickly and acted upon in a positive and constructive manner so that any lessons learnt can be shared, appropriate action taken and resources prioritized.

1. Headlines



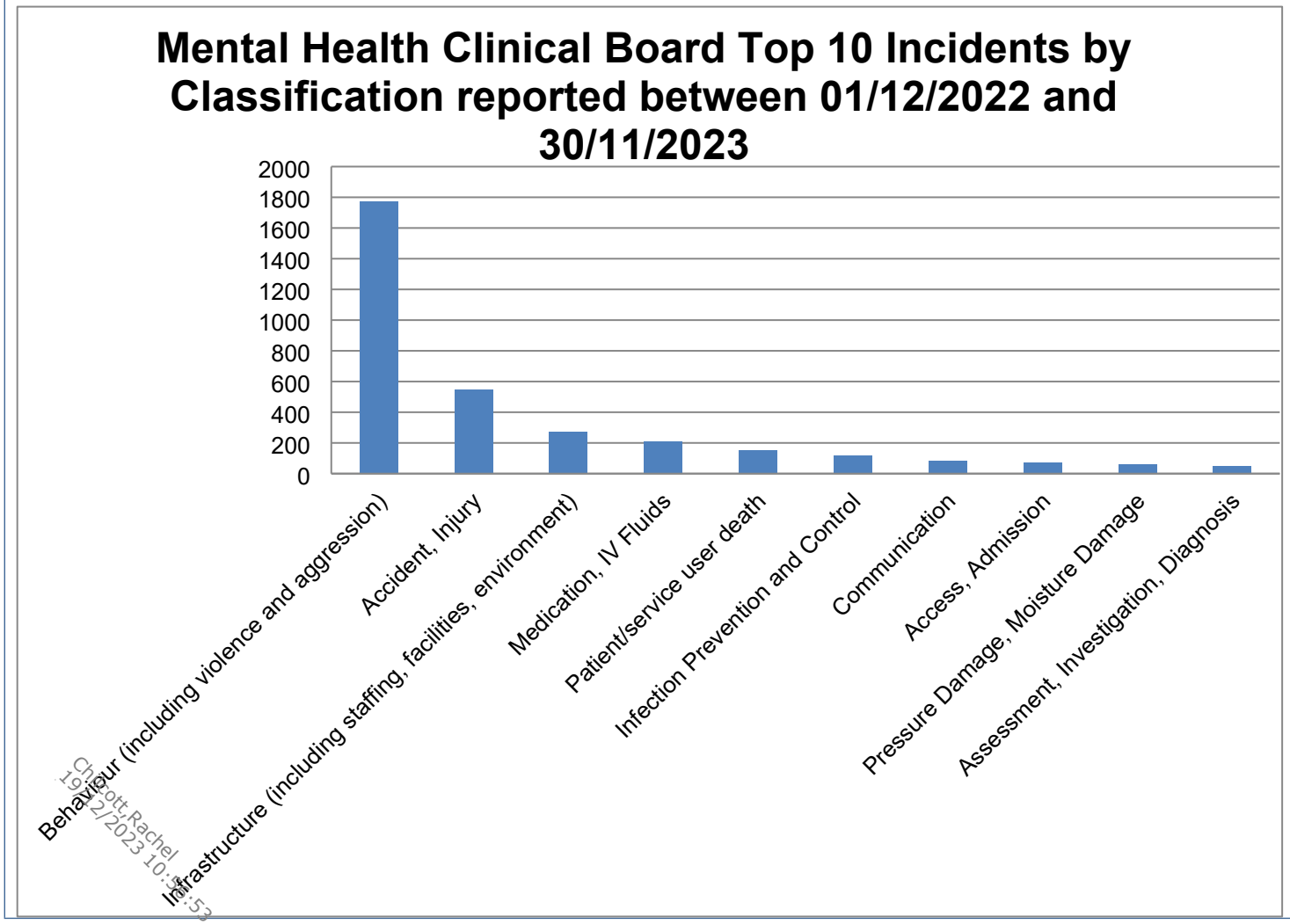
- Health.Roster / Safecare
- Tendable
- CDOG

2. Incident Analysis



Our top ten incident categories are heavily weighted towards behavioral incidents (predominantly violence and aggression). The Mental Health Clinical Board is concerned at the continued high incidence of aggression and physical violence towards staff, and operates, like the rest of the University Health Board, a zero tolerance approach. We are tracking incidents carefully and will escalate them with colleagues in Case Management and particularly the Police, and where appropriate will support police action.

The second highest category, titled “accident, injury” includes patient falls which will continue to be a significant risk, particularly in Mental Health Older Peoples’ Services. However the work done in promoting falls training has produced a dramatic reduction in injurious falls:



Response to clinical risk and National Reportable Incidents in the Acute Mental Health Inpatient setting

The Mental Health Clinical Board has previously reported on a number of suicides that took place in our in-patient services over a relatively short period of time. This constituted a “cluster” according to nationally agreed criteria and we considered the need to provide a comprehensive, evidence-based series of actions to understand and reduce this phenomenon to be of the highest priority. There were six suicides over a period of eleven months.

We put in place a programme of service development that we came to call “The In-Patient Safety and Stability Plan”, and have previously reported on the detail of that programme. This picece of work is now at an end and we have begun a period of evaluation, the intention being that the changes we have implemented should now move to “business as usual”.

The elements of the ISSP , and our progress against them are:

Returning Hafan Y Coed to its original footprint
The dramatic pressures created by the need to manage COVID in accordance with Welsh Government, Public Health and local UHB guidelines was extremely disruptive to the normal functioning of mental health in-patient services. These challenges are not unlike those experienced by staff and patients in other areas of health care.

We have now reviewed the entire “footprint” of the Hafan Y Coed site and all clinical areas are now functioning in the ways they were originally designed to do.

Review of National Reportable Incident / Sentinels / Lessons Learned systems and processes
The Mental Health Clinical Board has a well-established, long-standing process for gathering information about serious, nationally reportable events including suicides, near-misses and other events. This has evolved over a period of years into a sophisticated mechanism that is aligned to national reporting requirements and elicits themes and factors from which lessons can be learned and improvements made.

We have invited the Safety Incident Review Accreditation Network (SIRAN) to review the way we learn for adverse events, and their review took place recently. Initial, verbal feedback from the reviewers was positive but we await their formal response.

We are particularly pleased to report on the work……

Suicide Prevention Training
We are pleased to report that this training has been rolled out across the in-patient elements of MHCB and we are now planning the next phase for our community services. Discussions are taking place around offering the training to colleagues outside of MHCB, such as the prison.

Multi-Disciplinary Team Reviews
A task and finish group met and produced a series of principles and guidelines around improved MDT working in the mental health setting.

Cluster Response Plan
We met with the Regional Coordinator for Suicide and Self Harm and agreed the terms for our participating in any further Suicide clusters and Immediate Response Groups.

Implementation of the Wales Applied Risk Research Network (WARRN) risk assessment
We have comprehensively adopted WARRN as our baseline risk assessment tool.

Royal College of Psychiatrists Review of Adult In-patient Services at Hafan Y Coed
The Executive Board supported and commissioned this authoritative and comprehensive review, which took place in September and October. We have yet to received the formal feedback, but there were no immediate assurance concerns reported.

Review of the Observation Policy
This key policy, which governs the way in which we maintain the safety, dignity and security of our patients whilst they are in hospital, is of crucial importance. The poicy was extensively reviewed and ratified in September.

Management of Adverse Events and Lessons Learned

Improving healing, learning and service development following a patient safety incident

- Leadership
- Leadership – clinical practice
- Leadership – research and development
- Leadership – Education and Training
- Evidence and Evaluation
- Impact on patient care
- Further success

3. Risk Register

Risks of 15 & 16
No cameras in interview rooms in EAS HyC**: Risk score 15 Mitigated: 12**
Acute Ward smoking fire risk assessment**: Risk score:** 16
Physical health management and training in MHSOP felt to be inadequate, including insulin management and NEWS 2: **Risk score 15 Mitigated: 8**
Risk of harm to patients due to high medical caseloads in MHSOP outpatient teams: **Risk score 16 Mitigated: 12**
CHC placements have multiple risks associated. 1 financial risk of high cost placements, growing demand and rise in placement cost in line with inflation and cost of living rises. 2 Ability to monitor, review and address any quality or patient risk and safety concerns are limited by the capacity of the 3CT and the increasing demands upon the team from Court of Protection requests, facilitated discharge and pressure to find savings. **Risk Score: 16 Mitigated: 12**
ADHD: Demand above capacity, not meeting NICE guidance, high complaints, high waiting times. **Risk Score: 16 Mitigated: 16**

Risks of 17+
Staffing shortages in key professional groups**: Risk score 20 Mitigated: 12**
Mental Health Nursing Staff Recruitment**: Risk score 20 Mitigated: 12**
Violence and Aggression: Risk score 20 Mitigated: 8

Young Person in Adult Mental Health Placement: **Risk score 20 Mitigated: 12**
Ligature risks in mental health inpatient settings**: Risk score 25 Mitigated: 12**
Health and Social Care Patient Record Systems in MHSOP**: Risk score: 20 Mitigated: 12**
Patient Flow: Due to in inability to discharge patients from Mental Health Services into appropriate placements, step down to locality ward from PICU or find beds when patients are requiring admission or detention there is a risk of patient and public harm, delayed discharge and admission or patients held for extensive periods in the Emergency Assessment Suite. **Risk Score: 20 Mitigated: 12**

20+ unmitigated
Severe High Risk Eating disorders getting timely access to inpatient beds for refeeding or medical stabilisation **Risk Score: 20 Mitigated: 20**
New Section 117 ruling- potentially has significant and lasting financial implications for Cardiff and Vale UHB. Advised LA in Cardiff and the Vale Risk Score?
Poor estates: Gabalfa, Park Road, CAU, Hamadryad, Headroom, Pendine, Cynnwys Solace - damp issues, water leakage from roofs, poor facilities such as meeting rooms and limited office space. Lack of panic alarms, uncontrolled access to clinic rooms due to lack of internal lockable doorways - poor wireless signal: Risk score 20 Mitigated: 16

New Risks
MHSOP Phone systems. Cardiff LA using laptops to answer phones, when staff unavailable UHB has no system to answer calls leading to missed calls and unable to pick up messages **Risk Score 16 Mitigated 16**
Estates risk of building deterioration in HYC. Flooring faults resulting in costs of £900 per room- 8+ rooms now have required works. **Risk Score: 16 Mitigated 16**

4. Reviews

All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults (April 2023)

Recommendations:

1. The health board should look to facilitate protected time for staff to receive formal clinical supervision at regular intervals, in addition to less formal opportunities for knowledge sharing and problem solving.
2. The health board should look to support teams to improve the consistency of recording of the patient voice- "what matters", where it can be captured. PARIS contains the functionality to capture the "Service User Perspective", therefore there is opportunity to utilise this section better within the assessment.
3. The health board should consider staff access requirements of the various electronic patient record systems in use within the wider health and social care community, to reduce the duplication of effort, and opportunity for information to be overlooked. This may also improve the patient experience by avoiding the need to tell their story multiple times.
4. The health board should look to consider the incorporation of cultural and spiritual needs more frequently in mental health assessments given the diversity of the local population to ensure an individual's needs are met, in alignment with a biopsychosocial approach.
5. The health board should consider training additional occupational therapists from areas such as Frailty to be able to undertake specific functional assessments required to aid the diagnosis of dementia. This will reduce delays in diagnosis or moving someone onto the appropriate patient pathway when there are planned or unplanned staff absences.
6. The health board should consider and implement opportunities to improve communication between GP primary care services and older adult mental health teams.

Review of Psychological Therapies in Wales

Recommendations:

1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure.✓ Part 1 scheme being reviewed
2. The service should improve its collation and use of demand and capacity data to monitor the delivery of therapies. The service may wish to access further capacity and demand training and support from the NHS Wales Executive or other training providers to support this.
✓Discussed at NHS Exec Review

3. The HB should continue to align the psychological therapies delivered across the mental health service to ensure the staff skills are used effectively across services, gaps in service are eliminated and unwarranted variation is reduced. ✓We are developing a 'supervision map' to understand skills and support to deliver
4. The HB should review the service offer for older adults to ensure parity across the age range. ✓ Discussions with PMHSS and MHSOP ongoing
5. The HB should ensure that there are robust systems in place to ensure that patient feedback and outcomes are routinely collected. ✓ we have *My Clinical Outcomes*- needs integration to PARIS (January 24) and are developing Teams forms for Patient Feedback

5. Young People / CAMHS interface

We anticipate that the Mental Health Clinical Board will continue to provide in-patient beds for young people under Child and Adolescent Mental Health who require a swift response because of immediate clinical risk. It is recognized that, although necessary, the placing of young people in an adult mental health environment is sub-optimal in terms of patient experience and the particular needs of young people in acute distress. Although MHCB maintains a policy of always providing a bed when required to do so, the lack of appropriate placements for young people does present an added pressure on bed capacity for MHCB. It is noteworthy that these admissions are often complex and require a high level of clinical skill, and we are reliant upon close liaison with our colleagues in CAMHS to maintain good therapeutic care. A steering group looking at the care of Young People In Psychological Distress commenced in 2023 and we anticipate will continue its work in the future.

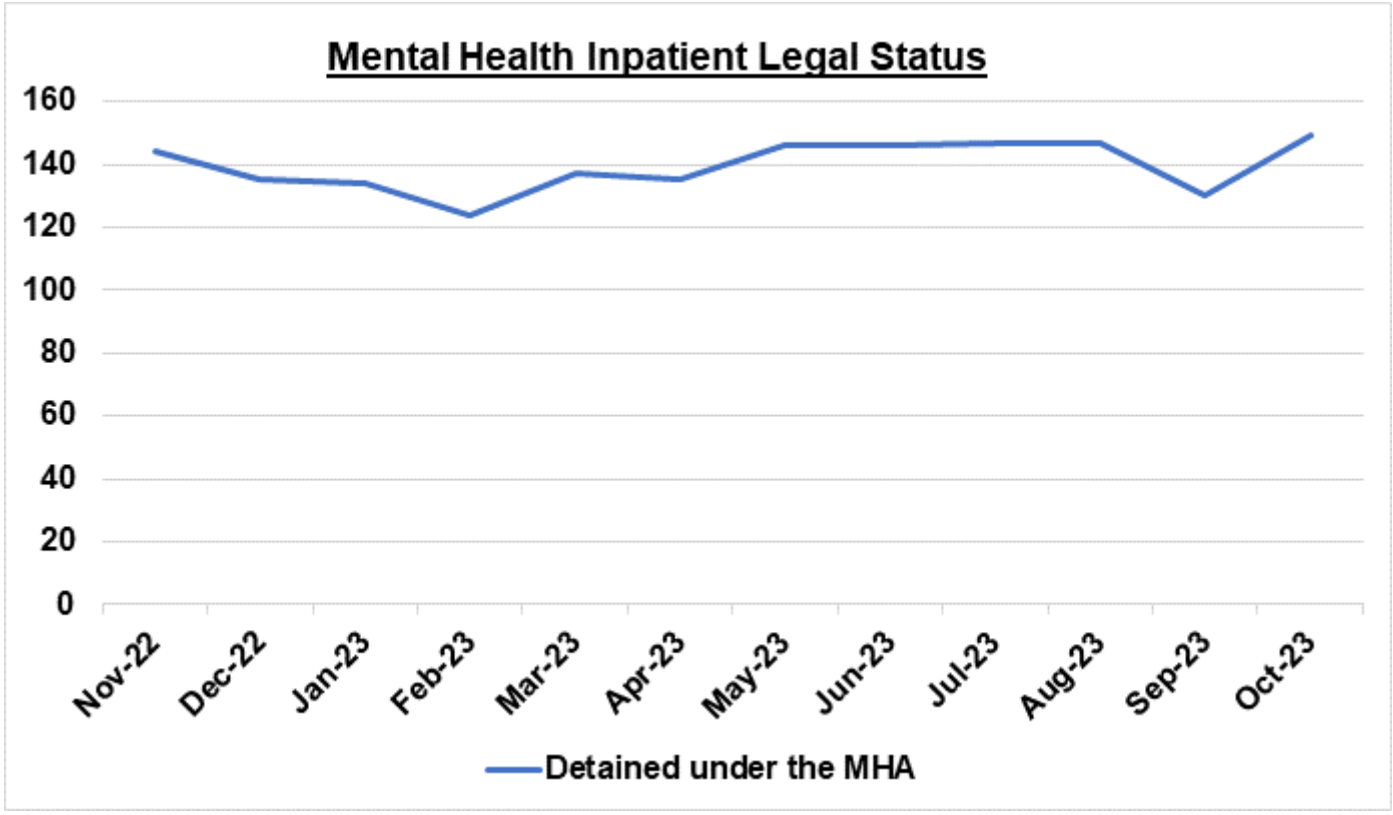
6. Use of in-patient environments at Hafan Y Coed for clinical reasons other than mental health.

