Quality, Safety & Experience Committee

Tue 13 February 2024, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee Meeting held on 19.12.2023

Ceri Phillips

1.4 - QSE Public Minutes_cp 19.12.2023 - CP.pdf (7 pages)

1.5. Action Log – Following the meeting held on 19.12.2023

Ceri Phillips

1.5.1. Royal College of Psychiatrists report update

1.6. Chair's Action taken since last meeting

Ceri Phillips

14:05 - 14:05
0 min

2. Items for Review & Assurance

2.1. Surgical Clinical Board – Assurance Report

Clare Wade

2.1 - QSE Surgery Clinical Board Assurance Report Jan 2024 - Working Template (5).pdf (31 pages)

2.2. Medication Safety – Deep Dive

Jason Roberts / Meriel Jenney

2.2 - Medicines Safety Deep Dive for corporate QSE Feb 2024.pdf (12 pages)

2.3. Quality, Safety and Experience Framework – effectiveness review

Angela Hughes / Alexandra Scott

2.3 - QSE framework update slides.pdf (15 pages)

2.4. Learning Committee Update - Verbal

Jason Roberts

14:05 - 14:05
0 min

3. Items for Approval / Ratification

3.1. Health Protection Plan

Claire Beynon / Sian Griffiths

- 3.1a - 240213 Cardiff and Vale Health Protection Plan_QSE cover paper_FINAL.pdf (3 pages)
- 3.1b - 231214 Cardiff and Vale Health Protection Plan_FINAL_for QSE.pdf (30 pages)

3.2. Policies:

3.2.1. 1) Intraoperative Cell salvage policy & procedure (UHB 030 & 403)

- 3.2.1a - Intraoperative Cell Salvage Policy & Procedure Cover Report.pdf (3 pages)
- 3.2.1b - UHB 403 Intraoperative Cell salvage procedure 2023.pdf (52 pages)

3.2.2. 2) Swab Instrument and Needle Count Policy & Procedure (UHB 191)

- 3.2.2a - Cover Report for Swab Policy.pdf (2 pages)
- 3.2.2b - Swab Instrument and Needle Count Policy and Procedure.pdf (27 pages)

3.2.3. 3) Inpatient Welsh Language Policy (UHB 513)

- 3.2.3a - QSE Committee paper - Welsh Language Inpatient Policy.pdf (3 pages)
- 3.2.3b - Welsh Language Choice for In-patient's Policy - For Consultation.pdf (3 pages)
- 3.2.3c - EHIA - Welsh Language Inpatient Policy.pdf (26 pages)

3.2.4. 4) Individual Patient Funding Request (IPFR) Policy

- 3.2.4a - IPFR Policy Report Board QSE Committee - 2023 - 24.pdf (3 pages)
- 3.2.4b - NHS Wales IPFR Policy -FINAL - December 2023.pdf (29 pages)
- 3.2.4c - IPFR EHIA.pdf (23 pages)

14:05 - 14:05
0 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees and Radiation Protection Group Chair's Report

Jason Roberts

- 4.1a - MCB QSE Minutes 19 Oct 23.pdf (6 pages)
- 4.1b - PCIC - 04 Minutes of last meeting 28Nov2023.pdf (10 pages)
- 4.1c - PCIC - Minutes of last meeting 16Jan24.pdf (7 pages)
- 4.1d - CD&T - Att 1 - Minutes 24.11.23.pdf (15 pages)
- 4.1e - C&W - Att 1 - CW QSPE Minutes 24.10.2023.pdf (14 pages)
- 4.1f - C&W - Att 1 - CW QSPE Minutes 19.12.2023.pdf (12 pages)
- 4.1g Radiation Protection Group Chairs Report 23.1.24.pdf (2 pages)

4.2. Healthcare Inspectorate Wales Annual Report 2022-23

Jason Roberts

- 4.3a - HIW - Annual Report 22-23.pdf (51 pages)
- 4.3b - 2023.12.04 Alun Jones, HIW Annual Report 2022-2023 Letter.pdf (1 pages)

14:05 - 14:05
0 min

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

No items.

14:05 - 14:05
0 min

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

Ceri Phillips

i) Private Minutes

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

ii) Prison Inquest Update

iii) Discharge Advice Letters (DAL) Update

iv) Opthalmology WET AMD - Verbal

v) Breast Look Back Exercise - Interim Update following Clinical Review

vi) Safeguarding Update

14:05 - 14:05
0 min

7. Any Other Business

Ceri Phillips

14:05 - 14:05
0 min

8. Review of the Meeting

Ceri Phillips

14:05 - 14:05
0 min

9. Date & Time of Next Meeting:

Ceri Phillips

26th March 2024 at 2pm

Via MS Teams

14:05 - 14:05
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 19th December 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
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Charles Janczewski	CJ	The UHB Chair
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
Edward Chapman	EC	Head of Clinical Engineering
Mark Doherty	MD	Director of Nursing – Mental Health
Sarah Martin	SM	Research & Development Manager
Matt Wise	MW	Consultant – Critical Care
Observers		
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Fiona Kinghorn	FK	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Fiona Jenkins	FK	Executive Director of Therapies and Health Sciences
Suzanne Rankin	SR	Chief Executive

QSE 23/12/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QSE 23/12/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/12/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/12/004	**Minutes of the Committee meeting held on 28.11.2023** The minutes of the Committee meeting held on 28.11.2023 were received. **The Committee resolved that:**	

	a) The minutes of the meeting held on 28.11.2023 were approved as a true and accurate record of the meeting.	
QSE 23/12/005	**Action Log following the Meeting held on 28.11.2023** The Action Log following the Meeting held on 28.11.2023 was received. The UHB Chair suggested that the items on the Action Log that were too far in the future be reviewed and placed on the annual work plan. **The Committee resolved that:** a) The Action Log from the meeting held on 28.11.2023 was noted.	
QSE 23/12/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QSE 23/12/007	**Mental Health Clinical Board – Assurance Report** The DON-MH provided two Staff Stories around the Recovery College, which included the experiences from a student nurse, and a service user. The DON-MH provided the Mental Health Clinical Board Assurance Report which provided assurance to the QSE Committee, and aimed to demonstrate that quality, safety and patient experience was at the heart of the delivery of services to mental health services users within CAVUHB. The UHB Chair asked whether the length of stay for inpatients formed part of their 'Business as Usual' portfolio, as he sought continual assurance on this. The DON-MH provided assurance that there was a piece of work underway around this, which formed part of the wider Length of Stay work across the UHB. The CC suggested that this be articulated on the 'Business as Usual' diagram included within the report. In the context of violence and aggression, the UHB Chair asked about staff wellbeing. The DON-MH responded that a wellbeing exercise had been put together by the Head of Psychology and People's Services, but it was not yet complete. Signposts were available across the UHB, such as Canopi, and the ability to provide clinical supervision from quality and practice development nurses had improved. He added that a programme of wellbeing support, which was mental health bespoke, would be in place sometime in the new year. The CC asked if there was any risk to other patients. The DON-MH confirmed that there were risks, and that they had seen assaults between patients. He explained that the only way to successfully mitigate this risk was to have appropriate staffing levels to intervene when necessary. Regarding one of the elements of the Inpatient Safety and Stability Plan (ISSP), the UHB Chair asked if the original footprint in Hafan Y Coed was still fit for purpose. The DON-MH responded that: - It would be an oversimplification to say that they wished to return to the old footprint, as the nature and function of wards had altered by design since COVID - Bed capacity currently met demand, but it needed to be managed carefully	

- Elm Ward had been closed due to concerns around managing it safely, and its future use was still being discussed
- The review of incidents had been completed and disseminated, and suicide prevention training had been rolled out to inpatient services, and it was being considered for the community, prison, and elsewhere in the UHB
- The cluster response plan was ongoing, and the WARRN risk assessment tool had been implemented
- The Royal College of Psychiatrists (RCP) Review was completed in October, and feedback was expected in January. The observation policy had been reviewed and was now more detailed and helpful.

The CVC asked for more detail on the RCP Review.

The DON-MH responded that they had approached the RCP to undertake a specific review on the suicide cluster that took place several years ago, and the clinical risk management processes within the clinical board. The College provided no immediate assurances, and they expected some more detailed feedback in January 2024.

The END added that the outcome of their internal investigation would be brought back to a future QSE and Board meeting in early 2024.

Action:

1. To report back on the feedback from the Royal College of Psychiatrists review (JR / MJ)

The UHB Chair asked for additional assurance around the Young People / CAMHS Interface, as it did not contain much detail.

The DON-MH responded that they had previously reported on the bed pressures and the issue of having young people in adult settings. Earlier in the year, they had set up a steering group called 'Young People in Psychological Distress' which included colleagues from Children & Women's departments – however, due to a lack of bandwidth, the group was currently on hiatus. He added that the expectation was for the conversation to continue the following year, but he wished to ensure that the Committee was kept up to date with its progress.

The CVC asked for the Committee to be continually briefed on progress in this area for assurance.

The UHB Chair noted two observations:

1. More information was needed around how learning from adverse events had been implemented, and how they intended to monitor future improvements as a result; and
2. For the DON-MH to liaise with the Director of Corporate Governance around the format of risk registers.

The EMD explained that the structure of the assurance reports was being worked through, to allow Clinical Boards to represent their data more clearly to the Committee.

The IM-C agreed that the risk registers needed to be clearer, and asked for an update on the mitigations regarding the smoking and fire risk assessment.

The DON-MH responded that mitigation was an inherent part of risk assessments, and that fire risks now formed part of individual's clinical care plans. He added that smoking had been switched off, and that technology had been introduced at the door of each ward to check every person when they entered.

Regarding the Mental Health Audit, the UHB Chair asked who was accountable for monitoring and implementing the actions to improve the turnaround of the recommendations, and when it would be on track.

	The END provided assurance that this information was tracked through their monthly Executive Reviews, and that they continually saw an improved picture. The UHB Chair asked if the Audit Committee could look at these recommendations to ensure that actions were being taken as appropriate, to provide the Board with full assurance. The ADWPS noted that they could take the audits through the Clinical Effectiveness Committee and Clinical Safety Group. The EMD informed Members that they had recently provided a presentation on the clinical audits being undertaken to the Audit & Assurance Committee, and that they had moved from a position of limited assurance to a position of assurance. She noted that the size and scope of the audits that they needed to review was enormous, but that the introduction of AMaT had made a significant difference in their ability to systematically review these audits. The CC asked whether there had been elements of double counting in the figures presented. The ADWPS noted that there could be, and that they needed to fine-tune the system. The CC emphasised that the interaction between the Audit Committee and this QSE Committee was vital, and that any audit recommendations and trackers that related to QSE issues should be return to this forum. The CC suggested that they needed to work at pace on how these Clinical Board Assurance Reports were framed, to be able to provide the necessary indicators to the Board for assurance. <u>Action:</u> 1. To share the report template with Clinical Boards to effectively provide assurance to the Board in the future (MJ) The ADPE praised the work being undertaken on the Recovery College. **The Committee resolved that:** 1) The content of the report were noted and discussed.	
QSE 23/12/008	**Quality Indicators Report** The ADWPS and the ADPE provided the Quality Indicators Report and slides which provided assurance in relation to a number of quality, safety, and patient experience priorities. Regarding National Reportable Incidents (NRIs), the DDPH asked if an analysis had been undertaken to determine whether the revised guidance around reporting intrauterine and neonatal deaths had accounted for the increase in NRIs. The ADWPS responded that there were additional reasons why the number of NRIs had increased: - They had revised their approach to reviewing Infection, Control & Prevention (IP&C) incidents – patients who had contracted an infection that was potentially healthcare associated were now being reported. Some of these reports were retrospective, which dated back to the beginning of 2023. - The Medical Examiner in Wales had reviewed close to 100% of inpatient deaths since 2021, and had picked up on some cases of harm or concern that had previously not been detected. - Once the UHB had reported their NRIs every month, they would subsequently be stood down after investigation, as they had received the assurance required.	

	The CVC noted that there seemed to be a reoccurring issue around the storage of medication. The END responded that in every HIW inspection, medication was highlighted as an issue, due to the fast-paced nature of the ward staff's work. The CVC asked if there was any appetite or resources available to tackle this issue. She acknowledged that a lot could be attributed to behaviour and stresses, but this issue should be resolved. The ADWPS agreed, and highlighted that: - The Clinical Safety Group (CSG) sought to address this – they had to move away from investigating individual incidents, and instead take a more strategic and Health Board wide approach. - The CSG sought to bring clinical advisory groups together to deliver strategies to reduce these risks. - A recent inspection in the Children's Hospital for Wales (CHfW) highlighted that they had not always systematically recorded the temperature of their fridges – once they investigated, they realised that information was not readily available to staff. A protocol had since been developed and displayed across the site. - Regarding medication storage, they realised that Estates needed to be involved in the strategic approach. The SSIPM noted that as part of the ward accreditation and improvement work, medication errors, storage, and other issues were addressed via the Tendable audits. Additionally, the improvement plans for the wards included tackling medication issues. The IM-C asked about the timeline around this work, and whether something could be reported back to the Committee in the following 3-6 months to measure improvement. <u>Action</u>: 1. For an update to be shared on the assurance work around the omitted medication being undertaken by Tendable, and the electronic prescribing project to a future committee (AS) The EMD provided assurance that there was an action plan against all of the themes highlighted, however there was concern around the volume of this work. The ADWPS highlighted that a Deep Dive on Medication Safety would be provided at the following Committee meeting. Regarding the use of Tendable, the UHB Chair asked whether there was a way that they could measure IP&C issues within the programme. The END responded that there were separate audits and inspections - the Executive Walkrounds contained a specific set of questions, the Ward Sisters conducted a range of audits in their clinical environments, and the IP&C team conducted specialist IP&C audits. The UHB Chair praised the Concerns team for the volume of work they had undertaken. **The QSE Committee resolved that:** a) The assurance provided by the report were noted.	
QSE 23/12/009	**Research Update** The EMD explained that the purpose of the paper was to provide an initial background regarding the breadth, depth, and complexity of the research and development undertaken within the organisation. She added that much of their core funding came from Health and Care Research Wales, who had recently reviewed the organisation positively.	

	The R&DM provided the Research and Development Update which summarised the research activities which had been undertaken by the UHB. The CVC asked what key risks Research & Development (R&D) faced. The R&DM responded that the main area of risk historically recorded on the risk register was the risk of an inspection. There were also risks to research within the organisation, mainly from an estates point of view. She added that the whole process needed to be reviewed, and that the risk register needed to contain sub-categories which linked to particular studies or directorates. The R&DM noted that this was in its early stages, and that the plan was to link with the University and the Joint Research Office to develop similar systems. The UHB Chair asked whether 700 studies were proportionate to the size of the organisation. The R&DM responded that the UHB could definitely do more, and that the team had looked at how to align research activity to the new Health Board strategy, and to be more strategic in their approach to research. The C-CC added that the UHB had underperformed in terms of research. He explained that access to novel therapies through clinical trials had huge benefits for patients, as well as economic benefits, and that it allowed the reduced use of acute services. It also helped attract and retain good staff and to develop expertise. The EMD highlighted the risk that research inherently held, and added that another risk was whether they could deliver that research, which was to be considered within the current climate. She noted that they were the most research active Health Board within Wales, but that they still did not do enough. The CC explained that given the current climate, it was important that the UHB was at the forefront of developments and driving research forward. He suggested that a conversation be had outside of the meeting on how they could work together to take this forward. <u>Action:</u> 1. To discuss proposals on how to increase the number and quality of research studies and report back to a future committee (MJ / MW / SM / CP) **The QSE Committee resolved that:** 1) The Committee noted the reassurance provided by the report.	
QSE 23/12/010	**Learning Committee Update - Verbal** This agenda item was delayed to the following meeting.	
QSE 23/12/011	**HIW Activity Overview to include HIW Primary Care Contractors** The END took the paper as read. The UHB Chair asked how they recorded and monitored the progress made against the HIW recommendations. The ADWPS responded that: - A function had been implemented onto the AMaT system – Clinical Boards were in the process of updating and completing them. - In some cases, clinical audits had been undertaken to provide assurance An exercise was ongoing to put historical HIW inspections onto the system - The following year, work would be done to start putting coding around the inspections to extrapolate themes such as medication or transfusion.	

	The END added that the Directors of Nursing provided an update on where they were regarding AMaT and the closure of action plans in their monthly Executive reviews. **The QSE Committee resolved that:** 1) The level of HIW activity across a broad range of services was noted; 2) The assurance provided by the improvements implemented and the processes to monitor and audit the improvements were noted.	
QSE 23/12/012	**Quality, Safety and Experience Framework – effectiveness review** The ADWPS and the ADPE provided a presentation which summarised the Quality, Safety and Experience Framework – effectiveness review. The CC suggested that the presentation be distributed and that they allow some time at the following meeting for comments and questions. **The QSE Committee resolved that:** 1) The QSE Framework – effectiveness review was noted.	
	Items for Approval / Ratification	
QSE 23/12/013	*No items.*	
	Items for Noting & Information	
QSE 23/12/014	**Minutes from Clinical Board QSE Sub-Committees** The Clinical Diagnostics and Therapeutics Clinical Board QSE Sub-Committee Minutes were noted for information. **The QSE Committee resolved that:** 1) The minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/12/015	**WHSSC Patient Safety Minutes** The WHSSC Joint Committee Minutes were noted for information. **The QSE Committee resolved that:** 1) The minutes from the WHSSC Patient Safety Minutes were noted.	
QSE 23/12/016	**Items to bring to the attention of the Board / Committee:** The CC highlighted the need to ensure there was liaison between the Audit & Assurance Committee and the QSE Committee around the trackers.	
QSE 23/12/017	**Agenda for Private QSE Meeting** *i) Private Minutes* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
QSE 23/12/018	**Any Other Business** *No items.*	
	Date & Time of Next Meeting: 13th February 2024 - 2pm-5pm - via MS Teams	

Report Title:	QSE Surgical Clinical Board Assurance Report				Agenda Item no.	2.1
Meeting:	QSE Committee Meeting		Public	X	Meeting Date:	13/02/2024
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Executive Nurse Director Jason Roberts					
Report Author(s):	Clare Wade – Director of Nursing, Ceri Chinn – Lead Nurse and Carolyn Alport Clinical Leader for QSE for Surgery Clinical Board					

Main Report

Background and current situation:

This report provides details of the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety and Patient Experience agenda during 2023. The data provided in this report is data that has been collected from 1st January 2023 to 31st December 2023.

We believe that in focusing on these 8 key priorities, we can aspire to provide safe, effective services that deliver excellent user experience. These eight key areas are:

- Safety Culture
- Leadership and the Prioritisation of QSE
- Experience and Involvement
- Patient Safety Learning and Communication
- Staff engagement and involvement
- Data and insight
- Professionalism of QSE
- Quality Governance Arrangements

Between January 2023 – December 2023, the Surgery Clinical Board (SCB) provided a significant number of emergency and elective services to service users of Cardiff and Vale University Health Board. The specialties within the Clinical Board that provide these services include Trauma and Orthopaedics (T&O), Breast, General Surgery, Spines, Urology, Head and Neck, Dental, Vascular and Peri-Operative Care. The Clinical Board employs 2247 whole-time equivalent (wte) staff and has a budget of £174 Million.

The Surgery Clinical Board provides services not only to Cardiff and Vale residents, but also beyond the local population at both the University Hospital of Wales and University Hospital of Llandough such as regional Spinal Surgery, Hepatobiliary Surgery and Vascular Surgery.

The Surgery Clinical Board also supports the activities of all other Clinical Boards within the Health Board through the provision of services provided by the Perioperative care Directorate, which includes Anaesthesia, Pain Management, Operating Theatres and Hospital Disinfection and Sterilisation Unit (HSDU).

Whilst many services provided by the Surgery Clinical Board are core activities, due to the high volume of activity and the diversity of its services, risk in the Clinical Board is high. Therefore, robust risk management arrangements are in place to reduce and manage these in order that our service users and staff are kept safe.

The Surgery Clinical Board has a well-established formal Quality, Safety and Patient Experience (QSPE) that meets bi-monthly which is co-chaired by the Asst Director for QSE and Value Based Healthcare and the Director of Nursing for Surgery Clinical Board. This structure is formally replicated in each of the Clinical Directorates. The QSPE group has two key sub-groups that report to it; a Health and Safety group and Infection Prevention and Control group. The Surgery Clinical Board also has a part time Clinical Leader for QSE who assists the Director of Nursing for Surgery Clinical Board to ensure that all aspects of quality, safety and patient experience within the Clinical Board are monitored and reviewed, acting to mitigate risks on an ongoing basis.

Safe Care

Patient Safety Alerts/Internal Safety Notices

The Surgical Clinical Board has a robust process for cascading all Patient Safety Alerts. The designated Quality and Safety Clinical Leader is responsible for maintaining and updating the local surgical Safety Alerts database containing the details of all safety alerts which have been released over the past 12 months together with the evidence to support actions which have been taken. Currently there is 100% compliance.
All notices are shared at the SCB QSE meetings and at the local Directorate Q&S meetings within the SCB.

NRI Management

From January 2023 to date there have been 7 reported Never Events.

- March 2023 - Wrong side Fascia Iliaca Block
- May 2023 - Wrong side finger surgery
- June 2023 - Retained neuro pattie swab
- June 2023 - Retained remnant of a Medisil drain
- June 2023 - Wrong side eye surgery
- September 2023 - Retained dental roll
- December 2023 – Fascia Iliaca Block to patient without a fractured hip.

There have been 23 National Reportable Incidents of which 4 have been investigated and subsequently downgraded, and 15 closures since January 2023. Others remain under investigation and will be prioritised so that they can closed as soon as possible.

NRI Category Breakdown

Category	Total
Clinical assessment and clinical diagnosis	7
Communication Issues	1
Diagnostic testing - Radiology	1
HCAI	3
Healthcare record	1
Medical Devices	2
non-medical equipment	1
Treatment or procedure issues	6
Unexpected Death	1

Current open NRI's

There are 14 current open NRI's. 4 investigations are overdue and 4 expected closures in January 2024.

Current investigations

- Delay in Breast cancer diagnosis.
- Lost to follow-up - Age related macular degeneration.
- Lost to follow-up stent removal.
- Increase in infection rates post hemiarthroplasty.
- No follow-up or referral of incidental CT findings.
- Missed liver lesion on Breast CT scan.
- Unexpected Death from PE
- Block given to patient following hip fracture pathway. Hip fracture not sustained.

Early Warning Notices

There have been 2 Early Warning Notices reported to Welsh Government. These were: -

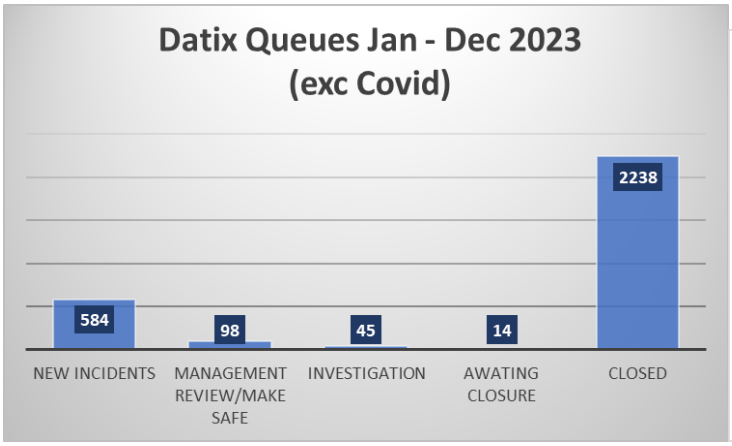
- A publication of an Ombudsman Report
- An initial direction hearing in the court of justice relating to a teenage patient and their treatment plan

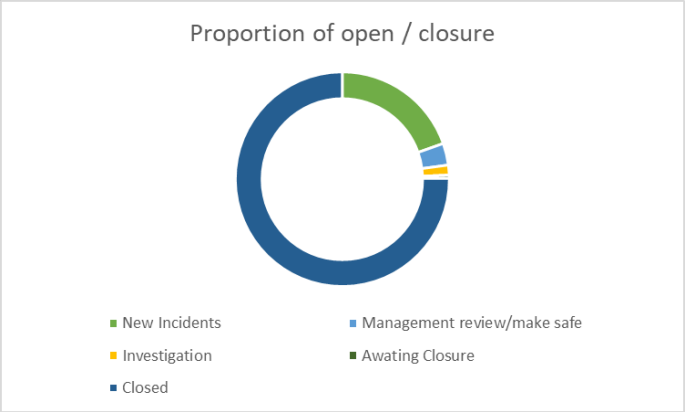
NRI's associated with Inquests -3

One inquest has been delayed from November 2022 and is now planned for February 2024. Additional information has been requested from the coroner regarding a death in the community following surgery in December 2021. Of the current NRI's, one is subject to His Majesty's Coroner's Inquest.

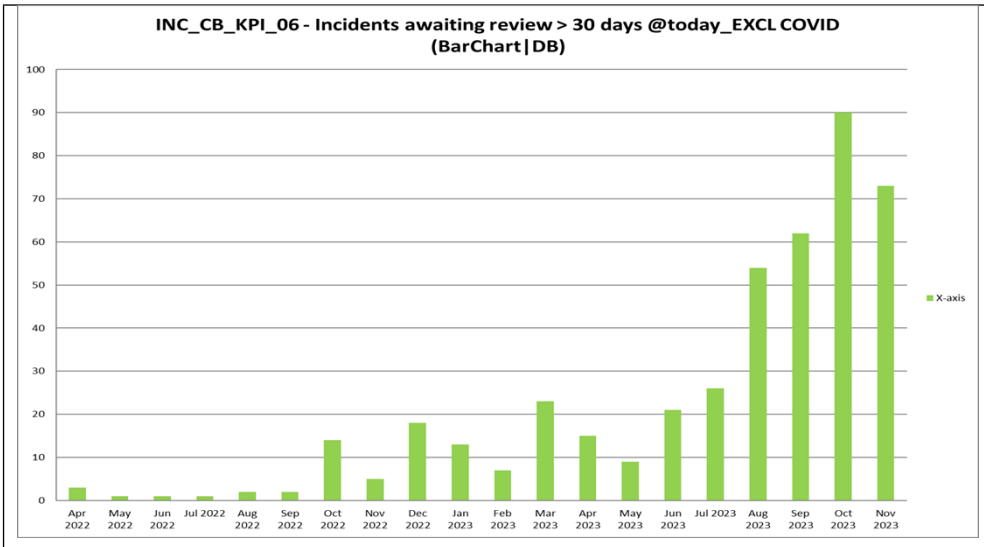
Patient Safety Incident Management

The Datix Cymru incident reporting system is thoroughly embedded within the Surgical Clinical Board. The Clinical Board demonstrates an open reporting culture with a high number of incidents reported, with the vast majority of incidents leading to no or minor harm. The current number of incident managers is 184, with 9 superusers included in this number. Surgery representation has continued at the Patient Safety Datix Cymru Group, and updates and changes are disseminated to incident managers.
At the end of Dec 2023 there were a total of 738 open incidents excluding COVID incidents, which is a 19.2% increase at this point in December 2022 when there were 619 open incidents. Datix queues are being actively managed, however due to operational pressures queue reduction is challenging. Monthly queue data is shared with all senior nurses and managers to help identify hot spots and enable the provision of targeted support for incident managers or specific areas which need additional support.

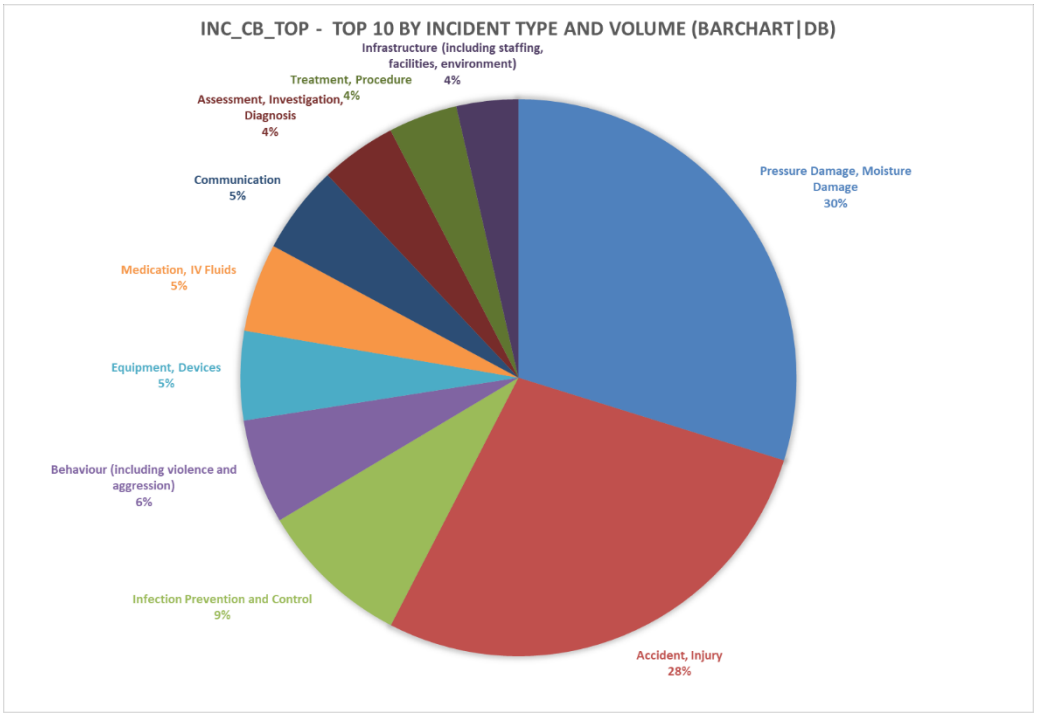




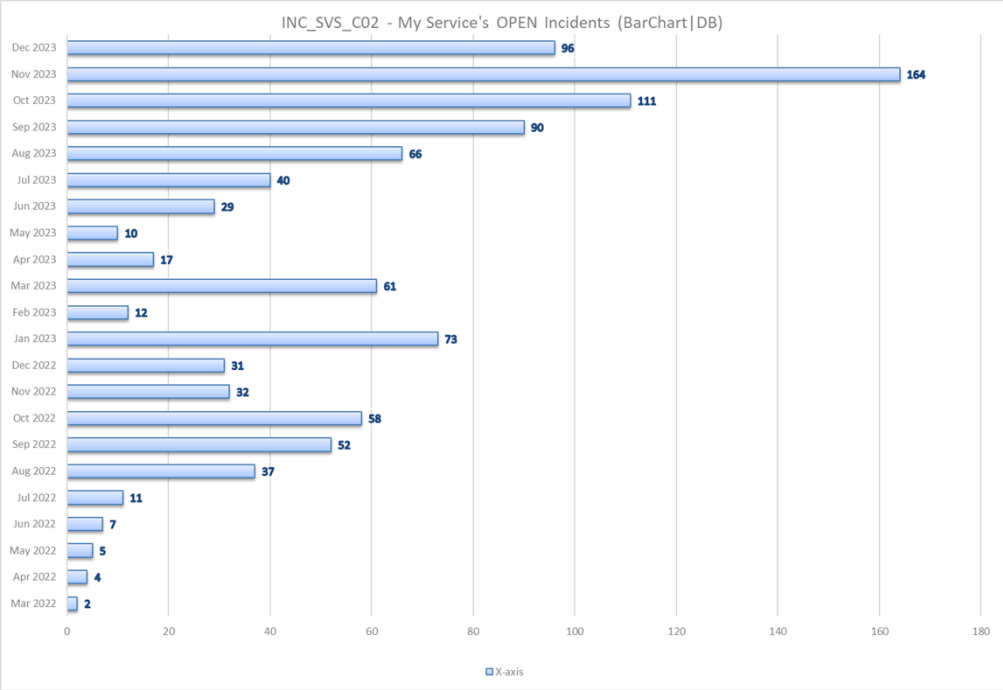
The KPI incidents >30 days awaiting review graph below demonstrates our future challenge and the need to work with and educate all incident managers to actively manage their assigned incidents and move them along efficiently to reduce these numbers.



Top 10 incidents



Open incidents by the end of December 2023



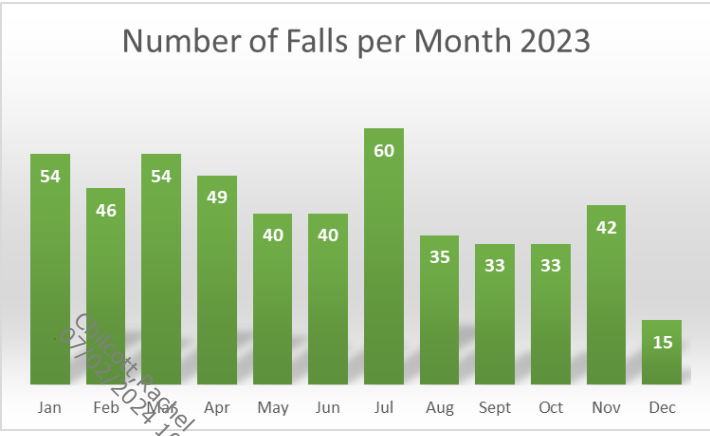
Falls

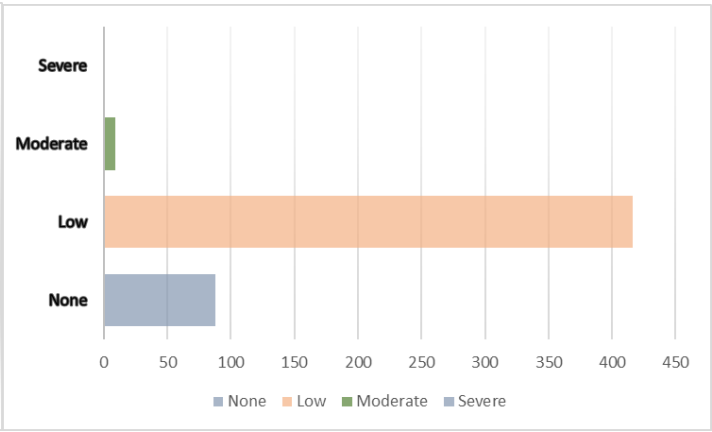
In total to date there have been 513 reported falls from 01. 01. 2023 – 31.12.2023 . Of this number 12 were injurious falls. A total of 5 within Trauma and Orthopaedics (T&O) and 7 within General Surgery, none of which met the criteria for NRI reporting. All falls focused reviews are scrutinised and discussed at the Falls Panel with representation from the Patient Safety Team.

Common themes identified were –

- Time of fall as the majority of falls appear to be reported in the nighttime hours.
- Increased risk of falls in patient who have a cognitive impairement.

Table 6



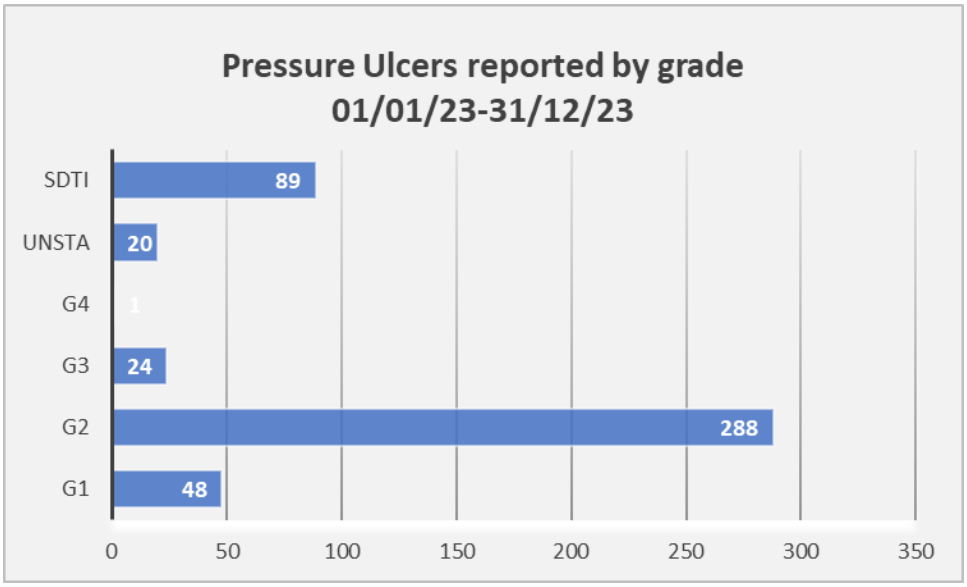


Pressure and tissue damage reduction and prevention

The SCB Pressure Area Scrutiny and Learning Panel was set up in April 2023, the meetings have been held every 4-6 weeks. Staff have benefited from presenting and discussing their patients as part of the group. To date 24 focused reviews have been discussed.

There have been specific challenges and risks highlighted with patients on B2, many of whom having existing peripheral vascular disease (PVD). They are therefore at much higher risk of developing pressure ulcers and then those pressure ulcers deteriorating or failing to heal. Consideration is being given to the detail of investigation these types of incidents require if PVD can be identified as a primary cause.

Within T&O Spinal patients have also been singled out for further discussion with the spinal teams regarding appropriate mattress selection, as in most cases the current recommendation is not to place these patients on a pro matt with pump (air mattress) due to their spinal injuries. As a result of one investigation carried out, a HCSW on A5N initiated a 'golden hour' pressure ulcer round check which the ward commenced in August 2023.



Safeguarding

All safeguarding referrals relating to community concerns or raised against staff working within the Surgery Clinical Board are subject to the required level of investigation and scrutiny to ensure safe care is provided. Investigations are led by Health Lead Professionals, with appropriate actions taken and shared more widely if required. The Clinical Board has key links with the Safeguarding Team to ensure openness and transparency and remains a standing agenda item on the QSPE and Nursing Board agenda. The Clinical Board has a Lead Nurse who is also our safeguarding lead who attends the UHB Safeguarding Committee on behalf of the Director of Nursing.

The Director of Nursing for Surgery meets with the Safeguarding lead and the Deputy Executive Nurses on a monthly to discuss and review all open cases.

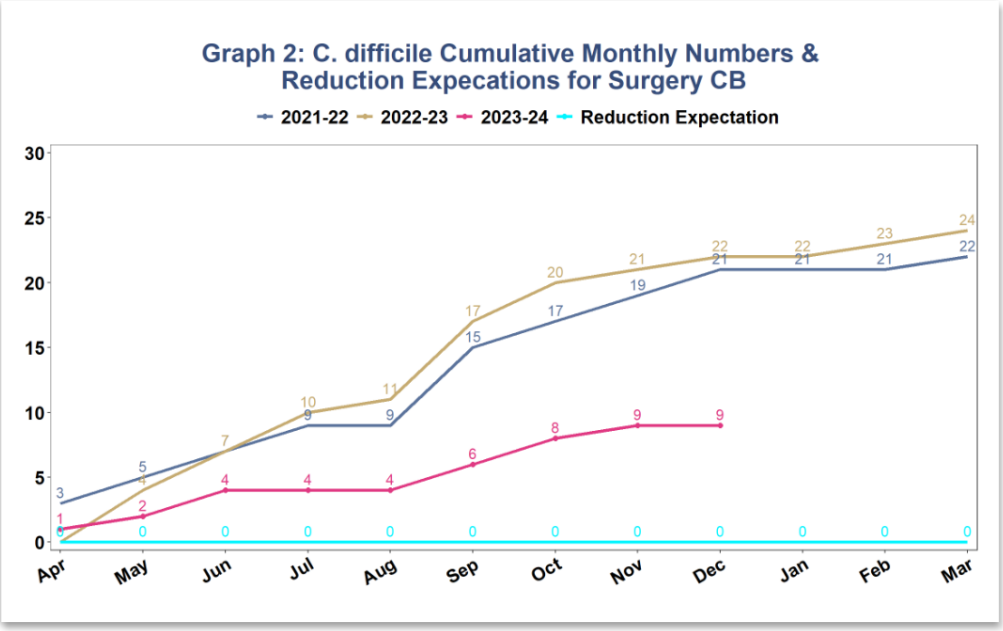
Infection, Prevention and Control

C Difficile

The SCB is pleased to report that there has been a 59% decrease in the number of cases of C-Difficile as compared to the same period last year, with 0 reported cases in December and an overall total of 9 cases from April-December 2023.

Table 1: Monthly Numbers & Cumulative Monthly of C. difficile for Surgery CB

	Monthly Numbers for 2021/22	Cumulative Monthly Numbers for 2021/22	Monthly Numbers for 2022/23	Cumulative Monthly Numbers for 2022/23	Monthly Numbers for 2023/24	Cumulative Monthly Numbers for 2023/24
Apr	3	3	0	0	1	1
May	2	5	4	4	1	2
Jun	2	7	3	7	2	4
Jul	2	9	3	10	0	4
Aug	0	9	1	11	0	4
Sep	6	15	6	17	2	6
Oct	2	17	3	20	2	8
Nov	2	19	1	21	1	9
Dec	2	21	1	22	0	9



MRSA

There have been no reported cases of MRSA for 2023, which remains the same as the equivalent period for 2022 and is in line with the expected reduction expectation of 0.

Table 1: Monthly Numbers & Cumulative Monthly of MRSA Bacteraemia for Surgery CB

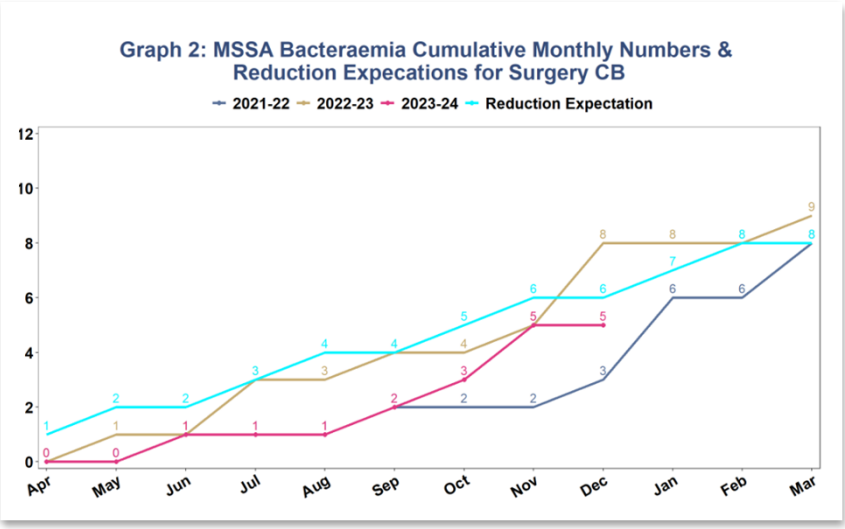
	Monthly Numbers for 2021/22	Cumulative Monthly Numbers for 2021/22	Monthly Numbers for 2022/23	Cumulative Monthly Numbers for 2022/23	Monthly Numbers for 2023/24	Cumulative Monthly Numbers for 2023/24
Apr	0	0	0	0	0	0
May	0	0	0	0	0	0
Jun	1	1	0	0	0	0
Jul	0	1	0	0	0	0
Aug	0	1	0	0	0	0
Sep	0	1	0	0	0	0
Oct	0	1	0	0	0	0
Nov	0	1	0	0	0	0
Dec	1	2	0	0	0	0

MSSA

There has been a total of 5 reported cases of MSSA from April-December 2023, this is equivalent to a 38% reduction compared to the same period in 2022 and is 1 case below the expected reduction target of 6.

Table 1: Monthly Numbers & Cumulative Monthly of MSSA Bacteraemia for Surgery CB

	Monthly Numbers for 2021/22	Cumulative Monthly Numbers for 2021/22	Monthly Numbers for 2022/23	Cumulative Monthly Numbers for 2022/23	Monthly Numbers for 2023/24	Cumulative Monthly Numbers for 2023/24
Apr	0	0	0	0	0	0
May	0	0	1	1	0	0
Jun	1	1	0	1	1	1
Jul	0	1	2	3	0	1
Aug	0	1	0	3	0	1
Sep	1	2	1	4	1	2
Oct	0	2	0	4	1	3
Nov	0	2	1	5	2	5
Dec	1	3	3	8	0	5



Pseudomonas

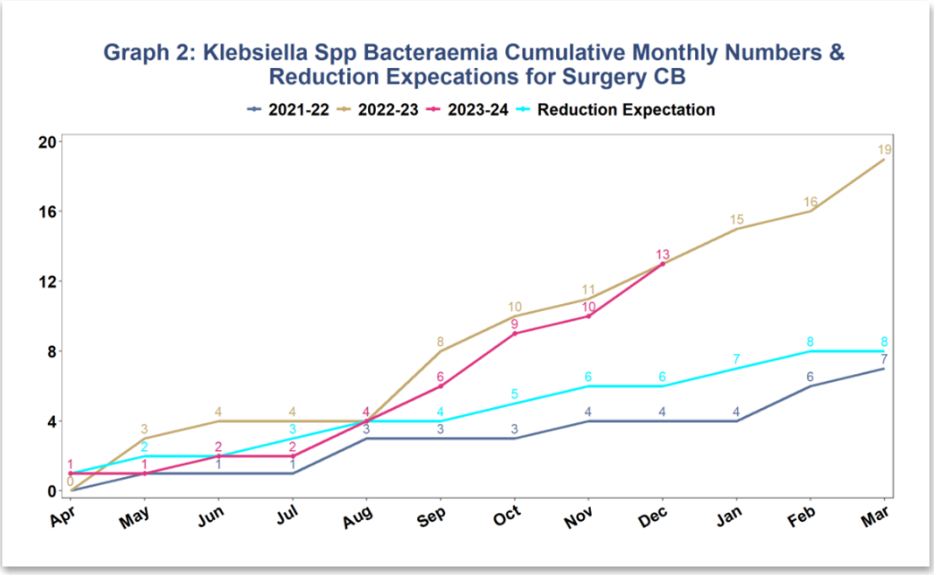
There has been 1 case of Pseudomonas reported on October 2023, as there were 0 cases in 2022 this 1 case is 1 over the reduction expectation of 0.

Klebsiella

There were 3 cases of Klebsiella reported in December 2023, this makes a cumulative total of 13 cases for this financial year. The total cases are equivalent to the same reporting period in 2022.

Table 1: Monthly Numbers & Cumulative Monthly of Klebsiella Bacteraemia for Surgery CB

	Monthly Numbers for 2021/22	Cumulative Monthly Numbers for 2021/22	Monthly Numbers for 2022/23	Cumulative Monthly Numbers for 2022/23	Monthly Numbers for 2023/24	Cumulative Monthly Numbers for 2023/24
Apr	0	0	0	0	1	1
May	1	1	3	3	0	1
Jun	0	1	1	4	1	2
Jul	0	1	0	4	0	2
Aug	2	3	0	4	2	4
Sep	0	3	4	8	2	6
Oct	0	3	2	10	3	9
Nov	1	4	1	11	1	10
Dec	0	4	2	13	3	13



Microbiology has raised concerns about a multi-drug gram-negative organism ST1778, which lives in the gut as part of normal flora but can cause infection. This organism came to light in November 2019, originally isolated in Rookwood Hospital and West 8 in UHL, Microbiology is now seeing a wider spread of this organism throughout the Health Board. Since May 2023 microbiology has identified 21 cases of ST1778 in patients on B2, there were a few cases over the months up until October 2023 when there was a period of increased incidence and a peak in December when screening was being undertaken. With reference to 'typing', there is a strong suggestion that there has been patient to patient or environmental transmission in most cases, as there were genetically identical organisms in multiple patients. ST1778 is being monitored by microbiologists and the infection control team, and a look back investigation starting from April 2023 has commenced, with epidemiology and audit data currently being collated.

A screening programme was undertaken on B2 in December 2023. 34 out of 38 patients were screened, of the 34 patients screened, 10 were confirmed as positive for ST1778. B2 staff are working closely with the IPC teams

to gather information to understand how transmission is occurring and implementing additional infection control measures to reduce further infections. In addition, the practice development nurse team within surgery are also undertaking Aseptic Non-Touch Technique (ANTT) refresher training.

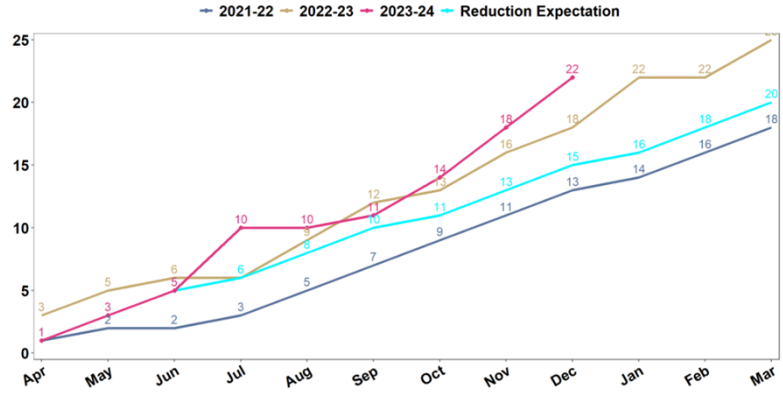
E Coli

There has been a cumulative of 22 cases for 2023. This is 22% more than in the same period last year which is in line with other areas of the Heath Board E-Coli was associated with several urinary tract infections particularly within T&O, as a result with help of the ICP team additional teaching has been undertaken with the use of Catheter Bundles.

Table 1: Monthly Numbers & Cumulative Monthly of E. coli Bacteraemia for Surgery CB

	Monthly Numbers for 2021/22	Cumulative Monthly Numbers for 2021/22	Monthly Numbers for 2022/23	Cumulative Monthly Numbers for 2022/23	Monthly Numbers for 2023/24	Cumulative Monthly Numbers for 2023/24
Apr	1	1	3	3	1	1
May	1	2	2	5	2	3
Jun	0	2	1	6	2	5
Jul	1	3	0	6	5	10
Aug	2	5	3	9	0	10
Sep	2	7	3	12	1	11
Oct	2	9	1	13	3	14
Nov	2	11	3	16	4	18
Dec	2	13	2	18	4	22

Graph 2: E. coli Bacteraemia Cumulative Monthly Numbers & Reduction Expecations for Surgery CB



Trauma

During the ortho-infection MDT in January 2023, concerns were raised regarding the reported increase of infections in patients undergoing hip-hemiarthroplasties between October 2022 - June 2023. During this time period the infection rate was calculated as 6.4% showing an increase compared to the normal average of 0.8-1.6% for this type of surgery. On average within this timeframe 2-4 patients would have normally present with infections, however 9 patients had been identified with infections.

Looking back from September 2022 – June 2023, 10 patients were identified for further investigation. Of these 10 patients it was discovered that 3 patients had sadly died with *'infection'* recorded as the cause of death on

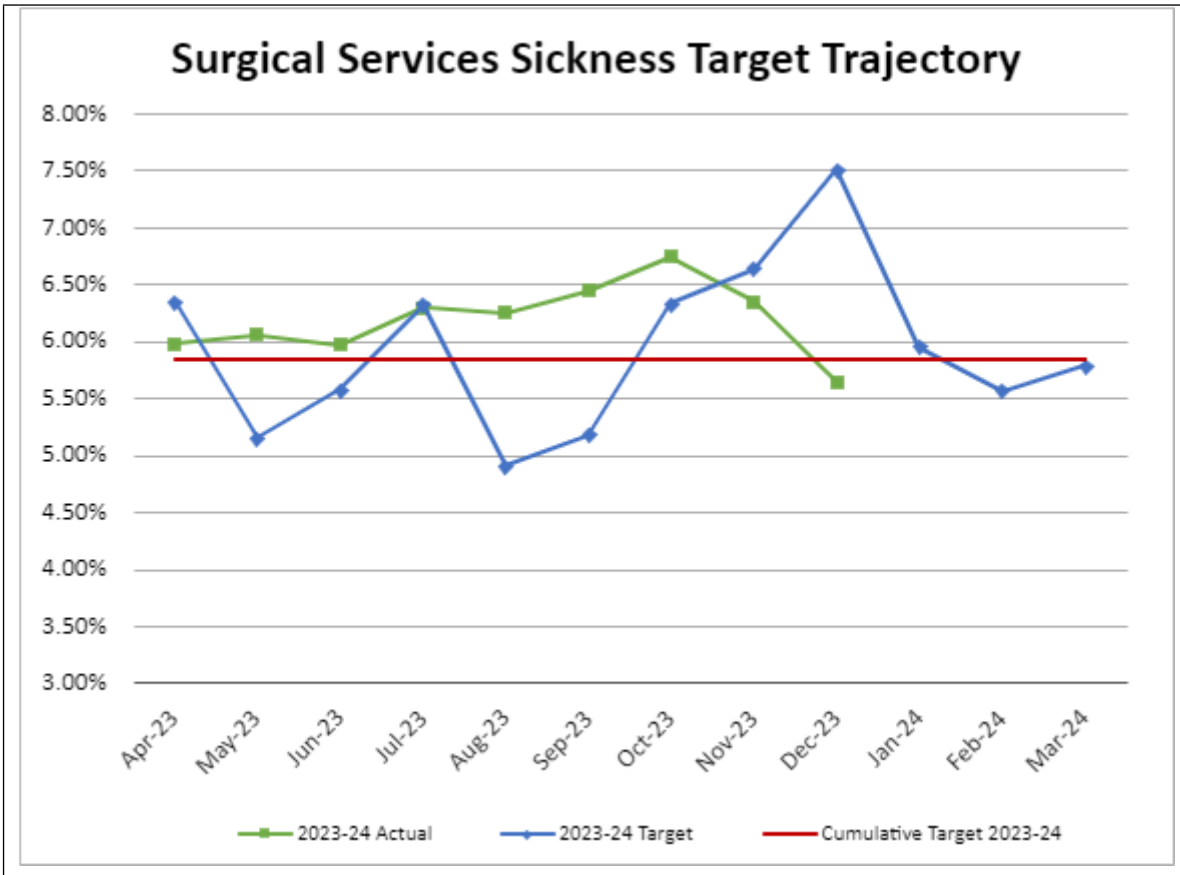
1a / 1b of their death certificates, and as a consequence all 3 cases were reported as National Reportable Incidents.
Following multi-disciplinary meetings, an investigation was launched to establish if there were any actions or inactions which may have caused or contributed to the deaths of the 3 patients and if there were any correlations which could be identified and attributed to any of the other patients acquiring post-operative hip infections.
An initial action plan has been formulated to address the immediate concerns and is currently being reviewed and updated. The Surgical Clinical Board continues to work closely with the Patient Safety Team and Infection Control Teams to complete these investigations.

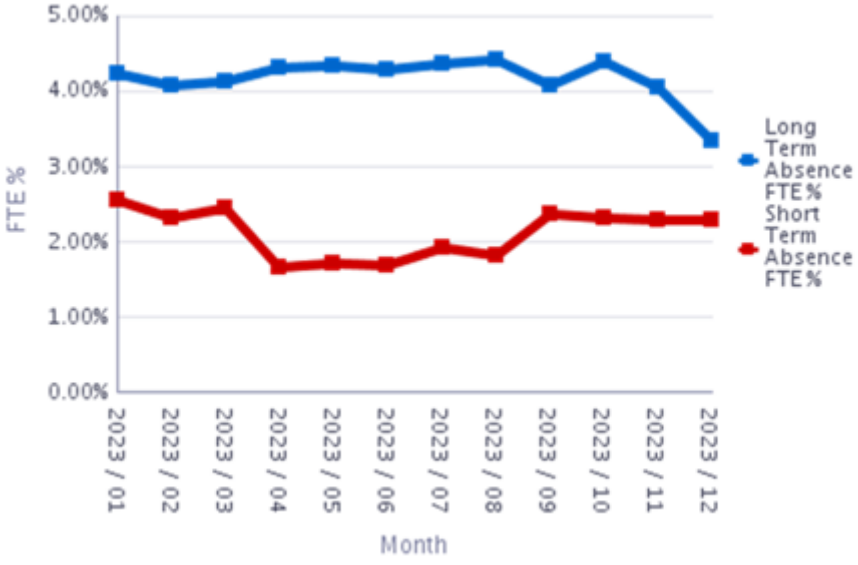
Workforce data - December 2023

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Long Term	4.31%	4.32%	4.36%	4.37%	3.90%	3.96%	3.77%	3.99%	3.35%
Short Term	1.6%	1.6%	1.77%	1.93%	2.0%	1.90%	2.57%	1.81%	2.29%
VBAs	60%	62.14%	64.89%	70.24	68.36%	64.4%	63.36%	64.23%	64.53%
Medical Appraisal	83.65%	85.19%	85.87%	88.21%	88.89%	91.2%	91.24%	90.28%	85.16%
Vacancies	4.61%	4.66%	4.00%	3.26%	4.47%	5.08%	4.70%	6.52%	5.54%
Statutory Mandatory Training	72.94%	72.93%	73.69%	70.24%	74.59%	81.24%	74.63%	74.68%	75.26%
Turnover	9.64%	9.35%	10.67%	10.54%	10.47%	8.95%	10.70%	10.48%	10.31%

Sickness
Actions that have been put in place to support managers with the sickness agenda are:

- Sickness panels to be arranged monthly to ensure support is in place for the both the manager and member of staff.
- The Senior People Services Advisors to lead and focus on any cases that are 12 months and over, aiming to secure a return to work or closure of sickness.
- Due to the top reason for sickness being 'S10 Anxiety/stress/depression/other psychiatric illnesses' the teams will continue to ensure contact is being made and Employee Wellbeing and other similar services are being promoted and shared.
- Health & Wellbeing Promotion via sickness surgeries and training will continue.
- Redeployment and proactive return to work opportunities will be available for staff.





Staffing

The Clinical Board inpatient wards are reviewed against the All Wales Nurse Staffing acuity data, and triangulated with quality indicators and professional judgement; to ensure the Clinical Board inpatient wards have the right number of Registered Nurses and the right skill mix to ensure the delivery of a high quality and standard of care for our patients

Work is being undertaken within the Clinical Board to look at different roles and workforce models to release the Registered Nurses time and ensure the workforce is fit for purpose. This may challenge the current traditional model of the nursing workforce. However, the difficulty in recruiting Registered Nurses is widely recognised, so exploring different workforce models is necessary in order to keep our patients safe. Within Peri-operative care, the Band 4 role Peri-operative Assistant Practitioners has been introduced and is working well. The number of wte staff in this role is hoping to be increased with the development of the UHL Surgical Hub and will also be introduced into the ward day surgery area.

Resources

Surgery Financial Position as of 31st December 2023

The Surgical Clinical Board has reported an overspend of £1.271m for the 9 months ended 31st December 2023, which is deteriorated of £170k in month

Position illustrated in the table below -

	In-Month			To Date		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Pay	12,630	12,597	**-33**	114,068	114,701	**633**
Non-Pay	3,712	3,857	**145**	33,460	34,340	**880**
Income	-639	-581	**58**	-5,178	-5,420	**-242**
Totals	**15,703**	**15,873**	**170**	**142,350**	**143,621**	**1,271**

The overspend is forecast to increase to 1.539m without further action and is summarised below -

	Actual	Forecast			
	Month 09 £'000	Month 09 £'000	Month 10 £'000	Month 11 £'000	Month 12 £'000
Operational	349	446	476	525	413
Local 1% CRP	22	22	24	27	29
Corporate 3% CRP	900	898	968	1,035	1,097
Totals	**1,271**	**1,366**	**1,468**	**1,587**	**1,539**

The Clinical Board needs to improve this position so that it can meet its statutory duties. The expectation is that a breakeven position is delivered, the local 1% savings target achieved, and a significant contribution is made to support the Health Board's 3% efficiency plan.

Key Actions required -

- Overspending Directorates need to improve their forecasts. Underspending Directorates are required to deliver their forecast.
- Recurrent delivery plans against the 1% savings target. Only Peri-Operative Care have this in place.

- Consider plans to further reduce the corporate CRP projected deficit.
- Planned Care trackers need completing to ensure all delivery costs are included.
- Each Directorate needs to review its longstanding Directorates.

A key priority of the Clinical Board over the last year has been to reduce the nursing spend on temporary staffing and the Clinical Board nursing team via an enhanced scrutiny process have reduced their agency temporary staffing nursing spend by 50% between April 2023 and November 2023. The SCB nursing teams have started using Safecare as a tool to monitor their nurse staffing levels and patient acuity over the last year and it has been rolled out in both UHW and UHL. The tool allows the Director of Nursing and Senior Nursing Team to have clear visibility across all areas about staffing risks.

Staff engagement

The Clinical Board supports the UHB's commitment for talent management and leadership and the importance of creating the right vision and environment for change, to enable teams to drive change forward to improve the experience of our patients and staff. An example of this is:

- Royal College of Nursing Award Winner 2023 – Health Care Support Worker Kelly Brown. Awarded for her work as a Memory Link Worker.
- International Nurses Day – Davinder Kaur, Interim Theatre Manager SSSU won a Leadership award for promoting the education of staff.
- Dr Antony Johansen – MBE New Years Honours list 2024

The Clinical Board has long recognised the importance of listening and engaging with staff. The engagement of staff in the development of the Clinical Board is inherit to its values. A Culture and Leadership Programme commenced in UHL Peri-Operative Care in October 2023, and we are awaiting the delivery of the report. The plan is to roll this out to other areas, starting with Main Theatres UHW which will commence January 2023.

Surgical Stars -

This year 'Surgical Stars' was held in Lecture Theatre 1. This event is a very important time for our amazing teams to reflect on the year's successes and challenges within the surgical clinical and a fantastic opportunity to share and celebrate all the achievements of our hard-working and dedicated Teams. Every year, it is inspiring to read the nominations and feel proud of the teams and individuals within them who are making a difference to our patients' care and supporting our staff every day. The task of choosing the winners and runners up is not an enviable one and becomes more difficult every year; every nomination is worthy of recognition. We are very proud to have such exceptional staff working within Surgery.

Congratulations to this year's winners and runners up –

Categories	Winner	Runner-up	Highly Commended
Values	Dr Shannu Bhatia- (Paediatric Dentistry)	Hannah Coyle (A6 South)	
Team	A6 North (ASU)	SDEC	Audiology and HPB CNS Team
Performance	Gheorge Vlad (West 3)	Jayne Christopher (C6)	Hayley Ferreira (Trauma Clinic)
Leader	Jon Barada (Main Theatres) and Richard Ducroq (B6)	Ellie-Louise Bullen (West 3)	Marvin Juanta and Rebecca Carter (SDEC)
Wellbeing	Clare Wakeham (B6)	Samantha Churchill (B2)	Jackie Cawley (West 3), Rebecca Carter (SDEC) and Toni Perry (West 3)
Hero	Sarah Angove (Audiology/ Cochlear Implant Team)	Mark Hernandez (C6)	Cherie Rogers (Pain Service) and Rachel Skinner (POPS Team)
Tendable	Rhiannon Joseph (B2)		

VBA's

Values Based Appraisals continues to be a challenge, but the Clinical Board is confident that this is moving in the right direction based on conversations. The compliance for VBA's is currently at **64.53%**. The SCB have discussed with all Directorates that improvement needs to happen and be sustained. The actions that need to be taken as part of this will be discussed at Directorate Performance reviews.

Actions to enable sustained improvement on VBA compliance:

The Clinical Board Performance and Planning Lead will pull a monitoring report together and a process for reminding line managers and for line managers to report back any issues of not being able to complete

Effective Care

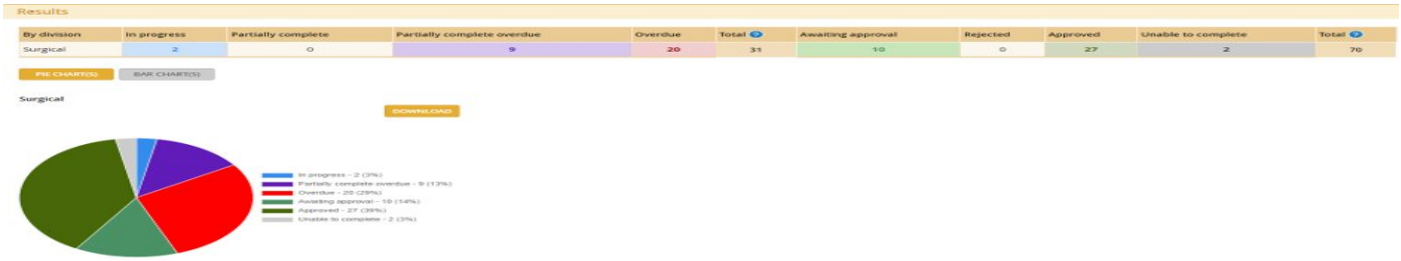
Mortality reviews

The mortality review process in the UHB (University Health Board) is currently under review after the introduction of the Medical Examiner's (ME) office. The Asst Clinical Director for Q&S for SCB and the Director

of Nursing for Surgery Clinical Board receives all deaths from the ME via CVUHB Organisational Learning Facilitator (OLF) into the QSE lead in SCB. The reports are scrutinised by the respective Clinical QS lead and presented at the monthly QS meeting. Outcomes are reported back via the QSE SCB meeting and the OLF and learnings are outcomed.
Once the UHB biweekly panel is set up in the New Year, ME reports are likely to be received via this route and the SCB will have a member on this panel for surgical input. The same internal processes will continue. We are in the process of developing a Mortality report on BIS for surgical patients alongside the AMD for QSE and IT.

National Audit

Each Directorate has a Clinical Audit Lead. Clinical Audit forms part of the Clinical Board Director's responsibilities. The Clinical Board has an audit/research plan for 2023/ 2024.
The Clinical Board has welcomed the introduction of AMaT (Audit Monitoring and Tracking) to support accurate and timely audit programmes and compliance and so far, 78 Clinical Board Audits have been logged on the AMaT system



5 Steps to Safer Surgery
The WHO 5 Steps to Safer Surgery checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patient's perioperative journey.
In February 2022 we integrated the checklist into the Theatreman programme in order to be able to accurately audit and monitor compliance and data. Integrating the system into a programme that was already being used and familiar to theatre staff enabled the process to be embedded into practice in a timelier manner. The programme is set up so that progression through each part of the checklist cannot be achieved before all the essential criteria has been completed for each of the 5 steps. The Peri-operative Directorate now receive weekly informatics from the IT department which allows areas of non-compliance to be identified and if any support or development is required. The data is providing us with information for each area, speciality, and team. Data has shown that compliance is very good and provides us with assurance that patients are receiving safe and effective care. Any areas of non-compliance that are identified is raised with Theatre Managers and discussed during the Directorate Senior Team meetings.

Tendable

Tendable has been successfully rolled out to all Surgical inpatient settings and theatres in 2023 and roll out will continue in 2024 to further outpatient areas and the dental hospital.

The quality improvement and auditing app is used across the Surgical Clinical Board to monitor standards of care and the clinical environment as well as patient and staff experience. It is used by over 70 members of staff across 17 inpatient areas, 3 outpatient areas and 50 theatre areas. The audit data is reported and communicated directly through the Tendable application and is reported locally via Cardiff and Vale UHB, Power Bi Nursing dashboards.

