Public Quality, Safety and Experience Committee

Tue 26 March 2024, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:10
10 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee Meeting held on 13.02.2024

Ceri Phillips

00 - QSE Public Minutes 13.02.2024 - CP.pdf (7 pages)

1.5. Action Log – Following the meeting held on 13.02.2024

Ceri Phillips

Action Log following 13.02.2024.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

14:10 - 15:35
85 min

2. Items for Review & Assurance

2.1. Specialist Services Clinical Board – Assurance Report

30 mins *Catherine Twamley*

2.1 - SpS Assurance Report for Board Committee - 2023 - 24.pdf (35 pages)

2.2. Quality Indicators Report

20 mins *Jason Roberts*

2.2 - Quality Indicators Report 20240318.pdf (20 pages)

2.3. Consent to Examination and Treatment

10 mins *Rebecca Aylward / Melanie Bostock*

2.4. Patient Safety Solutions - Valproate

5 mins *Meriel Jenney*

- 2.4a - Sodium Valproate alert 20240318.pdf (4 pages)
- 2.4b - Valproate improvement plan Appendix 1.pdf (8 pages)

2.5. Looked After Children – Assessment Backlogs

10 mins *Catherine Wood*

- 2.5 - Looked After Children Assessment Backlogs.pdf (5 pages)

2.6. MBRRACE-UK Neonatal report 2021 and National Neonatal Audit Programme

10 mins *Jason Roberts / Meriel Jenney*

- 2.6 - MBRRACE-UK QSE committee March 2024.pdf (5 pages)

15:35 - 15:40
5 min

3. Items for Approval / Ratification

Ceri Phillips

3.1. Policies:

5 mins

1. Optimising Outcomes Policy & Procedure (UHB 224)

- 3.2a - Optimising Outcomes Policy_update 2024_QSE_FINAL.pdf (3 pages)
- 3.2b - UHB 224 OOP Policy_REVIEW_FINAL.pdf (5 pages)
- 3.2c - UHB 224 OOP Procedures_REVIEW_FINAL.pdf (23 pages)
- 3.2d - OOPP EQIA_OOP_Jan 2024_FINAL.pdf (36 pages)

15:40 - 15:45
5 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees and the Safeguarding Steering Group (SSG)

- *Jason Roberts*

- 4.1.1 - MCB QSE Minutes 16 Nov 23.pdf (4 pages)
- 4.1.2 - CD&T - Att 1 - Minutes 22.1.24.pdf (14 pages)
- 4.1.3 - CD&T Minutes 16.2.24.pdf (12 pages)
- 4.1.4 - Safeguarding Steering Group (SSG) Final Minutes Jan 24.pdf (8 pages)

4.2. Annual Report for Quality, Safety and Experience Committee 2023-24

5 mins *Ceri Phillips*

- 4.2 - Annual Report of the Quality Safety and Experience Committee_cp.pdf (5 pages)

15:45 - 15:45
0 min

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

Ceri Phillips

No items.

15:45 - 15:50
5 min

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

Ceri Phillips

i. *Private Minutes*

ii. *Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*
iii. *Chair's Report RADAN Application*
iv. *Ophthalmology WET AMD Update*

15:50 - 15:55
5 min

7. Any Other Business

Ceri Phillips

7.1. Prison Inquest Update

5 mins *Jason Roberts*

15:55 - 16:00
5 min

8. Review of the Meeting

Ceri Phillips

16:00 - 16:00
0 min

9. Date & Time of Next Meeting:

Ceri Phillips

21st May 2024 at 2pm

Via MS Teams

16:00 - 16:00
0 min

10. Declaration

Ceri Phillips

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

Unconfirmed Minutes of the Quality, Safety & Experience Committee

Held on 13th February 2024

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		
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
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Paul Bostock	PB	Chief Operating Officer
Francesca Thomas	FT	Head of Corporate Governance
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Ceri Chinn	CC	Lead Nurse Peri-Operative Care
Rachel Thomas	RT	Director of Operations – Surgery Clinical Board
David Scott-Coombes	DSC	Clinical Board Director - Surgery
Timothy Banner	TB	Clinical Director Pharmacy & Medicine
Jenna Walker	JW	Medication Safety Officer
Rebecca Aylward	RA	Deputy Executive Nursing Director
Sian Griffiths	SG	Consultant in Public Health Medicine
Carolyn Alport	CA	Quality & Safety Clinical Nurse Lead - Surgery
Catherine Twamley	CT	Interim Director of Nursing – Specialist Services Clinical Board
Observers		
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Matt Phillips	MP	Director of Corporate Governance
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety

QSE 24/02/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QSE 24/02/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 24/02/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 24/02/004	**Minutes of the Committee meeting held on 19.12.2023**	

	The minutes of the Committee meeting held on 19.12.2023 were received, subject to minor wording amendments. **The Committee resolved that:** a) The minutes of the meeting held on 19.12.2023 were approved as a true and accurate record of the meeting.	
QSE 24/02/005	**Action Log following the Meeting held on 19.12.2023** The Action Log following the Meeting held on 19.12.2023 was received. QSE 23/12/005 – the CC noted that a discussion had not yet taken place, but an update would be provided at a future committee meeting. QSE 23/07/009 – it had been agreed that an update on MMBRACE would be brought to a future private and public meeting, with a focus on neonatal. QSE 23/12/007 – the templates had been circulated offline and could be marked as complete. QSE 23/12/007 – this action would be referred to the CVC / IM-CE for action. QSE 23/12/007 – Royal College of Psychiatrists (RCP) review update – the EMD noted that there had been another delay. It had been almost a year since they commissioned the RCP, and despite a review and discussion, there had been no update for three months. The EMD suggested that a formal request for an update would be made to the RCP in writing. **The Committee resolved that:** a) The Action Log from the meeting held on 19.12.2023 was noted.	
QSE 24/02/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QSE 24/02/007	**Surgical Clinical Board – Assurance Report** The Patient Story was presented, where the LNPOC provided the Committee with a summary of her experience as a breast cancer patient in Cardiff and Vale UHB (CAVUHB). The END thanked the LNPOC for sharing her story, which highlighted the importance of human touch and communication, as well as the anxiety that patients experience before radiology and blood tests. The EMD recognised that there was room for improvement in some areas. The IM-C suggested that the LNPOC's story and experience be archived within the Surgical Clinical Board, and he raised concerns about communication with patients from different cultures, ethnicities, and languages. The EMD asked the LNPOC for an example of an area that needed improvement. The LNPOC highlighted the difficulty in getting a GP appointment, and she suggested that staff be realistic with patients over the expected waiting time for test results. The DO-SCB presented the Surgical Clinical Board Assurance Report which provided the Committee with a summary of the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety, and Patient Experience agenda during 2023.	

The DO-SCB additionally highlighted the following:

1. Risk Registers – documentation was being reviewed at both the Directorate and Clinical Board levels.
2. Cases of redress and negligence – a big piece of work was being undertaken in the clinical board to review the concerns received, to identify themes, to tackle fixable issues, and to initiate wider conversations across the organisation.

The CBD-S explained that it had been a busy year and that there had been changes to the senior nursing team.

The EDTHS asked what work had been undertaken to rectify the increase in night-time falls, and whether the reduction in falls through December had been maintained in subsequent months. She also asked whether the equipment incidents (which accounted for 5% of total incidents) were reported to the Medical Equipment Group.

The LNPOC responded that most of the equipment incidents were within theatres, and confirmed that they linked in with the Medical Equipment Group.

Regarding falls, the DO-SCB explained that a piece of work was being undertaken which focused on reducing the length of stay, and that an action plan was in place. She noted that these concerns would be fed back to her team.

The END noted that there had been good evidence of a reduction in IP&C data, with MRSA and MSSA dropping by 30% or more. Additionally, the use of Tendable helped the clinical board to provide assurances to the Executive team on the quality agenda.

The IM-CE asked for more context around how the increase in theatre capacity had been achieved. She also asked how confident the Clinical Board were that their Value Based Appraisals (VBAs) were moving in the right direction.

The DO-SCB responded that:

- Theatre capacity – the Theatre Delivery Group met fortnightly and had been worked on improving and monitoring theatre utilisation, and they had increased the number of sessions throughout the year.
- VBAs – It had been a difficult task for their complex clinical board, but they were confident that the weekly reporting plan would help them reach the 85% target for March.

The CBD-S added the following:

- Theatre time was their most precious resource, and they wanted to get the most value for the large number of patients waiting.
- Theatres were not operating as desired as they wished for cardiac to return, which was planned for high volume low complexity surgery. They were optimistic that this would drive down waiting times once it starts the following summer.
- They had confidence in the data captured on theatre utilisation.
- Data also showed opportunities to improve around late starts and early finishes. They had redone their job plans over the previous year, with anaesthetists and surgeons starting at 7:30am to have time for pre-surgery tasks.

The COO noted that VBAs were monitored weekly at the Operational Delivery Group, and they had started to see some traction in recent weeks. He confirmed that the change of senior nurse had been nothing but positive.

The IM-C asked for more clarity and context around the incident percentages, as it was unclear how many patients this concerned in reality.

The DO-SCB suggested that she would circulate the figures which supported the percentages to the Committee outside of the meeting.