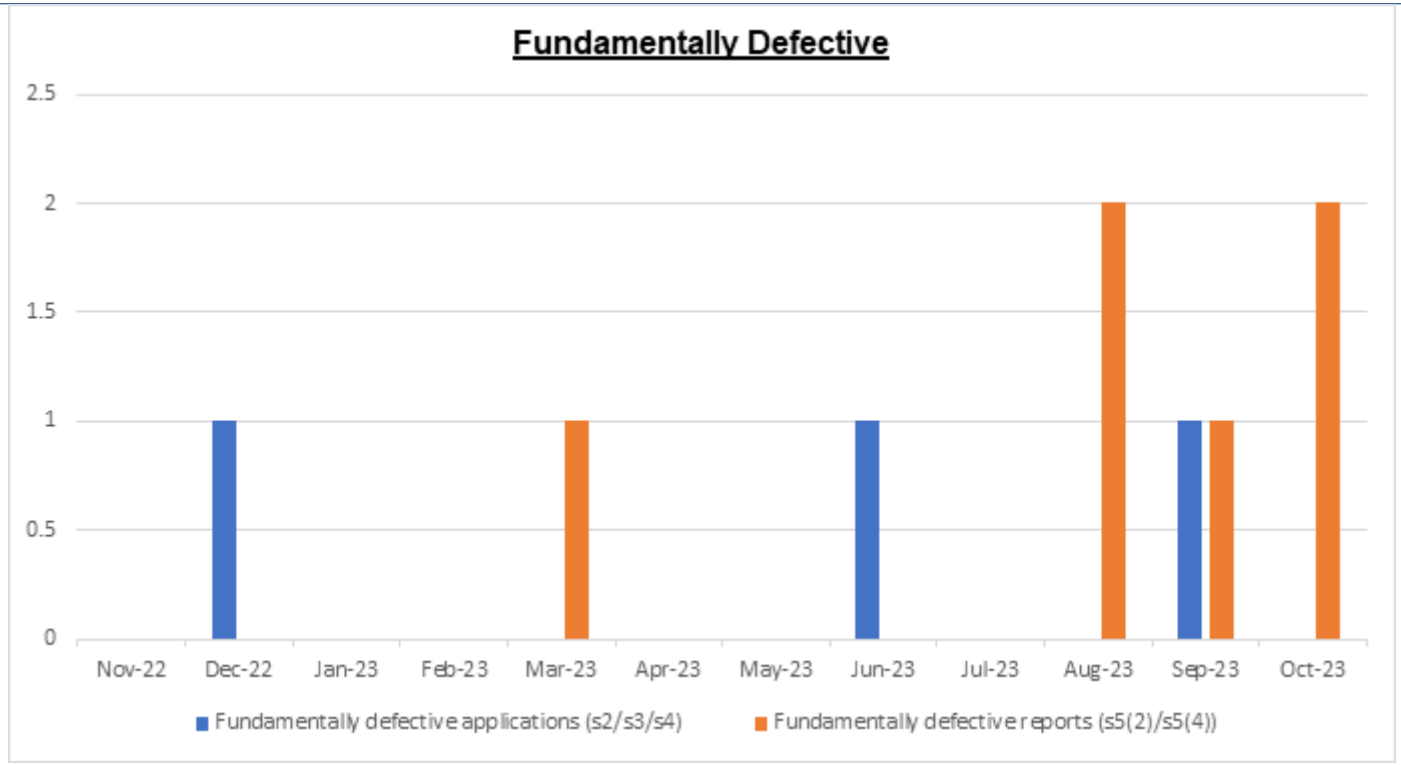
Because the various teams at Hafan Y Coed possess knowledge and skills around the management of challenging behaviour, and because our systems and physical environments are oriented to the safe management of those situations we have been asked to provide environments (specifically, Elm Ward which was temporarily empty) for two individuals who do not have a primary mental health diagnosis but who have autism. We have been pleased to work alongside colleagues in Learning Disabilities, CAMHS and the third sector to ensure care that is safe and resilient. Ultimately there will be lessons to be learned from these arrangements which may result in different ways of responding in the future, and it should be noted that our Integrated Medium Term Plans will require Elm Ward to be returned to a mental health at some point.

7. Mental Health Act

The MHCB Mental Health Act Office continues to provide scrutiny and oversight of MHA activity in Cardiff and Vale UHB. MHA activity is as follows:

Detained patients





December 2022

8. In December P was detained under section 3 in UHW. The papers were left on the ward as P was meant to be transferring to UHL or HYC that day but didn't end up transferring until 23/12/2022. The papers weren't passed to someone authorised to receive them therefore, they were never formally accepted on behalf of the hospital managers and P was detained without authority for 34 days

March 2023

9. In March a section 5(2) was completed for P who was in UHW. A section 5(2) only comes into effect once the paperwork has been furnished to the Hospital Managers, however, neither the ward staff or doctor completing the paperwork furnished the report, therefore the section 5(2) was not valid. Another section 5(2) was completed and correctly furnished to the Hospital Managers where a mental health act assessment took place and P was subsequently detained under section 2.

<u>June 2023</u>

10. In June P was assessed in Bath, detained under Section 2 and transferred straight to Hafan Y Coed. When P arrived with secure transport, the detention papers were given to the MHA office to scrutinise and various errors were found -

11. The AMHP had completed an English application instead of a Welsh application
12. The AMHP had electronically signed the form and Wales still requires a ‘wet’ signature
13. The date the AMHP last saw the patient wasn’t within the 14 day period allowed
14. Neither medical recommendations included a description on why P was being detained
15. Neither medical recommendations had ‘wet’ signatures

Due to the nature of these errors we immediately told staff that we were unable to accept the detention and P wasn’t detained under the MHA. We tried to contact the detaining AMHP but never got a response.
P agreed to stay informally however, 10 days later a MHA assessment was arranged and they were detained under Section 2.

<u>August 2023</u>

16. P was on a ward in UHW and a doctor scanned a copy of a Section 5(2) they had completed to the shift coordinator out of hours in order for them to formally accept the paperwork however, the doctor hadn’t put any reasons as to why informal treatment was no longer appropriate and why a MHA assessment was needed. The shift coordinator did try to get hold of the doctor for the reasons to be added but they couldn’t make contact. The ward was informed that P wasn’t being held on a Section 5(2) and if they felt one was necessary, they would need to contact a doctor to complete one.

17. P was on a ward in HYC and a doctor completed a Section 5(2) out of hours however, they made the report out to UHW which unfortunately wasn’t picked up by the shift coordinator when they formally accepted it but was picked up when the MHAO processed the paperwork that day. The ward was informed that P wasn’t being held on a Section 5(2) and if they felt one was necessary, they would need to contact a doctor to complete one.

<u>September 2023</u>

18. P was on a ward in UHW and a doctor completed a Section 5(2) however, various errors were found on the form

19. An English form had been completed instead of a Welsh form
20. No hospital named on the form

21. The doctor had only put one of their names rather than their full name
22. No reasons given as to why informal treatment was no longer appropriate and why a MHA assessment was needed
23. The doctor had dated the form the 2nd when it was the 7th

    The form was sent to the shift coordinator to formally accept and they tried to contact the ward to inform them it couldn't be accepted due to the errors but they were unable to get through. The next day the MHAO got through to the ward and they were informed that P wasn't being held on a Section 5(2) and if they felt one was necessary, they would need to contact a doctor to complete one.

24. P was assessed in the community, detained under Section 2 and transferred straight to Hafan Y Coed. Unfortunately, the AMHP had made the application to UHW and we were unable to contact them in order for a new application to be completed. As the application had been made out to the incorrect hospital, we were unable to hold P and advised the ward that the application was fundamentally defective and P would need to be told they were now informal. A new application was completed 3 days later.

<u>October 2023</u>

25. P was on a ward in UHW where a doctor completed a Section 5(2) form and sent it through to the shift coordinator however, the doctor hadn't provided a 'wet' signature on the form, only typed their name. This doesn't meet the Wales Regulations therefore, it was fundamentally defective. The shift coordinator did try to contact the ward but was unable to get through. The Mental Health Act office managed to get through on the Monday where we informed the ward that P wasn't being held on a Section 5(2) and if they felt one was necessary, they would need to contact a doctor to complete one.

26. P was on a ward in UHW where a doctor completed a Section 5(2) form and sent it through to the shift coordinator however, the doctor had completed an English form rather than a Welsh one therefore, as the form didn't meet the Welsh Regulations we were unable to accept it and it was fundamentally defective. The ward was informed that P wasn't being held on a Section 5(2) and if they felt one was necessary, they would need to contact a doctor to complete one however, the patient had already had a mental health act assessment and detained on a Section 2.

<u>MHA Audit</u>

The MHA office continue to audit all the wards and CMHT's within the UHB. This is to ensure compliance with the MHA and best practices are maintained. If any issues are found during the audit we will follow up with an e-mail to the ward manager and/or responsible clinician confirming what is needed to rectify the issue and re-audit within 4-6 weeks.

<u>Development Sessions</u>

The MHA office continues to run awareness sessions including a monthly MHA training day which is available to all staff within the Health Board, a monthly consent to treatment workshop and a quarterly rights and forensic workshop. We also run receipt and scrutiny training for all shift coordinators and we continue to support the Nurse Foundation Programme, Junior Doctor's Induction and the AMHP course for Swansea University with MHA training. We also provide bespoke training session for departments when requested.

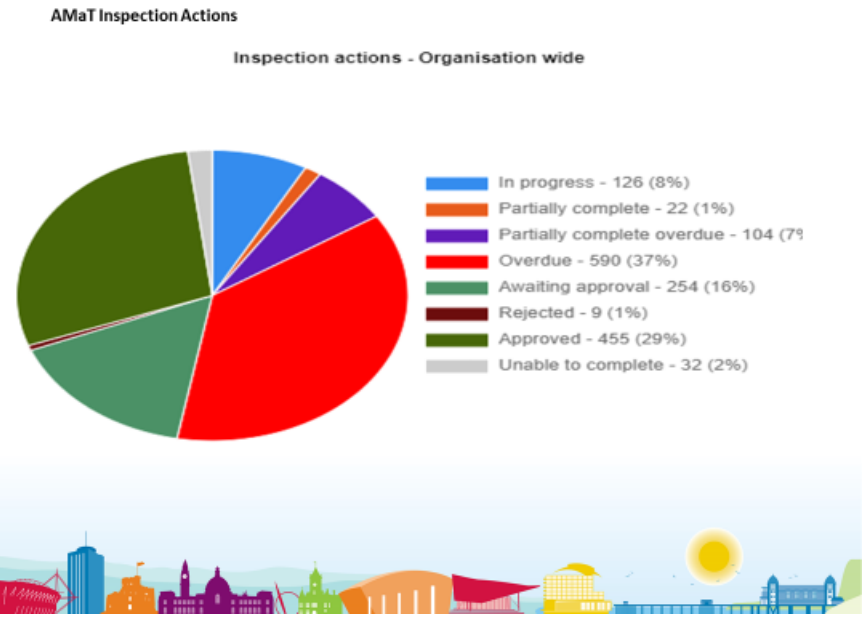
27. Mental Health Audit

There are seven clinical audits formally registered by the Mental Health Clinical Board. We are in a period of transition as the audit lead, Dr Bala Oruganti has moved to a new post and we are currently working to establish a new lead. There is some work to be done in scoping all existing audit work and ensuring that it is formally logged on the AMaT system..

An Audit of EDSOTT Against the TrACE Toolkit	Callum Ferguson	Specialist Trainee	Naomi Swift
Antipsychotic Use in the Management of Behavioural and Psychological S	Oliver Young	Specialist Trainee	Anjan Roy
Audit of Admission ECGs and Blood Tests on Cedar Ward HYC	Charles Pope	Core Trainee	Balarao Oruganti
Audit of Antipsychotic Prescribing for In-patients with Dementia at UHL t	Rakesh Puli	Core Trainee	Arpita Chakrabarti
Evaluation of Smoking Cessation Advice and Prescription of Nicotine Rep	Nicolas Upton	Core Trainee	Somashekara Shiva
Evaluation of Suicide Awareness and Mitigation Training	Ceri Olsen	Allied Health Professiona	Not Set
Nursing Staff Perceptions of Factors Associated with Nurse-led Group Fa	Laura-Beth McCarron	Other	Not Set

Audit Management and Tracking System (AMaT)
The Clinical Board has engaged with AMaT over the last year has captured much of its activity in terms of Quality Improvement, Inspection Plans and clinical review Patient Safety Learning recommendations. There remains work to be done in updating the system with the considerable amount of work done in terms of actions completed.

Inspection Actions



Chilcott Rachel
19/12/2023 10:56:53

28. Research and Development

The Mental Health Clinical Board is a leader in mental health research in Wales, outperforming other University Health Boards (UHBs) in terms of patient recruitment and number of research studies. Currently, the board is managing 12 active studies and developing 9 more, compared to 5 in 2020/21, 10 in 21/22 and 9 in 22/23, indicating a consistent year-on-year growth. In 2022, the board recruited 153 participants, and within this financial year, it has already enlisted 181.

The board's research portfolio is diverse, encompassing both interventional and observational studies. These studies explore a range of topics, including medicinal products, psychological therapies, and the application of technology in both primary and secondary care. The board has adopted an opt-out approach to research recruitment, known as "Participate". In the first quarter of 2024, the board plans to implement the Clinical Record Interactive Search (CRIS) tool, which will further enhance research opportunities.

The board is also focused on increasing the number of local principal investigators, leveraging the National Institute for Health Research (NIHR) Associate PI scheme to achieve this goal. To keep everyone updated, the board publishes a quarterly newsletter and is planning a conference on April 19, 2024. This ongoing development and communication underscores the board's commitment to advancing mental health research.

29. External Scrutiny

There were two Health Inspectorate Wales visits to the Mental Health Clinical Board in 2023:

9th January 2023: visit to Ash (Neuropsychiatry) and Pine (Addictions) In-patient units at Hafan Y Coed. There was an immediate assurance action around ensuring staff were fully updated in their SIMA (restraint) training---as some had fallen out of compliance during the time of COVID)

20th March 2023: visit to Ward E12 and E16 (dementia assessment wards) in Mental Health Services for Older People.

30. Staffing Levels and Oversight
The provision of safe, skilled staff, both in in-patient services and the community, continues to be a challenge.

MHCB participates in the extensive All Wales work undertaken in support of the implementation of the Nurse Staffing Levels (Wales) Act in Mental Health. This resulted in the development of a set of principles and standards describing and supporting the levels of care for Mental Health In-patient services, and this is a milestone towards which all mental health services across Wales have been working for quite some time. However, we are aware that there is no legislation (as there is under the Nurse Staffing Levels Act (Wales) fir other clinical fields) to mandate the implementation of those principles. It is recognized, however, that current in-patient establishments do not allow us to achieve the All-Wales principles and we are working to develop revised establishments that move us some way towards those principles whilst at the same time having regard to the very stringent financial limitations that currently obtain.

MHCB has now fully implemented HealthRoster, thus aligning itself with the rest of the University Health Board and will “switch on” SafeCare, the staffing analysis platform that will enable us to manage staffing resources and clinical need in a much more granular way.

We are pleased to report that we achieved an 80% reduction in use of agency nursing, without any adverse effect on patient safety.

31. Workforce and Development
Streamlined WOD report this month due to COVID absence, annual leave and changes in WOD structures. Outlined below are the key issues:

WOD KPI activity

Performance - September 2023													
Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
5.18%	£2,735,599	£574,529	13.92%	7.28%	55.69%	90.38%	25.00%	77.31%	3	4	1		1

Performance - August 2023													
Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
4.25%	£2,231,465	£549,989	14.07%	7.36%	58.14%	84.00%	37.21%	77.93%	3	3	1		1

Performance - July 2023													
Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
4.02%	£1,677,263	£504,100	14.24%	7.31%	58.49%	83.33%	42.22%	78.18%	3	3	1		1

Performance - June 2023													
Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
5.85%	£1,079,605	£413,275	13.30%	7.38%	54.42%	80.36%	22.22%	78.15%	1	3	1		1

Performance - May 2023

Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
6.48%	£704,981	£240,614	12.94%	7.37%	51.55%	75.00%	42.22%	77.19%	1	2	1		1

Performance - April 2023													
Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
16.10%	£325,273	£111,714	12.56%	7.50%	46.70%	76.79%	44.44%	76.07%	1	3			1

Performance - March 2023													
Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
5.74%	£3,353,320	£2,424,308	12.55%	7.57%	43.85%	75.93%	42.22%	75.35%		3			

Performance - February 2023

Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
5.84%	£2,863,476	£2,135,916	12.23%	7.53%	43.50%	76.36%	45.45%	74.54%	1	3			

Performance - January 2023													
Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
6.47%	£2,566,412	£1,925,826	12.32%	7.62%	43.10%	81.82%	52.27%	74.34%		3			

Performance - December 2022													
Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
7.95%	£2,242,033	£1,975,300	12.93%	7.48%	43.24%	77.19%	54.35%	73.33%		3			

Performance - November 2022

Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
8.61%	£2,045,386	£1,803,716	13.23%	7.39%	40.68%	78.95%	56.00%	74.02%					

Performance - October 2022													
Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
10.26%	£1,776,884	£1,617,154	12.90%	7.37%	37.33%	82.98%	56.00%	73.16%		3	1		

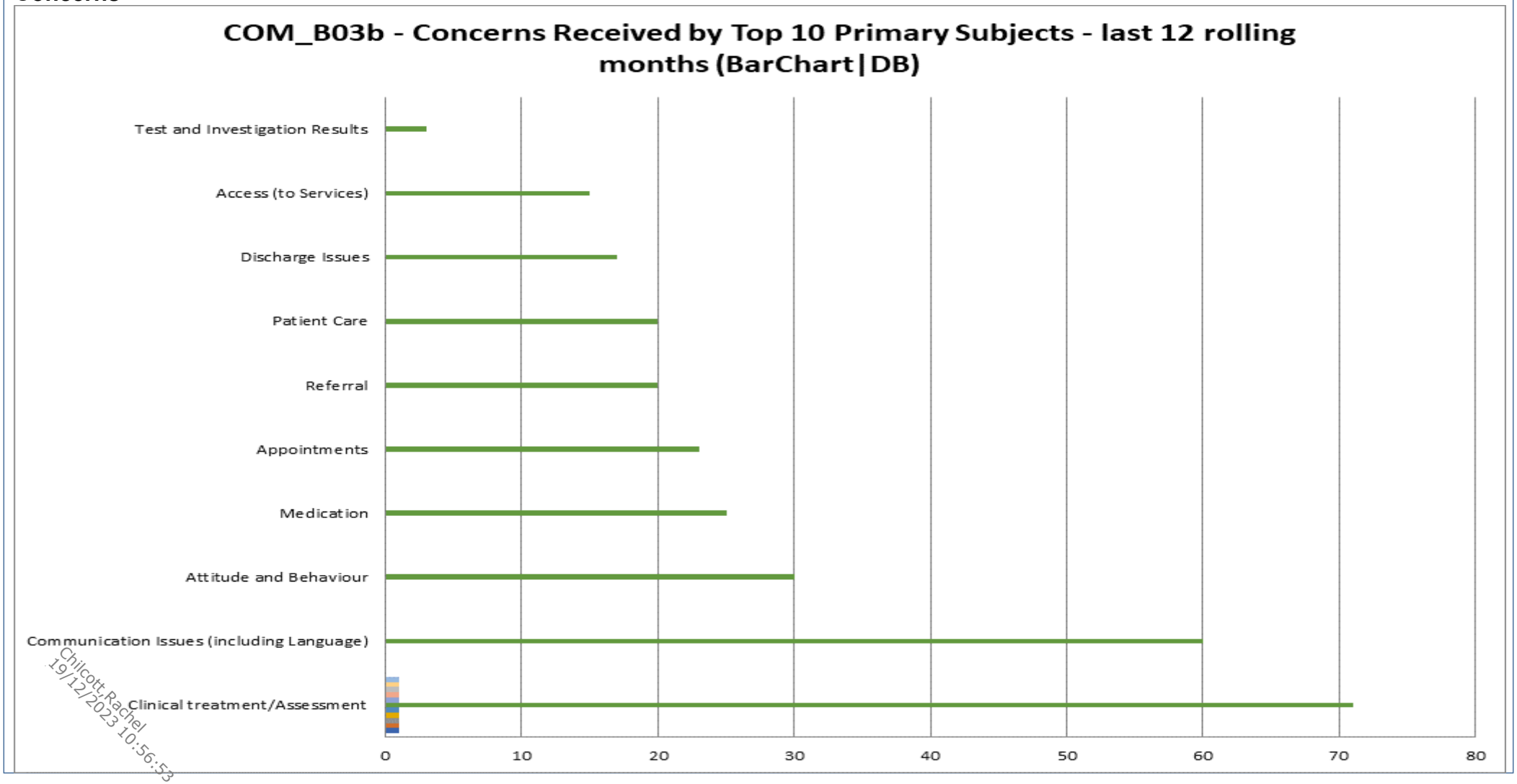
Key Updates:

The Mental Health Clinical Board has progressed with a series of key appointments that have helped contribute to the renewed stability of the board, including:

Deputy Director of Nursing
Directorate Lead Nurse for Adult Mental Health
Directorate Lead nurse for Mental Health Services for Older People
Clinical Lead for ADHD

Discussions are now underway regarding the role of Assistant Practitioners (Nursing) in Mental Health.