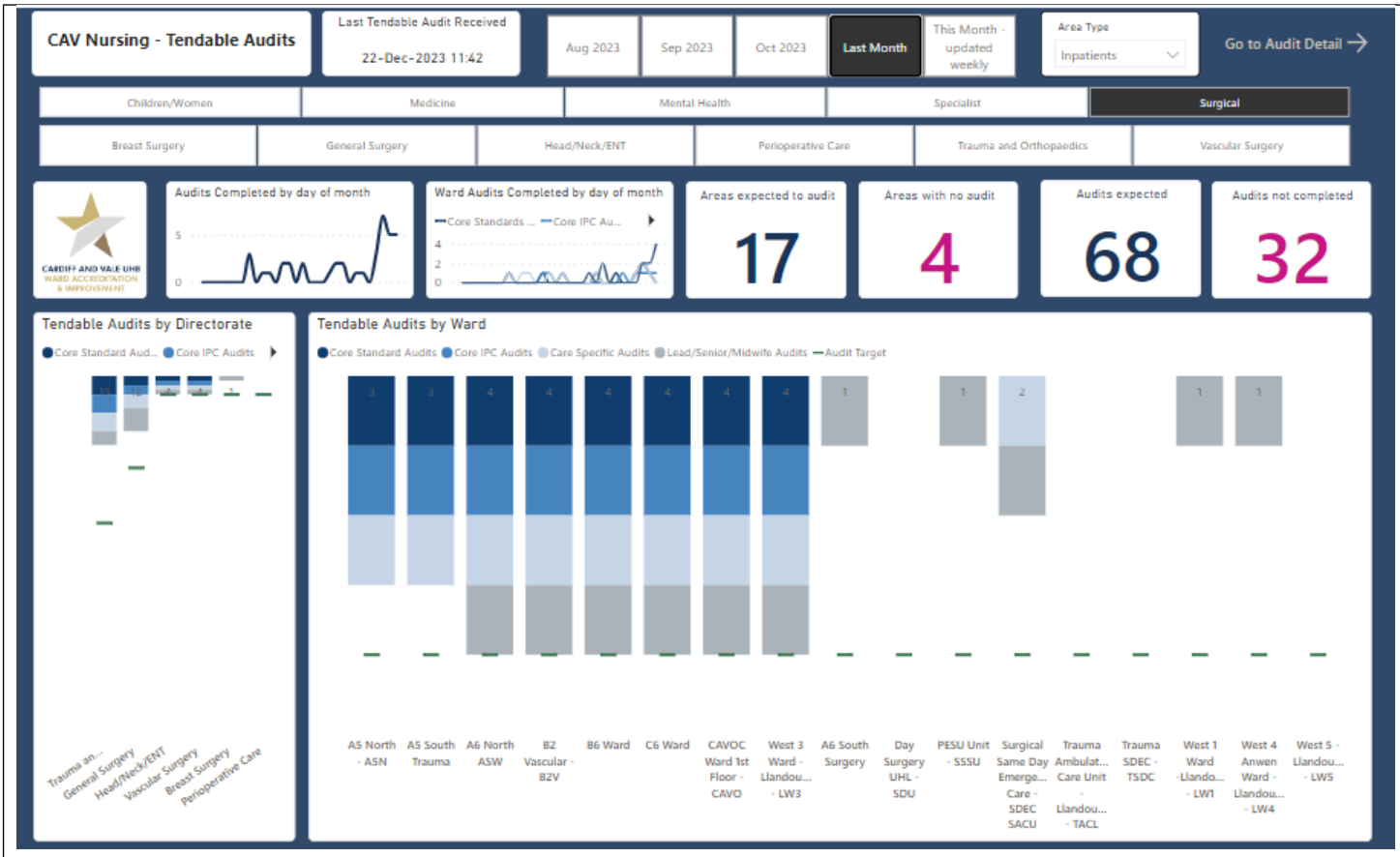
The Surgical Clinical Board use the data from their audits to drive improvements in practice and to shape their improvement agenda.

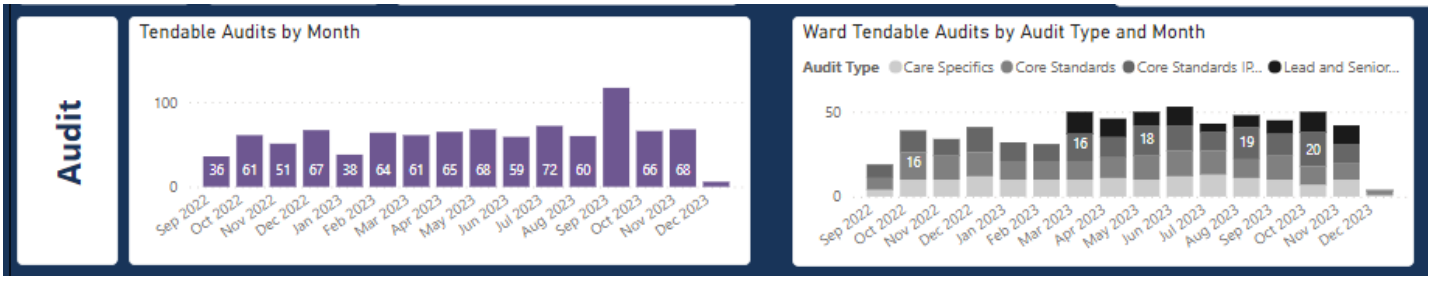
- For example, teams were able to triangulate data from their Tendable audits and local investigations of Surgical Site Infections to determine appropriate actions required to improve patient outcomes. An action plan was created collaboratively within Tendable to address the issues identified and a bespoke audit for the Theatre teams to undertake themselves to further assure themselves that their actions resulted in an improvement.
- Concerns were raised by the IPC team in July 2023 regarding Theatre 0, UHW audits results. Collaborative and focussed efforts to address the issues between July – November 2023 and have shown an improvement in results from 74.4% to 96.2%

Submitted	Inspection Type	Inspected by	Area	Site	Role	Average score
2023-07-24	Theatre Environment Audit	Babs Jones	UHW Green Main Theatre 0	University Hospital of Wales	Area / Ward Manager / Deputy	74.4%
2023-08-31	Theatre Environment Audit	Babs Jones	UHW Green Main Theatre 0	University Hospital of Wales	Area / Ward Manager / Deputy	89.5%
2023-09-01	Theatre Environment Audit	Babs Jones	UHW Green Main Theatre 0	University Hospital of Wales	Area / Ward Manager / Deputy	92.0%
2023-11-24	Theatre Environment Audit	Babs Jones	UHW Green Main Theatre 0	University Hospital of Wales	Area / Ward Manager / Deputy	96.2%

- Teams in Short Stay Surgical areas, such as Breast Surgery have tailored their audit questions and have been actively engaged in creating a bespoke questions to reflect their patient needs, and to ensure that their programme best reflects their service

Ward Compliance: Surgical Inpatient areas November 2023





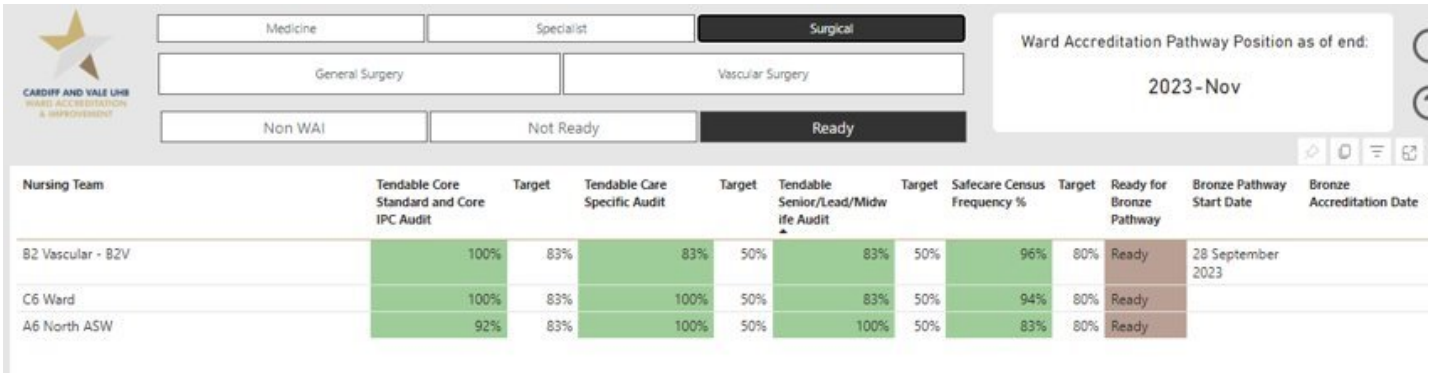
The Clinical Board monitor compliance with the ward audit programme monthly. Teams are expected to complete a:

- Core Standards audit
- Infection Prevention and Control audit,
- Care Specifics – monthly topic audit
- Lead and Senior Nurse review.

Theatre suites also follow this structure along with undertaking ad hoc QUAD Theatre audits and Theatre Environment audits.

The Surgical Clinical Board currently has three areas eligible to join the Ward Accreditation and Improvement programme.

The first, B2 Vascular joined the programme in September 2023 with A6 North (Trauma) and C6 (General Surgery) expected to commence in 2024.



Nursing Team	Tendable Core Standard and Core IPC Audit	Target	Tendable Care Specific Audit	Target	Tendable Senior/Lead/Midwife Audit	Target	Safecare Census Frequency %	Target	Ready for Bronze Pathway	Bronze Pathway Start Date	Bronze Accreditation Date
B2 Vascular - B2V	100%	83%	83%	50%	83%	50%	96%	80%	Ready	28 September 2023	
C6 Ward	100%	83%	100%	50%	83%	50%	94%	80%	Ready		
A6 North ASW	92%	83%	100%	50%	100%	50%	83%	80%	Ready		

Diabetes audits have been undertaken across the Clinical Board to gather a baseline of practices and to develop a structured improvement plan which will align with our length of stay work, optimising outcomes with associated length of stay benefits.

Total inspections completed	Average score
between 1 Oct 2023 and 31 Dec 2023	between 1 Oct 2023 and 31 Dec 2023
8	82.1%

Perioperative Care Improvement Programme

This information is presented to the Theatres Delivery Group on a weekly basis and has timelines for when sessions have/are introduced into the theatre timetables.
An additional 27% capacity has been achieved to date in the timetable.

Future are:-

- SSSSU Theatres to have additional capacity in High Volume Low Complexity (HVLC) lists and the commencement of UHL surgical hub lists when Cardiothoracic return to UHW later this year.
- Childrens Hospital for Wales Cat (emergency and priority) lists are working well and plan for this year is to increase capacity for specialties with highest demand where possible.

The Theatre workforce is now up to establishment, and we are in a position to begin to support the additional capacity. Current workforce projects ongoing;

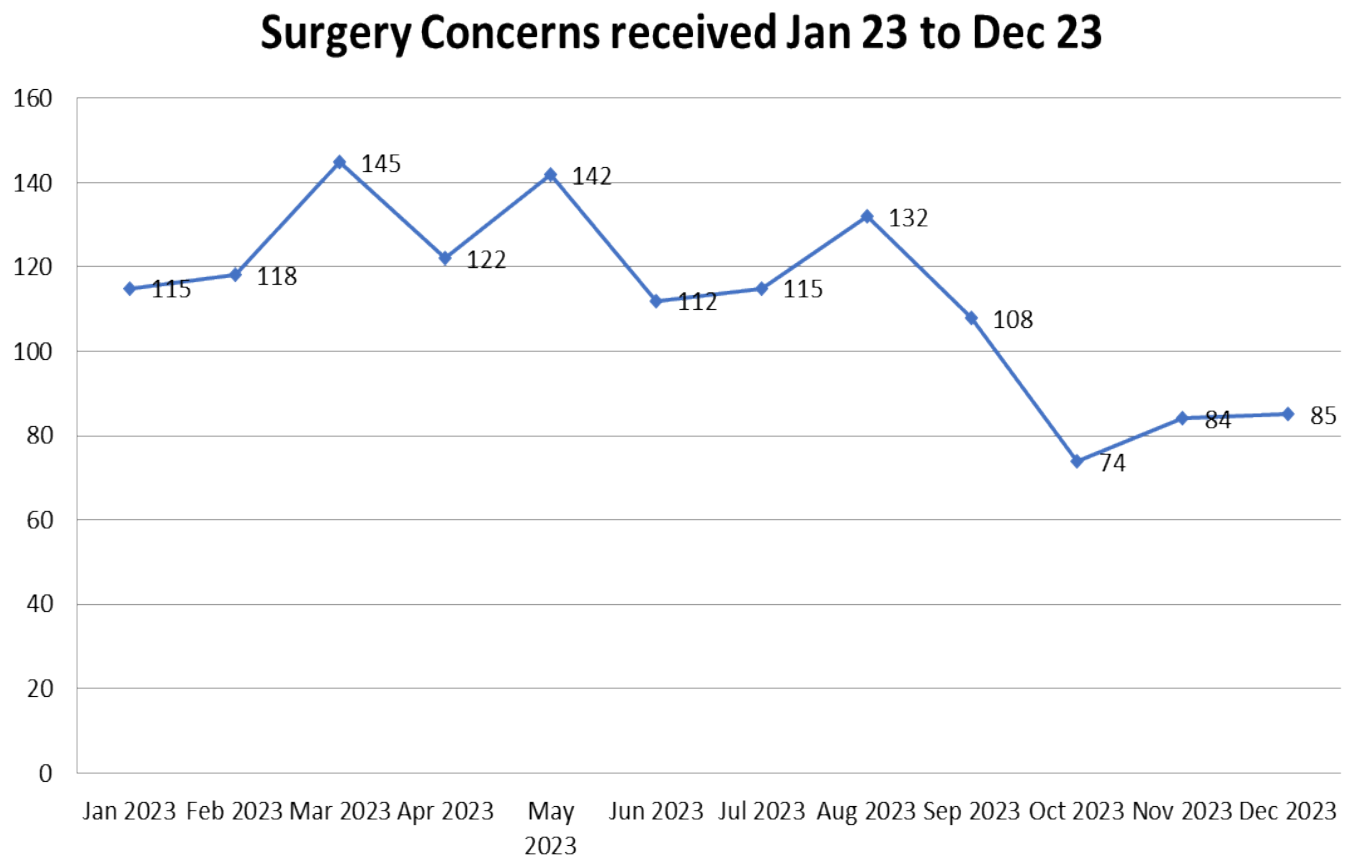
- Maintaining establishment through ongoing recruitment and retention strategies.
- Cardiothoracic theatre staff will be up to establishment by the end of February, which will release the final agency staff.
- Academic pathways for all roles within Peri-Operative Care.

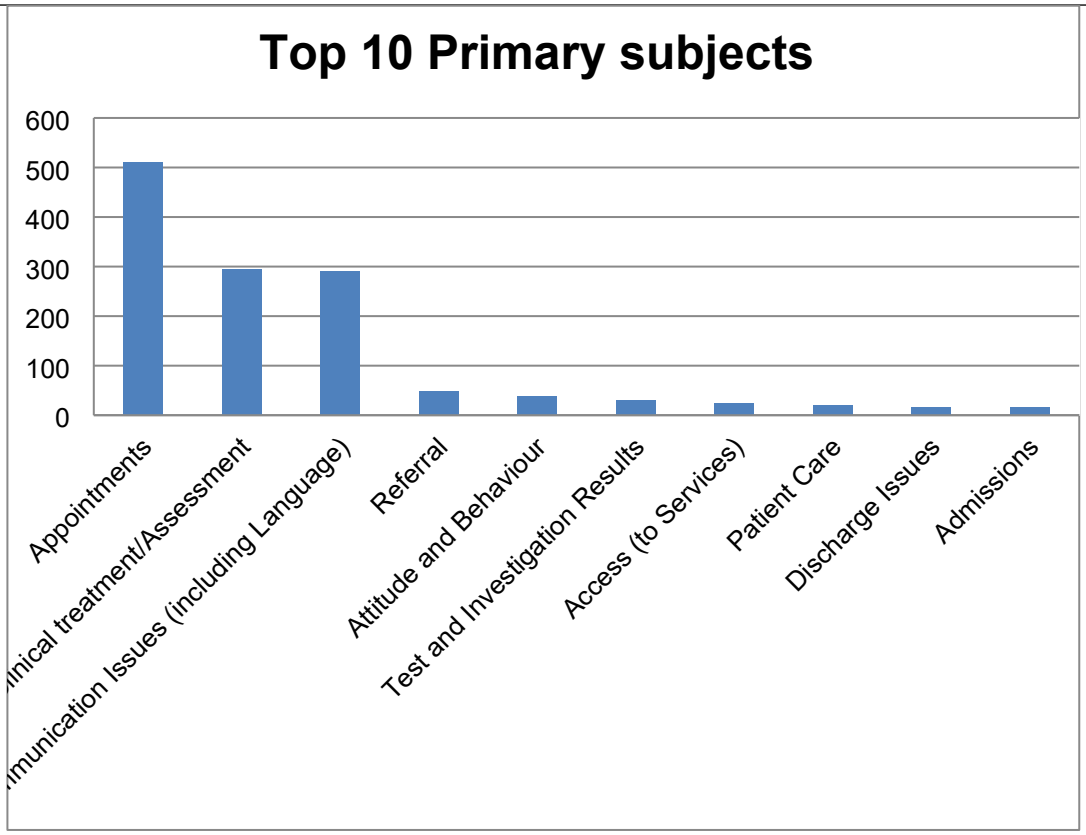
- Digitalised and streamlined induction process.
- Senior band 5 rotational post for succession planning.
- Monthly CL teaching sessions.
- The role of the Peri-operative Support Worker.
- Working with HEIW to create an ODP network.
- Development of the band 4 role within Peri-Op is a success not only within Ophthalmology but in HVLC lists in SSSU and UHL and we hope to increase the number of staff in this role in the future.

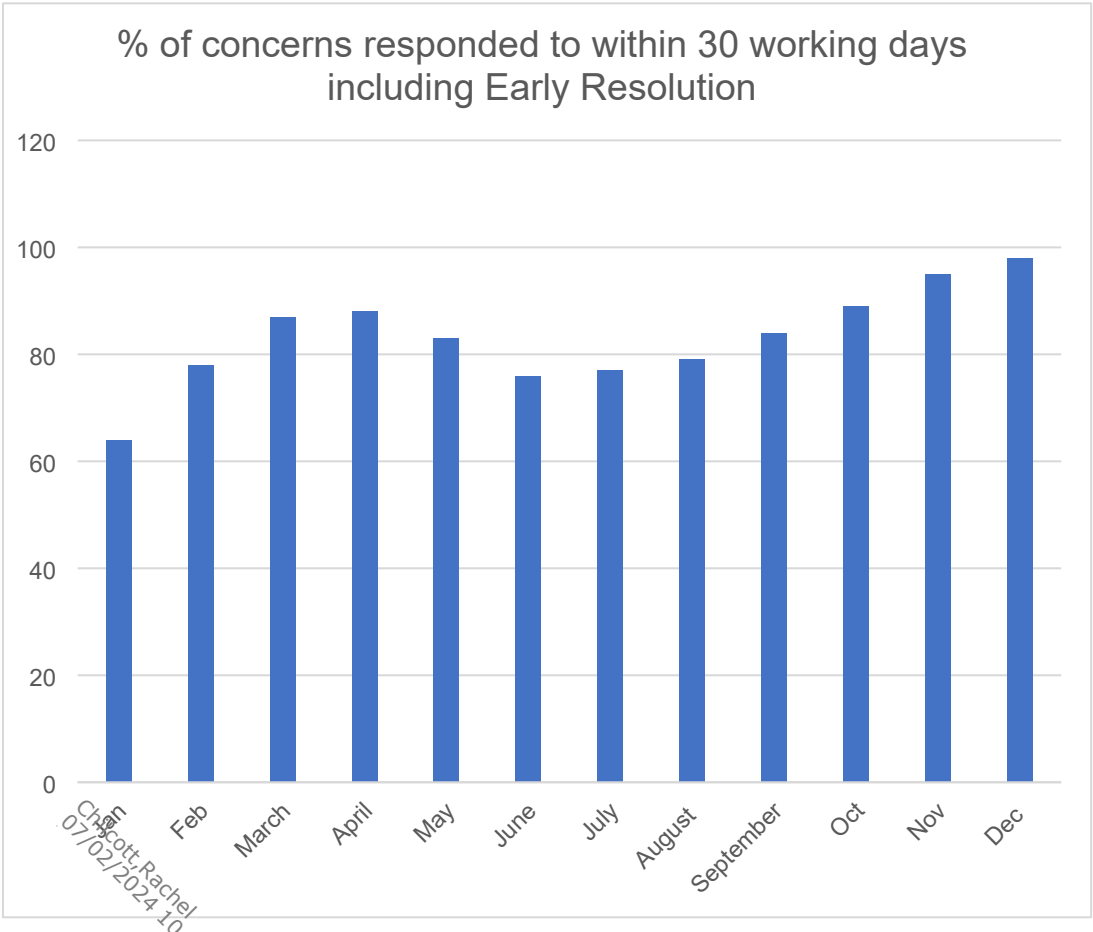
Person centered Care

Concerns

The management of concerns remains a key priority for the Clinical Board. We have been fortunate that during 2023 we have had 2 members of staff who unfortunately were unable to work in their substantive roles and therefore were able to prioritise investigating concerns received and sign and close them on behalf of the Director of Nursing for SCB. This helped to improve our compliance in meeting response times and ensures that we are able to be timelier in providing responses. Concerns data and themes are also discussed at our SCB monthly meetings and also at our CB quality and safety meetings as well as at Directorate level.




Top 10 Primary subjects
600
500
400
300
200
100
0
Appointments
Clinical treatment/Assessment
Communication Issues (including Language)
Referral
Attitude and Behaviour
Test and Investigation Results
Access (to Services)
Patient Care
Discharge Issues
Admissions


% of concerns responded to within 30 working days including Early Resolution
120
100
80
60
40
20
0
Jan
Feb
March
April
May
June
July
August
September
Oct
Nov
Dec
Chalcott Rachel
07/02/2024 10:34:44

22

	Surgical Services	
	Managed through PTR	Early Resolution
Jan 2023	40	65
Feb 2023	37	81
Mar 2023	34	118
Apr 2023	27	102
May 2023	42	98
Jun 2023	20	73
Jul 2023	43	68
Aug 2023	45	80
Sep 2023	57	64
Oct 2023	77	31
Nov 2023	72	25
Dec 2023	55	37

Redress

Since January 2023 9 new Redress cases have been opened within the SCB:

- 1 for Dental
- 3 Peri Op
- 1 Ophthamology
- 1 ENT
- 1 General Surgery
- 2 Trauma and Orthopaedics

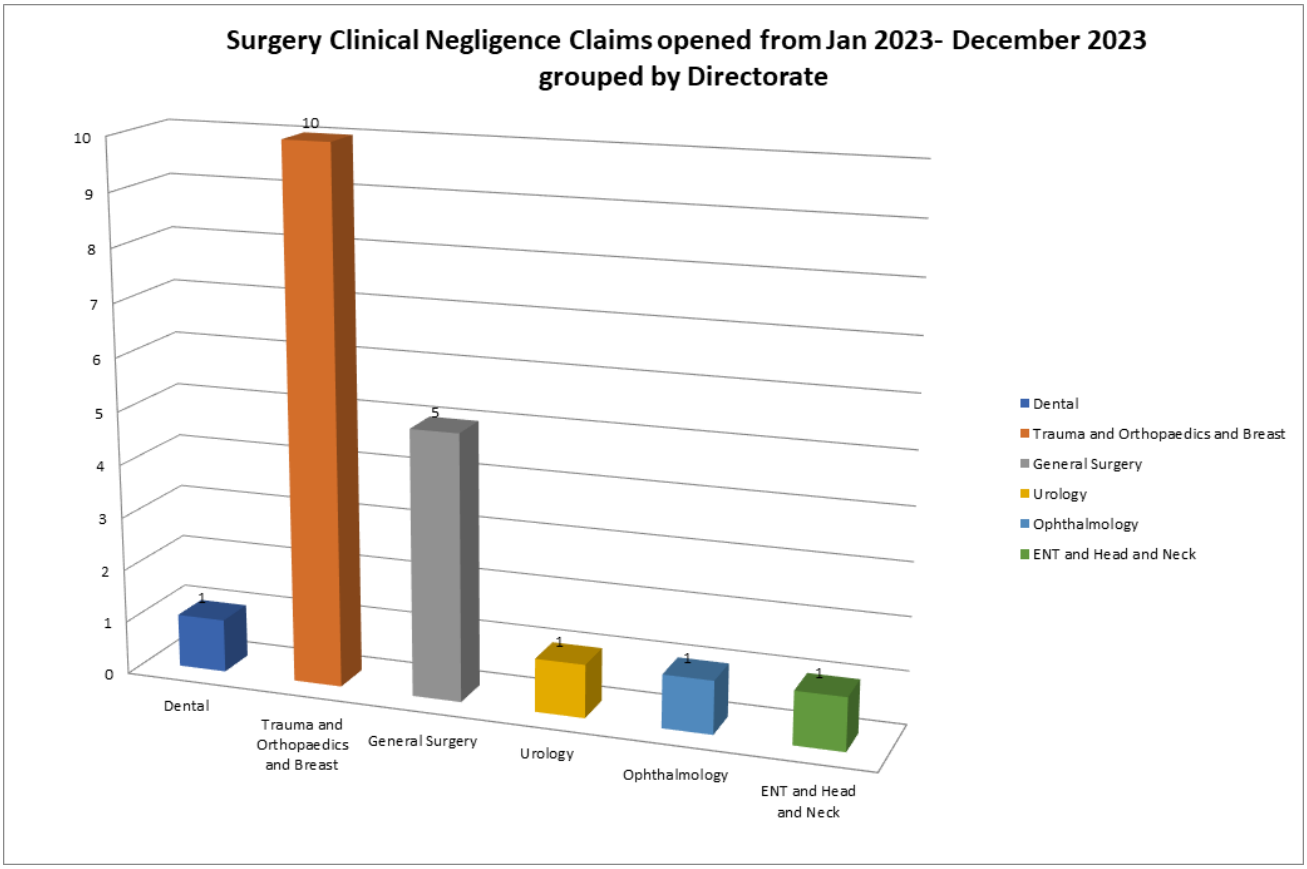
Examples of Settled Redress Cases are below:-

- ENT - the patient was seen on multiple occasions and there was a two-year delay in identifying a cholesteatoma during which time the patient experienced dizziness and symptoms of vertigo. She was offered £12,000 which she accepted and this case was settled under the redress scheme.
- Emergency Unit/Max-fax - the patient was seen by a locum dental trainee. The wrong type of sutures were used for a facial injury leading to the need for the patient to attend again at the Emergency Unit for re-suturing (with resorbable sutures which should have been used originally). Patient accepted £500.
- Ophthalmology - there was a delay in listing for surgery when this patient was lost to follow up. The delay led to the patient developing a full thickness macular hole. She was left with a permanent visual impairment which affects her work and activities of daily living. She accepted £25,000.

Clinical Negligence Claims

Since January 23 there have been 19 new claims received for Surgery Clinical Board

The main theme of the allegations remains a failure and/or delay to diagnosis and thereafter provide appropriate treatment.



Personal Injury Claims

As of 31st December, Surgery Clinical Board had 3 active PI claims

- 1 Slip
- 1 Violence and Aggression
- 1 Slip

7 claims have been closed in the last year.

There are no specific themes with the Personal Injury that have closed within the period, but the learning reflected in the main has been a general awareness, raising of the need for compliance to mandatory training in areas covering health and safety, manual handling and in violence and aggression.

Compliments

Surgery Clinical Board received 73 Compliments during the period January to December 2023

Some of these examples are:

- She was so patient, and understanding, she never made me feel like my phobia was invalid. It was the first experience I've had with someone who just accepted me as I was and supported me wholeheartedly instead of judging me and criticising me. I often think about the kindness she showed and how grateful I am for it. From holding my hand, to stroking my hair, to speaking to me with integrity and kindness, to making me laugh and to even accompanying me to the toilet when I was coming around from sedation but desperate to use the loo.

- Just a little thank you to all the wonderful staff who probably saved my life last Wednesday. I cannot thank you all enough. I owe you my future. God Bless. Live long and prosper!!

- I recently underwent robotic surgery on my tongue base, I am not only extremely grateful for the opportunity to receive such innovative treatment but also the care I have received every step of the way. The ENT outpatients department have been unbelievably efficient and friendly. The care has been second to none. I was fully informed at every point, I really couldn't have asked for better care. On the ward during surgery again the team were impeccable, I was fully aware of the pressure the whole hospital was under at the time via media however as a patient I felt like all staff had all the time I needed. The whole team involved really do deserve praise for their professionalism and care and I feel indebted to each of them.

- I was spending Christmas Day, lying flat on my back, unable to move imagining it would be *'one of the worst days of my life'.* I was deeply moved by the combination of professional care and Christmas cheer from the staff on A5 North. There was a small present waiting on my bed, and many staff had dressed up in Christmas themed outfits. The staff were unfailingly bright, full of festive cheer, and couldn't do enough for the patients. Despite my fears the fantastic attitude of the staff somehow made Christmas Day in hospital a *'magical experience'* and I am very grateful to all the staff and would like to thank them.

Timely Care

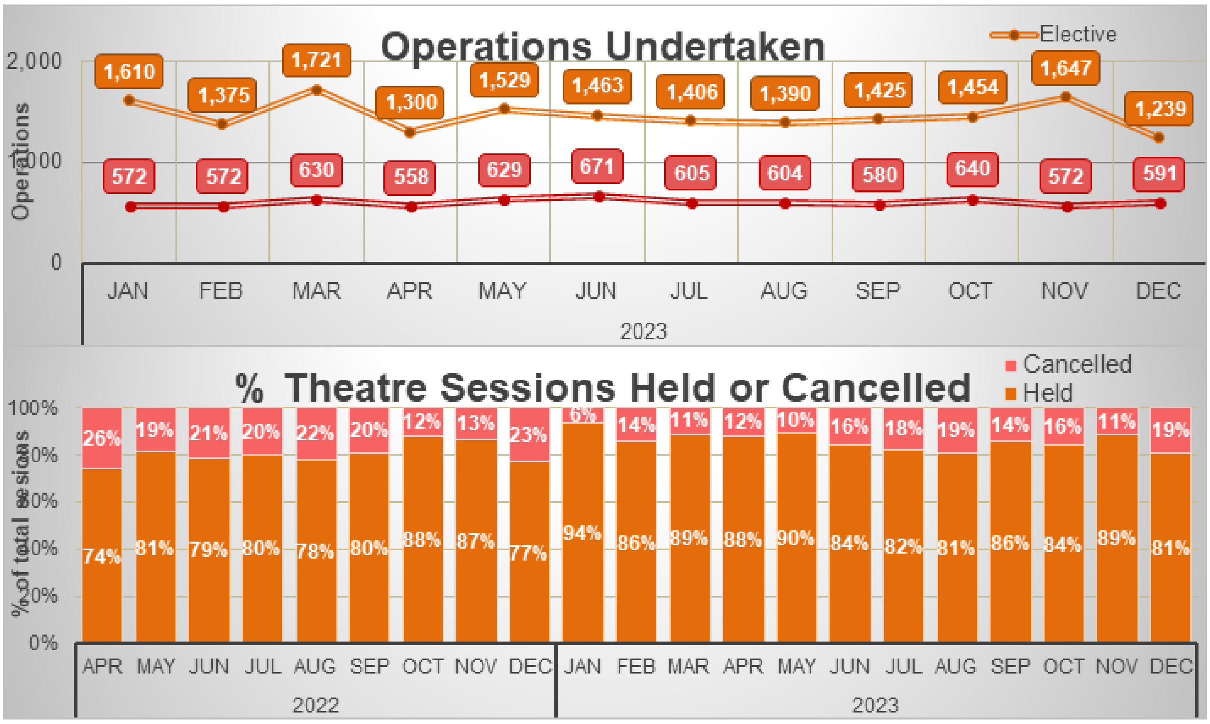
Timely Care QSE January 2023

Surgery Clinical Board is committed to delivering timely care to all its patients. In addition to working towards meeting the access standards set by Welsh Government, during 2023 we have focused on making changes to our services to improve access in a number of disciplines. The summary below highlights some of the Directorate specific initiatives that have been running and which have delivered improvements in patient care.

Theatre Delivery Group – Perioperative Care Directorate
The UHB has a three-year ambition to achieve the following across all specialties. During 23/24 we have been working towards the following standards.

- In / Of Utilisation – Achieve average of 85-95% standard in 50%
- Turnaround Time – achieve median of 10 minutes in 60% of specialities
- Specialty deep dive improvements

We continue to concentrate on improving efficiency of theatres and adressing the capacity gaps within specific specialties to assist improvements in access standards and the delivery of safe timely care.
The graphs below illustrate some of the date we regularly review by specialty. Data below shows combined totals:



Relocation of Fracture Clinic and Trauma Short Stay Unit – in August 2023 we relocated fracture clinic to Lakeside. We also relocated trauma short stay creating inpatient space on A5N. As a consequence of these changes we have seen improvements in patient care however there is further work to be undertaken in 2024 to align the trauma pathway with our inpatient capacity.

6 Goals – As Clinical Board we lead Workstream 3 Alternatives to Admission Programme. During 2022 SCB successfully opened Surgery Same Day Emergency Care Centre which accommodates most surgical specialties. During 2023 we have been monitoring this service and making adjustments to improve the patient experience. We have also been learning from the model and have now implemented a SDEC model within the Dental Hospital.

Hip Fracture pathway – A success of 2023 has been the ringfencing of beds for male and female hip fracture patients. These beds have enabled a reduction in the amount of time patients wait in EU.

Robotics Assisted Surgery Programme – during 2023 we further implemented a National Robotics Assisted Surgery Programme for colorectal, Upper Gastrointestinal, urological and gynaecology oncology along with three other Health Boards – ABUHB, BCUHB, SBUHB. The benefits of this programme have been to reduce hospital length of stay and reductions in our complication rate.

Finally, the Clinical Board is well underway in developing the **HVLC Surgical Short Stay Hub at Llandough** programme with plans to open in July 2024. This area will assist with increasing the throughput of UHB day case activity and enable patients across a number of specialties to access more time care during 2024.

Efficient Care

The SCB recognises the need for Leadership in Value and has in this last financial year dedicated a team to working on projects with a Value lens.

The first project (TNO) is currently undergoing interim analysis and is forecasted to be delivering on its financial, environmental, social and health inequalities outcomes. Projects have been growing organically over the last year and are supported by the Value team.

There are over 10 projects within different directorates such as Sentinel node Biopsy (Max Fax), Anaemia (Peri-operative Care), Micro shunt (Ophthalmology), Metro mapping the colorectal pathway (General surgery), UGI pathway analysis (General Surgery), PROMS (patient reported outcome measures) in Anaesthesia (Peri-operative Care) and Green Theatre (Grey theatre UHL). The Value projects involve work across the hospital departments and provide partnership working arrangements from Finance, Costings, Shaping change, IT, Procurement, Clinical staff, Welsh Value in Health centre, Patient Experience and the SCB team.

More in depth outcome analysis has been presented elsewhere but an example Value slide of TNO is shown below .

Value Based Healthcare | Project Summary Report

Project Name:	TNO service	**Date:**	Nov 2022
Project Team:	Berry,Al Hussaini, Hill, Dunstan	**Headline Outcomes:**	Evidence based Value benefit - £429,000 17.6 tonnes of waste recycled not landfilled

Background & Situation

Overreliance on GA – time delay, medical risk, hospital stay, triple bottom line
Time waste – Barium swallow
Secondary OPD – resource waste

Initiative

What is the change/ initiative planned

Changing patient pathway from theatre environment to OPD
Using technology
TNO – well tolerated – 5 min procedure

Methods, Measurement & Learning

Trans nasal oesphagoscopy in OPD
Streamlined service (Lean management)
Waiting times measured
OPD appointments measured
PROMS evaluation
Staff satisfaction
Doing the right thing at the right time

Expected Benefits / Benefits Realisation

Avoid the following: -
390 Endoscopies, currently undertaken within Theatre.
Freeing up 98 Theatre lists per year at a value of £166k.
510 Barium swallows, currently undertaken within Radiology, freeing up capacity at a value of £161k
850 Outpatient Follow Ups, freeing up capacity of £102k
Initial assessment of data –Start April 2023
17 patients – dysphagia – all discharged from OPD

Sustainable Value

Cost implications – Financial Value

Financial Costs
•The proposal requires an annual investment of £51k, to treat 750 patients per year.
•Consultant £26,449
•Nursing £4,451
•Outpatient Coordinator etc £5,400
•Decontamination £3,360
•Disposables/Local Anaesthetic £3,750
•Equipment Maintenance £8,000
•**Total Cost £51,411**
•Approval via CMG, with an estimated cost of c**£80k.**
•The £51k revenue assessment is recurrent.

Environmental & Social Value

Environmental Value
Minimum Equivalencies
11 cars driven for a year (126,000 miles driven)
Heating 6.4 homes for a year
Carbon sequestered by 843 tree seedlings grown for 10 years
17.6 tonnes of waste recycled instead of landfilled

Social Value
3 less visits to hospital;
1 less pre-assessment, 1 less investigation (panendoscopy +/- barium swallow), 1 less out-pt. f/up
Thus, 3 days less off work/interruption to life
Often a carer with the patient (so times this by 2)

Impact on health inequalities

Improves equity of access to diagnosis + treatment.
•Patients in low-income groups who are unable to access paid time off work, & frailer patients, may be less able to attend multiple visits. A one stop shop would appear to be far more accessible for ALL.
•There is also morbidity & stress associated with delayed/prolonged diagnosis + treatment pathways.

Scalability

- Project is scalable throughout NHS Wales
- Addition of other Consultants
- To include the cancer pathway

Equitable Care

POPS
PERIOPERATIVE CARE OF OLDER PEOPLE UNDERGOING SURGERY

The Surgery Clinical Board are very proud of the Perioperative Care of Older People (POPS) teams who are multidisciplinary team who see patient over the age of 65 with a frailty score of over 5 who are awaiting a planned general surgery

- Frailty assessments over 65 from POAC, Prehab to Rehab.
- Increased training and awareness for Post op delirium.
- Shared decision making -16% of patients not choosing surgery after a POPS review
- Currently working on a business case for sustained service.

A member of our PoPs team was a runner up in the 2023 **RCN Wales Nurse of the Year Awards - Health Care Support Worker Award**

Kelly Brown has worked as a Health Care Support Worker in the UHB for the past 17 years and is currently working as a memory link worker within surgery. Kelly was recognised for her outstanding commitment and achievements in this essential role supporting patients who are experiencing cognitive impairment or post-operative delirium. Kelly has ensured that cognitively impaired patients have received outstanding support and care during their admission.

Prehab2Rehab (P2R)

The Prehab2Rehab (P2R) programme is a UHB funded programme hosted by the SCB. It has a dual aim:

1. Maximising outcomes from planned (cancer) treatment ('MOT').
2. Providing a public health intervention, using the teachable moment of suspicion/diagnosis of cancer, to improve long term health and wellbeing.

P2R promotes early health and wellbeing intervention in the (cancer) pathway, creating maximum benefit for patients prior to treatment improving their treatment options, shortening recovery time immediately after treatment and enabling them to have a longer life; thus, delivering outcomes that matter to them.

Workstreams

1. Prevention/Promote

Primary care optimisation clinics have been developed, offering a medicine management review, lifestyle advice and screening for new comorbidities such as diabetes, anaemia and frailty. All people are signposted to Social Prescribing, Public Health Wales resources and the Keeping Me Well website to promote lifestyle change. The service capacity is ~1500+ people per year.

2. Optimisation - Preparation

Patients are offered medical optimisation (anaemia, diabetes, cardiology etc.) alongside exercise intervention, nutritional advice and emotional wellbeing support. The services expect to see 1500+ people per year.

3. Enhanced Recovery after Surgery /Rehab

Enhanced Recovery promotes the delivery of core evidence-based pre/peri/post-operative interventions and enables measurements of compliance for all major surgical patients.

4. Transformation and Benefits Realization

The sharing of data between primary and secondary care is enabling clinical effectiveness and outcome measurement.

What has been achieved this year

In 2023 we had:

- 26 clinics or group sessions/week
- 789 new patients at point of suspicion or at diagnosis/ pre-surgery
- 1225 attendances at our exercise classes by 229 pts
- 432 cardiology opinions in preparation for surgery
- 746 people prepared for surgery by pharmacy for anticoagulation, anaemia etc.
- 91% of our patients would recommend to their friends and family
- Recognition of Prehab2Rehab programme across the UHB, Wales and UK
- Regional Prehab2Rehab collaborative
- Formal Independent Evaluation underway with PHW

What do we know so far?

1. Smoking- higher-than-average attempt to quit rate compared to the Wales average
2. Medicines Management-Drug cost saving per person of £125
3. 'Comorbidity and Health Risk Burden'-Our population and patients have more disease burden than expected prior to the business case being developed. We have linked NHS numbers with primary care GP records to allow us to understand the chronic disease burden and lifestyle and hence risk of our patients at the start of the pathway.
4. Recovery Times in Hospital-Those who engage in prehab2rehab appear to benefit (2-day reduction in median LoS).

The Board / Committee are requested to: NOTE

NOTE assurance provided by the Surgery Clinical Board QSE assurance report and **AGREE** the mitigation being taken to improve quality, safety and experience and reduce harm by the Clinical Board

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	√

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Risk: **Yes/**No

As outlined in report
Safety: **Yes**/No
As outlined in report
Financial: **Yes**/No
There can be a financial impact connected with inadequate quality and safety standards as a result of legal claims. Improving standards can lead to an increase in expenditure whether for staffing or digital / equipment solutions. Financial penalties can also be imposed where required standards are not met.
Workforce: **Yes**/No
Yes as outlined in report
Legal: **Yes**/No
As outlined in report
Reputational: **Yes**/No
There is a reputational risk for the Clinical Board and the organisation when quality, safety and patient experience is not satisfactorily delivered
Socio Economic: Yes/**No**
Equality and Health: **Yes**/No
Yes, as outlined in report
Decarbonisation: Yes/**No**

Committee/Group/Exec	Date:

Report Title:	Medicines Safety Deep Dive				Agenda Item no.	2.2	
Meeting:	QSE		Public	x	Meeting Date:	13/02/2024	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Executive Medical Director						
Report Author (Title):	Medication Safety Officer						

Main Report
Background and current situation:

Improving medication safety is a key NHS priority, reflected in the World Health Organisation's Global Patient Safety Challenge Medication Without Harm, Welsh Government's long-term plan for Health and Social Care: A Healthier Wales, and the National Clinical Framework: A Learning Health and Care System. Moreover, these aims align with the strategic objectives of Cardiff and Vale University Health Board (CAVUHB) in the mission of caring for people and keeping them well, which includes avoidance of harm.

Medicines are the most common intervention in healthcare but errors in use can cause significant harm to the patient and their family (1). When things go wrong staff involved may be distressed and there may be legal and financial implications for the organisation. It is therefore important that CAVUHB continues to develop and maintain a culture of shared learning from both external recommendations from authorities such as the Medicines and Healthcare products Regulatory Agency (MHRA) and NHS Wales Delivery Unit, and from investigations of its own medicine safety incidents.

Safe

Learning from Incidents

The Once for Wales Concerns Management System (DatixCymru) is used across CAVUHB to report and manage incidents, including those that involve medicines. The purpose of collecting such data is to identify learning and implement improvement. Medicines related incidents are continuously reviewed and those of particular concern associated with high risk of harm, including never events, are prioritised for action. Emerging trends are investigated further.

Figure 1 shows that the majority of medicines related incidents reported during January – December 2023 resulted in no to low harm to the patient. This high level of no to low harm reporting is an indicator of a good safety culture across the organisation. Work continues to promote reporting of medicines related incidents, including near-misses, to further facilitate learning and improvement.

It must be noted that Figure 1 displays the level of harm as recorded by the reporter. This reported level of harm is subject to change following incident investigation. All incidents recorded by the reporter as being severe or catastrophic are discussed by the Medicines Safety Executive group in order to identify learning and determine actions for improvement. The majority of these incidents do not meet the criteria for severe harm as outlined in the Welsh Government's Levels of Harm Framework.

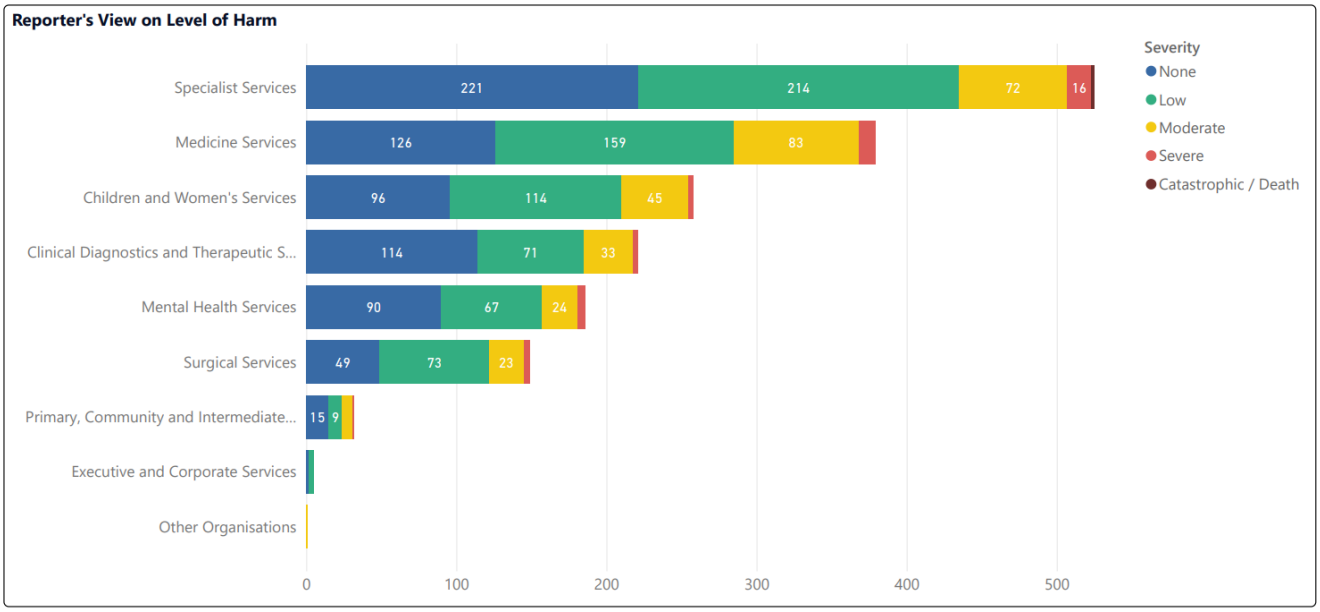


Figure 1. Reporters view of level of harm

As can be seen in Figure 2, the highest proportion of incidents reported during January – December 2023 occurred during the administration stage. The Medicines Management training package for nursing staff has recently been updated to include examples of incidents reported in order to raise awareness, aid learning and reduce the risk of further incidents.

Incident analysis highlighted that omitted medication (n=105) and delayed administration (n=91) were some of the most frequently reported types of administration errors. An audit undertaken by trainee pharmacists during August 2023 showed that 35% of medication charts had at least one inappropriately omitted dose. A UHB Task and Finish Group has been formed and is tasked with developing and communicating a strategy to support the timely management of adrenal crisis in adults and children (as per Patient Safety Notice PSN057). A further aim of this group is to promote the timely administration of all medicines, in particular those which are time critical. An audit tool has been developed and incorporated into the Tendable platform to monitor progress and provide assurance to the UHB in relation to omitted and delayed doses of medicines.

Suboptimal transition of care from one clinical area to another is known to increase the risk of medicines related incidents and has been show to increase the risk of adverse drug events and readmission after discharge. A UHB Task and Finish Group has been established to strengthen the discharge process and improve communication between healthcare sectors and with patients.

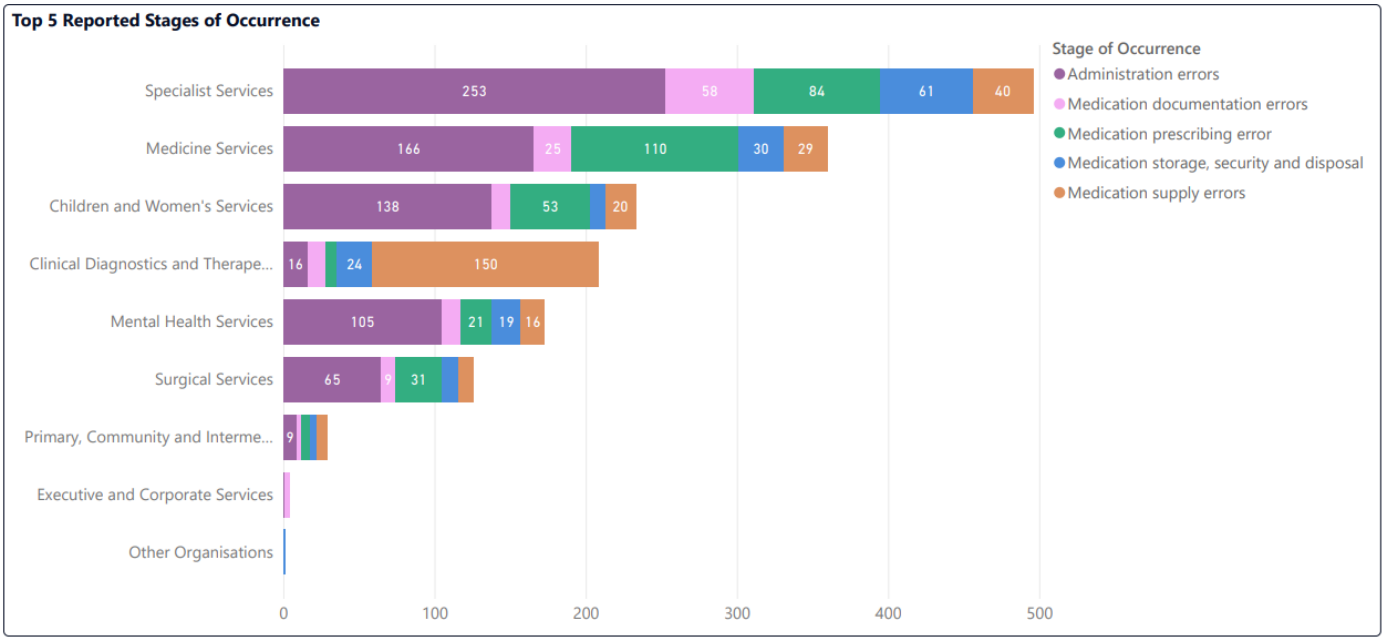


Figure 2. Top 5 Reported Stages of Occurrence

High risk medicines, including opiates, antimicrobials, anticoagulants, insulins and anxiolytics are known to have a heightened risk of causing significant patient harm. As can be seen in Figure 3 the Top 20 medicines reported in CAV during 2023 are reflective of this.

An example of action taken following further analysis of these incidents includes the issuing of the recommendation that a Bottle Adapter Compatible with ENFit Syringes should be used to draw up the required dose of CD oral liquid medicines, such as morphine and oxycodone, into an oral syringe. This action aims to reduce the risk of wrong route administration errors and unaccounted losses.

To support the safe use of insulin, including variable rate intravenous insulin infusions (VRIIIs) and the treatment of hypoglycaemia the following medication administration charts were introduced across the UHB in 2023:

- Blood glucose monitoring & treatment of hypoglycaemia
- Insulin administration record
- Variable rate intravenous insulin infusion chart.

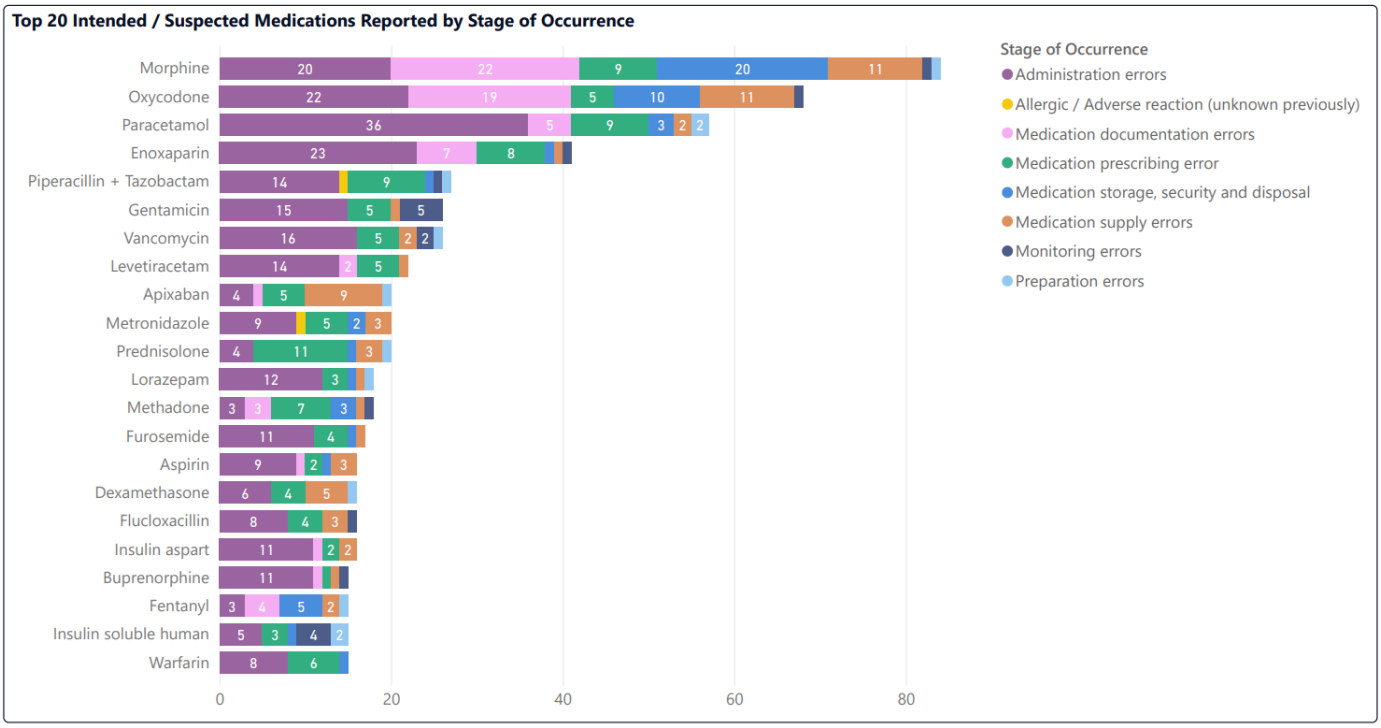


Figure 3. Top 20 Intended / Suspected Medications Reported by Stage of Occurrence

National Patient Safety Solutions

The Welsh Government leads this vital role in identifying any significant safety risks and concerns and develops Patient Safety Solutions at a national level for issue to the NHS in Wales. During 2023, two Patient Safety Alerts were issued by the NHS Wales Delivery Unit in relation to medicines.

1. PSA015: Safe use of oxygen cylinders in areas without medical gas pipeline systems. As per the PSA, actions were completed by the UHB's Medical Gas Committee.
2. PSA016: Potential risk of underdosing with calcium gluconate in severe hyperkalaemia. Actions outlined in the alert completed. Awaiting final ratification of the reviewed local guidance.

Implementation of new regulatory measures

Isotretinoin: In October 2023, the MHRA issued communication that new safety measures, including additional oversight of the initiation of treatment for patients under 18 years of age were to be introduced. The UHB are working to integrate these new measures into clinical practice when referring patients and when prescribing and dispensing isotretinoin.

Valproate medication: In 2018, the "Prevent" Pregnancy Prevention Programme was introduced in the UK [Drug Safety Update April 2018]. This programme sets out actions for each healthcare professional involved in the patient's care, aiming to minimise pregnancy exposure during treatment with valproate. In March 2021, a UHB Valproate Clinical Working group (CWG) was established to allow multiple clinical specialities, including neurology, paediatrics, mental health and primary care, to work through the complexities of prescribing and implementation of the Valproate Pregnancy Prevention Programme. The recommendations of the CWG were facilitated and implemented, including:

- Established a new model of care for patients of childbearing potential prescribed valproate with Specialist-led prescribing
- Established the need for a non-clinical co-ordinator role
- Established a database of UHB patients of childbearing potential that are prescribed valproate
- Audit Standard agreed by CWG

- Reviewed and agreed on the appropriate setting to prescribe valproate and made the necessary changes to the UHB formulary.
- Agreed a strengthened pathway for people, born female, prescribed valproate between the age of 13 and 55 years
- Established a framework for the Unlicensed use of Valproate in people of child-bearing potential
- Launched a designated UHB Valproate SharePoint page

Following completion of this work the group was disbanded in October 2023. In November 2023, the MHRA announced new regulatory measures for valproate. The CWG has therefore been reconvened to progress the additional actions as outlined in the National Patient Safety Alert (NatPSA/2023/013/MHRA) and support the embedding of previously agreed recommendations into clinical practice.

MHRA Drug Safety Updates
All Drug Safety Updates (DSUs) are reviewed. Additional local actions are carried out when required to ensure UHB compliance with the recommendations outlined in the DSU. Example:

Xaqua (metolazone) 5mg tablets: exercise caution when switching patients between metolazone preparations	Liaised with specialist teams and formulary colleagues. Information regarding the changes, including the need to prescribe by brand, were shared across the UHB in SBAR format, e-mail and via the Medicines Safety Executive Briefing. A plan was developed to enable referral of existing patients to specialist teams for review and safe/appropriate switching to the licensed preparation. A written leaflet for patients was produced with colleagues from the Welsh Medicines Advice Service. Digital systems e.g. WellSky, Inform, MTeD were updated to enable the appropriate metolazone brand to be selected.

A log of actions taken in response to the DSUs was created and further work is planned to strength assurance regarding this. Healthcare professionals are encouraged to sign up to receive direct communication from the MHRA regarding newly published DSUs. DSUs are circulated to relevant Clinical Board and Directorate Pharmacists for dissemination and are included in the Medicines Safety Executive Briefing which is shared with colleagues across the UHB. Work is underway to develop a robust process for recording actions and maintaining organisational memory of such alerts.

Communications to healthcare staff
Internal Safety Notices and Safety Memos communicate key safety information (both local and national) to healthcare staff and provide practical advice on risk reduction strategies. These notices and memos are shared with healthcare staff via the internal alerts process. They are also placed on the agendas of the Medicines Safety Executive and Clinical Board Quality, Safety and Experience meetings. During 2023 a number of these were published and shared across the UHB, including:

- Internal Safety Notice
  - Glass pre-filled syringes used in resuscitation: Bypass needle-free connectors
  - Shortage of Amiodarone 300mg/10mL Pre-filled Syringes: Use of amiodarone ampoules for injection may be required
  - Shortage of GlucaGen® 1mg HypoKit: Use of alternative glucagon product required
  - Fentanyl with Bupivacaine Bags: Use of alternative product required

- Safety Memo
    1. Carbomer Eye Gel: Potential risk of infection – precautionary measures required
    2. Calcium Gluconate 10%: Increased dose recommended for the treatment of hyperkalaemia
    3. Naseptin® Nasal Cream: Caution advised when prescribing, dispensing and administering
    4. Aurum® branded pre-filled syringes: Reports of possible defects which could affect use
    5. Combination fluids of glucose 5% and sodium chloride 0.45% containing different strengths of potassium chloride (0.3% or 0.15%) are available – check the label carefully.

A bimonthly Medication Safety Executive Briefing is published and disseminated widely across the UHB. The briefing highlights significant medication related incidents that have been reported and the recommended actions to mitigate risk. Also included in the briefing are summaries of recently published local and national resources including Internal Safety Notices, MHRA Drug Safety Updates, Patients Safety Alerts/Notices and other resources which support safe medication use.

Wider communication of important medicines safety issues is being strived for through the use of tools such as computer screensavers, posters and display screen graphics.

Adverse Drug Reaction (ADR) reporting
The Yellow Card Scheme is vital in helping the MHRA to monitor the safety of all medicines and medical devices in the UK. The Yellow Card Scheme relies on voluntary reports by Healthcare Professionals and members of the public, about suspected side effects to medicines.

The Yellow Card Centre (YCC) Wales is one of six regional adverse drug reaction (ADR) monitoring centres acting on behalf of the MHRA. YCC Wales is staffed by Pharmacy and Clinical Pharmacology colleagues based within CAVUHB. YCC Wales has a vital educational and communicating role to encourage suspected adverse reaction reporting via the Yellow Card Scheme to both patients and local health professionals in Wales. Staff at YCC Wales are available to give advice on Yellow Card reporting and offer education and training sessions about suspected ADRs to all health professionals and patient groups.

During 2023, YCC Wales co-ordinated a number of promotional events across Wales, including in CAVUHB. A total of 4024 reports of suspected ADRs to medicinal products originated from the YCC Wales region in 2022/23 (525 in CAV). This includes reports of suspected ADRs to COVID-19 vaccines submitted during July 2022- March 2023. The total number of reports represents an increase of 93% when compared with 2021/22 (2084) (146% increase in CAV). However, it is important to note that the 2021/22 reporting data did not include reports for COVID-19 vaccines. When COVID-19 vaccine reports from Q2 – Q4 are excluded from the 2022/23 reporting data, the total number of reports is 2839 (255 in CAV). This represents an increase of 36% (20% in CAV) when comparing non-COVID-19 vaccine reports from 2021/22 to 2022/23. In previous years, GPs were the highest reporting group, however, during 2022/23 the highest reporting group was members of the public.

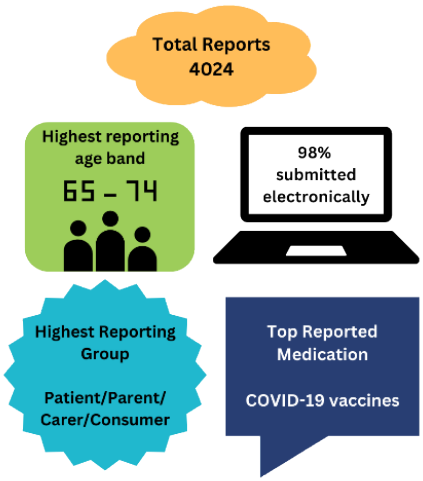


Figure 4. Reporting highlights from YCC Wales region 2022/23

Timely

Medication recalls/notifications are issued by the MHRA and/or Welsh Government. It is important that these are actioned appropriately within the required time frame (as stated in the

recall/notification). In 2023, a new pharmacy process and database was introduced to ensure timely communication and actioning of the recall/notification and to provide assurance and improved governance over the process. Since the introduction of the new process and database 14 recalls/notifications have been managed. 13 were actioned by the required deadline, the other narrowly missed the deadline.

Effective

Medicines Safety Executive Group

The Medicines Safety Executive (MSE) Group is a sub-group of the UHB's corporate Medicines Management Group. The purpose of the group is to:

- Identify risks in medicines use, and provide advice to UHB staff on how to minimise risk through information sharing and learning from medicines safety issues
- Guide and support quality improvement in clinical areas around medicines use
- Provide assurance on safe medicines use in the UHB.

The MSE Group is multi-disciplinary with representation from pharmacy, medicine, nursing and patient safety. The Associate Medical Director - Patient Safety and Governance and the Assistant Director for Quality and Safety are members of the group. Membership of the group includes representation from the Children and Women, Clinical Diagnostics and Therapeutics, Medicine, Mental Health, Primary, Community and Intermediate Care, Specialist Services and Surgery Clinical Boards. The group is currently chaired by a Consultant Clinical Pharmacologist.

In order to prompt discussions around medication safety a quarterly report is produced to inform the MSE membership of medicines related incidents occurring across the UHB and individual Clinical Boards. The report enables easier identification of incident themes and trends. It is a recommendation of the group that the report forms part of the agendas of Clinical Board Quality and Safety meetings.

NICE / HTW and AWMSG Guidance

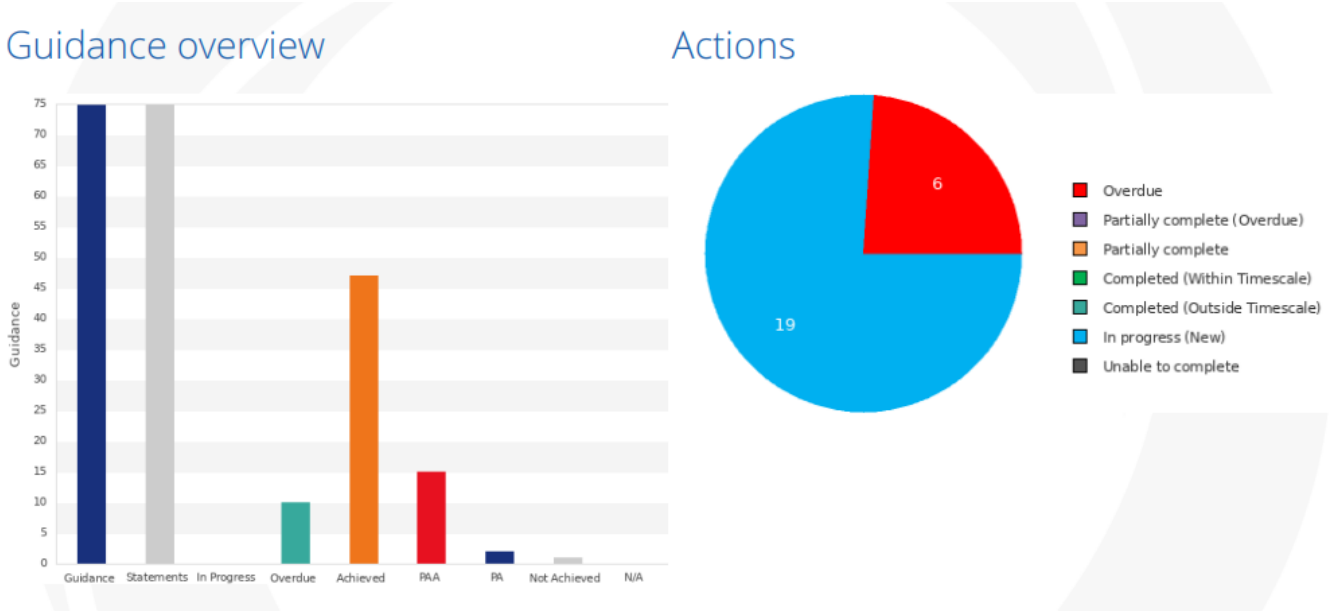


Figure 5. Consideration of AWMSG, HST and NICE TAs

Seventy-Five elements of All Wales Medicines Strategy Group guidelines (AWMSG), NICE Highly Specialised Technologies (HST) and NICE Technology Appraisals (TA) have been issued between January and December 2023. Sixty-two have been achieved in full or to an acceptable level, two have been partially achieved and ten pieces of guidance remain overdue on the audit system.

Where appropriate, audit of implementation and uptake is scheduled in AMaT to provide further oversight and assurance of implementation.

Penicillin Allergy De-labelling
Ten percent of people in the UK are thought to have a diagnosis of being allergic to penicillin. Research has shown that of these only 10 % have a true allergy label. This means that 9% of the population are carrying a diagnosis linked with increased treatment failure, increased hospital stays and increased risk of hospital acquired infection. An incorrect label therefore confers little benefit to the patient and potentially significant harm.

CAVUHB, through the Penicillin Allergy De-labelling (PADL) group, have developed an inpatient protocol to tackle this, the first in Wales. This protocol is currently going through the approval process for ratification by AWMSG to become an All Wales resource.

Procedure for the Managment of Staff Involved in Medication Errors
A revised procedure for the management of staff involved in medication errors has been introduced across the UHB. This procedure has been designed to support healthcare practitioners that have been involved in a medication error. The involvement in a medication error can often cause stress and anxiety for all individuals involved and this process should act as a guide to ensure the right support is provided. This procedure sets out actions to be taken by both the employee and employer to ensure that lessons are learnt from each clinical incident and that a proactive, open and fair approach with staff is adopted to encourage reporting of incidents within a framework that promotes professional development whilst protecting patient safety.

The Controlled Drugs Local Intelligence Network
Regional oversight of incidents associated with controlled drugs is governed through the Local Intelligence network (LIN). The LIN is facilitated by the UHB and chaired by the UHB Clinical Director of Pharmacy and Medicines Management and involves all local agencies that handle or are involved in controlled drugs, including South Wales Police.

The purpose of the group is to share learning and to act on preventable causes of adverse incidents and to provide assurance that incidents are reported and dealt with appropriately, including taking the necessary actions.

Efficient

Electronic Prescribing and Medicines Administration
In late 2024, the UHB will embark on a transformational change in implementing an electronic prescribing and medicines administration (ePMA) system. ePMA is a digital solution that allows medicines to be prescribed and administered digitally both throughout a patient's inpatient stay, from admission to discharge, and across outpatient and day-case settings. Medications prescribed digitally are clear and legible, reducing the risk of medicines administration errors.

The clinical decision support provided by ePMA helps to guide prescribing users to safely prescribe medication for their patient, informing them of any issues with allergies, duplication, interactions and provides dosing calculators for complex medicines. The system will also help users to prescribe consistently and according to local and national guidelines with order sets or protocols.

Unlike paper-charts, there is no expiry, and therefore prescribed medicines do not need to be re-written, releasing a significant amount of time for doctors to care for patients and helping to reduce the risk of transcription errors. In addition, ePMA provides a wealth of data regarding all aspects of medicines management. This has the potential to drastically increase our understanding of current practice and provide a wealth of improvement opportunities.

High Cost drugs

The UHB is planning to implement a high cost drugs monitoring system which will result in faster access to high cost drugs for patients and will ensure that medicines are prescribed in accordance with health technology appraisals guidance issued by the AWMSG and NICE. Blueteq is a web-based software system that is designed to enhance financial governance of high-cost medicines and assure compliance with national clinical guidance from the National Institute for Health and Care Excellence (NICE) and the All Wales Medicines Strategy Group (AWMSG). The system will provide fast approval for patient access to treatment, and detailed specific data will benefit audits and planning. The clinical data available in Blueteq HCD will help inform on service requirements in forecasting, planning and implementation activity for new medicines approved by NICE and AWMSG.

Equitable

Community Pharmacy Enhanced Service

The UHB have 102 independent contractor NHS contracted community pharmacies within the 9 primary care clusters, these sites enable access to pharmaceutical services and accessible healthcare in our local communities.