	The EMD asked for a strategic review on the priorities for the following year. The CBD-S responded that the situation was always unpredictable, but that one of their top priorities for the following six months would be patients lost to follow-up. The DO-SCB reiterated that the clinical board wished to focus on their risk management process and governance structure. She wished to ensure that all staff (both clinical and non-clinical) were aware of the concerns within their area and were focused on fixing them. **The Committee resolved that:** 1) The assurance provided by the Surgery Clinical Board QSE assurance report was noted; and 2) The mitigation being taken to improve quality, safety, and experience and reduce harm by the Clinical Board was agreed.	
QSE 24/02/008	**Medication Safety – Deep Dive** The MSO presented the Medication Safety Deep Dive report and slides, which provided the Committee with a summary of the work being undertaken in CAVUHB in relation to medication safety. The EMD highlighted the presence of champions in the areas of greater risk (e.g. paediatrics), who included clinicians, pharmacists, doctors, and nurses who all had particular areas of interest and focus. She added that the electronic prescribing and medicines administration (EPMA) was the essential next step for the health board in preventing errors, auditing, and recording drugs usage. The CDPM added that the EPMA system would provide better data and awareness of issues, such as missed doses. He discussed the challenge of maintaining knowledge of high-risk medicines and drug alerts, and hoped that the EPMA system would aid this by providing prompts. The CDPM hoped to return the following year to discuss the EPMA's achievements. **The QSE Committee resolved that:** a) The assurance provided by the work underway to oversee medicines safety was noted.	
QSE 24/02/009	**Quality, Safety and Experience Framework – effectiveness review** The ADPE noted that the slides had been presented and circulated at the previous QSE Committee, and asked if anybody had any questions. The IM-CE asked for more context around the digital stories. The ADPE explained that digital stories were presented in various formats (e.g. videos, presentations, and poems), and were shared across Wales through the All Wales Library, which hosted a collection of stories that were applicable to many health boards. She emphasised the need to explore the different ways of presenting the stories, and the respect given to individuals who shared their experiences and their editorial rights over the content. The IM-CE asked if they had undertaken an evaluation on any gaps within the stories. The ADPE explained they had analysed where the gaps were in their digital stories, and the goal for the following year was to focus on reaching out to underrepresented groups and delivering care in the community. The END asked what support the team needed to ensure that the quality, safety, and experience framework was integrated throughout the organisation.	

	The ADQPS responded that their data, insight, and digital journey was evolving – for example, the development of the EPMA system. Additionally, the scrutiny of the mortality data had changed the conversation about the quality of care. She acknowledged the difficulty in obtaining data, and the need for resources and accessible tools for clinical boards. The ADPE added that psychological safety was also crucial, and emphasised the need to listen to patients and staff and to take actions based on their feedback. The support of staff led to good quality of care. She added that the Duty of Candour should be a fundamental part of an organisation's culture, and not just a legal requirement. The EDTHS emphasised that they needed to ensure that everybody in the organisation used the same system as they moved forwards. The CC suggested that the progress with the EPMA be added as a QSE standing item the following year. **The QSE Committee resolved that:** 1) The Committee noted the reassurance provided by the report.	
QSE 24/02/010	**Learning Committee Update** The ADQPS presented the Learning Committee Update slides and summarised the following: - In 2021, the Quality, Safety and Experience Framework was published, which spanned five years. As part of this, they set out a revised structure for quality, safety and experience across the organisation, which involved the further development of the Clinical Effectiveness Committee and the production of a biannual report. - In 2023, efforts were focused on the delivery of the Clinical Safety Group, which oversaw all clinical advisory groups and linked them with the clinical boards. Additionally, the Executive Quality meetings had been revised to consider current and emerging issues, and to manage constraints and risks. - The final piece was the delivery of the Organisational Learning Committee to address the cross-cutting themes across the organisation. The committee oversaw the initial developments of improvements, spread good practice, and monitored interventions and improvements. • Some themes discussed included the transition from paediatric to adult services, the recognition and management of deteriorating patients, the follow-up of patients, the delivery of consent, and professional standards and the handovers of care between specialities. - Six enablers were identified to address these themes: culture and valuing people, workforce and leadership, data and insight, digital strategy, whole systems approach, and learning research. The membership of the Committee had been aligned to these enablers. - The aim was to address cross-cutting themes in a wide-reaching and long-lasting way, linking in with key members over the following few months. The initial meeting of the Organisational Learning Committee was planned for the end of the 2024 financial calendar year. The CC asked why the work was planned for the end of 2024. The ADQPS acknowledged the need to be realistic and the importance of understanding the role of the university and local authorities. A lot of work was needed to make the initiative run well and be successful from the outset, which might not be feasible to push for an earlier start. The IM-C asked how much work had been done in collaboration with the Digital team and the university in terms of innovation and systems.	

	The ADPE responded that two university students would soon join the Patient Experience Team to undertake project work around the analysis of themes, which would be useful for the Learning Committee. She emphasised the importance of developing and building on the existing relationships with the universities and other stakeholders. **The QSE Committee resolved that:** 1) The Committee noted the reassurance provided by the report.	
	Items for Approval / Ratification	
QSE 24/02/011	**Health Protection Plan** The EDPH noted that the initiative had come from close working relationships with regional colleagues established during the COVID period, particularly in the areas of testing, tracing, and vaccination. The Regional Partnership aimed to control and mitigate communicable diseases, and involved key partners such as Cardiff Council, the Vale of Glamorgan Council, and Public Health Wales (PHW). The CPHM presented the Cardiff and Vale Health Protection Plan report and slides, which described how their intention to build upon existing relationships and use their experience of the pandemic response to strengthen the regional system in line with the national principles (as set out by WG). The CC asked about the extent of engagement with organisations who were not core partners, but were still important for any health protection scheme (which included both private and public sector bodies). The CPHM responded that WG saw the year 2023-24 as a transition year from COVID to an all-hazards approach, and that relationships with third sector organisations could be critical. Broader relationships would need to be considered going forward. The CC asked what could be expected in 2023-24. The CPHM emphasised the importance of being prepared for future pandemics and working well together as organisations. She noted that measles was currently a concern, and a lot of planning was being undertaken around this. The CPHM added that they were dealing with communicable disease threats and planning for other national priority diseases such as TB, Hepatitis B, and HIV. They hoped to see delivery against the big national priorities in the following year. **The QSE Committee resolved that:** 1) The contents of the Cardiff and Vale Health Protection Plan was approved; and 2) The actions to drive further service development and integration within the UHB and across the partnership was actively supported.	
QSE 24/02/012	**Policies** The following policies were approved by the Committee: - Intraoperative Cell Salvage Policy & Procedure (UHB 030 & 403) - Swab Instrument and Needle Count Policy & Procedure (UHB 191) - Inpatient Welsh Language Policy (UHB 513) The following policy was noted by the Committee: - Individual Patient Funding Request (IPFR) Policy The COO sought clarification on the process of approval for these policies and where the discussion of these policies had taken place.	

	The DCG explained that there was an ongoing corporate effort to review the management and approval process of policies, and provided assurance that the issue would be addressed. Clarification would be provided once the work was completed. **The QSE Committee resolved that:** 1) The policies were noted and approved.	
	Items for Noting & Information	
QSE 24/02/013	**Minutes from Clinical Board QSE Sub-Committees and Radiation Protection Group Chair's Report** The Minutes from the Clinical Board QSE Sub-Committees and the Radiation Protection Group Chair's Report were noted. **The QSE Committee resolved that:** 1) The minutes from the Clinical Board QSE Sub-Committees and the Radiation Protection Group Chair's Report were noted.	
QSE 24/02/014	**Health Inspectorate Wales Annual Report 2022-23** The ADQPS informed the Committee that this report looked at Health Inspectorate Wales (HIW) activity over the previous year, as well and themes and trends across Wales. **The QSE Committee resolved that:** 1) The contents of the HIW Annual Report 2022-23 was noted.	
	Items to bring to the attention of the Board / Committee:	
QSE 24/02/015	*No items.*	
	Agenda for Private QSE Meeting	
QSE 24/02/016	*i) Minutes and Action Logs from the Private QSE Committee on 19.12.2023* *ii) Any Urgent / Emerging Themes – Verbal Update* *iii) Prison Inquest Update – Verbal* *iv) Discharge Advice Letters (DAL) Update* *v) Ophthalmology WET AMD* *vi) Breast Look Back Exercise – Interim Update following Clinical Review* *vii) Safeguarding Update – Verbal* *viii) Joint Inspection of Child Protection Arrangements (JICPA)*	
	Any Other Business	
QSE 24/02/017	The EMD informed the Committee that there may be a scheduling conflict for the next QSE meeting as it coincided with the planned Industrial Action.	
	Date & Time of Next Meeting:	
QSE 24/02/018	Tuesday 26th March at 2pm via MS Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 26th March 2024
(Following the meeting held on 13th February 2024)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 23/12/007	**Mental Health Clinical Board – Assurance Report**	To share the report template with Clinical Boards to effectively provide assurance to the Board in the future.	**13.02.2024**	Meriel Jenney	**COMPLETED** *Update shared on the 13th February 2024 - templates had been shared offline.*
QSE 23/12/012	**Quality, Safety and Experience Framework – effectiveness review**	Distribute the presentation and allow some time for questions at the next meeting.	**13.02.2024**	Angela Hughes Alexandra Scott Corporate Governance	**COMPLETED** *Update shared on the 13th February 2024.* *Slides shared on 22/12/2023*
QSE 23/07/009	**MBRRACE Update**	For a matrix report to be provided to the Committee to include the MBRRACE report.	**26.03.2024**	Meriel Jenney / Jason Roberts	Item added to Forward Plan for March 2024 QSE
QSE 23/12/007	**Mental Health Clinical Board – Assurance Report**	Report back on the feedback from the Royal College of Psychiatrists review. EMD to write to the RCP for feedback.	**26.03.2024**	Meriel Jenney / Jason Roberts	Item added to Forward Plan for March 2024 QSE
Actions in Progress					
QSE 23/12/005	**Action Log**	For the Committee Chair and the Director of Corporate Governance to review the items that are too far in the future and consider placing them on the annual work plan.	**26.03.2024**	Ceri Phillips Matt Phillips	**Update on 26th March 2024**

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 24/02/012	**Policies**	For the approval process for the policies coming to QSE to be clarified.	26.03.2024	Matt Phillips	**Update on 26th March 2024**
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					

Report Title:	Specialist Services Clinical Board Assurance Report			Agenda Item no.	2.1
Meeting:	Quality, Safety and Experience Committee	Public	x	Meeting Date:	March 26th 2024
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Executive Director of Nursing Jason Roberts				
Report Author (Title):	Catherine Twamley Interim Director of Nursing for Specialist				

Main Report
Background and current situation:

This report provides details of the arrangements, progress and outcomes within the Specialist Services Clinical Board (SpS CB) in relation to the Quality, Safety and Patient Experience (QPSE) agenda over the last 12 months. It highlights the achievements, innovation and transformational work undertaken to date, and describes key residual risks and their mitigating actions that carry forward into 2024/25.