Concerns


COM_B03b - Concerns Received by Top 10 Primary Subjects - last 12 rolling months (BarChart|DB)
Test and Investigation Results
Access (to Services)
Discharge Issues
Patient Care
Referral
Appointments
Medication
Attitude and Behaviour
Communication Issues (including Language)
Clinical treatment/Assessment
0
10
20
30
40
50
60
70
80
Chilcott Rachel
19/12/2023 10:56:53

Patient Feedback:

The Mental Health Clinical Board has now been incorporated within the Civica system, which has now started to randomly select up to 200 patients per day from the PARIS feed from 13th November. Formal feedback will be presented to the Directorates and Clinical Board from December 2023 onwards.

Claims

New Claims: 4
Active: 2
Total = 6 active PI claims for Mental Health Services

New Claims between 1/12/22 to 31/20/23		
Service	**Category**	**Outcome**
Acute	Violence and Aggression	Liability Investigation on-going
Acute	Violence and Aggression	Liability Investigation on-going
Acute	Violence and Aggression	Liability Investigation on-going
MHSOP	Violence and Aggression	Denied Liability
Active (received earlier than index period)		
Acute	Violence and Aggression	Denied Liability
MHSOP	Sharps Injury	Settled out of Court

Themes & Trends

All new claims received in the period relate to patient violence and aggression incidents, several relate to injuries sustained during restraint or incidents where restraint of the patient is required after the incident.

Investigations take longer due to the requirement to obtain consent from the patient for our Solicitor to be able to review the patient records. Statements from staff have been very helpful and crucial to early investigations.

Recommendation:

The QSE Committee are requested to:

Note and discuss the content of the report

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x

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

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

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

Equality and Health: Yes
Decarbonisation: No

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

Report Title:	Quality Indicators Report			Agenda Item no.	
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	19th december 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				

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:

- A significant rise in the number of Nationally Reportable Incidents has been observed in November 2023 as a result of revised guidance to report all Intrauterine deaths from 22 weeks gestation and neonatal deaths up to 28 days after birth. UHB revised Infection prevention and control processes have also led to an increase in reporting.
- Work is underway to support strengthened oversight of cancer follow up processes to include a safety net approach to cancer reporting from radiology and pathology.
- 431 medication incidents were reported between 01 June and 30 September 2023. The highest category of incidents were relating to administration of medication. Work is underway to address incidents relating to omitted doses across the UHB and work to progress electronic prescribing continues.
- The UHB is currently working to meet the requirements of three patient safety solutions. Prescribing of Calcium Gluconate and mitigation of associated hyperkalaemia; safe use of hospital beds and bed rails etc and the safe prescribing of Sodium Valproate.
- Positive verbal feedback was given following a recent HIW inspection in Island Ward in University Hospital of Wales. Improvements have been delivered in association with immediate assurance recommendations. The improvements will improve the record keeping of regular checks of fridges and resuscitation equipment.
- Inpatient mortality remains in line with the previous five-year average and all cause mortality continues to illustrate mortality rates above the five year average in line with the pattern seen across the UK.
- Progress of the Covid investigation programme is in line with the required trajectory and is expected to be completed within the required timeframe.
- Tendable is being used across 200 clinical areas and 3 awards are currently working towards bronze accreditation.

- During October and November the UHB received 628 concerns with 71% closed within 30 days and 34% closed under early resolution.
- A recent validation exercise undertaken by welsh Risk Pool awarded substantial assurance to the UHB for the application of Putting Things Right .
- 3705 full and partial patient experience surveys were completed on Civica in October and November. 84% of patients advised that they feel safe in the care of the UHB and 83% staff were always kind and caring.
- 1017 patient experience surveys were completed in the Emergency Unit between 01 October and 28 November. 74% of patients were satisfied with the overall experience 63% stated that they always felt cared for and 42% of patients said that they always received assistance when they asked for it. Volunteers are being deployed to EU and other areas that experience increased pressure during winter months, to support patients.
- 51 patient experience surveys were completed in Mental health services. 35% of patients felt that they always felt cared for and 24% said that they always received assistance when they asked for it.

Recommendation:

The Board / Committee are requested to: **NOTE** the assurance provided by the report

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

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

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

Prevention		Long term		Integration		Collaboration		Involvement	

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

Risk: Yes/No

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: Yes/No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: Yes/No

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: Yes/No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: Yes/No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: Yes/No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: Yes/No

The Socio Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES
(If this has been addressed in the main body of the report, please confirm)

Equality and Health: Yes/No

Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.
Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)
(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: Yes/No

If appropriate, has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made.
(If this has been addressed in the main body of the report, please confirm)

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

Chilcott Rachel
19/12/2023 10:56:53

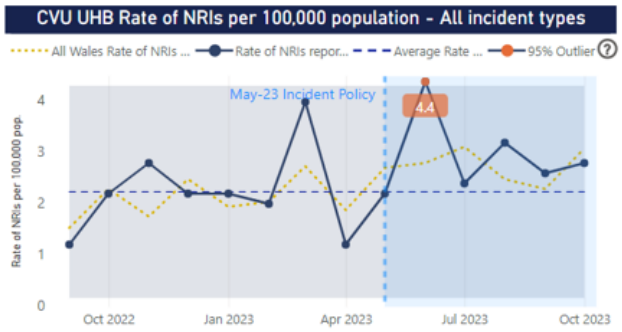
Quality Indicators Report

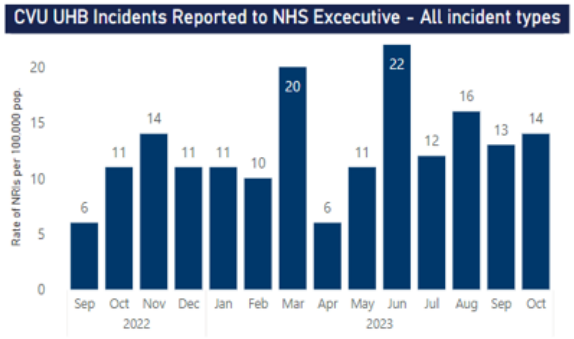
Quality Safety and Experience Committee

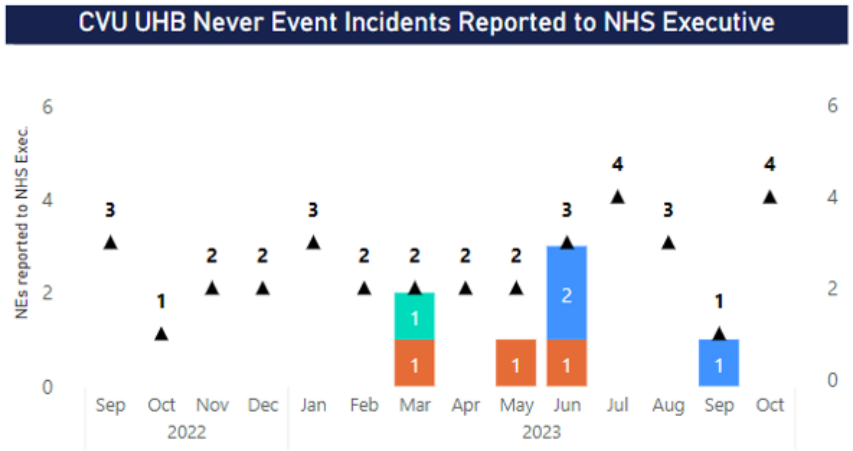
December 2023

Safe
Care

National Reportable Incidents and Never Events







Chilcott Rachel
19/12/2023 10:56:53

Fourteen NRIs reported in October 2023 and although the dashboard does not reflect November reporting there have been twenty eight NRIs reported in November reflecting a revised and strengthened approach to reporting health care associated infection prevention and control issues and nationally revised process for reporting intrauterine deaths from twenty two weeks gestation and neonatal deaths up to twenty eight days after birth.

Actions

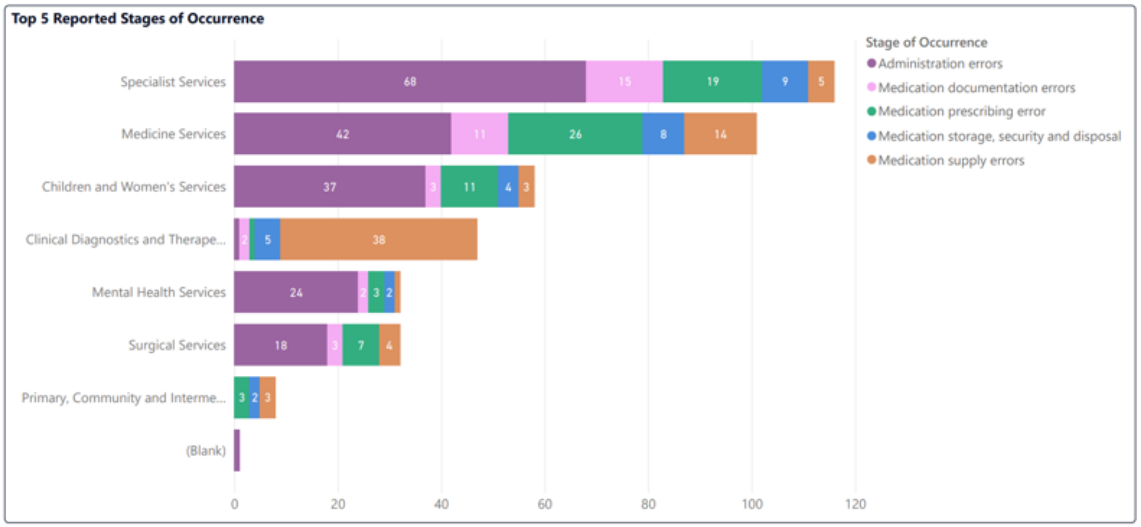
The Safe to Move framework originally designed in the second wave of the pandemic to support the safe movement of patients between wards has been updated to reflect the most up to date guidance on The management of Patients who are contacts of patients with Covid-19 and the management of patients who are clinically vulnerable.

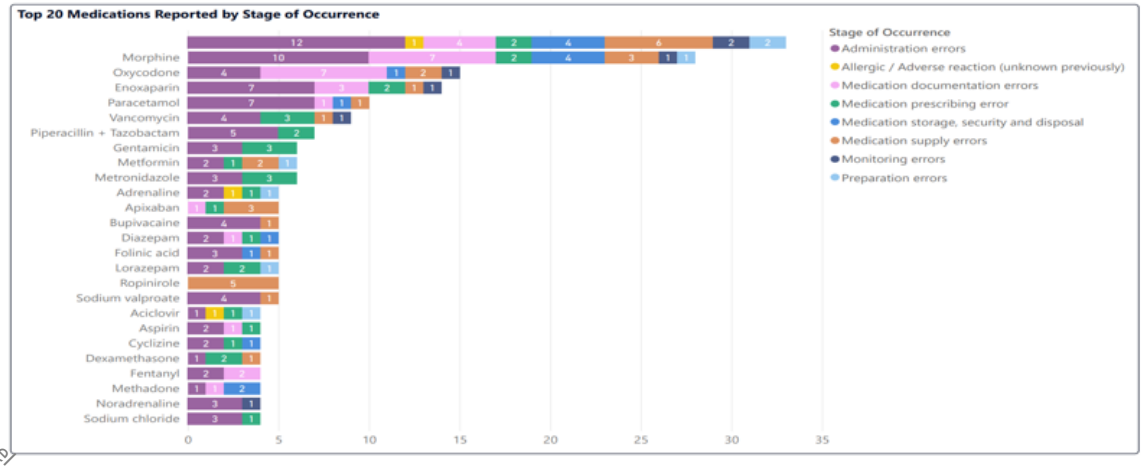
Development of a reporting process to flag results suspicion of cancer on the Radis radiology platform is being extended to also include histopathology results. Cancer Services will oversee these results to ensure timely follow up and actions. Validation of waiting lists is underway to ensure timely review of the most urgent patients.

Work is underway to review the oversight and governance of healthcare infections to support

Safe Care

Medication Incidents





431 Incidents reported between 01 June and 30 September

Top reporting occurrence is medication administration accounting for 44% of incidents with omitted doses the second most common incident in this category

Prescribing errors were the second most commonly reported incident with incorrect dose and delays in prescribing the two highest categories associated with prescribing errors.

Actions

In response to the concerns about the numbers of omitted doses of medications without a reason attributed an audit was developed on the Tendable App to support audit of medication administration on the wards.

A national list of critical time medications is being finalised which will support the UHB work being undertaken to strengthen the safe administration of these medications.

Work to ensure the safe administration of Sodium Valproate in patients of child bearing potential across the UHB will now be reviewed to take into account the requirements of the NPSA alert to support initiation of Valproate to this population by two independent clinicians.

Some medications requiring refrigerated storage, strengthened guidance is being developed to ensure staff are aware how to Safely manage drugs in the event that these conditions are breached.

Patient Safety Solutions

Safe Care

Current Compliance Status of outstanding PSS references (10/10/23)

PSS	ABU LHB	BCU LHB	CTMU LHB	CVU LHB	HDU LHB	PHW NT	PT LHB	SBU LHB	Velindre	WAST	Total
Alerts	1	0	0	0	0	0	0	0	0	0	1
PSA008											1
Notices	1	1	0	0	1	2	0	1	1	1	8
PSN026											1
PSN066											7
Total outstanding PSS	2	1	0	0	1	2	0	1	1	1	9

Status Key: Compliant; Non-compliant; No-response; N/A

PSA016 Potential Risk of Underdosing with Calcium Gluconate in Severe Hypokalaemia
The UHB declared is continuing to progress the work to address PSA016 and is expected to declare compliance by 15th December 2023.

Work includes a review of guidelines to ensure it aligns to the Adult Renal Association Clinical Practice Guidelines and putting in place a procedure to extend support from the critical care outreach team to ensure time critical treatment for severe hyperkalaemia is implemented.

NatPSA/2023/040/MHRA – Medical beds, bed rails, grab handles etc.
This alert has been issued by the medicines and Health-products Regulatory Agency with a target completion date of *****. This alert has been circulated within Wales but has not been re-issued by the NHS Executive.

A working group has been established and led by Medical Engineering to identify every hospital bed issued in the community
Occupational health are developing a single risk assessment that can be used to inform both the initial choice of equipment and its ongoing use. The hospital bed request process will be amended to mandate the inclusion of a risk assessment.

There is a requirement for the UHB to undertake a retrospective review and risk assessment of all healthcare beds and associated equipment currently in use in patient's homes. It is unlikely that this review will be complete by the target completion date of

NatPSA/2023/013/MHRA-Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients
This alert has been issued by the medicines and Health-products Regulatory Agency with a target completion date of *****. This alert has been circulated within Wales but has not been re-issued by the NHS Executive

There are already stringent patient safety requirements for the prescribing of Sodium Valproate to patients of child bearing potential because of the risk of serious harm to babies exposed to Valproate during pregnancy. This alert extends these measures further to require Valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply. At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes

Safe Care

HIW

Island Ward Children's Hospital for Wales

An unannounced inspection was undertaken on 27th and 28th December 2023. The report is pending , however two areas Were identified that required immediate action.
The need to ensure regular checks of the resuscitation trolley are logged

The need to ensure the regular checks of fridge temperatures are logged

The UHB has responded and put in place improved systems to improve record keeping of these checks and to audit compliance

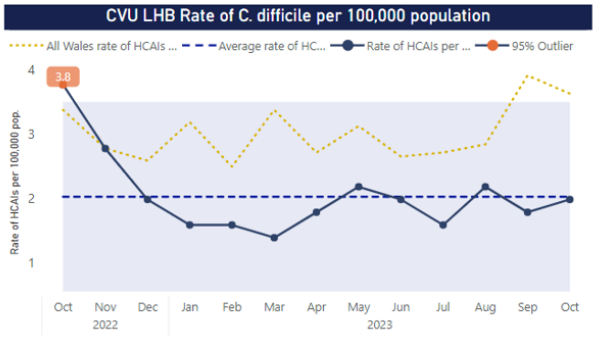
Improvements

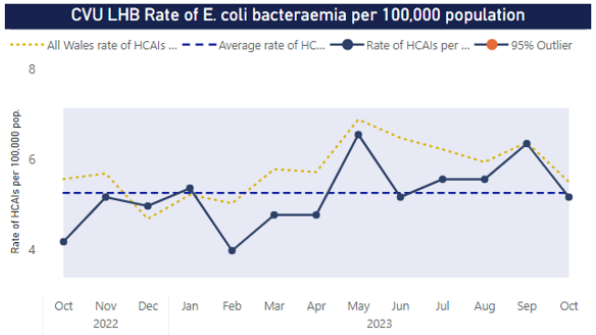
There are some recommendations that are common to many HIW inspections across the organisation, including record keeping of routine ward checks.