Community pharmacies are not required to hold a list of registered patients and are able to provide services to anyone who is resident in Wales or visiting from other parts of the UK. The community pharmacy sites in CAVUHB dispense around 1 million items per month in addition to the clinical services described below.

All our community pharmacies provide professional, non-judgemental and equitable access to a range of pharmaceutical services for the local population. As part of the routine Health board contract monitoring processes and community pharmacy team workstream we ensure all pharmacies are compliant with the Equality Act 2010.

In addition to the core NHS contractual essential services such as dispensing, 98% of CAVUHB pharmacies provide the Welsh Government nationally directed clinical service, the Community Pharmacy Clinical Service (CCPS), which requires them to provide **all** of the following services during their contracted hours:

- Common Ailment Service, this provides treatment and advice for 26 common conditions.
- Emergency Medicine Service, this provides access to those who have an immediate need for their regular medication, if they are unable to obtain a prescription without undue delay and cannot wait until their next prescription is due.
- Contraception Service, this provides confidential access to emergency contraception, short term Bridging QuickStart contraception and sexual health advice
- Flu vaccination Service, this provides eligible patients who are at risk of developing more serious complications from the virus access to a flu vaccination in their local area.

Other clinical services available from our community pharmacies include the Discharge Medicine Review (DMR) service, this service supports patients with their medicines on discharge from hospital and is provided in 100 of our 102 pharmacies. The Pharmacy Independent Prescribing service (PIP) allows our population to see a pharmacist independent prescriber for conditions such as ear infections, sore throats, UTIs and for oral contraception. We currently have 36 sites in CAVUHB that are listed as PIP sites and have a prescribing independent pharmacist on site. They will assess the patient within the community pharmacy, and prescribe the necessary medication, without the need to make an appointment with a GP.

Additionally, CAVUHB commission a number of local additional clinical services to support the population of CAVUHB such as Sore Throat Test and Treat Service, Urgent Medicine Service, Waste reduction service, Help me quit @Pharmacy L2 &L3 (Smoking cessation), Substance misuse supervision service, Needles syringe provision and Blood Borne virus testing service.

Person-centred

The work that is undertaken in relation to medication safety is centred around keeping patients, and those who come into contact with our services, safe.

The voice of patients and members of the public is important to ensure that services are developed in a way that is appropriate for them. As part of the work relating to the introduction of the new Valproate medication safety measures, a patient representative has been invited to join the Clinical Working Group.

Staff from the Yellow Card Centre Wales regularly engage with the All Wales Therapeutics and Toxicology Centre's Patient and Public Interest Group to raise awareness of the Yellow Card scheme and encourage reporting of suspected adverse drug reactions (ADRs).

References

1. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE Guideline 5. 04/03/2015. accessed online 01/02/24 available from: Introduction | Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes | Guidance | NICE

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

- Patient safety incident reporting is suggestive of a good reporting culture with the majority of incidents resulting in no or low harm.
- Administration of medication remains the highest reported category of patient safety incidents with omitted doses being a sub theme. The Tendable ward audit system is being used to provide inspection and audit administration of medications
- The UHB has overseen the implementation of actions to comply with two medication associate National Patient Safety Alert. Compliance was declared with PSA015: Safe use of oxygen cylinders in areas without medical gas pipeline systems. The UHB will be compliant with PSA016: Potential risk of underdosing with calcium gluconate in severe hyperkalaemia, once the final ratification of the reviewed local guidance is complete.
- The internal alert process is used to communicate key safety issues with UHB staff and to mitigate risk.
- In 2023, a new pharmacy process and database was introduced to ensure timely communication and actioning of recalls/notification and to provide assurance and improved governance over the process.
- The UHB has considered 75 elements of pharmacy related guidance in 2023
- A revised procedure for the management of staff involved in medication errors has been introduced across the UHB
- Local oversight of incidents associated with controlled drugs is governed through the Local Intelligence network (LIN). The LIN is facilitated by the UHB and chaired by the UHB Clinical Director of Pharmacy and Medicines Management
- The UHB is planning to implement a high cost drugs monitoring system which will result in faster access for patients and ensure that medicines are prescribed in accordance with national guidelines.
- In late 2024, the UHB will embark on a transformational change in implementing an electronic prescribing and medicines administration (ePMA) system.

Recommendation:

The Committee are asked to **NOTE** the assurance provided by work underway to oversee medicines safety.

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

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

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

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

Staff Engagement and involvement

They must be clear about the nature and importance of risk and how harm occurs,
the concepts of patient safety science, the ways in which we review and investigate unsafe care and concerns and the actions necessary to ensure that care is high quality and as safe as possible

Safety Culture

Building a strong patient safety culture where staff are supported to raise concerns, families and clinicians are treated fairly and incidents of unsafe care are investigated consistently, with a focus on systems rather than individuals

Objective	Action	Progress
Support Health Board learning of wide reaching themes	Development of Clinical Board Quality collaborative	Commenced in Medicine Clinical Board in August with a plan to expand into other Clinical Boards Brings together corporate quality functions including QSE IP&C corporate nursing etc to support identification of priorities and development of QI work
To increase awareness of patient safety and quality • To embed the necessary expertise to identify and effectively manage incidents and drive improvements into the clinical boards	development of quality and Patient Safety news Letter – The Safety Net	Revised news letter being published in January 2024 Contributions from across the UHB and corporately
Engage staff from across the organisation in improving quality and patient safety	Promotion of quality projects	Quality projects aligned to clinical Board quality priorities will be delivered
Develop the best possible safety learning networks across the organisation and Wales	All wales Patient Safety Facilitator Forum	Co-ordinated and chaired by the patient safety team. This forum brings together patient safety facilitators form across Wales to share learning
Increase engagement with the ward and clinical staff	Development of the Patient Safety Champion network	Scope patient safety champion role and develop a Clinical Board framework to support the implementation of the network

Patient Safety learning Improvement and Communication

embed learning through creativity and innovation across the Health Board focusing upon identified themes from a range of different QSE sources and focus on systems and human factors and not individuals

Leadership and Prioritisation

The World Health Organisation13 recognises that 'Developing and sustaining a strong patient safety-oriented culture requires strong leadership at all levels. There is a need for a new generation of patient safety leaders who are skilled and passionate to create the conditions and organizational and team cultures to ensure that all systems and procedures comply with the highest standards and to

Objective	Action	Progress
Standardise the approach to Patient Safety Investigations • To Improve the quality of patient safety reviews • To move from silo to organisational wide learning	Delivery of the Patient Safety learning review Tool with an associated hybrid training programme	Delivered to mental health Clinical Board and evaluated. Monthly training session running from January 2024
Deliver alternative and flexile approaches to Patient safety investigations that supports psychological safety	Explore the implementation of After Action Reviews with health board training Delivery of thematic reviews	Link with UCH to scope delivery Training from Acadami Wales / NHS Quest
Deliver meaningful approaches to quality assurance that supports learning and improvements	Agored Cymru accreditation achieved for clinical audit training	Offer training progress a project aligned to a Clinical Board quality priority. Projects to be sponsored by Clinical Board triumvirates and outcomes to be presented through Clinical Board quality forum
Establish simulation and human factors based learning from thematic analysis	UHB Human Factors programme under development	Licence for TeamSTEPPS – US agency for healthcare research and quality and further work to explore simulation based training

Data and Insight

capture and analyse different data sources to identify themes and trends of patient safety incidents to impart learning and undertake improvement activities

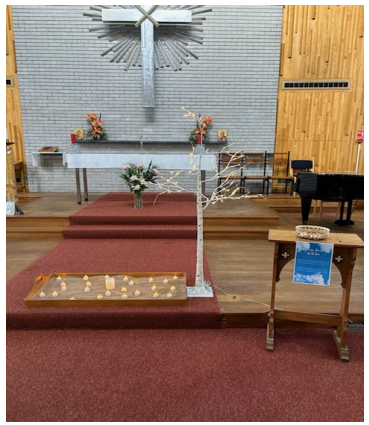
Objective	Action	Progress
To become a data driven organisation	Data analyst post developed with a clear function to support all parts of the quality and patient safety team	• Appoint in the new financial year • Consider feasibility of developing a digital quality lead
To Support learning from Mortality	Delivery of ME service Use of Power Bi to support improved data analysis and bench marking ability	• Medical Examiner reviewing 100% of inpatient mortality • Medical Examiner Dashboard • Embedded use of Tier 1 and 2 mortality indicators • Data driven Learning from mortality group
Datix Cymru	Development of UHB functionality of Datix Cymru and leading on areas of national work. Analysis form patient safety incident information	• Development of the Mortality Module • Implementation of alerts module Implementation of YellowFin Explore use of Power BI as a analytical model
Quality Assurance and Clinical Effectiveness	UHB implementation of AMaT quality management system	• In use across the entire UHB • Development of clinical audit forward plans • QI projects registered and progressed • Action planning for HIW and NRIS • Development of an alert module

Quality Governance

Implementation of a quality management system to support quality and improvement in all our services

Implement a revised clinical Board QSE assurance reporting template	Delivery of the Clinical Safety group to bring a cohesive approach to delivering quality in partnership with Clinical Boards and the Clinical Advisory groups	• Established group • Clinical Board assurance template • Clinical advisory group assurance template • Informed quality focus • Delivery of a quality management system
Oversight of Clinical effectiveness	Deliver a Clinical Effectiveness Committee with full engagement of Clinical Boards	• Themed CEC meetings with engagement from Clinical Board directors and Directors of Nursing • Oversight of all national audits • To expand to support implementation of NICE and HTW guidance

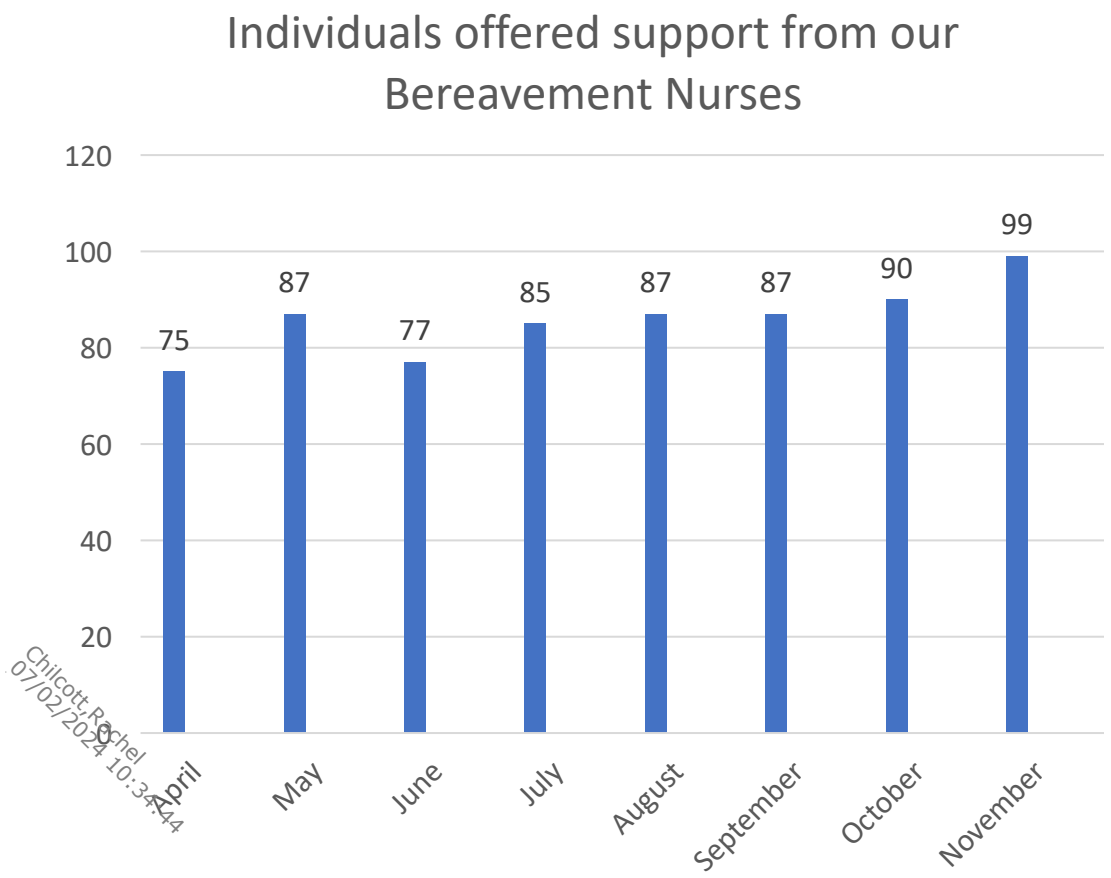
Adran y Gaplaniaeth a Gofal Ysbrydol
Department of Chaplaincy & Spiritual Care



- **Safety Culture:** Continuous support of staff and working closely with the Wellbeing team in offering support.
- **Leadership & prioritisation:** Regular meetings with Patient Experience management to adapt and promote programs.
- **Patient Safety learning Improvement and Communication:** Undertake staff training and awareness of spiritual and religious needs of patients and staff.
- **Data and Insight:** To continually asses the needs of the health boards stakeholders and monitor spiritual/religious needs via statistics. Between 30th November 2022 and 30th November 2023 the chaplaincy department have made **5,824** Patient visits, **6,798** Staff support conversations, undertaken **498** Services and led **1,659** Sacramental services (such as communions/Masses)
- **Quality Governance:** Continually monitor the care we give and asses the quality by regular meetings and feedback assessment
- **Additionally:** Making efforts to attend various MDT's and debrief sessions.

Bereavement Support Service
Patient Experience

Cardiff & Vale University Health Board
Bereavement Services
Gwasanaethau Profedigaeth
Bwrdd Iechyd Prifysgol Caerdydd A'r Fro



- Established a Bereavement Framework Steering Group for representatives from the Health Board to contribute and initiate change within each Clinical Board.
- Creation of a Bereavement Support Provider Forum whereby local and national bereavement support providers can engage and collaborate with one another.
- Supported staff within the Health Board via increased Occupational Health referrals and offering support following a Death in Service.
- Increased awareness of the service via training sessions, bereavement information boards, business cards, and development of a departmental logo.

Voluntary Services

Implementing a “What Matters to you” Campaign

Measuring What Matters

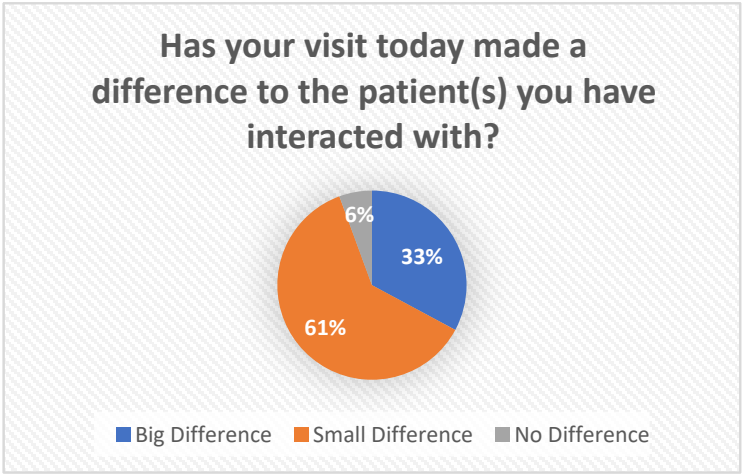
- Our evaluation question: **Do volunteers enhance the patient experience?**
- We ask volunteers for regular feedback: ***Has your visit today made a difference to the patient(s) you have interacted with?*** *(please see pie chart for overview)*
- Feedback

A selection of answers from volunteers to the follow up question: How do you know you did or didn't make a difference?

“Patients said that the activities helped to reduce his stress.”

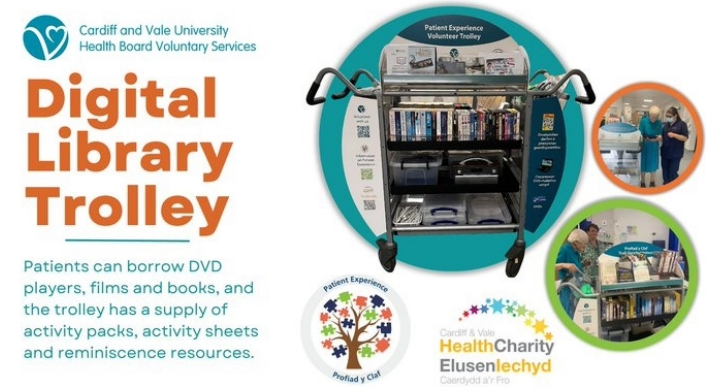
“Said they were thankful for our time and one said it made them feel normal again.”

“I saw changes in the patient's behaviour and their communication improved.”



Project Highlights 2023

- Pharmacy Project
  - 100 students in total visiting a selection of wards at UHL, UHW and SDH. They undertake surveys and befriending. They contribute around 192 hours a month with patients.
- Mental Health Volunteer Placement Scheme
  - 84 Volunteers were recruited, trained and placed this year to support our patients' mental wellbeing across 18 wards. (Last year this was 48 volunteers across 11 wards). Each month these volunteers will give 584 hours volunteering.
- Holistic Therapy Students
  - 6 Students from Cardiff & Vale College have started visiting patients in Haematology.
- Creative Volunteers
  - We created an Art & Craft role and Music role for volunteers to share their interests with patients. Currently there are 5 active across UHW and UHL and 11 more in recruitment. We also have 8 USW Creative therapeutic Students doing their placement with us.
- Digital Library Trolley
  - The trolley was piloted at Lakeside 1 & 2, and now also visits 3 wards in the main hospital. The trolley has DVD players, films and radios to lend to patients, as well as activity packs, books and spirituality items. We hope to bring this to UHL soon.



Unpaid Carers Information Service

'What matters to you?'

Unpaid Carers have told us they want to know what services are available to them and what they are entitled to. This year, in addition to providing information support to unpaid carers, we have focused on upskilling our work force through initiatives such as John's Campaign and the GP Carers Accreditation scheme.

As part of the GP Carers Accreditation Scheme surgeries, across Cardiff and the Vale are asked to nominate a Carers Champion who work with us to help the surgery identify and raise awareness of unpaid carers and signpost them to Services in the community that can support them.

During Covid the scheme was placed on hold. Since the relaunch **6** GP Surgeries have achieved their bronze level Carers Accreditation, with another **11** are working towards the award.

Since April 2023 we have supported **283** unpaid carers with information and advice via our Information Centres, phone, email and at community events.

John's Campaign advocates the rights of people with dementia in hospital to have their carers with them at any time. As a Health Board we have committed to adopt the principles of John's Campaign these include; Early identification of unpaid carers, Ensuring unpaid carers have a voice, and are informed and communicated with, and ensuring that unpaid carers are always made to feel welcome on the wards and where possible supporting them to continue their caring role, if they wish.

To date **7** wards are involved in the campaign, with another **3** in the initial stages of engagement, and we have provided training at **5** ward away days.

Information and Support Centres

Providing accessible information helping reduce health inequalities and in line with 'what matters to you?' campaign

- The teams across all three centres have supported **1,426** patients, visitors and staff with enquires and information and provided **22,767** patients and visitors with directions to get to their destination.

- The Information and Support Centre Manager has processed **43** successful Macmillan grant applications. In total **£14,800** worth of grants have been awarded to patients in need.

- The Centres have been used by other teams to provide a number of awareness raising sessions, including Bowel Cancer Awareness, Pancreatic Cancer Awareness, Carers Rights Day, Stop Smoking Clinics and a falls awareness crime scene in Patient Safety Week.

- The Information and Support Centre Manager, along with volunteers held a Macmillan Coffee Morning and raised **£200** for charity.

Butetown Multi-Cultural Link Workers

Effectively contribute to reducing Health Inequalities

The Link Workers have been supporting Immunisations Team with school Immunisation Information sessions. To date members of the team have attended **4** sessions so far with another **2** planned.

"I just wanted to give a huge thanks to the Multicultural team and Farida and Halima for supporting the recent support session at Grangetown primary. It was a success- 9 further consents were submitted for pupils to receive the nasal flu spray at this school. This is fantastic. We really do appreciate your help." *Feedback from School Nursing after 1st session*

"The aim of the pilot is to prevent childhood obesity through a system-based approach and to help bridge the gap between community and health. The Multi-Cultural Link workers have supported the pilot programme from the early stages by providing guidance on engaging with the different communities in the pilot area and sharing contacts for key local 3rd sector organisations." *Pipyn Programme Dietician*

The team continue to support PHW Dieticians link in with communities in regards to the Pipyn Programme. This is a pilot programme across 3 areas in Wales, funded through Public Health Wales in which Cardiff is a pilot area. The pilot in Cardiff is delivered by CAV UHB Public Health Dietitians and focusses on supporting families from a minority ethnic community, with children aged 3-7 years, living in South Cardiff.

Due to the measles outbreak in Cardiff the team have been supporting the local Public Health Wales Team understand the cultural barriers for parents in relation to the MMR vaccination and other childhood immunisations. In addition they have been supporting within their communities to disseminate information and dispel myths in relation to childhood vaccinations.

"Thank you so much for your time this morning, your insights were really helpful in my thinking about how we best communicate with the population that we need to reach with the messages around measles and MMR vaccine." *Principal Public Health Practitioner*

Civica 'Once for Wales' feedback platform

In October 2022, we implemented the Civica 'Once for Wales' feedback platform, which is an initiative currently being implemented across all Welsh Health Boards. We use the platform to run/process the bulk of our surveys, including routine and bespoke, which can be distributed through the platform via SMS, QR code, URL and App. The platform also provides other services, which we will be looking into next year e.g. IVR, postal, email.

Since going live on 28th October 2022:

- We have sent **128,508** SMS for our routine survey, seeing an overall response of **18**%. Currently, we send up to **1000** SMS daily and this includes:
  - Up to 600 patients randomly selected from PMS activity (inpatient, day case and outpatient).
  - Up to 200 patients attending the Emergency Department (UHW and Barry hospital). The routine surveying of the EU via SMS started in July '23.
  - Up to 200 Mental Health patients (inpatient, day case and outpatient) The routine surveying of Mental Health via SMS started in November '23.

- Currently we're running 20+ bespoke projects, both patient and staff, through the platform including: All Wales Palliative Care survey, Nosocomial survey, WAI survey, Pleural Team survey, POAC survey, RDC survey, to name a few.

- We've also introduced, earlier this year, the Bedside survey which enables patients to leave feedback whilst attending. Patients can access a survey via QR code or by telephoning the department. The QR code/contact details are found on posters and stickers placed in ward/outpatient areas and at the patient's bedside.

Plans for early next year:

- Currently our routine survey is available in English, Welsh, BSL/English and BSL/Welsh. And in a further 7 languages. This is planned for a January release.

- It is also hoped that early in the new year, we'll be able to distribute a number of kiosks in different areas around the UHB, to gather patient/visitors and staff feedback.

Since March 2023….

- The Digital Stories Network has grown to 94 members with the last meeting held on 5th December 2023 with representatives from all health boards, WAST, PHW, Welsh Blood and EMRTS
- Digital Story Toolkit for Wales was launched in September 2023 and is hosted on the NHS Executive Website
- 56 enquiries from staff about completing a Digital Story
- 27 Digital Stories have been completed since March 2023
- 70 Digital Stories have been completed in total since Sept 2021
- Total views of stories 3,171
- Number of videos (not Digital Stories) completed 46
- Shared skills and knowledge around Digital Stories with Neath Port Talbot Council and presented at SBUHB stakeholder group
- Prepared 2 Digital Stories in November 2023 about the Preparewell Program to be shown at WG visit on 1st December 2023
- 2 remembrance services recorded for families who have lost children and neonatal babies

Concerns

- Launched the Concerns survey to invite feedback from all our complainants following a formal response
- Introduced a dedicated acknowledgement team to personally contact complainants to ensure a person centred approach
- Successfully implemented Duty of Candour
- Received substantial assurance following Welsh Risk Pool assessment

Cardiff & Vale University Health Board		
Management of Concerns (Incidents)	REASONABLE ASSURANCE	
Management of Concerns (Complaints & Enquiries)	SUBSTANTIAL ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

Report Title:	Cardiff and Vale Health Protection Plan			Agenda Item no.	3.1
Meeting:	Quality, Safety and Experience Committee	Public	X	Meeting Date:	13th February 2024
		Private			
Status *(please tick one only):*	Assurance		Approval	✔	Information
Lead Executive:	Executive Director of Public Health				
Report Author (Title):	Consultant in Public Health Medicine				

Main Report
Background and current situation:

Regional partner organisations have always worked together to control and mitigate communicable disease risk. However, the response to the COVID-19 pandemic saw unprecedented levels of joint working both regionally and nationally, with new services set up to offer testing for COVID-19, contact tracing and mass vaccination.

In moving forward from the pandemic response, there has been an ambitious national ask that we drive forward reductions in incidence, improvements in detection and early intervention across multiple arenas of infectious disease. There is a desire to use learning from the pandemic to strengthen the national and regional health protections systems; 2023/24 is seen as a transition year for an integrated and sustainable model to be established.

Welsh Government (WG) has developed the following national principles to be adopted by regions in establishing local health protection and multi-disciplinary teams:

- Funding is provided *[by WG]* to support local health protection multi-disciplinary teams on a health board footprint, with health boards and local government working in partnership, to respond to health protection measures and threats
- An 'all-hazards' approach to health protection to be supported by all partner agencies, recognising there will be peaks of activity through the year according to national and regional demand
- Use learning from the pandemic to build agile teams that work well together nationally and locally to respond to current and future threats
- Teams will have a mix of skills and experience to:
  - Respond to Covid waves within a Covid Stable environment and deliver on the national approach for respiratory viruses
  - Have plans in place to scale up in the event of Covid urgent/future pandemic scenario, within the context of a national framework
  - Respond to outbreaks and wider threats using agreed processes in the Communicable Disease Outbreak Control Plan for Wales
  - Deliver on the National Immunisation Framework for Wales, ensuring high take up and equity of access
  - Undertake wider health protection work delivering a local approach under national frameworks and guidance e.g. to support those seeking refuge in Wales, support messaging in schools, provide support to care homes, work on TB and Hepatitis elimination etc
  - Work together locally and nationally to support and deliver work to address equity of access and opportunity

Cardiff and Vale Health Protection partnership is a complex and developing system, within which partners deliver statutory roles and functions, and where many operating practices are already well established and proven to be effective; we have agreed to focus on infectious disease in the first instance. As a Region, we have developed a Health Protection Plan (appendix) which describes how we intend to build on those existing relationships and use our experience of the pandemic response, to strengthen the regional system in line with the national principles. As partner organisations, we intend to add value by functioning in an even more integrated way to improve population health

outcomes and deliver measurable impact with regard to preventing and early detection of infectious diseases. The Health Protection Partnership will operate in line with the Public Health Respiratory Framework 2023 to 2024, updated on 2nd October 2023, which sets out the national response to COVID-19 and other respiratory viruses for Winter 2023/24, as well as the Communicable Disease Outbreak Plan for Wales.

A separate business case detailing how Welsh Government health protection partnership grant funding is proposed to be used within the Region to support a range of functions and improvement work in 2024-25, for example testing across multiple hazards; pan system immunisation services in line with the national Immunisation framework; inclusion health; additional work on Hepatitis B and C prevention; focused action on HIV and other arenas. This is being taken through the UHB Investment Group process, and is distinct from the overarching strategic intent, system work and headline anticipated actions in this Plan.

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

Regional partners are developing more integrated approaches to health protection, which build upon the statutory duties of individual organisations, and add value to the 'all hazards' response required for better health protection outcomes in our population. The University Health Board (UHB) is a key contributor to this partnership, and is responsible for provision of important functions of preventative and early intervention including immunisation, sampling, diagnosis and treatment services. Service response within the UHB is developing and evolving to support priority areas identified at a national and regional level, including HIV, Hepatitis B and C, and TB, as well as acute incident response. Ongoing contribution to the partnership approach is essential to preventing, mitigating and managing the risk from infectious disease, tackling health inequities, and preparing for future infectious disease emergency/pandemic scenarios.

Recommendation:

Quality, Safety and Experience Committee is requested to:

- **APPROVE** the contents of the Cardiff and Vale Health Protection Plan
- **ACTIVELY SUPPORT** actions to drive further service development and integration within the UHB and across the partnership

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
The Health Protection Plan identifies how regional partners will work together to prevent, mitigate and manage the risk posed by infectious disease to the people who live in, work in and visit Cardiff and the Vale of Glamorgan
Safety: Yes/No
Elements of patient safety are addressed in the plan, particularly in relation to infection prevention and control activities in health and social care settings
Financial: Yes/No
A separate business case has been submitted detailing how WG funding is being used across the partnership to support his agenda
Workforce: Yes/No
A number of UHB teams contribute to this approach, some of which are funded using the Health Protection funding from WG. The details are again considered in the business case
Legal: Yes/No
No specific legal risks identified
Reputational: Yes/No
There are reputational risks should the UHB not participate fully in delivering the Plan and the integrated partnership approach.
Socio Economic: Yes/No
The Plan (and approach) specifically identifies people who experience disadvantage because they are at higher risk of infectious disease, and identifies action to mitigate and prevent this increased risk.
Equality and Health: Yes/No
The integrated health protection system outlined in this partnership plan will have a direct impact on improving population health by reducing the risks posed by infectious disease. It also specifically targets inequities related to the occurrence of infectious disease experienced by some individuals, groups and settings. No formal EQIA has been conducted.
Decarbonisation: Yes/No

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

Chilcott Rachel
07/02/2024 10:34:44

Cardiff and Vale Health Protection Plan 2023/24

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1. INTRODUCTION TO THE CARDIFF AND VALE HEALTH PROTECTION PLAN

This Cardiff and Vale Health Protection Plan has been developed by local partner organisations to describe how they work together to prevent and mitigate risk from communicable disease. Whilst partner organisations have always worked together to control and mitigate communicable disease risk, the response to the COVID-19 pandemic saw unprecedented levels of joint working and much has been learned as a result. This Plan builds upon that learning and outlines a sustainable model for Regional working to take us in to the future.

Cardiff and Vale Health Protection partnership is a complex and developing system, within which some partners deliver statutory roles and functions, and where many operating practices are already well established and proven to be effective. This plan describes how we intend to build on those existing relationships and use our experience of the pandemic response, to strengthen the regional system and add value by functioning in an even more integrated way and improve population health outcomes. As a partnership, we have agreed that our initial focus will be to develop a sustainable model for communicable disease control, whilst recognising the links with environmental hazards and Civil Contingencies through existing arrangements.

There is a range of added value work in this plan which is supported through current funding arrangements. However, the model is built upon the principles and relationships that exist within the region, and which will continue to influence service delivery and further strengthen the important work that each partner is achieving; this can only strengthen existing relationships and resilience.

1.1 Background

Welsh Government's transition plan, Together for a Safer Future: Wales' long-term COVID-19 transition from pandemic to endemic was published in March 2022. It set out the principles of the continued response to COVID-19 and other respiratory infections. Under this plan, Health Boards were required to implement a public health approach to respiratory viruses, including COVID-19, protecting the most vulnerable in our society from serious disease, focusing on:

- Protecting the vulnerable by enabling access to vaccination & treatment.
- Maintaining capacity to respond to localised outbreaks and in high-risk settings.
- Retaining effective surveillance systems to identify any deterioration in the situation.
- Preparing for the possible resurgence of COVID-19 and increases in other respiratory viruses.
- Have robust plans around, for example, BBV elimination targets, increase prevention, proactively screen & manage TB, including in international students and testing and management of HIV

In December 2022, WG set out an ambition for 2023/4 to be a transition year, where the services and structures put in place by regional partners to manage the pandemic are scaled back, and that we build on the experience of the pandemic response to establish a more resilient system for managing 'all-hazard' health protection risks. For testing and tracing, funding for this financial year is seen as providing a platform upon which to develop and build an integrated health protection team approach across the region. For vaccination, arrangements are expected to be integrated towards business-as-usual arrangements for Covid alongside routine programmes such as influenza and childhood vaccination, and the vaccination response to other health protection threats. Both programmes were expected to plan based on 'Covid stable', but be prepared to scale up in the event of 'Covid urgent' or further health protection threats. National core principles to inform this work were shared in February 2023, and these have informed the development of this plan. Welsh Government has also committed to co-producing a National Framework for Health Protection in year to maximise consistency across Wales, which will take account of the Report of the Independent Review of the Health Protection System in Wales and the accompanying implementation plan, both of which were published on 7 February 2023. Welsh Government will with partners deliver on the recommendations, including equity, and develop a sustainable funding approach from April 2024. Furthermore, confirmation has also been received that Public Health Wales (PHW) will continue to assess risks and threats, provide guidance and develop training materials and support for health protection teams across Wales, and PHW health protection will continue to provide the acute health protection response through All Wales Acute Response (AWARe) duty team in conjunction with Environmental Health Officers in local authorities. Standard Operation Procedures (SOPs) will support interplay between the national team, AWARe and regions. Welsh Government will also continue to fund a national surge team to assist PHW AWARe team, and use 2023/24 to evaluate and determine the best model of this team going forward.

1.2 Partner organisations and teams contributing to the C&V Health Protection Partnership

The systems approach to health protection in the Cardiff and Vale Region will be delivered in partnership between a range of statutory organisations including Cardiff and Vale University Health Board (UHB), Cardiff Council (CC), Vale of Glamorgan Council (VoGC), Shared Regulatory Services1 (SRS) and Public Health Wales (PHW). The system is more extensive than this however, and includes all organisations teams and services that play a role in preventing and managing the risks posed by communicable disease and environmental hazards, such as third sector organisations (appendix 1).The partnership will need to be supported by a number of enabling functions within contributing organisations (box 1) and form links with relevant national partner organisations (box 2).

Box 1: Enabling Functions within contributing organisations

- Digital services – and Digital Health Care Wales (DHCW)
- Organisational Information Governance Leads
- Procurement services
- Waste management services
- Estates Services

Box 2: National Partners

- Welsh Government
- UK Government Home Office
- UK Health Security Agency (UKHSA)
- Care Inspectorate Wales (CIW)
- Food Standards Agency Wales

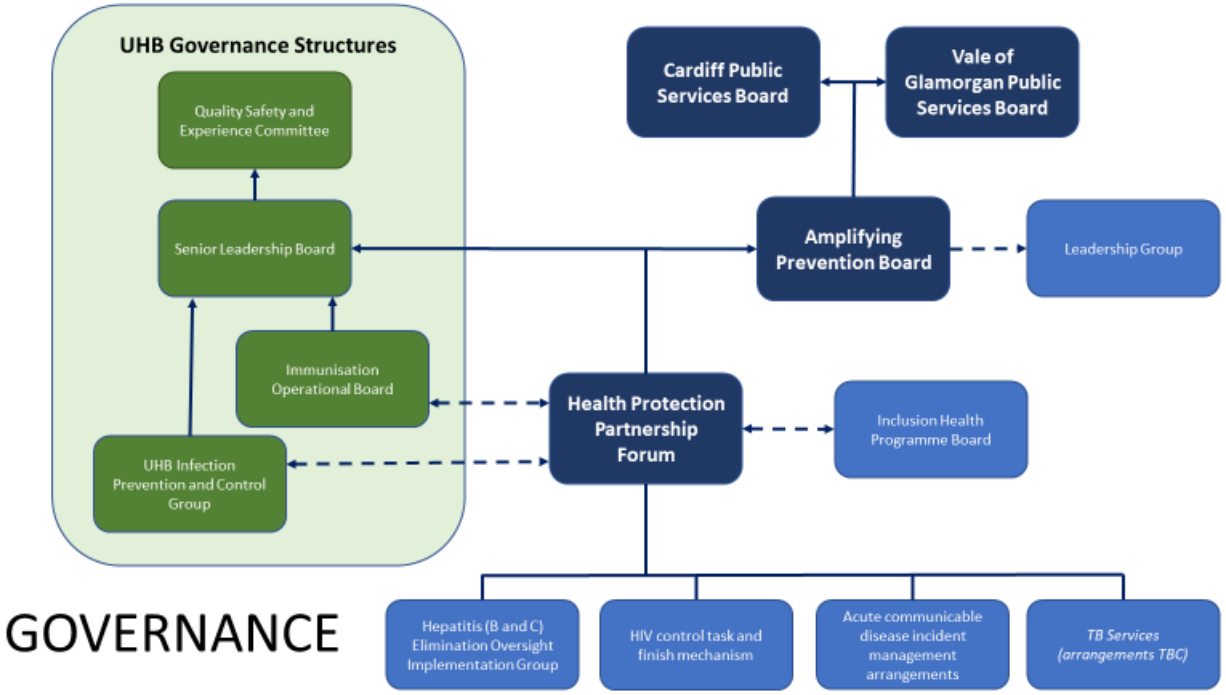
1.3 Cardiff and Vale Health Protection (Communicable Disease) Partnership Governance

Cardiff and Vale Health Protection Partnership brings together a complex and established range of programmes and services, which have pre-existing governance systems and operational procedures, with the aim of adding value to the regional health protection response (figure 1). A Health Protection Partnership Forum (developed from the Regional Public Health Response team set up for the COVID-19 response, known locally as the operational 'Bird Table') will provide the forum to identify opportunities to collaborate, coordinate and enhance operational delivery. The Health Protection Partnership Forum will report through the Amplifying Prevention Board to the two Public Service Boards. Immunisation services are provided by the UHB, and so governance oversight is provided by the UHB via the Senior Leadership Board to the Quality Safety and Experience Committee; an Immunisation Service

[1] Shared Regulatory Services is commissioned by Cardiff and Vale of Glamorgan Local Authorities (LA), with staff employed through Vale of Glamorgan LA)

lead will be part of the Health Protection Partnership Forum to ensure operational continuity. Similarly, the UHB Infection Prevention and Control Team reports via UHB governance structures, but participates in the Health Protection Partnership Forum to ensure operational links are maintained. The UHB provides clinical support and delivery for certain partnership programmes (i.e. Viral Hepatitis, HIV and TB) and so these will report to both UHB and Partnership governance routes. Responsible Officer members from the Amplifying Prevention Board will ensure Chief Executive Officers and Leaders are briefed on the development of the Health Protection Partnership and any escalated concerns via the Leadership Group.

Figure 1



1.4 Key Frameworks and Plans

A regionally coordinated approach to health protection will operate in line with the full range of legislation, frameworks and plans that govern delivery for constituent organisations. The following are of particular relevance in relation to health protection:

- The Communicable Disease Outbreak Plan for Wales
- National Immunisation Framework for Wales
- National Framework for Health Protection (when published)
- Roles and Responsibilities document from WG (when published)
- Operational Delivery plans for each constituent organisation

2. THE ROLE OF THE CARDIFF AND VALE HEALTH PROTECTION PARTNERSHIP

2.1 Population served

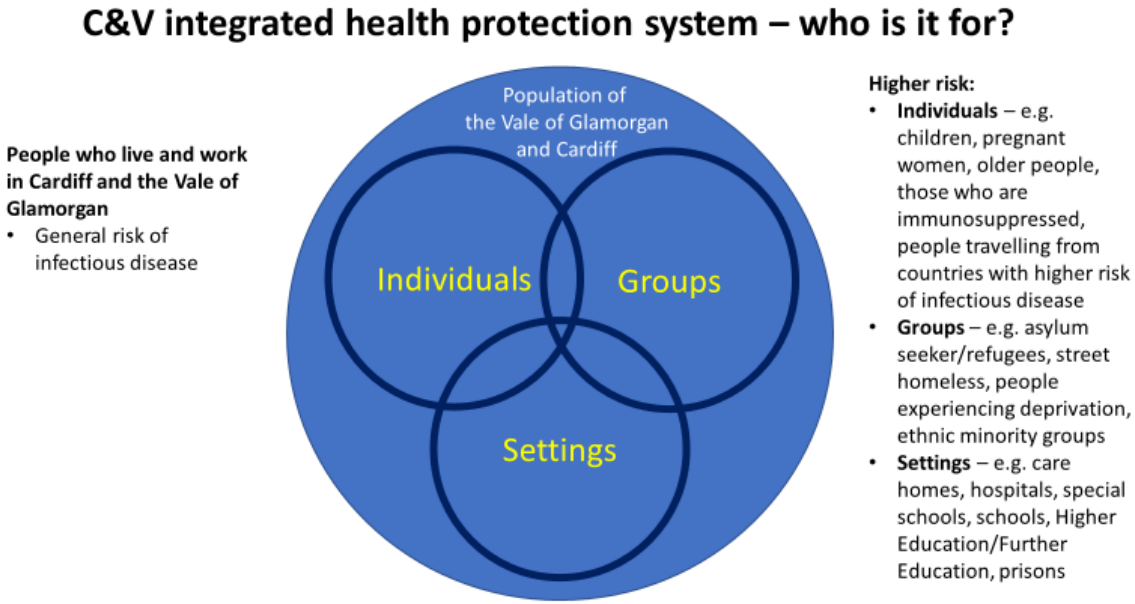
Cardiff is the capital city of Wales and is continuing to grow faster than any other capital city in Europe. In population terms, it is the largest city in Wales with a population of 370,000 and also the most ethnically diverse. Population alone however, does not fully represent Cardiff's significance as a regional trading and business centre as the population swells by approximately 70,000 daily with commuters and visitors. Cardiff is the seat of government and the commercial, financial and administrative centre of Wales. Cardiff boasts one of the most vibrant city centres in the UK and on a typical weekend, Cardiff's night time economy can attract over 40,000 people and sometimes more than 100,000 when the City's Principality Stadium hosts international events. The city also has a large student population and is an asylum seeker Home Office initial assessment and dispersal area.

The Vale of Glamorgan covers 33,097 hectares with 53 kilometres of coastline, and a population of over 130,000 residents. The area is predominantly rural in character, but contains several urban areas of note such as Barry, Penarth, Dinas Powys and the historic towns of Cowbridge and Llantwit Major. Barry is the largest town, a key employment area and popular seaside resort. The rural parts of the Vale provide a strong agricultural base together with a quality environment, which is a key part of the area's attraction. The area includes Barry Docks area and Cardiff International Airport. The Vale of Glamorgan has seen significant growth in its older population which is predicted to continue.

Persistent inequalities are evident in the populations of Cardiff and the Vale of Glamorgan, linked to differing experienced of the wider determinants of health (such as education, housing and income) throughout life. These inequalities mean there is a 7.6 year gap in life expectancy between men experiencing least and most deprivation, and a 13.3 year difference in healthy life expectancy; for women the gaps are 6.3 and 16.9 years respectively. Many of these differences are preventable and inherently unfair, and are termed inequities. The COVID-19 pandemic has further exacerbated inequities in our population. All partners have pledged to work collectively to improve the experience for our population and reduce inequities.

Cardiff and Vale Health Protection Partnership will work to prevent, control and mitigate risk from infectious disease for the people who live and work in the region. Whilst all members of the population are potentially at risk from communicable disease, we recognise that certain characteristics of individuals, groups and settings may place them at higher risk of exposure to infectious disease or of experiencing poorer outcomes. Such higher risk characteristics can also co-exist (figure 2). Recognition of individuals, groups and settings at higher risk will inform regional planning and our targeted approaches.

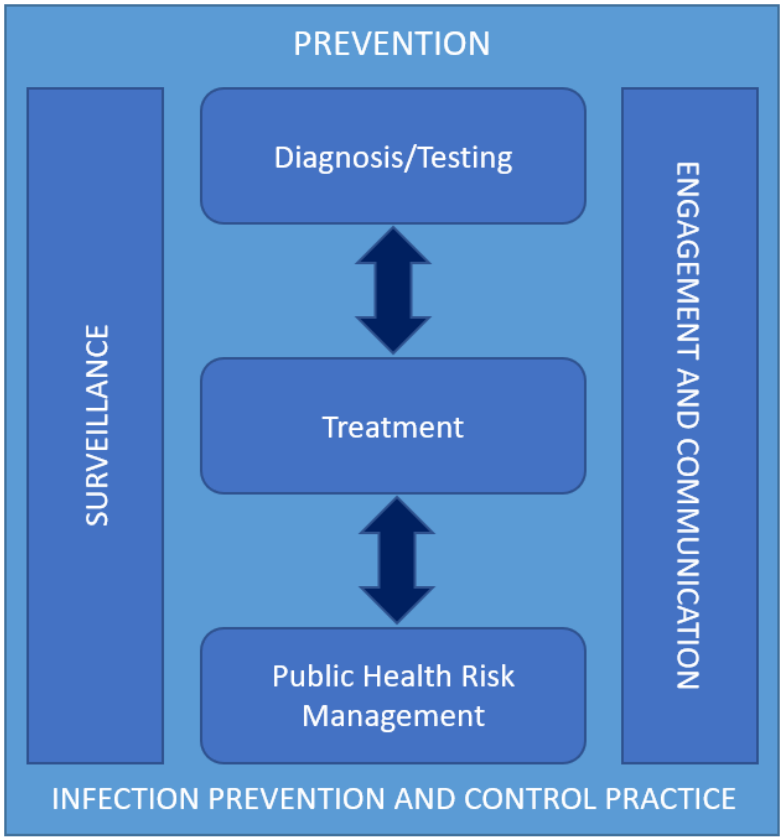
Figure 2



2.2 Functions

Cardiff and Vale Health Protection Partnership aims to deliver diagnosis/testing, treatment, including vaccination and public health risk management for an 'all hazards' communicable disease remit, on a background of working to prevent and reduce risk from infectious disease and strengthen infection prevention and control practice. In conjunction with this is the need to establish timely surveillance and effective systems for communication (figure 3).

Figure 3



Public health risk management can include a wide range of actions including providing general infection prevention and control advice, recommending isolation, contact tracing, provision of prophylaxis, prescription of immunoglobulin and immunisation. It may also involve assessing risk at population level to support development or amendments to health protection policy, guidance and legislation. Similarly, preventative action encompasses a vast range of activity from case finding, prescription of Pre-Exposure Prophylaxis (PrEP) and vaccination to statutory functions such as food hygiene inspections and water quality assessment; it can also include promotion of healthy behaviours and behavioural insights informed campaigns. Health protection legislation also enables local authorities to instigate legislative measures such as 'Regulation 8 requests to cooperate' and Part 2A Orders.

2.3 Strategic Aims and Objectives for 2023/24

2.3.1 Strategic Aim

To deliver an effective health protection system in partnership in Cardiff and Vale of Glamorgan, which adds value to existing services and the systems established during the COVID-19 pandemic, and is able to prevent, treat, and mitigate risk associated with an all hazard communicable disease remit.

2.3.2 Strategic Objectives

To achieve this, partner organisations will deploy relevant resource to:

- Monitor surveillance reports to identify trends and risks
- Protect our local population through safe, innovative, timely, person-centred and equitable immunisation delivery, maximising uptake in the process
- Provide access to diagnosis, sampling, testing and treatment that is timely and effective
- Respond appropriately to cases and clusters of infectious disease, and implement actions to mitigate risk and control spread
- Ensure that processes are in place to manage communicable disease outbreaks, in line with the Communicable Disease Outbreak Plan for Wales
- Supporting the development of health inclusion services delivering primary care to health inclusion groups (groups with the worst health outcomes), which will increase access to health protection services.
- Enhance partnership working opportunities between primary care and health protection services
- Ensure vulnerable settings such as health and social care, prisons and other critical services, are supported by appropriate advice and helped to implement guidance on prevention and management of disease outbreaks
- Signpost those impacted by infectious disease to sources of support if required, including those needing to isolate
- Deliver clear and effective communication to the public and professionals in response to communicable disease incidents, programmes and campaigns
- Prepare for possible COVID-19 Urgent and future pandemic scenarios
- Minimise wider harm incurred through our response to outbreaks or epidemics
- Employ robust quality improvement principles and tools to learn from experience and continuously improve outcomes for our population

2.3.3 Guiding criteria and principles

Welsh Government has indicated that regions across Wales should develop integrated health protection teams which meet the following criteria:

1. Multi-disciplinary health protection teams will work on the Health Board footprint, with Health Boards, local government working in partnership to respond to health protection measures and threats
2. An 'all-hazards' approach to health protection will be supported by all partner agencies, recognising there will be peaks of activity through the year according to national and regional demand
3. Teams will have a mix of skills and experience to:
    a. Respond to Covid waves within a Covid Stable environment and deliver on the national approach for respiratory viruses
    b. Have plans in place to scale up in the event of Covid Urgent/future pandemic scenario, within the context of a national framework
    c. Respond to outbreaks and wider threats using agreed processes in the Communicable Disease Outbreak Control Plan for Wales
    d. Deliver on the National Immunisation Framework for Wales, ensuring high take up and equity of access
    e. Undertake wider health protection work delivering a local approach under national frameworks and guidance, for example to support those seeking refuge in Wales, support messaging in schools, provide support to care homes and work on TB and Hepatitis elimination
    f. Work together locally and nationally to support and deliver work to address equity of access and opportunity

Cardiff and Vale Health Protection Partnership will initially focus on establishing a system wide and sustainable approach to communicable disease management. In addition, partners in Cardiff and Vale have agreed to work collectively to the following principles:

1. We will focus on adding value to the system, building on existing arrangements and learning from our pandemic partnership response
2. Our regional partnership will proactively identify opportunities to share resource across services where possible, and support staff to take on a mixed and broad range of functions up to the limits of their competence and registration

This plan identified the actions which need to be taken to deliver added value in addition to existing and statutory functions.

3. CARDIFF AND VALE HEALTH PROTECTION PARTNERSHIP PLANNING FRAMEWORK

The following planning framework will be adopted to inform the work programme for the remainder of 2023/24, and develop the plans and processes that will deliver the added value of a comprehensive and integrated system to prevent and manage communicable disease within the Cardiff and Vale Region; it is anticipated that the framework will continue to inform partnership work in succeeding years.

3.1 Surveillance

Communicable disease surveillance data for the most frequently occurring communicable diseases in Wales is produced by Public Health Wales' Communicable Disease Surveillance Centre. Other surveillance data is produced at a UK, European and Global level. National surveillance data will be used in combination with regional service use data to identify and respond to concerning trends and manage risk.

3.2 New/acute cases, incident and outbreak response

3.2.1 Existing operational practice

New cases of infectious disease may present to any healthcare setting, although the majority will present to primary care services. Many infectious diseases are mild and self-limiting and do not require further clinical or public health management. Depending on the disease and its presentation, a number of teams and services across the UHB may be involved in diagnosing and treating the condition. Likewise, any public health action (such as contact tracing, prescription of prophylaxis, advice on exclusion from school/work) may be taken by a range of teams. Table 1 provides a high-level summary of the lead teams or organisation by condition, although in practice it is much more nuanced and complex.

Table 1 Mapping of lead services and teams for specific diseases

Functions	COVID	Core response to communicable diseases	Hep B	Hep C	TB	HIV	STI	High consequence infections
Sampling/Diagnosis	GP/UHB	GP/UHB	UHB	UHB	TB	UHB	DOSH	ID
Treatment	GP/UHB	GP/UHB	ID	ID	TB	ID/DOSH	DOSH	ID
Public Health Management	SRS/UHB/ PHW	PHW/SRS	PHW/SRS	PHW/SRS	TB /PHW/SRS	ID/DOSH	DOSH	PHW/SRS/UHB

Key:
PHW = Public Health Wales Health Protection
SRS = Shared Regulatory Services
UHB = General Health Board Services

GP = General Practitioner Services
ID = UHB Infectious Disease Service
TB = UHB Integrated TB service
DOSH = UHB Department of Sexual Health

A number of communicable diseases are notifiable because of potentially serious sequelae to individual and population health. (The list of notifiable diseases can be found here.) Registered medical practitioners must notify any of the diseases on this list to the Proper Officer of the Local Authority or the Health Protection Team. In practice in Wales, all notifiable diseases should be notified via AWARe.

AWARe is usually the first point of contact for queries in relation to the public health management of communicable disease for both professionals and the general population. The Specialist Health protection teams follow nationally agreed guidance and SOPs to manage risk.

Specialist Health Protection would usually lead the initial investigation of clusters of communicable disease, although Local Authority officers may be the initial responder for gastrointestinal incidents, including in care homes, schools and early years settings. Incidents are often managed in collaboration between partners, particularly PHW Specialist Health Protections and Environmental Health (SRS). (See section 3.4.3 for a description of care sector support)

If an outbreak is declared, partners will follow the approach outlined in the Communicable Disease Outbreak Plan for Wales.

PHW Specialist Health Protection provides on out of hours health protection service to manage newly occurring, significant incidents overnight, at weekends and bank holidays.

3.2.2 Added value partnership developments

As a region, we have identified a number of resources that need to be put in place to better support this acute response:

- A high-level SOP to articulate the function of key partners, their remit and contact details
- Confirmation of partnership out of hours contact for communicable disease incidents, to include ways to access resources such as sampling and contact tracing
- Avian influenza testing pathway
- Hep A immunoglobulin pathway

We intend to use our retained contact tracing resource in the most effective way possible, and be able to deploy them to support the public health management of a range of conditions. We have therefore identified an action to scope how the resource can be deployed to support an all hazards remit, and a wider range of functions.

3.3 Planned/preventative infectious disease management

3.3.1 Vaccination and Immunisation

3.3.1.1 Existing operational practice

Cardiff & Vale UHB employs a multi-team approach to deliver the routine immunisation schedule for Wales and the requirements of the National Immunisation Framework for Wales. This inclusive approach encompasses School Nursing teams, General Medical Services (GMS), Community Pharmacy, as well as more specialized teams like CAVHIS (Cardiff & Vale Health Inclusion Service), the Prison Health teams and DOSH (Department of Sexual Health).

The Mass Immunisations & Testing team has taken on a pivotal role in vaccination and immunisation for the UHB. Since meeting the unprecedented demands posed by the COVID-19 pandemic, the role of the team has evolved to apply the learning across the wider immunisation programmes. The team continues to deliver mass vaccination, including the Winter vaccination programmes and spring/autumn booster programmes as required.

Vaccination and immunisation are integral components within the partnership. They serve a dual purpose - proactively limiting and preventing the spread of serious illnesses and diseases, and reactively responding to health or disease outbreaks. This approach not only safeguards individual health but also plays a vital role in curbing the transmission of diseases within communities.

Public Health Wales' Vaccine Preventable Disease Programme (VPDP) supports the delivery of immunisation programmes across Wales, including producing detailed surveillance data to monitor uptake. Vaccination leads within the UHB, including in the UHB's Public Health Team, use this data to steer and target local strategy and delivery; in particular this data is used to direct action to tackle low uptake and inequity of uptake.

3.3.1.2 Added value partnership developments

Partner organisations worked closely together during the pandemic to support Covid-19 vaccine uptake in general, and equity of access for all eligible populations, through a range of approaches. This partnership response has been continued, with a focus on increasing uptake and reducing inequity of childhood vaccinations. The partnership response has been part of the 'Amplifying Prevention' approach adopted by partners following publication of the Annual Report of the Director of Public Health for Cardiff and the Vale of Glamorgan (2020) which was published in September 2021. Detailed work in 2023/24 is focussing on MMR vaccine uptake in particular.

3.3.2 Hepatitis B/C

3.3.2.1 Existing operational practice

Hepatitis B prevention services mainly involve the delivery of the Hepatitis B vaccination and also Needle Syringe Programmes in our community. In contrast Hepatitis C involves case finding/testing and treatment services. This includes: Primary Care (GP practices; Cardiff and Vale Health Inclusion Service; and the Department of Sexual Health); Secondary Care (including the Infectious Diseases Service; Mental Health and Substance Misuse services); Independent Community Pharmacies; third sector organisations; HMP Cardiff and hostels.

3.3.2.2 Added value partnership developments

In order to respond to the Welsh Health Circular on the elimination of Hepatitis B and C (WHC/2023/01), a Cardiff and Vale Hepatitis (B and C) Joint Recovery Plan was created in partnership. The delivery of this is overseen by the Cardiff and Vale of Glamorgan Hepatitis B and C Elimination Oversight Implementation Group. This feeds directly into the Health Protection Partnership Forum. Within the Recovery Plan are several strategic actions to include: exploring options for referral pathways for hepatitis B vaccination for identified high risk individuals, and ensuring opt out testing protocols are implemented across treatment and support services for hepatitis C.

3.3.3 HIV

3.3.3.1 Existing operational practice

HIV testing is available in all clinical sites in Cardiff & Vale, but is a universal offer for attenders of sexual health clinics, infectious diseases outpatients and antenatal screening. It is recommended for those with clinical indicator conditions[2] in primary care, acute medical admissions and outpatient medical consultations along with prior to cytotoxic chemotherapy treatments.

Outpatient HIV treatment is provided in two sites in Cardiff & Vale, at the Dept of Sexual Health at the Cardiff Royal Infirmary and additionally at Infectious Diseases at UHW. Specialised inpatient treatment is at UHW under ID.

The HIV Action Plan published in early 2023 encourages health boards to consider late diagnosis of HIV as a priority and both services contribute to late diagnoses reviews and multidisciplinary meetings.

Sexual health also deliver Pre Exposure Prophylaxis (PrEP) services to ensure those at risk of HIV acquisition can take medications to prevent transmission.

3.3.3.2 Added value partnership developments

There is an outreach team at the Dept of Sexual Health to assist patients lost to traditional methods of follow up and where liaison with other departments such as the Cardiff & Vale Health Inclusion Service. The aim being that all people living with HIV take effective treatment and no longer pass the virus to their sexual partners, with the aim of eliminating HIV transmission in Wales by 2030, as per the UNAIDS goals.

[2] https://www.bhiva.org/file/5f68c0dd7aefb/HIV-testing-guidelines-2020.pdf Appendix 1, Pg 26

Fast Track Cardiff is a collaboration between the UHB, Cardiff Local Authority, Cardiff University, people living with HIV and people thought to be at high risk of HIV. This group has been established with the aim of co-producing service change and implementing the HIV Action Plan for Wales 2023 to 2026.

There are plans to formulate a delivery response across Cardiff & Vale UHB to specific actions in the HIV Action Plan which need further work, where the UHB is the responsible body for implementation, although the details are not finalised at present as this requires a co-ordinated response across Clinical Boards.

3.3.4 Tuberculosis (TB)

3.3.4.1 Existing operational practice

Cardiff & Vale UHB has an integrated TB Service, coordinated from within Medicine Division, but with contributions from both secondary and community services including those from Public Health Wales and Cardiff University (see appendix 2). Service provision and future development plans are in line with the recommendations identified in the Elimination of TB action Plan for Wales 2024-2030 (still in its draft form).

Cardiff & Vale UHB TB service provides a comprehensive service which offers prompt clinical review of any symptomatic individuals. Screening for active TB and Latent TB infection screening is offered to all newly arrived asylum seekers and refugees, adults and children, as part of the initial health assessment at Cardiff and Vale Health Inclusion Service. Cardiff and Vale Health Inclusion Service identifies and refers those who are symptomatic or have positive mantoux or quantiferon tests to the TB service for further investigation and management.

PHW Health Protection team, UHB TB service and UHB Local Public Health Team collaborate in response to complex TB cases involving extensive contact tracing and follow up action. Local Authority Environmental Health Officers (Shared Regulatory Services) are also involved where there is a risk in the wider community or workplace concerns (for sites where the local authority is the enforcing authority for health and safety legislation), providing their expert knowledge and statutory public health powers; the Health and Safety Executive would be engaged with other workplaces.

3.3.4.2 Added value partnership developments

The TB service will continue to raise awareness among health care professionals in all sectors of the signs and symptoms of TB, including the necessity to consider TB as a potential diagnosis. The following actions are planned to either provide or enhance provision of measures to improve awareness of TB in targeted groups or the general local population:

- Review the position regarding re-instatement of TB screening of students at international colleges and universities within Cardiff and Vale, particularly with regard to students from high TB prevalence countries.
- Develop an outreach service which collaboratively works alongside Health Inclusion services, accessing hard to reach populations such as those who are homeless, in hostels or prison who we know have an increased risk of TB transmission.
- Develop automatic flags for GP systems to identify new entrants/registrants at increased risk of TB, and requiring TB and other multi-pathogen screening.

- Further develop systems to identify and refer possible cases

3.3.5 COVID/ Acute Respiratory Infection (ARI) and Winter Preparedness

3.3.5.1 Existing operational practice

The mass immunisations and testing team is responsible for the administration of COVID vaccines. This is primarily carried out through designated vaccination centres. These centres have consistently surpassed the target of 75% vaccination coverage since its establishment. As part of their approach, the team collaborates closely with General Medical Services (GMS) and community pharmacy colleagues. This collaboration is crucial in meeting the extensive immunisation needs and, importantly, in ensuring equitable access to vaccination opportunities for all.

Influenza vaccination is coordinated via a mixed model. School nursing teams take the lead for school-aged children, while General Medical Services (GMS) teams oversee the vaccination of infants and adults. The Mass Immunisations team plays a lead role in immunising the health and social care workforce. They also offer support to partners in the form of 'mop-up'/catch-up capacity (addressing inequities), allowing GMS and school nursing colleagues to redirect their resources towards other essential work programmes.

ARIs have the potential to cause significant disruption in closed settings. The partnership response to these is described elsewhere in this document.

3.3.5.2 Added value partnership developments

In the context of winter preparedness, the partnership remains active in exploring opportunities to support seldom heard groups. There is a continuous education focus to ensure that citizens have the knowledge to make informed decisions.

3.4 Supporting people at higher risk from infectious disease

3.4.1 Individuals

Some people are at higher risk of contracting infectious disease, or be more likely to experience serious outcomes, as a result of individual factors such as age, pregnancy or being immunosuppressed. A range of actions can be taken to prevent infection and minimise the risk to these individuals, ranging from personal behaviours like hand washing to treatments such as prophylactic antibiotics and immunisation. Such actions are usually part of the clinical management of specific conditions, and so form part of the core business of medical teams. A key action to support highly clinically vulnerable individuals this Winter within our region is to confirm the pathway for obtaining COVID antivirals.

3.4.2 Groups

Certain groups of people are at increased risk communicable disease due to factors experienced by that group. Within our region, Health Inclusion groups have been identified as a priority.

3.4.2.1 Health Inclusion Groups - Existing operational practice

Cardiff and Vale Health Inclusion Service (CAVHIS) is a Health Board managed service for groups that face significant challenges when attempting to access health and social care services. It is situated in the centre of Cardiff and managed by the Primary, Community and Intermediate Care (PCIC) Clinical Board. The service has been developed over the past two and a half years with the aim of delivering an integrated service with cross sector partners providing care to traditionally excluded groups.

The service began as Cardiff Health Access Practice (CHAP) and was resourced to provide health screening to newly arrived people seeking asylum who were placed in Cardiff for Home Office initial assessment.

The current model registers those newly arrived in Cardiff via the asylum 'irregular routes' for full General Medical Services and offers registration when GP practices remove individuals from their lists.

CAVHIS provides evidence based Health and Public Health screening for:

- new arrived people seeking asylum,
- people under Home Office refugee resettlement programmes,
- survivors of trafficking and those who are destitute and facing 'No recourse to public funds'.
- General Medical Service care for individuals under Section 98 of the Immigration and Asylum Act 1999

CAVHIS re-branded in September 2021 to reflect a broader service ambition which now includes:

- Limited urgent primary care for multiply excluded single homeless individuals via outreach clinics into various frontline hostels.
- An Alternative Treatment Scheme – primary care for individuals who due to episodes of violent behaviour, after formal risk assessment, are judged to need a security presence.

The longer-term vision of the service is to develop, in partnership with Local Authority and Third sector services provision of an 'Integrated and Co Located Health Inclusion Service'.

3.4.2.2 Health Inclusion Groups - Added value partnership developments

A portion of the health protection Welsh Government funding this year has therefore been allocated to further strengthen the health protection function within CAVHIS. Health protection funding in 2023/24 has primarily been aimed at strengthening outreach, by equipping a van to offer clinical services, a point of care testing machine and staff to provide sexual health outreach and service user engagement. It has also been used to secure both adult and paediatric Infectious Disease Consultant sessions within the CRI to further improve access to such specialist advice and an outreach role is also planned.

3.4.3 Settings

The COVID-19 pandemic graphically demonstrated how vulnerable certain settings are to communicable disease risk. Such settings include prisons, houses of multiple occupancy, asylum seeker accommodation, hostels and special schools. However, the greatest risk and poorest outcomes were experienced by care homes. As a region, we intend to work to ensure that the care sector is appropriately supported to reduce the risk of communicable disease incidents through good IPC practice, and to manage incidents when they occur.

3.4.3.1 Support to care settings – Existing operational practice

A number of partnership teams support the care sector. The SRS COVID Health Protection Team, which is staffed by Environmental Health Officers and experienced former contact tracers (now Health Protection Officers), have supported the sector throughout the pandemic. They have formed strong relationships with settings across both local authorities and will often be contacted by homes who have concerns about respiratory illness. Single cases of respiratory illness are managed with advice. If there are two or more linked cases, the setting should report through to the PHW AWARe team, the incident is logged on Tarian and the Care Home SOP is followed. If COVID is confirmed in the setting, the SRS Health Protection Team will provide ongoing management of the incident; all other respiratory pathogens are managed by PHW.

Single cases or clusters of other infectious diseases are usually reported to AWARe. In the case of gastrointestinal disease, the SRS Communicable Disease team would be involved to provide advice and organise testing; they would also provide follow up to the setting until the incident is over. The same team would also be engaged if Legionella was suspected to be a causative organism.

A number of other partnership teams also support the care sector:

- Cardiff Social Service team
- Vale of Glamorgan Social Service team
- UHB Nurse Assessor Team
- UHB IP&C Team

In addition, Care Inspectorate Wales acts as regulator to both nursing and residential homes, and would be involved when concerns are raised. The Health and Safety Executive would also be involved where poor infection prevention and control measures were putting staff at risk in nursing homes; the same concerns in residential care homes would be investigated by the SRS Communicable Disease Team, which enforces health and safety legislation in this setting.

Similarly, a number of organisations are involved in providing training opportunities to care sector organisations, including PHW, Health Education and Improvement Wales (HEIW) and both Local Authorities.

A daily incident log is circulated to relevant PHW, SRS and Local Authority Teams. Multi-agency meetings are arranged as necessary to discuss specific incidents and concerns. Regular multi-agency oversight meetings have also been re-established in Cardiff Local Authority area.

3.4.3.2 Support to care settings – added value partnership developments

A partnership multiagency group has been convened to coordinate partnership support to care homes, and share best practice. The group will meet monthly. Contributors include PHW Health Protection, PHW Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Programme (HARP) Team, SRS, representatives from both Cardiff and Vale of Glamorgan Councils, and a number of UHB teams including the Mass Immunisation and Testing Team, LPHT, Infection Prevention and Control Team (IP&C), Nurse Assessor Team and Hospital Discharge team.

As a Region we have assessed that we do not need to provide any additional region-specific training, as there is a risk of causing confusion. Rather, we will work together to ensure training opportunities are disseminated and offered in as clear, organised and co-ordinated way to providers.

However, we recognise that the number of organisations providing support to the care sector may cause confusion to providers. A key action for the partnership is to clearly set out the routes of escalation in the event of a communicable disease incident, and to share with providers. We are also mapping the extent and nature of 'over the threshold' advice already being provided to care homes to assess whether there are any gaps in provision.

3.5 Scaling Up

All regional partner organisations have existing business continuity plans to be enacted in the event of emergency situations. As a partnership, we also have experience of working collaboratively to deliver a pandemic response. During the remainder of 2023/24, we will aim to develop a repository of relevant documents and procedures that we used during the pandemic as a 'grab bag' that could be drawn on rapidly in a future pandemic or COVID Urgent scenarios. This would include resources such and job descriptions for contact tracers, scripts, SOPs and the details of how tracing teams were rapidly stood up. We also intend to undertake scenario planning to test our regional responses as a tool to developed a shared understanding of the role of each organisation in a future emergency. This work would need to be set in the context of national pandemic planning.

3.6 Engagement and Communication

Communication professionals from all partner organisations are key members of the health protection response team for both acute and planned responses. There were established linkages between partnership communications teams which were further strengthened during the COVID-19 response; the ability to mobilise communication rapidly across the partnership is a positive legacy of the pandemic response. As noted previously, in general the Public Health Wales Communication Team will take the lead for communications to both public and professionals in relation to acute communicable disease incidents and outbreaks. Depending on the topic and situation, any of the local partner organisations may lead communications related to planned communicable disease related activity.