QPSE is at the core of all that we do and our operating framework is described below. Governance structures and oversight have and continue to develop significantly in alignment with the 6 domains of quality as defined by the Duty of Quality Statutory Guidance 2023.

Following an overview of SpS CB, the first 2 sections of the report are dedicated to the quality domains of 'Safe Care' and 'Person Centred Care'. It then focuses on the separate services and teams within SpS CB. This is to try to depict the unique essence of SpS CB and how across all areas, the 6 domains of quality are delivered.

SpS CB have embedded the culture of being more open to risk, innovation and transformation, where clear links to improving patient quality, safety and experience can be evidenced.

During the financial year 2023/24, SpS comprised of 7 clinical directorates with associated clinical services and sub-specialties and held a budget of £212m. There are 2049 whole time equivalent (WTE) staff in post. The CB delivers a number of highly specialised services serving the South East region, South and mid-Wales region and wider all Wales population, as well as providing secondary care services to the local Cardiff and Vale population.

The services provided by SpS CB are predominantly Welsh Health Specialised Services Committee (WHSSC) commissioned and provide for the wider regional and Welsh population. Services are structured through the directorates below:

- Cardiothoracic Services
- Critical Care
- Major Trauma
- Haematology & Clinical Immunology
- Nephrology & Transplant
- Neurosciences
- Artificial Limb & Appliance Service (ALAS)

The Supportive Care Service which consists of a palliative care consultant and clinical nurse specialists also sits within SpS, the model having been developed within cardiology. It has now expanded to support renal, hepatology and also respiratory services having received funding from Welsh Government through Value Based Health Care. Currently the Supportive Care Service sits outside of a defined directorate.

The CB developed and has governance responsibility and oversight of the Integrated Assessment and Care Unit (IACU), which opened in October 2022. This area is currently running at 60 beds within the Lakeside Wing Building. This model is under review as part of ongoing planning work and the Bed Closure Programme within the UHB.

This report provides assurance of the progress being made within the SpS CB with regard to:

- The Welsh Government Quality Delivery Plan for the NHS in Wales
- The CBs operational plan and IMTP
- Leadership and the prioritisation of the QPSE agenda within an open culture
- Ongoing review, monitoring and management of risk
- Infection, Prevention and Control Annual work programme
- Health and Care Standards
- Financial and information governance
- Organisational development and workforce planning
- Patient safety culture
- Quality governance arrangements
- Promoting a positive culture for staff engagement, development and the understanding of everyone's responsibility for safe, quality care
- National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)

Safe Care

The CB has an agreed agenda and comprehensive work plan for the next 12 months. The plan includes monitoring service delivery against required standards, monitoring and managing risks through the e-Datix reporting system and the risk register.

Assurance is received via the robust mechanisms which are in place such as the UHB's internal audit processes, use of AMaT, the nursing specific dashboards and also through the SpS CB Quality, Safety and Experience (QSE) Committee and formal business meetings.

AMaT allows all of the learnings from investigations and clinical audits to be stored securely in one place and can be accessed to give assurances and demonstrate service improvement. The QSE Committee and formal business meetings have strong multidisciplinary representation and are fully minuted. The nursing dashboards used across the organisation have also been strongly adopted within SpS and are discussed in more detail further on in this report.

The QSE Committee is a formal and well-established group that meets every 3 weeks. It is co-chaired by the Medical Lead for Quality and Safety, Mat Davies who is a Consultant Nephrologist and the interim Director of Nursing (DON) for Specialist Services, Catherine Twamley. There is good engagement from core teams that span across all of the directorates to include the Infection, Prevention and Control Team, the Health and Safety Team, the Pharmacy Team, Resuscitation Services and the Patient Safety Team who are regular contributors to the agenda. The CB is also fortunate to have a Band 7 QSE Facilitator in post, Tracey Vine.

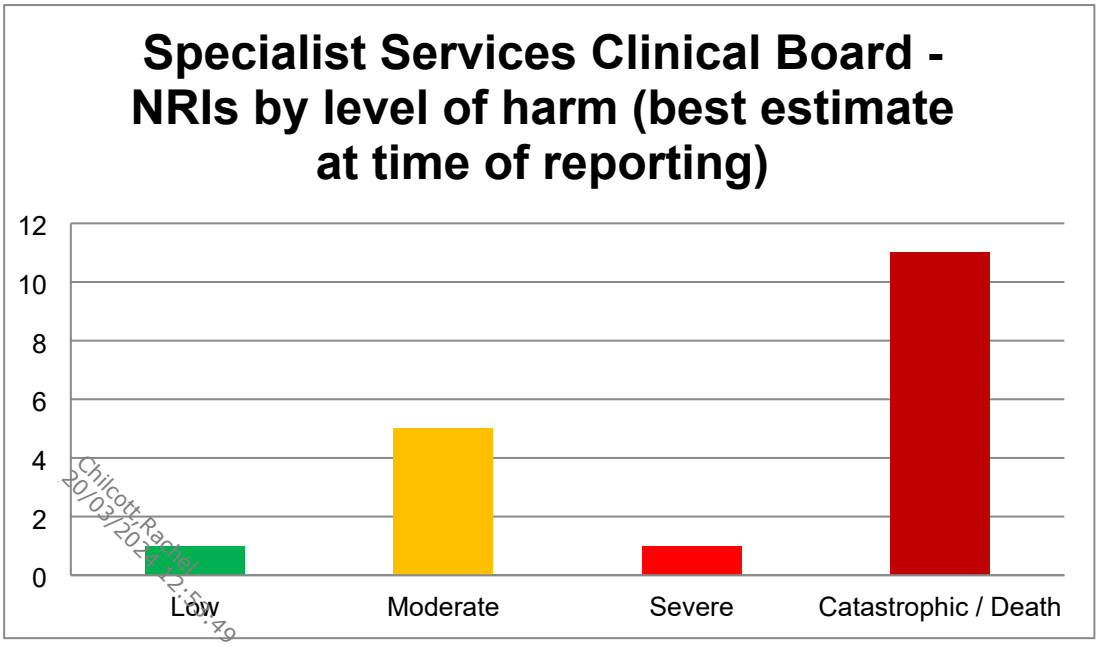
In addition to the frequency with which they are convened, these meetings are now rotated between days and times so that clinicians with fixed clinical commitments have the opportunity to attend the meetings and contribute to the safety culture within the CB. This also allows for the general optimisation of attendance. The agenda has been refocused to allow each directorate to share their escalations, quality improvements and wellbeing initiatives alongside items for discussion and escalation at a UHB level. The aim of the focused agendas is to allow directorates the space to align their risk register with escalations and initiatives that bring together a rounded view of each directorate, rather than just discussing the immediate priority of the day which has been the focus historically. This structure is replicated in each of the clinical directorates.

Health and safety is incorporated into the QSE meeting with this being the focus of every third meeting. Other key attendees include the fire advisor and other individuals and / or departments, for example the Estates Team, are also invited as indicated.

SpS CB also have an Infection, Prevention and Control (IP&C) Group that meets bi-monthly and reports into QSE. The IP&C Group has its own formal terms of reference and is minuted with a range of stakeholders who attend to ensure that there is wide engagement in the overarching quality and safety agenda. The aim of this approach is to draw themes and learning opportunities together so that actions, learning and service developments can be shared collaboratively.

NRI (National Reportable Incident) Management

During 2023, 18 Nationally Reportable Incidents (NRIs) were reported to the NHS Executive within SpS CB. As the chart below demonstrates, most incidents were reported due to an outcome of catastrophic harm/death. There has been 1 Never Event, a wrongly sited nasogastric tube. This was reported as a low harm incident.



The CB started 2023 with 10 open NRIs. In August 2023, as the result of a good closure profile, we were in a good position with only 4 open NRIs progressing. At the end of 2023, there were 9 NRIs open again and 2 of these were overdue with the NHS Executive.

The main themes have been pressure damage (x5), IP&C (x4) and assessment, investigation and diagnosis (x4). The others have been unrelated incidents.