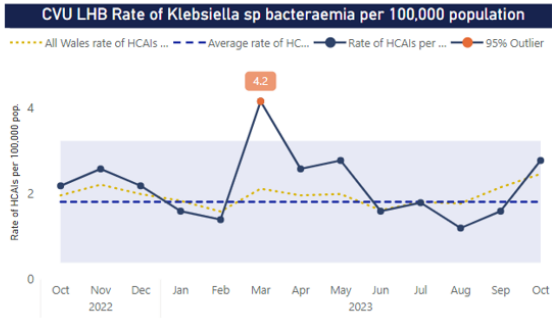
To support wider reaching actions to address these recommendations these will be discussed at the Medicines Safety Executive and the UHB Resuscitation Group.

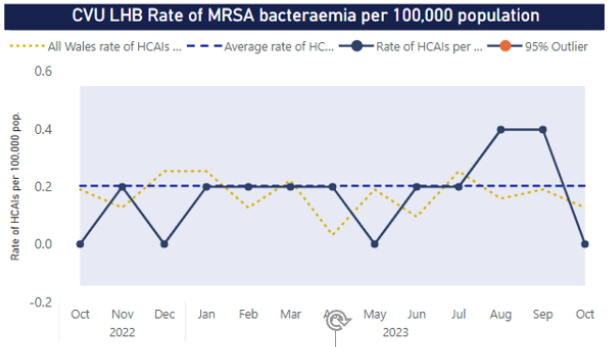
Safe Care

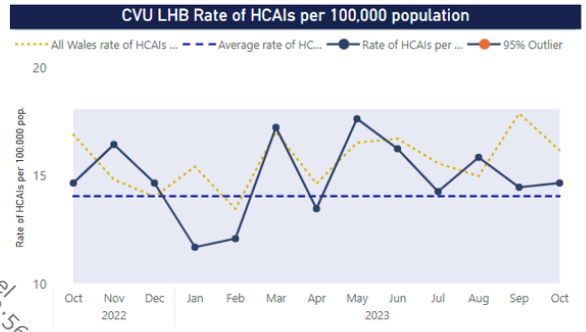
Infection Prevention and Control

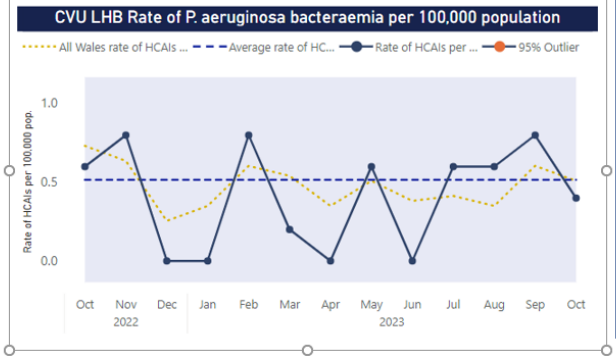












- Between April 23 and November 23, there were 74 cases of C. difficile. The current rate is 22.00 cases per 100,000 population which is 34% lower than the equivalent period in 2022/23 and on trajectory

- There were 116 cases of S. aureus bacteraemia. The current rate is 34.49 cases per 100,000 population which is 39.8% higher than the equivalent period in 2022/2 and not on trajectory and has the 2nd highest rate across Wales

- There were 234 cases of E. coli bacteraemia. The current rate is 69.57 cases per 100,000 population which is 0.7% higher than the equivalent period in 2022/23. The UHB is not on trajectory despite having the second lowest rate in Wales

- There were 82 cases of *Klebsiella spp* bacteraemia which is 8.5% lower than the equivalent period last in 2022/23. The UHb is not on trajectory to meet the reduction expectation

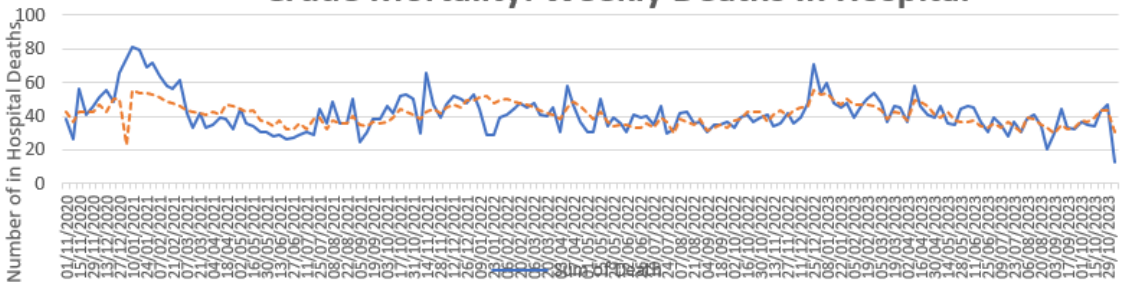
- There were 15 cases of *P. aeruginosa* bacteraemia which is 33.3% lower than the equivalent period in 2022/23.
The current maximum number to achieve the RE is 18 cases, thus CAV is 29% under the current RE number. CAV is on trajectory to achieve the RE number while also having the 3rd lowest rate across the 6 UHBs.

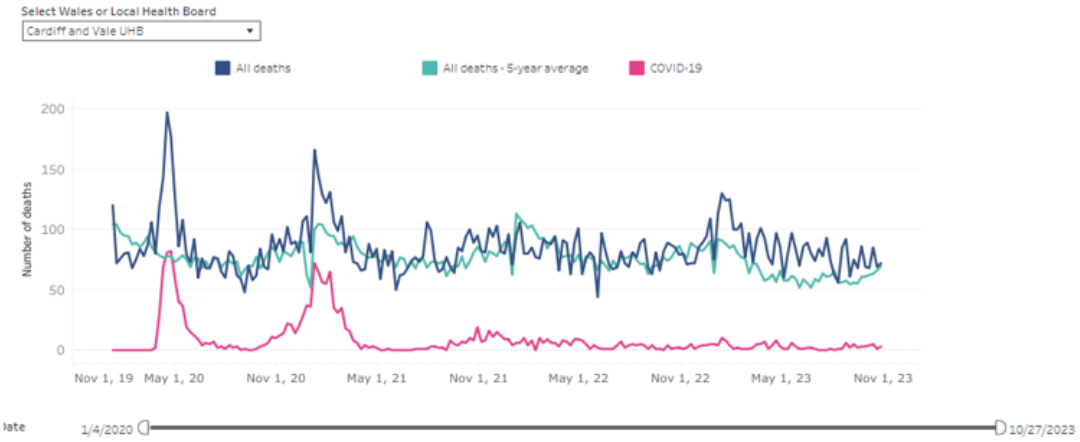
Effeithiol
Effective

Effective Care

Mortality

Crude Mortality: Weekly Deaths In Hospital





Provisional figures to Week 43 2022 for Welsh residents have been produced using data provided by ONS to Public Health Wales. This analysis is based on date the death was registered, not when it occurred. There is usually a delay of at least five days between occurrence and registration. The analysis requires the joining of weekly and daily data using NHS numbers. Figures may differ slightly between those published by ONS due to the use of different extracts of the data at different time periods. Data is therefore subject to change as more information is received. COVID-19 was identified using ICD-10 codes U07.1, U07.2, U09.9 and U10.9 (any mention), and U07.1, U07.2 and U10.9 (underlying cause only). COVID-19 (any mention) refers to deaths that had COVID-19 mentioned anywhere on the death certificate, whether as underlying cause or not.

Number of deaths by age group and sex, all deaths and COVID-19 deaths (any mention), Wales, Week 1 2020 to week ending 27 Oct 2023 (Week 43)

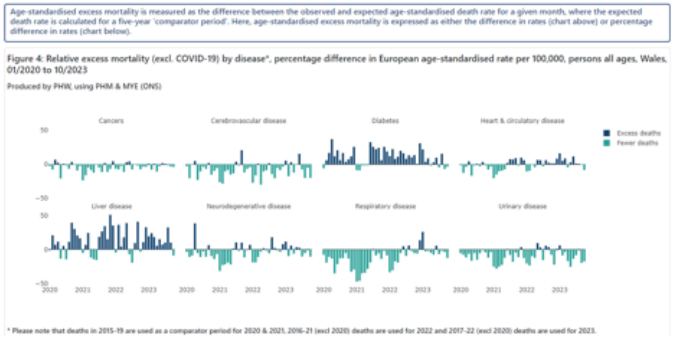
Inpatient Mortality

The Crude Inpatient Mortality chart demonstrates continued inpatient mortality in line with the five year average for the same reporting period.

Close to 100% of patients that die as an inpatient now receive independent scrutiny from the medical examiner who then refer cases back to the UHB where further consideration of any elements of care is required. Approximately 33% of ME cases in UHW and 38% of cases in UHL are referred back to the UHB. This compares to national rates of between 16%- 64% from hospital sites across Wales and an average referral rate of 46.6% in quarter 1 of this financial year

All Cause Mortality

Excess deaths have been observed across Wales and UK since late 2022. Work undertaken by Public Health Wales demonstrates the relative excess mortality by disease, where there is any mention of the disease on the death certificate as opposed to being the underlying cause of death.

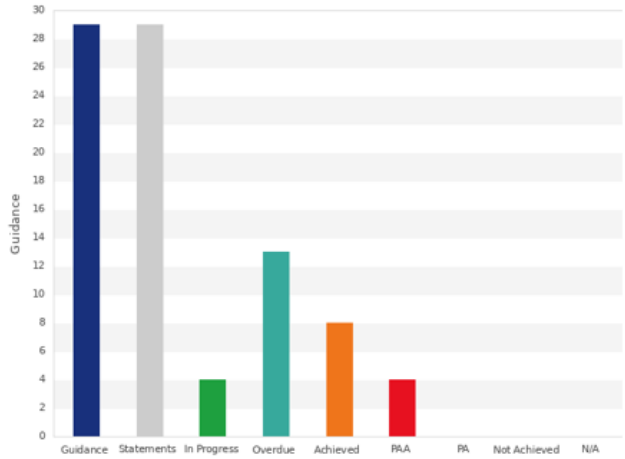


Effeithiol Effective

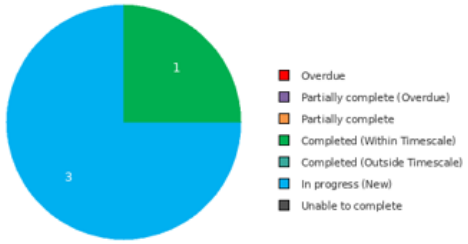
Effective Care

Clinical Effectiveness

Guidance overview



Actions



- **Guidance (29)** - total number of guidance (that may contain one or more statements)
- **Statements (29)** - total of 'In Progress', 'Achieved', 'Partially Achieved', and 'Not Achieved' bars
- **In Progress (4)** - number of the trust's Guidance Statement entries that do not currently have a status
- **Overdue (13)** - number of the trust's Guidance Statement entries that are overdue
- **Achieved (8)** - number of the trust's Guidance Statement entries that have this status value
- **PAA (4)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Acceptable' status value
- **PA (0)** - number of the trust's Guidance Statement entries that have 'Partially Achieved' status value
- **Not Achieved (0)** - 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

Title
Ovarian cancer: recognition and initial management (April 2011)
Urinary incontinence in neurological disease: assessment and management (August 2012)
Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer (June 2013)
Pneumonia in adults: diagnosis and management (December 2014)
Multi-grip upper limb prosthetics (December 2019)
Suspected cancer: recognition and referral (June 2015)
Hearing loss in adults: assessment and management (2018)
Suspected neurological conditions: recognition and referral (May 2019)
Thyroid disease: assessment and management (November 2019)
Stroke rehabilitation in adults *This guideline updates and replaces NICE guideline CG162 (2013).
Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients
Tocilizumab for the treatment of rheumatoid arthritis (February 2012)
Pegunigalsidase alfa for treating Fabry disease
Bimekizumab for treating active psoriatic arthritis
Daratumumab with lenalidomide and dexamethasone for untreated multiple myeloma when a stem cell transplant is unsuitable
Bimekizumab for treating axial spondyloarthritis
Rimegepant for treating migraine
Tofacitinib for treating active ankylosing spondylitis
Ruxolitinib for treating polycythaemia vera *This guidance updates and replaces NICE technology appraisal guidance TA356 on ruxolitinib for treating polycythaemia vera (terminated appraisal).
Daridorexant for treating long-term insomnia
Tirzepatide for treating type 2 diabetes
Mirikizumab for treating moderately to severely active ulcerative colitis
Baricitinib for treating severe alopecia areata
Glofitamab for treating relapsed or refractory diffuse large B-cell lymphoma after 2 or more systemic treatments
Cabozantinib for previously treated advanced differentiated thyroid cancer unsuitable for or refractory to radioactive iodine
Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction
Lutetium-177 vipivotide tetraxetan for treating PSMA-positive hormone-relapsed metastatic prostate cancer after 2 or more treatments
Zanubrutinib for treating chronic lymphocytic leukaemia
Foslevodopa–foscarbidopa for treating advanced Parkinson's with motor symptoms