4 STRATEGIC ACTION PLAN

Action Area	Action	Lead	Timescale	Measure of success
New/acute case response	Scope and develop extended roles for Health Protection Officers	SRS Service Lead	January 2024	Roles described
	Scope and develop extended roles for immunisation and testing team	Health Protection Manager	January 2024	Roles described
	Develop Avian Flu testing pathway, and explore the opportunity to expand this to include other communicable diseases, including other high consequence infections	Health Protection Manager	February 2024	Pathway complete
	Develop high level SOP to map out main contacts for each organisation and key settings	Health Protection Manager	December 2023	SOP complete
	Develop SOP for accessing partnership Health Protection incident support for C&V both in and out of hours	Health Protection Manager	December 2023	SOP complete
	Develop core principles to enable available contact tracing resource to support a wider remit in a variety of settings for the benefit of the partnership health protection response, including: – criteria for the use of HPOs as opposed to UHB resource – Training and development requirements – Information Governance arrangements	SRS Service Lead/ Health Protection Manager	March 2024	Roles and requirements clearly described
	Finalise pathway for accessing Hep A immunoglobulin	Pharmacy Lead	March 2024	Pathway complete
	Review Information Governance requirements to support new model	Consultant in Health Protection/Director of Public Protection/Consultant in Public Health Medicine/ Health Protection Manager	January 2024	Requirements reviewed
Planned/preventative management	Implement actions for 2023/24 identified in Hep B/C Elimination Plan	Consultant in Public Health Medicine	March 2024	Actions delivered

	Identify priority delivery areas for Cardiff and Vale from the HIV Action Plan for Wales 2023-2026	Clinical Director or HIV Lead Consultant for Dept of Sexual Health / Consultant in Public Health	March 2024	Priorities identified
	Implement priority regional actions for 2023/24, identified in 'Elimination of Tuberculosis: An Action Plan for Wales 2023-2030'	Lead TB Clinical Nurse Specialist/ All Wales TB Nurse Consultant	March 2024	Priorities identified and implemented
Supporting People at higher risk from infectious disease	Confirm pathway to access antivirals for extremely vulnerable groups and care home residents in line with Welsh Government policy and NICE guidance	Health Protection Manager	December 2023	Pathway agreed
	Deliver actions identified in Health Protection business case to support health inclusion groups	CAVHIS Clinical Director	March 2024	Actions delivered
	Confirm regional arrangements for support to care homes both when dealing with an acute incident and for prevention	SRS Service Lead / Health Protection Manager/Consultant in Public Health Medicine	December 2023	Regional arrangements clearly described and shared with providers
	Develop a plan to support access to educational opportunities for care settings providers with a view to increasing confidence in infection prevention and control	SRS Service Lead / Health Protection Manager	October 2023	Plan implemented
	Map 'over the threshold' support currently provided to care homes in Cardiff and the Vale of Glamorgan, identify if there are gaps, and propose mitigating action	Consultant in Public Health Medicine/ Consultant in Health Protection/Director of Public Protection	January 2024	Action complete
Scaling up	Confirm regional plans to scale up the regional health protection response in the event of a COVID Urgent or future pandemic scenario Develop document repository containing key resources for future COVID Urgent/pandemic situations	Consultant in Health Protection/Director of Public Protection/Consultant in Public Health	March 2024 March 2024	Plans complete Key resources accessible to all partners

	Plan at least one table top exercise to test regional arrangements	Consultant in Public Health/ Emergency Planning Lead	March 2024	Tabletop exercise delivered

5 KEY PERFORMANCE INDICATORS/ TARGETS

Metric	Baseline	Target
Up to date with all routine immunisations age 4 yrs	81.3%	Increasing uptake to retun to pre-pandemic levels and overtake them.
MMR 2nd dose – age 5yrs		Increasing uptake to retun to pre-pandemic levels and overtake them.
Uptake of flu vaccine in clinically at-risk groups (6 month – 64 yrs)	39.7%	Increasing uptake of winter respiratory vaccinations with an upward trajectory towards national targets.
Uptake of Covid-19 vaccine in clinically at-risk groups (5-49yrs)	39.3%	Increasing uptake of winter respiratory vaccinations with an upward trajectory towards national targets.
% uptake of Flu vaccine in NHS employees with direct patient contact	41%	Increasing uptake of winter respiratory vaccinations with an upward trajectory towards national targets.
% uptake of Covid-19 vaccine in 2022/23 Autumn Booster in healthcare staff	64.5%	Increasing uptake of winter respiratory vaccinations with an upward trajectory towards national targets.
Numbers of unique individuals tested for Hep B (reactive anti-HBc)	3773 (2022)	Increase in annual number tested
Rate per 100,000 population tested for Hepatitis C (anti-HCV or HCV-RNA)	3224/100,000 (2022)	Increase in rate per 100,000 tested
Number of people commencing treatment for for Hepatitis C	81 (2022)	Increase in number of people commencing treatment

APPENDIX 1: Mapping of organisations, teams and lead roles contributing to the Health Protection Partnership in Cardiff and Vale Region

Organisation	Lead roles with responsibility for Communicable Disease	Contributing Teams
Cardiff and Vale UHB	Executive Director of Public Health*	Immunisation and Testing Team (including Immunisation Coordinators)
	Executive Director of Nursing	Infection Prevention Control Team
	Health Board Clinical Lead for Microbiology*	Integrated TB Team
		Infectious Disease Team
		Pharmacy/Medicines Management
		Blood Borne Virus Team
		Cardiff and Vale Health Inclusion Service (CAVHIS)
		Department of Sexual Health (DoSH)
		School Nursing Team
		Local Public Health Team
		Substance Misuse
		PRIMARY CARE (commissioned services) – General Medical Services and Community Pharmacy
		UHB Communications Team***
Cardiff Council		Corporate Health and Safety Team
		Social Services
		Cardiff Council Communications Team***
Vale of Glamorgan Council		Corporate Health and Safety Team
		Social Services
		Vale of Glamorgan Council Communications Team***
Shared Regulatory Services**	Director of Public Protection*	Health Protection Partnership Team
		Communicable Disease Team
		Port Health Team
		Food Safety Team

Public Health Wales	Consultant in Communicable Disease Control (CCDC)*†^/Consultant in Health Protection (CHP)*†	Regional Health Protection Team
		All Wales Acute Response Team (AWARe) (National Resource)
		Microbiology Services
		Communicable Disease Surveillance Centre (CDSC) (National Resource)
		Vaccine Preventable Disease Programme (National Resource)
		Healthcare Associated Infection and Antimicrobial Resistance Programme (HARP) (National Resource)
		Inclusion Health Team (National Resource)
		Public Health Wales Communications Team (National Resource)***
Third Sector		Hepatitis C Trust
		Glitter Cymru
		Pride Cymru
		Terrance Higgins Trust
		Substance Misuse Services
Cardiff University		

* Core member of an Outbreak Control Team, as described in the Communicable Disease Outbreak Plan for Wales

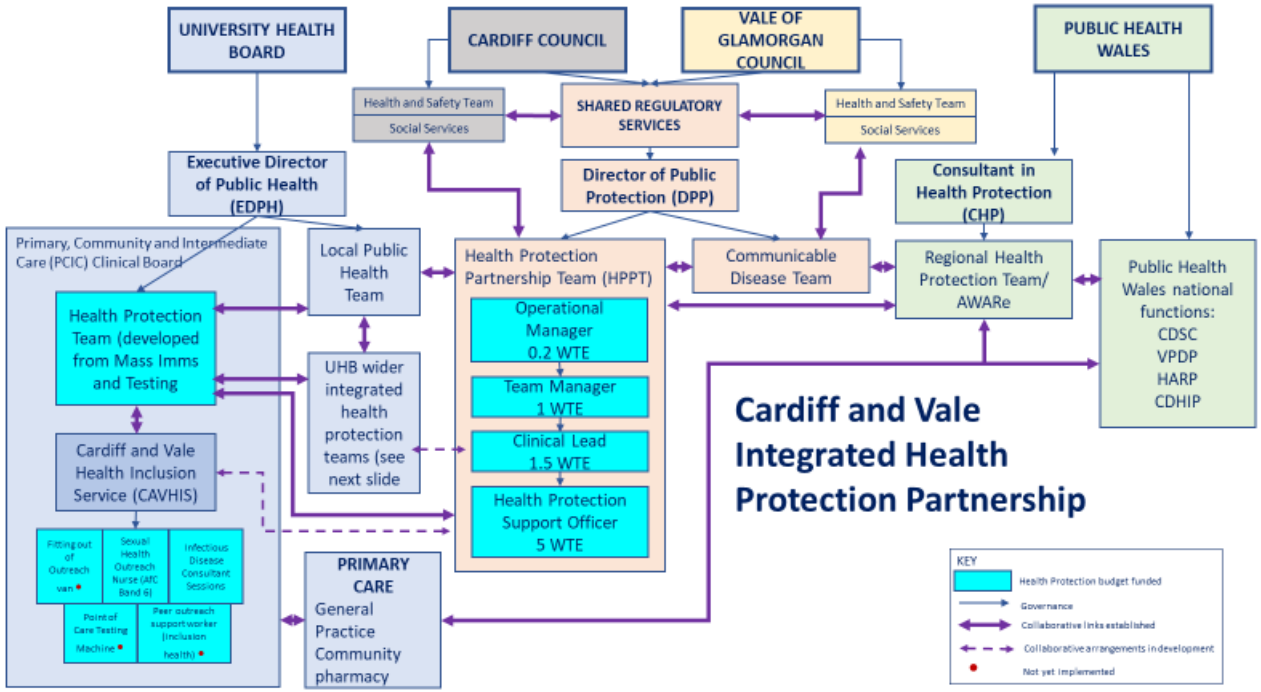
** Shared Regulatory Services provide a key link to relevant teams in both local authorities

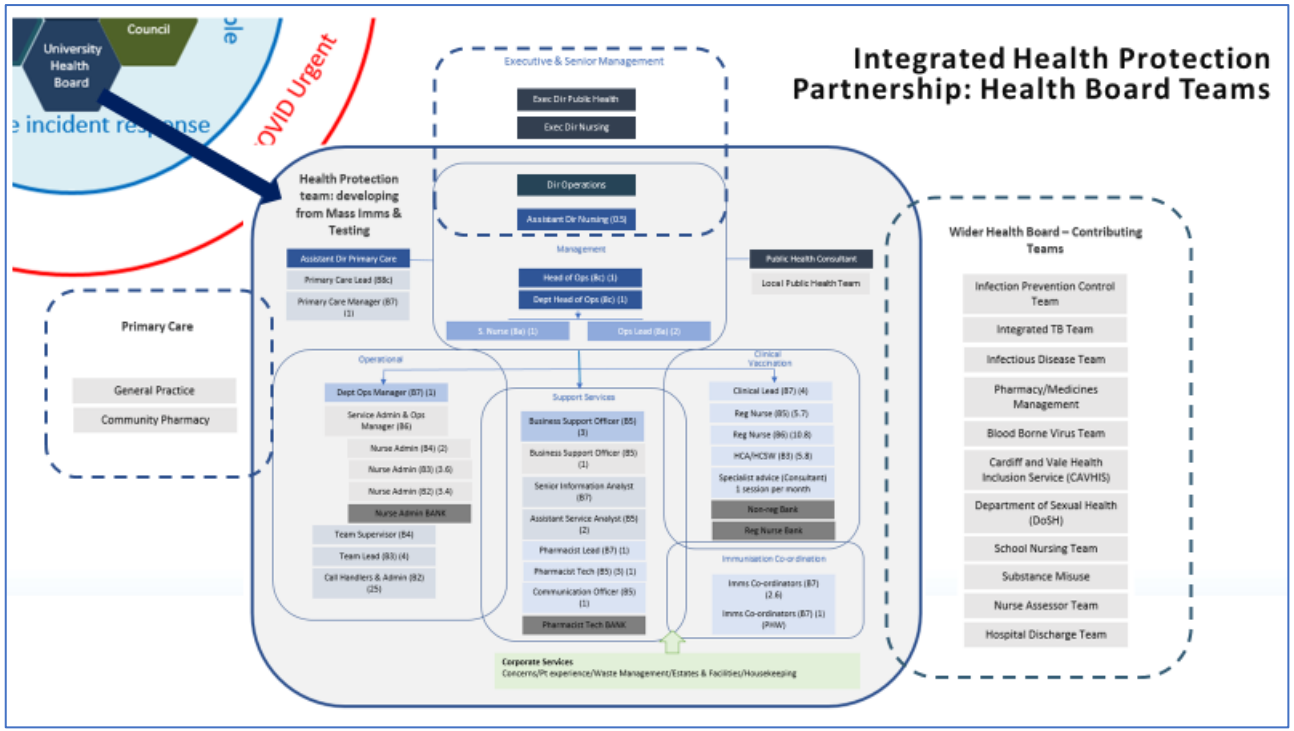
*** Communication Teams work collaboratively to support health protection aims. In general, the Public Health Wales Communication Team will take the lead for communications to both public and professionals in relation to acute communicable disease incidents and outbreaks.

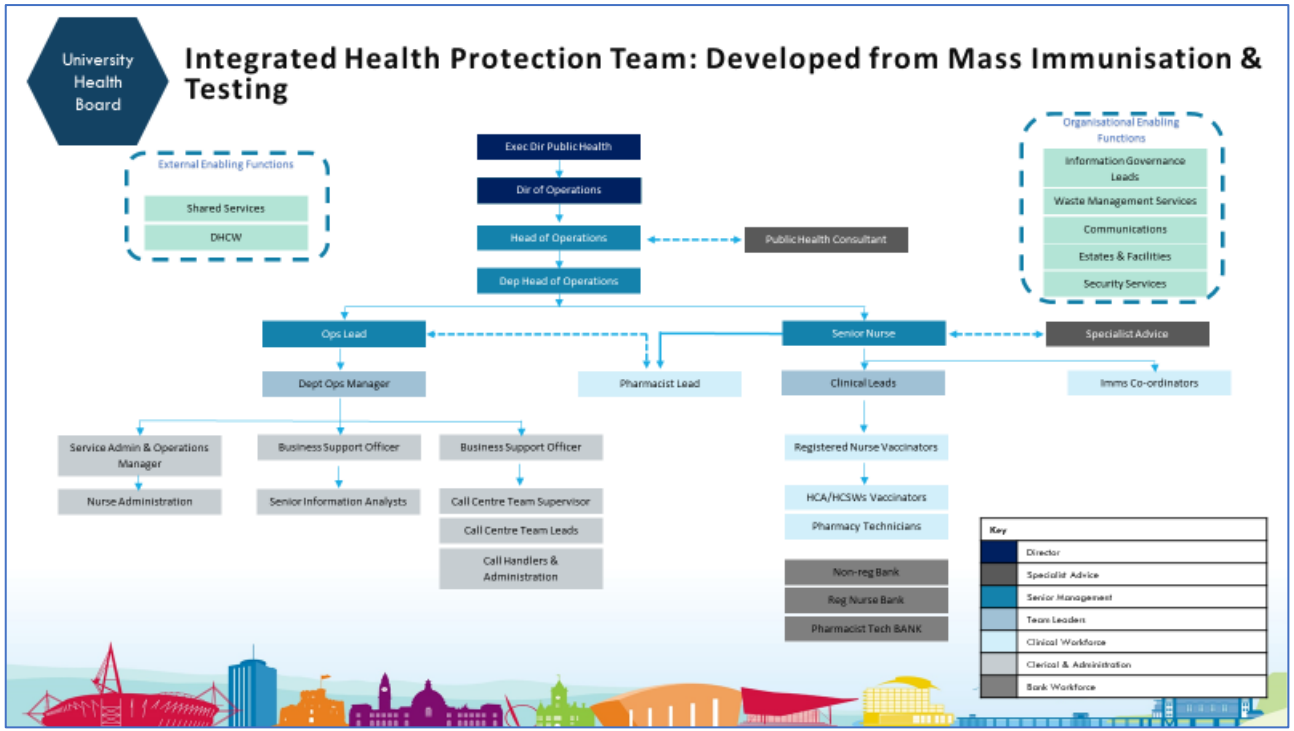
† Proper Officer for the Local Authority

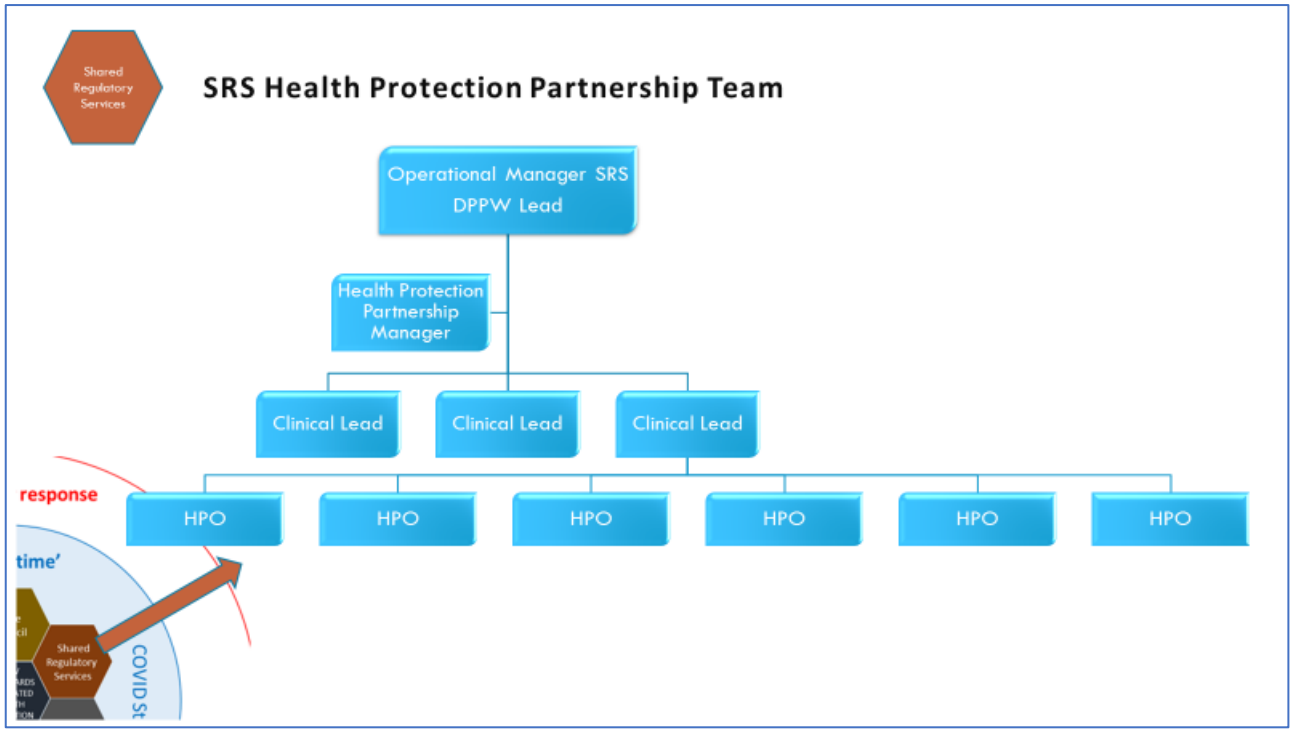
^ Port Medical Officer

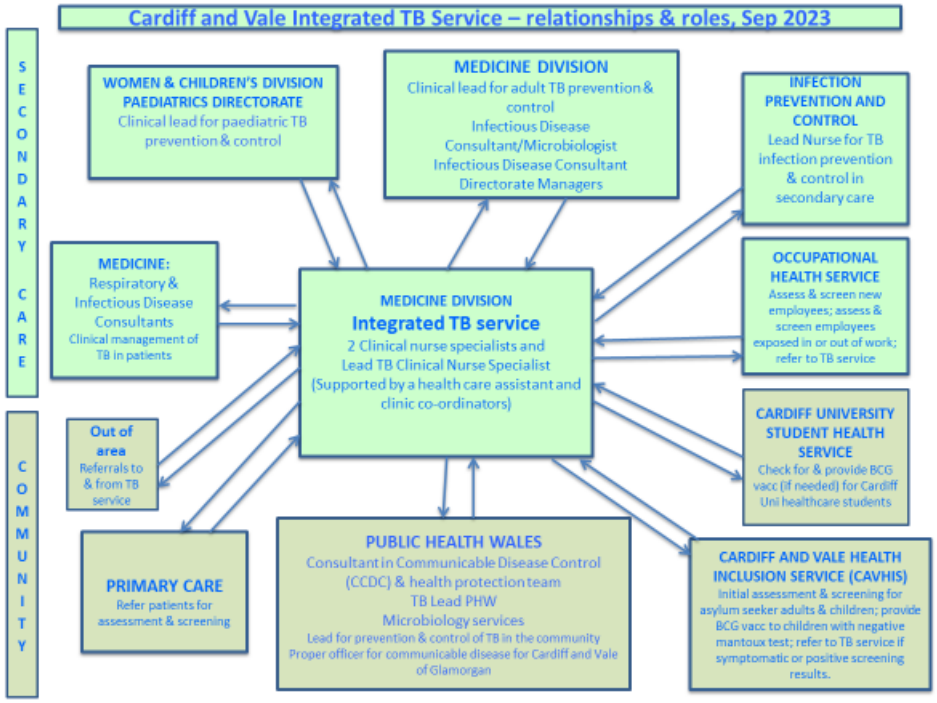
APPENDIX 2: Cardiff and Vale Health Protection Partnership Organograms











Report Title:	**Intraoperative Cell Salvage policy and procedure**			Agenda Item no.	3.2
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	13.02.2024
		Private			
Status *(please tick one only):*	Assurance		Approval √	Information	
Lead Executive:					
Report Author (Title):	**Dr Simon Logan, Consultant Anaesthetist** **Barbara Jones, Perioperative Care Directorate Education Lead**				

Main Report
Background and current situation:

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

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

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

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

Recommendation:

The Committee is requested to:

- **APPROVE** the Intraoperative Cell Policy and Procedure
- **RATIFY** Chair's Action to approve the Intraoperative Cell Salvage Policy and Procedure

and

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

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	√	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	√

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

Prevention	√	Long term		Integration		Collaboration	√	Involvement	√

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

Risk: No

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: 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: 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: 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: 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: 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: 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: 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: No

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:

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

Intraoperative Cell Salvage Procedure

Introduction and Aim

This procedure is supporting the Intraoperative Cell Salvage Policy.

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

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

Objectives

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

Scope

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

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

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

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

Disclaimer

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

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

Contents

ROLES AND RESPONSIBILITIES

The UHB

The UHB is responsible for

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

The Clinical Lead

The Clinical Lead is responsible for

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

The Cell Salvage Co-ordinators

The Cell Salvage Co-ordinators are responsible for

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

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

- Ensuring audit is complete
- Regular Quality Control of machines

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

Prescribing Responsibilities

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

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

Labelling Responsibilities

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

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

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

Individual Responsibilities

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

Documentation responsibilities

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

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

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

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

TRAINING

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

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

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

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

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

Update training is recommended under the following circumstances:

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

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

INDICATIONS AND PATIENT SELECTION

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

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

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

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

CONTRAINDICATION AND WARNINGS

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

Contraindications

ICS should not be used in the following situations:

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

Warnings

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

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

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

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

Cautions

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

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

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

PATIENT INFORMATION AND CONSENT ISSUES

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

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

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

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

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

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

CONDITIONS FOR USING ICS

Use of ICS Equipment

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

Anticoagulant

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

Wash Solution

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

Labelling

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

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

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

Re-infusion

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

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

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

Expiry

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

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

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

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

Documentation

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

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

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

Disposal of used ICS equipment

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

Cleaning and Disinfection of ICS Machines

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

Maintenance of Equipment

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

MANAGEMENT OF MASSIVE REINFUSION

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

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

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

Quality Assurance

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

Personnel

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

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

Equipment

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

Product Quality

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

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

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

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

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

ADVERSE EVENT REPORTING

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

Examples of Adverse Events include:

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

AUDIT

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

RESOURCES

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

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

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

EQUALITY

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

IMPLEMENTATION

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

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

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

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

REVIEW

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

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

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

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

APPENDIX 2 – Intraoperative Cell Salvage in Obstetrics

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

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

- National Institute Health and Care Excellence

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

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

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

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

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

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

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

Additional measures necessary in obstetrics ICS:

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

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

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

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

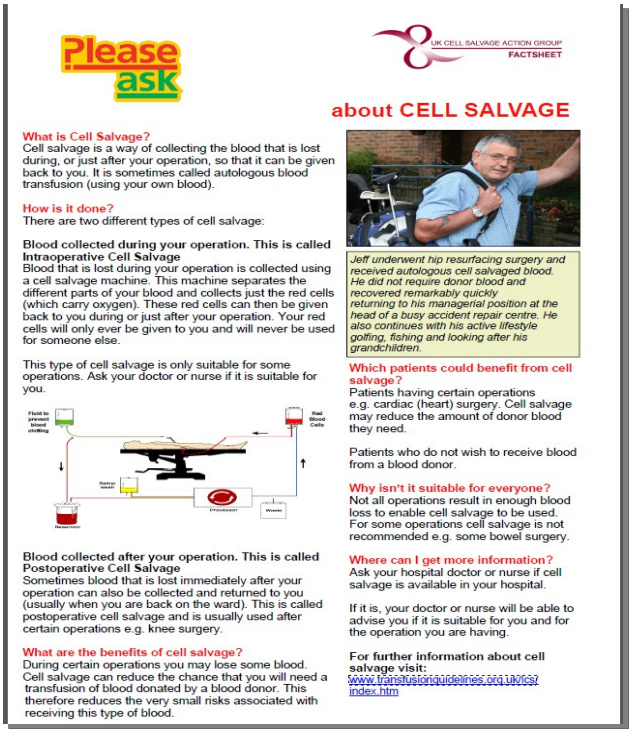
The same protocol should be followed for Rh negative mothers who have undergone reinfusion of ICS blood. The presence of foetal red cells in the ICS blood is likely because the ICS device cannot distinguish foetal from maternal red cells. Depending on the test results it may b that higher doses of Anti-D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

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

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

APPENDIX 3 – Cell Salvage Patient Information Leaflet

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



Please ask

UK CELL SALVAGE ACTION GROUP FACTSHEET

about CELL SALVAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

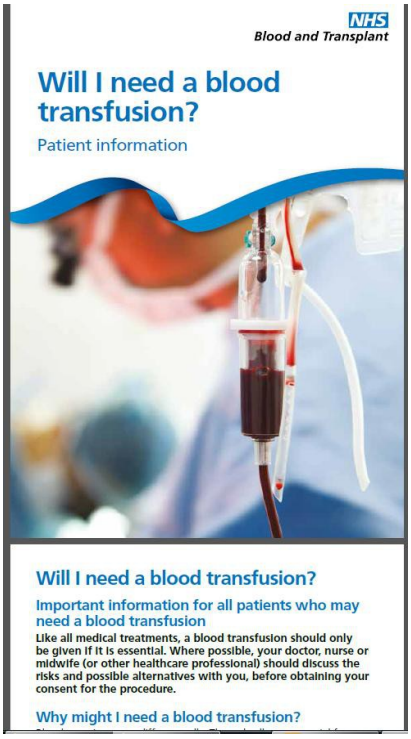
APPENDIX 4 – Manufacturers' Guidelines

These are held centrally by the Clinical Lead for ICS

APPENDIX 5 – Autologous Transfusion Label

These are held centrally by the Clinical Lead for ICS

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



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

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

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

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

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

APPENDIX 7 – Blood loss calculation

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

The information required is:

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

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

Anticoagulant used – An estimate of volume used

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

Theatre suction

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

Blood Loss Calculation:

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

APPENDIX 8 - Heparin Concentration

Heparin Saline

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

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

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

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

Equality & Health Impact Assessment for

Intraoperative Cell Salvage Policy and Procedure

Please note:

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

Please answer all questions: -

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

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

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

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

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

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Where the patient is aged under 16 years, a person with parental responsibility must give consent if the patient is not *Gillick* competent. If there is reason to doubt the patient's mental capacity to consent to ICS and the patient is aged 16 years and over, then the Mental Capacity Act 2005 must be followed.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	The policy and procedure lists supporting documents to ensure appropriate consent to treatment and to affirm the rights of patients and their autonomy without discrimination. The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good management practice. **Note -** the Arial font size 14 recommendation is aimed at communication and information needs for	Staff must be familiar with the list of documents associated with informed consent.	Mandatory training compliance. Evidence of clinical audit.

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	The policy and procedure lists supporting documents to ensure appropriate consent to treatment and to affirm the rights of patients and their autonomy without discrimination. The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good management practice. **Note -** the Arial font size 14 recommendation is aimed at communication and information needs for	Staff must be familiar with the list of documents associated with informed consent.	Mandatory training compliance. Evidence of clinical audit.

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Where the patient is aged under 16 years, a person with parental responsibility must give consent if the patient is not *Gillick* competent. If there is reason to doubt the patient's mental capacity to consent to ICS and the patient is aged 16 years and over, then the Mental Capacity Act 2005 must be followed.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	The policy and procedure lists supporting documents to ensure appropriate consent to treatment and to affirm the rights of patients and their autonomy without discrimination. The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good management practice. **Note -** the Arial font size 14 recommendation is aimed at communication and information needs for	Staff must be familiar with the list of documents associated with informed consent.	Mandatory training compliance. Evidence of clinical audit.

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	receiving autologous blood collected using ICS (all such decisions should be documented).		
6.8 People who are attracted to other people of: • **the opposite sex (heterosexual);** • **the same sex (lesbian or gay);** • **both sexes (bisexual**	There appears not to be any impact on staff or patients in terms of sexual orientation.	N/A	N/A
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	Bilingual information leaflets are available for patients. This is in line with our current Welsh Language Scheme and the future Welsh Language Standards.	Staff to be familiar on how to access welsh speaking colleagues to support the patient. Information should be available in Welsh.	Provide welsh language training

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of vibrant culture and thriving Welsh language		Service to encourage Welsh language 'active offer' to those receiving the procedure.	
6.10 People according to their income related group: **Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health**	Minimal Impact is anticipated The procedure aims to deliver an achievable equitable service regardless of an individual's income. Any decisions are clinically made.	N/A	N/A

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	People will be consulted regarding ICS dependent on the surgical procedure being undertaken and their own preferences. Geographical location will have no impact on the decision.	N/A	N/A
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including	Indirectly associated with this procedure – patients listed for elective surgery will have the opportunity to improve their wellbeing with healthcare professional support pre-operatively.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Positive impact by ensuring staff are appropriately trained for their roles associated with cell salvage in order to maintain safe practice and thus job security. Aseptic Non-Touch Technique processes (ANTT) has been introduced as an all-Wales approach to reducing healthcare associated infection. The PADR process supports further development appropriate to role and future employment ambitions.	Ensure all staff involved with aseptic techniques associated with ICS are trained and assessed in ANTT	Enable the trained ANTT facilitators to continue rolling out ANTT in accordance with the all-Wales approach
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of	N/A	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	If a patient has a carer or parent/guardian we will ensure they receive the appropriate information.	N/A	N/A
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic	Intraoperative Cell Salvage has the potential for a positive impact in terms of supporting the prudent use of donated blood in accordance with the Welsh Health Circular (WHC),	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
development; biological diversity; climate Well-being Goal – A globally responsible Wales	“Better Blood Transfusion: Appropriate Use of blood”.		

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

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

Action Plan for Mitigation / Improvement and Implementation

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

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As part of its implementation this procedure document will be circulated to all relevant personnel and implemented in all areas which may be involved in ICS. This will include: • Consultant Lead for Transfusion • Clinical Lead for ICS • Manager for Theatres • Transfusion Practitioner • Jehovah's Witness Hospital Liaison Committee • Senior Nurse / Theatre Managers • Relevant surgical specialities • Obstetrics and Gynaecology It will also be available via the UHB Intranet. Members of the public will be able to access it via the website of the UHB with hard copies being provided on request. Guidance on and queries relating to the procedure should be addressed to the organisation's Clinical Lead for ICS.	N/A	N/A	N/A

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

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

Report Title:	**Swab, Instrument and Sharps Count Policy and Procedure**			Agenda Item no.	3.2
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	13.02.2024
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Executive Medical Director				
Report Author (Title):	Perioperative Care Directorate Education Lead				

Main Report
Background and current situation:

Ensuring the correct count of swabs, instruments and sharps is crucial to ensuring the safety of patients during the peri-operative period.

The overriding principle for the count is that all swabs, instruments and sharps must be accounted for at all times during an invasive surgical procedure in any setting, to prevent foreign body retention and subsequent injury to the patient.

The overall aim of this policy is to ensure that all swabs, needles and instruments are accounted for at all times to prevent foreign body retention and subsequent injury/harm to the patient.

The UHB is committed to ensuring patient safety and recognises that the peri-operative period poses a high risk to the patient. It is the intention of this policy to identify good clinical practice within the peri-operative environment and to ensure the health and safety of patients throughout their journey within this environment. To reduce the incident of a “never event” and promote engagement in the “WHO” checklist process.

Ensuring the correct count of swabs, instruments and sharps is crucial to ensuring the safety of patients during the peri-operative period.

The Perioperative Care Directorate Policy & Procedure group identified the need for the Swab Instrument and Sharps Count procedure to be considered for ratification as a UHB policy so that clear guidance can be accessible for all those affected and accountable.

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

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

Recommendation:

The Committee is requested to:

a) APPROVE the Swab, Instrument and Sharps Count Policy and Procedure; and
b) APPROVE the full publication of the Swab, Instrument and Sharps Count Policy and Procedure in accordance with the UHB Publication Scheme

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an “X” in the below boxes as relevant

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

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

Five Ways of Working (Sustainable Development Principles) considered *Please place an "X" in the below boxes as relevant*									
Prevention	X	Long term		Integration		Collaboration		Involvement	

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

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

Chilcott Rachel
07/02/2024 10:34:44

Reference Number: UHB 191 **Version Number:** 4	**Date of Next Review:** **Previous Trust/LHB Reference Number:** Trust Ref No 70

SWAB INSTRUMENT AND SHARPS COUNT – POLICY AND PROCEDURE

Introduction and Aim

Ensuring the correct count of swabs, instruments and sharps is crucial to ensuring the safety of patients during the peri-operative period.

The overriding principle for the count is that all swabs, instruments and sharps must be accounted for at all times during an invasive surgical procedure in any setting, to prevent foreign body retention and subsequent injury to the patient.

A count must be undertaken for all procedures in which the likelihood exists that swabs, instruments and/or sharps could be retained.

Although UK statute law does not dictate what system or method of swab, instrument and needle counts should be performed within a peri-operative environment, as a healthcare provider, the law is quite clear in that the UHB and its staff have a 'duty of care' to all its patients. Therefore the UHB and its peri-operative staff are accountable to patients for the care delivered and, as such, must ensure that the patient is not harmed by negligently leaving foreign objects within body cavities during clinically invasive procedures.

Retained objects are considered a preventable occurrence, Never Events List England (2015). Careful counting and documentation can significantly reduce, if not eliminate these incidents (AORN, 2006). A count must be undertaken for all procedures for which swabs, instruments and sharps could be retained.

Although it is the responsibility of the user to return all items, it is recognised as ‘custom and practice’ that the scrub practitioner implements the checking procedure in order to be able to state categorically that all items have been returned.

Team work, good communication and accountability are all crucial to safe practice within the peri-operative environment. This is recognised by the various professional bodies.

The overall aim of this policy is to ensure that all swabs, needles and instruments are accounted for at all times

The UHB is committed to ensuring patient safety and recognises that the peri- operative period poses a high risk to the patient. It is the intention of this policy to identify good clinical practice within the peri-operative environment and to ensure the health and safety of patients throughout their journey within this environment. To reduce the incident of a “never event” and promote engagement in the World Health Organisation (WHO) checklist process.

Objectives

- To prevent foreign body retention and subsequent injury/harm to the patient.

Scope

The Royal College of Surgeons in their Good Surgical Practice (2008) state that "Surgeons work in partnership with others in the health care team – which includes other professionals, technicians, support staff and management – in order to offer safe and effective care to patients. They must work to develop effective relationships, respecting the professionalism of all colleagues. Knowledge and understanding of, and respect for, the roles and views of others are essential to achieving good patient outcomes."

The Health Professions Council (2014) states that as a professional "You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner and that you must communicate properly and effectively with service users and other practitioners."

The Health Care Support Worker Code of Conduct (2011) states that "You must be accountable by making sure you can always answer for your acts or omissions".

The NMC Code of Conduct (2015) states that "you must maintain you knowledge and skill for safe and effective practice" and "be aware at all times of how your behaviour can affect and influence the behaviour of other people".

Equality Impact Assessment	An Equality Impact Assessment has been completed. The Equality Impact Assessment completed for the policy found here to be no impact.
Documents to read alongside this Procedure	Waste Management Policy Risk Management Policy Equality and Human Rights Policy Policy for the management of a throat pack
Approved by	Quality Safety and Experience Committee

Accountable Executive or Clinical Board Director	Medical Director
Author(s)	Peri-Operative Care Directorate Education Lead

Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
UHB 1	14/06/2013	05/07/2013	Document revised and updated. Replaces previous Trust version reference no 70
UHB 1.1	30/12/2014	31/12/2014	Section 4.8 updated Section 8 – numbering corrected. Procedure for Ensuring Correct Swab, Instrument & Sharps Count updated to include new Section 6 - The Procedure for the Insertion of Throat Packs. All subsequent sections moved to next number.
UHB 2	15/12/2015	15/12/2015	Scope updated to reflect new references. The following aspects of section 14: 2.2, 4.1, 4.3, 4.11, 5.3, 5.9, 5.14, 5.17 6 - Throat pack removed as specific policy developed and subsequent sections numbered accordingly. 6.1 and 6.12 were all updated.
UHB 3			Section 4.3 updated to reflect checking procedure should designated runner change
UHB 4INTERIM	20/07/23	20/07/23	Section 8.3 updated to reflect procedure for location of neuro pattie swabs

CONTENTS

1. METHOD

All staff are responsible for ensuring that:

- Their practice is in line with this policy and any additional local guidelines
- Staff must comply with the provision of this policy and where requested demonstrate compliance
- Information regarding failure to comply with the policy is reported to their line manager and where appropriate the incident reporting system is used
- Information regarding any changes in practice or legislation that would require a review of this policy is immediately responded to.

Countable items may include, but are not limited to:

• X-ray detectable gauze swabs	• Blades
• packs	• local infiltration needles
• lahey swabs (peanuts, pledgets)	• tapes
• gauze strips	• liga-reels
• neuro patties	• slings/sloops
• needles	• shods
• instruments, including screws or detachable parts	• ophthalmic micro sponges
• sponges	• bulldogs
• red swab/pack ties	• cotton wool ball (including dental) and dental rolls
• diathermy tips and cleaners	• throat packs

A full swab, instrument and sharp count should be performed prior to;

- The commencement of surgery
- The commencement of the closure of any cavity
- Where there is a changeover of scrub practitioner
- At the commencement of skin closure

When checking swabs the scrub practitioner should ensure the integrity of the swab.
Instruments and items with detachable parts should also be included in the count at the commencement and end of the procedure. The surgical team must allow time for these counts to be undertaken without pressure.

The count must be audible to those counting and be conducted by two members of staff, one of whom MUST be a registered member of the Perioperative team (i.e. a registered nurse, operating department practitioner (ODP), registered midwife or dental nurse).

On completion of any count, a verbal statement must be made by the scrub practitioner to the effect that all swabs, instruments and sharps are accounted for, and verbal acknowledgement should be received from the operating surgeon in order to avoid any misunderstanding

2. RESOURCES

No additional resources were identified as a result of approval of this policy and procedure.

3. TRAINING

Cardiff and Vale UHB is a teaching hospital and therefore supports the placement of students in the peri-operative environment. During their placement in the department they will have supernumerary status and will not be asked to participate in the count.

During the orientation/induction programme for all new peri-operative staff, an introduction and a copy of the UHB Policy and Procedure for Swabs, Instruments and Sharps Count will be given to individuals by a member of the peri-operative education team. All new peri-operative staff, including healthcare assistants/support workers, will undertake the 'in-house' training programme, which leads to the competence required in the induction booklet.

Additional training and department meetings will be used to update peri-operative staff with regards to the any changes in practice and the principles of best-practice in swab, instrument and needle checking, during quality and safety sessions.

4. AUDIT

Compliance with this Policy and Procedure will be internally audited on an annual basis. Compliance will also be monitored through the external QUAD annual process.

5. DISTRIBUTION

This Policy and procedure will be shared at Clinical Board and Directorate Quality and Safety meetings, will be displayed on departmental notice boards and will be available for viewing via the Cardiff and Vale UHB Intranet. A copy will also be provided to all Clinical Directors, Clinical Board Nurses, Lead Nurses for onward distribution and circulation to staff as necessary

6. REVIEW

This policy and procedure will be reviewed every 3 years or as often as is necessary to ensure continued compliance.

7. FURTHER INFORMATION

AORN 2006 Recommended Practices for Sponge, Sharp and Instrument Counts. In: Standards, Recommended Practices and Guidelines Denver AORN Inc

Association for Perioperative Practice 2007 Standards and Recommendations for Safe Perioperative Practice Harrogate, AfPP

Australian College of Operating Room Nurses 2006 Counting of Accountable Items Used During Surgery, Standard S3. In ACORN Standards for Perioperative Nursing ACORN, Australia www.acorn.org.au

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Setting*. Harrogate, NATN

NATN (1998a) *Infection Control. Principles of Safe Practice In the Perioperative Environment* Harrogate NATN

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Risks* Harrogate NATN

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Never Events List (2015) NHS England. Available at: http://www.england.nhs.uk/ourwork/patientsafety/never-events/

Nursing Midwifery Council (NMC) (2015) Code of Professional Conduct London NMC

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Alexander's Care of the Patient in Surgery 10th Edition St Louis Mosby

Operating Room Nurses Association of Canada (ORNAC) 2005b Module 3
Safety/Risk Prevention and Management 5 Surgical Counts, in Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice Available from: www.ornac.ca

Royal College of Surgeons (2008) Good Surgical Practice, London, RCSEng

Rothrock J (Ed) (2002) Alexander's Care of the Patient in Surgery 12th Edn p36-37 London, Mosby

Tingle J (1997) Legal problems in the operating theatre: learning from mistakes *British Journal of Nursing* 6 (15) 889-891

WEDS (2011) Health Care Support Worker Code of Conduct and Code of Practice. Available from www.weds.wales.nhs.uk/codehcsw-code-of-conduct-code-of-practice [Accessed 7July 2015]

Woodhead K, Wicker P (2005) A Textbook of Perioperative Care Oxford, Churchill Livingstone

8. PROCEDURE FOR ENSURING THE CORRECT SWAB, INSTRUMENT AND SHARPS COUNT

1. INTRODUCTION

The overriding principle for the count is that all swabs, instruments and sharps (this will include surgical blades, suture and injection needles and all other disposable items) must be accounted for at all times during an invasive surgical procedure in any clinical setting, to prevent foreign body retention and subsequent injury to the patient. For guidance in relation to management of Throat Packs please see separate UHB Policy.

The main areas for consideration are:

- Education/Training
- Packaging
- Responsibility for counts
- Checking procedure
- Counting Techniques
- Count Discrepancy
- Documentation

2. EDUCATION AND TRAINING

	ACTION	RATIONALE
2.1	On induction all staff (nurses, operating department practitioners (ODP) and unregistered staff) must have a supernumerary status whilst training.	So that they are supervised prior to working independently. All staff know how to access the policy and its importance in safe peri-operative practice.

2.2	All staff will have their own copy of the Swab, Instrument and Sharps Count policy and have read and understood it before participating in swab, needle and instrument counts. Staff will be expected to sign a signatory sheet when issued with the policy which will then be placed in their training file.	New staff are aware of the location of the policies and procedures To provide an audit trail
2.3	All newly appointed staff will be trained and assessed against the standards in the induction booklet before participating in swab, needle and instrument counts. This booklet will be retained in the staff member's training/personal file on completion of their induction which is kept with the practice education team.	All staff are to be aware of their responsibilities regarding the adherence to departmental policies. To maintain records and ensure evidence of training.

3. PRINCIPLES OF PRACTICE

	ACTION	RATIONALE
3.1	A swab, instrument and sharps count must be performed for all clinically invasive procedures and recorded immediately on the swab board using one pen colour only	In the event of an incident the procedure was followed and the checking procedure was complete.
3.2	All swabs, including lahey swabs, patties and packs that are used during invasive procedures must have an x-ray detectable marker fixed securely within the swab or pattie. This excludes cotton wool balls used in ENT	The swab will be visible on an X- ray and the swab marker will not become detached.
3.3	All swabs must be in bundles of five (5) and of a uniform size and weight and counted in fives (5) and recorded on the swab board as such.	There is a standardised procedure for counts and to reduce the risk of errors occurring and to provide an accurate baseline for all subsequent counts.

3.4	All items used as swabs must be counted in fives and documented on the swab board. This includes patties, lintenes and cotton wool balls.	To provide an accurate baseline for all subsequent counts
3.5	At all times during the procedure the scrub practitioner must be aware of the location of all swabs, instruments, sharps and medical devices used in the procedure.	The scrub practitioner is aware of the location and use of all the swabs, sharps and instruments.
3.6	The surgeon must not remove any item from the scrub practitioner's trolley without permission.	The scrub practitioner is aware of the location and use of all the swabs, sharps and instruments.
3.7	The surgeon will inform the scrub practitioner of the placement of any swab inside the patient and this will be recorded on the swab board.	The scrub practitioner is aware of the location of all swabs.
3.8	All scrub staff must maintain a neat and organised approach to their work.	If there is a change of scrub practitioner that the working area is easy to take over and check.
3.9	In the event of a NCEPOD (National Confidential Enquiry On Patient Outcome and Death) 1 emergency, it is recognised that a count may not be performed until the patient's condition has stabilised. Packaging of all recordable items must be retained as a cross check.	The packaging can be used to facilitate a count at the earliest appropriate opportunity, and this must be documented in the patient's notes and patient's theatre care plan.
3.10	If any interruption occurs during the counting procedure, the count should be started again from the beginning	To allow a complete and accurate count.

3.11	If a counted item is inadvertently dropped off the sterile field, the circulating staff member should retrieve it, show it to the scrub practitioner and segregate it from the sterile field but remain visible to be included in the count.	To maintain the integrity of the count.

4. RESPONSIBILITY FOR COUNT

	ACTION	RATIONALE
4.1	Each count must be performed by the scrub practitioner and another member of staff, one of whom must be a registered theatre practitioner who will be able to count the swabs, sharps, instruments and other items. If the scrub practitioner is of a supernumerary status the responsibility of the count will remain with the supervising registered practitioner.	So that the correct swabs, sharps, instruments and other items are accounted for.
4.2	The same two members of staff (registered practitioner and designated circulator) must perform all the counts during the procedure whenever possible.	Continuity of the count and checking procedure will be maintained reducing the risk of errors occurring.

4.3	Should the scrub practitioner change for any reason during the procedure, a complete count must be performed together by the incoming and outgoing practitioner where possible, recorded in the patient's care plan and signed by both practitioners. If it is not possible to do the check together then the incoming practitioner and outgoing practitioner will carry out their own checks with the designated runner. Should the designated runner change for any reason during the procedure a complete count must be performed together with both the incoming and outgoing runner and the scrub practitioner where possible, recorded in the patients care plan and signed by all involved with the check. If it is not possible to do the check together then the incoming designated runner will carry out the checks with scrub practitioner.	To check that the count is correct at handover or change of team members and that all items are accounted for.
4.4	Where there is a changeover of staff and a check is not possible, the reason must be recorded in the care plan	To provide best practice and safety for the patient.
4.5	When there is more than one scrub practitioner, a decision must be taken prior to the commencement of the case to establish who will be the lead scrub practitioner for the duration of the procedure (see multi-site procedure).	To provide continuity of care and safe practice throughout the procedure for patients and staff
4.6	All items that remain in the patient intentionally such as packs must have a radio opaque marker and the number and type recorded in the patient's notes and care plan.	To inform the ward staff that the patient has an insitu pack and to prevent inadvertent retention.
4.7	Swabs, sharps, instruments and other accountable items must remain in the theatre until permission for removal has been given by the lead scrub practitioner.	To provide best practice and safety for the patient, to ensure integrity of count.

4.8	Dressings must not be opened before the final count. Should the dressings be included in the procedure pack, they should be isolated on the sterile tray until the final count is complete.	These items are not X-ray detectable.
4.9	All staff present in the operating theatre must assist in the count by allowing the scrub practitioner to complete the count without interruptions.	To allow a full and accurate count.
4.10	On completion of the final count the scrub practitioner will inform the surgeon that the swabs, instruments, sharps and all other accountable items are correct and the surgeon must audibly acknowledge the results. If the count is incorrect then follow the procedure in section 8.	The theatre team are all aware of the correct count to minimise Misunderstandings.
4.11	Immediately prior to the patient leaving the theatre the theatre team must complete the World Health Organisation (WHO) sign out checklist and the designated circulator and lead scrub practitioner must record on the WHO checklist form and in the patient's care plan that all checks were undertaken and were correct.	A permanent record is maintained and care is documented.

5. CHECKING PROCEDURE FOR SWABS

SWABS INCLUDE ALL ITEMS USED AS A SWAB E.G. PATTIES, LINTENES AND COTTON WOOL BALLS.

	ACTION	RATIONALE
5.1	A full swab count must be performed prior to the commencement of surgery.	To provide a baseline for further checks.
5.2	The swabs will be recorded on the swab board in the theatre immediately after completion of the count and prior to the commencement of surgery.	To provide a visible record of swabs in use.

5.3	At the initial count, and when added during the procedure, swabs must be counted into separate bundles of five. All swabs should be separated so that the radio-opaque line is visible throughout the check.	To maintain the integrity of the count.
5.4	In the event of an incorrect number of swabs (i.e. not five) the entire bundle; red tie and outer packet must be removed from the sterile field, sealed in bag, removed from theatre and the duty manager informed. The batch/lot number and packaging must be retained so as to ensure other items in the batch are removed from stock and that appropriate bodies/agencies are notified. An incident form via e-datix must be completed.	To ensure that the count is accurate and to follow reporting procedures.
5.5	When checking each bundle of swabs the red tie must be accounted for and stored securely in a designated place and be accounted for at the end of the procedure	The scrub practitioner is aware of the location and use of all the swabs
5.6	A full swab count will be performed at the commencement of the closure of any cavity and at the commencement of the skin closure (final count) this must be documented in the patient's care plan.	To assist the practitioner in maintaining control of the swabs
5.7	Swabs should be counted out of the sterile field. The technique used should be safe and incorporate infection control measures in conjunction with standard precautions. All swabs should be completely separated and counted in multiples of five before they are placed into an appropriate disposal system.	To maintain the sterile field and to reduce to a minimum any risk of cross-infection.

5.8	When abdominal mops are used they may be handed out individually to be weighed. They must be kept in full view of the scrub practitioner at all times. They must only be discarded when in multiples of 5.	All swabs are counted and discarded in multiples of 5 to prevent any errors.
5.9	Swabs must be recorded on the swab board; the circulating staff member must finish this procedure without interruption. The information on the swab board must not be wiped clean until the patient has left the operating theatre.	To prevent any errors.
5.10	The surgeon will inform the scrub practitioner of the placement of any swab inside the patient and this will be recorded on the swab board by the designated circulator. When the swab is removed the indicator on the swab board is to be crossed out but not erased from the board.	To reduce the risk of leaving a foreign body in the wound.
5.11	Swabs must not be cut or altered unless specifically intended for this purpose.	To reduce the risk of leaving a foreign body in the wound.
5.12	It is acknowledged that for specific cardiac operations it is necessary to cut swabs to remove them from the operating site. These must be tied together immediately and counted as one swab within a bundle of 5.	To reduce the risk of leaving part of the cut swab in the wound.
5.13	The integrity of the swabs must be checked during the count including any attached tapes.	To prevent tapes or markers being lost or left in the patient.
5.14	All abdominal mops must be used with a clip attached to its tape and all small swabs must be mounted on sponge holders/relevant device once a deep cavity is open. Any deviation from the above must be on the consultant's instruction.	To maintain safe use of the swabs.

5.15	In surgery where the cavity is too small to take mounted swabs (e.g. paediatrics and cardiac) loose swabs may be used. Where these are used entirely within the cavity, they must be documented on the swab board.	To assist the practitioner in maintaining control of the swabs.
5.16	Any additional items added to the sterile field must be counted and recorded on the swab board by the designated circulator.	To maintain the accuracy of the count.
5.17	In ophthalmology where the operation site is on the lids or the globe, swabs are not counted. These swabs are not x-ray detectable. Best practice would indicate however that a count be undertaken.	Swabs are too large to be lost in this type of surgery.
5.18	All used swabs should remain in theatre and be available for inspection throughout a clinically invasive procedure.	To allow checks to be made in the event of a discrepancy.
5.19	If there is a discrepancy in the closure counts, the procedure described in section 8 Count Discrepancy must be followed	To allow a systematic approach to the search for the lost item.

6. CHECKING PROCEDURE FOR INSTRUMENTS

	ACTION	RATIONALE
6.1	Before starting any case trays and supplementary instruments must be checked that; • They are correct for the surgery planned and are in good working order • Are in date • That packaging is intact, dry and without holes • Sterility indicator strips If any tray or supplementary instrument does not comply then it should be rejected and another item used.	To ensure that the tray/instruments are fit for purpose.

6.2	The tracker label must be removed and put on the correct form. This form must be completed with the patient's hospital number, date and scrub practitioner's name and taken with the used trays/instruments to HSDU or SSU.	To provide an audit trail.
6.3	A full instrument count must be performed prior to the commencement of surgery by the lead scrub practitioner and designated circulator.	To provide an accurate baseline for all subsequent counts.
6.4	All tray instruments including loan trays are to be checked against a pre- printed tray list. Any discrepancy is to be noted on the tray list and reported to the decontamination unit using the appropriate non conformity form. This form must be returned with the instrument or tray at the end of the procedure.	To provide an accurate baseline for all subsequent counts.
6.5	The designated circulator must call aloud from the tray list. The lead scrub practitioner must acknowledge verbally that each item is present. Items should be completely separated during the checking procedure. At the initial and final count each item must be ticked on the tray list.	To provide an accurate count and to record that these items are present. Separation of items allows items to be easily seen and counted.
6.6	The designated circulator must record on the tray list; • The name of the lead scrub practitioner and designated circulator in full • The theatre • Patients hospital number • Patient (e.g. 1st, 2nd) • date	To maintain a record of the staff involved in the counts in the event of a discrepancy.

6.7	All instruments and items with removable parts must be checked for integrity and included in the counts at the commencement and end of the procedure.	To prevent any loss and discrepancies.
6.8	Supplementary instruments must be counted at each instrument count. They can be checked against their packaging, their barcode or the tracking list.	To prevent any loss and discrepancies.
6.9	A full instrument count will be performed at the commencement of the closure of any cavity and at the commencement of the skin closure (final count). This must be documented in the patient's care plan.	To prevent any loss and discrepancies.
6.10	All instruments must be returned to the HSDU/SSU on the correct tray according to that tray list accompanied by the completed tracking form. The tray list must be Completed and all instruments secured on pins as appropriate.	To prevent any errors.
6.11	All supplementary instruments must be returned to HSDU/SSU either in an appropriate container e.g. inside a plastic bag and then placed on the instrument tray and accompanied by the completed tracking form.	To maintain an audit trail.

6.12	In the event of an instrument breaking during the procedure the scrub practitioner must ensure that all pieces have been returned to them. The instrument must be returned with either the appropriate tag attached or in a bag clearly labelled, to the HSDU / SSU. An electronic incident form is to be completed via e-datix.	To prevent injury to staff or the patient and to allow decontamination before being sent for repair or investigation.
6.13	If there is a discrepancy in the closure counts, the procedure described in section 8 Count Discrepancy must be followed.	To allow a systematic approach to the search.

7. CHECKING PROCEDURE FOR SHARPS AND OTHER ITEMS

	ACTION	RATIONALE
7.1	Sharps should be recorded at the commencement of the procedure and recorded individually on the dry wipe (swab) board according to the number marked on the outer package. Sterile suture packs must be retained and used for a check back procedure.	All sharps are to be recorded accurately. Saving the suture packet will aid the scrub practitioner in maintaining an accurate count.
7.2	Opening all packages during the initial sharps count is not recommended. Used sharps on the sterile field should be retained in a disposable, puncture resistant sharps container.	To reduce the chance of needle stick injury and to aid with the ongoing count.
7.3	A full count including sharps will be performed at the commencement of the closure of any cavity and at the commencement of the skin closure (Final count). This must be documented in the patient's care plan.	To prevent any loss and discrepancies.
7.4	A correct sharps count must be performed before the closure of sharps containers/pads.	They should not be opened once closed.
7.5	Snuggers are to be counted and recorded on the swab board.	To prevent loss of the item inside the patient.
7.6	Any additional sharps and recordable items as listed on page 4 must be included in the count and added to the swab board.	To ensure an accurate count.

7.7	In the event of a sharp breaking during the procedure the scrub practitioner must ensure that all pieces have been accounted for and returned to them. It may be necessary to inform the manufacturer and the Medical and Health Care Products Regulatory Agency if a manufacturing fault is suspected. An incident form is to be completed via E-Datix.	To prevent harm to the patient and staff and to record the incident.
7.8	If there is a discrepancy in the closure counts, the procedure described in section 8 Count Discrepancy must be followed.	To allow a systematic approach to the search.

8. PROCEDURE TO BE FOLLOWED FOR COUNT DISCREPANCY

	ACTION	RATIONALE
8.1	If any discrepancy in the count is identified by the scrub practitioner, the operating surgeon must be informed immediately and a search implemented at once. Closure should cease unless it is a life or limb situation.	The surgical team are made aware of the issues and they will assist in the checking for the missing items.
8.2	If a thorough search does not locate the item, an X-ray is to be taken before the reversal of anaesthesia and before the patient leaves the operating theatre if undergoing local / regional anaesthetic procedures.	To confirm that the patient is not at risk of a retained foreign body and to prevent further surgery to remove the item.

8.3	A plain X-ray is recommended (MHRA 2005b). Fluoroscopy/image intensifier should not be used in these circumstances. If the swab count is incorrect and a neurosurgical pattie swab is identified as missing, a CT Scan **MUST** be performed, a plain film x-ray will **NOT** be suitable for these swabs. This must be conducted before the definitive closure of the wound and prior to reversal of anaesthetic in order to rule out retention (See APPENDIX 1)	Fluoroscopy/image intensifier may fail to locate radio opaque swabs. A neuro pattie swab is not always clearly visible under plain fil x-ray when there is interference from equipment and other materials during surgical procedures.
8.4	Missing micro items (such as needles which cannot be detected on X-ray) are to be recorded on the patient care plan and the theatre register (e.g. Theatreman). An X-ray should be performed at the discretion of the surgeon.	All records are correct should the item be found at a later date.

8.5	If an instrument, swab, sharp or other item is missing the following action must be taken; • The surgeon will check the patient's surgical cavity and the area around the wound • The scrub practitioner will perform another count • Circulating staff will check the theatre and the area immediately around and under the operating table. • Circulating staff will check all bins in the theatre and will open all swab bags and recount their contents if still missing • Circulating staff will open all swab bags and recount their contents if still missing	To confirm that the item is not in the patient. Correct reporting of incidents will allow staff to be able to learn from the incident through investigation.
	If still missing: • Inform the patients consultant • Inform the duty manager / senior nurse • X-ray the patient in theatre • Document the incident in the patients care plan and notes • Complete an online e-datix incident form and refer to the Incident, Hazard and Near Miss Reporting Policy Complete a HSDU / SSU document for missing instruments	

10. DOCUMENTATION

	ACTION	RATIONALE
10.1	It is the responsibility of the scrub practitioner to ensure that department documentation and the patient's computerised record e.g. Theatreman is completed and record the outcome of the count	As per UHB and AfPP guidelines to maintain correct records.
10.2	A record of the count must be recorded in the patient's care plan indicating name of lead scrub practitioner and designated circulator responsible for the final count.	As per UHB and AfPP guidelines to maintain correct records.

APPENDIX 1

Safety Memo

Peri-Operative Care Directorate

To: All Staff

From: Paul Warman – Interim Lead Nurse

CC: All staff

Date: 18.07.2023

Re: Swabs, Sharps and Instrument Policy – Interim Action.

Dear All

There has recently been an incident where a patient was returned to theatre for removal of a retained neurosurgical pattie swab.

I am circulating this safety memo as an interim measure to appropriate staff to raise awareness of the issue.

Recommendation

It has been highlighted during an ongoing investigation that neurosurgical pattie swabs are not clearly visible under plain film x-ray when there is interference from equipment and other materials during surgical procedures.

If the swab count is incorrect and a neurosurgical pattie swab is identified as missing, a CT Scan **MUST** be performed, a plain film x-ray will **NOT** be suitable for these swabs. This must be conducted before the definitive closure of the wound and prior to reversal of anaesthetic in order to rule out retention.

Thank you for your co-operation with this.

Best Wishes,
Mr Paul Warman
Interim Lead Nurse

Report Title:	Welsh Language Inpatient Policy			Agenda Item no.	*3.2*
Meeting:	Quality, Safety & Experience	Public	X	Meeting Date:	13.02.2024
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Executive Medical Director				
Report Author (Title):	Welsh Language Officer				

Main Report
Background and current situation:

As a public sector organisation, Cardiff & Vale UHB is required to comply with the Welsh Language Standards. The regulatory body for these Standards is the Welsh Language Commissioner.

There are 121 Welsh Language Standards which came into force in 2019 and the Health Board currently reports compliance with 82 of these Standards.
The Welsh Language Commissioner has determined through Standards Enforcement Investigation (CS1063) that the Health Board has failed to comply with Standard 24, which requiures the Health Boards to:

"Produce and publish a policy on how to establish whether an in-patient ("A") wishes to use the Welsh language during A's in-patient admission if A is unable to inform you that A wishes to use the Welsh language to communicate with you during an in-patient admission."

By publishing the Welsh Language Inpatient Policy, the Health Board will be compliant with Standard 24.

To provide a brief context of the Welsh language in Cardiff and Vale, in the 2021 census Cardiff was the only area of Wales which saw an increase in Welsh language speakers. Although there is some disagreement regarding the accuracy of figures, Welsh Government's Stats Wales estimates that there were approximately 128,800 Welsh speakers within Cardiff and the Vale of Glamorgan; which is just over a quarter of the population. This indicates that a considerable portion of our population may benefit from Welsh language services. Having this policy in place will not only improve the Health Board's compliance with the Standards, but will also support with the provision of Welsh language services to our Welsh speaking community.

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

Implementation of this policy will be supported through the rollout of the Welsh Nursing Care Record (WNCR).

The WNCR is transforming nursing documentation by standardising forms and turning them from paper to digital. For the first time, nurses will be able to complete assessments at a patient's bedside on a mobile tablet, or other handheld device, saving time, improving accuracy, and minimising duplication.

Included in WNCR, will be the option for patients and service users to have their language preferences recorded as part of their records.

Under 'Communication Needs', there are options for first language and preferred language to be recorded, in addition to a question asking whether the individual wishes for the admission to take place in Welsh. The need for an interpreter can also be noted and there is an open text box for the member of staff admitting the patient to record any action required.

The WNCR allows for audits to be undertaken which will enable departments to identify staff who are not routinely collecting the information. This in turn will help in identifying those who may require additional training in collecting the information from patients.The system will also identify areas and departments which are not routinely collecting the information, enabling the Corporate Nursing Team, to engage with those areas and ensure that the process for using the system is followed and that language preference is recorded.

A pilot is currently being undertaken in five wards covering St David's Hospital and Barry Hospital.

The system is scheduled for rollout to University Hospital of Wales and Llandough Hospital in early February 2024, and is anticipated to be in place accross all sites by September 2024.

The Health Board's Corporate Nursing Team are working with the Informatics Team to ensure staff receive training in using the system effectively. Recording a patient's communication needs, including language preference, will form part of the training. The training will be available in person or online to improve accessbility for staff.

The Health Board has also adopted a pioneering approach in the use of Tendable to drive improved quality throughout the healthboard and enhance the data available to management through mobile inspection and auditing tools.

During the summer of 2023, the Health Board designed a Tendable audit to be undertaken every six months. The audit includes whether patients with Welsh language communication needs were present on the ward, whether their language preference was recorded on the system, and where the patient's language preference was Welsh, to identify if there was a member of staff with appropriate Welsh language skills available.

The use of audit systems (WNCR and Tendable) will enable us to measure the robustness of the policy, systems and processes to ensure we identify and overcome barriers.

Recommendation:

The Committee is requested to:

a) Approve the policy

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "X" in the below boxes as relevant

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

Five Ways of Working (Sustainable Development Principles) considered
Please place an "X" in the below boxes as relevant

Prevention		Long term	x	Integration	x	Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category.* ***If yes please provide further details.***
Risk: Yes
Not having a Welsh Language Inpatient Policy in place will result in the Health Board continuing to be non-compliant with Standard 24 of the Welsh Language Standards and could also impact care given to our Welsh speaking communities.
Safety: Yes
By not having a Welsh Language Inpatient Policy in place, there is a risk that our staff will be unclear on the process of supporting a Welsh speaking patient on our wards. This lack of clarity could result in miscommunication and the patient not receiving appropraite care.
Financial: Yes/
Non-compliance with the Welsh Language Standards can lead to financial penalities from the Welsh Language Commissioner up to £5,000.
Workforce: Yes
Providing our staff with clarity on the policy for supporting Welsh language speaking patients will lead to improved care to our Welsh speaking communities.
Legal: Yes
The Health Board is legally required to comply with the Welsh Language Standards. Failure to comply with these standards can lead to various legal sanctions, including a Standards Enforcement Investigation which can lead to a £5000 fine.
Reputational: Yes
The Welsh Language Commissioner undertakes Standards Enforcment Investigations when it is believed an organisation is not complying with the Welsh Language Standards.
Socio Economic: No
Equality and Health: Yes
Please find EHIA attached.
Decarbonisation: No

Approval/Scrutiny Route:	
Committee	Date:

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

Welsh Language choice for in-patient's policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that the organisation complies with its Welsh Language Standards, including providing patients an active choice on whether they wish to communicate in Welsh or English.

Policy Commitment

The policy commits the organisation to ask an in-patient on the first day of the in-patient admission whether a patient or service users wishes to use the Welsh language to communicate with the staff during that in-patient admission.

If the patient or service users wishes to speak Welsh then processes should be in place to ensure staff are able to speak Welsh with the patient during the in-patient's admission.

Supporting Procedures and Written Control Documents

This Policy and the Welsh Language Standards describe how the organisation will respond to in-patient preferred language of either Welsh or English when receiving services by the organisation.

Clinical Boards and other front lines areas should have measures in place to ensure that they can provide a level of services for patients who prefer to speak Welsh. This includes:

- Staff to ensure that they have registered their Welsh Language skills on their Electronic Staff Record.
- Clinical Boards and front-line areas to ensure that patients are asked their preferred language which is then recorded on Welsh Nurse Record or on Patient Management Systems such as PMS and Paris.
- Clinical Boards and front-line areas to utilise their staff's Welsh Language skills to design service that will provide the best level of services in Welsh for their patients who prefer to speak Welsh.
- Ensuring staff have completed their mandatory training on Welsh Language Awareness Training.
- Encourage staff to develop their Welsh Language Skills via available courses offered by the health board.
- Encourage staff with Welsh Language skills to wear the '*iaith gwaith'* to show patients, service users and their friends & family that they are happy to speak Welsh.

Other supporting documents are:

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

- Standard 23 – 24: Cardiff and Vale University Health board Welsh Language Standards
- More than Just Words Welsh Language in Healthcare Framework 2022-2027
- Welsh Language Policy
- 5-year Clinical Consultation Plan
- Equality Act 2010.

Scope

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

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this policy/supporting procedure. *Note: if an EqIA has not been completed indicate why*

Health Impact Assessment	A Health Impact Assessment (HIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this policy/supporting procedure. *Note: if a HIA has not been completed indicate why*
Policy Approved by	Board/Committee/Sub Committee
Group with authority to approve procedures written to explain how this policy will be implemented	For example: Health System Management Board
Accountable Executive or Clinical Board Director	…… Director [insert title of post holder]

Disclaimer

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

Summary of reviews/amendments

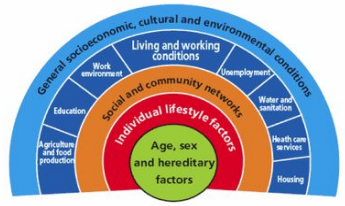
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*
2			

Contents Page

Appendices *(if required)*

Equality & Health Impact Assessment (EHIA)

Tegwch a Chynhwysiant
Equity & Inclusion



Los determinantes de la salud. Dahlgren y Whitehead 1991.

Equality & Health Impact Assessment for

Welsh Language choice for in-patient's policy

Please read the Guidance Notes in Appendix 1, 2 & 3 (located at the back) prior to commencing the EHIA for help and support in completing this document.

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required (submit to equality team)
- Appendices 1-3 must be deleted prior to submission for approval
- We have put helpful hints in, to support you in completion of the Document. Please delete them before submission.
- Useful links have been added to relevant sections for quick reference and support.