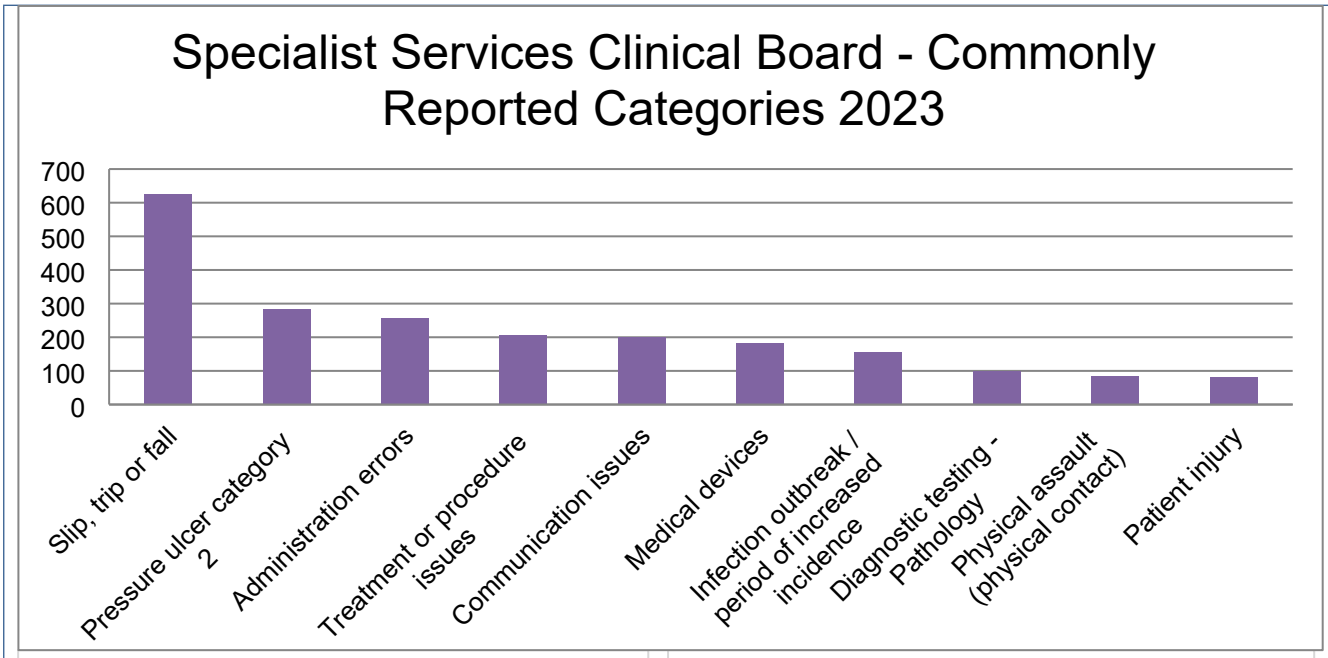
At time of writing this report, the CB has 10 NRIs open with 5 overdue:

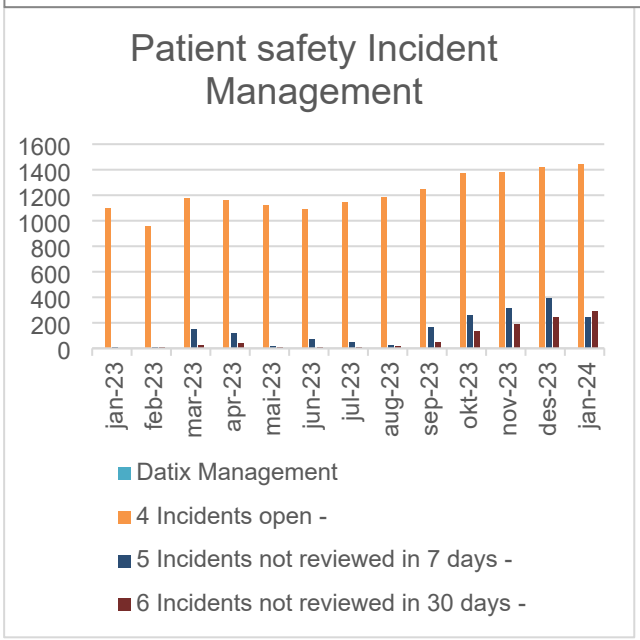
- There are 2 incidents open which are directly linked with review by the Cardiology Team and acceptance of patients within the Emergency Unit (EU) and Acute Medicine Directorate
- There were 4 NRIs were reported due to having healthcare acquired infections (HCAIs) present on their medical certificate of cause of death. New advice from the NHS executive has requested that these incidents be reviewed to ascertain whether the HCAI was avoidable before reporting. The NRIs that were reported before this advice, are under review and will be scrutinised with IP&C and microbiology to come to a decision for closure
- A patient lost to aneurysm surveillance within Neurosurgery in 2017, who sadly died in Cwm Taf Morgannwg UHB due to the aneurysm rupturing, accounts for another NRI
- There is 1 NRI reviewing a patient who presented in EU with chest pain, raised blood markers for a myocardial infarction (MI) and a raised marker for pulmonary embolism (PE). The patient was treated for an MI successfully but died following discharge. The post-mortem reported the patient died from a PE
- There is 1 NRI that was reported as a patient who contracted cryptococcal meningitis was not treated until they were hospitalised because the positive result had been lost within the system. This is a joint investigation with Public Health Wales
- The most recent NRI was reported as a near-miss incident. The patient suffered an emergency within Haematology Day unit and was at risk of cardiac arrest due to unclear escalation procedures within the area

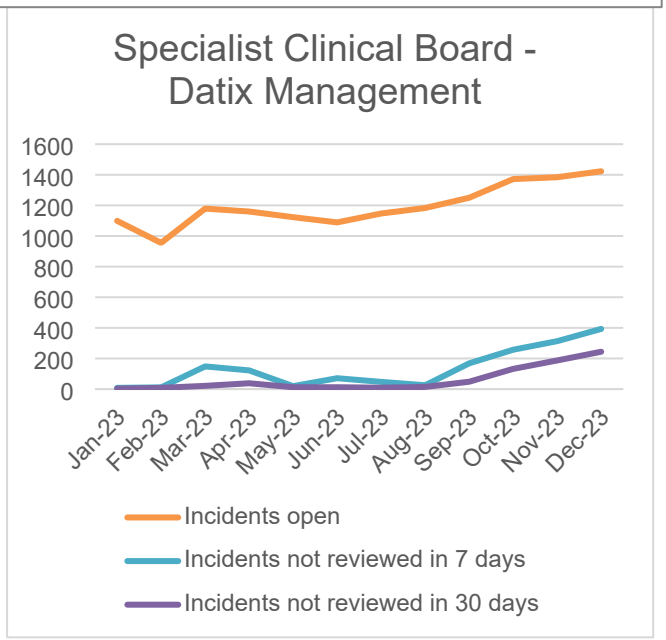
The CB has a robust review of all NRI's through initial fact-finding meetings, with subsequent progress meetings, followed by a closure and action planning meeting. The CB also has post closure meetings at regular intervals to ensure actions are completed and also embedded in clinical practice to provide further reassurance. Each report is presented at the SpS QSE Committee and shared more widely as appropriate. We are committed to ensuring that NRIs are closed within timescales set by NHS Wales Delivery Unit to ensure patients and their families receive feedback in a timely manner.

In October 2023 the Clinical Board Q&S facilitator reduced their hours to part time prior to retiring. Due to unforeseen circumstances, the CB was without a QSE facilitator for the months of December 2023, January 2023 and up until February 26th 2024. This evidentially did have an impact that the team are now working hard to resolve as a priority.

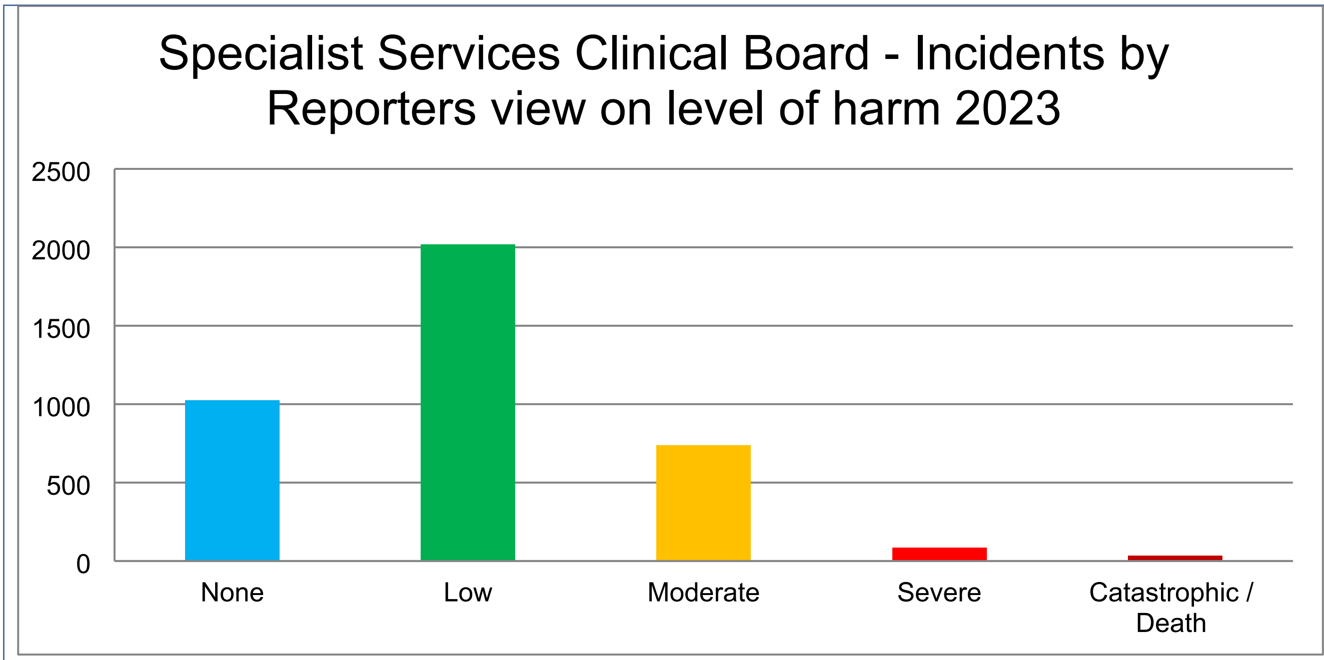
Datix/ Patient Safety Incident Management







In January 2024 there were 1447 Datix open, 247 had not been reviewed in 7 days and 289 not reviewed in 30 days.