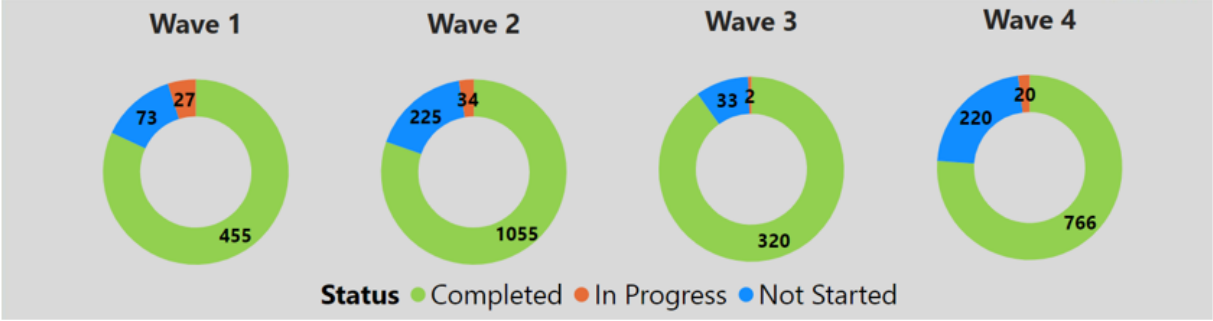
Effeithiol Effective

Effective Care

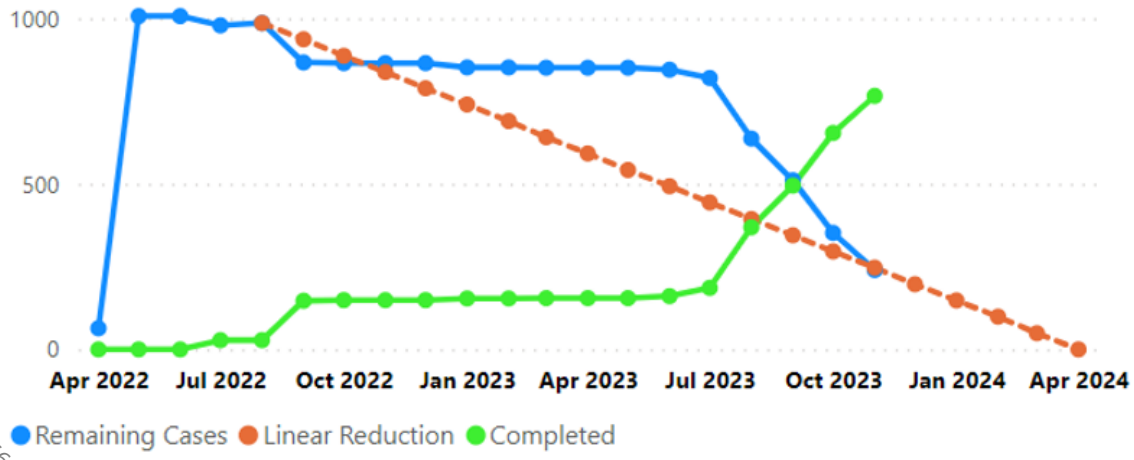
Covid Investigations

NNCP Data - Cardiff and Vale UHB

GIG CYMRU NHS WALES — National Nosocomial COVID-19 Programme



Required Trajectory



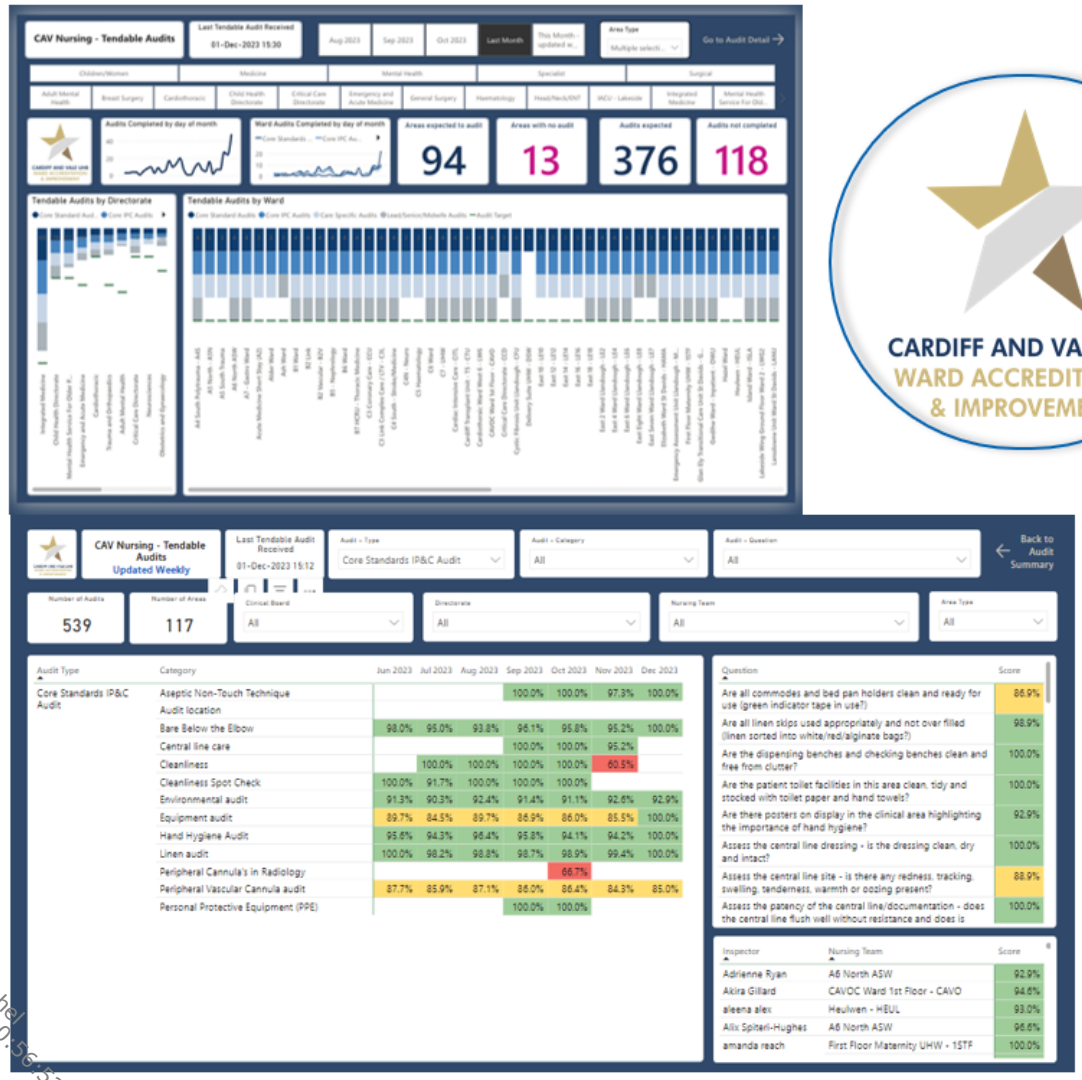
Chilcott, Rachel 19/12/2023 10:56:53

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

Effeithiol
Effective

Effective Care

Tendable



CARDIFF AND VALE UHB
WARD ACCREDITATION
& IMPROVEMENT

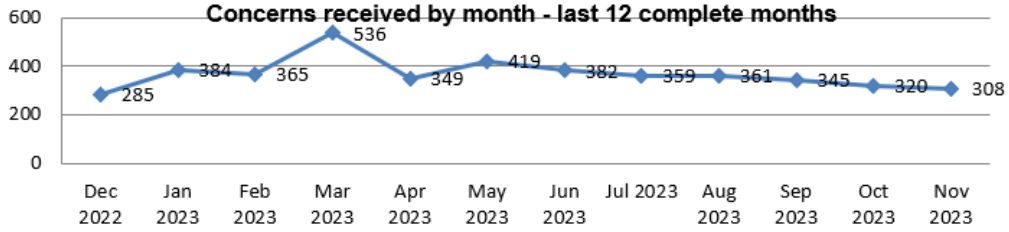
- Tendable is being used in over 200 clinical areas across the UHB to review quality standards, drive improvements and demonstrate good practice.
- Nursing teams complete a structured monthly audit programme which is aligned to the Ward Accreditation and Improvement programme.
- 3 wards are currently working their way through obtaining bronze accreditation. Last month, 9 wards become eligible to join the accreditation programme, because of their Tendable compliance. They will begin their Bronze accreditation at the beginning of 2024
- Other multi-disciplinary teams are also beginning to see the benefits of Tendable such as dietetics, pharmacy and radiology. Audit programmes are written with staff working in the clinical areas and aligned with national standards, local policy and procedures.
- A PowerBI dashboard has been released for teams to track their audits and progress in real time. This information sits alongside a Nurse Staffing dashboard (slide 16) and HCAI dashboard. Development work is underway to integrate Welsh Nursing Care Record and HealthRoster data into these dashboards.

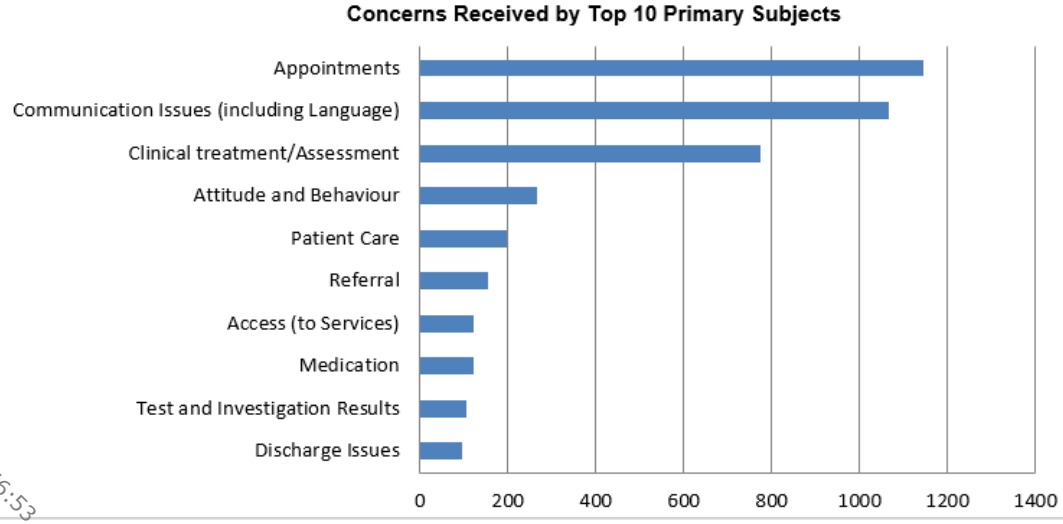
Person Centred Care

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.





We currently have 282 active concerns. 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.

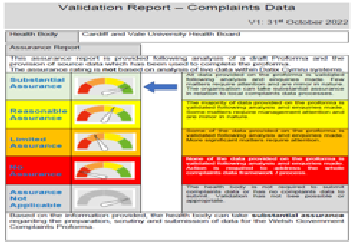
The second chart demonstrates the 10 main themes noted in Concerns.

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

During October and November 2023, the Health Board received :

- 628 Concerns
- 71% closed within 30 working days (including Early Resolution)
- 34 % closed under Early Resolution (within 2 days including day of receipt)
- 155 Enquiries
- 94 Compliments

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.

	Population	Complaints Received	Complaints Received per 1000 residents (adjusted)	Complaints Closed	Within 30 days %	Referred to Public Services Ombudsman for Wales	Referred %	PSOW Cases Closed	PSOW Intervened %	Early resolution %	PSOW Upheld%
Aneurin Bevan University Health Board	591,225	1,502	5.08	1,459	78.27%	80	5.48%	94	37.23%	26.60%	8.51%
Betsi Cadwaladr University Health Board	698,369	1,218	3.49	1,181	44.20%	115	9.74%	119	35.29%	21.85%	13.45%
Cardiff and Vale University Health Board	496,413	2,215	8.92	2,180	79.86%	72	3.30%	74	22.97%	16.22%	1.35%
Cwm Taf Morgannwg University Health Board	445,190	1,520	6.83	1,103	85.77%	51	4.62%	61	29.51%	14.75%	13.11%
Hywel Dda University Health Board	385,615	1,187	6.16	1,147	67.65%	67	5.84%	69	36.23%	26.09%	10.14%
Powys Teaching Health Board	132,447	68	1.03	68	36.76%	10	14.71%	14	7.14%	0.00%	7.14%
Swansea Bay University Health Board	389,372	1,223	6.28	1,108	60.74%	65	5.87%	69	21.74%	15.94%	5.80%
Velindre University NHS Trust	-	107	-	98	98.98%	3	3.06%	4	0.00%	0.00%	0.00%
Welsh Ambulance Services NHS Trust	-	489	-	532	63.72%	20	3.76%	19	10.53%	10.53%	0.00%
Wales	3,138,631	9,529	6.07	8,876	70.54%	483	5.44%	500	30.60%	20.20%	9.00%

Despite a significantly high number of concerns our referrals to the Ombudsman remain low

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

Person Centred Care

Person Centred Care

Patient Experience - CIVICA

Tell Us in 2 Survey

SMS sent: 18476

Bedside QR code: 376

Survey responses: 3705

Response rate: 18%

89% were satisfied with their overall experience.

Tell Us in 2 Survey results (combined SMS and Bedside).

Based on **3705** partial/full survey completions (1st Oct – 28th Nov 2023).

- 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.

We aim to send up to 600 text message survey links per day to patients using our general services to gather feedback.

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.

Currently, the Tell Us in 2 survey is available in English, Welsh, BSL/English and BSL/Welsh. The next step will be to review the survey, with a view to produce one general design that can be used in all settings and then have this translated into a further 7 languages, including: Arabic, Bengali, Czech, Mandarin, Kurdish, Sorani, Farsi, Polish.

We are aware that having the surveys available in multiple languages will require the feedback, of anything other than English, to be translated. Therefore, we are starting to link with local translation providers/review software options, in order to reduce any delay on when that feedback is made available to staff.

The survey software also enables respondents to increased/decreased the survey text size at any point during a survey and the surveying App has a read aloud facility. We are also looking into software that can convert speech into text.

Person Centred Care

Patient Experience - CIVICA

Emergency Unit Survey

SMS sent: 7817

Surveys responses: 1017

Response rate: 13%

74% were satisfied with their overall experience.

Emergency Unit Survey results.

Based on **1017** partial / full survey completions (1st Oct – 28th Nov 2023).

- Did you feel that you were listened to? **68%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **33%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **61%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **63%** of respondents answered 'Always'.
- If you asked for assistance, did you get it when you needed it? **42%** of respondents answered 'Always'.
- Did you feel you understood what was happening in your care? **64%** of respondents answered 'Always'.
- **74%** were satisfied with their overall experience.

We aim to send up to 200 text message survey links per day to patients using our Emergency Unit to gather feedback.

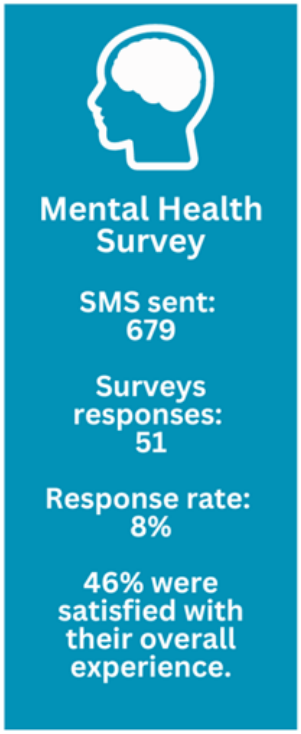
To alleviate people feeling anxious and stressed while waiting, the PE Team have introduced mobile loaning library trolleys stocked with books, magazines and patient activity packs for all levels of cognitive impairments to provide distraction. Personal radios and DVD players and DVDs are also available 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.

Volunteers are being deployed to areas suffering from the effects of Winter Pressures, such as EU to help keep patients updated and informed and to help relieve pressure on staff.

Person Centred Care

Patient Experience - CIVICA



Mental Health Survey results.

Based on **51** partial / full survey completions (1st Oct – 28th Nov 2023).

- Did you feel that you were listened to? **41%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **0%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **55%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **35%** of respondents answered 'Always'.
- If you asked for assistance, did you get it when you needed it? **24%** of respondents answered 'Always'.
- Did you feel you understood what was happening in your care? **41%** of respondents answered 'Always'.
- **46%** were satisfied with their overall experience.

We aim to send up to 200 text message survey links per day to patients using our Mental Health services to gather feedback.

Posters, stickers and signs are placed around hospital sites and at bed sides displaying a QR code, inviting patients to share their recent experiences of using the Health Board's services. Once scanned, the QR code gives the individual to access the "Tell Us In 2" survey - a short questionnaire, which takes around two minutes and can be completed in English or Welsh. All responses are anonymous.

When individuals complete the questionnaire, it is asked that they give an open and honest opinion of their experiences so the Health Board can share compliments, best practice or suggestions, to learn from experiences and help shape services for the future.

For those requiring special assistance in completing the questionnaire, a dedicated telephone helpline is available from 10am-1pm, Monday – Friday and a dedicated email address has been created to manage feedback enquiries.

We have already begun to evaluate and improve upon the work we have undertaken, to ensure our feedback mechanisms are accessible to all.

Effeithlon
Efficient

Efficient Care

Safe Care

- This infographic provides overview for all 25B wards under the Nurse Staffing Levels (Wales) Act. The dashboard can focus down into each area.
- SC compliance since June recorded for 25B wards. This continues to be monitored monthly.
- Both professional judgement and red flags are recorded, providing overview across the Health Board.
- Increasing compliance in SafeCare over the last 6 months, has increased the number of acuity scores recorded. Monitoring of trends of acuity levels using Welsh Levels of Care continues.
- Nurse staffing levels for both registered and unregistered against planned shifts is recorded in the final graph. Nurse staffing levels across 25B wards are being met during the night with an improving picture for day shifts in October and November.

Report Title:	Healthcare Inspectorate Wales Activity				Agenda Item no.		
Meeting:	Quality, Safety & Experience Committee		Public	x	Meeting Date:	19 December 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Head of Quality Assurance and Clinical Effectiveness						

Main Report
Background and current situation:

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

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

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

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

All General Practices and General Dental Services / Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local CHC. The HIW inspections result in an Action Plan which is assessed and followed up on by HIW. The UHB then ensures ongoing compliance with the outcomes of the inspection.

A HIW publication schedule is available on the Health Care Inspectorate Wales Website:

Publication schedule | Healthcare Inspectorate Wales (hiw.org.uk)

Unannounced Inspections

Mental Health Services Hafan y Coed Ash & Pine Wards

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection to Pine and Ash Wards at Hafan Y Coed Mental Health Hospital, University Hospital Llandough on 9th, 10th and 11th January 2023. Overall the HIW inspection found that staff were committed to providing safe and effective

care. With processed in place to manage and review risk to maintain the health and safety of the patients, staff and visitors at the hospital.

Staff were witnessed interacting and engaging with patients and visitors respectfully. Staff were passionate about their role and showed enthusiasm about how they supported and care for their patients and wards provided calm and therapeutic environments which were in keeping with patients' needs. However, some improvements were required in relation to infection prevention and control, training compliance and medicines management.

HIW issued an immediate assurance letter as inspectors identified an overall staff compliance with Strategies and Interventions for Managing Aggression (SIMA) was low for both Ash and Pine Wards. The inspection identified some members of staff have been involved in incidents of restraint who were not compliant to do so, increase to the risk against injury during incident restraints.

Further recommendation for improvement included:

- Staff to be provided with personal alarms
- Ensuring clothing and bedding not to be placed on bedroom doors
- A review of the security access to Ash ward preventing unauthorised access.
- Ensure correct administration of medication records and to ensure the safe storage of medication
- Ensuring sufficient patient information which are individualised and clearly documented within patient care plans
- Ensuring appropriate maintenance of all clinical rooms

An improvement plan was submitted to HIW addressing the issues highlighted.

The full report can be accessed via the link: Mental Health HIW Ash and Pine Ward

Mental Health Services Hafan y Coed Wards E12 and E16

HIW completed an unannounced inspection on Ward 12 and Ward 16 at Llandough Hospital on 20th, 21st and 22nd March 2023. Inspectors overall found staff to be a dedicated team who were committed to providing a high standard of care to patients. Staff were caring, kind and compassionate towards patients. No immediate concerns were identified by the inspection team.
There were some areas of improvement required which include:

- Improvements to the outdoor space to improve therapeutic time for patients
- Mandatory training compliance and regular staff meeting are held regularly and are minuted.

An improvement plan has been submitted to HIW and all actions have been completed by the Mental Health Clinical Board team. The full report including the action plan can be accessed via the link: Mental Health HIW Ward E12 and E16

Specialist Services Ward B5 caring for patients with renal disease and T5 – kidney and pancreas transplant patients

HIW completed an inspection on Ward B5 and T5 to which the ward was given 24 hours' notice to prepare safe covid-19 arrangements. The inspection team identified that staff to provide kind and compassionate care and ensured patients dignity when providing care.

HIW issued an immediate assurance letter in relation to the following:

- Maintenance was required to lockable medicine cupboards and fridges
- Ensuring appropriate stock levels of medication, ensuring medicines are checked and stored appropriately
- Mandating staff training compliance

- Service lift to be operational to promote the safe removal of waste from the ward

An action plan was submitted to HIW for all immediate assurances which have been undertaken. A further improvement plan was also submitted which included:

- Suitable action to taken for the provision of communication aids on the ward
- To promote the use of the welsh Language including promotion of 'Active Offer'
- Ensure information is available and clearly displayed on the ward

All actions have been completed and addressed, in response HIW provided conformation they have received sufficient assurance. The full report which included the action plan can be accessed via the link: Specialist Services HIW Ward B5 and T5

Surgical Services - Dental Hospital

HIW attend the University Dental Hospital for an announced inspection of general dental practice at the hospital on 24th April 2023. No immediate concerns were identified during the inspection.

HIW overall found that patients rated the service as 'very good' and 'good' and the hospital make efforts to ensure appointments times are suitable to patients. Staff were observed to treat patients with kindness and respect. The inspection identified that patients were provided with sufficient information and guidance regarding their care. Some improvements were recommended to support service improvements, these included:

- More accessible bilingual information
- Ensure maintenance for lifts in the hospital to be carried out.

An improvement plan has been submitted to HIW and all action have been completed. Full access to the report and the improvement plan can be accessed via the link:

Surgical Services HIW Dental Hospital

Medicine Clinical Board – Ward A7 – Gastroenterology

An unannounced HIW visit took Ward A7 on 12th and 13th June 2023. The visit highlighted some immediate assurance were required in the following areas:

- The medication storage room door required staff to manually force to door to close and at risk of being left unlocked.
- Expired medication were found in the medication room.

An immediate action was submitted to HIW, the medicine clinical board have completed these actions. Some improvements were identified regarding the storage of intravenous fluids, an improved planning, referral and discharge process and surface dust on the ward.
An improvement plan was shared with HIW and all action have been undertaken.

Overall HIW found the ward to be providing safe and effective care to patients, with good arrangements in place to prevent pressure damage and prevent patent falls. Hydration and specialist nutrition needs for patient were in place and patient were well cared for. Staff were seen to treat patients with kindness and respect and made efforts to protect their privacy and dignity when providing care. Access to the full report and improvement plan can be accessed via the link:
Medicine Clinical Board HIW Ward A7

Children's Hospital of Wales Island ward

HIW attended Island Ward for an unannounced visit on 27th and 28th November 2023. The full report has not been published, however, overall the inspection was positive.