Please answer all questions: -

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Welsh Language Officer - Equity, Inclusion and Welsh Language Team
3.	Objectives of strategy/ policy/ plan/ procedure/ service Policies and Procedures - Home (sharepoint.com)	The policy aims are to ensure that the Health Board offer patients and service offers services in either Welsh or English. The policy is based on Standard 24 of the Health Board's Welsh Language Standards set by the Welsh Language Commissioner in May 2019.
4.	Evidence and background information considered. For example • population data • staff and service user's data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the design and development stages Chilcott Rachel 07/02/2024 10:34:44 Public Health Wales Observatory	According to Stats Wales, Cardiff and Vale University Health board has approximately 132,000 Welsh language users living within communities of Cardiff and Vale of Glamorgan. Cardiff has now the highest amount of, according to Stats Wales, of Welsh Language users in Wales. **Welsh Language Skills on ESR** Cardiff and Vale University Health Board employs over 17,000 staff. Cardiff and Vale endeavours to capture information about the current Welsh language skills of our staff by encouraging them to self-assess and record their skills via the NHS Electronic Staff Record (ESR). However, not all staff have access to ESR so the data is currently incomplete. Current data shows that 36% of the staff have registered their language skills. The organisation will be planning to improve the level of Welsh Language registration on ESR during the coming year. **Welsh Language Standards** In 2019, the Welsh Language Commission provided the set of 121 standards that the organisation was expected to comply to ensure it provided a quality healthcare

	Cardiff and Vale of Glamorgan Population Needs Assessment - Cardiff & Vale Integrated Health & Social Care Partnership (cvihsc.co.uk) CAVUHB - Home (sharepoint.com)	and public service through the medium of Welsh. (*ranging from telephone services and correspondence to one-to-one meetings with clinical consultants*): Welsh Language in Healthcare - Cardiff and Vale University Health Board (nhs.wales) **Patient Experience Research** Extensive research shows that there is a positive impact of offering Welsh medium care. The Mwy na geiriau / More than just words strategy provides patient/staff experience of the impact in providing healthcare in Welsh: Service Provider: *"Throughout my career, I've seen many situations where there has been a lack of availability of Welsh-medium staff which has led to a misinterpretation of patients' needs or even a misdiagnosis because patients are confused, in pain or have lost the ability to understand and speak English"* Service User: *"In Welsh I can talk about experiences and personal things. The flow isn't the same in English. You have to translate, especially when you are talking about something that is so important."* Service User*: "I think it is hard to ask for a Welsh language service. You don't want to upset the people who are treating you."* Further information: Mwy na geiriau / More than Just Words Strategic Document. Other patients and service users to use their preferred language of Welsh can lead to better patient outcome. Patient feedback shows how it can affect how patients relate to their care when discussing it in Welsh: "*If the doctor could speak Welsh, I would be able to feel quite close to him*" "*He liked the nurses who spoke Welsh... He became quite close to them. He could relax with them.*" Staff also appreciate the importance of using Welsh with patients:

		"*…. I'll ask, "Do you speak Welsh?" and I get so much more information out of the patient when I ask them that.*" **The Welsh Government More than Just Words Strategic Framework** The organisation is also required to implement this strategic framework, introduced by the Welsh Government to increase the level of Welsh language services offered by the organisation. It ensures that patients and service users are pro-actively asked for their language choice through their patient journey and improve the awareness and importance of the Welsh language choice amongst the staff. The strategy also puts importance of improving Welsh Language skills of staff and encourages the recruitment of staff with Welsh Language skills: More than just words: action plan 2019 to 2020 | GOV.WALES The Welsh Government's More than Just Words has a policy to improve the Welsh Language care for NHS Wales patients and service users. One part of the policy is the importance of the 'Active Choice' where: "*An Active Offer simply means providing a service in Welsh without someone having to ask for it. It means creating a culture that places the responsibility on health and social care providers to provide a proactive language offer so that people can access care, as equal partners, through the medium of Welsh*."
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The policy would affect the general public, patients, service users and staff: 1. The public would receive information, notices and messages in the language of their choice of English or Welsh. 2. Patient and service users will be able to receive healthcare treatment and service through the chosen language of either Welsh or English.

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

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

How will the strategy, policy, plan, procedure and/or service impact on? -	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Refer to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65 Chilcott Rachel 07/02/2024 10:34:44	Children in Welsh medium education may potentially be better able to access health care in Welsh, and very young children in Welsh speaking households may have little or no English. Ensuring a high level of care is available in Welsh thus ensures that these young people have the best access to healthcare. Whilst individuals in older groups (60+) are less likely to be Welsh speakers according to the census, those who do speak in that group may have a particularly vital need for healthcare in Welsh. Some conditions associated with age such as Dementia or Alzheimer's have been associated with a loss of language skills, particularly in acquired languages and for	Ensuring that language choice is being asked during patient intake and registered on patient management systems. Ensuring that front line areas are aware of the language choice made by the patient, and ensuring staff provide best care as possible in that language.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
Chilcott Rachel 07/02/2024 10:34:44	individuals whose first language is Welsh this frequently results in a deterioration in their ability to use English (see Welsh Government More than Just Words Framework). Widening the availability of services in Welsh would be particularly beneficial for this group. There will be a positive impact on people under the age of 18 who may find it easier to communicate through the medium of Welsh. This may due to the language individuals use within at home, school or community and lack confidence to communicate in English. There will be a positive impact for older patient and service users who prefer to use Welsh when discussing their healthcare. This is particularly important for patients with dementia and the		

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
	ability to speak Welsh would be crucial when talking with nursing and medical staff.		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Patients and services users with a disability will be able to use their preferred language of Welsh to improve communication with staff. This will help them to reduce stress and anxiety. Welsh speaking service users with long term illnesses and disabilities who are used to speaking welsh with families, communities and friends will find it easier to discuss their ailments in Welsh. Some neurodiverse colleagues could face challenges adapting to the change in behaviours and expectations described in this policy. However, those who have Welsh as a first language could find that an improved bilingual	1. Ensure that individuals are given a language choice during intake. 2. Staff register the patient language choice on all patient management systems (i.e. Welsh Nursing Care Record) 3. Front line areas will ensure that individuals are able to use Welsh in face-to-face areas as much as possible. 4. Provide bilingual patient information. 5. Measures in place for staff to use their preferred language of Welsh in situations as described under the organisational section of the Welsh Language Standards.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
	environment makes it easier for them to cope.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender Stonewall Gender Identity Research & Education Society – Improving the Lives of Trans People (gires.org.uk) Chilcott Rachel 07/02/2024 10:34:44	Patients of different genders will be able to use their preferred language choice of Welsh during treatment. This will help to reduce anxiety and stress during distressing situations. Individuals will be able to convey their emotions and information better. Welsh speakers come from diverse range of backgrounds including those who are undergoing reassignment. Many of them will find it easier to discuss their treatment/process with our healthcare staff in their preferred language.	1. Ensure that individuals are given a language choice during patient intake. 2.Staff register the patient language choice on all patient management systems (i.e. Welsh Nursing Care Record) 3. Front line areas will ensure that individuals are able to use Welsh in face-to-face areas as much as possible. 4. Provide bilingual patient information. 5.Measures in place for staff to use their preferred language of Welsh in situations as described under the organisational section of the Welsh Language Standards.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	Patients who are married or have a civil partnership might use Welsh with their partners throughout their partnership/marriage. Their partners/spouse might prefer to use Welsh regardless of the patient's choice, especially when discussing their partners'/spouses care.	1. Ensure that individuals are given a language choice during intake and/or discussion about their healthcare. 2. Front line areas will ensure that individuals are able to use Welsh in face-to-face areas as much as possible. 3. Staff register the patient language choice on all patient management systems (i.e. Welsh Nursing Care Record) 4. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. Individuals are protected for 26 weeks after having a baby whether they are on maternity leave.	Women will be able to use their preferred language of Welsh as part the maternity services individuals receive by the organisation. It will improve their communication to staff and convey their emotions and feelings in stressful situation. It will also encourage them to use	1. Ensure that individuals are given a language choice during intake and/or discussion about their healthcare. 2. Front line areas will ensure that individuals are able to use Welsh in face-to-face areas as much as possible.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
	Welsh as part of their maternity period if indviduals want to maintain Welsh as the language of communication between them and the baby.	3. Staff register the patient language choice on all patient management systems (i.e. Welsh Nursing Care Record) 4. Provide bilingual patient information.	encouraging staff to use Welsh language skills and use them with patients.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers The Runnymede Trust	Patients and service users of different race, nationality colour, culture or ethnic origin will be given a language choice when receiving healthcare treatment. Those who prefer to use Welsh will then be able to communicate easier with our staff when receiving treatment.	1. Ensure that individuals are given a language choice during intake and/or discussion about their healthcare. 2. Front line areas will ensure that individuals are able to use Welsh in face-to-face areas as much as possible. 3. Staff register the patient language choice on all patient management systems (i.e. Welsh Nursing Care Record) 4. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Welsh speakers might hold their religious faith through the medium of Welsh. Therefore, individuals might prefer to discuss any faith aspects of their care through the medium of Welsh.	1. Ensure that individuals are given a language choice during intake and/or discussion about their healthcare. 2. Front line areas will ensure that individuals are able to use Welsh in face-to-face areas as much as possible. 3. Staff register the patient language choice on all patient management systems (i.e. Welsh Nursing Care Record) 4. Provide bilingual patient information. 5. Ensure that patient language choice is communicated to the Chaplaincy Team	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay);	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially	1. Ensure that individuals are given a language choice during intake and/or discussion about their healthcare.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
• both sexes (bisexual) Stonewall	when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.	2. Front line areas will ensure that individuals are able to use Welsh in face-to-face areas as much as possible. 3. Staff register the patient language choice on all patient management systems (i.e. Welsh Nursing Care Record) 4. Provide bilingual patient information.	when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language Chilcott Rachel 07/02/2024 10:34:44	Patients and service users who prefer to use Welsh will be able to use their preferred language of Welsh when receiving healthcare service. This will help them to communicate better with staff members, leading to better outcomes. It will also lead to reduction in anxiety and stress during distressing moments.	1. Ensure that individuals are given a language choice during intake and/or discussion about their healthcare. 2. Staff register the patient language choice on all patient management systems (i.e. Welsh Nursing Care Record) 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.10 People according to their income related group:	Welsh speakers come from a diverse range of communities.	1. Ensure that individuals are given a language choice during	1. Achieve compliance to the Welsh language standards

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	Many of them prefer to receive healthcare in the preferred language of Welsh	intake and/or discussion about their healthcare. 2. Front line areas will ensure that individuals are able to use Welsh in face-to-face areas as much as possible. 3. Staff register the patient language choice on all patient management systems (i.e. Welsh Nursing Care Record) 4. Provide bilingual patient information.	around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities Chilcott Rachel 07/02/2024 10:34:44	Our Welsh speaking patients and service users range across the South Wales area, especially for our specialist services. Individuals will be able to continue to use their preferred language of Welsh with this organisation.	1. Ensure that individuals are given a language choice during intake and/or discussion about their healthcare. 2. Front line areas will ensure that individuals are able to use Welsh in face-to-face areas as much as possible. 3. Staff register the patient language choice on all patient	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Refer to where the mitigation is included in the document, as appropriate
		management systems (i.e. Welsh Nursing Care Record) 4. Provide bilingual patient information.	
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	None		

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

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

How will the strategy, policy, plan, procedure and/or service impact on? -	**Potential positive and/or negative impacts and any groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Refer to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities	The policy will improve the health equality for patients and service users who prefer to use Welsh when communicating with healthcare staff.	1. Ensure patients are asked their preferred language 2. Healthcare staff register the language choice of patients.	1. Continue to ensure that their front-line staff members are asking the language choice as standard practice during patient intake. 2. Register the language choice on patients' management systems (i.e. Nursing Record Care Record)
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (e.g., immunisation and vaccination, falls prevention). Also consider the impact on access to supportive services including smoking cessation	Participants would be able to gain more if individuals are able to do it in their chosen language such as Welsh. It would also lead to higher amount of participation from the public.	1. Ensuring that services offer a language choice by the service. 2. Register language choice onto patient management systems. 3. Ensure information is available bilingual. 4. Utilise the language skills of staff to provide the best of service for those who prefer to use Welsh.	1. Continue to ensure that their front-line staff members are asking the language choice as standard practice during patient intake. 2. Register the language choice on patients' management systems (*i.e. Nursing Record Care Record*) 3. Register to Welsh Language skills of staff within teams. Use their skills when rolling out services for the public and service users.

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts and any groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Refer to where the mitigation is included in the document, as appropriate
services, weight management services etc. Creating healthier places spaces.pdf (wales.nhs.uk)			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	n/a	n/a	
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff, and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents;	Ensuring that the patient/service user environment is bilingual will allow patients and service users feel at home and accessible.	Provision of bilingual information *(such as pamphlets and posters)*	Ensure that information is bilingual *(this includes posters and pamphlets)*

How will the strategy, policy, plan, procedure and/or service impact on? -	Potential positive and/or negative impacts and any groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Refer to where the mitigation is included in the document, as appropriate
quality and safety of play areas and open spaces			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos	n/a	n/a	n/a
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate	n/a	n/a	n/a

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

8.1 Please summaries the potential positive and/or negative impacts of the strategy, policy, plan, or service	The policy will have a positive impact on improving the Welsh Language agenda by ensuring that staff ask patients for their preferred language when receiving treatment as an inpatient.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	• The Health Board will ensure that its staff in frontline areas will provide a language choice of either Welsh or English • The Health Board should ensure that systems in places (e.g. patients management systems) that would record patient language choice	Clinical Boards	Ongoing	Clinical Areas to action the policy and ensure that in-patients are asked for their preferred language during in-take. Patient management system should be able to prompt or log the patient language choice.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

8.4 What are the next steps?
 	
Some suggestions: -
• Decide whether the strategy, policy, plan, procedure and/or service proposal:
  ○ continues unchanged as there are no significant negative impacts
  ○ adjusts to account for the negative impacts
  ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)
  ○ stops.
• Have your strategy, policy, plan, procedure and/or service proposal approved
• Publish your report of this impact assessment
• Monitor and review
	There are no negative impacts on the implementation of the policy.
	
	The Health Board to continue with the roll-out of language choice for patients when receiving care.
	
	Clinical Boards can use patient and service user management system such PMS, PARIS and Nursing Care Record to ensure that patients language choice is been recorded and actively considered as part of their overall care.
		Director of Operations / Clinical Boards	Ongoing	Front line areas to ensure that language choice of the patient is asked and registered.

Appendix 1

Equality & Health Impact Assessment

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

Guidance

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

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)[1]

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

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

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

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)[2]
- Equality Act 2010[3]
- Well-being of Future Generations (Wales) Act 2015[4]
- Social Services and Well-being (Wales) Act 2015[5]
- Health Impact Assessment (non-statutory but good practice)[6]
- The Human Rights Act 1998[7]
- United Nations Convention on the Rights of the Child 1989[8]
- United Nations Convention on Rights of Persons with Disabilities 2009[9]
- United Nations Principles for Older Persons 1991[10]
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance[11]
- Welsh Government Health & Care Standards 2015[12]
- Welsh Language (Wales) Measure 2011[13]

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

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

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently based on their 'protected characteristics' (i.e., Their age, disability, gender reassignment, marriage or civil partnership, pregnancy or

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

maternity, race, religion, sex, or sexual orientation) and if it will affect their human rights. It also takes account of care responsibilities and Welsh Language issues. They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure, or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently based on where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

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

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

Completion of the EHIA should be an iterative process and commence as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and be used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service

and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

For further information or if you require support to facilitate a session, please contact equityand.inclusion@wales.nhs.uk or kate.roberts6@wales.nhs.uk

Based on

- Cardiff Council (2013) Statutory Screening Tool Guidance
- NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools, and templates[14]
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide

Resources for Equality Health impact Assessments

Diverse Cymru – list of useful reports
Equality in Wales - Diverse Cymru

Welsh Health Impact Support Unit (focus on health inequalities)
Home - Wales Health Impact Assessment Support Unit (phwwhocc.co.uk)

What Works Wellbeing
Homepage - What Works Wellbeing

Nice Guidance
Find guidance | NICE

Creating healthier places and spaces for our present and future generations (Public Health Wales and Natural Resources Wale
Creating healthier places spaces.pdf (wales.nhs.uk)

The Kings Fund
Ideas that change health and care | The King's Fund (kingsfund.org.uk)

Institute of Health Equity
Resources & Reports - IHE (instituteofhealthequity.org)

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

[Protected characteristics | Equality and Human Rights Commission (equalityhumanrights.com)]

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

Tips

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

Report Title:	NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)			Agenda Item no.	3.2
Meeting:	Quality, Safety and Experience Committee	Public	x	Meeting Date:	20/02/2014
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Abigail Harris, Executive Director of Strategic Planning				
Report Author (Title):	Commissioning Manager – Strategy and Development				

Main Report
Background and current situation:

Current Situation:
Following a Judicial Review in December 2021, the Welsh Government in July 2022 agreed that a specific and limited review of the All Wales IPFR Policy would be undertaken to clarify how the policy should be interpreted. The changes made to the policy seek to clarify the wording of the policy where the KC felt that there were legal ambiguities following the Judicial Review.

In September 2022, the Joint Committee (JC) approved the proposal for WHSSC to embark on an engagement process with key stakeholders, including the All Wales Therapeutics and Toxicology Centre (AWTTC), the IPFR Quality Assurance Advisory Group (QAG), the Medical Directors and the Board Secretaries of each of the Health Boards (HBs) and Velindre University NHS Trust (VUNT), to update the WHSSC IPFR Panel ToR and on the specific and limited review of the All Wales IPFR Policy.

Background:
In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards work together with the Welsh Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All-Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011. The policy has been updated on several occasions with the last update previously in 2017.

A comprehensive range of NHS healthcare services are routinely provided locally by primary care services and hospitals across Wales. However, each year, requests are received for healthcare that falls outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR).

The challenge for all Health Boards and WHSSC is to strike the right balance between providing services that meet the needs of the majority of the population in the geographical area for which it is then given responsibility, whilst having in place arrangements that enable it to accommodate people's individual needs. To manage this aspect of the Health Board and WHSSC's responsibilities, there will always need to be in place a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board or WHSSC will have to make.

NHS Wales introduced the Policy on decision making for IPFR's to ensure an open, transparent, fair, clearly understood and easily accessible process is followed. It describes both the principles underpinning how decisions are made to approve or decline individual patient requests for funding and the process for making them.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:
Overall the language within the Policy has been clarified to allay any ambiguity following the Judicial review. The way in which an IPFR request is processed and considered has not been altered. The main amendments to the All Wales IPFR Policy are: • Details regarding how to request a legal challenge have been removed • Value for money section (section 4.7) has been strengthened • The 'Decision Making Guide' been placed into appendix 1

Recommendation:
The Committee is requested to: Note the contents of the NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR).

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: Yes
The IPFR Policy requires the authorisation on the front page of the form from the relevant Clinical Board Director and Clinical Director to confirm that they consent to the requested funding to be from the Clinical Board budget. The only deviation from this is for IPFR requests from Velindre Cancer Centre. To support this, there is a Scheme of Financial Delegation that sits alongside the IPFR Policy.
Workforce: No
Legal: Yes

If the IPFR Policy is not adhered to, the Health Board may be at risk of legal challenge. To mitigate this, the Cardiff and Vale IPFR Team submit randomized cases for independent quarterly audit which is monitored by the Welsh Government and are regularly reviewed by Internal Audit. The IPFR Policy has a Review Procedure to allow for concerns to be addressed prior to any legal action.
Reputational: Yes
Non-adherence to the IPFR Policy may carry a reputational risk.
Socio Economic: No
Equality and Health: Yes
Decarbonisation: No
Not Applicable

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

Chilcott Rachel
07/02/2024 10:34:44

NHS WALES POLICY
MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR)

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL December 2023
Linked Documents	Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Health Boards and Primary Care providers across Wales

Welsh Health Specialised Services Committee (WHSSC)
Public Health Wales (PHW)
Public Domain via Internet Sites

Policy Development: All Wales IPFR Policy Implementation Group

Consultation: Legal Advice from TBC
NHS Wales Medical Directors
Stakeholder groups

Approved: **December 2023**

Date of Publication: DD/MM/YEAR

Date of Next Review DD/MM/YEAR

Lead Health Board Contact: Contact details as per individual Health Board

Table of Contents

1 INTRODUCTION

1.1 Background

In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards would work together with the Welsh Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All-Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011.

1.1.1 In October 2013, The Minister for Health and Social Services announced a review of the IPFR process in Wales. An independent review group was established to explore how the current process could be strengthened.

1.1.2 In April 2014, the "Review of the IPFR process" report was published. The report concluded that the IPFR process in Wales is comprehensive and supports rational, evidence-based decision making for medicine and non-medicine technologies which are not routinely available in Wales. The review group also made a number of recommendations to strengthen the IPFR process.

1.1.3 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being, and Sport agreed the time was right for a new, independent review of the IPFR process. The panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017.

1.1.4 Following a Judicial Review in December 2021, the Welsh Government in July 2022 agreed that a specific and limited review would be undertaken to put beyond doubt how the policy should be interpreted.

1.2 Purpose of this Policy

1.2.1 To ensure an open, transparent, fair, clearly understood and easily accessible process is followed, the NHS in Wales has introduced this Policy on decision making for IPFR's. It describes both the principles underpinning how decisions are made to approve or decline individual patient requests for funding and the process for making them.

1.2.2 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.3 A comprehensive range of NHS healthcare services are routinely provided locally by primary care services and hospitals across Wales. In addition, the Welsh Health Specialised Services Committee (WHSSC), working on behalf of all the Health Boards in Wales, commissions a number of more specialist and highly specialist services at a national level. However, each year, requests are received for healthcare that falls outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR).

1.2.4 Each Health Board in Wales has a separate Policy called 'Interventions Not Normally Undertaken' (INNU) setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because:

- There is currently insufficient evidence of clinical and/or cost effectiveness; and/or
- The intervention has not been reviewed for the indication under consideration by the National Institute for Health and Care Excellence (NICE) or the All-Wales Medicines Strategy Group (AWMSG); and/or One Wales Medicines process or Health Technology Wales.
- The intervention is considered to be of relatively low priority for NHS resources.

1.2.5 The INNU policy should be read together with this policy on making decisions.

1.2.6 The challenge for all Health Boards and WHSSC is to strike the right balance between providing services that meet the needs of the majority of the population in the geographical area for which it is then given responsibility, whilst having in place arrangements that enable it to accommodate people's individual needs. Key to this is having in place a comprehensive range of policies and schedule of services that the Health Board and/or WHSSC has decided to fund to meet local need within the resource available. To manage this aspect of the Health Board and WHSSC's responsibilities, there will always need to be in place a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board or WHSSC will have to make.

1.2.7 In line with the requirements of the Equality Act 2010 and the Welsh Government guidance 'Inclusive Policy Making' issued in May 2010, a detailed equality impact assessment has been completed to assess the relationship between this policy and the duties of the Act.

1.3 Explaining Individual Patient Funding Requests (IPFR)

1.3.1 IPFRs are defined as requests to a Health Board or WHSSC to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board or WHSSC has arranged to routinely provide, or commission. This can include a request for any type of healthcare including a specific service, treatment, medicine, device, or piece of equipment.

Such a request will normally be within one of the three following categories;

- a patient and NHS clinician have agreed together that they would like a

treatment that is either new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatments (for example, a request to use a cancer drug that has yet to be approved by the Health Board for use in that particular condition);

- a patient and NHS clinician have agreed together that they would like a treatment that is provided by the Health Board in certain clinical circumstances but is not eligible in accordance with the clinical policy criteria for that treatment (for example, a request for treatment for varicose veins for cosmetic reasons alone);

- a patient has a rare or specialist condition that falls within the service remit of the WHSSC but is not eligible in accordance with the clinical policy criteria for treatment (for example, a request for plastic surgery where the indication is personal preference rather than medical need).

1.3.2 IPFRs should not be confused with requests for packages of care for patients with complex continuing healthcare needs – these are covered by separate Continuing Healthcare arrangements. Further information can be obtained from the Health Board's Nursing Department.

1.3.3 IPFRs should also not be confused with treatments that have already been provided or administered. Requests **will not** be considered for retrospective funding.

1.3.4 If the clinical circumstances for the specific individual patient have changed, an IPFR application form describing / explaining / justifying:
- why the patient is likely to gain a significant clinical benefit from the proposed intervention; and
- demonstrating that the value for money of the intervention for that particular patient is likely to be reasonable,

then a case may be submitted to the Health Board or WHSSC for consideration for further prospective funding. For example, if a patient funds a treatment themselves and their clinician believes they can demonstrate that the patient has gained significantly more clinical benefit from the intervention than would normally be expected for that treatment, an IPFR can be submitted for consideration.

1.3.5 The three categories of treatment described in 1.3.1 will only potentially be funded in specific clinical circumstances. It is important to note that the NHS in Wales does not operate a blanket ban for any element of NHS healthcare but equally the granting of funding in one case does not mean that funding will be provided for the same treatment for other patients. We will consider each IPFR on its individual merits and in accordance with the arrangements set out in this policy. We will determine if the patient should receive funding based on the significant clinical benefit expected from the treatment and whether the cost of the treatment is in balance with the expected clinical benefits.

1.3.6 In this policy, the words "significantly different to the general population of patients" means that the patient's condition does not have substantially the

same characteristics as other members of that population. For a patient to be significantly different, their particular clinical presentation is unlikely to have been considered as being part of the population for which the policy was made.

1.3.7 In practice, it is not always practical to determine the "benefit" of an intervention in numerical terms in the same way, for example as NICE or the AWMSG. In these situations, a description of the benefit should be used to enable IPFR panels to compare the description of the incremental clinical benefit likely to be obtained. In general, the clinician should compare the benefits of the intervention being requested with what he or she considers to be the next best alternative, which may in some cases be best supportive care.

1.3.8 Whether an intervention provides "value for money" is assessed conceptually in terms of the incremental cost per incremental quality-adjusted life year (QALY) of benefit. Whilst "reasonable" value for money is to be interpreted in the same way that "cost-effective" is used in the Health Technology Appraisal (HTA) process operated by NICE and AWMSG.

1.3.9 Recognising that it can never be possible to anticipate all unusual or unexpected circumstances this policy aims to establish a clear guide to making decisions on IPFRs to determine whether the evidence that the patient is likely to gain a significant clinical benefit, and the value for money of the intervention for that particular patient is likely to be reasonable, has been presented.

Please refer to the decision-making guidance in Appendix 1 to see how panel members determine the significant clinical benefit expected by the treatment, and whether the cost of the treatment is in balance with the expected benefits.

2 THE LEGAL CONTEXT OF THIS POLICY

2.1 Health Boards exercise functions delegated to them by the Welsh Ministers under various statutes and in particular under the National Health Service (Wales) Act 2006 and under secondary legislation made under that Act.

2.2 In addition to specific statutory obligations, Health Boards are public bodies, which are required to comply with their legal obligations to act in accordance with the rights if individuals under the European Convention of Human Rights as defined in the Human Rights Act 1998 and under common law.

2.3 Health Boards must therefore be able to demonstrate that their decisions are within their powers and comply with their legal obligations. In terms of the exercise of their powers, they must show that they have considered all relevant issues in the decision-making process, giving them appropriate weight and that those decisions are rational, logical, lawful and proportionate.

Careful consideration needs to be given in relation to all decisions; particular care may need to be given in the following circumstances:

- when evidence is not clear or conclusive.

- when the issue is controversial and may not have the support of NICE, AWMSG, One Wales or HTW.
- when life or death decisions are involved.
- when limiting access to specific services or treatments.
- when setting priorities.
- when other Health Boards or WHSSC may have used their discretion to make a different decision on a specific topic.

2.4 It is lawful for WHSSC and Health Boards to adopt policies about which treatments will, and which will not, be routinely funded. It is also lawful for WHSCC and Health Boards to adopt this Policy to define the circumstances in which a decision can be made to fund an intervention for a patient where other patients are lawfully denied funding for the same intervention as a result of policies or as a result of an absence of a policy approving funding for that intervention.

2.5 Consistency in policy and approach, together with clarity about clinical criteria for treatment and a consistent approach to dealing with IPFR requests should reduce the need for patients to have to go through a review or appeal process at any level. This should be the desirable outcome as far as it is possible.

3 PRINICIPLES UNDERPINNING THIS POLICY

The principles underpinning this policy and the decision making of the Health Board are divided into five areas - the NHS Core Values, the Prudent Healthcare Principles, Evidence-based Considerations, Ethical Considerations and Economic Considerations.

3.1 NHS Core Values are set out by the Welsh Government as: -

- Putting quality and safety above all else: providing high value evidence-based care for our patients at all times.
- Integrating improvement into everyday working and eliminating harm, variation, and waste.
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness, and wellbeing for future generations of the people of Wales.
- Working in true partnerships with partner organisations and with our staff; and
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems, and environment to work safely and effectively.

3.2 Prudent Healthcare Principles

- Achieve health and wellbeing with the public, patients, and professionals as equal partners through co-production.
- Care for those with the greatest needs first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do not harm.
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

3.3 Evidence-Based Considerations

3.3.1 Evidence-based practice is about making decisions using quality information, where possible, and recognising areas where evidence is weak. It involves a systematic approach to searching for and critically appraising that evidence.

3.3.2 The purpose of taking an evidence-based approach is to ensure that the best possible care is available to provide interventions that are sufficiently clinically effective to justify their cost and to reduce inappropriate variation using evidence-based practices consistently and transparently. NICE issue Technology Appraisals and the All-Wales Medicines Strategy Group, One Wales and Health Technology Wales issue guidance which Health Boards and WHSSC are required to follow.

3.3.3 Additionally, a central repository for evidence-based appraisals is available which provides support for clinicians making an application. This is located on the shared database. Users are able to upload and access the information available which will continue to be developed over time as evidence /new reports are produced.

3.3.4 It is also important to acknowledge that in decision making there is not always an automatic "right" answer that can be scientifically reached. A "reasonable" answer or decision therefore has to be reached, though there may be a range of potentially reasonable decisions. This decision is a compromise based on a balance between different value judgements and scientific (evidence-based) input. Those vested with executive authority have to be able to justify, defend and corporately "live with" such decisions.

3.4 Ethical Considerations

3.4.1 Health Boards and WHSSC are faced with the ethical challenge of meeting the needs of individuals within the resources available and meeting their responsibility to ensure justice in the allocation of these resources ('distributive justice'). They are expected to respect each individual as a person in his or her own right.

3.4.2 Resources available for healthcare interventions are finite, so there is a limit to what Health Boards and WHSSC can routinely fund. That limitation is reasonable providing it is fair, and not arbitrary. It must be based on the evidence both about the effectiveness of those interventions and their cost. A cost-effective intervention is one that confers a great enough benefit to justify its cost. That means policies must be based on research, but research is carried out in populations of patients, rather than individual patients. That leaves open the possibility that what is true for patients in general is not true about a specific individual patient. Fairness therefore also requires that there must be a mechanism for recognising when an individual patient will benefit from a particular intervention more than the general population of patients would. Identifying such patients is the purpose of the IPFR process.

3.4.3 Welsh Government communications set out six ethical principles for NHS organisations and these underpin this policy. They are:

- treating populations and particular people with respect.
- minimising the harm that an illness or health condition could cause.
- fairness.
- working together.
- keeping things in proportion; and
- flexibility

3.5 Economic Considerations

3.5.1 It is a matter for Health Boards and WHSSC to use its discretion to decide how it should best allocate its resources. Such resources are finite and difficult balancing decisions have to be made. Health Boards and WHSSC must prioritise the services that can be provided whilst delivering high-quality, cost-effective services that actively avoid ineffective, harmful, or wasteful care that is of limited benefit. The opportunity cost associated with each decision has also to be acknowledged i.e., the alternative uses to which resources could be put.

4 MAKING DECISIONS ON IPFR

4.1 In line with the principles set out earlier in this document, Welsh Government communications set out the key factors for 'good decision making'. These are:

- openness and transparency.
- inclusiveness.
- accountability.
- reasonableness.
- effectiveness and efficiency.
- exercising duty of care.
- lawful decision making; and
- the right to challenge and appeal.

This policy aims to ensure that the Health Board and WHSSC has a clear and open mechanism for making decisions that are fair, open, and transparent. It enables those responsible for decision making to demonstrate that they have followed due process, given full consideration to the above factors, and has been both rigorous and fair in arriving at their decisions. It also provides a clear process for challenge and appeal.

4.2 In accordance with Welsh Government communications, NICE definitions, and the criteria set out in this policy, Health Boards and WHSSC should make decisions on IPFRs based on; the evidence presented to demonstrate the expected significant clinical benefit, and the evidence presented outlining the patient's individual clinical circumstances. Decisions should be undertaken whilst taking into reasonable account the evidence base, and the economic and ethical factors below:

- **evidence-based considerations** – clinical and cost effectiveness; service and policy implications.
- **economic considerations** – opportunity cost; resources available; and
- **ethical considerations** – population and individual impact; values and principles; ethical issues.

Non-clinical factors (such as employment status) will not be considered when making decisions on IPFR.

This Policy does not cover healthcare travel costs. Information on patient eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the Welsh Governments 'healthcare costs' website.

4.3 The following criteria must be used by all Health Board and WHSSC IPFR Panels when making IPFR decisions. It is the responsibility of the referring clinician to ensure that sufficient information is placed before the panel to allow the panel to be able to determine whether the criteria are satisfied.

A patient will only be entitled to NHS funding for the requested intervention or drug if the panel conclude that the criteria under **either (a) or (b)** below are satisfied:
(a) If guidelines (e.g. from NICE or AWMSG) recommend NOT to use the intervention/drug, or the clinical access criteria of an applicable policy are not met: I. The clinician must demonstrate that the patient's clinical circumstances are significantly different to other patients for whom the recommendation is not to use the intervention. II. The clinician can demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention, and III. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.
(b) If the intervention has NOT been appraised (e.g. in the case of medicines, by AWMSG or NICE), and there is no applicable policy in place: I. The clinician can demonstrate that the patient is likely to gain significant clinical benefit, and II. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

4.4 An IPFR panel is required to decide whether the application fulfils Part A or Part B and then consider the application against the relevant criteria. A panel may only approve applications which meet all of the applicable criteria above. It is however the responsibility of the requesting clinician to demonstrate the clinical case for the patient in respect of the criteria outlined.

4.5 Considerations under Part A

4.5.1 Where a recommendation has been made not to use an intervention, the panel is required to consider whether the patients' clinical circumstances are significantly different to other patients for whom the recommendation is made not to use the intervention'. That process will usually require a comparison between the patient for whom treatment is being requested, and other patients with the same medical condition who could have been offered the requested intervention if the relevant guidance and/or applicable policy allowed.

4.5.2 The panel next need to consider whether there is a significant difference between the clinical circumstances of the patient for whom funding is being requested, and the comparator group, and whether the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected for patients for whom the recommendation has been made not to use the intervention. If, but only if, both of these criteria are met on the facts of an individual Part A case, the panel will then consider whether the intervention is deemed value for money as described at paragraph 4.7 below.

4.6 Considerations under Part B

4.6.1 In the absence of any appraisal or applicable policy, the panel need to consider whether the referring clinician has provided sufficient evidence to conclude that the patient is likely to gain significant clinical benefit from the intervention requested. If, but only if, both of these criteria are met on the facts of an individual Part B case, the panel will then consider whether the intervention is deemed value for money as described below.

4.7 Value for money

4.7.1 The assessment as to whether the intervention provides "value for money" is a matter of judgement for the panel. The panel should reach a decision exercising its broad discretion to decide whether the value for money of an intervention for a particular patient is likely to be reasonable.

4.7.2 The panel should consider the likely overall costs to the NHS of the requested intervention compared with the next best alternative treatment that is routinely funded on the NHS. The panel should in a similar way consider the overall benefit (effectiveness) of the intervention compared with the next best alternative treatment that is routinely funded on the NHS. If the requested intervention is estimated to be more effective and less costly (than the alternative treatment) then it is likely to represent value for money. If the treatment is less effective and more expensive, then it is unlikely to be deemed value for money. If the treatment is more effective and more costly or less effective and less costly then the panel will need to make a judgement as to whether the treatment is likely to represent value for money. For any scenario, other factors may affect treatment choice, and these should be documented as part of the discussion.

4.7.3 Where presented as part of the evidence, an incremental cost effectiveness ratio ("ICER") and quality- adjusted life year (QALY) may be considered by the panel provided this is relevant to the individual case and there is appropriate expertise by the group to do so. When assessing this evidence, the panel should consider relevant thresholds in relation to NICE and AWMSG when considering if the intervention is a cost-effective option.

4.8 When making decisions, the panel are entitled to have regard to the factors set out at Appendix 1 to this policy, if the panel consider that addressing those issues may assist the panel in coming to decisions on the criteria set out at paragraph 4.3 above. The panel are not obliged to consider all the factors set out Appendix 1 to this policy and may consider that some of the factors are not relevant on the facts of an individual case or do not assist the panel in coming to its decision on those criteria.

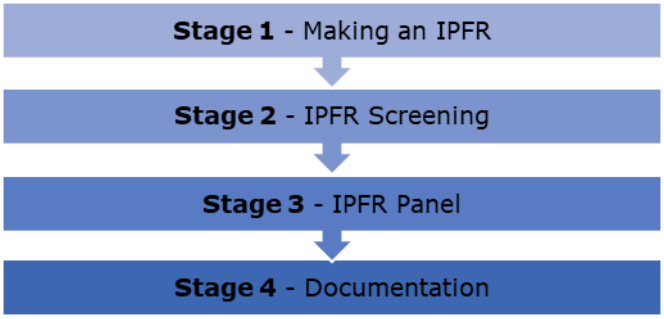
5 HOW TO MAKE A REQUEST FOR FUNDING UNDER THIS POLICY

5.1 Information on how to make an IPFR

A patient leaflet is available explaining how an individual patient funding request (IPFR) can be made. These can be downloaded from the Health Board, WHSSC or AWTTC website. Further information can be obtained from the IPFR Co-ordinator.

Copies of this policy and the IPFR application forms can also be obtained via the website, or by contacting the IPFR Co-ordinator.

5.2 Summary of the IPFR Process



5.3 Stage 1 Making an IPFR

The patient and their NHS clinician (agree together that a request should be made). The IPFR application form is completed by the clinician on the patient's behalf. This will ensure that adequate clinical information is provided to aid the decision-making process.

The requesting clinician must sign the application form to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

Ideally, applications for specialised and tertiary services should be completed by the patient's secondary care clinician, unless extenuating circumstances dictate otherwise. This is to ensure that all pertinent information is included in the form thereby avoiding the delay that will arise from the need to request further information before the application can be processed. All IPFR applications should demonstrate support from the relevant clinical lead, head of department or multi-disciplinary team (MDT). Where relevant, advice may also be sought from the internal clinical team.

It is necessary for clinicians to provide their contact details as there may be times when additional clinical information is required during a panel meeting to aid a decision.

The application form is sent to the IPFR Co-ordinator electronically or in hard copy so that the authorised consent of the clinician is recorded.

The IPFR application form must be completed in full to enable the IPFR Panel to reach a fully informed decision.

Should the IPFR Co-ordinator receive an application form which has not been completed sufficiently enough to determine whether or not the request can be screened out or taken to the IPFR Panel, or the incorrect form is completed, the form should be returned to the requesting clinician **within three working days**.

The requesting clinician is responsible for completing and re-submitting the application form **within ten working days**. Should this time elapse, a chaser letter will be sent providing a **further ten working days** to make a submission.

Where the information has still not been provided in the time set, the case shall be closed, and the requesting clinician notified accordingly.

5.4 Stage 2 Screening of the IPFR

The IPFR application will be considered by the IPFR Senior Officer to determine whether the application needs to be screened out because:

(a) the request meets pre-agreed criteria for a service already commissioned/provided and can be automatically funded.
(b) an alternative and satisfactory clinical solution is found.
(c) the request represents a service development which needs to be passed to the relevant Division or Director for their action.

The IPFR Senior Officer should then communicate the outcome of the screening stage to the requesting clinician using a standard letter, **within five working days** of the decision being made. This letter will also include reasons for the decision and information on any further courses of action required.

5.5 Stage 3 Considerations by the IPFR Panel

Requests that are not screened out will be considered at a meeting of the IPFR Panel. The IPFR Co-ordinator will ensure that the panel has all of the information needed to reach a decision and will ensure that each case is anonymised before each meeting.

Panels will convene at least once per month in order to ensure that applications are dealt with in a timely manner. The volume and urgency of applications may require panels to meet more frequently as and when required.

The panel will consider each IPFR on its own merits, using the decision-making criteria set out in this policy (see appendix 1). Where possible, they should set out their assessment of the likely incremental clinical benefit and their broad estimate of the likely incremental cost so that their judgements on value for money are clear and transparent. The IPFR Co-ordinator or Senior Officer will complete a record of the panel's discussion on each IPFR, including the decision and a detailed explanation for the reason for that decision.

A standard decision letter should be prepared to communicate the decision to the requesting clinician. Correspondence will also be sent to the patient to inform them that a decision has been made and their clinician will contact them within 5 working days to discuss. If this has not happened, patients are encouraged to contact their clinician.

These letters will be sent **within five working days** of the panel's decision and will also include information on how to request a review of the process where a decision has been made to decline the request.

5.6 Who will sit on the IPFR Panel?

The Health Board will appoint core members of the IPFR Panel which will comprise:

- Executive Public Health Director (or deputy – Public Health Consultant)
- Executive Medical Director (or deputy - Associate/Assistant Medical Director)
- Executive Director of Nursing (or deputy – Assistant Director of Nursing)
- Director of Therapies & Clinical Science (or deputy - Assistant Director of Therapies)
- Director of Pharmacy and / or Chief Pharmacist or deputy; and
- Two lay representatives.

The Chair of the Panel will be selected from the group of core members and must have a clinical background (with the exception of WHSSC – see Terms of Reference at Appendix 3).

Each organisation may also wish to appoint up to a further two Panel members at the discretion of the Chair of the Panel, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning.

Please refer to the Terms of Reference at Appendix 2 and 3 for details of the Health Board and WHSSC IPFR Panel.

5.7 What about clinically urgent cases?

The IPFR Policy and process allows for clinically urgent cases, as deemed by the requesting clinician, to be considered outside of the normal screening and panel processes. In these circumstances, the Chair or Vice Chair of the IPFR panel is authorised to make a decision outside of a full meeting of the panel, within their delegated financial limits. Any such decisions will be made in line with the principles of this policy, considering the clinical urgency of the request outlined in the application form by the clinician. Those marked urgent will be considered within 24-48 hours (working days only) as per the application form.

5.8 Can patients and clinicians attend the IPFR Panel?

Patients are not permitted to attend IPFR Panels. The reasons are that it would make the process less fair because it would draw to the attention of panel members characteristics of the individual patient that should not influence their decision-making. The IPFR process is anonymous therefore allowing patients to attend would jeopardise this level of scrutiny. The IPFR Panel will normally reach its decision on the basis of all of the written evidence provided, including the IPFR application form and other documentary evidence which is provided in support. Patients and clinicians are able to supply any written statements they feel should be considered by the Panel**. Any information provided which relates to non-clinical factors will not be considered.** Local Llais teams are able to support patients in making such statements if required.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on specific issues and/or request independent expert clinical advice for consideration by the panel at a future date. The Chair of the IPFR Panel, may also contact the referring clinician to get more clarification in respect of an individual referral.

The provision of appropriate evidence to the IPFR Panel will be entirely at the Chair of the IPFR Panels discretion.

5.9 Documentation

The IPFR Co-ordinator will maintain a confidential electronic record of all requests. A separate, confidential hard copy file may also be maintained. This information will be held securely in compliance with Data Protection requirements and with Caldicott Guidance.

The IPFR Administration Team retains a record of the IPFR application and subsequent decision and any outcome data that is provided by the clinician. Data will be retained to help inform future planning requirements by identifying patient cohorts both at a local and national level. Data will also be used for the production of an annual report on IPFR's every year as required

by the Welsh Government. This will not include any identifiable data and will use aggregated data.

In addition, a central repository for clinical evidence will be available and will develop over time as and when new evidence reports are produced / become available.

Any information will be held in line with the NHS Information Governance Retention Policy

6 HOW TO REQUEST A REVIEW OF THE PROCESS

If an IPFR is declined by the panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, a review hearing can be requested in line with the following:

6.1 The 'review period'

There will be a period of **25 working days** from the date of the decision letter during which they may request a review by the review panel ('the review period"). The letter from the Health Board or WHSSC that accompanies the original decision will state the deadline for any review request. In calculating the deadline, Saturdays, Sundays, and public holidays in Wales will not be counted.

6.2 Who can request a review?

A review can be requested either (a) by the original requesting clinician on the patient's behalf or (b) by the patient with the original requesting clinician's support. **The review request form must be completed by the clinician**. Both the patient and their clinician must keep each other informed of progress. This ensures the patient is kept informed at all times, that the clinician/patient relationship is maintained, and review requests are clinically supported. Patients are able to access advocacy support at any stage during this process.

6.3 What is the scope of a review?

It does not constitute a review of the merits of the original decision. It has the restricted role of hearing review requests that fall into one or more of three strictly limited grounds. A review request on any other ground will not be considered.

The 3 grounds are:

Ground One: *The Health Board or WHSSC has failed to act fairly and in accordance with the All Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR).*

Health Boards and WHSSC are committed to following a fair and equitable procedure throughout the process. A patient who believes they have not been treated fairly by the Health Board or WHSSC may request a review on this ground. This ground relates to the procedure followed and not directly to the decision and it should be noted that the decision with which the patient does not agree is not necessarily unfair.

Ground Two: *The Health Board or WHSSC has prepared a decision which is irrational in the light of the evidence submitted.*

The review panel will not normally entertain a review request against the merits of the decision reached by the Health Board or WHSSC. However, a patient may request a review where the decision is considered to be irrational or so unreasonable that no reasonable Health Board or WHSSC could have reached that conclusion. A claim that a decision is irrational contends that those making the decision considered irrelevant factors, excluded relevant ones, or gave unreasonable weight to particular factors.

Ground Three: *The Health Board or WHSSC has not exercised its powers correctly.*

Health Boards and WHSSC are public bodies which carry out its duties in accordance with the Statutory Instruments under which it was established. A patient may request a review on the grounds that the Health Board or WHSSC has acted outside its remit or has acted unlawfully in any other way.

6.4 How is a review request lodged?

A review request form should be completed and logged with the IPFR Co-ordinator of the Health Board or WHSSC within the review period. The review request form must include the following information:

- The aspect(s) of the decision under challenge and
- The detailed ground(s) of the review request

The review request form should be sent to the IPFR Co-ordinator so that the signatures of both the patient and their clinician are recorded. A scanned version sent electronically will also be acceptable as long as signatures are present.

If the patient signature cannot be obtained in a timely manner or at all, the requesting clinician can sign to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

6.5 Initial scrutiny by the IPFR Senior Officer

The review documents lodged will be scrutinised by the IPFR Senior Officer who will look to see that they contain the necessary information. If the review request does not contain the necessary information or if the review does not appear to the IPFR Senior officer to fall under any one or more grounds of

review, they will contact the referrer (patient or their clinician) to request further information or clarification.

A review will only be referred to the review panel if, after giving the patient and their clinician an opportunity to elaborate or clarify the grounds of the review, the Chair of the review panel is satisfied that it falls under one or more of the grounds upon which the review panel can hear the review.

The Chair of the review panel may refuse to consider a review that does not include all of the above information.

6.6 What is the timescale for a review to be heard?

The review panel will endeavour to hear a review **within 25 working days** of the request being lodged with the Health Board. The date for hearing any review will be confirmed to the patient and their clinician in a letter.

This review process allows for clinically urgent cases, as deemed by the referring/supporting clinician, to be considered outside of the panel process by the Health Board's Chair together with a clinical member of the review panel. Any such decisions will be made in line with the principles of this policy.

6.7 Who will sit on the Review Panel?

The Health Board will appoint members of the review panel. The panel will comprise (see Terms of Reference at Appendix 4 for full details);

- Health Board Independent Board Member – Lay (Chair of the Review Panel)
- Health Board Independent Board Member (with a clinical background)
- Health Board Executive Director, or deputy (with a clinical background)
- Chief Officer of the Community Health Council, or deputy
- Chair of the Local Medical Committee, or deputy
- WHSSC Representative at Director level (where applicable)

The Health Board will intend to inform the patient and their clinician of the membership of the review panel as soon as possible after a review request has been lodged. None of the members of the review panel will have had any prior involvement in the original submission.

In appointing the members of the review panel, the Health Board will endeavour to ensure that no member has any interest that may give rise to a real danger of bias. Once appointed, the review panel will act impartially and independently.

6.8 Can new data be submitted to the review panel?

No, because should new or additional data become available then the IPFR application should be considered again by the original panel in order to maintain a patient's right to review at a later stage.

6.9 Can patients attend review panel hearings?

At the discretion of the panel, patients and/or their unpaid representative may attend review panel hearings as observers but will not be able to participate. This is because the purpose of a review hearing is to consider the process that has been followed and not to hear new or different evidence.

If new or different evidence becomes available, the case will automatically be scheduled for reconsideration by the IPFR Panel. Patients and/or their unpaid representatives are able to make their written representations to this IPFR Panel in order for their views to be considered.

It is important for all parties to recognise that review panel hearings may have to discuss complex, difficult and sensitive information in detail and this may be distressing for some or all of those present. Patients and/or their unpaid representatives should be aware that they will be asked to retire at the end of the review panel discussion in order for the panel to make their decision.

6.10 The decision of the review panel hearing

The IPFR Senior Officer will complete a record of the review panel's discussion including the decision and a detailed explanation for the reason for the decision. They will also prepare a standard decision letter to communicate the decisions of the panel to the patient and referring/supporting clinician.
The review panel can either;

- uphold the grounds of the review and ask the original IPFR Panel to reconsider the request; or
- not uphold the grounds of the review and allow the decision of the original IPFR Panel to stand.

There is no right to a further review unless new and relevant circumstances emerge. Should a patient be dissatisfied with the way in which the review panel carried out its functions, they are able to make a complaint to the Public Services Ombudsman for Wales.

6.11 After the review hearing

The Chair of the review panel will notify patients and their clinicians of the review panel's decision in writing. This letter should be sent **within five working days** of the panel and will also include information on how to make a complaint to the Public Services Ombudsman for Wales www.ombudsman-wales.org.uk.

6.12 How will WHSSC undertake a review?

As the WHSSC is a collaborative committee arrangement to support all Health Boards in Wales, it will not be able to constitute a review panel. WHSSC will therefore refer any requests it receives for a review of its decisions to the Health Board in which the patient resides. A WHSSC representative who was not involved in the original panel will become a member of the review panel on these occasions.

The Health Boards IPFR Senior Officer will be present at these review hearings to advise on proceedings as per their governance role. In the interests of transparency, and not to confuse the applicant, the WHSSC Senior IPFR Officer will be responsible for circulating the review documentation to review panel members, clerking the hearing, and preparing the standard decision letter to communicate the decision of the review panel to the patient and clinician.

7 QUALITY ASSURANCE

The IPFR Quality Assurance Advisory Group was established in 2017 to monitor and support all IPFR panels to promote quality in decision making and consistency across Wales. The Group meets quarterly to assess anonymised random sample IPFR reports in relation to their completeness, timeliness, and efficiency of communication in line with the NHS Wales IPFR policy process.

8 REVIEW OF THIS POLICY

8.1 This Policy should be reviewed every 3 years or as required to reflect changes in legislation or guidance. The review will be undertaken by the All-Wales IPFR Policy Implementation Group. Any changes made will be undertaken in line with the groups Terms of Reference (see appendix 5) and authorised by the responsible Health Board and WHSSC Committee. Any delay in conducting a review will not prevent WHSCC or a Health Board from being able to rely on this policy.

8.2 Any of the following circumstances will trigger an immediate review of the linked INNU Policy:

- an exemption to a treatment policy criterion has been agreed.
- new scientific evidence of effectiveness is published for all patients or sub-groups.
- old scientific evidence has been re-analysed and published suggesting previous opinion on effectiveness is incorrect.
- evidence of increased cost effectiveness is produced.
- NHS treatment would be provided in all (or almost all) other parts of the UK.
- A National Service Framework recommends care.

9 MAKING A COMPLAINT

9.1 Making an IPFR does not conflict with a patient's ability to make a complaint through the Health Boards or WHSSC's Putting Things Right process, details of which can be found on their website.

9.2 If it is not possible to resolve a concern through local resolution the person raising the concern can refer the matter to the Public Services Ombudsman for Wales (PSOW). Further information is available on the Ombudsman's website www.ombudsman-wales.org.uk.

Patients are able to access advocacy support at any stage during this process.

APPENDIX 1: DECISION MAKING GUIDE

This Guide cannot change the meaning of the criteria under paragraph 4.3 of the Policy and may not be relevant to each individual case.

IPFR Panel Decision-Making Factors	**IPFR Panel Evidence for Consideration in Decision-Making**
SIGNIFICANT CLINICAL BENEFIT	
Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population? ***And*** Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage?	Consider the evidence supplied in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Is evidence supplied to explain why the clinical presentation of this patient is significantly different to that expected for this disease and this stage of the disease? • Is evidence supplied to explain why the clinical presentation means that the patient will gain a significantly greater clinical benefit from the treatment than another patient with the same disease at the same stage?
EVIDENCE BASED CONSIDERATIONS	
Does the treatment work? What is the evidence base for clinical and cost effectiveness?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What does NICE recommend or advise? • What does the AWMSG recommend or advise? • What does the Scottish Medicines Consortium recommend or advise? • What does Public Health Wales advise? • Is there advice available from the One Wales Medicines process or Health Technology Wales? • Is there peer reviewed clinical journal publications available? • What information does the locally produced evidence summary provide? • Is there evidence from clinical practice or local clinical consensus? • Has the rarity of the disease been considered in terms of the ability for there to be comprehensive evidence base available? • Does the decision indicate a need to consider policy or service change? If so, refer to service change processes.
ECONOMIC CONSIDERATIONS	
Is it a reasonable cost? What is the cost of the **treatment** and is the cost of the treatment likely to be reasonable? i.e. Is the cost of the treatment in balance with the expected clinical benefits?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What is the specific cost of the treatment for this patient? • What is the cost of this treatment when compared to the alternative treatment they will receive if the IPFR is declined? • Has the concept of proportionality been considered? (Striking a balance between the rights of the individual and the impact on the wider community), in line with Prudent Healthcare Principles. • Is the treatment reasonable value for money?
ETHICAL CONSIDERATIONS	
How has the decision been reached? Is the decision a compromise based on a balance between the evidence-based input and a value judgement?	Having considered the evidence base and the cost of the treatment requested, are there any ethical considerations that have not been raised in the discussions? • Is the evidence base sufficient to support a decision? • Is the evidence and analysis of the cost sufficient to support a decision? • Will the decision be made on the basis of limited evidence and a value judgement? If so, have you considered the values and principles and the ethical framework set out in the policy? • Have non-clinical factors been excluded from the decision? • Has a reasonable answer been reached based on the evidence and a value judgement after considering the values and principles that underpin NHS care?

APPENDIX 2

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (Health Board)

PURPOSE

The Health Boards IPFR Panel is constituted to act as a Committee of the Health Board and holds delegated Health Board authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The IPFR Panel cannot make policy/commissioning decisions for the Health Board. Any policy proposals arising from the panels considerations and decision will ultimately be reported to the Health Board's Quality & Patient Safety Committee for ratification. Financial authorisation is as follows: - The Panel's authorisation limit will be set at the delegated financial limit as per the individual Health Board structure. - Any decisions resulting in a financial cost in excess of this must be reported to the Health Board Chief Executive for budget authorisation.	• Executive Public Health Director or deputy • Executive Medical Director or deputy • Executive Director of Therapies and Health Science or deputy • Director of Pharmacy and/or Chief Pharmacist or deputy • Executive Director of Nursing or deputy • Two Lay Representatives A further two panel members may be appointed at the discretion of the panel Chair, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning. In Attendance: • IPFR Co-ordinator • Finance Advisor (if required) • Senior Pharmacist (if required)

PROCEDURAL ARRANGEMENTS

Quorum: Chair or Vice Chair plus 2 panel members with a clinical background.

Meetings: The IPFR Panel will normally be at least once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently. In these circumstances, the Chair or Vice Chair

of the IPFR Panel is authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits.

Recording: The IPFR Co-ordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.

Training: All Panel members will receive a local induction.

Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.

Panel Interest: At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.

Consensus: IPFR panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision

APPENDIX 3

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (WHSSC)

PURPOSE

The Welsh Health Specialised Services Committee's IPFR Panel is constituted to act as a Sub Committee of the Welsh Health Specialised Services Committee (the "Joint Committee") and holds delegated Joint Committee authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will act at all times in accordance with the All-Wales IPFR Policy taking into account the appropriate funding policies agreed by WHSSC.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	**MEMBERSHIP AND ATTENDANCE**
The IPFR Panel cannot make policy/commissioning decisions for the Health Boards. Any policy proposals arising from the Panel's considerations and decisions will be reported to the WHSSC Management Group and/or Joint Committee for ratification. Financial authorisation is as follows: **Individual Patient Packages** The WHSSC scheme of delegation states that financial approval is required for individual NHS patient treatment charges outside of LTS's and SLA's concerning one off treatment costs exceeding £750,000. Therefore, any approved IPFR treatment exceeding £750,000 needs to be reported to the Joint Committee. **Lifetime costs** The WHSSC scheme of delegation states that financial approval is	• Independent Chair (from open recruitment) • 2 Lay representatives** • Health Board IPFR Panel Chairs from each Health Board or nominated clinical deputy. • 2 Vice Chairs (appointed from within the panel membership) • WHSSC Medical Director or nominated deputy. • WHSSC Director of Nursing or nominated deputy. A further two panel members from the NHS in Wales may be appointed at the discretion of the Chair of the Panel in conjunction with the WHSSC Medical and/or Director of Nursing, for example a member of an ethics committee. In attendance from WHSSC • IPFR Co-ordinator • Finance Advisor (if required) • Governance Advisor • Other WHSSC staff as and when required to clarify on policy/commissioning arrangements/evidence evaluation. For particularly complex cases the IPFR Panel may invite other individuals with clinical, pharmacy or commissioning expertise and skills, unconnected with the requesting provider to support decision making.

required for individual NHS patient treatment charges outside of LTS's and SLA's for lifetime costs exceeding £100,000,000. Therefore, any approved IPFR exceeding £1,000,000 needs to be reported to the Joint Committee. Any decisions resulting in a financial cost in excess of these limits must be reported to the Managing Director of Specialised and Tertiary Services for authorisation and the relevant Health Board for information and if over £1 million to the Joint Committee for approval or ratification (if a chairs action was undertaken).	

** **Definition: Not registered as a healthcare professional, either lay (not currently healthcare worker) or lay plus (no healthcare experience ever) (Health Research Authority 2014) will be eligible.**

PROCEDURAL ARRANGEMENTS

Quorum: The Panel will be quorate with 4 of the 7 Health Board representatives, 3 of which must be clinical, 1 WHSSC Clinical Director or deputy and the Chair or Vice Chair.

Meetings: The IPFR panel will normally be held as a minimum once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently.

Where possible, a virtual panel will be held to consider urgent cases. If this is not possible due to the urgency of the request, or availability of panel members, then the Managing Director of Specialised and Tertiary Services with either the Medical Director or Director of Nursing and Quality and the Chair of the WHSSC Panel (or a vice chair) are authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits, on behalf of the Panel.

Urgent cases will be reported at the next scheduled IPFR panel. An electronic National IPFR database of all cases will be maintained by AWTTC.

Recording:	The IPFR Co-ordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.
Training:	All Panel members will receive a local induction programme. Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.
Members Interest:	At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.
Consensus:	IPFR Panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision.
Review of the TOR:	The Terms of Reference of the WHSSC Panel will be reviewed in line with the All-Wales IPFR Policy.

APPENDIX 4

TERMS OF REFERENCE – REVIEW PANEL

PURPOSE

The IPFR Review Panel are constituted to act as a Committee of the Health Board and holds delegated Health Board authority to review (in line with the review process outlined in this policy) the decision-making processes of the Individual Patient Funding Request (IPFR) Panel.

The Review Panel may uphold the decision of the IPFR Panel or, if it identifies an issue with the decision-making process, it will refer the issue back to the IPFR Panel for reconsideration.

The Review Panel will normally reach its decision on the basis of all of the written evidence which is provided to it and will not receive any new information.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The Review Panel has delegated authority from the Board to undertake reviews, limited to the purpose set out above. In exceptional circumstances, the Review Panel may also wish to make a recommendation for action to the Board. The action can only be progressed following its ratification by the Board (or by its Chief Executive in urgent matters).	• Independent Board Member – Lay (Chair of the Review Panel) • Independent Board Member (usually with a clinical background) • Executive Director or deputy (with a clinical background) • Chief Officer, Community Health Council, or deputy • Chairman, Local Medical Committee, or deputy • WHSSC representative at Director level (as required) In Attendance: • IPFR Senior Officer (governance advisor) • WHSSC IPFR Senior Officer (as required)

PROCEDURAL ARRANGEMENTS

Quorum: As a minimum, the Review Panel must comprise 3 members (one of whom must have a clinical background, one must be an Independent Board Member and one must be a Health Board Officer).

Meetings: As required.

Urgent Cases: It is recognised that provision must be made for occasions where reviews need to be heard urgently and before a full panel can be constituted. In these circumstances, the Health Board's Chair can undertake the review together with a clinical member of the Review Panel. This ensures both proper accountability of decision making and clinical input.

Recording: The IPFR Senior Officer will clerk the meetings to ensure a proper record of the review discussion and outcome is made.

See detail under section 6.12 on how WHSSC will undertake a review.

Equality & Health Impact Assessment for

NHS WALES POLICY MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR) Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive - Strategic Planning Melanie Wilkey, Deputy Director of Commissioning melanie.wilkey@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	A comprehensive range of NHS healthcare services are routinely provided locally by primary care services and hospitals across Wales. However, each year, requests are received for healthcare that falls outside this agreed range of services. We refer to the funding requests for such treatments as Individual Patient Funding Requests (IPFR).
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment	The procedure operates within the principles of the: • Cardiff and Vale University Health Board's Shaping Our Future Wellbeing Strategy, • 2010 Equality Act, • Human Rights Act 1998, • Welsh Language Act 1993 and Welsh Language (Wales) Measure

	• engagement and involvement findings
	• research
	• good practice guidelines
	• participant knowledge
	• list of stakeholders and how stakeholders have engaged in the development stages
	• comments from those involved in the designing and development stages
	
	Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].
		2011,
		• Related policies such as Interventions Not Normally Undertaken, Top-Up Policy, the NHS Wales Prior Approval Request Policy and the Healthcare (International Arrangements) (EU Exit) Regulations 2023 (the HIA Regulations)
		• Related UHB policies such as flexible working and Dignity at Work policies.
		• R v North West Lancashire Health Authority Ex Parte A(2000)1WLR 977CA NHS (Wales) Act 2006
		• Colin Ross v West Sussex Primary Care Trust 2008 EWHC 2252 (admin) Health Commission Wales: A Review (2008), Professor Sir Mansel Aylward
		  • R (Condliff) v North Staffordshire Primary Care NHS Trust [2011] EWCA Civ 910, [2012] PTSR 460
		  • The case of Maria Rose Wallpott (MW) – v- (1) WHSSC & (2) Aneurin Bevan UHB (ABUHB)Case No: CO/3775/2021
		• Priority Setting: Managing Individual Funding Requests (2008), NHS Confederation Routledge Report 2009
		• Improving the Availability of Medicines for Patients in Wales: Report of the Routledge Report Implementation Group 2011 R (on the Application of AC) v Berkshire West Primary Care Trust [2011] EWCA Civ 247.
		• Oxfordshire PCT Equality Impact Assessment on Individual Funding Request Policy (March 2011)
		• the National Health Service (Wales) Act 2006 and the Community Health Councils (Constitution, Membership and Procedures) (Wales)

		Regulations 2010) Following a Judicial Review in December 2021, the Welsh Government in July 2022 agreed that a specific and limited review would be undertaken to put beyond doubt how the policy should be interpreted. It was agreed at an All Wales Medical Directors Group (AWMDG) meeting, that a de-minimis review with comprehensive stakeholder engagement could be taken forward by the WHSSC team and that this should report into WHSSC's Joint Committee with final approval being sought from the Health Board's. During this review of the IPFR Policy, WHSSC took advice from a King's Counsel (KC) in identifying amendments for the all Wales IPFR policy following the judgment handed down in the judicial review "Maria Wallpott –v- WHSSC & ABUHB" in December 2021. WHSSC . A stakeholder engagement process took place between the 10th and the 22nd December 2022. The consultation documentation was issued to a broad range of stakeholders including the WHSSC IPFR panel, the All Wales Toxicology and Therapeutics Quality Assurance Group (AWTTC QAG), the NHS Wales IPFR Policy Implementation Group (PIG), Medical Directors and Board Secretaries of each of the HBs, Welsh Government (WG) and Velindre University NHS Trust (VUNT). Additionally, a stakeholder engagement workshop was held on the 2nd December 2022 in Cardiff and a number of engagement briefings were held. During the 2017 review of the IPFR policy views were sought from patients, carers, relatives, patient representatives, health charities, lobbying groups, clinicians, healthcare professionals, IPFR panel members in local health boards (LHBs) and the Welsh Health

		Specialised Services Committee (WHSSC), Assembly Members (drawing from their constituency correspondence), political parties and pharmaceutical industry representatives. The review group held a total of ten face-to-face engagement sessions in Wrexham, Aberystwyth and Cardiff during November 2016. In each location, there was a session specifically for patients, patient organisations, and healthcare professionals, as well as one in Cardiff for the pharmaceutical industry. The review group considered the published documents outlining the approach taken to IPFRs in England, Scotland and Northern Ireland. And looked at statistics on IPFRs in Wales and, where available, the equivalent processes elsewhere.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Clinicians submitting an IPFR request and their patients for whom the request is for, who are residents of the UHB will be affected by the Policy.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The IPFR application form requires patients to disclose their date of birth. This is collected to help:- • Establish the legal status of the patient and the need for an appropriate adult (parent or guardian) to act as an advocate on behalf of the patient. • To help locate the patient's hospital or general practice records as appropriate when required. The panel provides clinical	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	based decision making and therefore social factors such as date of birth are redacted prior to review at the IPFR panel. Protected characteristics are not provided to the IPFR Panel for review and consideration therefore, this information is not taken into account during the decision making process. The IPFR application form requires patients date of birth only, therefore, age data is not collected and cannot be measured.		
6.2 Persons with a	The Policy would be made		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	accessible to staff in alternative formats on request or via usual good management practice. The IPFR application form does not routinely require patients to disclose this information. It is at the referrers discretion to disclose this information if it is relevant to the treatment being sought in the IPFR request. Therefore this data is not routinely collected and cannot be measured.	N/A	N/A
6.3 People of different genders: Consider men, women, people undergoing gender reassignment	IPFRs referrals from clinicians of any gender and for patients of any gender are dealt with in the same way. All protected patient	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	characteristics, including gender are redacted in the information provided to the IPFR Panel for review and consideration, therefore this information is not taken into account during the decision making process. However, where there is evidence that capacity to benefit from a treatment is related to gender, this may affect the decision of the IPFR Panel. The IPFR application form The IPFR application form does not routinely require patients to disclose information relating to their gender or gender reassignment. It is at the		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	referrers discretion to disclose this information if it is relevant to the treatment being sought in the IPFR request. It has been noted that NHS England were legally challenged in the case of AC v Berkshire West PCT [2010] EWHC. The challenge itself related to the evidence for 'exceptional significance' for the IPFR commissioning decision rather than the collection or discrimination of the protected characteristic.		
6.4 People who are married or who have a civil partner.	The IPFR application form does not require patients to disclose their marriage or civil partnership status. Therefore this data is not collected and cannot be measured.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	The IPFR application form does not routinely require patients to disclose this information. It is at the referrers discretion to disclose this information if it is relevant to the eligibility or treatment being sought in the IPFR request. Therefore this data is not routinely collected and cannot be measured.	N/A	N/A
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears not to be any impact on patients regarding race, nationality, colour, culture or ethnic origin. The IPFR application form does not require patients to disclose this information. Therefore this data is not collected and cannot be measured.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	The IPFR application form does not require patients to disclose this information. It is at the referrers discretion to disclose this information if it is relevant to the eligibility or treatment being sought in the IPFR request. Therefore this data is not collected and cannot be measured.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The IPFR application form does not require patients to disclose this information. Therefore this data is not collected and cannot be measured.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or	The All Wales procedure, claim forms, website information and patient leaflets will all be made available in Welsh. Patients		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	have the discretion to apply through the medium of the Welsh language in line with the UHB's Welsh language policy. Receipt of applications in the Welsh language will be measured accordingly.		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	The IPFR application form does not require patients to disclose this information. Therefore this data is not collected and cannot be measured.	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	The IPFR application form requests the patient's address on the application form to ensure that the patient is a Cardiff and Vale resident and to allow for communication regarding	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	requests. All protected patient characteristics, including address are redacted in the information provided to the IPFR Panel for review and consideration, therefore this information is not taken into account during the decision making process.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups or risk factors to take into account with regard to this Policy. All patient identifiable information is redacted from the request prior to being presented at the IPFR panel and is therefore not taken into account.		