The CB demonstrates an open reporting culture with high numbers of incidents reported. Fortunately, the majority result in no or minor harm with less than 1000 incidents being reported as moderate. The challenges for timely closure are acknowledged, those deemed severe or catastrophic harm are the primary focus however. Since 1st April 2023, all 'no harm – moderate incidents' are under review by the Duty of Candour Team to review levels of harm, whereas all severe and catastrophic incidents are reviewed by the Patient Safety Team. Of 83 'severe incidents' and 32 'catastrophic incidents' reported, only 1 and 11 incidents met the criteria for harm respectively and were therefore reported as NRIs.

The period of time with reduced Q&S facilitator hours and subsequently nobody in post has also had an impact on Datix queues and is likely to have contributed to the incline of incidents unmanaged. One of the key priorities for the new DON and Q&S facilitator is to review designated Super Users across all directorates, provide Datix clinics and bespoke individual support to those managers with significant queues.

Critical Care is the highest Datix reporting area and historically Critical Care was a hot spot for Datix reports that were not opened and reviewed in a timely manner. In June 2022 therefore, a new quality and safety (Q&S) lead role was piloted in Critical Care. This led to a number of initiatives being implemented that have continued, been embedded and developed over the last year. These include:

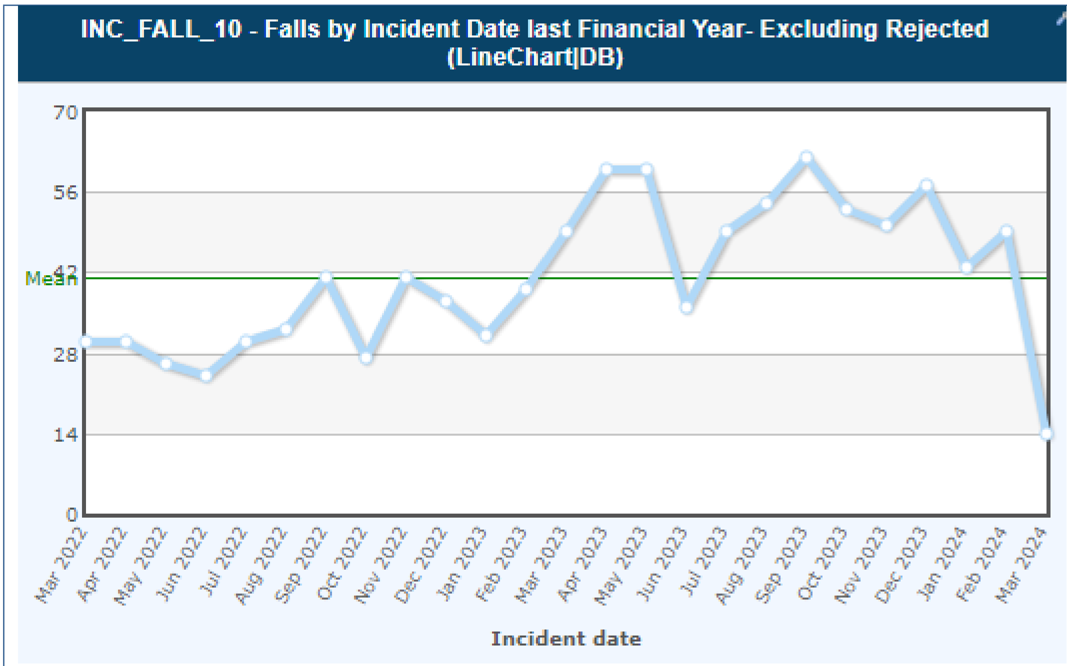
- Collaborative working on QSE issues between nursing and medical staff
- 'Topic of the Month' shared throughout the MDT and driven by Datix reporting
- Medical and nursing safety briefing informed by the latest reported clinical risk incidents
- Improved QSE meetings with an increased attendance due to greater accessibility for the wider team
- An increase of 20 audit champions identified who attend the directorate QSE meeting
- Part time Band 6 quality & safety role created to support Datix administration
- A monthly Quality & Safety Newsletter
- Reduced incidence of avoidable pressure damage and an established accessible process for reporting
- Patient mattress upgrades
- The Q&S lead attends the daily Huddle Meeting to ensure any quality and/ or safety issues are identified and actioned promptly and that awareness is immediately disseminated to the clinical area
- New Medication error flowchart embedded in practice

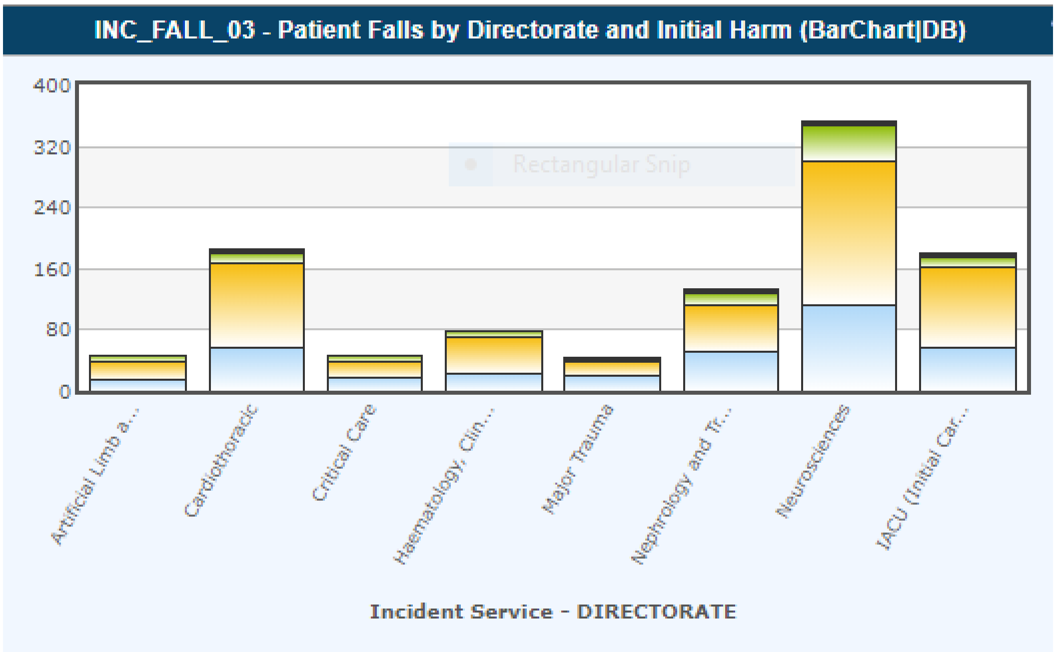
- A follow up ‘Contributory Factors Workshop’ took place that was attended by all senior nursing staff. This identified themes emerging from incident data and provided feedback to the directorate team. This has been accepted for the ‘Spread and Scale’ academy in March 2024.
- Change & Innovation Band 5 link roles created
- Team Training Days include training on quality, safety and incident reporting processes
- Unit Coordinator Training now includes training on Quality & Safety and incident reporting processes
- Pressure damage and IP&C white boards created in Operational Hub
- Manual Handling Training Days completed
- Bariatric patient manual handling equipment upgraded
- New patient bed introduced with side tilt capability to support care of bariatric patients
- Q&S lead informs clinical psychologist of potentially distressing incidents so that staff can receive support in a timely fashion
- Electronic noticeboards introduced to improve information sharing with the wider team.
- The Datix management structure has been expanded to ensure full MDT participation and engagement.
- Launch of a change strategy for critical care, working with the shaping change team to create a process for change that includes a proposal form, utilising the QSE meeting for discussion/trouble shooting, listening to feedback and including all stakeholders. This is part of a 2-5-year plan for structured change aligned to quality improvement projects, and clinical incident reports/adverse events
- Piloting the UHB’s ‘Glove off’ campaign in collaboration with the Intensive Care Society

The improved safety culture has empowered a good reporting culture, the timely management of clinical incidents, feedback to close the loop and used as a driver for change, whilst aligned with our quality improvement strategy. The feedback from the staff is that they feel safe in work, have a voice, are listened to and empowered to take forward change initiatives that are focused on improving patient and staff safety and well-being.