Staff were reported to be friendly and provide safe and effective care. Some immediate assurances were required, these included medication fridge temperate and infant milk fridge storage temperature checks. An action plan has been drafted and due to be submitted to HIW.

Follow up inspection reports

Maternity Services in UHW were subject to an unannounced inspection in November 2022 and a follow up inspection in March 2023. Both inspections resulted in immediate assurance requirements and a single combined improvement plan.

The inspection identified areas that required improvement that included

- The need to improve the privacy and dignity of patients care for in the induction of labour environment
- The need to improve the support available to women from a Black, Asian and minority ethnic background.
- The need to improve the timeliness of patient safety reviews and responses
- Improved compliance with mandatory training
- Improved environmental oversight including Infections prevention and control audits.
- The need to improve medicines storage

The inspection also noted areas of good practice that included good multidisciplinary team working and good record keeping and documentation. The majority of patients and their families told the inspection team that they felt well cared for and the bereavement and perinatal services were seen to be very supportive.

An extensive improvement plan was developed to address the recommendations and these have been combined with recommendations from the Ockenden report and the Welsh Maternity and Neonatal Oversight Report .

Maternity: 20230621UHWMaternity-Full-EN.pdf (hiw.org.uk)

Primary Care Contractor Reviews

The responsibility for responding to recommendations made following HIW reviews lies with the independent contractor.

The Primary Care Team undertakes a review of each practice report and any potential actions for follow-up including concerns raised or immediate assurance requirements. These are followed up to gain assurance the necessary improvement have been made and sustained.

General Medical Services:

During the period of January – November 2023 there have been 3 full reports and 3 Immediate Assurance letters received.

Grange Medical Practice

Report available on the Healthcare Inspectorate Wales Website: Grange Medical Practice | Healthcare Inspectorate Wales (hiw.org.uk)

Inspection Date – 16/01/2023

Immediate Assurance Letter

During the inspection, HIW found areas of concern which could pose an immediate risk to the safety of patients. In summary, the issues found are:

• Inconsistent checks and storage of emergency drugs
• Lack of appropriate DBS checks
• Clinical staff without Hep B vaccination
• Staff are not up to date with statutory and mandatory training, and there is a lack of monitoring of such training activities.

The practice has responded to the concerns and these have been completed and checked by HIW.

Full Report
The following actions have been confirmed as complete and have been accepted by HIW

• The practice manager must develop a training matrix to effectively keep track of mandatory staff training.

• Staff should make every effort to ensure patients' preferred language is recorded consistently across patient records.

• Staff must ensure they are providing the active offer for Welsh speaking patients.

• We recommend Welsh speaking staff wear 'Iaith Gwaith badges' so patients can easily identify them.

• Staff must ensure a date is added to the Business continuity plan and a date for annual review.

• Data shredding stored in clinic rooms and storage rooms currently pose a fire risk. Staff must ensure that bags of shredding are stored securely in outdoor bin area.

• Staff must ensure the safeguarding policy is updated to include details of the current Safeguarding lead at the practice and contains information specific to Wales.

• Staff must ensure they have access to the current All Wales safeguarding guidance. We recommended all staff access the All-Wales Safeguarding phone app.

• Staff should ensure all yellow clinical bins are kept locked, even whilst in locked rooms.

• All staff must be aware of the process in place to remove flags from patient records, indicating a potential child at risk.

Rumney Primary Care Centre
Report available on the Healthcare Inspectorate Wales Website: Rumney Primary Care Centre | Healthcare Inspectorate Wales (hiw.org.uk)

Inspection Date – 18/01/2023

Full Report (Quality Check)

The following actions have been confirmed as complete and have been accepted by HIW.

• The practice must review the risk assessment for the delivery of seasonal flu/COVID-19 vaccinations to ensure that it follows the most up-to-date guidelines and criteria for preventing respiratory transmitted viruses.
• The practice must provide to HIW details of the most recent staff meeting minutes
• The practice must ensure policies and procedures are dated, version controlled and have in place a date for review.
• The practice must ensure that training in IPC is repeated on a regular basis. The practice must provide to HIW evidence of staff training in IPC

Lansdowne Surgery
Report available on the Healthcare Inspectorate Wales Website: Meddygfa Lansdowne Surgery | Healthcare Inspectorate Wales (hiw.org.uk)

Inspection Date – 27/03/2023

Immediate Assurance Letter
During the inspection, HIW found areas of concern which could pose an immediate risk to the safety of patients. In summary, the issues found are:

- Storage of medicines within unlocked cupboards and drawers.
- An unlocked medication fridge located within an unlocked room.
- Expired children's influenza vaccine kept within the medication fridge
- Blank prescription sheets stored within an unlocked drawer
- Medications stored within lockable cupboards with their keys left in situ

The practice has completed and submitted its follow up actions to HIW.

Full Report
The following actions have been confirmed as complete and have been accepted by HIW.

• Multiple expired sterile items were found within clinical rooms
• Provide consent forms and written information in a range of formats (e.g. Easy-Read, large print)

• Develop, implement, and maintain an appropriate medicines management policy and procedure to include arrangements for the safe and secure storage of medication and prescription pads and materials and replacement and removal of expired materials from clinical rooms

• Implementation of improved infection prevention and control procedures to include formal training for the IPC lead nurse, implementation of audits such as hand hygiene, overall IPC compliance and a healthcare waste audit

• Implementation of a mandatory training programme and oversight of the same in line with General Medical Council guidelines

• Develop, implement, and maintain a robust policy and procedure for the checking and confirmation of the immunisation status of staff.

Llantwit Major & Coastal Vale

Full Report not yet published on the Healthcare Inspectorate Wales Website.

Inspection Date – 05/09/2023

Immediate Assurance Letter
In summary, the issues found are:
• Provide the lead IPC nurse with an appropriate training programme to support them in their role
•Undertaken an annual IPC audit of the medical practice
•Undertake regular hand hygiene audits of staff.
•Replace all expired curtains within clinical rooms
•Ensure PPE and items used in the treatment of patients is stored in an appropriate manner to prevent against contamination and uphold standards of IPC in line with IPC guidelines
•Remove all paper posters and notices and replace with laminated versions where possible
•Ensure all staff have in place a level of training in IPC appropriate to their role.
•Remove the sample collection bin from outside the practice and implement a more appropriate

method for the acceptance of patient samples

The practice has completed and submitted its follow up actions to HIW.

General Dental Services:
During the period of January – November 2023 there have been 5 full reports including 2 Immediate Assurance letters and 1 immediate assurance letter currently without full report.

Newport Road Dental Practice
Inspection date: 16/11/2023
Full report published: 16/02/2023

Improvement plan points from full report:

- Oral health promotion information must be provided to patients when required.
- Treatment planning and treatment options for patients must always be recorded in patient records.
- The practice should reflect on the patient feedback and improve access to appointments for patients.
- The practice must implement a more structured process to actively seek the views of patients such as issuing questionnaires or feedback forms.
- Milk must not be stored in the same fridge as clinical materials.
- The kitchen should be deep cleaned and cleared of all unnecessary clutter and storage.
- Cleaning equipment and materials must be stored in a separate designated lockable cupboard.
- The collection and disposal of gypsum must be added to the existing waste contract.
- A contract must be set up with the local council for the removal of non-hazardous household) waste.
- Surgery 2 must be decluttered, organised and restocked with appropriate and sufficient dental instruments before being used to treat patients.
- Written treatment plans must be provided to patients and a copy kept in the patient's record.
- Oral cancer risk assessments must be recorded in patient records at all times.
- The justification and grading of X-rays must be recorded in patient records at all times
- Appropriate radiographs must be taken as clinically required and the clinical findings of radiographs must be recorded in patient records at all times.

Practice has provided evidence of compliance for all areas of improvement raised in the full report and HIW were satisfied with responses. UHB followed up and provided support to the practice. Report and actions were presented at Dental Q&S meeting and agreed complete.

Wyndham House Dental Practice
Inspection date: 24/02/2023
Immediate assurance received: 24/02/2023

Immediate assurance raised:

- The registered manager must ensure that all pre-employment checks are undertaken before a member of staff is employed at the practice.
- The registered manager must ensure that all medication is stored securely and in an appropriate location at the practice.

Practice was contacted for immediate assurance response and this was provided.

Full report published: 30/06/2023

Improvement plan points from full report:

- The registered manager must ensure that all pre-employment checks are undertaken before a member of staff is employed at the practice.
- The registered manager must ensure that all medication is stored securely and in an appropriate location at the practice.
- The registered manager must ensure that external containers for safe storage of clinical waste, must be secured to a non-moveable surface.

Practice has provided evidence of compliance for all areas of improvement raised in the full report and HIW were satisfied with responses. UHB followed up and provided support to the practice. Report and actions were presented at Dental Q&S meeting and agreed complete.

Hywel Samuel Dental Practice
Inspection date: 30/01/2023
Full report received:02/05/2023

Improvement plan points from full report:

- The practice must ensure that documents such as the complaints policy, patient information leaflet and statement of purpose, are available bilingually in the waiting area of the practice.
- The practice must ensure that staff complete smoking cessation and antibiotic audits for the practice as soon as possible
- The practice must ensure that a tick box option is added to patient records, in order to easily identify patients who are smokers

Practice has provided evidence of compliance for all areas of improvement raised in the full report and HIW were satisfied with responses. UHB followed up and provided support to the practice. Report and actions where presented at Dental Q&S meeting and agreed complete.

Porthkerry Dental Practice
Inspection date: 05/06/2023
Immediate assurance received: 07/06/2023

Immediate Improvement letter received

- No inspection certificate for Melag autoclave
- Not all staff have DBS checks

Full report received: 20/09/2023

Practice has provided evidence of compliance for all areas of improvement raised in the full report and HIW were satisfied with responses. UHB followed up and provided support to the practice. Report and actions were presented at Dental Q&S meeting and agreed complete.

Clifton Dental Practice
Inspection date: 03/07/2023
Full report received: 03/10/2023

Improvement plan point from full report:

- CPR Medical emergency training face to face to be completed face to face 19th October

Porthkerry Dental Practice
Inspection date: 29/11/2023
Immediate assurance received: 05/15/2023

Currently being worked through by Primary Care team. Practice has been contacted for a response to the issues raised by the immediate improvement plan. Awaiting full report.

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

Monitoring of HIW Activity within Cardiff and Vale UHB

The Health Board has procured AMaT (Audit tracking and Monitoring System) which is a central web based management system for monitoring and tracking quality assurance activity across the UHB. The system has a multitude of functionality and modules, one of which is an inspections module. The system has been used in England with CQC inspections and can be utilised similarly for HIW inspections.

Current processes focus on completion of immediate improvements identified but it is acknowledged that capturing the progress and completion of all action plans across the UHB is challenging. It is recognized that a more robust approach is required to fulfil quality assurance requirements.

Since the implementation of AMaT has supported this process, by providing oversight of all Improvement plans from HIW inspections.

There are currently preliminary discussions occurring on an All Wales basis with AMaT users regarding the potential increased functionality and capability of AMaT to achieve direct secure communication with HIW. This would require agreement of All NHS organisations in Wales. Further information on the limitations and benefits will be shared will be shared in due course.

HIW Strategic Plan 2022-2025

HIW have published their Strategic plan for 2022-2025. The strategy focuses on the learning that has taken place over the past 3 years, and in particular during the pandemic. Full publication available on the health Care Inspectorate wales Website

20220323 - HIW Strategic Plan FINAL - EN.pdf

HIW Operational Plan 2022-23

HIW launched their Operational Plan 2022-2023 in June 2022. The plan outlines the actions they aim to take to achieve their new priorities, which were set in the Cardiff and Vale UHB Strategic Plan 2022-2025. These are:

- Focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- Adapt their approach to ensure we are responsive to emerging risks to patient safety
- Work collaboratively to drive system and service improvement within healthcare
- Support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Recommendation:

The Committee is requested to:

- **NOTE** the level of HIW activity across a broad range of services.
- **Note** the assurance provided by the improvements implemented and by the processes to monitor and audit the improvements

- **AGREE** that the appropriate processes are in place to address and monitor the recommendations.

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

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

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

Committee/Group/Exec	Date:

Report Title:	Research and Development Update			Agenda Item no.	
Meeting:	QS&E	Public		Meeting Date:	19th December
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive:	Executive Medical Director				
Report Author (Title):	Sarah Martin				

Main Report
Background and current situation:

Background

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

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

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

Research Development As part of developing a research idea, research protocols will undergo a high level of scrutiny. In order to obtain research funding, researchers are expected as a minimum to, engage and have involvement from public and patients, input from professional societies and external expert peer review.

Research Approvals

Research will undergo a combination of national and local approvals before it is able to commence within the Health board. The UK Policy Framework for Health and Social Care Research set out the principals of good practice in the management and conduct of health and social care research. These principles protect and promote the interests of patients, service users and the public in health and social care research.

Nationally, all research is required to be reviewed and approval issued by a Research Ethics Committee (REC) and the Health Research authority (HRA). The REC will conduct an independent review to ensure that the research proposal is ethical, taking into the requirement and impact on the participant. The HRA assesses the governance and legal compliance of a study. If the research is a clinical trial of a medicinal product (CTIMP) or a study of an unlicensed device the study requires review and authorization from the Medicines and Healthcare Product Regulatory Agency (MHRA). Additional national approvals are required if a study involved Genetic Modified Organisms, ionizing radiation or to obtain information without consent.

Locally, the studies undergo a review of Capacity and Capability by the R&D department to ensure that the organization has appropriately trained the staff resources and adequate facilities to ensure that the study protocol can be delivered. To make this assessment the R&D office engage with the researchers, departments and support services to ensure it is feasible to delivery and then obtain sign

off by the directorate research lead, directorate manager before final sign off by the JRO director. It is only once these reviews are completed that the study can commence within the health board. Additionally therapies with genetically modified organisms are reviewed locally by the GMSC (Genetically Modified organisms Safety Committee) chaired by Professor Richard Stanton.

Monitoring of Clinical Trials Activity

The research regulations outline requirements for monitoring trial activity. All clinical trials must be registered on public international trials registration websites (such as https://clinicaltrials.gov).
Each protocol will outline the safety reporting requirements including reporting to the regulators.
Each trial is required to have a trial steering group and independent Data Safety Monitoring Board (DSMB). The latter is comprised of independent trialists and a senior trials statistician. The DSMB will meet at defined time points according to the statistical analysis plan, but at any time deemed necessary if there is a safety concern or new information which effects the ongoing conduct of the trial. The DSMB reports to the chief investigator and steering group and will recommend that the trial continues, or stops on the basis of futility or harm.

Regulatory Compliance and Quality Assurance

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

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

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

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

CAV were last inspected by MHRA as a sponsor organization in 2012. CAV are acting as sponsor for 1 CTIMP study which would be subject to MHRA inspection. If we were to be inspected as a sponsor organisations we would be responsible for hosting and covering the costs of the inspection, which is charged as a day rate per inspector who attends, and could range from £20k-£30k.

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

Health board Research Governance, Leadership and Accountability

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

JRGG is chaired by Professor Colin Dayan JRO Director and is attended by JRO Senior Management team, the R&D leads from each directorate, research delivery managers. There is also representation from Pharmacy, Biobank, Genetically modified Safety Committee (GMSC) and Information Governance (IG).

The Cardiff Joint Research Office (JRO) reports into to the QSE (via the Medical Director).
Since the September 2022 the JRGG has focused on

- Inspection readiness
- Oversight of Incidents and Breaches
- Revised Audit Processes and scope of Audit cycle
- Development of QA group to oversee development of a joint risk register

Key points to be raised with the QS&E have been outlined below.

NHS R&D Framework

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

At the annual review with HCRW we were asked to document how the health board is currently performing against the R&D framework and to provide details of future plans that organization has to become a more research supportive organization. It was also noted that compared to similar sized organizations in England, it might be expected that CAV expand their industry and academic hosted research activity by up to two-fold. Our response is included as appendix 2.

The R&D senior management team plan to use the framework to inform R&D planning as part of the health board strategy refresh.

Issues for QSE

1) Regulatory Inspection

It is felt that we are at a high risk of being selected for regulatory inspection, it has been over 10 years since CAV hosted an MHRA inspection and we are about to take on sponsorship for a CTIMP study.

A recent regulatory inspection of the health board as a host organization highlighted that we a need for a renewed focus on quality to ensure inspection readiness.

There were 4 main themes which were identified from the inspection findings which are known to be common inspection findings and applicable for research across the Health Board.

- Delegation log management
- Consent
- Principal Investigator (PI) oversight
- Sponsor communication

Inspection findings were disseminated to all researchers and all research teams at the Research Investigators meeting on the 19th April 23. Attendance was monitored and any principal investigators who did not attend are being followed up.

The following actions have been taken address this

Annual Audit Plan

The annual audit plan was submitted and approved by JRGG which outlines plans for 2023/24 to increase oversight of research conduct in the Health Board.

This plan includes

Auditing of Non-commercial hosted CTIMP studies. These are studies which are not regularly monitored by the sponsor and therefore lack an external quality review. R&D are to perform audits on 10% of non-commercial CTIMP studies to review compliance.

Reviewing monitoring reports from external monitors, e.g. commercial companies. To understand findings and ensure actions are addressed in a timely manner.

Incidents or breaches will be fully investigated and study activity audited.

To date 7 audits have been completed, no major findings have been identified. The findings of this work will inform an appropriate risk based approached for ensuring oversight in the future.

Inspection Readiness

Any inspection exposes a risk to research across the organization, so it is important that the R&D department provides support to the researchers through the process.

Research teams have been instructed that R&D are to be informed of all regulatory inspections and external Audits. On notification of an inspection R&D will work with the teams to prepare for the visit, this support includes but is not limited to, providing space to host the inspection, full review of study documentation to ensure completeness, review of study source documentation to ensure research practices can be verified and training for staff on inspection process.

The JRO Quality Management group has been established as a sub-group of JRGG. One of the tasks for the QMG will be to establish an inspection readiness group. R&D have provided inspection readiness training to 30 members of staff to prepare for this work.