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.		
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological	As part of the decision making process, the IPFR panel consider ethics of funding requests e.g. whether the allocation of funds for high cost drugs is a fair and equitable allocation of resource for a single patient.		

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this All Wales IPFR Policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	All non-clinical information will be redacted from the information provided to the IPFR panel during the decision making process.	IPFR Commissioning Officer	Ongoing	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very limited impact identifi it it is unnecessary to undertake a more detailed assessme and formal consultation is not required.	N/A	N/A	
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or servi proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out	Minimal changes have been made to the policy. The changes include amendments to the WHSSC IPFR Panel Terms of Reference and revisions to the policy wording based on advice from a King's Counsel (KC) following a judicial review concerning Maria Rose Wallpott (MW) – v- (1) WHSSC &			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	(2) Aneurin Bevan UHB (ABUHB). The changes have resulted in no change to the impact of the policy. The updated policy is due to be considered by the QSE Committee. When an IPFR policy is developed or reviewed, this EHIA will form part of that consultation exercise and publication. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
	policies are reviewed within 3 years (1 year if a statutory requirement).			

Minutes of the Medicine Clinical Board Quality, Safety & Experience Committee Meeting Held on 19 October 2023 14:30 – 16:00, Via MS Teams

Present:	
Jane Murphy	Director of Nursing
Barbara Davies	Deputy Director of Nursing
Sian Rowlands	Head of Quality and Clinical Governance
Aneurin Buttress	Consultant, Integrated Medicine (IM)
Catherine Evans	Interim Deputy Head of Patient Safety, Patient Safety Team
Manon Owen	Directorate Pharmacist for Integrated Medicine
Derek King	Clinical Nurse Specialist, Infection Prevention & Control
Jason Roome	General Manager, Integrated Medicine
Dave Pitchforth	Lead Nurse, Specialised Medicine (SM)
Wayne Parsons	Lead Nurse, Integrated Medicine
Angela Jones	Senior Nurse, Resuscitation Service
Natasha Whysall	Senior Nurse, Specialised Medicine
Claire O'Keeffee	Senior Nurse, Integrated Medicine
Jenna McLaren	Senior Nurse, Acute & Emergency Medicine
Elinor Gerrard	Senior Nurse, Acute & Emergency Medicine
Rachael Maiden	Senior Nurse, Integrated Medicine
Gill Spinola	Senior Nurse, Integrated Medicine
Sarah Cornes-Payne	Nurse Lead, Diabetes, Integrated Medicine
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Alun Tomkinson	Clinical Board Director
Louise Platt	Director of Operations
Lyndsey MacDonald	Consultant, Emergency Medicine
Clare Tibbatts	Consultant, Specialised Medicine
Kath Prosser	Quality & Governance Lead, Medicine
Dave Mcrae	Lead Pharmacist for Medicine
Ceri Richards-Taylor	Lead Nurse, Integrated Medicine
Ceri Martin	Lead Nurse, Acute & Emergency Medicine
Liz Vaughan	Professional & Practice Development Nurse

Item No	1. Standing Items	Action
MCBQSE/ 2023/0153	**Welcome & Introductions** – were undertaken. **Declarations of interest** – none raised.	
MCBQSE/ 2023/0154	**To receive the minutes of the previous meeting held on 21/09/23** The group resolved: the minutes were agreed and accepted.	
MCBQSE/ 2023/0155	**Action log following the meeting held on 21/09/23**	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2023/0156	**Patient Story, Acute & Emergency Medicine**, delivered by Elinor Gerrard Patient X, an 82-year-old male, was admitted to the assessment unit earlier this year with abdominal pain and progression of underlying cancer. He was seen on arrival by the Palliative Care Team, had various scans and was advised that he was unlikely to make it through this admission. Patient X disclosed to his partner and daughter that he wanted to get married before he died. The medical team completed extensive paperwork, the patients partner and daughter submitted the paperwork and met the Registrar. The team rallied around and purchased 'just married' balloons. The Chaplain did not have anything to hand to make the environment less clinical, however, was offered to drive to another	

	site to find something. The Red Cross Team advised they had vouchers to use for patients in need and that they would use these for the patient and went to Tesco's for flowers. The Tesco's Manager made up a bouquet and donated them to the patient. Media Resources were ready to take photo's if needed. Unfortunately, the Registry Office advised that 24 hours-notice of marriage was required and that they would have to return the next day, which was very distressing. Patient X went to a cubicle on A1 so his family could stay with him over night. The next morning the family went to Cardiff Registry office, returned to the hospital and the couple were married at 10.30am. Patient X and his wife were grateful for all that the staff had done in fulfilling Patient X's last wish. Patient X died at 2pm that day. This was a normal busy day and staff went out of their way to support the patient. The group resolved: this story is an example of excellent teamwork and patient care. **Actions from discussion**: EG to thank the teams and everyone who participated in making this happen.	Elinor Gerrard
3. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2023/0157	**Concerns, Claims, Compliments** **Gastroenterology** – 'to Dr Durai, Rachael and Kate - thank you all for the outstanding care you have given me for the past couple of months. It's so important to me to know I have such amazing caring people looking out for me. You have been there for me for nearly 10 years now, in my lowest moments, so words are never enough, but I will always be grateful for all of your efforts to make sure I can live my life to the fullest. Thank you all, you really are superheroes. You make such a big difference in my life. I painted this whilst in A7 but never got the chance to give it to you guys. Forever thankful and grateful'. **Emergency & Acute Medicine -** 'I would like to pass my thanks to all staff in the following areas. My brother was admitted to EU very unwell, staff were excellent and the doctors were fantastic despite being very busy yet taking the time to listen. Thank you so much for your care and kindness I am aware how busy you all are. **Ward A2** - 'What a lovely staff team. Taking the time to listen to my brothers concerns giving him confidence and making him feel safe. The ward staff were so caring and again nothing was too much trouble'. **Ward A7** – 'All staff were helpful and so caring to my brother. You should all be proud as you are excellent nurses and doctors who took the time to assist him and give him the reassurance he needed'. **Stroke** - 'thanks to Dr Shetty and the team on the stroke ward C4 and colleagues in A&E for looking after me with such care and kindness. I am very grateful for the thorough way my symptoms were investigated as I found this both comforting and reassuring at a time when I felt very fragile. My very best wishes and sincere thanks'. The group resolved: to keep noting compliments and share with teams. **Actions from discussion:** none.	

MCBQSE/ 2023/0158	**Infection Prevention and Control up-date**
	15 days since last MRSA bacteraemia (UHL W2)
	43 days since last MSSA bacteraemia (UHL E8)
	9 days since last *C difficile (UHW LSGF2)*
	12 days since last E. *Coli* bacteraemia (UHL E7)
	20 days since last Pseudomonas bacteraemia (UHW A7)
	15 days since last Klebsiella bacteraemia (UHW A7)
	• There are currently 2 outbreaks within the MCB affecting 22 patients, 8 staff members, resulting in 6 bed days lost.
	• DMT scores – All wards within MCB are compliant for the last 4-week period.
	• There are 2 outbreaks within the MCB, affecting 22 patients, 8 staff members, resulting in 6 bed days lost.
	• DMT scores – All wards within MCB remain compliant for the last 4-week period.
	• HCAI reduction goals, MCB position based on same period 2022-2023:
	  ○ 32% increase with *C. difficile,* (16 cases).
	  ○ 34% increase with *E. coli.*
	  ○ 100% increase / reduction with *Pseudomonas.*
	  ○ 25% reduction with SAUR Bacteraemias.
	  ○ 12% increase has been seen *with Klebsiella*
	• There are 3 outstanding RCA's for September.	

	• IP&C teaching has received poor attendance. • IPC Link practitioner Study Day on 2/11/23. • COVID cases have plateaued both within the UHB and in the community. • Staff Vaccination has been good to date. • Influenza activity is currently below baseline. • PHW indicate that there is no evidence to suggest that this year will be a 'bad' flu season. • Vaccination programme – 16 staff have volunteered to vaccinate staff in their areas. On 27/10/23 JM/ KP will visit some areas offering vaccination for staff. • RSV – this is the main circulating respiratory virus, at very high intensity. The group resolved: to note the above. **Actions from discussion**: none.	
MCBQSE/ 2023/0159	**Safeguarding** The group resolved: an update will be given at next month's meeting. **Actions from discussion** – none.	
MCBQSE/ 2023/0160	**Cancer Pathway update, risk to Gastroenterology patients** – DP discussed the paper he prepared regarding risks around surveillance waiting times. In totality there are approx. 7,000 patients on the endoscopy waiting list. Some patients are waiting up to 85 weeks for diagnostics and therapeutics and particularly the surveillance cohort. Demand is outstripping capacity of the team. An overarching action plan is in place. The group resolved: the significant risk has been escalated to the Executive Board. **Action from discussion** – none.	
3.ITEMS FOR APPROVAL/ RATIFICATION		
MCBQSE/ 2023/0161	**National Reportable Incidents (NRIs) – updates and closures** **Integrated Medicine, ID24263 IV Cannula Infection** – delivered by Rachael Maiden Relates to an unexpected death of a patient known to mental health services, pre-duty of candour and managed via the NRI process. It was identified that when the cannula site was checked, the area appeared infected, sore, red and bruised. The cannular and dressing were removed and cleaned. The patient developed septicaemia and was admitted with worsening shortness of breath. The patient's respiratory condition deteriorated and was deemed unsuitable for critical care. The patient continued to deteriorate and passed away. **Learning** – the MSSA infection tool was carried out which showed poor compliance with standards of PVC documentation and use of PVC bundle; poor standards of 'bare below the elbow' and hand hygiene. VIP scores were not updated to show when the cannular was inserted and removed. The patient was taking immune-suppressant medication. Staff have been educated on cannula use and this has been the main focus of safety briefings. IVs should not be left in longer than 72 hours. There was a delay in sharing the investigation due to workload pressures. Audits are a powerful tool. Action: A7 have a separate bundle they have taken out of the yellow booklet so it is more obvious. A7s compliance is much better with the nurse completing the form. DP to share information on this with the group. Action: East 2 have linked with their medical team and have prepared a form which has been shared with Vince who is happy with this, it is working really well and compliance is improving. All relevant information is on one form. Claire O'Keeffee will share the form. Currently the PVC bundle is better than previously, but still needs improvement. Action: DK will link in with DP and CR-T regarding the PVC bundle, currently used on East 2. To use at UHW. Compliance with the PVC bundle figures is 77% for MCB, with the target being 90%. **ANTT** – LV has been running training days. This week is Infection Prevention and Control week. BD will circulate information today on priorities in MCB. **ID1549 Non-compliance with PSN057 Adrenal Crisis**, presented by Rachael Maiden	Dave Pitchforth Claire O'Keeffee Derek King

The patient presented to EU on 22/3/22 following a fall at home. The patient had a complex medical history and on 27/3/22 died unexpectedly on Heulwen South having not received hydrocortisone replacement therapy for 3 consecutive days. An NRI process commenced. The family were informed. This was prior to Duty of Candour implementation. The family did not want any further contact after the investigation.
Learning – the urgency of the steroid replacement therapy was not recognised. There was no Pharmacy input to patient care whilst in the Emergency Unit. There was no ward-based Pharmacy service at the weekend, therefore, medication was not picked up by the normal Pharmacy reviews. At the time there was inadequate staffing on Heulwen South. Looking at staff education, recognition of people with adrenal insufficiency at the front door right to the way through to the ward and dealing with critical medication. Pharmacy are in the process of developing a critical medication list.

ID39712 Avoidable Pressure Damage – presented by Wayne Parsons
An 89-year-old man was admitted to ward with category 2 pressure damage to sacrum which evolved to unstageable whilst the patient was in hospital. The focus review showed a 2-week delay in getting the correct mattress. The patient's dietary and fluid intake was poor. This case was discussed at the Pressure Scrutiny Panel which found this to be avoidable.
Learning – continued education of obtaining timely TVN advice. Importance of following advice regarding mattress selection. The pressure area focus review has been shared with the relevant staff.

Integrated Medicine, ID26810 Injurious Injury – presented by Rachael Maiden
An 83-year-old patient had an unwitnessed fall in hospital resulting in a fractured neck of femur requiring surgical intervention. The Patient, originally in IACU, was transferred to Lakeside. The patient was Covid positive. Insufficient information was given in the handover of the patient's needs. There was evidence of intentional-rounding. The patient was using a Zimmer frame at the time and was in a cubicle and not visible when the fall took place.
Learning – have accurate and timely handovers for effective care. Tendable audits are well embedded in clinical order.

Specialised Medicine - ID26550 Dermatology – presented by Natasha Whysall
This refers to a gentleman with an extensive history of skin cancer and was under the care of Dermatology. During the Dermatology appointment it was highlighted the patient had other areas of concern. Following review in Dec 22, an 8-week routine follow up appointment was planned and surgery scheduled for 20/12/23. The outpatient appointment did not appear to be booked as planned. Histology reports were not back in time for the patient to be discussed in the meeting in January 23, therefore, the MDT meeting was rescheduled. When the meeting took place, it was decided that the patient would need further treatment for a high-risk tumour. The patient's outpatient clinic appointment was to be expedited, however, the Co-ordinators were not made aware of this. The patient attended clinic in February 23 for post-operative wound dressing. He was brought back into clinic for a biopsy and further investigations were arranged urgently. Invasive surgery took place in March 23.
Learning – there were missed opportunities when the patient attended clinic. He was a complex patient, under a lot of clinicians and CNS's. Need to ensure a member of staff attends the MDT with assigned responsibility of ensuring appointments are booked as a result of the MDT meeting. Need to put a flag in the system to ensure patient appointments are not cancelled. The Dermatology internal tracking system is being reviewed. The patient advised a couple of times that his appointments had been cancelled.

Emergency and Acute Medicine: ID27077 delivered by Ceri Martin
At 15.23pm on 14/3/23 the patient presented to EU with abdominal pain, weight loss, shortness of breath, dizziness, history of lymphoma. The patient was fairly unwell on arrival and categorised as category 3. There was excessive pressure in the whole Health Board that day and exceptional measures were taken. Medical staff from other areas came to support the EU and see patients. At 18.45pm the patient was seen by a Surgical Registrar and an F1. The patient had slightly escalated news, they did not follow the patient through, they identified the patient for blood tests, ECG, but did not understand

	the ask of them. The message did not get passed to nursing teams or EU teams. The patient was in the waiting room until the EPIC took over at 10pm. The patient was found collapsed, was moved into resus for extensive resuscitation, and died 2 hours later. An investigation commenced across all Clinical Boards and OPAT. **Learning** – the findings were exceptional pressures, high number of patients in the EU for consecutive days, busy waiting room, issues with capacity in whole of Health Board (HB). The Surgical Team from a different area were unsure of what was required of them. Lack of communication of what was expected of staff. On arrival the patient was categorised correctly, however, there was a lack of escalation in the patient's journey. Electronic task boards are being implemented and patients will be added on a RAG rating basis. Working groups will implement the changes. Better communication within the department regarding if staff from other areas are coming to support let them know what is required of them. Use the function of the white board to see what clinical priorities patients are. Escalation of the acute referral policy is required. The group resolved: to note the above. **Actions from discussion:** none.	
MCBQSE/ 2023/0162	**Learning from Events Reports (LFERs)** **Case Ref: RED92 (ED CES)** – related to an earlier Ombudsman case, which has gone through the redress process. Has now been signed off. **Case Ref: CN/UHW/DCIQ1066 (ED Hill-Sachs type fracture)** – learning for ED regarding minor injuries and also learning in terms of surgery. This has been signed off. **CN/UHW/4329 (ED eye injury)** – has been signed off. Pro-forma was in place to correctly document what had been done. Ensure all is documented correctly and that procedures are correctly followed. The group resolved: to note the learning from the above. **Action from discussion**: to note the learning from the above.	
MCBQSE/ 2023/0163	**HIW / HEIW Reports and Improvement Plans:** HIW National Review of Patient Flow – a journey through the stroke pathway. A Plan has been submitted to HIW regarding this. Further recommendations have been made and responses are being submitted shortly for both the visits as below: • HEIW Targeted Visit Report Gastroenterology revisit 24/7/23. • HEIW Targeted Visit Report General Internal Medicine revisit 18/9/23. The group resolved: to note the above. **Action from discussion**: none.	
4. ITEMS FOR NOTING AND INFORMATION		
MCBQSE/ 2023/0164	**Patient Safety Alerts/MDAs/ISNs:** Public Health Wales Briefing: Increase in UK cases of Cryptosporidiosis. The group resolved: all to note the briefing above. **Action from discussion**: none.	
MCBQSE/ 2023/0165	**Medicines Safety Briefing for Healthcare Staff July 2023** The group resolved: no issues raised. **Action from discussion**: none.	
MCBQSE/ 2023/0166	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions, for noting:** • MCB IP&C Meeting 06/10/23 (minutes currently not available) • MCB Health and Safety Governance (first meeting 04.10.23) • Medicines Access and Governance Group Minutes, 15/9/23 The group resolved: to note the above. **Actions from discussion:** none.	
MCBQSE/ 2023/0167	**Duty of Candour** – new process flow chart in place. The Patient Safety Team will help the Clinical Boards with any NRI's. The group resolved: the work that all teams have done is appreciated. **Action from discussion**: none.	

MCBQSE/ 2023/0168	**Feedback from UHB QSE Committee dated 30/08/23** The group resolved: MCB will be presenting at the UHB QSE Meeting on 28/11/23. **Action from discussion**: none.	
5. ANY OTHER BUSINESS		
MCBQSE/ 2023/0169	**MCB QSE Teams Channel** The group resolved: papers for meetings are available on Teams. **Action from discussion**: none.	
MCBQSE/ 2023/0170	**MCB Facebook Group** The group resolved: this is now live for staff to post anything on there of interest, quality, safety and governance related. All to encourage staff to join the MCB Facebook group. **Action from discussion**: none.	
MCBQSE/ 2023/0171	**The following were shared for noting:** • Diabetes Education Resource • Falls Project. • Safety Leaflet • Major Trauma Newsletter, issue 4 • Medicines Safety Briefing for Healthcare Staff, September 2023 • Patient Safety Newsletter, Summer 2023 • UHB Quality Statement of Intent 2022-23 The group resolved: all to note the relevant resources. **Action from discussion**: none.	
6. DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2023/0172	Thursday 16 November 2023 14:30-16:00 via MS Teams	

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

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
HELD AT 11 AM ON 28TH NOVEMBER, 2023, 11 AM
Venue: MS TEAMS

Attendees	
Anna Llewellin	Director of Nursing
Anna Mogie (AM)	Deputy Director of Nursing (Chair)
Helen Kemp (HK)	Deputy Clinical Board Director (Chair)
Jane Brown (JB)	Head of Dental and Optometry
Lisa Waters (LW)	Senior Nurse for Quality and Education
Kate Morris (KM)	Medicines Management – Primary Care Pharmacist – Team Lead for Clinical and Governance Workstream
Gneeta Joshi (GJ)	Community Director of Clinical Governance
Lynne Topham (LTop)	Locality Manager, South and East Locality
Helen Donovan (HD)	Locality Lead Nurse, North & West Locality
Jayne Gay (JG)	Clinical Manager, Out of Hours
Rachel Armitage (RA)	Quality and Safety Manager
Ruth Cann (RC)	Consultant Nurse Older Vulnerable Adults
Victoria Whitchurch (VW)	Head of Operations, Mass Imms
Ellen Davies (ED)	Clinical Nurse Specialist in Infection Prevention & Control
Janice Aspinall (JA)	Health and Safety Representative
Hannah Wilce (HW) Elaine Lewis (EL) Darren Cousins (DC)	In attendance to present item 23 (ePMA electronic Prescribing and Medicines Administration)
Andrew Jones (AJ)	In attendance to present item 12 (UPCC Governance Framework)

Apologies	
Clare Clement (CC)	Head of Medicines Management
Lisa Dunsford (LD)	Director of Operations
Clare Evans (CE)	Assistant Director Primary Care
Sarah Griffiths (SG)	Head of Primary Care
Kate Roberts (KR)	Vale Interim Lead Nurse
Andrea Rich (AR)	Lead Nurse, Palliative Care
Theresa Blackwell (TB)	PCIC Business Manager
Neil Morgan (NM)	Vale Locality Manager
Lorna McCourt (LMc)	Staff Side Trade Union Representative
Rebecca Gill (RG)	Senior Nurse, Primary Care
Louise Thomas (LTho)	Quality & Safety Officer

ITEM NO.	**TITLE**	**ACTION**
11/23/01	AL welcomed everyone to the meeting and the following introductions were made: AJ introduced himself as the Workstream to Programme Manager for PCIC. DC introduced himself as a Consultant in Sexual Health and HIV and explained that he would present the ePMA programme later in the meeting. EL introduced herself as the Programme Lead and General Manager in Pharmacy. She was attending with DC to present ePMA. HW introduced herself as the ePMA Project Manager.	
11/23/02	Apologies of absence were noted as above.	
11/23/03	No declarations of interest were raised.	
11/23/04	<u>Minutes</u> The minutes of the meeting held on 26th September, 2023 were accepted as an accurate record. There were no other matters arising.	
11/23/12	<u>UPCC Governance Framework</u> Item 12 was moved up the agenda. AJ explained that he was attending the meeting to talk about the evaluation of the Urgent Primary Care Centres (UPCC). Item 12a was shared on screen; AJ explained that the CAV UPCCs were established 4 years ago as a cluster project	

	in Central Vale. WAG was looking at the development of UPCCs at the same time as part of the modernisation of Primary Care and the project quickly evolved. The initiative was up and running by 2020 at the National Pathfinder was announced. CAV joined the Pathfinder for the UPCCs already established and rolled out to Eastern and Western Vale as per the requirement of the Pathfinder phase. UPCCs have been progressed into Cardiff over the past 12 months. The programme was rolled out into Cardiff West last week with appointments increasing from a few hundred a week to over 1000. The programme remained to be rolled out to the Cardiff South West cluster. AJ ran through the capacity breakdown by UPCC noting that 85% of appointments were booked into the UPCCs by GP practices for patients with eligible acute conditions such as sore throat, UTI, etc. CAV was taking the initiative to deal with any issues at source, thus reducing the volume of calls to 111 and presentation at EU. The majority of patients were dealt with and discharged from the UPCC. There were over 35k urgent care appointments last year with each appointment costing £35.38. This amount was reducing as the rollout continued. The Central Vale model (which was the most mature model) showed that less calls had been made to 111 and there was lower attendance at EU as a result of the UPCC. Patients who did attend EU were more appropriate patients whose needs could not have been met in Primary Care. HK queried if it had been clarified where the governance lied when calls were received from 111 and EU. AJ explained that 111 and EU redirections were handled centrally by CAV 247. The EU redirections pilot began in May 2023 with small numbers being redirected to UPCC. He confirmed that there was an agreed pathway in place and governance had been agreed as part of the pathway in terms of 111. AM and HK pointed out that UPCCs were introduced to support capacity and sustainability in GP practices but queried if Primary Care would prefer a model whereby the additional funding (of £32 38 per appointment) was provided directly to GP practices. AJ explained that UPCC was a national policy, therefore practices were encouraged to utilise the model. He pointed out that there were just 2 or 3 practices in the South & East locality that did not utilise UPCC. These practices are unable to book directly into UPCC, forms have to be completed so this could contribute to the non-engagement. AJ agreed to screenshot the statistics from Kings' Funded Research that showed that UPCC was good value for money. AL thanked AJ for the excellent presentation provided.	
011/23/23	<u>ePMA (electronic Prescribing and Medicines Administration)</u> Item 23 was moved up the agenda. EL thanked the group for inviting her and her colleagues to the meeting to introduce ePMA. She explained that ePMA was part of a portfolio managed through DHCW and WAG with a patient access project underway. It was hoped that ePMA would replace the COPS system (printing prescription system) by December 2025. CAV had chosen a supplier it would like to utilise and hoped to receive a funding letter before Christmas in order to commence the programme in January. DC explained that ePMA would also replace the paper drug chart that was used across the UHB with a digital system that would provide clinical decision support,	

	improved data availability and reporting, tools for improved patient care and the potential to close the loop on administration and supply. The programme seemed very straight forward but the infrastructure and training requirements within CAV secondary care would be huge. The team were aiming to begin piloting the scheme in Autumn 2024 and the implementation plan would be under supervision with WAG and DMTP. EL explained that B5 and C5 would be the initial piloted areas, followed by B7. The plan was to have the Medicine Clinical Board on board by February 2025. The team was working with the digital teams to ensure the digital infrastructure was fit for purpose, noting that it would be the largest digital transformation the organisation had seen. It was hoped that COPS would be replaced, with an ambition of being reliant on the ePMA programme nationally. Prescriptions would then be sent electronically to community pharmacies. There would be a huge implication for nursing; no drug would be provided unless the ePMA system had been utilised. The team would link in with AM and her team when rolling the project out to PCIC. HK noted that PCIC would be very happy to work with the team and it was agreed that a quarterly update would be provided at the PCIC QSE meetings. The aim of the project was for all patients (and all healthcare) to have access to all of their medication, e.g. CAV would be able to see all secondary and primary care mediations prescribed should a patient have been seen in a different Health Board before moving to the CAV area. AL thanked the ePMA team for presenting at the meeting. EL, DC, HW and AJ left the meeting.	
11/23/05	<u>Action Log</u> Please refer to item 5.	
11/23/20	<u>Denosumab SOP</u> HD to check if the Denosumab SOP needs to be taken through the Medicine Clinical Board.	HD
11/23/06	<u>Patient story</u> The patient story was deferred in KR's absence.	
11/23/07.1	<u>OOH Business Report</u> Capacity and demand were being looked at, ensuring staff were correctly place. There were workforce challenges in 111 press 2, a few notices had been provided. Dental staffing and structure were being looked at. A GP rota change had been implemented. Non clinical staff were going through OCP.	
11/23/07.2	<u>N&W Locality Business Report</u> Workforce was in a good position. Student streamliners had been recruited and the majority of DN vacancies were filled. There were 2 CRT nursing vacancies for the new safe at home team. Skill mix and experience continued to be a challenge.	

	Parking continued to be an issue at St David's with waits of up to an hour for a parking space which was impacting on staff wellbeing and team capacity. Patients had received fines despite registering their cars and having parked in patient areas. The issue had been escalated again.	
11/23/07.3	Vale Locality Business Report Please refer to item 7.3 in KR and ND's absence.	
11/23/07.4	South and East Locality & HMP Business Report LTop joined the meeting. The main HMP risks were nursing vacancies. There was a 6.5 WTE band 5 vacancy in an establishment of 11, this included 2 staff who were on secondment. It was predicted that the figure could be reduced to a 4.5 WTE vacancy in January. A band 7 post had been advertised, in the hope of attracting somebody with extended nursing skills. LTop was providing an update on HMP risks to the Executive closed meeting later that day. An assessment of HMP performance had been carried out marked against the HIW assessment of Swansea Bay recommendations. There were band 7 vacancies in the District Nursing team. DOSH staff morale posed quality risks should staff be absent from work. LTop flagged the significance of the Milcare issue which was absorbing a huge amount of time managing the risks associated with a potential loss of 30k records. An SBAR had been presented to SMT.	
11/23/07.5	Medicines Management Community Pharmacy risks had been separated from general medicines management risks on the risk register. There was a new risk relating to pharmaceutical needs assessment that would be presented at a PCIC QSE meeting. The Valporate risk was likely to come down as a reduction had been seen in prescribing to the age group were patients had been referred back to secondary care. The RAAC risk in some of the community pharmacies had been incorporated into the overarching Primary Care risk. Other high risks that remained unchanged were domiciliary care, medication support and the impact on patient discharge and community pharmacy sustainability, the prescribing budget and patient group directive. A pharmacist began maternity leave last week and a pharmacy technician was due to start maternity leave in January. A prescribing support pharmacist was due to retire at the beginning of December; the post would not be replaced as it was introduced via the clusters. A new member of staff will join the governance workstream in January. An appeal had been made regarding statutory compliance.	

	Two freedom of information requests on rebates had been received since the last meeting was held in September. Self-assessments had been carried out with a GP practice and a dental practice regarding controlled drug regulations. Two complaints had been received regarding the closure of Lloyds in Thornhill along with a few complaints regarding medication availability of community pharmacy services and medicines in general through the Health Board formulary. Four formulary applications had been progressed on behalf of the PCIC Clinical Board. Antimicrobial guidelines had been updated. Documents had been updated and made available to prescribers regarding pain management and the All Wales COPD guidance. There were 2 potential QI projects to be taken forward, one regarding medicines optimisation and high risk patients utilising pharmacy technicians, and another prescription mapping of the waste reduction scheme. The team had been focussing on the duration of treatment of antibiotics and utilising script switch in order to utilise a shorter duration of antibiotics. The team was working with Lymphedema, helping them progress their cellulitis improvement plan. Flu and Covid vaccines continued in community pharmacies There would be no further paper copies of BNF from 2024.	
11/23/07.6	<u>Palliative Care</u> Please refer to item 7.6 in AR's absence.	
11/23/07.7	<u>Primary Care</u> GMS contract negotiations between WAG and GPC Wales for 2023/24 had failed, impacting on contract sustainability, thus created a new risk. RAAC posed as one risk for all four contractor professions. All practices had been written to with Estates taking the project lead. The new optometry contract came into force on 20.10.2023. The contract would be phased. The GDS centralised waiting list had 23k patients listed with a wait time of approximately 27 months. CDS had set up a session for homeless patients. A business case was being worked on for vulnerable groups within dentistry. AM highlighted the health needs assessment for people in UMI.	
11/23/07.8	<u>Mass Vaccination Centre (MVC) report</u> There were ongoing issues regarding workforce size and stability. The team had struggled to get key posts through scrutiny panel and was not seeing the interest seen in previous years. They were not seeing the level of bank that was needed	

	to meet capacity, which was reducing capacity and the ability to deliver at speed. Two MVCs were being run a day as a result which was impacting in terms of equity and access, with a slower rollout than in previous years. A hybrid approach had been taken with Primary Care involvement but concerns had been raised against the model by both GPs and citizens. The team had provided a reason for the decision being made. There had been issues with wastage across the programme, especially in Primary Care settings. There had been 8 confirmed measles cases in Cardiff and staff and citizens were being urged to check their vaccine statues. VW was due to meet with the LMC to look at a delivery model encouraging people to come forward for their vaccines. Woodland House would be closed over the Christmas period; the immunisations team was working on a relocation plan. It was noted that posters informing of the closure were inaccurate and stated that managers would be aware of where their staff would be relocated to. RA pointed out that the MVC team had been subject to a large number of moves and huge disruption in a relatively short space of time and should be commended for the way in which the service had been managed in order to continue operating.	
11/23/08	<u>Risk Register</u> Please refer to item 8. New risks had been added across the Clinical Board in a number of areas. Executives are to be made aware of risks running at level 20+. All other risks would be held by the triumvirate of localities. RA had met with Emma Lewis to discuss how the risk register could be moved to SharePoint. The corporate team were undertaking a review of the risk register process.	
11/23/09	<u>Business Continuity</u> There was no update as the meeting with civil contingencies had been cancelled. TB awaited an update following on from the business continuity exercise that was undertaken mid-October.	
011/23/10	<u>PCIC Quality report</u> There were no NRIs within the Clinical Board, highlighting a very positive safety culture. There was one open IRMER that was reliant on GP feedback. There were 3 avoidable pressure damage incidents (NRI numbers 32447, 44436 and 32551) that had triggered the Duty of Candour, one of which had gone to redress panel with financial compensation to be claimed. There were 506 open incidents, including 36 open incidents from 2022. LW offered her support to individuals and teams who may need guidance with their incidents. Community Pharmacy incidents were no longer linked to PCIC data and were reported separately.	

	The Tendable rollout had begun and the team was working with the Tendable team looking at the rollout across DN teams. The system would provide tangible data for audit purposes. LW passed her congratulations to Tracy Valade on her appointment to regional lead for QNI in Wales. LW referred to the lovely compliments received, which were noted in item 10. Excellent student feedback had been received and would be shared via ECOD.	
11/23/11	<u>Lessons learnt</u> Item 11 referred to a clinical negligence claim regarding a patient who had contacted OOH and later suffered a stroke. The patient believed he was not assessed properly by OOH and suffered harm as a result. The claim was investigated and it was identified there was potentially a breach following guidelines around headaches that was not accepted by OOH, resulting in the stroke. Issues and actions were identified and submitted to the Welsh Risk Pool which were accepted through the Welsh Risk Approval Committee process. The doctor concerned had taken actions and the incident had been discussed at QSE meetings to ensure lessons were learnt, shared and understood throughout the Clinical Board and all clinicians working in the service.	
11/23/13	<u>Quality and Safety sessions</u> Quality and Safety sessions were previously referred to by secondary care as clinical audit days when clinics were cancelled and clinical audits were discussed, along with other improvement work in a protected time environment. It was noted that it would be useful for the PCIC Clinical Board to undertake similar sessions. RA queried if this issue could be discussed at QSE or by the SMT. AL stated that she would endorse the sessions but would need to discuss the matter at senior management level due to consequences for the team regarding the impact on service.	AL
11/23/14	<u>IPC update</u> ED had set up a number of IPC training sessions aimed at PCIC staff. The sessions had been running on a monthly basis; requests were received for the sessions to be held on Teams. Only 2 – 3 staff joined the Teams meetings so training has resumed to face to face. AL would liaise with ED outside of the meeting to look at supporting the coordination of training. A number of successful training sessions had been run with practice nurses; ED thanked RG and Michelle Treasure for their help. New IPC videos would be circulated, commode and bed cleaning training videos had been updated. Covid and flu vaccinations were still available. ED urged staff to encourage their staff to attend the drop-in sessions. The IPC team had been part of a European wide point prevalence survey, led by Public Health in care homes throughout October and November looking at antibiotic usage.	AL

	There had been 20 C'diff cases between April – October 2023. The total expectation for the year is 20 but a further case was identified in November meaning that the C'diff reduction expectation had not been meet. However, a 25% reduction had been seen on last year's cases. A 72% RCA return rate was seen, with South & East having a 100% return rate. The Vale saw an 80% return rate and the North & West saw a 33% return rate. However, it was noted that the RCA return is not mandated. A C'diff Health Pathway is being written. HK advised ED to share any communication issues with Aled Roberts who was leading the discharge advice letter (DAL) workstream. ED would provide narrative for HK to circulate to the DAL group.	ED/HK
11/23/15	<u>PCIC care home QA report</u> No care homes were under the highest level of escalation and there were no embargos on placements. Item 15 provided information regarding the issues and themes experienced in care homes and noted what PCIC was doing to support the quality of care in the homes.	
11/23/16	<u>IPC guidance GMS practices</u> HK would ensure that item 16 (the IPC guidance link) was included in the weekly GMS email.	HK
11/23/17	<u>Cryptosporidiosis briefing</u> A Public Health brief (please see item 17) had been circulated regarding cryptosporidiosis.	
11/23/18	<u>Safeguarding</u> There was nothing to note.	
11/23/19	<u>Duty of Candour – Making a meaningful apology</u> Item 19 provided guidance regarding making a meaningful apology. A flowchart had been developed, providing a structured process to follow when a Duty of Candour was declared. LW noted that comments and feedback would be appreciated.	
11/23/20	<u>Denosumab SOP</u> This item had already been discussed under item 5, PCIC action log.	
11/23/21	<u>Dementia programme</u> This would be presented at January 2024's meeting due to time constraints.	
11/23/22	<u>Marie Curie Cardiff and Vale Quality of Care Review Report 2022-23</u> Item 22 had been shared for information to provide assurance that learning activity within hospices was expected.	
11/23/24	<u>Faecal incontinence</u> Item deferred in KR's absence.	
11/23/25	<u>Student evaluations</u> This item had already been discussed.	
11/23/26	<u>Any Other Business</u> Discussions were being held regarding the recording of items in part 2 of the agenda.	

	It was suggested that business unit reports are placed at the end of the agenda of future meetings. HK highlighted that the Health Board was looking at the Quality Improvement Assessment framework which would be presented at the Senior Leadership Board. The framework was an All Wales QIA.	LTho
PART 2	The Group noted the papers submitted for information.	
Date and time of next meeting: 17th January, 2024 at 11.00 am.		

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

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
HELD AT 11 AM ON 16TH JANUARY, 2024, 11 AM
Venue: MS TEAMS

Attendees	
Anna Llewellin	Director of Nursing (Chair)
Anna Mogie (AM)	Deputy Director of Nursing (Chair)
Helen Kemp (HK)	Deputy Clinical Board Director (Chair)
Sarah Griffiths (SG)	Head of Primary Care
Lisa Waters (LW)	Senior Nurse for Quality and Education
Kate Morris (KM)	Medicines Management – Primary Care Pharmacist – Team Lead for Clinical and Governance Workstream
Gneeta Joshi (GJ)	Community Director of Clinical Governance
Lynne Topham (LTop)	Locality Manager, South and East Locality
Helen Donovan (HD)	Locality Lead Nurse, North & West Locality
Carol Preece (CP)	Lead Nurse, South & East Locality
Neil Morgan (NM)	Vale Locality Manager
Rachel Armitage (RA)	Quality and Safety Manager
Lorna McCourt (LMc)	Staff Side Trade Union Representative
Helen Earland (HE)	Clinical Operational Lead, GP Out of Hours
Andrea Rich (AR)	Lead Nurse, Palliative Care
Theresa Blackwell (TB)	PCIC Business Manager
Lorelai Buck (LB)	Out of Hours Coordinator
Melanie Bostock (MB)	Consent Lead Manager
Ann Yates (AY)	Director of Continence Services
Ruth Cann (RC) (joined late)	Consultant Nurse Older Vulnerable Adults
Louise Thomas (LTh) (minutes)	Quality & Safety Officer

Apologies	
Clare Clement (CC)	Head of Medicines Management
Lisa Dunsford (LD)	Director of Operations
Clare Evans (CE)	Assistant Director Primary Care
Jane Brown (JB)	Head of Dental and Optometry
Kate Roberts (KR)	Vale Interim Lead Nurse
Rebecca Gill (RG)	Senior Nurse, Primary Care
Victoria Whitchurch (VW)	Head of Operations, Mass Imms
Ellen Davies (ED)	Clinical Nurse Specialist in Infection Prevention & Control
Janice Aspinall (JA)	Health and Safety Representative
Justine Cosby (JC)	Head of Healthcare, HMP
Sian Griffiths (SGr)	Public Health Wales representative
Matthew McCarthy (MMc)	Interim Head of Safety, Quality and Organisational Learning
Georgina Davis (GD)	Safeguarding Nurse

ITEM NO.	**TITLE**	**ACTION**
01/24/01	AL welcomed everyone to the meeting.	
01/24/02	Apologies of absence were noted as above.	
01/24/03	No declarations of interest were raised.	
01/24/04	<u>Minutes</u> AL asked for any comments regarding the minutes of the last meeting that was held on 28th November, 2023 to be sent to LTho. There were no other matters arising.	ALL
01/24/05	<u>Action Log</u> Please refer to item 5.	
01/24/06	<u>Patient story</u> Lorelai Buck presented a patient story on behalf of her grandfather who reached end of life in February 2023 after being cared for by family and carers since September 2022. The family called the Out of Hours service on 19th February,	

	2023 following on from their loved one clearly being distressed after multiple GP visits and medication no longer taking effect. The palliative nurse responded to the family within 20 minutes, was reassuring and informed the family of all possible options available to them. Arrangements were made for an Out of Hours GP to visit Lorelai's grandfather to administer the necessary medication. Lorelai went to collect her grandfather's medication but unfortunately, it was not in stock at the pharmacy she attended. However, the pharmacist reassured Lorelai and contacted Out of Hours to find a resolution. The pharmacist praised Out of Hours for the way in which the matter was dealt with and Lorelai was in receipt of the medication within 30 minutes. She took the medication to her grandfather and found the GP already at his home. The GP took the time to explain what was causing her grandfather's symptoms (this was something that his regular GP had not done), was very informative and explained what the medication prescribed by Out of Hours would do to help in his final moments. The GP left the family, leaving all information they may have needed before the GP practice reopened on Monday morning. The family could see that their loved one was beginning to settle and could not thank the Out of Hours GP enough. Sadly, Lorelai's grandfather passed away peacefully in his sleep that night. The family felt that the Out of Hours service enabled his passing to be peaceful and dignified, to which they are very grateful. They could not thank the service enough for its rapid response to their calls and the support provided to them. AL thanked Lorelai for sharing the positive experience her family had with the GP Out of Hours service. RA noted the challenges being faced by pharmacists and the impact it has upon patients. AR queried if the regular GP could have put an action plan in place the previous Friday to prevent the family's upheaval on the weekend.	
01/24/07	<u>Risk Register Update</u> The Executive Team was reviewing the way in which risks are managed within the organisation. Training would be organised following on from this. RA asked the group to review item 7 and to report back to herself and AL should there be any queries or questions. SG acknowledged the GMS team's efforts in relation to the risk register.	ALL
01/24/08	<u>Business Continuity</u> The Health Board has proposed a new structure for Business Continuity planning and will not affect the templates currently used. TB will provide an update to SMT and will continue to link in with teams on an individual basis.	
01/24/09	<u>PCIC Quality Report</u> LW and RA have been scrutinising all Datix incidents on a weekly basis. There were 481 open Datix incidents, the majority of which were deemed as low harm. There were 25 open Datix incidents dating back to 2022. LW encouraged the group to review any historic incidents and noted that she and RA would be happy to provide help and guidance. AL suggested that RA and LW target individuals to help support with their outstanding Datix incidents. LW thanked everyone for the way in which they had been managing their incidents. Tendable audits are working well in HMP and MVC and there is ongoing work to ensure rollout in the DN teams.	

	LW thanked the group for the timeliness in which they responded to concerns, noting that the Clinical Board's performance was tracking at around 80%. AL noted that she and HK had set up regular meetings looking at Quality and Safety across the Clinical Board and will invite LW to look at the concern trends which can be represented with the Q&S report.	AL
01/24/10	<u>Consent process</u> Melanie Bostock introduced herself and explained that she was covering the role of Consent Lead whilst Chloe Evans was on maternity leave. A consent peer review had taken place between 01.09.2023 – 31.12.2023 when over 200 sets of notes were reviewed. The five areas concentrated on were Obs and Gynae, Surgery and sub specialities, Interventional radiology, Interventional cardiology and Dermatology. The process revealed that the Health Board was good at highlighting the benefits and risks of surgery and procedures, but was very poor at explaining and offering viable alternatives along with explaining outcomes should procedures not be moved forward with. Consent training will be mandatory across Wales and will be repeated every 3 years by all staff who undertake Consent as part of their practice. ESR training and monthly face to face training will be available. Bespoke training could be arranged for cohorts of staff. MB will find out how other Health Boards are managing independent contractors. The Consent team is promoting the use of IDO leaflets across the UHB. The leaflets have been in place for some time but compliance figures are dropping instead of increasing. All areas should be using the IDO leaflets; please contact the IDO team should they be required. LW believed that staff may not be aware of where they can access IDO information; MB confirmed that there was a screensaver providing this information and information was being circulated with pay slips. MB will be meeting with the IDO team soon to discuss how IDO can be promoted across the organisation. The first Consent meeting is scheduled on 24.01.2024 where it is anticipated that each Clinical Board will be represented with discussions being fed back to each area. AM queried mental capacity and consent. MB explained that out of the 200 patient notes that were looked at, there was just 1 consent form 4 and she felt that patients may be consenting inappropriately. The MCA team is looking at more practical training which will be updated in accordance with feedback received. AL thanked MB for her presentation and the conversations it generated.	MB
01/24/11	<u>Agree Primary Care QSE Terms of Reference</u> All Primary Care contractor professions (GMS, Community Pharmacy, GDS, CDS and Optometry) have been incorporated into the Primary Care Terms of Reference which focusses on contract delivery. Membership has been tightened and mirrors the Primary Care Panel meetings.	
01/24/12	<u>IPC update</u> Please refer to item 12 in ED's absence.	
01/24/13	<u>Safeguarding</u> Safeguarding is undergoing a Joint Inspectorate Review of Child Protection Arrangements (JICPA) on 15th & 16th January.	

01/24/14	Risk, Response and Review: Multi-Agency Safeguarding Item 14 reviews multiagency responses. Themes noted in the document will be discussed at the internal review.	
01/24/15	National Patient Safety Alert - Valproate Item 15a and 15b are for noting regarding the use of sodium valproate in women of child bearing age, and its risks associated with the unborn baby. The alert is being held by Neurology (was previously DOSH, PCIC). A regional medication policy is in place and a business case has been developed to support the policy. A UHB valproate working group has been established to enable the implementation of the regulation. RA noted that the Patient Safety Team is managing the compliance report for the whole organisation. They have requested that every Clinical Board presents this item at their Q&S meeting and would like to receive a copy of the minutes and agenda. KM explained that the Pharmacy team had had a few Valproate cases returned to them by mental health and neurology asking the team to speak with individual practices regarding patients who had disengaged.	LTh
01/24/16	CPET and Health Pathways Maria Dyban's team will be invited to the next meeting.	LTh
01/24/17	Faecal incontinence Ann Yates explained that she had been asked by the Journal of Community Nursing to write an article regarding faecal incontinence. The first part of the article looked at the anatomy and discussed 'forgotten symptoms' which referred to those who suffered with faecal incontinence but did not come forward regarding their situation. The work identified relevant learning points. It noted that faecal incontinence was a taboo subject with individuals feeling ashamed, embarrassed and had been forgotten about by Health Care Professionals. The condition is common but unreported, and has serious consequences with social and working lives being impacted upon. The condition is more associated with, but not limited to those aged over 85 years of age in residential and nursing homes. The second part of the article dealt with traumatic and non-traumatic causes and looked at causes and risk factors, noting that conservative therapies should be looked at before referring. AY noted that CAV deals with the automatic repair of third and fourth degree tears in childbirth, has a dedicated bowel and bladder team where self-referrals can be made via the district nurse hub, and PCIC has an established health path-way for faecal incontinence and constipation. CAV is the only Health Board in Wales with a pelvic floor hub, with direct access to physios, colorectal surgeons and gynaecologists. The promotion of continence in people of age and in nursing homes was discussed, noting that pads are automatically used in such patients.	
01/24/18	Compliments Items 18a and 18b detail the lovely compliments received.	
01/24/19	Supportive individuals' guidance Item 19 was produced as a result of questions and queries received by the Governance team from independent practitioner contractors when invited to	

	meetings. The document provides a consistent approach outlining who could be the clinician's representative, what their role would be and the expectation of the role. It advises that any information should be shared with the supportive colleague by the practitioner, not the Governance team. Formal meetings are minuted and shared with all at the meeting for comment before being finalised. The final paragraph of the document addresses the management of conflict of interest between the practitioner and any member of the team. The document was approved by the group and will be included in the papers sent to practitioners when invited to a meeting.	
01/24/20	<u>OOH Business Report</u> Further to item 20, there are ongoing issues with the recruiting of band 6 and 7 senior staff within the 111 press 2 team. This is directly impacting upon the support available to the band 5s. HE noted that 5 collapses had occurred within the CRI perimeter over the past 6 weeks due to the use of illicit drugs. Some staff had sustained needle stick injuries as a result of this and have received support from Occupational Health. Some of the homeless population are present at the site. The police, security, CAVIS and OOH are working together in relation to this. The risk is being recognised at Exec level with proactive steps being taken to mitigate the risk. LMc noted that Staff Side and the Health and Safety team are aware of the risk and can offer support if needed.	
01/24/21	<u>N&W Locality Business Report</u> Further to item 21, CCTV in the Llanrumney CRT office continues to be out of order. The locality office experienced a ceiling collapse over the Christmas period. The office is safe at present and Estates is planning to make repairs. The workforce situation has improved and recruitment is being made into the Safe at Home team.	
01/24/22	<u>Vale Locality Business Report</u> There was no representative or business report. LTh will chase the report and circulate to the group.	LTh
01/24/23	<u>S&E Locality & HMP Business Report</u> Further to item 23, CP noted that the man on fluid residing in HMP remained in hospital.	
01/24/24	<u>Medicines Management</u> Further to item 24, the Valproate working group has been established as previously discussed. Workforce has reduced by 6 members of staff due to sickness, maternity leave and staff leaving. KM referred to the late night Community Pharmacy violence and aggression incident that is being dealt with and highlighted that such incidents can affect whether the Pharmacy wishes to continue operating their service. CP noted the individual who was banned from accessing many pharmacies in Cardiff and refused to attend the pharmacy she has not been banned from.	

	KM confirmed the Community Pharmacy team had received the supportive documents for contractors.	
01/24/25	Palliative Care Further to item 25, problems had been experienced with long range pagers in hospital. Wi-Fi phones were being looked at as an alternative to the pagers.	
01/24/26	Primary Care The minutes of the Primary Care QSE meeting will be used as the Primary Care business report going forward. Please see item 26. SG noted that 11 practices are reporting at level 3, and 21 practices reporting at level 4. The issue has been noted at Executive level and will be taken to the Board next week. GMS negotiations have failed. The contract was agreed but the financial arrangements were not, causing the negotiations to stall. The risk is not known at present but has been added to the risk register. A number of practices have been identified with possible RAAC. A surveyor's report will be produced for each practice to confirm its presence. SG talked about the junior doctors' strike and noted the number of GP practices that hosts trainees and registrar trainees. Although these posts are supplementary to establishment, the strikes could possibly impact upon the practices. Support has been offered to practices but no requests have been received to date.	
01/24/27	MVC report The winter programme has come to an end. Mop up sessions are being held for flu and Covid vaccinations. A team has been employed to support the MMR mop up campaign following on from the measles outbreak.	
01/24/28	Any Other Business There was no other business.	
PART 2	Please note the papers submitted for information.	
Date and time of next meeting: Tuesday 12th March, 2024 at 11.00 am.		

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

Held on 24th November 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
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
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Becca Jos	BJ	Deputy Director of Operations
Alana Adams	AA	Principal Pharmacist Medicines Information and Advice
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Suzanne Rees	SR	Lead Nurse
Hadas Reshef	HR	Head of Occupational Therapy
Elaine Lewis	EL	General Manager, Pharmacy
George Oliver	GO	Physiotherapy Service Lead
Alison Borwick	AB	Quality Manager, Biochemistry
In attendance:		
Daniel Rigler	DR	Consultant, Child Health
Melanie Bostock	MB	MCA Consent Lead Manager
Hannah Wilce	HW	Project Manager, Pharmacy
Ciara Danielsen	CD	Clinical Pharmacist
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Sarah Lloyd	SL	Director of Operations
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
Timothy Banner	TB	Clinical Director, Pharmacy
Susan Beer	SB	Public Health Wales Representative

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 23/307	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 23/308	**Apologies for Absence** The apologies for absence were noted.	
CDTQSE 23/309	**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 16th October 2023 were accepted as an accurate record.	
CDTQSE 23/310	**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 23/133 R&D Nomination for Pharmacy* A nomination is needed for an R&D Lead in Pharmacy. Elaine Lewis to follow this up. *CDTQSE 23/241 Cleaning Products for Radiology Equipment* JF advised that work is ongoing with the IPC team to identify suitable products as there are different specifications required for different types of equipment. *CDTQSE 23/244 Feedback on HTA Inspection* SJ reported that the inspection was very positive. Minor findings were identified relating to temperature probes that need to be put in place in the paediatrics section and in the temporary unit in the mortuary . There was a focus on the good practices to be shared with other UHBs, particularly around forms and policies. Staff were identified as caring about their jobs. The inspectors also looked at the facility and advice was provided on estates work needed in the mortuaries. SG will provide further feedback when the formal report is received. *CDTQSE 23/282 Lighting issues in Clinical Engineering* EC advised that immediate improvements have been made but the workshop lighting is still unresolved. HL will escalate to the Health and Safety Operational Group.	**EL** **SG**

	The Group resolved that: a) The update on the actions from the previous meeting were noted.	**HL**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 23/311	**Concerns and Compliments Report** In October 2023, the Clinical Board received 43 concerns; 10 formal and 33 early resolution concerns. There were 0 breaches in response times. 6 compliments were received. The top 3 reasons for concerns relate to: Difficulties cancelling/arranging appointments continues to be the main reason of reported concerns at 46.5% Waiting times – 14% Concerns relating to medical treatment – 9% HL acknowledged the challenge for managers in responding to Early Resolutions concerns within the 2-day turnaround time, particularly for those with clinical commitments and has provided feedback to the Concerns team of the difficulties in meeting this timeframe. **The Group resolved that:** a) The concerns report was received which highlights the individual departments' figures.	
CDTQSE 23/312	**National Reportable Incidents** The NRI report for the Clinical board lists incidents that are being led by other Clinical Boards. There are no formal NRIs open for this Clinical Board to manage. There are 3 injurious falls that are being investigated, 2 on Glan Ely Ward and 1 in Lakeside Wing relating to a patient with Physiotherapy. **The Group resolved that:** a) Any themes relating to the patient falls will be presented to this meeting when the investigations are completed.	
CDTQSE 23/313	**New NRIs** There is a potential NRI relating to a delay in a patient receiving an ultrasound scan. The patient had initially cancelled their appointment and the issue arose relating to the timeframe around rebooking the patient.	

	The Group resolved that: a) The incident is currently under investigation.	
CDTQSE 23/314	**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 23/315	**Risk Register Updates** JF reported that a risk assessment relating to significant findings and alert system that is in place in Radiology is being completed and will be discussed within the directorate. SS reported that the 2 main risks in Point of Care Testing relates to pregnancy testing devices and blood bases. The pregnancy testing risk rating has been reduced as new equipment is being implemented over the next 2 months in high risk, high throughput areas. To reduce the risk relating to Blood gases, the team is trying to procure a new blood gas management system and blood gas analysers. GO noted that space within Podiatry and Speech and Language Therapy departments in an issue. Demand in Physiotherapy is increasing and the lack of admin and clerical staff to support appointment bookings is resulting in a significant number of concerns being raised by patients . The Pelvic Physiotherapy Team is also projecting an increase in waiting times over the next three months. **The Group resolved that:** a) The updates relating to risks were noted.	
CDTQSE 23/316	**Patient Safety Alerts** EC reported that a medical device alert was received relating to Mobile Diagnost system where an alternate workflow was causing an inability to set new parameters for examinations. An alert was also received relating to the Vivid Ultrasound system with batteries. This was not an issue in Cardiology but not for this Clinical Board. 2 alerts were received relating to Allura and Azurion fluoroscopy x-ray machines, in terms of the foot pedals. The one alert highlighted that the foot pedal was not activating due to a flat battery which could result in not delivering radiation. The second alert highlighted that the foot pedal could stick and deliver additional doses unintentionally. Updates were provided to the	

	instructions and checks will be undertaken by the service provider. EC clarified that the National Patient Safety Alert relating to bedrails discussed at the last meeting, although primarily a community issue, applies across the Health Board. Meetings have been held with the Patient Safety team, Directors of Nursing, Occupational Therapists, Physiotherapists and community staff and a follow up meeting is being held in December. There is a list of 7 actions issued by the MHRA which need to be completed by March. The recommendations suggest reviewing regularly every patient's risk assessment for the issuing of beds. This is not achievable in the Community where there are at least 6000 patients that would require review. A pragmatic risk-based approach will therefore be taken where patients that are of a higher risk of entrapment are assessed as the priority. The guidance also states the requirement for beds to meet the needs of all patients, and there is a national concern around the ability to achieve this standard and a request will be made to discuss this on a national level with the MHRA. **The Group resolved that:** a) The good engagement across Clinical Boards in meeting to identify a risk-based approach was noted.	
CDTQSE 23/317	**Medical Device/Equipment Risks** Stock has been received for therapy flow meters and the clinical engineering team will visit areas. The Clinical Engineering team have noticed lapses in the way suction and oxygen at the bed head is being set up. Staff should check that the equipment is in place and set up correctly on a regular basis. If staff are unclear on the set up and need support to contact the team. A medical gases e-learning training package is available. **The Group resolved that:** a) As this is more applicable to other Clinical Boards, HL will escalate to the Directors of Nursing.	**HL**
CDTQSE 23/318	**Point of Care Testing** SS stated there is an issue with blood glucose meters connecting to Health Board network systems, particularly following Operation POET. Any areas with issues with devices not connecting to the network to report them to the Point of Care Testing team. They are collating the issues on a spreadsheet	

	which is being submitted to the network team to resolve the issues. **The Group resolved that:** a) HL will escalate the message to the Directors of Nursing.	**HL**
CDTQSE 23/319	**IP&C/ Decontamination Issues** SR reported that the next UHB Decontamination Group is meeting next week and the next IPC Group will be held in December. Radiology are now using the Tendable system for their IPC audits and Podiatry are interested in implementing this. It was requested that if there are any other departments seeking support to implement Tendable to inform SR. GO asked if there is any guidance on which services should be using which specific tools, as presentations have also been given on AMAT, and I-Auditor. It was noted that they are all good systems and departments should implement their preferred solutions. The importance is keeping information and data on the system up to date and closing out actions. The Clinical Board has Vaccine Champions who are able to administer Covid-19 and influenza vaccinations to staff. The Mass Vaccination Centres have also opened up for walk-in sessions for staff. JF asked if there are up to date IPC procedures relating to ANTT. JF to advise SR which specific procedures she needs to refer to and she will link in with the IPC team. **The Group resolved that:** a) All directorates will encourage staff to receive their vaccinations.	
CDTQSE 23/320	**Safeguarding Update** Melanie Bostock was in attendance to present an update on Consent. There is an increasing level of litigation and 20% of this relates to the consent process and there is a drive around how consenting is undertaken. A Health Board Peer Review commenced on 1st September in Obs and Gynae, Surgery, Interventional Radiology, Interventional Cardiology and Dermatology. Each of these areas are required to review 20 patients and undertaken a review of their consent process from beginning to end. Consent training is to become mandatory across Wales and to be repeated every 3 years. This will include all clinicians, nurses	

	and AHPs who undertake consent as part of their practice. Staff who require the training will be identified at UHB level. Patient information and consent forms are being reviewed and policies and procedures are being written. Staff need to document when patients are provided with EIDO leaflets in the patient notes so there is a record. Work has recently commenced on developing a database of all locally approved patient information leaflets. This is a significant task. The Cardiff and Vale UHB Consent Examination and Treatment Policy has been updated. A UHB Consent Group is being set up and the first meeting will be held in January. **The Group resolved that:** a) The Clinical Board needs to identify a representative to attend the UHB Consent Group.	
CDTQSE 23/321	**Health and Safety Issues** JD advised that the Health and Safety Operational Group is being held next week. This Clinical Board will not be part of the next round of Health and Safety Serious Incidents Meeting due to the lack of serious incidents that have occurred. EC noted that equipment has been placed in the corridor by SDEC causing an obstruction. JD will visit the area. **The Group resolved that:** a) There were no issues to escalate.	**JD**
CDTQSE 23/322	**Regulatory Compliance** It was noted that the regulatory compliance metrics in Pharmacy have significantly improved. A DGM inspection of the Aseptic Unit will be discussed at the next meeting. **The Group resolved that:** a) Overall the regulatory compliance metrics are in a good position.	
TIMELY		

CDTQSE 23/323	**Initiatives to Improve Access to Services** **Appointment Booking Initiative in Health Records** SO reported that Health Records submitted a successful bid for Planned Care funding and are starting work with a company, Booking Lab to provide patients with online booking appointments for Phlebotomy in Barry Hospital. This will initially be part of a pathfinder exercise to establish if this could be extended to other areas where there is a straightforward booking system such as physiotherapy. The Appointments Booking Centre will still be scheduling appointments, but will allow patients who want to engage digitally to book their appointments. It is hoped that the first patients will be able to do this early in the New Year. The learning will be shared and if this initiative can be spread, discussions will be held with services interested in implementing this. GO asked if the system is for new patients and follow ups or whether it is only able to support a one-off appointment. SO advised that it will start for one off appointments. GO asked if the appointment booking system is linked to any patient systems. SO advised that the system supports integration with patient information systems, however at present the functionality will be transactional. The D&T system is used currently to record appointments in Phlebotomy and this will be explored in the future. He also noted that the booking system translates into Welsh and certain information can be requested from the patient before the appointment is made. The system allows patients to cancel online. **The Group resolved that:** SO will provide an update and a demonstration to the meeting in January.	**SO**
CDTQSE 23/324	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** BJ noted that the 8 week waiting times in Radiology have significantly increased, largely driven by the Health Board's focus on addressing cancer patients, urgent waiters and inpatients. However, this month has seen a reduction. Paediatric dietetics is reporting a reduction in the numbers of its waiting times breaches. Overall, the adult dietetic waiting list is increasing and this is being exacerbated by the recent implementation of drugs to address weight loss.	

	Speech and Language Therapy waiting times have also increased and there is capacity in place to reduce this, therefore this position needs to be reviewed. The Podiatry position deteriorated this month; this is an area that usually reports 0 breaches. **The Group resolved that:** a) The waiting time position was noted.	
EFFECTIVE		
CDTQSE 23/325	**Feedback from UHB QSE Committee** **The minutes of the meeting held on 26th September 2023 were received.** **The group resolved that:** a) There were no issues to raise from the minutes.	
CDTQSE 23/326	**NICE Guidance** **The Group resolved that:** a) There was no new guidance to share.	
CDTQSE 23/327	**Research and Development** **The Group resolved that:** a) There was no update to report.	
CDTQSE 23/328	**Service Improvement Initiatives** Elaine Lewis and Daniel Rigler presented on the EPMA, Electronic Prescribing and Medicines Administration System. EPMA is part of a wider portfolio funded by Welsh Government and is part of a national framework that DHCW has put in place. Cardiff and Vale is the first Health Board in Wales to procure the system from this framework. EPMA is a digital version of the drug chart. It also has associated clinical decision support e.g. it allows allergy information to be inputted and flags if there are interactions between drugs and provides dosing support. It provides improved data availability and reporting and tools for improved patient care e.g. ensuring national medication guidelines are being followed. The system also has the potential to close the loop on administration and supply.	

	EPMA will address issues with paper charts around quality and legibility of prescribing. Inaccuracies of drug administration due to issues with poor handwriting, ink smudges, etc. will be eliminated. The aims of the programme are: • To replace all handwritten prescribing and administration across all secondary care sites. • Engage with all staff to raise awareness, education and support prior to and following the implementation. • Utilise a gradual implementation strategy to ensure lessons are learnt at each stage. • Ensure the system is comparable to current processes. • Ensure the communication of medicines to other local and national health services. • Maximise the potential of EPMA and use the technology and data to improve service efficiency and patient safety. A procurement process has been completed and a preferred supplier has been identified. The system will be implemented locally in each Health Board, however Cardiff and Vale will collaborate with Cwm Taf Health Board and Swansea Bay for shared learning. A rollout plan for implementation has been devised. The pilot will commence in Renal followed by B7 to test the medical model. The pilot and implementation will take between 12-18 months. Demonstration sessions will be arranged to allow staff to see the system in practice and use a test environment. User groups are being set up to input into the development of the system and training for staff. Super Users will be identified in Clinical Boards to provide support. HL asked whether there will be visibility for staff who look at drug charts but do not actually prescribe. , ill they have visibility. It was noted that it has been acknowledged that there are non-prescribers that need to view the drugs charts and different levels of access will be given to staff. **KidzMedz Cymru Update** Clara Danielson was welcomed to the meeting to provide an update on KidzMedz Cymru. The initiative launched in June to encourage children to learn how to swallow tablets and capsules in a safe manner. The aim this year is to teach 400 children and realise a reduction in liquid medicines. This is done via a six-step technique, which starts the child with smaller pills and then builds up to a larger capsule.	

	The initiative is currently active in the majority of paediatric outpatient clinics. The resource pack is complete and sent to Heath Boards across Wales and a SharePoint page and website has been set up. 100 kits have been issued which equates to 1 kit per child. An unexpected benefit of the scheme is that the gastro pharmacist has been teaching children to take a capsule in Endoscopy and this has prevented children from needing to come in for an endoscopy under GA or sedation. The initiative is now applying for a LATCH funding bid. If successful this will fund a play therapist for 1 afternoon a week to teach in oncology areas and monitor progress and collate data. In terms of the next step, the initiative will rollout to Haematology and Oncology in December and launch in Community Paeds in January 2024. HL asked if there is data to prove that patients are retaining their skills and not reverting back to liquid medicines. It was noted that capturing data has been a challenge and databases are being maintained where possible. HL suggested that EPMA will be a good system for tracking and capturing data. **The Group resolved that:** a) Updates on the implementation of the EPMA system will be brought to future meetings.	
CDTQSE 23/329	**Information Governance/Data Quality** SO reported that an improved automated system is needed for dealing with Subject Access Requests to improve quality and turnaround times. A system has been identified and the Health Records department will pilot this in the first instance. and if the system is robust, this could be widened across the Health Board in the future. **The Group resolved that:** a) If the system is robust, this could be widened across the Health Board. b)	
CDTQSE 23/330	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** JF provided feedback on the HIW Inspection in Radiology. This was a positive inspection and the inspector acknowledged the knowledge of staff. Small actions were identified for improvement and progress has been made in addressing these issues. The self-assessment was completed prior to the day which was appreciated by the inspector who also noted that this had been thoroughly completed.	

	The Group resolved that: a) The formal report has not yet been received and an update will be provided in January.	**JF**
CDTQSE 23/331	**Policies and Procedures** **CD&T Clinical Board Risk Management Procedure** The procedure was circulated for comments. **The Group resolved that:** a) Any amendments to be submitted to Helen Jenkins.	
EFFICIENT		
CDTQSE 23/332	**Exception Reports from Directorates** GO raised awareness of the power outages in Lakeside yesterday that impacted on outpatient physiotherapy and wards. The team lost water and internet access. JF noted that power was also lost in the X-ray rooms in Trauma Clinic and a mobile unit was needed. SO reported that it was linked to work in the tunnels. Medicine Clinical Board will be escalating concerns. HL noted that a power outage is planned in UHL on 27th November. **The Group resolved that:** a) Medicine Clinical Board will be escalating the concerns around the power outage in Lakeside.	
CDTQSE 23/333	**Health and Care Quality Standards** **The Group resolved that:** a) There were no updates to report.	
CDTQSE 23/334	**Clinical/Internal Audits** **The Group resolved that:** a) Departments are encouraged to use the AMAT system for any internal audits.	
CDTQSE 23/335	**Waste and Sustainability** EC noted that recycling bins for mixed waste within the Clinical Engineering department have been replaced by segregated bins. The CD&T Green Group will be meeting in December. to review the results of the Autumn objectives and to set the objectives for Winter. **The Group resolved that:**	

	a) The CD&T Green Group will review the results of the Autumn objectives and set the objectives for Winter.	
EQUITABLE		
CDTQSE 23/336	**Feedback from Clinical Board Inclusion Ambassadors Group** **The Group resolved that:** a) The Inclusion Ambassadors Meeting in November was cancelled.	
CDTQSE 23/337	**Equality and Diversity Issues** **The Group resolved that:** a) There were no issues to report.	
PERSON CENTRED		
CDTQSE 23/338	**Patient Story** Sion O'Keefe presented a patient story from Outpatients. A patient attending an appointment at an Outpatients clinic was in attendance with their 6-year-old child. The patient became unwell and collapsed in the long, open plan corridor. The area where they collapsed was cordoned off by screens and patients were cleared from the area to further down the corridor. The child of the patient was looked after by a Healthcare Support Worker and was unaware of what was happening. The patient was in a poor condition and there was a lack of clarity over who was responsible for the patient. The clinical team responsible for the episode of the patient's care in clinic that day left the nursing team to attend to the patient. The patient's first language was not English and a translator who had been present for the patient's appointment was present. The Response team arrived and the patient was admitted to EU however there was a lack of understanding and knowledge of the patient's condition. There was no knowledge around the other parent to the child and there was a communication barrier to be overcome as the child, whilst able to speak English, was only 6 years of age so communication was limited. It emerged that the other parent was abroad and the child had siblings aged 16 and 17, and the thought process began whether they were capable of looking after themselves and the 6-year old. There was no support available to the department for this predicament or to provide direction of how to support the child and the siblings if they were to go home alone. When the siblings came in, contact was made with the other parent who was very distraught and was asking if the siblings could see the patient. The siblings were very mature in the attitude they demonstrated and it was arranged for them to visit	

	their parent in EU. Fortunately, it became apparent that there were relatives that could look after the 6-year old and her siblings. There was a good outcome the patient, who recovered and was able to be discharged that day. The incident however raised the issue that the outcome could have been very different and there are a lot of lessons to be learned from this episode. It raised the question of whose responsibility it is for patients in this situation. The outpatient nursing team is of the view that their role is to support the clinical staff. An engagement exercise is needed with clinicians around their support if this incident should occur again. Also, if there is a safeguarding/capacity issue, there needs to be a greater understanding of the actions to be taken. **The Group resolved that:** a) The learning will be captured for training and awareness in the Outpatients department. b) Learning from this will be useful for sharing across the Physiotherapy departments as this could occur in their areas. c) The Outpatients team were thanked for their response to a complex situation.	
CDTQSE 23/339	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 23/340	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/341	**National User Experience Framework/Feedback from Patient and Service User Surveys** **The Group resolved that:** a) There was no patient survey information to review.	
CDTQSE 23/342	**Staff Awards and Recognition** **The Group resolved that:** a) There were no staff awards to discuss.	

ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 23/343	CD&T Health and Safety Group Minutes 19.10.23	
ANY OTHER BUSINESS		
CDTQSE 23/305	Nothing further to report.	
CDTQSE 23/306	**Date & time of next Meeting** It was agreed to cancel the next meeting in December. The next meeting will be held on 22nd January 2024 at 11am via Teams.	

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

Present:		**Title**
Abigail Holmes	AH	Director of Midwifery & Neonatal Services, C&W Clinical Board (Chair)
Natalie Vanderlinden	JA	Designated Education Clinical Lead Officer (DECLO)
Alison Lewis	AL	Patient Safety Facilitator
Ryan Paxford	RP	Senior Fire Safety Advisor
Alison Davies	AD	Lead Nurse, CYPFHS Directorate
Anthony Lewis	AL	Clinical Board Pharmacist
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Ashleigh Trowill	AT	Operational Service Manager, CYPFHS Directorate
Laura McLaughlin	LM	Risk Manager, O&G Directorate
Rachael Sykes	RS	Assistant Head of Health & Safety
Siwan Jones	SJ	Clinical Nurse Specialist, Infection Prevention & Control
Martin Edwards	ME	Assistant Clinical Director, CHFW Directorate
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Lois Mortimer	LM	Head of Midwifery/Directorate Lead Nurse, O&G Directorate
Tina Freeman	TF	Senior Nurse, CHFW Directorate
Samuel Barrett	SB	General Manager, CHFW Directorate
In Attendance		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Apologies:		
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board
Catherine Wood	CW	Director of Operations, C&W Clinical Board
Becci Ingram	BI	General Manager, CYPFHS Directorate
Janice Aspinall	JA	Lead Health & Safety Representative, Staff Side

Item No	Agenda Item	Action
CWQSE/ 2023/176	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2023/177	**Apologies for Absence** **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2023/178	**Minutes of the previous Q&S Meeting held on 26th September 2023** The minutes of the meeting were agreed to be an accurate record **The CWQSE resolved:** a) The minutes were noted and agreed	

CWQSE/ 2023/179	**1.4 To note and update the action log of the meeting of 26th September 2023** The action log was noted and updates provided. **The CWQSE resolved:** a) Action log to be updated and final version circulated for noting of updates.	**KH**
HEALTH & SAFETY		
CWQSE/ 2023/180	**HSE Inspection Visit Update** HSE Inspection will take place on 15th November and will be attending CHFW and Maternity Services. The inspection will cover management of MSD and V&A and will review areas such as risk assessments and training. Compliance for manual Handling and V&A require improvement. Initial internal audits have been undertaken and action plans have been developed. Further meetings are taking place to review the actions and progress made to date. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2023/181	**Feedback from last UHB Operational H&S Meeting** • Tunnel safety group is being resurrected and consideration is being given with regards to locking the tunnels down. Representatives will be asked to attend to make plans for essential users and access, alternative routes etc. • RACI Document was shared and will be disseminated out for noting of accountability and responsibilities, once ratified. • HSE Audit was noted • Presentation provided on personal injury claims • Lone Worker procedure was approved and is now available on the H&S SharePoint Agreed that the minutes from the meeting would be shared once ratified at the November meeting. **H&S Dashboard – September 2023** The dashboard was shared for information. 2023-09 H&S Dashboard - September- Completed.pptx **C&W Training Compliance Information (from the dashboard)** The breakdown was noted for information. **The CWQSE resolved:** a) Update was noted. b) UHB Operational Health & Safety Minutes to be circulated for information	**KH**
CWQSE/ 2023/182	**To note the C&W Clinical Board Exception Report – August 2023** The report was shared and noted for information. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2023/183	**Breakdown of DNA's for training courses by Clinical Board** Noted for information. All were asked to ensure that any cancellations are provided as soon as possible. The cancellation notice can be provided, up to the day of training.	

	The CWQSE resolved: a) Update was noted.	
CWQSE/ 2023/184	**To note the latest COSSH Report** Noted for information. Status report provided to highlight any areas that require review and risks assessments are up to date. A piece of work is being undertaken to ensure there is a robust process in place for all COSSH Assessments across the UHB. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2023/185	**Fire Safety Update** Noted for information. Over the last three months, there have been 3 fires within the Health Board. Learning points were identified and shared (full detail within the main report). Meeting with fire authority held, and it was noted that over 50% of unwanted alarms relate to cooking processes. If there are any instances where staff are cooking in non-designated areas, items will be removed. Fire risk assessments are currently at 100% compliance, with 36 open risks scoring 16 or above. Zero of these risk assessments relate to Children & Women's Clinical Board. The Clinical Board is currently reporting 76% for Fire Safety training compliance. Introduction of a deputy fire safety management committee is being developed and representatives from each of the Directorates will be required to attend. Fire Warden training is in place and further dates are awaited. Drop in fire sessions are being considered for the new year. Dates will be shared when released. Queries were raised, with regards to fire wardens and whether there is opportunity for support as the current warden in Maternity is currently off on long term sick. It was noted that this is not possible, as fire wardens are specific to the area, however x2 further sessions are being considered for UHW/UHL. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2023/186	**Feedback from H&S Staff Side** No update noted due to apologies received from representative	
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		
CWQSE/ 2023/187	**Health & Care Standards Directorate QSE Exception Reporting** The detailed report was shared for information and an update was provided on the key highlights from the report. **CYPFHS Directorate Report** • Agreement on national protocol to extend HCSW support to the Fluenz Programme • SBAR developed in relation to Paediatric Continence Service and review of products. • Additional immunisation sessions have been undertaken in Moorland	

Primary Schools following 6 confirmed cases of measles.

- Lack of accommodation room space continues which is impacting on services. A risk assessment is being progressed to review the overall risks and mitigations for the Directorate
- Unwell child, who became unresponsive in LCC Outpatient Clinic. Request has been received for a BM machine to be implemented, and this is currently being reviewed for training and competency assessment.
- Reduced staffing plans in place across Generic Health Visiting and Flying Start services. Anticipated that the 27-month contacts will be reintroduced from 1st November, with a view to offer the full programme from January 2024.
- Homeless accommodation is increasing which is challenging for the generic & flying start health visiting services due to staffing levels, due to the requirement for intensive visiting.
- Risks assessments are being completed for the Goleudy services due to capacity concerns.
- Joint NRI with Adult Mental Health Services – further update will be provided when available
- Purpose T being rolled out across Community Services
- Mouse infestation in Ty Gwyn
- SARC continues to be an issue as the work for the region is impacting on capacity for Cardiff. Safeguarding rota continues to have gaps and there is no backfill for the community Dr when covering the safeguarding rota. Work is ongoing and the regional rota is anticipated to be in place shortly with colleagues joining from Newport and Swansea Bay.
- LAC – backlog of health assessments continues and demand and capacity assessment is being undertaken to look at opportunities to….
- Transfer of care issues continue with regards to CYP who move out of area and further work is required on a national level with regards to a memorandum of understanding and responsibility for overall care.
- World Children's Day on 20th November and a celebration event is being arranged within the CHFW.
- Cardiff is to be recognized by UNICEF as a Child Friendly City on 27th October 2023.

Timely Access

- At the end of September 2023, there were 338 patients waiting for an assessment with the Continence Service. The longest wait was 84-weeks.
- At the end of September 2023, Eating Disorders do not have a waiting list. Assessments are taking place within a week of referral
- At the end of September 2023, there was a backlog of 100 initial health assessments to be completed within Looked After children Service.
- At the end of September 2023, the ND waiting list had increased slightly to 2,597 patients waiting for an initial assessment. The longest wait for an assessment was recorded at 185 weeks.
- At the end of the month, there were 106 patients waiting for assessment with EWMH Service with a longest wait of 5-weeks. Achieving Part 1A compliance hitting 87%.

Within EWMH, improvement has been made on the Part 1B target and have achieved 22% compliance, which is a significant improvement from 0% from the last few months. There has been a reduced in the longest wait which is currently at 16weeks.

It was noted that there are currently issues with ADHD Medication at present due to a national shortage. Joint statement and patient letters will be

	disseminated outlining how this will be managed. AL agreed to share when information is available. **The CWQSE resolved:** a) The report provided was noted for information and key highlights and actions were recorded. b) Joint Statement and Patient letters regarding national shortage of ADHD medication to be shared.	**AL**
CWQSE/ 2023/188	**CHFW Directorate Report** • X4 open NRI's x2 of which will be closed this week. • NICU and PICU remain the greatest areas of risk. • Winter plan has now come into action and the predictions are following the predicted upward forecasted pattern which was expected. Reduced numbers of elective patients requiring overnight and longer stays and day surgery lists are being maximized. • Themes of Datix incidents continues to be lack of suitably trained staff and unexpected admission to NICU. • Some workplace inspections have taken place. Water fountains have been installed in PICU. • X2 new RIDDOR incidents reported in month. Investigations are taking place • Manual Handling & V&A training compliance needs to be improved and meeting is arranged to review action plans in readiness for the upcoming HSE inspection. • No new pressure damage incidents have been reported in month. Paediatric Scrutiny panel has been implemented and a new SOP in place which has been shared with the Tissue Viability team and WHSSC. • New RIDDOR guidance for Patient Falls have been shared • Recent MRSA outbreak in NICU has been closed down. Work on the action plan continues and ongoing IP&C Audits are taking place. • CRO Audits poor and plans are in place to improve going forwards • Overall Tendable audits were 93.3% for the month. • Reduction of medicines management Datix incidents. Microguide for vancomycin is being reviewed by Pharmacy and a pop up alert has also been added to WCP (following a recent NRI investigation), to alert the requesting Dr to check levels before making any dose adjustments. Junior Induction programme also now includes training on dosing and interpreting levels for vancomycin agents. This also covers Human Factors and communication. • Staff Voices continues and monthly newsletters continue. • Communication sessions are being implemented this week with regards to tertiary patients waiting in DGH and between specialities. • Research continues for Children for CF, new drug being trialled. Study for diabetic patients has seen significant results on continuous infusion and further information is going to be shared at a forthcoming Directorate Q&S Meeting. • Informal concerns themes relate to waiting times for surgery and bloods. For formal concerns there are 8 formal concerns, of which 4 are overdue. X2 concerns relate to a consultant change, which could be a factor following the press coverage relating to Martha's Rule. This will be monitored. • Recruitment continues across a number of areas, with commencement of a number of key roles in post. • 15wte overseas nurses have been agreed for recruitment and this international recruitment process is ongoing. • **Timely Access** • No patients waiting over 104 weeks for Paediatric Surgery. 233 patients	

	waiting over 36weeks and of the 233 patients, 156 are over 52 weeks. • Protected day case unit is open and no cancellations have been seen within the first month, which is positive. Also the service is performing more theatre operations in month than was predicted, which is very positive for patients. • No children waiting over 52 weeks for outpatient surgery appointment. The longest wait is at 28weeks but they have an appointment date. • Work continues within General Paediatrics to ensure that there are no patients waiting over 52 weeks for a new outpatient appointment by the end of March 2024. There are currently 207 patients waiting between 36-52weeks which is a reduction from 289 in September. • Weekly utilisation continues to identify empty clinic space to ensure full utilisation. SOS and PIFU has been launched in General Paediatrics and further go live dates are anticipated within the coming months. This work has been supported by the Shaping Change team. • Paediatric Cardiology, longest wait is at 26weeks. Work continues to ensure that all patients are allocated an appointment at 24weeks. • Endoscopy – there are 157 patients waiting, 8 of which are over the 8 week target. Additional endoscopy list will be implemented from November which is anticipated will bring down the waiting list to circa 50 patients by the end of March 2023 **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2023/189	**O&G Directorate Report** • Currently a number of patients waiting an appointment for the Birth Afterthoughts service. • Theme of referrals to perinatal mental health service for women being traumatized by their birth experience during COVID and now in subsequent pregnancies. A plan is in place to discuss further with the psychology service to see how they can support • Alice Gower now the professional lead for infant feeding. • Birth partner project supports antenatal education for women and induction of labour information. This has been translated into the top 5 languages and work is progressing with the Public Health Team with regards to the patient facing website, for this to also be available in different languages. • Perinatal Mental Health guideline is being updated to include emotional mental health needs guidance for protected characteristics • FGM Defibrillation pathway is being reviewed and further training is being provided in this procedure. • Baby loss awareness week. Tree in the sanctuary and the maternity unit was lit as remembrance. Additional bereavement midwife now in post, and review of the pathway for women who suffer miscarriage between 14-16 weeks on Gynaecology is being progressed. • Teardrop Suite to be relocated • 180 incidents reported in September, 800 current open incidents. For investigations - X8 in Gynae, x2 of which are NRIs, x18 in Obstetrics, x6 of which are NRI's. • X5 new RA for consideration for Directorate Risk Register • X7 Medication Errors reported in September. No significant issues to note. • Mandatory Training days are due to recommence in November 2023, CTG and PROMPT Training Days have continued to take place. • Homebirth service to recommence from 31st October 2023 • Funding for mural outside Antenatal clinic with the theme of inclusivity and this is progressing.	

	• New midwife lead in post for Clinical Governance & Risk. Recruitment has taken place to a number of posts, and Lois Mortimer has been formally appointed as Head of Midwifery. Recruitment continues in a number of areas across the Directorate. • Staff Voices is ongoing and is being well received. **Timely Access (taken directly from Directorate Report)** **52 week OP** Qtr 3 441 Total 242 Without TCI's Of the 242; 21 Prolapse (1 slot available before 31/12) 16 Urogynae (32 slots available before 31/12 – incl Barry clinic) 205 Pooled (21 slots available before 31/12) Qtr 4 1294 Total 1052 Without TCI's **104 week IPDC** Qtr 3 303 Total 290 Without TCI's Qtr 4 545 Total 526 Without TCI's **156 week IPDC** Qtr 3 3 Total 1 Without TCI (Bristol pt) Qtr 4 50 Total 43 Without TCI Cancer Update to follow. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Cancer update to be shared outside the meeting.	**LMc**
CWQSE/ 2023/190	**New Risks to be considered for the Clinical Board Risk Register** There were no new risks for noting from the meeting.	
SAFE CARE		

CWQSE/ 2023/191	**Patient Safety Update** New incidents update from the previous meeting was provided and it was noted that there has been a significant improvement to the incidents from 2022, and all were asked to continue to encourage timely review going forward. Discussion ensued with regards to the x3 outstanding incidents, which are ATAIN cases. Assurance was provided that the incidents have been reviewed, and these will be moved through the process as soon as this is progressed through the ATAIN internal review process also. **The CWQSE resolved:** a) Update report was noted.	
CWQSE/ 2023/192	**NRI/RCA Governance Sub Group Minutes – 12.09.2023** Noted for information. There were no exceptions to note for this meeting. **The CWQSE resolved:** a) Minutes noted for information.	
CWQSE/ 2023/193	**3.2 NRI/PSLR/Closure Forms for noting/exception reporting** All cases noted below have been discussed as part of the NRI/RCA Governance Sub Group held on 10th October 2023. The minutes will be shared for information following ratification. **SBAR, PSLR and Improvement Plan Patient KA (Datix Ref 20853)** Further comments have been received following factual accuracy checks. Further work is required prior this being progressed towards closure. **SBAR, PSLR and Improvement Plan Patient GC (Datix Ref 18756)** Early NND. Baby was born via emergency caesarean section following a placental abruption, and sadly died the next day. The patient had low PAPP-A and had received serial growth scans which were normal, however the patient did not receive aspirin which would have been recommended with low PAPP-A in the first pregnancy. X2 issues were identified (taken from the SBAR): Issue 1: Aspirin risk assessment not completed at 17 weeks Issue 2: Timings of ambulance staff assessment at home 1. Was the antenatal care provided to GC in line with national guidance including management of low PAPP-A? The information leaflet was given to GC and serial growth ultrasound scans arranged. The aspirin risk assessment form was not completed correctly or reviewed again at the scheduled 17-week midwife appointment. As such, no aspirin was prescribed. It is unclear whether this had an impact on experiencing a placental abruption. 2. Was the management of antenatal bleeding timely and in line with national guidance? Management of antenatal bleeding was timely and in line with national guidance. Despite there being a perceived delay in transfer this has been reviewed by WAST and CAVUHB and felt to be within the expected transfer times. 3. Was adequate neonatal care provided to GC after birth and in NICU?	

	GC received prompt resuscitation with ongoing assessment at birth from a senior neonatal team. Her escalation of care was timely and appropriate along with attempts to manage and reverse the persistent severe acidosis. Two minor issues in care were identified; none of them would have had an impact on her outcome. The family were kept informed of progress and detailed discussion took place while decisions about ongoing care were taken. A second opinion was sought from another consultant before the final decision regarding her care was agreed. In the opinion of the reviewer, neonatal care was appropriate and adequate. Recommendations were noted as: • 16-week sticker to be included in all antenatal notes for use by the community midwife highlighting the need for aspirin risk assessment • Consider adding a checklist to the low PAPP-A leaflet for women to self-assess their need for aspirin • Antenatal team to discuss whether aspirin should be offered to all women with Low PAPP-A **SBAR and PSLR Patient NG (Datix Ref 18739)** 36+1week placental abruption IUD. It was noted that there was excellent multi-professional management of placental abruption, however there were X5 issues that were identified as part of the investigation (taken from the SBAR): Issue 1: No aspirin risk assessment or uterine artery Doppler performed Issue 2. No transfer booking referral in Cardiff & Vale UHB record Issue 3: Inappropriate referral to fetal medicine service Issue 4: Assessment of proteinuria Issue 5: Inaccurate plotting of middle cerebral artery Doppler and subsequent management Conclusion on terms of reference and specific review questions: There were a number of issues in care where changes made may have prevented the subsequent death of Baby MG through placental abruption. There was no aspirin prescribed despite high risk factors for both a small for gestational baby but also pre-eclampsia. The subsequent placental abruption may have been avoided had there been placentation supported by the administration of aspirin. Later when a small baby was diagnosed through serial ultrasound scans, there was identification of abnormal Dopplers which should have prompted expedited birth in CTMUHB. When the patient was seen in the FMU in Cardiff the Dopplers were plotted on validated charts embedded in the FMU viewpoint system which gave normal readings. Had they been plotted on different charts such as those in CTMUHB then it may have highlighted a baby at additional risk. Given that these were documented as being normal it led to discharge from hospital with a planned date of birth at 37 weeks rather than planning birth by Caesarean as an emergency procedure. Recommendations were noted as: 1. Consultant Obstetricians and Fetal Medicine Consultants to determine which Doppler chart to be used within Cardiff & Vale Health Board and reviewed with the Maternity & Neonatal Network Guideline Group 2. Liaison between Health Boards to determine triggers for delivery where MCA Dopplers being performed outside a Fetal Medicine Unit. If being used	

	outside of FMU then a clear pathway needs to exist to ask for advice rather than delaying management to be seen in the tertiary unit. 3. CTMUHB to ensure an action plan developed to ensure consistent aspirin prescription for high-risk women and to review the performance of uterine artery Dopplers in line with national guidance. 4. Audit of referrals from other units to FMU for small for gestational age 5. Development of a clear growth assessment pathway in CAVUHB incorporating uterine artery Dopplers and the use of middle cerebral artery Doppler to time delivery 6. Sharing of learning from this case focussing on management of the small for gestational age baby and highlighting the concurrent development of pre-eclampsia as part of the spectrum of uteroplacental disease. **SBAR, PSLR and Improvement Plan Patient BH (Datix Ref 33479)** Case involved a patient who was being treated with Vancomycin for a wound infection and subsequently developed a very high level of Vancomycin which caused an acute kidney injury. The patient was an 8yr old with Autism who had spinal surgery and was discharged home. 13 days post-surgery the patient was readmitted and prescribed vancomycin to treat a wound infection. The patient was known to be difficult to cannulate and had pulled out her cannula on a number of occasions. As a result of these issues there were delays to access for medication and only part doses/no medication being administered. As vancomycin is nephrotoxic at high blood levels there is a need for regular monitoring to keep the levels within a therapeutic range. The levels were regularly monitored and showed below therapeutic drug levels so were increased in order to achieve a higher level. A combination of omitted doses and incomplete doses led to a falsely low vancomycin level, this in turn led to doses being increased which when then given successfully for a period of time resulted in nephrotoxicity and an acute kidney injury. Recommendations (taken from the SBAR) were noted as: • Share outcome of review with relevant parties for learning and education. • Ask Pharmacy for clarification of crystallisation of Vancomycin and how this could affect dosing. (Avoiding crystallisation of the vancomycin by appropriately flushing burettes between medication) • Pharmacy to advise around prescribing in children outside of ideal weight range. • Inform Local Programme Director about the possible need for more teaching in prescribing, including in obese children and working with drug levels for Paediatric Trainees. • Share the report with parents, if desired, to ensure they fully understand the difficulties of managing vancomycin in this case and the in-depth review that has taken place to try and avoid this in future. The case now part of junior induction training and increased teaching for medical staff which includes dosing for ideal weight interpreting levels with consideration to actual vancomycin given and how to respond to high levels human factors and communication issues. Prescribing for children outside of normal weight ranges is being reviewed for the Paediatric Micro guide also.	

	A warning on Welsh clinical portal for high or low vancomycin or gentamicin levels and has been added and a request that the clinician considers whether the patient has received the prescribed doses at the expected times prior to requesting a level or adjusting a dosage of a level is now on the Welsh clinical portal in Cardiff and Vale. It was noted that the patient is doing well and there are no lasting effects from the acute kidney injury sustained. **SBAR and Improvement Plan NS (Datix Ref 26469)** Case involved patient who suffered a pneumothorax following change of endotracheal tube due to a cuff leak. During the intubation attempt the patient had desaturated therefore a period of hand ventilation was required. In the process of the tube change and BVM ventilation she experienced a pneumothorax. There were four issues identified as part of the investigation (taken from the SBAR): **Issue 1.** Elective ETT change delayed till the end of the day despite a leaking ETT cuff being identified at 0500. A busy PICU meant the ETT change being conducted out of hours when there would be less support available in case of problems and less staff to be part of the intubation team. Two consultants were present for this procedure. **Issue 2.** Consultant 1 was unfamiliar with C-MAC and its use but persisted with using it. They should have recognised their unfamiliarity with the equipment and sought alternative equipment or asked someone more familiar to take over. This may have contributed to the accidental removal of bougie and ETT through increased cognitive workload and a failed first attempt at intubation due to unfamiliarity with the equipment. On failure of this initial intubation attempt Consultant 2 took over. During the intubation attempt NS had desaturated therefore a period of hand ventilation was required. Whilst Consultant 2 was holding the ETT for the nursing staff to secure it with ETT tapes Consultant 1 was ventilating the patient. During this period of hand ventilation Consultant 2 observed that the airway pressure limiting (APL) valve on the circuit was set quite high meaning the bag was very distended and therefore under high pressure, they recommended releasing the valve to reduce the pressure otherwise a pneumothorax could occur. **Issue 3.** A larger circuit was used for hand ventilation with airway pressure limiting (APL) valve tightly closed. The bag should not be allowed to become overdistended/tense. Excess pressure delivered during hand ventilation most likely caused the pneumothorax and requirement for chest drain insertion. **Issue 4.** Documentation of procedures is brief. The report recognised that high airway pressures to ventilate the patient had been necessary over a prolonged period. Airway pressures required for ventilation should be minimised however in this case higher pressures were unavoidable to maintain adequate ventilation and oxygenation. High airway pressures can cause a pneumothorax.	

	The recommendations were noted as: • Elective procedures are carried out during "normal" working hours where practicable • Training for all staff on use of airway equipment including multi-professional simulation/in situ simulation. • Human factor training for staff • Create or adapt Adult ITU SOPs for use on PICU The improvement plan has been developed and work is progressing on the actions identified. There have been some final questions in relation to system issues and once this has been clarified, the report can progress to closure. Discussion ensued with regards to the process for closure and it was agreed that further discussion would be held outside of the meeting to ensure that there is a robust closure process in place to progress and close the investigations. AL also noted that further training is being rolled out from January 2024 which will support the investigating officers throughout the investigation process. **The CWQSE resolved:** a) The cases were noted and approved for progression to closure (except the case of KA which requires further discussion/review) b) Final report/Improvement plan for KA will be shared for information following final agreement c) Review of closure process meeting to be progressed outside of the meeting.	**LMc** **AH/KH**
CWQSE/ 2023/199	**3.5. Infection Prevention Control Update Report** The report was shared for information. For Tier 1 organism bacteraemias there were x2 cases reported in October. X1 MSSA in Rainbow Ward X1 Pseudomonas in Puffin Dialysis unit. Current position against expected targets are included within the report. MRSA Outbreak has been officially closed and significant improvements seen. There are currently no infections or outbreaks within the Clinical Board. For COVID numbers have decreased, currently only x3 cases within C&W Clinical Board wards. There have been increases in the incidences of norovirus throughout the hospital, and also RSV cases, as we approach the winter period. Joint audits are ongoing. Poor compliance for CRO and MRSA screening. Specific teaching for maternity staff is being provided for CRO and MRSA screening teaching. Back to basics training session will be provided on 16th November 2023 and will be circulated to all Ward Managers across the Clinical Board. Detail will be circulated following the meeting. X9 outstanding RCA's – x2 for Obstetrics & Gynaecology and x7 for Acute Child Health. Full details included within the report. Link practitioner days have been circulated. Currently only x2 attendees from the Clinical Board. Request made to share information. Review of current IP&C link practitioners is being undertaken and contact will be made for further practitioners where required.	

	The CWQSE resolved: a) Update noted. b) Back to Basics Training Session details to be shared outside of the meeting	**SJ**
CWQSE/ 2023/200	**Safeguarding** No issues to note for this meeting. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/201	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Internal Safety Notice 2023 006 – Glass pre-filled syringes The alert was noted and has been disseminated widely across the Clinical Board. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/202	**NICE Guidance – Update on Progress** Report shared for information. **The CWQSE resolved:** a) Update noted.	
TIMELY CARE		
CWQSE/ 2023/203	**4.2 Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:** a) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2023/204	**V&A and Manual Handling Training Guidance** • V&A - V-A-Training-Guidance-Oct-2021-v2.pdf • Manual Handling - MH Training Guidance Oct 2021. v2.pdf Shared for information. The group were asked to review the guidance to ensure that the mandatory training competencies are correctly to allocated to all staff. It was agreed that improving compliance is a priority for all and plans are in place to improve this trajectory going forward, specifically in the areas of violence and aggression and manual handling. **The CWQSE resolved:** a) Guidance noted and shared. b) Competencies to be reviewed.	**ALL**
CWQSE/ 2023/205	**RIDDOR Guidance** Shared for information. **The CWQSE resolved:**	

	a) Guidance noted and shared.	
ANY OTHER BUSINESS		
CWQSE/ 2023/206	**Electronic Prescribing** Procurement phase is now complete and a provider has been identified. C&W will be part of the second phase of the rollout which will be towards autumn/winter next year (2024). **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/207	**Medicines Safety Executive Update** Medicines Safety Update to be provided at meetings going forward. Standing item will be added to meetings from next meeting (under safe care section). Sodium Valproate update to be provided at the next meeting to assure the Clinical Board that current guidance is being followed and any necessary actions required as a result of this guidance. **The CWQSE resolved:** a) Update noted. b) Items to be added to the next agenda	**KH** **AL**
CWQSE/ 2023/208	**Date and Time of Next Meeting** Tuesday 28th November 2023, 8.30am, Microsoft Teams	**ALL to note**

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 19th December 2023 at 8.30am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, Children & Women's Clinical Board (CHAIR)
Abigail Holmes	AH	Director of Midwifery & Neonatal Nursing, Children & Women's Clinical Board
Lois Mortimer	LM	Head of Midwifery/Directorate Lead Nurse
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Alison Lewis	AL	Patient Safety Facilitator
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Ashleigh Trowill	AT	Operational Service Manager, CYPFHS Directorate
Laura McLaughlin	LMc	Risk Manager, O&G Directorate
Becci Ingram	BI	General Manager, CYPFHS Directorate
Hannah McLoughlin	HM	Clinical Governance & Risk Lead Midwife, O&G Directorate
Siwan Jones	SJ	Clinical Nurse Specialist, IP&C
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Martin Edwards	ME	Asst Clinical Director, CHFW Directorate
Samuel Barrett	SB	General Manager, CHFW Directorate
In Attendance		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Elaine Lewis	EL	General Manager, Pharmacy
Hannah Wilce	HW	Project Manager, ePMA Project
Daniel Rigler	DR	General Paediatrician
Apologies:		
Catherine Wood	CW	Director of Operations, C&W Clinical Board
Anthony Lewis	AL	Clinical Board Pharmacist

Item No	Agenda Item	Action
CWQSE/ 2023/209	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2023/210	**Apologies for Absence** **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2023/211	**Minutes of the previous Q&S Meeting held on 24th October 2023** The minutes of the meeting were agreed to be an accurate record. **The CWQSE resolved:** a) The minutes were noted and agreed	

CWQSE/ 2023/212	**1.4 To note and update the action log of the meeting of 24th October 2023** The action log was noted and updates provided. **The CWQSE resolved:** a) Action log to be updated and final version circulated for noting of updates.	**KH**
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		
CWQSE/ 2023/213	**Presentation Update – Electronic Prescribing and Medicines Administration (ePMA)** Update was provided on the Electronic Prescribing and Medicines Administration System. The project is progressing an electronic shared medicines record which will be available to view wherever the patient is being treated. Electronic prescription service is being rolled out which will mean that your prescription will be electronically be transferred to the patient's chosen pharmacy. Electronic prescribing will be rolled out across all inpatient areas by the end of 2025. Discussions are underway with regards to the Special Schools and community services rollout. ePMA will replace the paper drug charts across the UHB and will provide support for; • Clinical decision support (allergies, interactions, dosing and formulary) • Improved data availability and reporting • Tools for improved patient care e.g. antimicrobial stewardship, VTE prevention, medication set up according to local and national guidelines • Potential to close the loop on administration & supply The rollout will take place gradually to ensure that there is engagement and lessons learnt at each stage and ensure appropriate communications across local and national health services including primary care. This system will allow improvement for patient safety across all services. Queries were raised with regards to whether this will include links to anaesthetic charts. Discussions are ongoing with anaesthetists, but acknowledged that this will not replace all charts. The pilot sites have been identified and the implementation plan has been developed with the aim to begin the pilot from August 2024, and ensure learning as part of the implementation process. For Children & Women's Clinical Board this is anticipated for March-April 2025, and the go live process will take place over one weekend. When the system is available, demonstrations will be provided. Requests for staff to become champions in Clinical Boards to support training and use of the system. It was agreed that a champion would be identified by each of the Directorates within the Clinical Board to represent the unique elements of the services within the Directorates. Discussions ensued with regards to the WiFi and aging computers/hardware and the impact this could have to the system. It was noted that there is support from the Health Board and acknowledgement of the importance of the WiFi. Bids have been submitted to Welsh Government which includes hardware requirements also. Business continuity plan is in place for ePMA. It was acknowledged that there will be hardware challenges to consider, however it was noted that there are a number of potential mobile opportunities that are available for consideration, that will run alongside the stand-alone system. Queries were raised with regards to midwifery exemptions and whether the system will have capacity to include this. It was noted that user groups can be	

	set up on the system that will allow the opportunity for this remit of drugs that can be prescribed as part of local practice. **The CWQSE resolved:** a) Update was noted. Further update will be provided when demonstration is available.	
CWQSE/ 2023/214	**Children's Therapies Service Update** Consultation process is underway for all therapies services to amalgamate and move to CD&T Clinical Board. It was noted that whilst this will benefit the processes for CD&T to align budgets etc. however there will be no change in the way that the teams operate and relationships and partnership working will remain the same. The consultation paper will be shared for information following the meeting. **The CWQSE resolved:** a) Update noted b) Consultation paper to be shared for information following the meeting.	**SB**
CWQSE/ 2023/215	**EIDO Update** Deferred. **The CWQSE resolved:** a) Update was deferred. Further date to be arranged.	**KH**
CWQSE/ 2023/216	**Update on recent HIW Visit to CHFW** HIW inspection undertook an unannounced visit to Island Ward. The verbal inspection report was very well received and good working around leadership and staff team working, with a good MDT approach. CAMHS provision was noted and acknowledged that there had been significant improvements made. Training update was provided and was well received. A few areas were identified for improvement including: • Recording and checking of the defibrillator • Drug/Milk Fridges temperature checks – protocol has been written to ensure that milk fridges are checked every night, the same as the drugs fridge. These have also been added to the Tendable Audits to ensure that the data is recorded. Wording has been amended on Tendable with regards to resus trolley checks, to ensure that full months checks are undertaken. Further tendable audit is added in for a fortnightly checks also. The written report is awaited and feedback has been shared with the teams. Thanks, were expressed to the whole team for the hard work that has been undertaken and to recognise the positive feedback received from the initial response. LM agreed to check the process for drug and milk fridges within O&G Directorate also. Protocol to be shared for information. AJONES noted that this has also been shared with Director of Nursing colleagues as this would be a health board wide issue so that this can be demonstrated in other areas also. AJ noted that work has been undertaken with regards to resuscitation trolleys and checks, and it was noted that there has been an electronic check in of resus trolleys across adults services within the health board for a while, and the next phase is to rollout to Paediatrics which is being expedited. Roll out date will be	**LM** **KM**

	shared when available. Liaison is taking place with the ward on the tendable audits as the resus service doesn't have any audit on Tendable as AMaT is being used. Queries were raised with regards to the check in and it was noted that this relies on an individual undertaking the checks. It was noted that there is an internal memory within the defibrillator which will record if the checks have been undertaken that can be undertaken retrospectively. Checks for manual defib is by printout. AJ noted that the AMaT audit information will also be bolstered to ensure that the checks are adequately recorded and picked up in the actions for the inspections. AMaT was selected as the system allows flags can be highlighted for areas where this is not being undertaken. Concerns were raised with regards to how this will logistically be logged onto AMaT as the staff completing the audit may not have time to log on to the system in the middle of the night. It was noted that this can be completed by use of a QR code rather than the need for a log in to be required. It was noted that this is being undertaken within Emergency Medicine and this has significantly improved compliance. It was agreed it would be useful to visit to see how the system works. **The CWQSE resolved:** a) Update was noted. b) Review of process for Drug/Milk Fridges within O&G to ensure that checks are completed as appropriate. c) Review of the system undertaken within Emergency Medicine to be reviewed for information as to how this works well.	**AJONES/KM**
CWQSE/ 2023/217	**Health & Care Standards Directorate QSE Exception Reporting** The detailed report was shared for information and an update was provided on the key highlights from the report. **CYPFHS Directorate Report** • Regulation 28 action plan is almost complete and will be submitted as soon as this is reviewed. • Accommodation issues remain which are scattered across Cardiff and Vale UHB. Risk assessments have been completed for each of the care groups identifying the top three priorities. • Healthy Child Wales Programme – 27-month contacts have been reinstated, with the 3.5yr old's being reinstated in January, which is an improving picture. • Some issues remain with regards to cross boundary issues for Health Visiting. There have x3 missed births, which have been incident reported and being reviewed for escalation. • Children looked after specialist health visiting roles pilot is hoped to be launched early in the New Year. • Issue with access for Band 5 staff being able to access the CAMHS Module and further discussions are taking place with ECOD. • Joint Safeguarding inspection with safeguarding child protection on 15th January, work is ongoing in preparation for this. **Timely Access** • Emotional Wellbeing and Mental Health part 2 compliance is currently at 87% which is just under the target, however it was noted that there is under reporting for the number of young people on the part 2. It was reported that 74 young people in total identified as receiving care under part 2 in November	

	and work is ongoing to identify the actual increase in numbers of those young people receiving part 2 care. • Work continues on the clinical pathways and lots of young people who are being converted from assessment to intervention are going onto the part 1B pathway which has seen a significant increase to the numbers waiting and performance. This data is currently being validated, and it is anticipated that compliance will increase from early next year. • Difficulty in achievement of ALN target for complex needs and disabilities. Reports are being completed, but as there is not a specific type on the PARIS system, this looks to be outstanding. Work is ongoing to look to resolve this issue as soon as possible. • For Neurodevelopment service, there were 2780 young people awaiting assessment at the end of November 2023, however there has been a significant reduction in the longest wait, which has decreased from 189weeks to 149weeks. There has been a focus on long waiters and there has been a positive impact. • For Looked After Children service, only 5% of young people were seen within 28 days in November for an initial health assessment and the backlog currently sits at 107 young people awaiting initial assessment. Work continues with regards to remodeling and transformation of the whole neurodevelopment service to improve the waiting times and positive improvement being made. Recruitment is being finalised for a clinical lead who will commence in post by March/April 2024. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2023/218	**CHFW Directorate Report** • X3 open NRI's, x2 of which are almost ready for closure. • Main areas of risk continue to be NICU and PICU, with winter predictions showing an upward trajectory and a high number of PICU admissions. • Winter plan continues with reduced numbers of elective patients requiring overnight stay and day surgery is being maximized, which is working well. • H&S Inspection on 15th November which assessed Manual Handling and V&A. Positive work undertaken which is continuing and the final report is awaited. • X1 RIDDOR reported in month • Training compliance trajectory plans are in place for improvement for Mandatory training. • Overall Tendable score was 95.4% across the CHFW Hospital • QR codes continue for staff voices on the wards, monthly newsletter and communication through staff facebook page continues. • "You said, we did" posters have been circulated and HIW feedback has been shared with staff. • Research – CF Trial and Diabetic studies are ongoing. • Main themes for informal concerns remain for waiting times for surgery and bloods. X6 formal concerns in progress and compliments received in month with a theme of helpful and caring staff. • Recruitment continues across a number of areas with a number of appointments progressing. **Timely Access** Update to be provided outside of the meeting.	

	The CWQSE resolved: a) The report provided was noted for information and key highlights recorded. b) Timely access update to be provided outside of the meeting.	
CWQSE/ 2023/219	**O&G Directorate Report** • Long waiting list for Birth Afterthoughts service, with the appointments being held within 12weeks • Work continues with regards to Prompt cards for top five languages to be updated. • Birth Partner project continues with wellbeing drop in sessions being undertaken and this has been evaluated well • Induction of labour information is currently being translated into the top 17 languages with work ongoing to ascertain if more is required. • FGM defibrillation pathway work continues. • Antenatal/Parent Classes being run in two languages with interpreters in attendance, and looking to establish a more regular service. • 160 datix incidents reported for November 2023. A number of these are individual patient cases but relate to multiple incidents which cannot be moved/closed until the whole investigation is completed for the individual cases. It was noted that there have been some incidents that have reappeared from the old Datix system and this is being investigated. AL agreed to feedback to the team to explore the reason for these re-appearing from the old system. • X9 open investigations, x2 of which are NRI. X20 open investigations, x7 of which are NRI and x4 MBRRACE cases. • X2 pressure area incidents reported within Gynaecology • X2 falls reported within November • IP&C inspection in antenatal clinic 97% • X7 medications incidents reported in month. • Blood Management – positive work to encourage and recruiting of blood donors of birth partners and their families which has been very well received by the Blood donation service. This initiative has also been shared with other maternity services across Wales to try to encourage further support. • Grow 2.0 went live in September and uptake for training has been very positive. • Focus on MEWS and ATAIN and sessions available on Teams being facilitated as part of the Maternity and Neonatal Safety Programme. • Ongoing weekly staff drop in sessions held with the Head of Midwifery • Funding for placental growth factor testing has commenced from December within the Obstetric Assessment with a plan to roll out fully in the New Year. • Euroking incidents with historical data being overlayed and loss of contact with the server. A business plan is in place to look to procure an alternative option to move from Euroking asap. This risk is also recorded on the Directorate Risk Register • New Gynae referrals system has been developed and a soft launch is taking place. • From feedback from HIW inspection, monitoring of compliance of daily checks has been developed via an electronic digital screen system to allow more oversight of this. • New maternity and neonatal voices partnership held on 1st November and feedback has been positive. • PADR rates for Birthrate plus compliance is currently at 57% and non-birthrate plus compliance at 75% and the target for March is 85% • Sickness rates have increased in month and is currently at 7.57% • Mandatory training rate at 86%	

	• Recruitment continues across a number of areas with a number of appointments progressing. **Timely Access (taken directly from Directorate Report)** 156 weeks Inpatients/Day cases Qtr 3 (up until 31/12/23) Total 1 Without TCI's 1 (In process of transferring to Bristol) Qtr 4 (up until 31/3/24) Total 28 Without TCI's 24 104 weeks Inpatients/Day cases Qtr 3 (up until 31/12/23) Total 244 Without TCI's 230 Qtr 4 (up until 31/3/24) Total 397 Without TCI's 378 52 weeks Outpatients Qtr 3 (up until 31/12/23) Total 125 Without TCI's 8 Qtr 4 (up until 31/3/24) Total 808 Without TCI's 537 Cancer: • End of November position = 15 confirmed patients over 63 days. 5 of whom were tertiary • December predicted position = 12 USC breaches **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2023/220	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** No new risks noted. Request was made for the latest versions of the Directorate Risk registers to be submitted in order for the Clinical Board Risk register to be updated as required in readiness for the next submission. **The CWQSE resolved:** a) Directorate Risk Registers to be submitted to the Clinical Board for review	**ALL**
SAFE CARE		
CWQSE/ 2023/221	**Patient Safety Update** Patient Safety Training sessions are being launched from January next year, and sessions will be held on a monthly basis. Consideration to be given to the staff members who will be carrying out the reviews for attendance. The online videos will need to be completed prior to attending the face to face training. The training date can be booked via the following link:	

	https://forms.office.com/e/eVnBjATNu4D A maternity specific training session is also being arranged but the generic session will be available at any time. Meeting has taken place with the NHS Executive regarding the requirement to report MBRRACE investigations requiring reporting as an NRI. It was noted that there is a high degree of concern across maternity services across Wales and the need for there to be an oversight. It was acknowledged with regards to duplicate reporting, however this will continue for now. With regards to possible delays in closure dates due to the need for the MBRRACE investigation process to be completed, this will be noted as part of the closure to outline the reason for delay. **The CWQSE resolved:** a) Update was noted.	
CWQSE/ 2023/222	**3.2 NRI/PSLR/Closure Forms for noting/exception reporting** All cases noted below have been discussed as part of the NRI/RCA Governance Sub Group held on 14th November 2023. The minutes will be shared for information following ratification. **SBAR, PSLR and Improvement Plan Patient NCB (Datix Ref 31370)** Update was provided on the recent investigation and the full detail shared within the supporting SBAR and PSLR. It was noted that there was a delay in the investigation due to a response that was required from the manufacturers regarding the surgicell product used, which was a positive learning review and shared learning experience within the service and with the manufacturers. The company is also attended the next audit session to discuss the products in the new year. The NRI investigation has been closed and report shared. **The CWQSE resolved:** a) Update was noted	
CWQSE/ 2023/223	**Clinical Negligence Claims for noting** • Learning from Events – CN/UHW/DCIQ47 – TN • Learning from Events – CN/UHW/3730 – HA The LFER's for x2 clinical negligence claims were noted for information and sharing of lessons learnt. There were no specific exceptions to not for the meeting. **The CWQSE resolved:** a) LFE Reports were noted and shared.	
CWQSE/ 2023/224	**3.5. Infection Prevention Control Update Report** The report was shared for information. X3 cases reported in month - X1 Klebsiella and x2 C Diff reported in Rainbow. Typing is awaited on the C Diff cases to ascertain if there are any links as both were reported within the same week. Further update will be provided.	

	There are 12 outstanding RCA investigations for the Clinical Board – x3 for Obstetrics & Gynaecology and x9 for Acute Child Health which are being progressed. CRO and MRSA screening will be covered as part of the Back to Basics Training sessions in January 2024. There has been a number of challenges with increasing numbers of COVID, flu and norovirus and impact on staff sickness. There are no current outbreaks within the Clinical Board however there are increasing numbers within the community. WHC Measles Circular has been shared, following the Measles outbreak that was declared in November. The request has been made for an audit of all staff MMR status by the end of January 2024. Local Risk Assessments will need to be completed for submission to Occupational Health and a request was also made to the Directorate Team to encourage staff who are not up to date or unsure if they are up to date to make initial contact with Occupational Health. Reminder that FFP3 masks be used for all patient care for suspected or confirmed cases of measles or chicken pox. Need to ensure that all staff are fit tested as appropriate and any concerns to be highlighted to the Clinical Board as required. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/225	**Safeguarding** Independent audit of safeguarding is being undertaken across the Health Board and update will be provided following the completion of this audit. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/226	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Public Health Wales – STEC 026 Briefing • **ISN 2023 007 – Overfilled Citrate Blood Tubes** • Safety Memo – Carbomer Eye Gels • **NatPSA_2023_013 Valproate** • Briefing Note: Detection of human case of influenza A(H1N2)v 29/11/2023 • PHW Briefing Note – Emergence of Clostridioides Difficile Ribotype 955 The alerts were noted and have been disseminated widely across the Clinical Board. Compliance forms to be completed as required and returned to the Clinical Board asap. **The CWQSE resolved:** a) Update noted. b) Compliance forms to be completed for submission.	**ALL**
CWQSE/ 2023/227	**NICE Guidance – Update on Progress** Report shared for information. **The CWQSE resolved:** a) Update noted.	

TIMELY CARE		
CWQSE/ 2023/228	**Implementation of ALNET Act – Meeting Statutory duties & aspirations** Report was shared for information. The report is a summary of x3 publications that were published and the relevance of the ALNET act to Health. The ALNET act is part of a wider reform to transform the experience and outcomes of children and young people with additional needs. Focus on identifying needs early ensuring that all learners with ALN are supported to overcome their barriers to learning and achieve their full potential. For section 65 and section 20 referrals being issued, there is a statutory duty to respond. With regards to the section 20 referral, there is need to respond within 6 weeks and once a need is identified, this needs to be secured, and also identify whether the service or treatment needs to be provided in Welsh. There have been some concerns highlighted with regards to the implementation of the ALNET act and the lack of collaboration between Education and Health from an All Wales perspective (full detail included within the report). Key performance indicators for the ALNET Act are being considered focusing on the section 65 and section 20 requests, and attendance at PCP meetings. Adherence to statutory duties and improving collaboration and service delivery is key. Process is in place for ALN correspondence being received centrally and uploaded to the PARIS System in order to ensure appropriate response and any remedial actions required. Ongoing work is taking place with regards to updating the system. It was noted that PCP attendance has been noted as being the most significant impact of the implementation of the ALNET Act, and whilst this is not a legal requirement for Health to attend, there is a need to ensure that the information is available for the meeting. Requests have been made for 6 weeks' notice for any requests for information to be received and any requirement for attendance. Update was provided on NHS ALP and how to identify this. Work has been shared with Welsh Government and senior education officers and has also been shared internally. Online training sessions have also been provided and will continue for the rest of the academic year in order to assist health professionals in identifying whether they have ALP or not and an ALP decision making tool is being considered from an All Wales perspective. Thanks, were expressed to NV for all her hard work. An impact and risk assessment is being completed within the CYPFHS Directorate to understand the requirements and the impact of the requests on the service. It was noted that the requests being received is a significant impact on resources and the need for a review of capacity and demand, to understand what can be achieved and what may need to be escalated. **The CWQSE resolved:** a) Update noted	
CWQSE/ 2023/229	**4.2 Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:** a) Update noted.	

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2023/230	**Centre of Expertise on Child Sexual Abuse - Key Messages from Research on Harmful Sexual Behaviour in online contexts** Shared for information. **The CWQSE resolved:** a) Document noted and shared.	
CWQSE/ 2023/231	**Medicines Safety Newsletter** Shared for information. **The CWQSE resolved:** a) Newsletter noted and shared.	
CWQSE/ 2023/232	**Maternity Safe Sleeping Leaflet** Shared for information. **The CWQSE resolved:** a) Leaflet noted and shared.	
CWQSE/ 2023/233	**Child Practice Review Report & Action Plan – CVSB CPR05/2019** Shared for information. **The CWQSE resolved:** a) Report & action plan were noted and shared.	
CWQSE/ 2023/234	**Gynaecology & Maternity Concerns Reports** Reports were shared for information. **The CWQSE resolved:** a) Leaflet noted and shared.	
ANY OTHER BUSINESS		
CWQSE/ 2023/235	**C&W Clinical Board Governance Arrangements** Update was provided on the work being undertaken to review the governance arrangements within the Clinical Board. It was noted that a workshop will be held in early February to share further information on the required changes and process being followed. Further detail of which will be shared in due course. The expectation will be to provide assurance to the Clinical Board that governance and assurance are embedded into daily practice with regular review of actions/audit and said actions/audit points being scheduled through the AMaT System. As part of this process the Directorate Reports template will be replaced by an electronic submission proforma which will be trialled from January 2024, further detail of which will follow in due course. **The CWQSE resolved:** a) Update noted.	

CWQSE/ 2023/236	**Children & Women's Clinical Board Christmas Card** Disseminated to the Directorate Teams for wide dissemination to all staff to wish everyone a Merry Christmas and Happy New Year on behalf of the Clinical Board. Thanks, were expressed to all for their continued commitment and support provided throughout all services. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/237	**Date and Time of Next Meeting** Tuesday 23rd January 2024 (H&S Focus), 8.30am, Microsoft Teams	**ALL to note**

Report Title:	Chair's Report Radiation Protection Group			Agenda Item no.	
Meeting:	UHB QSE Committee	Public		Meeting Date:	
		Private	x		
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Fiona Jenkins, Executive Director of Therapies and Healthcare Sciences				
Report Author (Title):	Lesley Harris, Professional Head of Radiography UHL/Chair of Radiation Protection Group				

Main Report
Background and current situation:

This report is a summary from the UHB Radiation Protection Group held on 23rd January 2024 and highlights the key issues that were raised.

There is ongoing work to complete the process of all areas providing assurance that their Employers Procedures, Local Rules, Radiation Risk Assessments and Dosimetry Administration and Monitoring Procedures have been reviewed a Medical Physics Expert.

Radiology UHW was subject to a HIW Inspection in November. Feedback was very positive with only minor recommendations made in the formal report. A response to the formal report has been submitted to HIW with a request for some corrections to be made.

Following the cessation of production in the Radiopharmacy Unit, a permit variation is being submitted to increase holding and waste limits to accommodate the supply of vials.

There has been a significant increase in the number of radiation incidents being reported. An annual summary will be produced bi-annually from this year going forward to raise awareness across the Health Board.

Radiation training for Junior Doctors is being developed, outlining legislation requirements.

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

As highlighted above.

Recommendation:

The QSE Committee are requested to:

Note the summary of the key issues from the meeting.

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

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

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

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

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

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

Chilcott Rachel
07/02/2024 10:34:44

Healthcare Inspectorate Wales Annual Report 2022-2023

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate of the NHS and regulator of independent healthcare in Wales.

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our goal is

To be a trusted voice which influences and drives improvement in healthcare

Our values

We place people at the heart of what we do

We are

Independent
We are impartial, deciding what work we do and where we do it

Objective
We are reasoned, fair and evidence driven

Decisive
We make clear judgements and take action to improve poor standards and highlight the good practice we find

Inclusive
We value and encourage equality and diversity through our work

Proportionate
We are agile and we carry out our work where it matters most

We have set four strategic objectives through which we deliver our goal of influencing and driving improvement in healthcare.

01

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services

02

We will adapt our approach to ensure we are responsive to emerging risks to patient safety

03

We will work collaboratively to drive system and service improvement within healthcare

04

We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

What we do

We are responsible for **inspecting, reviewing, and investigating NHS services and independent healthcare services throughout Wales.** When we find services are not being delivered safely and effectively we take action so that health boards and independent healthcare providers know where they need to make improvements

We review the quality and safety of healthcare services against a range of standards, policies, guidance, and regulations

Inspections and Reviews are carried out by teams that are led by HIW staff and supported by specialist peer reviewers, healthcare professionals who provide specialist, up to date knowledge about services and quality standards

We highlight areas requiring improvement and draw attention to good practice where we find it

We monitor concerns and safeguarding referrals, identifying themes and trends

We recommend immediate improvements, and longer term actions, to NHS services and independent healthcare services

We inspect NHS services in Wales

We regulate and inspect independent healthcare services in Wales

We take regulatory action to ensure registered independent healthcare services meet legislative requirements

We undertake a programme of reviews to look in depth at national or more localised issues

We have a team of **87 staff who work for us**, across Wales, supporting our functions and undertaking our assurance work

We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor service.

Contents

Foreword

Alun Jones
Chief Executive

Welcome to our Annual Report for 2022 – 2023. This Summer marked the 75th anniversary of the National Health Service (NHS), and most people living in Wales today will not have known a time without this institution.

A key milestone this year was the introduction of The Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Act aims to strengthen the overall focus on delivering quality services, and improving engagement with the population across Wales, both in terms of better understanding their needs and improving openness and honesty when things do not go right. The key focus of HIW's work, is to provide an independent view and assessment of the quality and safety of healthcare services. During 2022 – 2023, we have aligned our approach to seeking assurance in preparation for taking account of how well healthcare services are embedding their responsibilities against the duties of the Act.

This report sets out our key findings from the regulation, inspection, and review of healthcare services in Wales. It outlines how we carried out our functions across Wales, seeking assurance on the quality and safety of healthcare services through a range of activities including inspections and review work in the NHS, and regulatory assurance work in the independent healthcare sector. It provides a summary of what our work has found, the main challenges within healthcare across Wales and provides our view on areas of national concern.

In providing an independent view of healthcare services, we seek to contribute to an understanding of the risks and challenges that are preventing services from operating effectively and impacting on the quality of care being delivered to patients.

This has once again been a turbulent year for healthcare services in Wales. Whilst there are initiatives in place to help support healthcare services cope with unrelenting demand,

> **"Whilst patients may well have been satisfied with the staff providing their care, they were not satisfied with the long waits and difficulty in getting treated by services in a timely manner."**

our work during this year did not find evidence of these making a clear and significant difference to services at the front line. Increasingly, we have needed to make in year changes to our programme of work to enable us to undertake inspections in the areas of highest risk. Whilst patients may well have been satisfied with the staff providing their care, they were not satisfied with the long waits and difficulty in getting treated by services in a timely manner. Whilst staff continued to describe their passion for working with people and supporting people with care, they were not satisfied with the immensely pressured environments of work they find themselves in on a daily basis.

Our role covers the regulation and inspection of independent healthcare services in Wales. These services represent an area of growing importance, where innovations in science and technology mean the frequent development of new treatment options and services, many of which are offered by the independent healthcare sector. Many of the specialist mental health care beds in Wales are provided by independent healthcare providers. The sector cares for some of the most vulnerable patients in Wales, dealing with high levels of risk and complex needs. Our work over this time has sought to challenge the sector to ensure that the standards and quality provided are in line with their regulatory responsibilities and provide a quality service to the patients they care for.

Our work within NHS acute hospitals has shown the intense daily pressure in patient admission areas and on inpatient wards. Within Emergency Departments across Wales, we have noted overcrowding, long waits for triage and long waits for treatment, plus ongoing delays in being admitted into the most appropriate beds. Our work over this period has also shown that within General Practice and Dentistry, access to NHS services remains a matter of real concern to patients. When we refer to access, we are describing the ability to source appointments and/or to be registered as a patient with either a GP or Dentist. Once patients are in direct receipt of care and treatment from the NHS, either within Primary or Secondary care services, they consistently told us how well they felt they were being cared for and recognised the professionalism of staff. Through our work we have once again seen a highly skilled and committed workforce, delivering care with compassion and innovation. The workforce of the NHS remains its biggest asset and building on the many positives, with staff, will remain central to navigating the challenges that lie ahead.

We have found one clear issue throughout our work, which is, that at any junction in the care and treatment pathway of a patient, there is huge potential for delay, a pause in treatment, and an overall introduction of risk that is not there at other times. Our work within mental health, for example, has found that this is the case when patients with a diagnosis and care and treatment plan are moving from one part of the service to another.

We have also continued to find that inefficiencies in record keeping and in record keeping systems introduce unnecessary risk into the continuity and quality of patient care.

Three key themes to have arisen from our concerns monitoring service, which takes calls and information from members of the public, are the difficulty in accessing a regular dentist and getting any dental care; difficulty in getting an appointment with a GP; and difficulty in accessing mental health services. This feedback from members of the public is highly concerning and is an early warning of future public health challenges which must be heeded.

Our objectives are ambitious and through them we aim to make a difference to the people of Wales by contributing to improvements in healthcare. In this report you will find some examples of how we have used our work to further this aim. I am proud of the organisation I lead, and the contribution we can make to healthcare in Wales.

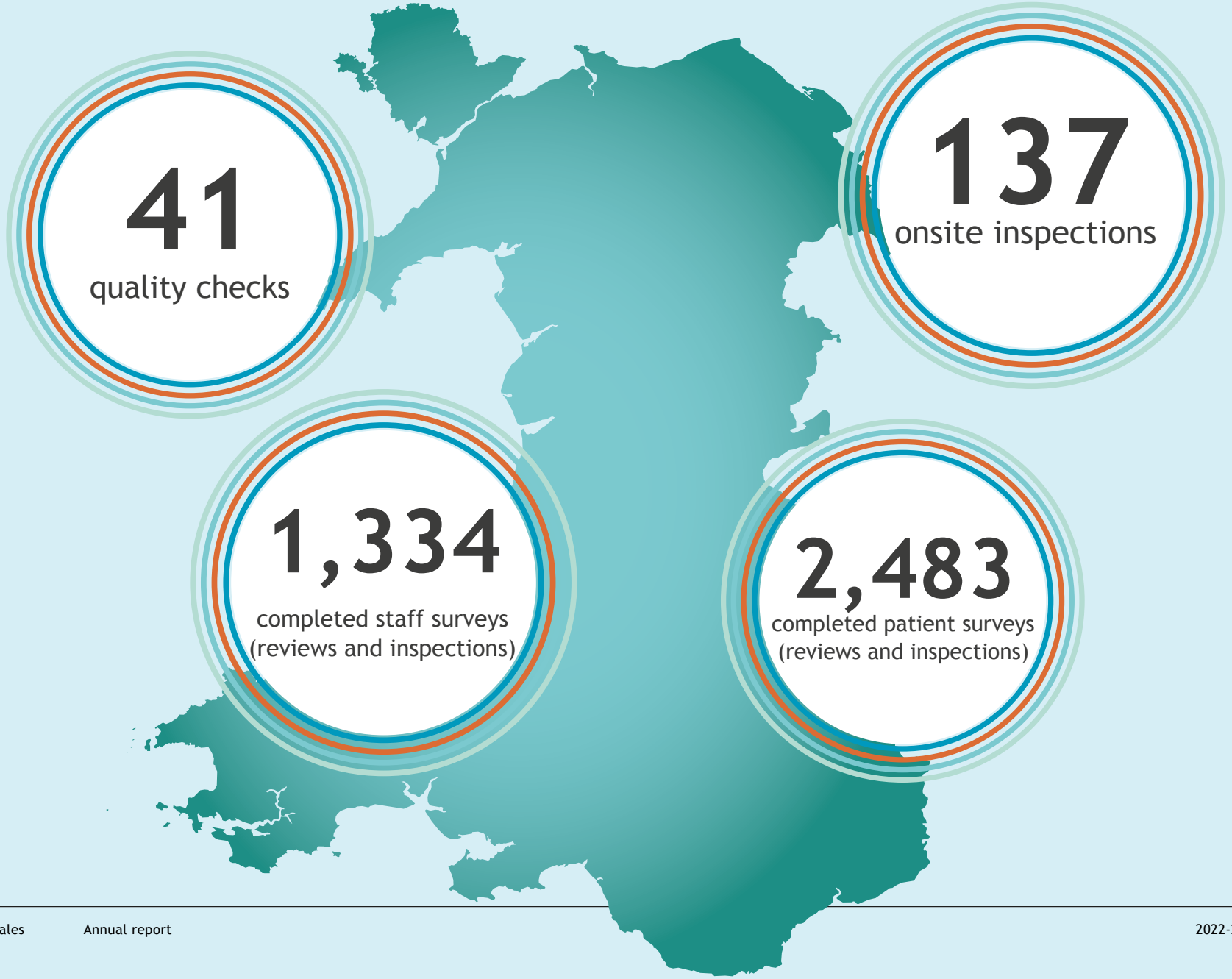
Now, more than ever, healthcare in Wales needs continued innovation, and a vision and understanding of what works and what does not. We have a clear role in illustrating, through our work, what good quality looks like within services and where we find issues with quality we will continue to shine a light on these, pushing services to put them right.

If you have any questions, comments, ideas, or feedback on our work, please do get in touch with us – we would love to hear from you.

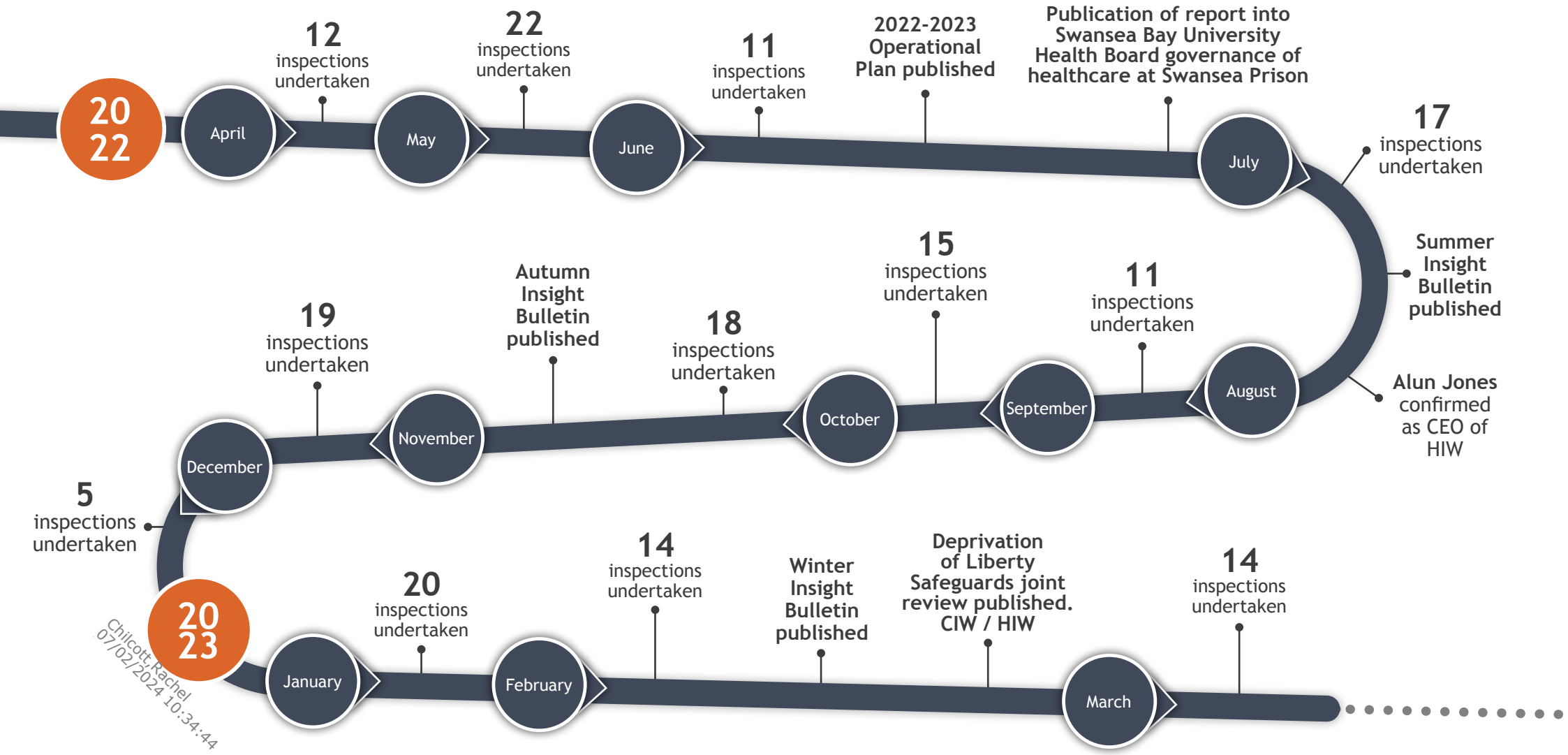
Alun Jones

Chief Executive
Healthcare Inspectorate Wales

HIW in Numbers



Timeline of our work



Engagement and Collaboration

Engagement

Speaking and listening to people who use healthcare services and who work within healthcare services is a key priority for us, and something that we are also committed to improving on. By listening to people who use and work in services, we can better understand what matters to people and can gain a greater understanding of the culture within a service and insight into the experience patients receive.

Across our inspection, quality check and review work, 4,677 people gave us their views on the care they had received, or the service they were working within.

Of the 4,677 separate responses, 4,107 related to our inspection activity and 570 related to our review work.

We heard from:

- **2,633 patients overall**
- **1,826 staff overall**
- **99 Carers / family members**

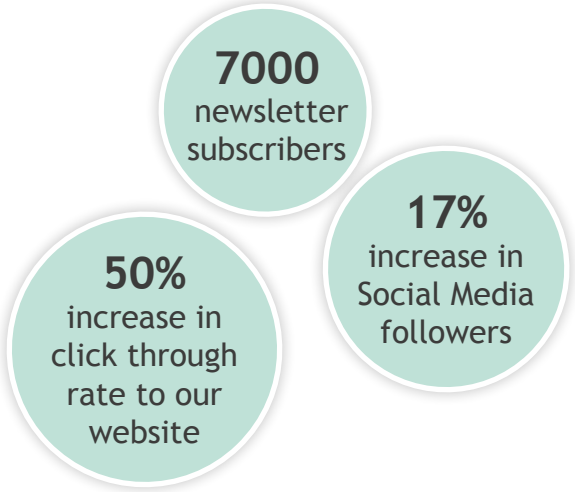
During our inspection and review work we ask patients to tell us about the care they receive by completing a short survey. When we are able to speak to patients in person during onsite visits, we gather views directly. We are also now using videos on our social media channels to help explain and promote our work.

In February 2022, we launched on LinkedIn and in our first year we have reached 7k users. This channel is providing a useful additional avenue for engagement with healthcare professionals. We have continued to use Twitter and Facebook to engage widely with social media users about our work, encouraging people to click through to our website where they can find out more about our work and role in Wales. We have seen a 50% increase in people clicking through to our website from our social media posts. We aim to post varied and interesting content across all three social media channels, posting 1.5k times during the year and seeing a 17% increase in our followers.

This is not our only means of engagement, in the spring of 2022, we launched our new Insight Bulletin. This is a quarterly update which we issue electronically to over 7000 subscribers on our mailing list. Within this we summarise our work from the quarter, and in summer 2022, added a new Learning and Insight section to the bulletin, providing us with a central area to share themes and learning emerging from our work.

We implemented a new approach to report writing in April 2022 which involves publishing a public summary and a full detailed report for the setting. We also updated our report writing style, removing duplication, and making the content easier to read.

In early 2022, we launched our HIW Stakeholder Advisory Group. Membership of the group is made up of a wide range of organisations who work with and represent people with protected characteristics. We are immensely proud of this group and it has continued to strengthen during the year. The group has influenced the way in which we ask patients for feedback during inspections and reviews and has challenged us to think more critically about the way in which our work is both designed and delivered so that we are able to capture as diverse a range of views as possible. The group is one of the ways in which we are working towards our strategic priority of better understanding the quality of healthcare being delivered to people and communities as they access, use and move between healthcare services.