Falls

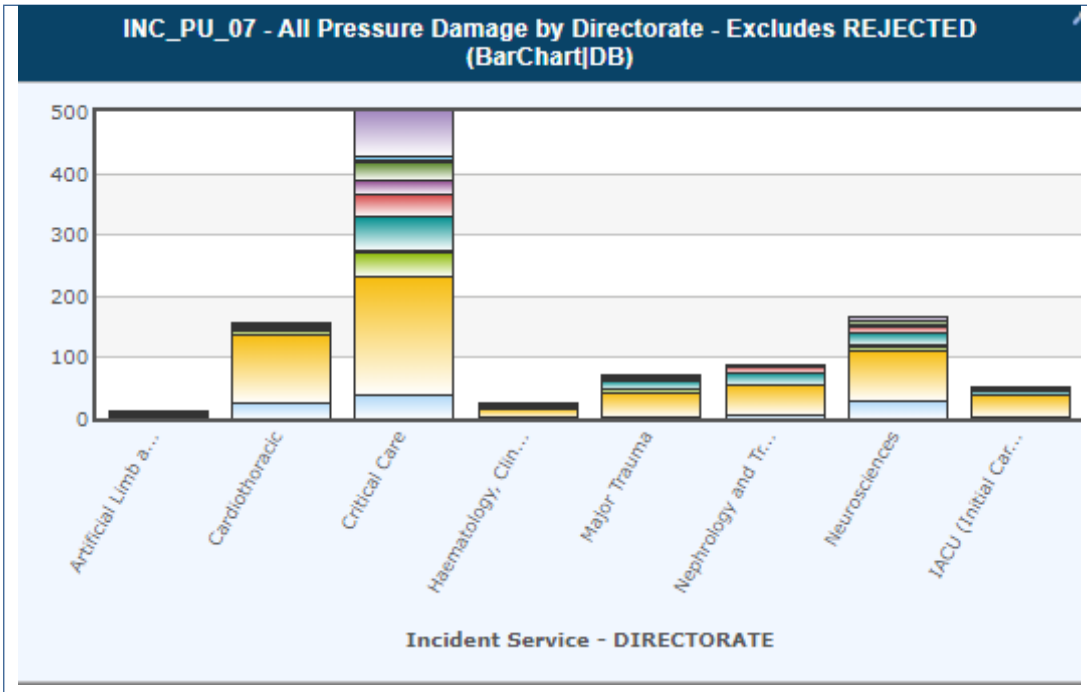
Falls are the most reported incident within SpS CB and as the graph below demonstrates, there has been a notable increase in numbers. At the end of 2022, going into 2023, when an increase was previously seen, falls education and awareness work was undertaken. This may have had an impact on the reporting culture and subsequent higher numbers. To note however, no injurious fall was deemed to have caused severe harm and no fall has been NRI reportable since Dec 2022. Significantly more falls are reported within the Neurosciences Directorate than within any other area. It is likely that their patient cohort and staffing challenges are a contributary factor and a meeting is to be convened to assess whether a review of this area is indicated.





Pressure and Tissue Damage, Reduction and Prevention

The work previously undertaken in Critical Care and driven by their Q&S lead, led to a decrease in Category 3 (full thickness skin loss) pressure damage, as detailed in last year's assurance report, which has been maintained. SpS CB have therefore subsequently developed their own Pressure Damage Group over the last year which is a spread and scale version of this to reduce avoidable damage through shared learning. This includes a pressure damage scrutiny panel led by the Critical Care Team with a quorum to include a tissue viability nurse, a representative from the Patient Safety Team, a senior nurse and the Q&S lead for Critical care. At this, a focused review is presented for the panel to scrutinise to establish if the incident was avoidable or unavoidable. This informs the Datix, timely follow on process and provides shared learning for the directorates and CB. The data would suggest that device related pressure damage is notable within the SpS and this is therefore an item to be added to the next agenda for discussion.



Safeguarding

The CB currently has 39 safeguarding referrals open, 13 of these relate to pressure damage. Many of these, 18 to include 10 in relation to pressure damage, are actually historical (open over a year). The plan to tackle this is to implement Safeguarding Review Clinics led by a safeguarding representative and the DON to discuss any open issues, prevention of closure and promote learning from referrals. Safeguarding is a standing item on the QSE Committee agenda but a focus will be dedicated to this during the next meeting at regular intervals in 2024.

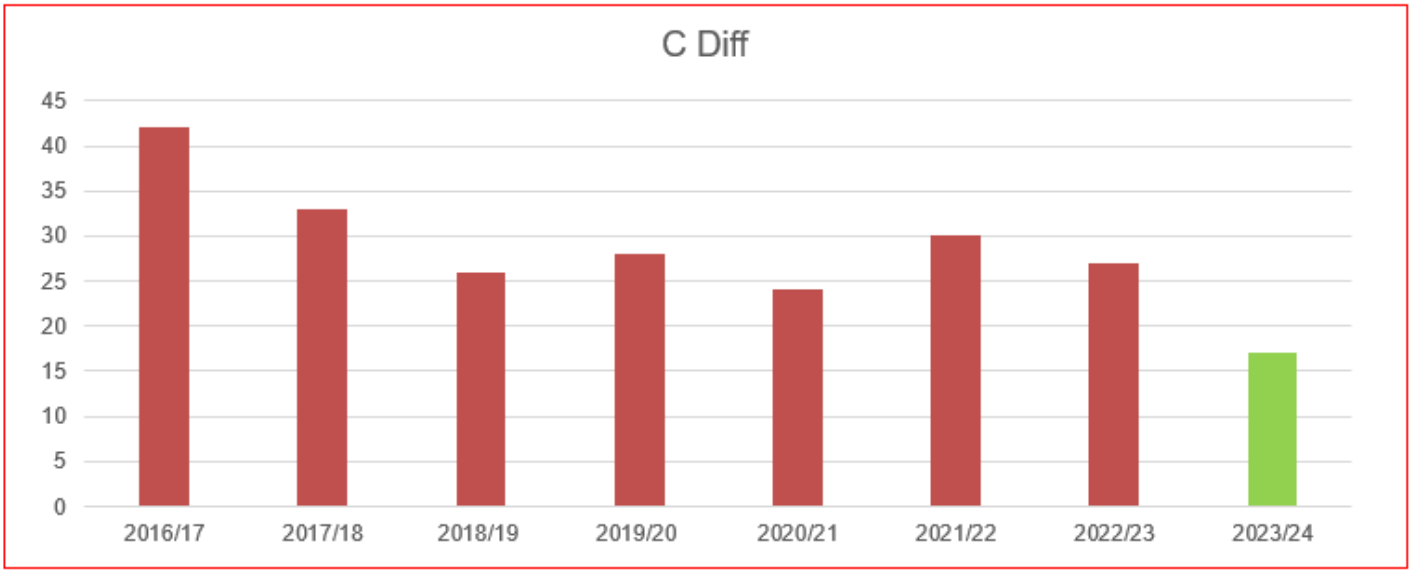
Safeguarding investigations are led by health lead professionals with appropriate actions taken. Critical Care are a high reporting area. SpS CB have good mandatory safeguarding training (79.75%) and domestic abuse training (70.46%) compliance.

Infection, Prevention and Control (IP&C)

SpS CB are fully engaged with the expected reduction figures for all healthcare acquired infections and the associated challenges. Environmental, hand hygiene and bare below the elbow audits, in addition to IP&C audits on Tendable, are undertaken monthly to ensure standards are maintained. The CB has also reintroduced an IP&C Group over the last year that meets bi-monthly. The purpose of these meetings is to drive forward the UHB IP&C agenda with multidisciplinary input and assign specific responsibilities. This relaunched group has a different emphasis to previously with each directorate presenting a patient story, IP&C initiative or any IP&C related shared learning. The group then determines actions for improvement to improve outcomes. Presentations over the last 6 months have included an overview from the Critical Care IP&C Group, a C. Difficile case presentation from a ward manger and a case presentation on Community MRSA screening by Dr. Mat Davies (Consultant in Nephrology and Transplant and QSE Lead for Specialist Services).

Clostridium Difficile

The reduction expectation for 2023/24 is set at 22 cases. To date SpS CB have had 17 cases and is therefore on target to meet the reduction expectation. This equates to a 37% less than the equivalent period in 2022/23. This improvement is possibly a reflection of isolating patients at the earliest opportunity, improved antimicrobial stewardship and discontinuation of PPIs.



E Coli

The CB have had 39 cases which equates to 22% more than the equivalent period in 2022/2023 and a 22% increase. Discussion with IP&C has not identified a theme.

Pseudomonas

To date there have been 4 cases which equates to 43% less than the equivalent period in 2022/23 with 3 cases less in Critical Care.

Klebsiella

The CB have had 24 cases which equates to 20% more than the equivalent period in 2022/2023.

In 2020 an outbreak of Multi Drug Resistant Klebsiella started in the Spinal Rehabilitation Centre originally based in Rookwood Hospital and then moved to a new facility in UHL. A total of 41 cases were reported and 35 of those were within the main outbreak strain. Infection rates were high however disease severity was low. Given the nature of the unit, the time scale of the outbreak along with a slow reduction in cases, the outbreak was only officially closed in August 2023. There is an exit strategy and screening programme in place alongside the clinical staff remaining alert to any potential new cases.

MRSA

The CB have had 4 cases of MRSA to date for the 2023/2024 period, which is an increase in comparison to the previous year. This picture is aligned with the trend across all health boards.

MSSA

The CB have experienced an increase in cases compared with 2022/2023 with 37 cases. Again, this trend is not just within SpS CB.

MRSA and MSSA

The Nephrology and Transplant Directorate have been a hot spot that has primarily accounted for this with a spike in line infections in regional dialysis units. In April 2023 it was noted that there had been 21 bacteremias compared with 9 over the same period in 2022, 18 of those were associated with intravascular devices. **Typing showed no evidence of transmission events**. Outbreak meetings took place and actions were drafted. All of the regional satellite dialysis units were also

visited by the IP&C team and audited. These audits used a standardized tool and included a review of equipment, hand hygiene, bare below the elbow, bed and mattresses and environment as part of the below themes:

- General environment
- Clinical rooms and clean storage
- Bathrooms/ washrooms/ toilets
- Dirty utility
- Domestics' room

The audit results were generally positive but with some environmental issues that needed to be addressed. A root cause analysis investigation (RCA) was undertaken for each case with no themes identified. Actions taken included the addition of new line insertion bundles to Tendable, a refocus on ANTT compliance and IP&C to revise the RCA tool to capture specific information pertaining to renal patients.

Following this, no bacteremias were seen from august 2023 until December. Since December 2023 however there have been 3 incidents. A re-audit is therefore going to be conducted as per original plan.

In summary, the highest increase has been seen in MRSA and MSSA bacteremias; there were a total of 38 cases of which 22 were deemed line related. The CB are on target to meet the reduction expectations for Clostridium Difficile and Pseudomonas but not MRSA, MSSA, E Coli and Klebsiella.