Researcher Requirement and Oversight

The Site Principal Investigator is the person responsible for the research activity at their site. Therefore they need to be able to demonstrate oversight of all research activity including the activity that maybe delegated to another member of the research team.

It is recognised the importance that researchers engaged in research have time within their job plan to ensure they can provide the oversight required. R&D are completing a scoping exercise to identify how many researchers have time in their job plan to conduct research and working with directorates and researcher to support the job planning process.

2) Research Related Clinical Incidents

A clinical incident reported for a patient receiving treatment as part of a phase 1 Huntington's trial. The incident has been investigated by patient safety (ID 34808) and by the commercial sponsor. The study recruitment was put on hold while the investigations could be completed. R&D are working on a response to patient safety report.

A number of corrective and preventative actions have been identified and actioned to address the study specific findings of the investigations but the following have been identified as areas of learning for R&D;

- Risk Based oversight

  Current process requires R&D leads to provide a verbal update to JRGG on a quarterly basis. R&D recognise the need to have better oversight of study activity post study approval, especially for early phase or complex studies.

  A risk-based review process is being developed which will issue each study a risk rating at point of R&D issuing confirmation of capacity and capability. Studies deemed to be a high risk will be subject to higher levels of oversight post approval.

High risk studies will be captured on a risk register and required to provide updates to JRGG.

The oversight required will be tailored to reflect the risk and an oversight plan will be agreed with the research team.

A process for reporting of serious Adverse Events to the JRGG will be further considered and a plan agreed and formalized.

- Clarification of roles and Responsibilities
  The incident has highlighted a need for better understanding of how the research sits within the clinical setting.

  R&D feasibility processes have been reaffirmed to ensure that every speciality area involved in a study is made aware of the proposed research as part of our feasibility review. As part of this process we are adding detail to make it explicit as to what our ask is as part of this process.

  To further support this we will be meeting with the directorates and research leads to reaffirm their role in reviewing projects. This is to ensuring that if a research project presents a clinical challenge or a change to clinical services this is to be flagged with R&D to so can ensure suitable arrangements can be made with regards to oversight and ensuring compliance.

At any one time The UHB has over 700 studies running and approve approximately 170 new studies each year.

Since 2021, the Health Board, in common with other large academic health trusts, has created a Joint Research Office (JRO) with Cardiff University to share expertise around research governance, costing and contracting processes and identify opportunities for collaborative working. Locally, the R&D office supports a review of Capacity and Capability by the R&D department to ensure that the organization has appropriately trained the staff resources and adequate facilities to ensure that the study protocol can be delivered.

It is recognized that the UHB is at an increased risk of being selected by the MHRA for a regulatory inspection. R&D will be developing a program of work to ensure inspection readiness which may result in request for support from the executive team. If the outcome of the inspection were to be unfavorable it could limit our ability to conduct research which would directly adversely affect patient care and would damage the organisation's research reputation.

The R&D team would like to provide assurance to the Committee that there is a robust process in place to review and issue approval for research within the Health Board and that there is a risk-based process being implemented to ensure there is oversight of research activities post approval. High risk studies are captured on a risk register and are required to provide an update to the JRGG.

A process for reporting of serious Adverse Events to the JRGG will be further considered and a plan agreed and formalized.

Recommendation:

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

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

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

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

Appendix 1 – Health and Care Research Wales R&D Framework – Research Matters, what excellence looks like in NHS Wales

NHS_RD_Framework-FINAL_eng.pdf

Appendix 2 –NHS R&D framework- self assessment Cardiff and Vale

NHS RD Framework- Self ass

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

Held on 16th October 2023 Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Director of Nursing/Multi Professional Teams
Adam Christian	AdC	Clinical Board Director
Sian Jones	SJ	Directorate Manager, Laboratory Services
Jonathan Davies	JD	Health and Safety Adviser
Mathew King	MK	Head of Podiatry/Assistant Director of Therapies and Health Sciences
Seetal Sall	SS	Point of Care Testing Manager
Robert Bracchi	RB	Medical Advisor to AWTTC
Alun Roderick	AR	Laboratory Service Manager, Haematology
Jo Fleming	JF	Quality Lead, Radiology
Tracy Wooster	TW	Sister, Outpatients
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer/Assistant Director of Therapies and Health Sciences
In attendance:		
Nicola Hadley	NH	Young Persons Independent Domestic Violence Adviser
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
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
Jamie Williams	JW	Senior Nurse, Radiology
Paul Williams	PW	Clinical Scientist, Medical Physics
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Melissa Melling	MM	Head of Medical Illustration
Rhys Morris	RM	CD&T R&D Lead
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Timothy Banner	TB	Clinical Director, Pharmacy
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 23/268	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 23/269	**Apologies for Absence** The apologies for absence were noted.	
CDTQSE 23/270	**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 22nd September 2023 were accepted as an accurate record.	
CDTQSE 23/271	**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* RB advised that the lift was subject to an SAFeD examination on 18th September and a LOLER examination on 22nd September to be repeated in six months' time. The lift passed both examinations. RB will arrange for HL to be sent a copy of the report. *CDTQSE 23/133 R&D Lead for Pharmacy* AA to feedback to Pharmacy that a nomination for an R&D Lead is required. *CDTQSE 23/212 Update on Paperless Results* SJ reported that Biochemistry are considering how to action the cessation of printing of results unless in exceptional circumstances. There are still some departments keen to receive printed reports, even though results are available direct from the Welsh Clinical Portal. Thoughts are therefore being given to introducing this in a phased approach. *CDTQSE 23/241 Suitable Cleaning Products for Equipment in Radiology* JF to provide an update at the next meeting on the issues around identifying a suitable cleaning product for Radiology equipment.	**RB** **AA** **JF**

	CDTQSE 23/244 Feedback on HTA Inspection SG to provide feedback following the HTA inspection at the next meeting. *CDTQSE 23/245 Patient Participation Booking* SO to report on the initiative at the next meeting. **The Group resolved that:** a) The update on the actions from the previous meeting were noted.	**SG** **SO**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 23/272	**Concerns and Compliments Report** In September 2023, the Clinical Board received 52 concerns; 2 formal and 50 early resolution concerns. There was 1 breach in response times. 8 compliments were received. There has been a significant increase in concerns relating to patients experiencing difficulties in contacting appointment bookings lines, particularly in Physiotherapy and Radiology and this theme accounted for 58% of the total concerns received. **The Group resolved that:** a) It was noted that SO will be presenting on the appointment booking initiative in Health Records at the next meeting and this may be an opportunity for shared learning.	
CDTQSE 23/273	**National Reportable Incidents** The open case is due to be closed this month. **The Group resolved that:** a) The NRI report was received and noted.	
CDTQSE 23/274	**New NRIs** 2 New NRIs have been reported, however other Clinical Boards are managing the cases. One case relates to paediatric medicines where pharmacy are involved in the meetings; the other relates to a patient transferred from UHW to St Davids Hospital. As this does not involve Glan Ely Ward, this case is to be managed by Medicine Clinical Board and CD&T Clinical Board are not involved.	

	The Group resolved that: a) The case relating to St David's hospital needs to be removed from the CD&T Clinical Board tracker.	
CDTQSE 23/275	**Duty of Candour Cases** There were no new cases to report. **The Group resolved that:** a) Any new cases will be discussed at this group.	
CDTQSE 23/276	**Risk Register** HL has met with departments to review their risk registers and understand the context around their risks and the scorings. **The Group resolved that:** a) There were no new risks to escalate.	
CDTQSE 23/277	**Patient Safety Alerts** **ISN 2023 006 Glass Pre-Filled Syringes Used in Resuscitation** The ISN has been circulated for awareness but is not applicable to this Clinical Board. **Medstron Bed Rails** EC provided an update on the safety alert that was discussed at the last meeting. A task and finish group is being set up to address the issues raised in the national safety alert. A representative from Occupational Therapy is part of this group. **The Group resolved that:** a) The issues raised in the Medstron Bed Rails alert whilst more related to community beds, are also applicable across the Health Board.	
CDTQSE 23/278	**Medical Device/Equipment Risks** **The Group resolved that:** a) There were no further medical device or equipment issues to report.	
CDTQSE 23/279	**Point of Care Testing** **The Group resolved that:** a) There were no point of care testing issues to report.	

CDTQSE 23/280	**IP&C/ Decontamination Issues** The Decontamination Policy is due for review. A post for a UHB Decontamination Lead is out to advert and this will be a priority task for the postholder when they commence in post. **The Group resolved that:** a) HL will advise directorates when the policy is out to consultation.	
CDTQSE 23/281	**Safeguarding Update** **Introduction on the new Young Persons Independent Domestic Violence Advisor (IDVA) Service** NH, Young Person IDVA advised that the Cyfannol Hub opened in May this year in the Emergency Department. This is the first service of its kind. The service supports victims of domestic violence and consists of support from the Adult IDVA, Child and Young Persons IDVA. CAMHS, Psychology Liaison, Violence Prevention Team and Frequent Attenders Team. The Child and Young Persons IDVA role started in November 2022 to support young people 11-17 years of age who are victims of domestic violence. The role provides specialist advocacy and high-quality support to those highest at risk of domestic, relationship abuse and sexual violence. This involves providing immediate support and advice within a hospital setting; risk assessment/ management; safety planning, advice and guidance. The wellbeing and safeguarding needs of the young person is paramount in terms of their immediate needs and ensuring there is long term community support in place for them. It is recognised that young people are attending the Emergency department due to self-harm, abdominal pain, mental health concerns, anxiety etc. and there are sometimes hidden victims there. NH presented a case study of a 16-year-old female who was an asylum seeker who attended the Emergency department with abdominal pain. Additional tests identified she was pregnant and whilst discussing this with her, there was a disclosure of rape. NH was able to advise her on forensic needs, sexual health needs and ensuring there were community services in place. She liaised with the school health nurse and with the family. There was joint working with sexual assault referral centre and safeguarding referrals were made. HL asked if the Young Persons IDVA service is for patients presenting at EU only or available for other departments in the Health Board. NH advised that the service is usually for patients presenting at A&E but suggested that she is contacted by other	

	departments if they need support as she can provide advice on any disclosures and refer out if required. Papers were circulated highlighting events being held for National Safeguarding Week. **The Group resolved that:** a) NH will provide her presentation slides so that members of the group have her contact details. b) The events being held for National Safeguarding Week will be shared across departments.	
CDTQSE 23/282	**Health and Safety Issues** EC raised the issue that lights in the workshop are failing. This has been raised as a high health and safety risk as the lights in the stairwell no longer work and there is only one light working in the male toilets. The light fittings are the fluorescent tubes that are not energy efficient and will possibly be obsolete from March next year. There is a rolling energy replacement programme to LED lights across the UHB and given the immediate risk to Clinical Engineering , this has been escalated to the UHB Energy Officer. JD advised that he will also raise the issue to try and get this resolved. MK reported that a flood occurred in CRI following the storm last week, affecting a kitchen and a patient stairwell. Estates responded quickly but work is still outstanding. EC also reported that a fire occurred in CRI relating to disposal of batteries used in palliative care pumps. EC has provided advice on mitigating the risks of fire by following the correct disposal of batteries and will also ensure this is communicated widely. MK highlighted that Podiatry changed practice around its use of the glue used for orthotics following concerns relating fumes. The Health and Safety team provided good advice on an alternative practice and this has been shared. **The Group resolved that:** a) MK to advise HL if the estates work outstanding at the CRI is not completed. b) EC will communicate widely on the appropriate disposal of batteries used in palliative care pumps.	**JD** **EC**
CDTQSE 23/283	**Regulatory Compliance** HL reported that an inspection of Radiopharmacy was undertaken by the MHRA earlier this month. Deficiencies were	

	raised during the inspection and a response was submitted last week to the MHRA. The UHB is awaiting their response. Production in the unit has been suspended whilst the team are working through the actions and considering a longer-term plan. The HTA will be undertaking an inspection in Cellular Pathology at the end of October and beginning of November. The HIW will be inspecting Radiology and Dexa in Medical Physics. There is generally an improvement in the regulatory compliance metrics. A DGM inspection in SMPU and feedback was generally positive and the work to improve their metrics was acknowledged. Likewise, Blood Transfusion has also made significant progress in their metrics. **The Group resolved that:** a) The findings from the inspections will be shared in the Regulatory Compliance Group and feedback will be provided at this meeting.	
TIMELY		
CDTQSE 23/284	**Initiatives to Improve Access to Services** SO will present the work around Patient Participation Booking at the next meeting**.** **The Group resolved that:** a) Any initiatives in departments to improve access to services will be shared at this meeting.	**SO**
CDTQSE 23/285	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** **The Group resolved that:** a) There was no update to report on waiting times targets.	
EFFECTIVE		
CDTQSE 23/286	**Feedback from UHB QSE Committee** At the meeting held on 30th August, there was a focus on stroke performance and work ongoing around the stroke pathway to improve the patient experience for stroke patients. The Laser Risk Management Policy and Procedure and the Consent to Examination or Treatment Policy were both approved.	

	An update was provided on the Childhood Immunisation action Plan and information was also shared on the vaccination equity strategic plan. **The group resolved that:** a) The minutes of the meeting held on 30th August 2023 were noted.	
CDTQSE 23/287	**NICE Guidance** **The Group resolved that:** a) There was no new guidance to share.	
CDTQSE 23/288	**Research and Development** **The Group resolved that:** a) There was no update to report.	
CDTQSE 23/289	**Service Improvement Initiatives** **Digital Therapies** During the pandemic, the need for digital transformation become more pronounced. Therapies worked with an external consultancy company, Q5 to support the rehab model and following on from this they were also asked to conduct a digital review and set up a model for digital transformation within Therapies. Work focused on 6 workstreams: PARIS interoperability; this is the electronic patient record. Office 365 – there were opportunities around the use of Office 365 that had not been explored. Digital futures – AI and virtual reality are areas to start looking into for future innovation. Patient engagement – Attend Anywhere consultations are being used but engagement with patients is needed to ensure the service is delivery its service in an equitable and inclusive manner. Business intelligence – Look at improvements in the ability to analyse and evaluate services. Digital capabilities of staff – needed to understand a baseline of staff's capabilities and what support needed to be put in place. The governance arrangements and the terms of reference for each workstream were defined to work towards delivering the	

	aims and outcomes. Targets and outcome measures were set for the workstreams to help implement improvements. There was collaboration between the workstreams to avoid duplication. Regular meetings were put in place and there was continuous evaluation of what had been learnt. Therapies are working with HEIW to ensure AHPs are involved with the Florence Nightingale Programme to start to have digital maturity across professions and embed a culture where digital is everyone's responsibility. The HCPC regulations have recently changed with the standards of proficiency, which incorporates digital as part of everyone's role. Therapies are therefore ensuring that staff have the opportunity to satisfy those standards by having training and packages available to them at the required level. A part of the engagement workstream a powerful patient story has been produced that demonstrated the barriers and the opportunities that digital offers service users. **The Group resolved that:** a) The patient story will be presented to a future meeting. b) Sickness records have been automated and this work has been submitted to the DHCW Centre for Excellence for spread and scale across Wales. This was initially met with resistance from Staff Side as they felt it took away an element of the personal approach. This work has been revisited to ensure there is a consistent approach in the application of the policy and that it is executed effectively.	
CDTQSE 23/290	**Information Governance/Data Quality** **The Group resolved that:** a) There were no further information governance/data quality issues to report.	
CDTQSE 23/291	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** HIW will be undertaking an inspection of Radiology and the Dexa service next month. **The Group resolved that:** a) Feedback will be presented to this group following the visit.	
CDTQSE 23/292	**Policies and Procedures** A report was circulated on EIDO usage across the Health Board. It was noted that Cardiff and Vale's usage is lower than other Health Boards.	

	Consent Policy The Consent Policy was received for noting. **The Group resolved that:** a) In Radiology, not all procedures are covered through EIDO leaflets and this has been escalated. b) HL suggested departments link in with Melanie Bostock, Consent Lead to highlight where there are gaps.	
EFFICIENT		
CDTQSE 23/293	**Exception Reports from Directorates** Therapies, Pharmacy and Radiology submitted exception reports from their local QSE and Health and Safety Groups. **The Group resolved that:** a) Departments will continue to submit exception reports.	
CDTQSE 23/294	**Health and Care Quality Standards** JF reported that in advance of the HIW inspection in Radiology, an issue that needs to be addressed is that there is no storage solution in the Radiology waiting area for patient information leaflets. The department has enquired if any departments have a stand that they are no longer using but there is nothing available. **The Group resolved that:** a) An order is placed for a leaflet stand with justification for the need for the purchase.	
CDTQSE 23/295	**Clinical/Internal Audits** JF noted that IP&C audits are now live on Tendable. JF has checked that IPC Link Practitioners in Radiology are registered to use it. **The Group resolved that:** a) Departments are encouraged to use the AMAT system for any internal audits.	
CDTQSE 23/296	**Waste and Sustainability** The CD&T Green Group is being refreshed. Going forward meetings will be held seasonally and departments will be given targets and objectives to achieve related to each season. **The Group resolved that:**	

	a) The set of objectives for Autumn will be shared at the Green Group meeting this week.	
EQUITABLE		
CDTQSE 23/297	**Feedback from Clinical Board Inclusion Ambassadors Group** **The Group resolved that:** a) There was no feedback to report.	
CDTQSE 23/298	**Equality and Diversity Issues** **The Group resolved that:** a) There were no issues to report.	
PERSON CENTRED		
CDTQSE 23/299	**Patient Story** There was no patient story presented at today's meeting. **The Group resolved that:** a) A patient story will be presented from the Outpatients/Patient Administration directorate next month.	
CDTQSE 23/300	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 23/301	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/302	**National User Experience Framework/Feedback from Patient and Service User Surveys** HL advised there has been a relaunch of Civica information and HL has been involved in discussions on how to get more meaningful data relating to this Clinical Board. Radiology UHL department is gathering patient feedback. It has been noted that there has been some resistance from patients and visitors in using the electronic version. **The Group resolved that:**	

	a) Results from patient experience surveys will be shared at this meeting.	
CDTQSE 23/303	**Staff Awards and Recognition** JF was winner of the Clinical Board Staff Recognition Scheme in August for the Quality, Safety and Patient Experience Award. EC noted that his team were winners in the Capital and Estates Awards for a Special Award for their contribution to Operation POET. 2 projects in Therapies are shortlisted for the Welsh AHA Awards. The Quick-Change Project won the Improving Public Health Practice to Reduce Health Inequalities Award. This was an initiative between Public Health Wales and Podiatry to reduce health inequalities which involved exercise for children in schools. Podiatry, through the Diabetic Foot Network was recognised for their work around patient activation methods and risk assessing patients based on their activation. The team won the Quality and Care Award for Diabetes. **The Group resolved that:** a) The good news stories were noted.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 23/304	Regulatory Compliance Group Minutes October 2023	
ANY OTHER BUSINESS		
CDTQSE 23/305	Nothing further to report.	
CDTQSE 23/306	**Date & time of next Meeting** 24th November 2023 at 11am via Teams.	