Collaboration

We place considerable importance on collaboration and joint working with other organisations. The added insight and expertise we can draw on when we collaborate with others increases the impact of our work. The provision of healthcare is complex and sharing intelligence with partners enables us to gain insight and experiences that, with our organisational resources alone, we would not be able to achieve.

During 2022-2023, we hosted two Healthcare Summits, attended by regulatory and improvement bodies for healthcare across Wales. Healthcare Summit meetings take place bi-annually to enable discussion between audit, inspection, regulation, and improvement bodies.

They provide an interactive forum for sharing intelligence on the quality and safety of healthcare services provided by NHS Wales. The meetings enable us to foster close working relationships, and share intelligence between participating organisations as we all play our respective roles in driving healthcare improvement in Wales.

During the year we continued to work closely with our partner, Care Inspectorate Wales (CIW). In February 2023 we jointly published our report into the use of Deprivation of Liberty Safeguards (DoLS) in Wales. The Safeguards apply to people over the age of 18 in hospitals or care homes, who cannot consent to treatment or care.

Since 2019, we have been part of Joint Inspections of Child Protection Arrangements (JICPA), working alongside Care Inspectorate Wales (CIW) plus Estyn; Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS) and Her Majesty's Inspectorate of Probation (HMI Probation) to carry out this work.

In 2022-2023, we continued this work and published our findings of a review of the multi-agency arrangements in Denbighshire for responding to cases of abuse and neglect.

The report outlines our findings about the effectiveness of partnership working and the work of individual agencies in Denbighshire.

In common with many areas across Wales, we found the challenges in recruitment and retention of staff across key agencies in Denbighshire was impacting on the arrangements for safeguarding children. This is made more difficult by the high levels of demand and increasing complexity of children's needs.

We found there are systems and relationships in place to facilitate effective partnership working where a child is at risk of harm. Partners are working to a shared ethos of safeguarding children at different levels of vulnerability. Organisational leaders have a shared vision with a positive approach to regional safeguarding arrangements.

This clear strategic commitment has resulted in the commissioning of a sufficient range of effective local services to support children and families.

Assurance and Inspection Findings NHS Services

Acute Hospital Inspections

In 2022 – 2023, we carried out 19 acute hospital inspections across Wales.

We visited all Health Boards and Trusts where inpatient care is provided.

Our work showed that in general, the demand for inpatient beds and having enough staff to manage the high number of patients was a significant challenge.

The numbers show that we did more of our work in unscheduled care areas compared to scheduled care. The reason we did this was because of the complexity and overall higher risk level in these areas. Across these pieces of work, we needed to use our Immediate Assurance process in 58% of the inspections (11 out of 19). This is a highly concerning figure and demonstrates that at present, acute inpatient healthcare carries the highest level of risk in services across Wales. This figure is currently higher than we found in our inspections of mental health services, an area of healthcare which historically tends to see very high levels of patient risk. This latest finding indicates that mental health services are tackling the risks they face more successfully and strongly suggests that within inpatient acute care, more needs to be done to tackle risk, and quickly.

In the previous year, we introduced our Service of Concern process for the NHS. In 2022 – 2023, we considered 13 NHS services through this process which involves increased scrutiny of the issues identified through inspection and intelligence. In May 2022, we designated the Emergency Department at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board as being a Service Requiring Significant Improvement (SRSI) which is a service with the most significant levels of risk.

Our findings on a national level, from our assurance and inspection activity were:

Huge demand for services continues

Compliance with mandatory training remains mixed and in general, across Wales, there are challenges in ensuring the workforce keep this up to date

The quality of the discharge planning process needs to be improved

Reducing risks within the inpatient environment is something that needs to be improved on. For example, we continue to find medicines unsecured, harmful substances not locked away and equipment not maintained as regularly as needed.

In 2021-2022, our work found evidence of significant pressures in the emergency care system. In 2022-2023, our overall summary is the same and if anything, pressures have increased. These pressures mean that we have seen overcrowded emergency departments, delays in ambulance handover of patients, long waits for triage and long waits for treatment to start. This of course, is not the finding in all instances, but the cases where we saw delay represent the majority rather than the minority. The challenge for staff working at the front line within these emergency and urgent care areas is enormous and the impact on them is equally huge.

The challenge within planned care areas differs in that there are huge challenges in getting patients discharged to more appropriate placements, or back home with support. There are often delays in this due to shortages in social care staff and social workers to assess discharge needs. Patients frequently stay in hospital beds for a long time after they are medically fit to leave because of the unavailability of support services.

When patients are able to be seen and treated by emergency and urgent care services, then admitted and cared for as inpatients, and discharged as soon as they are medically fit, the outcomes for them are far more positive then when they are delayed at each stage of their journey. The delays being experienced lead to adverse patient outcomes in the form of deconditioning, higher risk of hospital acquired infections, loss of social networks and, the initial assessment of support needs on discharge no longer being accurate and needing to be repeated due to a change in condition.

This year, once again, we found that in planned care areas, such as oncology and cardiac wards, where the staff have more control over admission and can provide more patient centred care, there were fewer areas requiring improvement.

Although responses we received to our staff questionnaires indicated low staff morale, particularly related to challenges around staffing numbers and high demand for services, this did not generally seem to impact on the experience patients had of staff. Patients told us staff were kind and compassionate.

Our inspections continued to note low levels of compliance with mandatory training for staff. Mandatory training plays a key role in ensuring staff can provide safe and effective care to patients.

The case studies demonstrate two of our pieces of work from 2022-2023 relating to acute hospitals in the NHS. This work, challenged services and health boards to look for different ways of doing things when outcomes for patients could be improved.

CASE STUDY

National Review of Patient Flow a journey through the stroke pathway

Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. Our national review of Patient Flow continued during 2022 - 2023 to explore this.

At a time when the NHS in Wales has continued to deal with significant pressure, staff shortages and huge demand for beds, the review explored the challenge of trying to provide timely care to confirmed stroke patients when resources are under such demand.

In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, we elected to focus our review on the stroke pathway. National reviews are deep dive pieces of work which enable us to explore a service, care pathway, or department in depth.

During the period from April 2022 to the end of March 2023, we gathered evidence about the care and treatment provided to patients on the stroke pathway across Wales, undertaking nine site visits in total. The site visits involved our review team consulting with health boards in Wales including the Welsh Ambulance Service Trust (WAST), reviewing the processes in place from calling an ambulance to arrival at an emergency department, to admission when patients were receiving inpatient care and through to discharge.

The review found a high demand for inpatient beds and complexities involved in discharging medically fit patients from hospitals which led to the acute hospital system in Wales operating under extreme pressure. Unnecessarily long stays in hospital due to delayed discharge can place patients at risk of hospital acquired infections or deterioration whilst awaiting discharge. The bottleneck at the point of discharge has a knock-on impact on emergency departments, ambulance response times, inpatient care, planned admissions and overall staff wellbeing.

CASE STUDY

Inspection of Maternity Services, Glangwili Hospital, Hywel Dda University Health Board

HIW completed an unannounced, onsite inspection of the maternity unit across three consecutive days in November 2022, this included the antenatal and postnatal wards, the midwifery led unit, the labour ward and the triage assessment area. Inspectors found the maternity care provided had improved since HIW's previous inspection in 2019, but there were still some areas which required attention.

We found staff were committed to providing a high standard of care to patients. There were many examples where the inspection team witnessed staff being compassionate, kind and friendly to patients and their families. Most patients we spoke to told us they were happy and receiving good care at the hospital. Inspectors also noted that there were good arrangements in place to provide patients and families with bereavement support. We considered the quality of management and leadership, and the culture of the workforce, to be very good.

Staff were encouraged and supported to become involved in quality improvement projects to enhance the care provided, and to aid their ongoing development. Staff were positive about the support and leadership they received and described a positive culture around reporting and learning from incidents. Inspectors noted that the leadership team were visible, supportive, and very engaged with the staff. There was dedicated and passionate leadership displayed by the Head of Midwifery, who was described as energetic, approachable, supportive and visible. There was also a focus on staff wellbeing, including good welfare support and team building activities. Improvement had also been made to collaborate with other health boards effectively.

Some women on the post-natal ward indicated that when they required pain relief, it was not always given in a timely manner, or they were not given an explanation as to why they could not receive the medication. The health board must ensure that there is efficient, safe, and timely administration of pain relief for patients.

Inspectors evidenced improvements had been made regarding security measures to ensure babies were safe and fully protected within the hospital. However, on the first night of the inspection, inspectors noted that the cupboards containing patient records were unlocked and the doors were open. Inspectors immediately raised this with senior management and the cupboard doors were subsequently locked. Management must ensure staff are locking medication fridges and cupboards containing patient records when not in use. We also found that not all staff were compliant with mandatory training and that management needed to ensure rotas are reviewed to ensure there is sufficient resourcing.

Some staff we spoke with raised a concern in relation to the variance of responsiveness of consultants to an emergency when requested by junior doctors and midwives. This was also echoed by comments made in the staff survey we undertook.

We found that there had been significant improvements made since our previous inspection in 2019. There were well-defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was achieved through a rolling programme of audit and an established governance structure, which enabled key/ nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

Ongoing improvements need to focus on staff compliance with the clinical room processes, such as medication fridges being consistently locked when not in use and cupboards containing patient records being always locked.

General Practice

During 2022-2023 we carried out 20 pieces of assurance work to GP practices across Wales. nine of these used our remote Quality Check methodology and 11 were onsite inspections. We needed to use our immediate assurance process in 30% of these inspections (6 out of 20 pieces of work).

This inspection year marked our first using our newly refreshed General Medical Practice (GP) methodology. The updated methodology considers the wider primary care landscape including referrals and signposting to other services.

GP practices are under significant pressure and are facing unprecedented demand. Long wait times at Emergency Departments and on long waiting lists for treatment are increasing the pressure on GP services. We used our immediate assurance process, reflecting high risk to patients, on more occasions during 2022 – 2023 compared to the previous year.

We found a range of issues such as:

- Incomplete safeguarding records and poor follow up of concerns
- Checks of emergency equipment and drugs not completed
- No DBS checks on staff including administrative and reception staff
- Medicines not safely stored
- Medication fridge temperature checks not completed
- Poor compliance with mandatory training including safeguarding, CPR and infection prevention and control
- Out of date equipment including sterile sutures, sterile gloves, urine sample collection packs, minor surgical operations packs and needles, some of which were dated 2006.

20 pieces of assurance work

11 Onsite Inspections

9 Quality Checks

Our patient experience surveys regularly conclude that staff treat patients with dignity and respect, but around a quarter of patients tell us they struggle to access an urgent appointment.

Difficulty in accessing GP appointments was one of three clear themes to come out of our HIW Concerns service during 2022-2023.

The effects of delayed appointments on patients encompass physical health, emotional well-being, and overall healthcare experiences.

Delayed access to medical care can lead to worsened health conditions. Conditions that could have been treated effectively with timely intervention might deteriorate, resulting in prolonged suffering, increased complications, and potential long-term consequences. Chronic conditions may worsen, requiring more complex interventions and leading to avoidable hospitalisations.

Patients who struggle to obtain appointments often experience heightened anxiety and stress. The uncertainty of not knowing when they can see a doctor can exacerbate existing mental health conditions or trigger new ones. This emotional toll can further impact their ability to cope with health issues and make informed decisions about their care.

Frustrated by the inability to secure timely appointments, some patients may resort to using emergency services for non-urgent issues. This strains emergency departments and diverts resources away from patients with genuine emergencies.

It is crucial that leaders within this area consider the repeated concern from patients who are unable to access the service and consider what else can be done to alleviate the pressure on GP services.

Mental Health

We look at how NHS mental health and independent mental health care services meet and comply with a range of professional standards and guidance, including the Mental Health Act 1983 and the Independent Healthcare (Wales) Regulations 2011.

During 2022 – 2023 we undertook 20 pieces of work to mental health care services across Wales. Out of these, 16 were onsite inspections to inpatient units, 3 inspections of Community Mental Health Teams (CMHT's) and one larger piece of review work to Cwm Taf Morgannwg Mental Health service. Across these 20 pieces of work, we used our immediate assurance process on seven occasions, this represents 35% of the work where issues found at inspection and review carried the most immediate risk to patients.

A positive area across the majority of our inspections was the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving.

Patients who are in an acute and/or challenging phase of their illness may require a degree of effective observation to ensure that their safety and the safety of others is protected. Staff must deliver a holistic plan of care in the least

restrictive way, balancing this with a risk-based approach. In four of our visits to hospitals, within health boards, we identified a lack of managing aggression/physical intervention training for staff, including bank staff. This is a significant issue because well trained staff decrease the incidents of patients and staff being injured during a restraint.

We found that patient records did not always evidence episodes of patient restraint accurately, and observational charts were not always being kept up to date.

There was also lack of staff training and guidance in this area, and during one inspection, a complete lack of any patient engagement for extended periods of time.

We found little improvement to the following areas, despite raising these in 2021-2022:

- workforce challenges – issues with recruitment and retention of staff
- medicines management – a range of issues with the storage, administration and audit
- patient observations – lack of effective recording, training of staff and the timely review of policies/procedures
- patient information – lack of information available for patients on key topics
- risk assessments and care planning documentation – including risk assessments not completed and lack of a timely review
- environment of care – a lack of audits and the management of environmental ligature risks
- governance - a lack of audit and oversight of key areas including training.

Difficulty accessing mental health services was a key theme to emerge from our HIW Concerns team which hears directly from members of the public. We repeatedly heard of the difficulty in getting support from mental health services and of the poor outcomes for patients who have not received the level of support that was needed.

The inability to access mental health services can lead to the deterioration of mental health conditions. Individuals grappling with anxiety, depression, bipolar disorder, or other mental health issues may experience worsening symptoms in the absence of proper care and support. This deterioration can impact all aspects of life, from work and relationships to physical health.

Without timely intervention, individuals facing mental health challenges are at a higher risk of experiencing crisis. Delayed access to mental health services can extend recovery times for individuals dealing with mental health disorders. Early intervention is often crucial in managing and alleviating symptoms. Protracted delays in receiving treatment may prolong suffering and hinder the individual's ability to regain stability and functioning. Mental health challenges affect not only the individual but also their families and communities.

CASE STUDY

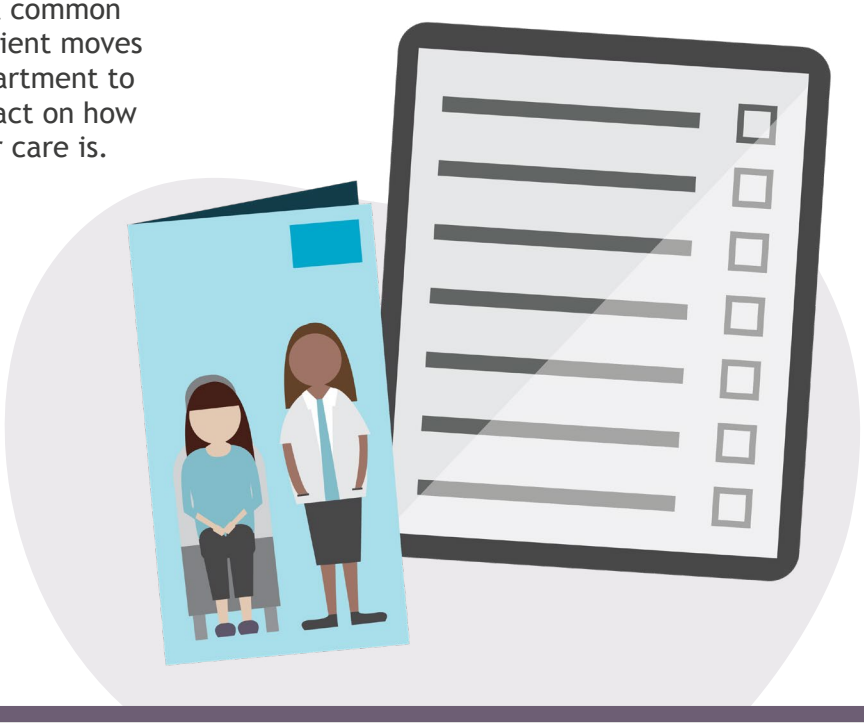
Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board

We reviewed the discharge arrangements for adult inpatients on mental health wards in Cwm Taf Morgannwg University Health Board (CTMUHB) from adult (18-65) inpatient mental health units. The decision to undertake the review was made as a result of intelligence indicating significant concerns about the health board's mental health services. This included serious incidents, issues identified through previous HIW inspections, and concerns reported to HIW by patients, the public and staff whistle-blowers.

The review focussed on the quality and safety of discharge arrangements for adults discharged from inpatient mental health units into the community. The review considered the relevant policies and procedures in place, an evaluation of patient records, and information gained through interviews with a range of staff who worked within the health board's mental health services.

As a result of the review, HIW made 40 recommendations for improvement. Some patient safety concerns were of such significance, the health board was issued with an immediate assurance letter, following which, it was required to submit an immediate improvement plan to HIW.

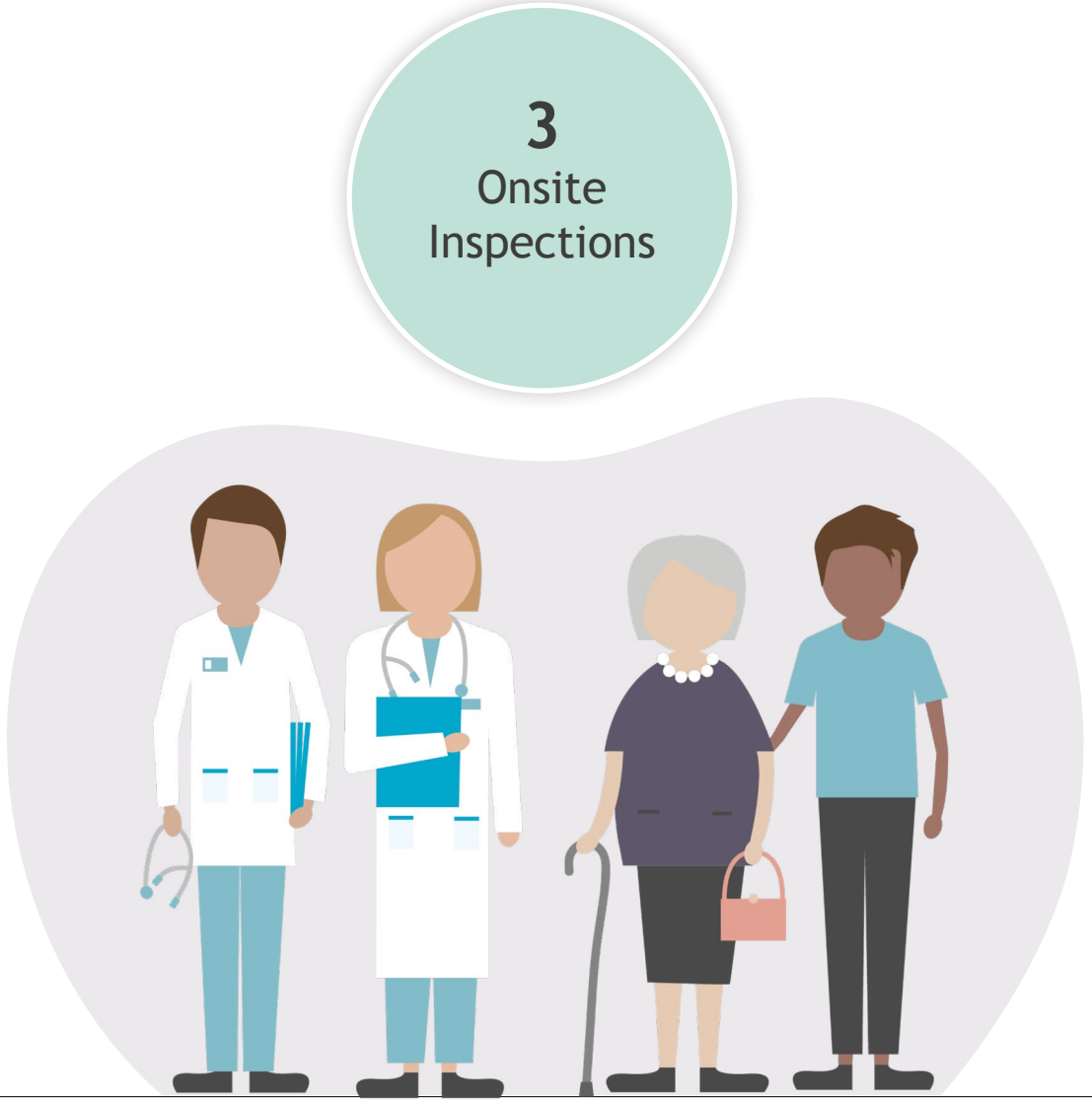
We found evidence of highly complex systems which made the delivery of timely and effective patient care more challenging. As with our National Review of Patient Flow, a common thread was that at the point a patient moves from the care of one team or department to another, there is a significant impact on how timely and well co-ordinated their care is.



Learning Disability Services

HIW undertook three inspections of facilities providing learning disability services. Within these inspections, we noted a range of positive findings including, staff interacting and engaging with patients appropriately and patients being treated with respect and dignity. In addition, there was a range of suitable community-based activities available for the patient group. However, we did find that staffing numbers were not always at a level which met patient needs.

Although this was a small number of inspection visits, we did find issues of concern in one of the three services inspected. There were risks to patient safety within this unit due to ligature risks not being managed appropriately.



Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)

Medical ionising radiation is used in many healthcare settings, including dental practices and widely within hospital care. It is used to diagnose injuries and illnesses as well as being a form of treatment, for example x-rays and radiotherapy treatment.

It is a highly technical area of healthcare, that used carefully and in accordance with the regulations has huge benefits but there is potential for harm if it is not used safely.

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The regulations are intended to protect people from hazards associated with ionising radiation and they set out the responsibilities of those undertaking the procedures which use ionising radiation. Within the regulations, these individuals are called duty holders and will comprise of the employer, referrer, IR(ME)R practitioner and operator. Their responsibilities are to meet safety standards and ensure radiation protection, for example, minimising unintended, excessive, or incorrect medical exposures.

During 2022-2023 HIW completed eight IR(ME)R inspections, covering the three modalities of medical exposures. These inspections also covered both NHS and independent hospitals.

HIW was assisted in these inspections by a member of the Medical Exposures Group (MEG), which is part of the UK Health Security Agency (UKHSA), acting in an advisory capacity. All the inspections were undertaken onsite. As part of the process, we asked providers to undertake a full self-assessment and then we held discussions with staff about the content of the self-assessments and the supplementary evidence provided to support the self-assessment. Whilst onsite we also reviewed clinical and other relevant records as well as observing the environment in which services were delivered. We also requested patient and staff feedback through online surveys.

Feedback from patients was overwhelmingly positive with patients confirming that they had been treated with dignity and respect and had been helped to understand the risks and benefits of the procedure they were receiving. Radiology areas were good at letting patients know of waiting times and any delays in being seen, patients told us they appreciated this. During our IR(ME)R assurance activity we continued to meet experienced and committed teams of professionals, with a good team working ethos. Overall, staff we spoke with demonstrated a good awareness of their responsibilities under IR(ME)R. There was a need to improve the written procedures governing the use of ionising radiation and required against the regulations in this area.

We heard from some staff who felt there were insufficient numbers of them to do their job well and to achieve a good work-life balance. We also heard that they did not always feel listened to by management when they raised this. Although more generally, staff told us they felt very well supported in their work by senior management and the wider organisation.

Dental Practices

During 2022-2023, we undertook 74 pieces of assurance work to dental practices across Wales. Out of these, 44 pieces of work were conducted onsite at the practices, where a HIW team including a qualified dentist working as HIW dental peer reviewer, spent time examining the practices, policies and procedures which governed the way each practice was run. We also conducted 30 quality checks which are our remote method of seeking assurance, first developed at the height of the COVID-19 pandemic. The composition of work represented a huge shift back to our teams carrying out onsite inspection work. The 44 onsite pieces of work in 2022-2023 compares to just 9 undertaken onsite in 2021-2022.

Difficulty in accessing dental appointments and securing a regular dentist was one of three key themes to emerge from our HIW Concerns service this year. Securing timely access to dental care is a critical component of overall health and well-being, yet the difficulty in obtaining dental appointments has become a pressing concern with far-reaching consequences. Factors such as limited availability of dental providers, high demand for services, and changes to dental contracts have all impacted patients' ability to access timely dental care and treatment.

Evidence clearly identifies that delayed or infrequent dental appointments can lead to the progression of oral health issues. What might initially be a minor dental concern could develop into a more complex problem, requiring more invasive and costly treatments. Oral health is closely interconnected with overall health. Dental issues such as gum disease have been linked to systemic conditions like heart disease, diabetes, and respiratory problems.

Delayed access to dental care can result in prolonged discomfort and pain for patients. Toothaches, gum sensitivity, and other oral pain can significantly impact daily life, affecting eating, speaking, and even sleeping. The physical discomfort can also contribute to emotional stress and reduced quality of life.

Frustration over delayed dental appointments can lead some patients to seek relief through emergency dental services or hospital emergency departments. This not only strains healthcare resources but often also results in only temporary measures rather than comprehensive treatment.

Regular dental appointments provide opportunities for oral health education and preventive guidance. When patients are unable to access these appointments, they miss out on valuable information about maintaining proper oral hygiene, which can further contribute to deteriorating oral health.

Across all 74 pieces of work, we used our Immediate Assurance process on 6 occasions. This means that in 8% of our work to dental practices in 2022-2023, we came across concerns which had the highest level of risk to patient safety and therefore needed action to be taken and assurance of this action provided to HIW within 48 hours.

We also made a substantial number of recommendations for improvement. The key themes emerging from our dental inspections are described below:

We identified a number of key themes through our dental inspection and assurance activity:

Environmental:

- A poor standard of cleanliness in decontamination areas. In some practices HIW Inspectors uncovered ineffective decontamination processes, including inadequate cleaning of instruments and ineffective use of 'dirty/clean' pathways.
- We reported inappropriate storage of items in clinic and decontamination rooms such as food and cleaning materials, including high numbers of clinical fridges containing non-clinical items such as food and out of date medication. Practices should ensure there are procedures in place to reduce the risk of contamination and to support good standards of infection prevention and control.
- There were numerous examples of practices not undertaking audits of their work. Audits offer an opportunity to review the consistency and quality of care and treatment that is provided to patients, and they are a quality improvement tool, which can provide many benefits and support better practice.
- A number of practices did not have a system in place which ensured all risk assessments were being kept up to date. We noted that some fire risk assessments were out of date and fire drills were not being carried out and evidenced. Risk assessments are an important management tool, which help to keep patients and staff safe and should be reviewed and updated regularly to reduce risks.
- During some inspections, we highlighted the poor maintenance of first-aid kits, emergency drugs and resuscitation equipment – some included out of date items posing a significant risk to patients.

Staffing:

- The majority of dental practices needed to improve their documentation when recording staff training and evidencing that all staff had completed mandatory training sessions.
- Annual appraisals, clinical supervision and staff meetings were often overlooked. We recognise these aspects have been challenging to maintain at times during the COVID-19 pandemic, but practices must continue to prioritise this to support their staff.

General:

- Through our assurance work, inspectors did note practices had out of date or incorrect information on informative literature including patient care leaflets. Practices should conduct regular audits of materials to ensure the information available to patients and staff is relevant and accurate.

Assurance and Inspection Findings Independent Healthcare

HIW's role in the independent healthcare sector in Wales is to register and regulate independent healthcare services. The independent healthcare sector encompasses a huge variety of services, from acute hospitals, mental health hospitals, to independent clinics and laser services. Many dental practices in Wales are also independent healthcare services, providing private dental healthcare, or a mix of NHS and private dentistry.

Independent healthcare services must register with HIW, and once they are successfully registered, they will be subject to ongoing regulation which is done through inspections and checks that providers are meeting the requirements of their registration, complying with the relevant regulations and providing a safe service.

During 2022 – 2023, HIW registered 53 independent healthcare providers. This number included new dental practices and new laser clinics. In total, we had 21 additional services registered with us by the end of the year.

Once registered, any changes a service intends to make to their conditions of registration, requires an application to vary what they are registered to provide. An application to vary a registration will not automatically be approved. Each application involves scrutiny by HIW as to the appropriateness of the proposed changes. During 2022-2023, HIW processed and approved a total of 24 registration variations.

In addition to this, all independent healthcare services have a manager who goes through a registration process to enable them to run a service. In 2022-2023, HIW processed and approved 88 new managers of independent healthcare services.

Registration activity:

53 new providers registered

24 variations of registration approved

88 new registered managers approved

During the 2022-2023 period, we responded to intelligence which suggested there were 24 unregistered providers, across a range of different service types, operating services they were not registered to provide. We followed up each of these cases, requiring the provision of services was stopped until a registration with HIW had been successfully processed.

Where inspections or intelligence indicate serious concerns in registered services, we monitor them through our Service of Concern process. We monitored 26 independent healthcare services through this process during 2022-2023. Whilst not all of these were designated as a Service of Concern, they were all subject to increased scrutiny which triggered follow up assurance and inspection work as required.

In order to check that registered services are continuing to meet the requirements of their registration, and providing a safe, quality service to patients, HIW undertakes a programme of inspection work each year.

In 2022 – 2023, we undertook a total of 31 individual pieces of assurance work to independent healthcare settings. This figure can be broken down further into:

Eight inspections to independent mental health services and 74 dental practice inspections were completed. These are discussed elsewhere in the report.

Our Immediate Assurance process was used in two of seven inspections to independent clinics, a rate of 29%. Improvements required included carrying out a health and safety risk assessment; ensuring evidence of cleaning schedules is recorded, and improving infection, prevention and control arrangements. Recommendations were also made at some independent clinics to improve the feedback process with patients, ensuring that feedback is actively sought and reviewed, and ensuring that complaints procedures are up to date and readily available in the event patients need to use them.

We carried out one inspection to a non-acute independent hospital. This was to PCP Cardiff, a drug and alcohol detoxification and rehabilitation service providing residential treatment on a private basis. Patients receiving treatment there were very complimentary of the staff and the care they were receiving. We found that the service was not adequately managing the risk of ligature and needed to improve medicines management procedures. We issued a non-compliance notice, requiring remedial action within 48 hours of our inspection in order to rectify this. The service was receptive to our findings and complied with the urgent improvements required.

Hospices

Hospices provide care to adults, young people and children who have a terminal illness or a long-term condition that cannot be cured.

During 2022 – 2023, we completed:

3

Onsite inspections to hospices in Wales comprising both adult only hospices and one hospice providing care to children. All three are provided by the independent healthcare sector.

Overall, our assurance and inspection work of hospices throughout the year was positive with evidence that services provided safe and effective care.

Without exception, we found evidence of positive interactions between staff, patients and their families and carers. The care provided was tailored and clearly person centred. Care plans were updated regularly and evidenced changes in condition and any treatment changes. Families and carers who provided us with feedback were very positive about the experience of care being provided, and the support they were being given.

We did find across all three inspections, that the equipment and medication kits for dealing with medical emergencies needed to be better maintained and kept updated. These kits are used in for example, an adverse reaction to medication. All three services were highly receptive to our findings and have addressed this.

Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

During the year 2022-2023, we conducted 19 onsite inspections to laser and IPL registered providers across Wales.

From these 19 inspections we identified non-compliance with relevant regulations in six cases. This means that in 32% of these inspections, we found laser and IPL providers were not meeting all the requirements they need to comply with in order to meet the requirements of their registration. The issues we found required us to use our Immediate Assurance process and request urgent action.

These included, using machines which they were not registered to use, treating patients outside of the age range they were licensed to treat and having no first aider.

The regulations under which laser and IPL providers are required to operated are specific and require them to comply with a number of areas in order to demonstrate their fitness to provide these services. We found a number of areas where we were repeatedly making recommendations for improvement through these inspections. In general, these related to the governance arrangements for these services. Good governance helps to ensure services are safe for the public to receive. Laser and IPL providers should therefore ensure they are familiar with their responsibilities against the regulations. The themes from our work during this time are set out below and providers should use these as learning points, considering whether they can make any improvements based on what we have found and recommended.

In a number of cases we found that the correct documentation, such as written policies and procedures were not available, or were not kept up to date. Staff training records and recruitment records also needed improving in some cases. The provision of a first aider, appropriately trained first aiders and an up to date first aid kit were also recommendations made in a number of these inspections.

19
onsite
inspections

Findings from Concerns, Investigations and Notifications

Three key themes have come through our concerns:

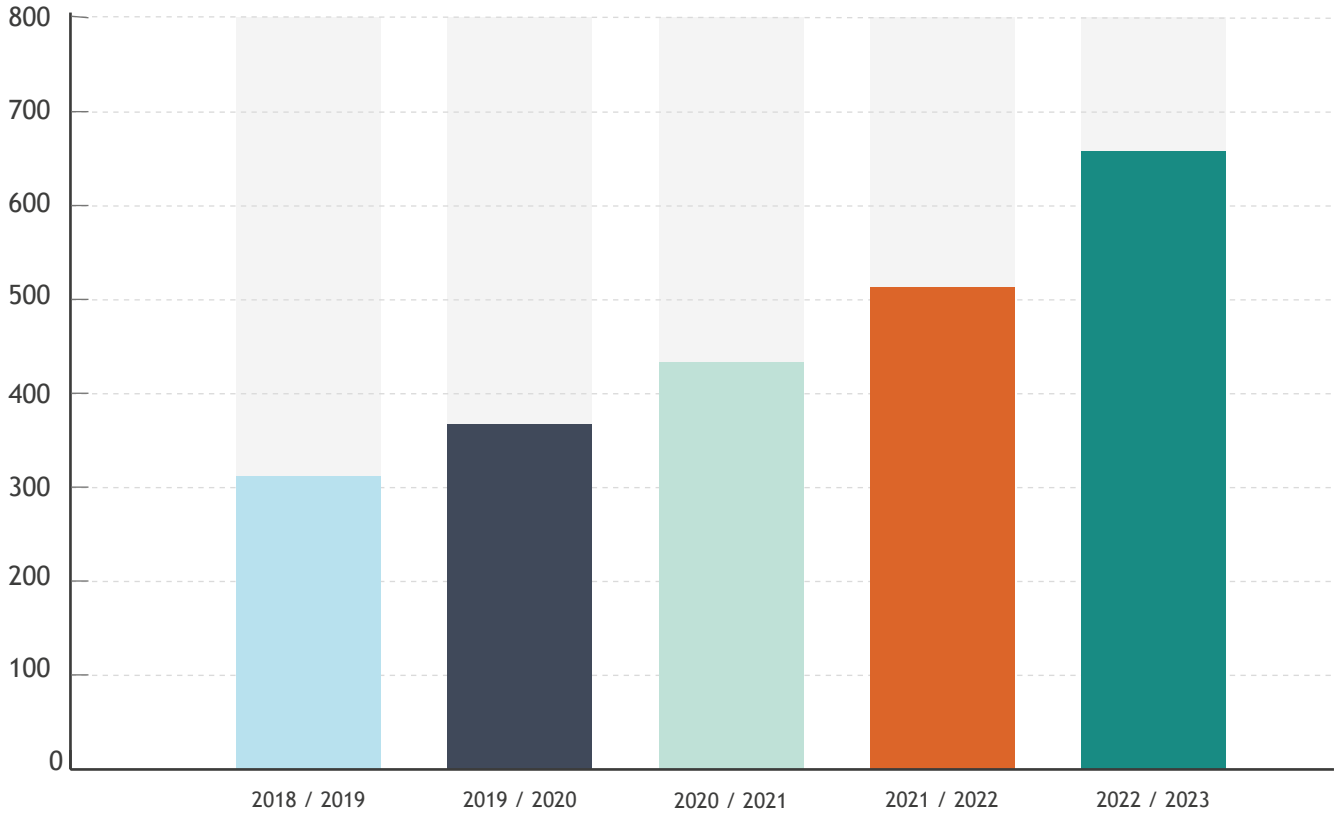
- Access to GP appointments
- Access to dental appointments / care and treatment
- Mental Health appointments and access to services

Complaints play a crucial role in identifying issues and fostering improvement within the healthcare sector. Feedback, often conveyed through complaints, provides valuable insights into areas of concern, inefficiencies, and lapses in quality. These grievances shed light on both systemic and individual problems, ranging from administrative processes to clinical care standards. By addressing and analysing complaints, healthcare organisations can pinpoint recurring patterns, root causes, and potential risks.

The concerns we receive provide an important opportunity to identify problems within a healthcare service. The intelligence received from these concerns enables an evaluation of risks to be identified and conceptualised. Consequently, HIW places significant importance on the intelligence received from concerns and uses it to drive its inspection and assurance activities.

As an organisation HIW is committed to managing concerns fairly, efficiently, and effectively. In total we received 659 concerns from 1st of April 2022 to 31st of March 2023. This represents an increase of 145 concerns compared to the previous year which equates to a 28% increase in the number of concerns received. Over the last 5 years we have seen a 111% increase in the number of concerns received.

The last 5 years of numbers of concerns



High-risk concerns require immediate action and response within 2 working days, either by HIW or another agency. Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days. Low-risk concerns are those concerns that are generally dealt with by way of signposting towards NHS Putting Things Right processes or the respective local complaints process for independent health providers, with responses being be actioned within 7 working days

The number of high risks concerns received has increased considerably over recent years.

We have experienced a **258%** increase in the number of high-risk concerns received compared with 2021-2022

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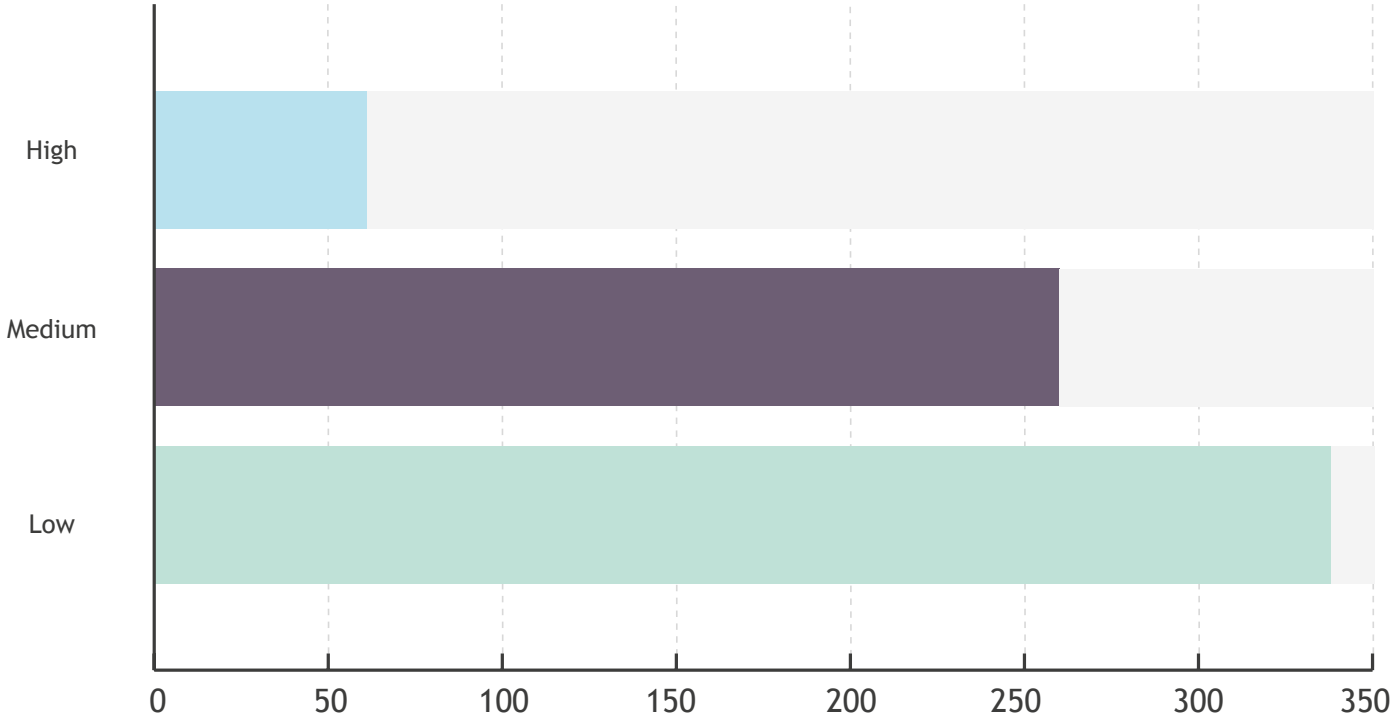
Risk level of concerns received



HIW responds immediately to all high-risk concerns. This can be in the form of immediate escalation to the health boards / trusts or independent healthcare settings. In addition, some high-risk concerns require the immediate intervention via safeguarding structures or the police.

Abbreviations

ABUHB
Aneurin Bevan University Health Board (UHB)

BCUHB
Betsi Cadwaladr UHB

CVUHB
Cardiff and Vale UHB

CTMUHB
Cwm Taf Morgannwg UHB

HDdUHB
Hywel Dda UHB

IHC Settings
Independent Healthcare Settings

PTHB
Powys Teaching Health Board

SBUHB
Swansea Bay UHB

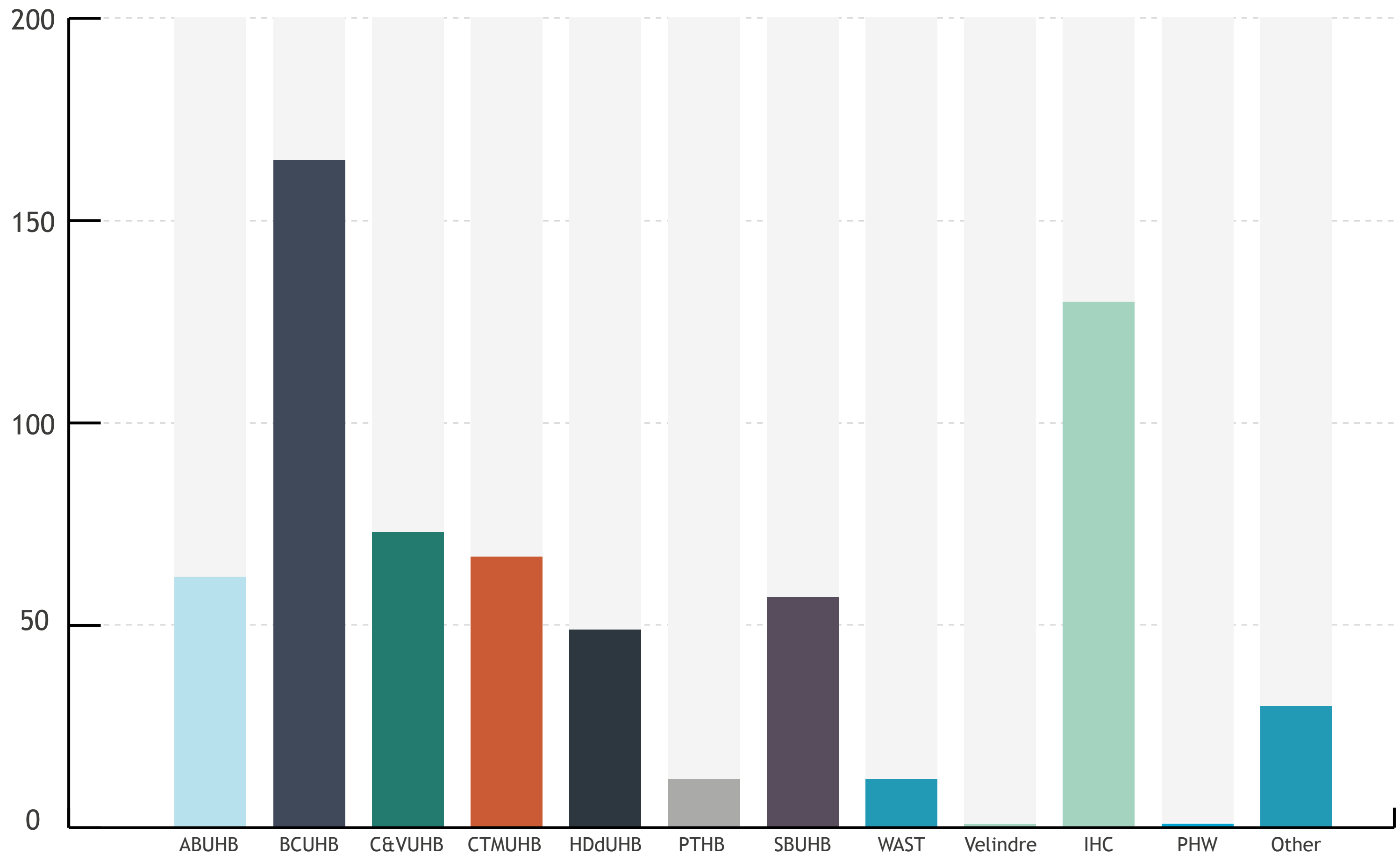
PHW
Public Health Wales

Velindre
Velindre University NHS Trust Welsh

WAST
Ambulance Services NHS Trust

IHC
Independent Healthcare

Location of concerns



Whistleblowing Concerns

25 received for 2019-2020

100 received for 2020-2021

61 received for 2021-2022

133 received for 2022-2023, an **85% increase compared** to previous year.

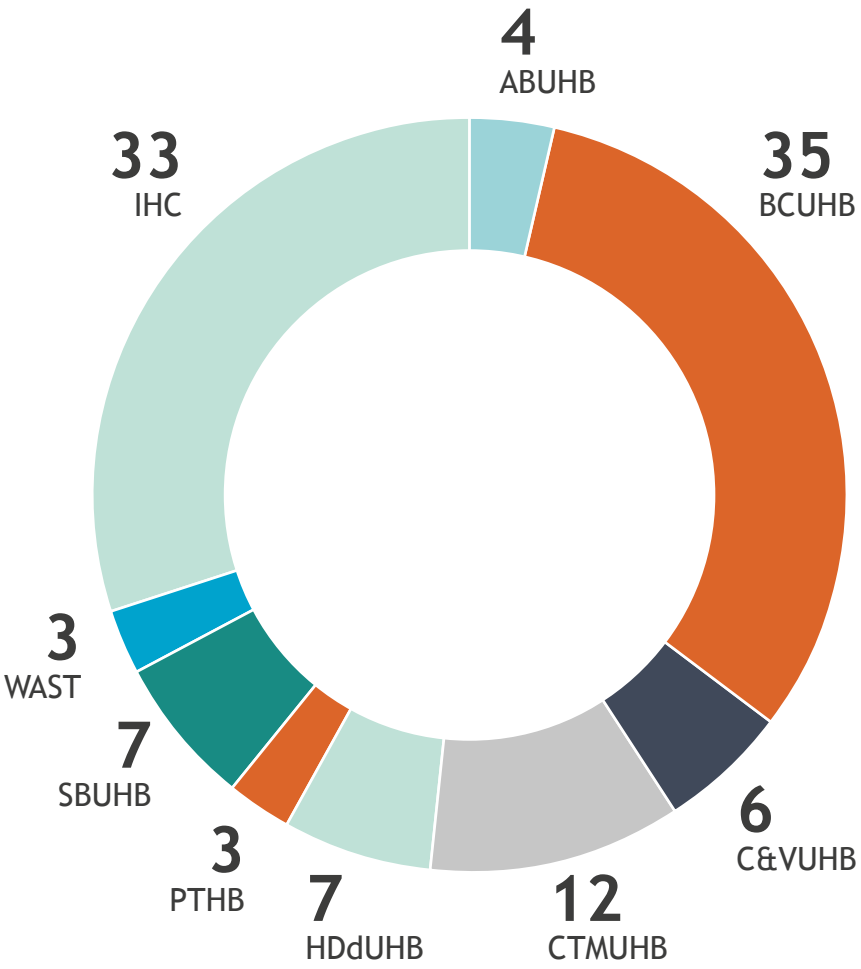
What is whistleblowing?

Whistleblowing is the term used when someone who works in or for an organisation wishes to raise concerns about malpractice, wrongdoing, illegality, or risk in the organisation. These concerns can affect patients, the public, other staff, or the organisation itself.

Whistleblowing applies to raising a concern within the organisation as well as externally, such as to a regulator like HIW. HIW has a special role for people who are thinking about "blowing the whistle" about concerns they have about wrongdoing in healthcare in Wales. HIW is a "prescribed body" under the whistleblowing laws, so employees, former employees, temporary agency staff or contractors who bring us concerns about their employer's activities can have some protection for their employment rights.

All healthcare professionals must follow their professional code of conduct and we would always recommend that they raise their concern within their own organisation first. However, if they feel unable to do this, or have already gone through this route, we will listen to the concern and explain how we can help. We may need to pass on the information they give us to another organisation or regulatory body if it is more appropriate for them to investigate the concern.

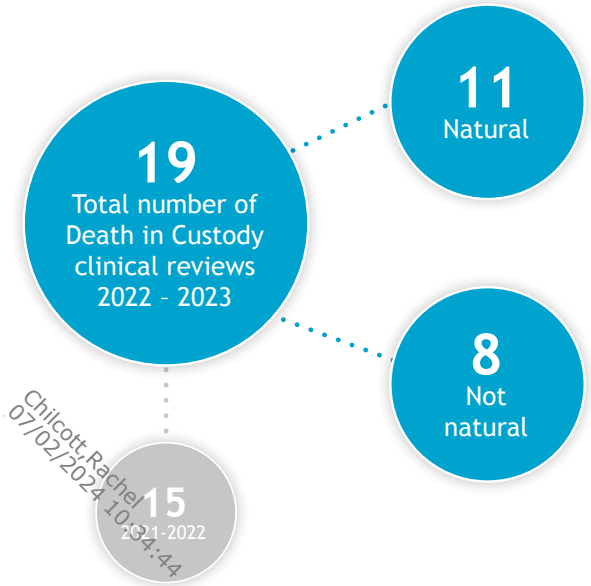
Location of Whistleblower 22/23



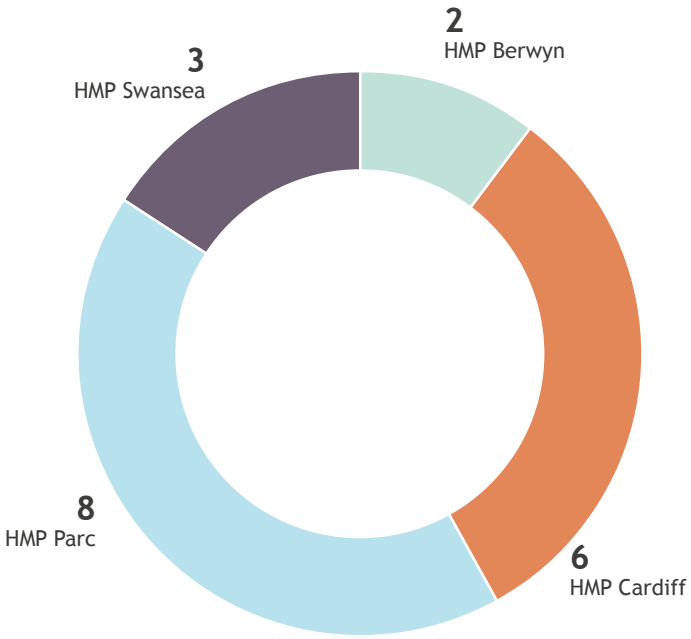
Death in Custody

Every death that takes place in a prison or other authorised location in Wales is subject to an examination by the Prisons and Probation Ombudsman (PPO). HIW assists these inquiries by conducting a clinical review of each death that occurs in a Welsh prison or other authorised location.

The fundamental goal of our clinical reviews is to assess and evaluate the level of care and medical treatment given to inmates while they in a prison or other authorised location. We aim to evaluate whether the care and treatment provided was equitable to what a person in the community could expect to receive.



Location of death:



Common Theme

A common theme identified in our reviews is the failure of prison healthcare staff to record a full set of baseline observations (vital signs) during the very early healthcare screening appointment that prisoners will have on, or shortly after arrival.

Having a comprehensive set of observations for a prisoner at the start of their incarceration is crucial. These measurements offer important insights into the body's functioning, helping healthcare professionals detect any changes. When a prisoner becomes unwell, regular clinical observations also need to be taken so that abnormalities can be spotted, and deterioration can be recognised and acted on. When this does not happen, there can be poor outcomes for patients.

Notifications

Independent healthcare providers are required to inform us of significant events and developments in their service submitting notifications against Regulation 30/31 of the Independent Healthcare (Wales) Regulations 2011.

The total number of regulatory notifications received in this reporting period is 1,847. This figure includes notifications against the following set of regulations:

- Independent Healthcare Regulations (IHC)
- Private Dentistry Regulations (DR)
- IRMER Regulations

A breakdown of the grand total shows the following number of notifications against each of the regulations:

IHC Regulations
1,713

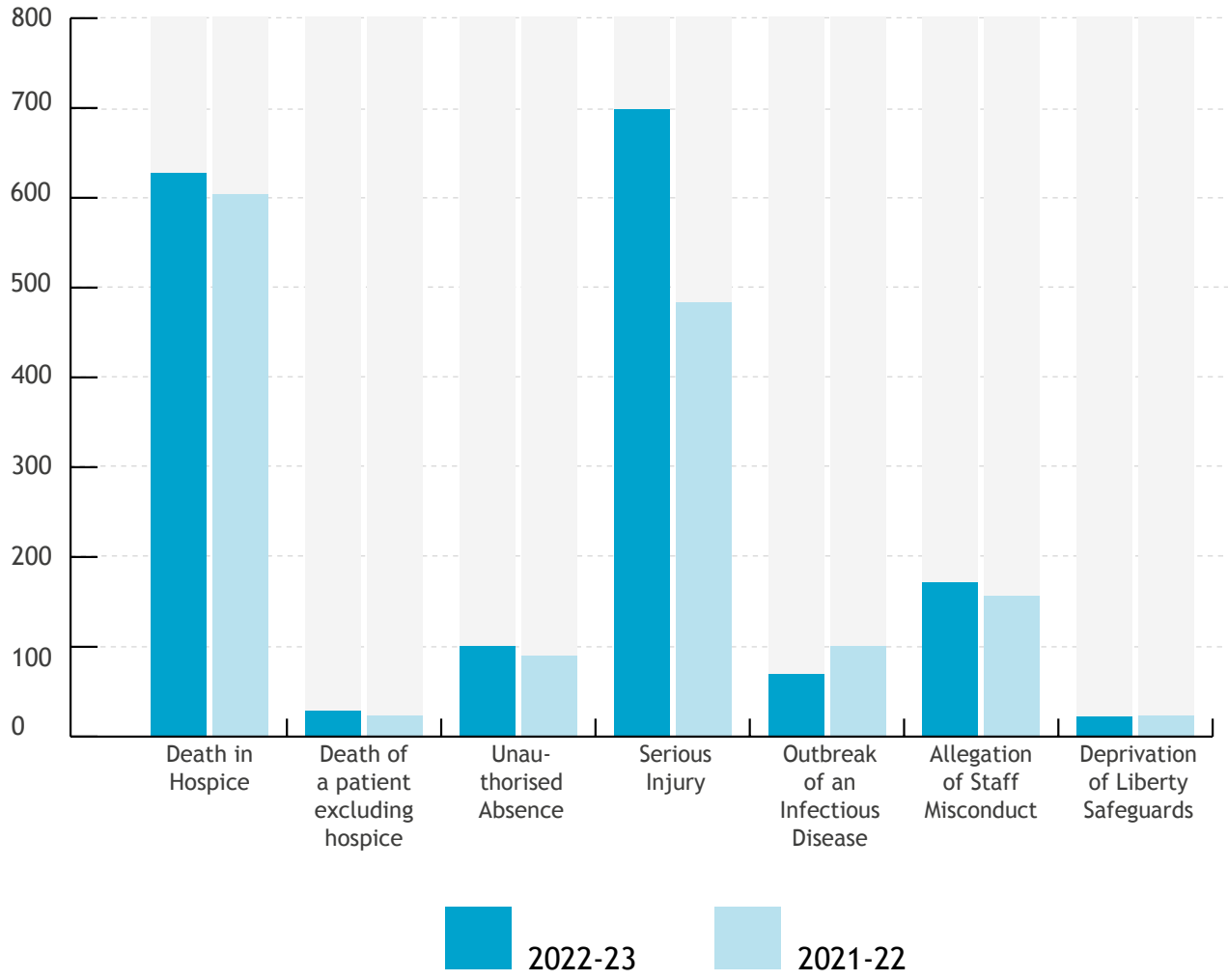
Private Dental Regulations
32

IRMER Regulations
102

Each regulation has its own reporting threshold. IHC Regulation 30/31 includes the following categories:

- **Death in Hospice**
- **Death of a patient excluding hospice**
- **Unauthorised Absence**
- **Serious Injury**
- **Outbreak of an Infectious Disease**
- **Allegation of Staff Misconduct**
- **Deprivation of Liberty Safeguards**

The graph shows a breakdown of the number of notifications received against each category and provides a comparison to the same reporting period last year.



Private Dentistry Regulation

Includes the following categories,

Serious Injury

Outbreak of Infectious Disease

Allegation of Staff Misconduct

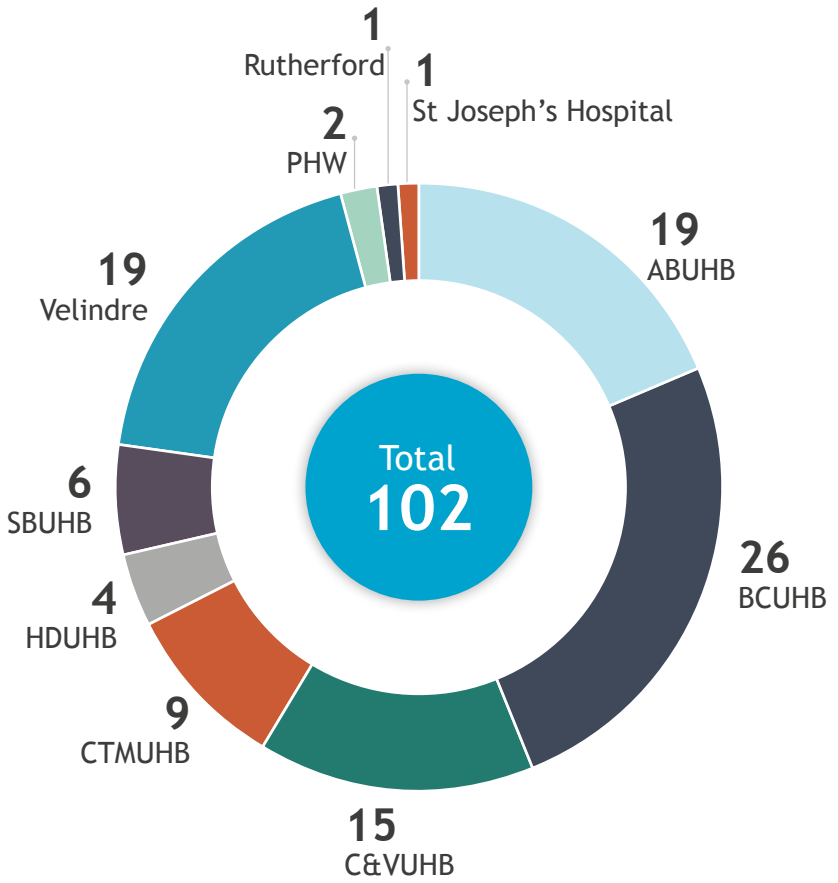
Death of a Patient

Category	2022-23	2021-22
Serious Injury	2	6
Outbreak of an infectious disease	30	147

There has been a significant reduction in the number of notifications received, mainly in the number of outbreaks of infectious diseases reported. This significant drop in the number of Outbreaks of infectious diseases is due to the COVID-19 pandemic.

IRMER

The chart below shows a breakdown of the number of notifications received against the IRMER regulations for this reporting period.



Safeguarding

256
Significant drop in the number of referrals received

In 2021/2022 we received 404 referrals

128
NHS

125
Independent Healthcare

3
Other

NHS

	Financial Abuse	Neglect	Physical Abuse	Psychological / Emotional Abuse	Sexual Abuse	Grand Total
Aneurin Bevan University Health Board		11	4			15
Betsi Cadwaladr University Health Board	2	25	13	2	3	45
Cardiff and Vale University Health Board		2				2
Cwm Taf Morgannwg University Health Board		24	8	3		35
Powys Teaching Health Board		6	7		4	17
Swansea Bay University Health Board		7	2			9
Welsh Ambulance Service NHS Trust		5				5
Total	**2**	**80**	**34**	**5**	**7**	**128**

Independent Healthcare

	Financial Abuse	Neglect	Physical Abuse	Psychological / Emotional Abuse	Sexual Abuse	Grand Total
Aberbeeg Hospital			1			1
Aderyn					1	1
Cefn Carnau Hospital		3	7			10
Coed Du Hall			2			2
Heatherwood Court Hospital		7	1	1	1	10
Hillview Hospital		4	4	3		11
Llanarth Court		11	13	6	4	34
New Hall			1	2		3
Nuffield Health The Vale Hospital		1				1
Rushcliffe Independent Hospital (Aberavon)			1			1
St Peter's Hospital		5	11	3	1	20
Ty Cwm Rhondda				2		2
Ty Grosvenor	1	14	7			22
Ty Gwyn Hall	2		4	1		7
Total	3	38	51	17	6	125

Three of the referrals were in relation to settings not regulated or inspected by HIW.

Second Opinion Appointed Doctor (SOAD) Service for Wales

HIW operates the SOAD service for Wales, employing registered medical practitioners to approve some forms of treatment for patients who are detained under the Mental Health Act. Ultimately, the role of the SOADs is to safeguard the rights of patients who are detained under the Mental Health Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether the patient has capacity to consent.

They must be satisfied that the patient's views and rights have been taken into consideration. After careful consideration of the patient and approved clinician's views, a SOAD has the right to change the proposed treatment. For example, a SOAD may decide to authorise only part of the proposed treatment or limit the amount of treatment which can be given.

The SOADs have a responsibility to ensure the proposed treatment is in the best interest of the patient. Approved clinicians refer cases to HIW seeking a SOAD opinion. Case reviews are requested in the following circumstances:

- liable to be detained patients on Community Treatment Orders (CTO) (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients
- serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57)
- detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58)
- patients under eighteen years of age, whether detained or informal, for whom electroconvulsive therapy (ECT) is proposed, when the patient is consenting having the competency to do so (Section 58A), and
- detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A).

Total Number of SOAD cases dealt with by HIW in 2022 - 2023:

694

Medication:
640 requests related to the certification of medication

ECT:
42 requests related to the certification of ECT

Both:
12 requests related to the certification of both medication and ECT

By comparison, during 2021-2022, HIW dealt with 759 requests for a SOAD review.

Medication:
640 requests related to the certification of medication

ECT:
42 requests related to the certification of ECT

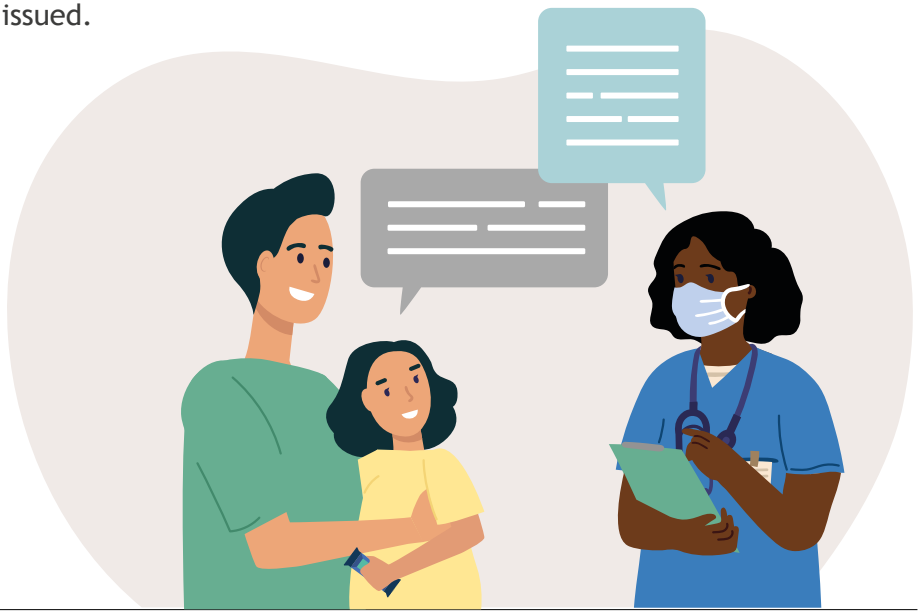
Both:
36 requests related to medication and ECT

Review of Treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the seventh consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are routinely reviewed by our lead SOAD for Wales on a monthly basis. There was a delay in the timeliness of the review of treatments in 2022-23, this was due to a vacant Lead SOAD position. However, all cases have now been reviewed with appropriate action taken where applicable.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continues to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.
- There were a few instances where T3 forms were being utilised instead of the appropriate CO forms, due to temporary methodology guidance implemented during the COVID Pandemic. These have now been rectified and refreshed guidance has been issued.



1 The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.
The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

Our Resources

The table shows the number of full or part time posts in each team within HIW during 2022-2023.

Team	Posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence and Methodology	14
Clinical Advice (including SOAD service)	6
Corporate Services (including business support)	18
Strategy, Policy and Engagement	7
Total	**87**

For 2022-2023 we had a budget of approximately £4.3m.

We have posts equivalent to approximately 87 full-time equivalent staff. We currently have a panel of over 200 specialist peer reviewers with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have 44 Patient Experience Reviewers and Experts by Experience.

Finance

The table shows how we used the financial resources available to us in the last financial year to deliver our work in 2022-2023.

HIW staff continue to be our most important resource. A programme of learning and development opportunities has once again been designed and delivered in accordance with feedback from staff. We have refreshed our internal People Forum which provides a strong and valuable source of feedback to senior HIW managers on staff matters and organisational development.

We have continued to recruit into specialist peer reviewer roles, and increased our pool of patient experience reviewers. This has strengthened our access to up to date clinical expertise and provided additional resource who can engage directly with patients during inspection work.

Our electronic Customer Relationship Management (CRM) system is now well established and providing valuable data supporting the work of all teams across HIW.

	£000'S
HIW Total Budget £	£4,372,000

Expenditure	
Staff costs	4,176,468
Travel and Subsistence	26,225
Learning & Development	29,854
Non staff costs	80,210
Translation	59,834
Reviewer costs	405,761
ICT Non CRM costs	16,810
Depreciation of assets	8,000
Total expenditure (a) £	4,803,162

Income	
Total income from Independent Healthcare (b) £	528,239
Total Net Expenditure (a-b) £	4,274,923

Arolygiaeth Gofal Iechyd Cymru
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Chief Executives and Chairs
Health Boards and NHS Trusts Wales
Via Email

4 December 2023

EMBARGO: Healthcare Inspectorate Wales (HIW)
Update: Annual Report 2022 – 2023 / Publication Policy Changes

Dear Chief Executive and Chair

I would like to inform you that HIW will be publishing its 2022-2023 annual report at 00:01 on Wednesday 6 December 2023. Please find a copy of our report attached. Please note media outlets will receive a copy under embargo on Tuesday 5 December 2023.

This report sets out our key findings from the regulation, inspection, and review of healthcare services in Wales. It outlines how we carried out our function across Wales, seeking assurance on the quality and safety of healthcare services through a range of activities including inspections and review work in the NHS and regulatory assurance work in the independent healthcare sector. It provides a summary of what our work has found, the main challenges within healthcare across Wales and provides our view on areas of national concern.

Our objectives are ambitious and through them we aim to make a difference to the people of Wales by contributing to improvements in healthcare. In this report you will find some examples of how we have used our work to further this aim. I am proud of the organisation I lead, and the contribution we can make to healthcare in Wales.

Should you wish to follow up on anything contained within the report then please get in touch with your HIW Relationship Manager or me directly.

I would also like to take this opportunity to alert you to a change within our process for publishing reports, for certain types of inspection. Currently, HIW briefs all Members of the Senedd, media outlets and key stakeholders under embargo, before publishing inspection reports for emergency departments, maternity services, and inpatient mental health units across Wales, regardless of whether the inspection findings were positive or negative. This process is also used for other types of inspection where there are findings of a significant nature. Following a recent review of operational commitments and resources, we will no longer routinely share embargoed reports for mental health units, unless there are findings of a significant nature from the inspection of these services. We will continue to promote all our inspection reports on the day of publication via our own social media channels and apply our exceptional handling process to other types of inspection where there are findings of a significant nature.

Yours sincerely

Alun Jones
Chief Executive
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

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