Antimicrobial Stewardship

The Antimicrobial Stewardship Pharmacy Team provide quarterly reports that feed into the SpS CB QSE meetings, giving an insight into antimicrobial prescribing across our clinical areas. These reports are based on regular antimicrobial audits, and highlight areas demonstrating good compliance with the 'Start Smart Then Focus' principles, which are a marker of appropriate antimicrobial prescribing. There has been a general improvement in compliance across SpS CB. Areas for improvement have also been highlighted however, such as documentation of intended duration of treatment. An area for development currently being considered is the potential of an intravenous antibiotic to oral switch ward round.

Staffing

The digital platform SafeCare was initially implemented across SpS CB to acute inpatient ward areas (Section 25B wards under the Nurse Staffing Wales Act) during February 2023. The platform was introduced to provide live information regarding nurse staffing information in relation to patient acuity and meet the reporting requirements of the 2016 Act. Following the successful implementation across the 10 inpatient 25B wards, this rollout was quickly extended to other specialist units such as IACU and the Coronary Care Unit. Critical Care is now using SafeCare during the weekday and is working through how the platform can be used out of hours. Compliance across the 25B wards in Specialist Clinical Board is 88% and the infographic below provides greater detail of the SafeCare compliance together with information relating to the nurse staffing levels and patient acuity. Using this information within the dashboard; particularly the acuity data and professional judgment of the nursing team, has triggered conversations with the PolyTrauma Unit and their directorate management team around their nurse staffing establishments.

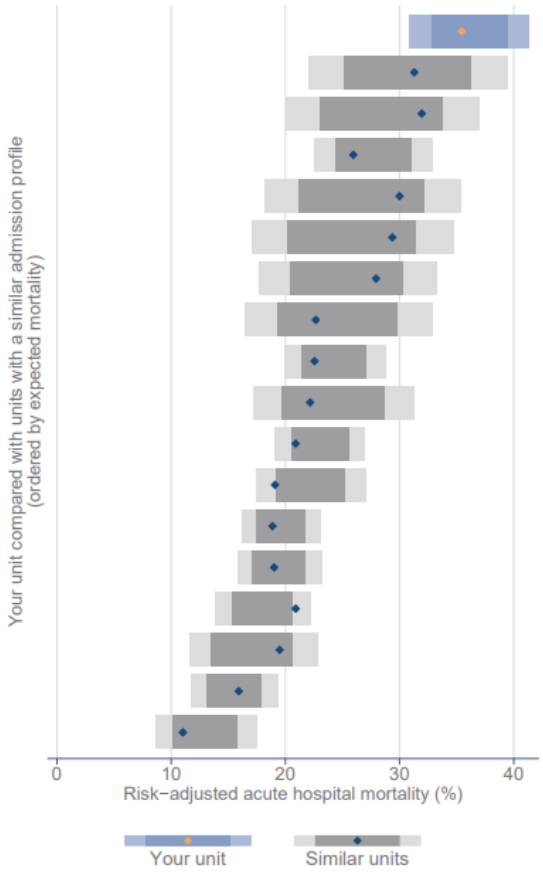
Mortality Reviews

The Intensive Care National Audit and Research Centre

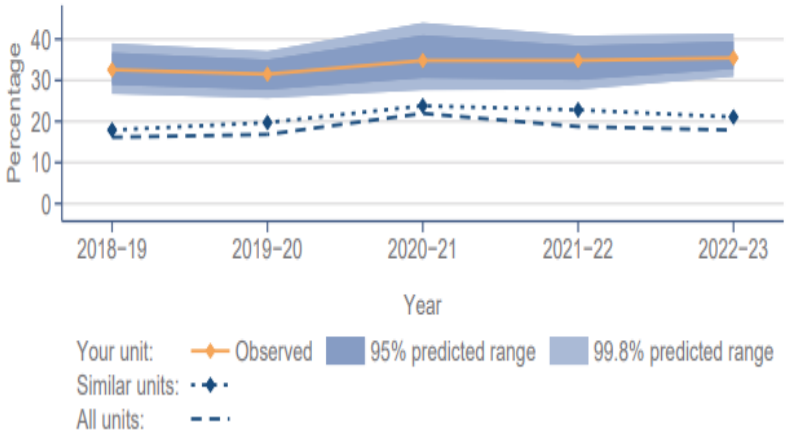
The Health Board participates in the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme (CMP), which audits patient outcomes from all adult general critical care units in Wales, England and Northern Ireland. ICNARC collects data from patients who are likely to become, currently are or are recovering from being critically ill. ICNARC supports clinicians to identify best care for patients by facilitating improvements in the structure, processes, outcomes and experiences of critical care. ICNARC data includes all patients that are admitted to critical care, to include their physiological score which predicts a risk of death, co-morbidities and diagnosis. Data is collected for the duration of length of stay and shared to organisations quarterly.

The mortality rate (35.4%) as illustrated by the orange dot illustrates an observed mortality rate above that of 15 similar units in the comparator group for the period April 2022- March 2023. The box plot however illustrates that the UHB mortality rates is in line or below the expected percentage of 36.2% and within the expected range of 32.8- 39.4%.

Variation in observed rates between originations can be accounted for by the differences in the case mix, acuity and morbidity of the patients compared for the UHB compared with critical care units in the comparator group.



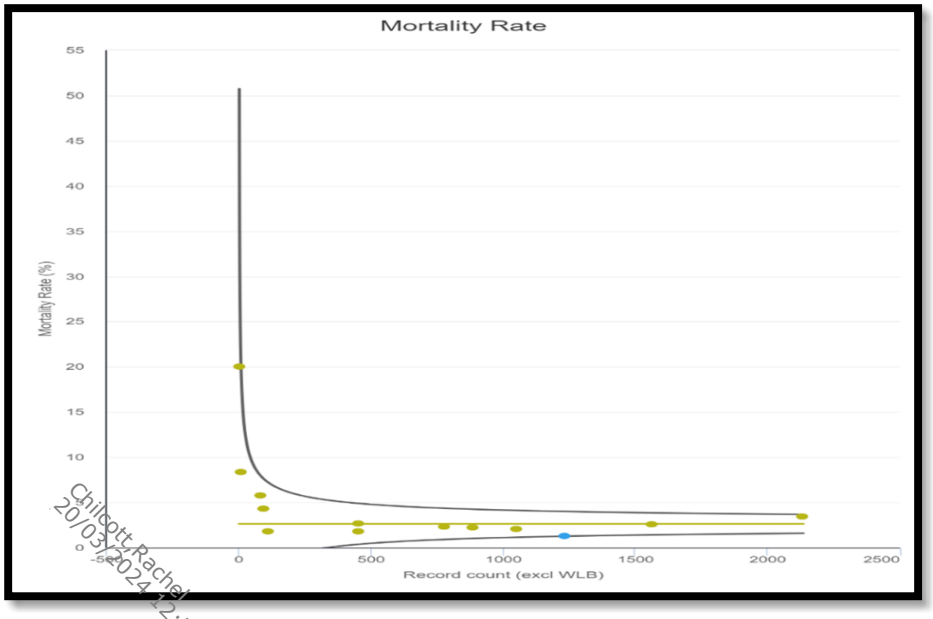
	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range
Quarter 1	274	257	35.8	36.8	(30.7, 42.5)	(27.4, 46.0)
Quarter 2	253	239	36.4	38.4	(32.0, 44.4)	(28.6, 48.0)
Quarter 3	322	274	31.8	34.5	(28.7, 40.0)	(25.6, 43.3)
Quarter 4	306	223	38.6	35.2	(28.7, 41.3)	(25.3, 45.0)
Full year	1155	993	35.4	36.2	(32.8, 39.4)	(30.9, 41.4)



Cardiothoracic Surgery

The UHB has access to and contributes data to the CHKS (provider of healthcare intelligence and quality improvement service) system. This allows mortality rates, among other data, to be benchmarked against comparable NHS health boards and trusts. Mortality rate data can be viewed at specialty level – funnel plots for cardiothoracic surgery and neurosurgery are shown below.

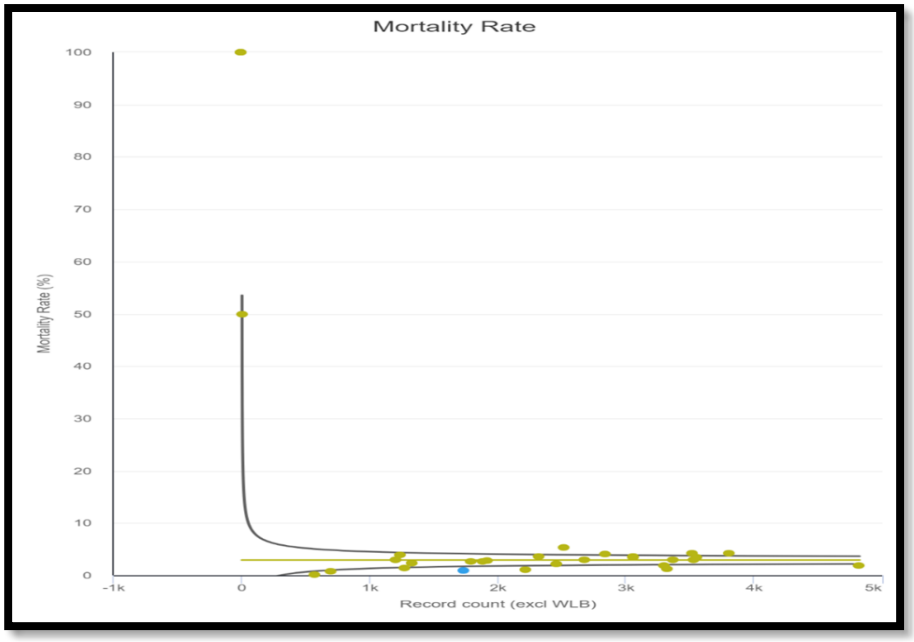
Cardiothoracic Surgery:



Data from Sep 22 – Aug 23, the most recently available peer group data.
● = Cardiff and Vale UHB, ● = Peer Health Board/Trust

The above plot shows that the mortality rate for cardiothoracic surgery is within the expected range for the number of cases undertaken and is lower than peer comparators with similar case numbers.