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Carolyn Donoghue**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**23rd October 2023**

Summary of key matters considered by the Committee and any related decisions made

As the morning had been taken up with the Quality Patient Safety Development Day there was no presentation or Patient Story at this meeting. The Chair welcomed two new members to the committee representing Cardiff & Vale University Health Board and the Deputy Regional Director for Llais.

1.0 COMMISSIONING TEAM AND NETWORK UPDATES

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

- **Cancer & Blood**

It was noted that no new risks for the portfolio had been added to the Risk Register since the last report.

- Members noted the improved traction on the performance issues within the All Wales Lymphoma Panel (AWLP) service and following the submission of a final report by the service, it is likely a recommendation will be made to reduce the level of escalation level by the next meeting.
- The Harm Review being undertaken on the North Wales (NW) plastics service remains outstanding. No timescales for completion were presented to the committee and members asked for further clarity.
- Whilst the Burns South Wales (SW) remains in Escalation Level 3 the capital case has been approved by Welsh Government and it is anticipated that the interim staffing arrangements can be sustained until the new build is complete.
- A Neuro Endocrine Tumour Stakeholder meeting was organised by Cardiff & Vale University health Board on the 17th October 2023.

- **Neurosciences**

Members noted that one new risk scoring above 15, relating to staffing levels within Neuro-rehabilitation at CVUHB, had been added since the last report was received. The committee was informed that due to quality issues with current provider commencement of Designated Provider process for the South Wales Deep Brain Simulation (DBS) service has been initiated. A letter has been sent to Llais informing them of the position.

- **Cardiac**

No new risks for the Cardiac portfolio had been added to the Risk Register since the last report. Members noted the updates against the two services, which currently remained in escalation at level 2.

- **Women & Children**

Members were concerned that there were five service areas with risks scoring 15 and above and that two new risks scoring above 15, both relating to Neonatal at CVUHB, had been added since the last report was received.

There are five service areas with high risks and in Escalation Level 3 are noted as follows and further detail and actions can be found in the summary of services in escalation, which is attached to the report.

- Paediatric Intensive Care (CVUHB)
- Paediatric Surgery (CVUHB)
- Neonatal Intensive Care (CVUHB)
- Paediatric Cardiac Surgery (UHBNHSFT)
- Wales Fertility Institute (WFI) (SBUHB)

The committee were informed that an extraordinary Exec to Exec meeting with CVUHB was due to take place later that day to consider the areas of concern and agree a way forward. It has been proposed that all three will be brought into a single Escalation process with joint Exec Leads to provide additional support. It was also noted that Paediatric Surgery is not meeting contract volumes but ministerial measures are being met. A recommendation will be considered at the November Joint Committee for the escalation objectives to remain that Paediatric Surgery achieves contract volumes.

It was noted that the SBUHB assurance report was not submitted to HFEA on time. A further WHSSC escalation meeting is scheduled for the 27th October 2023, and the worst case scenario will be to source a new provider.

- **Mental Health & Vulnerable Groups**

One new risk has been added to the risk register regarding the magna security locks in the North Wales CAMHS unit. Assurance was received that this was being closely monitored and a meeting with the provider had identified the need for a capital bid to fund the necessary remedial works. A number of incidents had

been reported to WHSSC following that meeting and it was agreed that these would be further escalated to the BCUHB DoN for urgent consideration.

Members received an update regarding progress on the development of a Children and Young People's Gender Identity Service led through the NHS England transformation programme.

Members noted that there are a number of safeguarding concerns at an NHSE Eating Disorder provider and these have been escalated to NHSE for discussion and investigation. The relevant safeguarding teams are aware and the care coordinators from the Health Boards have been asked to review the individual patients. A more detailed report was to be received at the next meeting.

The new Eating Disorder unit in Tŷ Glyn Ebwy Hospital, Hillside, Ebbw Vale is due to be opened by the Deputy Minister for Health on the 9th November 2023. This will allow for repatriation of out of area placements and reduce the risk identified with one of the current independent providers.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members received an update of the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio and noted that no new risks for the portfolio had been added to the Risk Register since the last report.

2.0 OTHER REPORTS RECEIVED

Members received reports on the following:

- **Services in Escalation Summary**

A copy of each of the services in escalation is attached to the report at ***Appendix 1***

- **CRAF Risk Assurance Framework**
- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**
- **Incident and Concerns Report**
- **Report from the WHSSC Policy Group**.

3.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee September 2023
- Welsh Health Circular: Speaking up Safely Framework
- QPSC Distribution List; and
- QPSC Forward Work Plan.

4.0 ANY OTHER BUSINESS

It was noted that there had been a Development Day for QPS members and Quality Leads from the Health Boards that morning. The theme of the session

was to consider the impact of the Duty of Quality Act in terms of future reporting and monitoring of commissioned services. It had been well attended and a report will be presented at the next meeting.	
Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above. Members expressed concerns regarding the number of services that were in escalation in the Women & Childrens portfolio and asked that these were escalated for the attention of the Joint Committee.	
Summary of services in Escalation • Attached (***Appendix 1***)	
Matters requiring Committee level consideration and/or approval • None	
Matters referred to other Committees As above.	
Confirmed minutes for the meeting are available upon request	
Date of Next Scheduled Meeting	5 December 2023

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

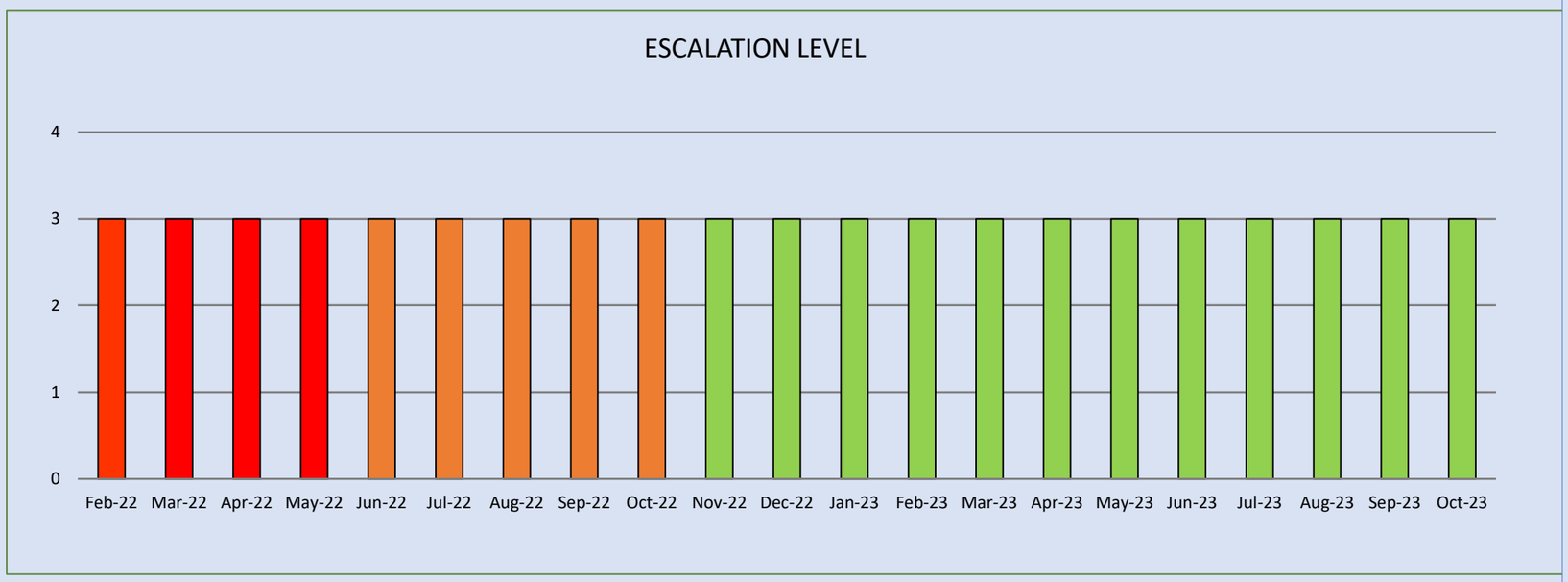
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**

Rationale for Escalation Status :
Remains at level 3.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.
The capital case may be delayed to the initial intended timeline as the case goes through the scrutiny process.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed
To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed

SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	Completed
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	Completed
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which went to their Investment in Infrastructure Board on 22nd June; it had been hoped that the works would commence in May. There may, therefore, be a 2 month or so departure from original timelines. At the SLA with Swansea on 5th June, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	Completed
The capital case has now been approved by Welsh Government. The level of escalation will therefore be reviewed further to the next escalation meeting which is scheduled for November. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete.	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

- **July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22nd the outcome is not confirmed as yet.**
- **October 2023: the capital case has been approved by Welsh Government. Timeline tbc.**

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023, 26/07/23, 12/09/23 & 10/10/23
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

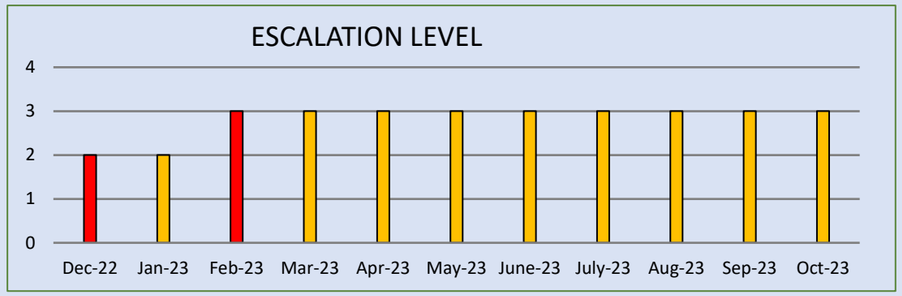
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The original plan did not deliver contracted volume,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in implementation. The current financial pressures and savings plans requested by WG have resulted in the Health Board re-profiling the trajectories and unlikely to meet contract volumes for the remainder of the financial year.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	Completed 06/10/23
Special Executive to Executive meeting scheduled with provider.	Director of Planning & Performance	23 October 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.
May 2023 – a number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:
New Service in Escalation

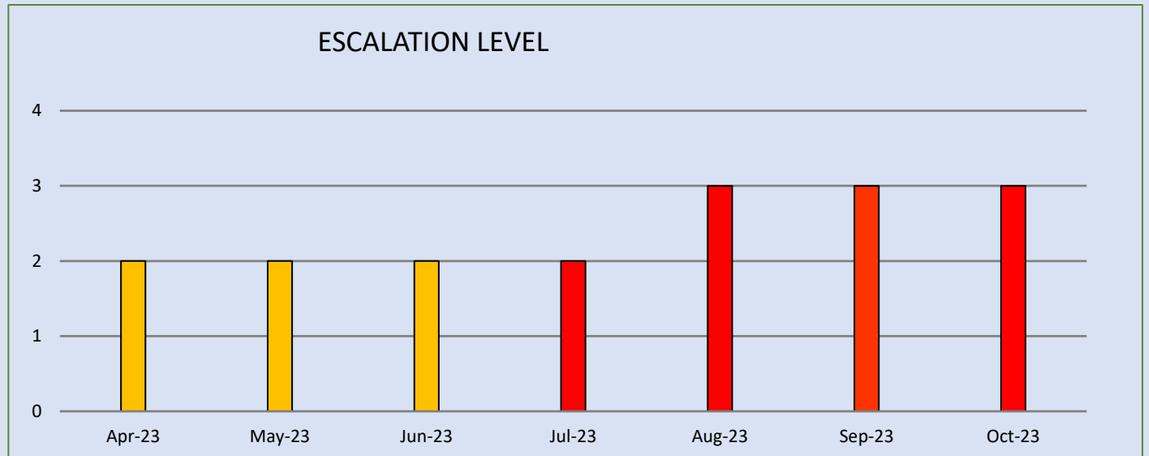
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level

Rationale for Escalation Status :
Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of WHSSC through various routes including HiW and the daily SITREP.

WHSSC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	31 October 2023	
Requested action plan to be developed against the escalation objectives.	Senior Planning Manager	31 October 2023	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	31 October 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Issues/Risks:

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:
New Service in Escalation

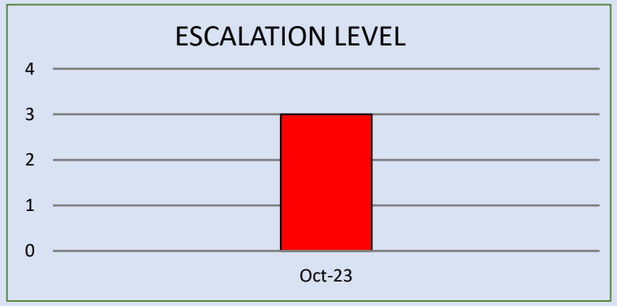
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Rationale for Escalation Status :

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

WHSSC assurance and confidence level in developments:

The service were only notified of escalation in late September therefore at the time of writing the report the objectives have not yet been set.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Develop agreed objectives for escalation	Planning Manager	31 October 2023	
Health Board to develop detailed action plan against the agreed objectives	Planning Manager	14 November 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Issues/Risks:

Appendix 1

Executive Director Lead: Iolo Doull
Commissioning Lead: Dominique Gray-Williams
Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

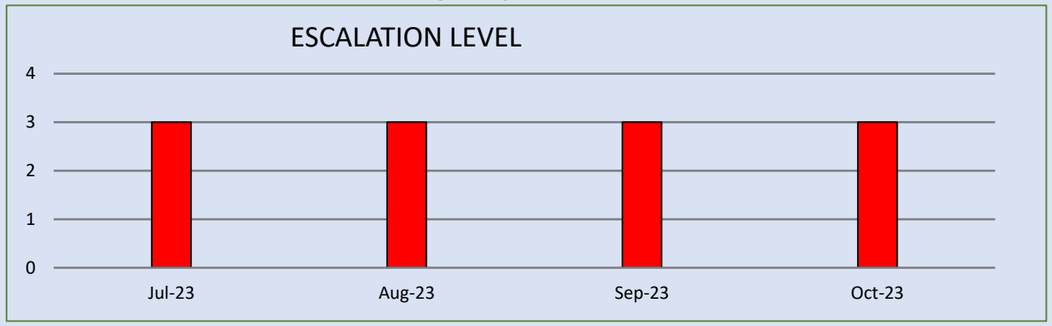
Service in Escalation: Wales Fertility Institute

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

WHSSC assurance and confidence level in developments:

Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to WHSSC data submissions, however, the service need to ensure time is given both internally and to WHSSC to allow for review and consideration of documentation.
The service are due to submit a progress report to the HFEA by the 18th October. HFEA re-inspection is due to take place in January 2024.

Actions:

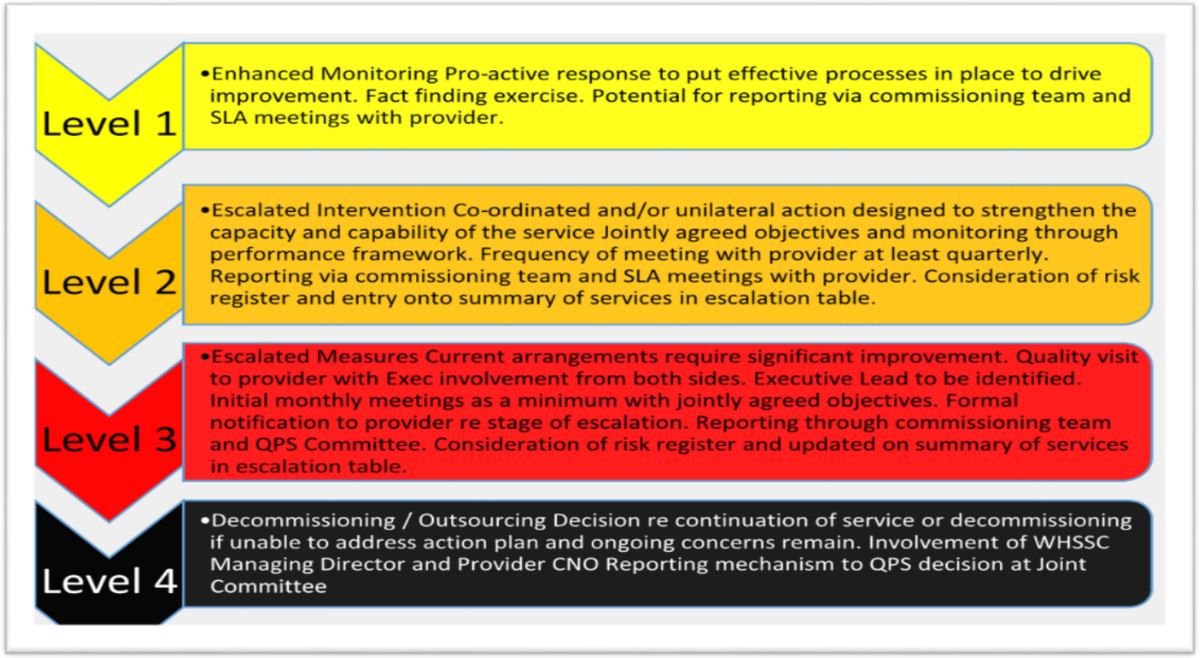
Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to Exec	Assistant Specialised Planner	7th August 2023	7th August 2023
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023	Assistant Specialised Planner	Monthly	Ongoing
Quality visit	Assistant Specialised Planner	14th November 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7th August 2023	7th August 2023
SMART Action plan reviewed and agreed	Service Manager	19th September 2023	19th September 2023

Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

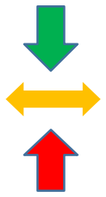
Appendix 1

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.
Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.

Appendix 1



SERVICES IN ESCALATION



Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month