Neurosurgery



Data from Sep 22 – Aug 23, the most recently available peer group data.
● = Cardiff and Vale UHB, ● = Peer Health Board/Trust

The mortality rate for neurosurgery is lower than expected for the number of cases, indicating better than average performance among the peer comparison group for the reporting period September 2022 to August 2023.

Renal services

Data on renal services within the UK is collected by the UK Kidney Association. The most recent publication (2023) covers data from 2017-2020. Survival rates over 1-year for adult patients on Kidney Replacement Therapy (KRT) are shown below, with Cardiff and Vale UHB being within the 95% expected range for the number of KRT patients.

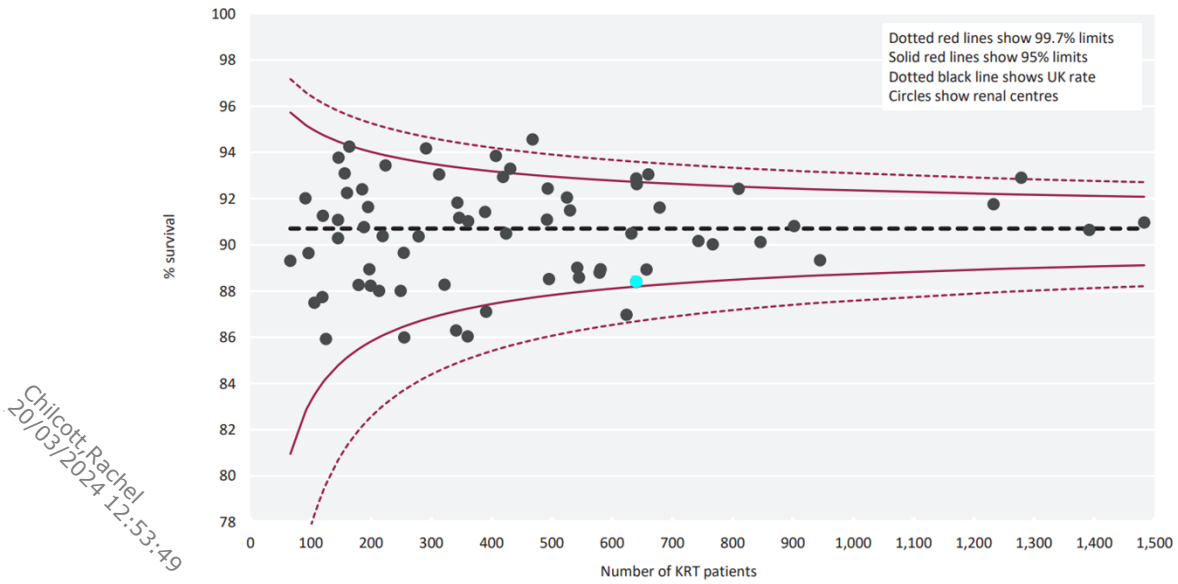


Figure 2.24 1 year after 90 days survival (adjusted to age 60 years) of incident adult KRT patients by centre (2017–2020 4 year cohort)

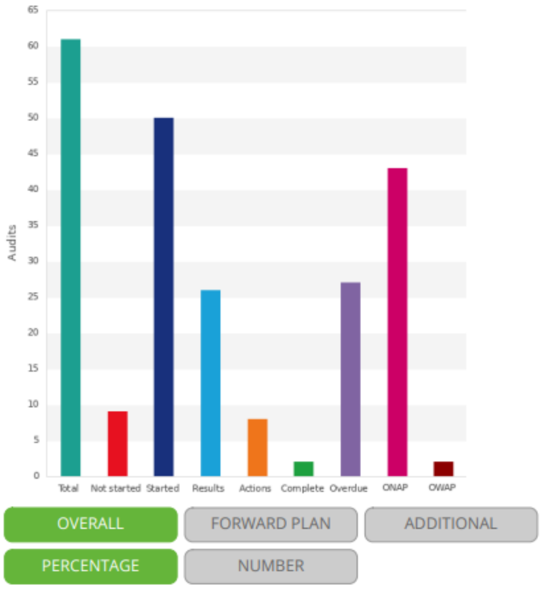
Mortality reviews are routinely undertaken as part of directorate QSPE meetings. Mortality level 2 reviews are undertaken through Mortality and Morbidity meetings and for a number of services, such as Major Trauma and Renal services, shared with the relevant networks and UK Renal Registry respectively.

The CB is fully engaged and working with independent medical examiner (ME) reviews. Our QSE consultant lead attends the UHB Mortality Group and Mortality Review Panel meetings which feed into our Clinical Board QSE Committee. Mortality indicators for SpS are currently being worked on with the ME recognizing the unique nature of a number of clinical areas.

National Audit

The Clinical Board have been driving the use of AM@T (Audit Management and Tracking) for audit, service evaluation and quality improvement. It is also used to store and monitor its improvement plans, for example relating to Healthcare Inspectorate wales (HIW), Community Health Council (CHC), Health Education and Improvement Wales HEIW visits and NRIs.

Clinical Project Activity



Total number of projects	61	100%
Total number of open projects	59	97%
Number of open projects with no results	33	56%
Number of open projects with results	26	44%
Number of open overdue projects (no action plans)	43	73%
Total number of active projects (with action plans)	6	10%
Number of active overdue projects (with action plans)	2	3%
Number of closed projects	2	3%
Number of abandoned projects	0	N/A

Forward Plan Year: 2023-2024 | **Division**: Specialist Services | **Speciality**: Artificial Limb and Appliance Service (archived), Cardiac Services, Critical Care, Nephrology, Bone Marrow Transplant, Haematology, Immunology & Metabolic Medicine, Neurosurgery, Neurology/Physiology/Spinal, Clinical Board - Specialist Services (for Meeting use Only), Posture & Mobility Service, Limb Prosthetics, Orthotics, Welsh Artificial Eye Service, Electronic Assistive Technologies, ALAS Directorate, ALAS General, Cardiology, Cardiac Physicology, Thoracic Surgery, Major Trauma, Transplant, Spinal Rehabilitation

National Audit of Adult Cardiac Surgery

The 2023 National Audit of Adult Cardiac surgery summary report contains data from the period 2020-2023 and includes 1397 Cardiff and Vale UHB submissions. EuroSCORE risk stratification figures consistently demonstrate that patients operated on at Cardiff and Vale are a higher risk cohort when compared to national averages. The UHB has continued to be well above average in terms of risk adjusted in-hospital survival rates. In addition, the UHB performed better than average in terms of mortality after elective and urgent coronary artery bypass graft (CABG) procedures recording no deaths during this three-year period. Re-opening rates following isolated CABG were significantly lower at Cardiff and Vale compared with the national average.

No CVA's (strokes) or TIA's (mini strokes) were recorded for this UHB following first time CABG. Post-operative complications after CABG were also lower than national averages. Waiting times for elective and urgent CABG procedures have reduced during the last three years, however, the waiting time is still above that recommended, however, this issue is not unique to Cardiff and Vale. A

current concern is service delivery is at serious risk in terms of significant numbers of cancellations due to infrastructure and resource issues to include theatre availability and capacity and that MDT time available is currently inadequate for the complexity of the service provided.

HIW

By speciality	In progress	Partially complete	Partially complete overdue	Overdue	Total	Awaiting approval	Rejected	Approved	Unable to complete	Total
Totals	0	0	4	2	6	3	0	59	0	68
Cardiac Services	0	0	4	0	4	3	0	43	0	50
Critical Care	0	0	0	0	0	0	0	2	0	2
Nephrology	0	0	0	2	2	0	0	14	0	16

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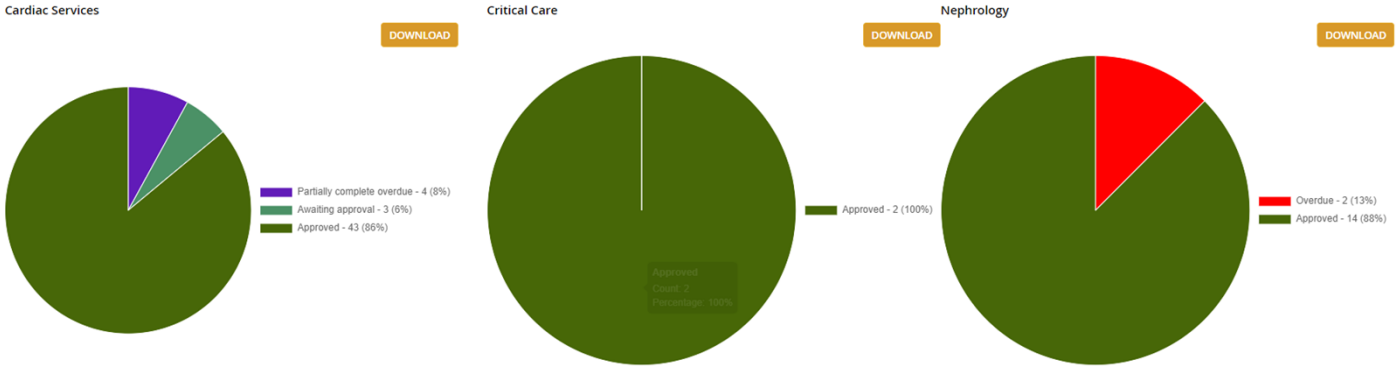
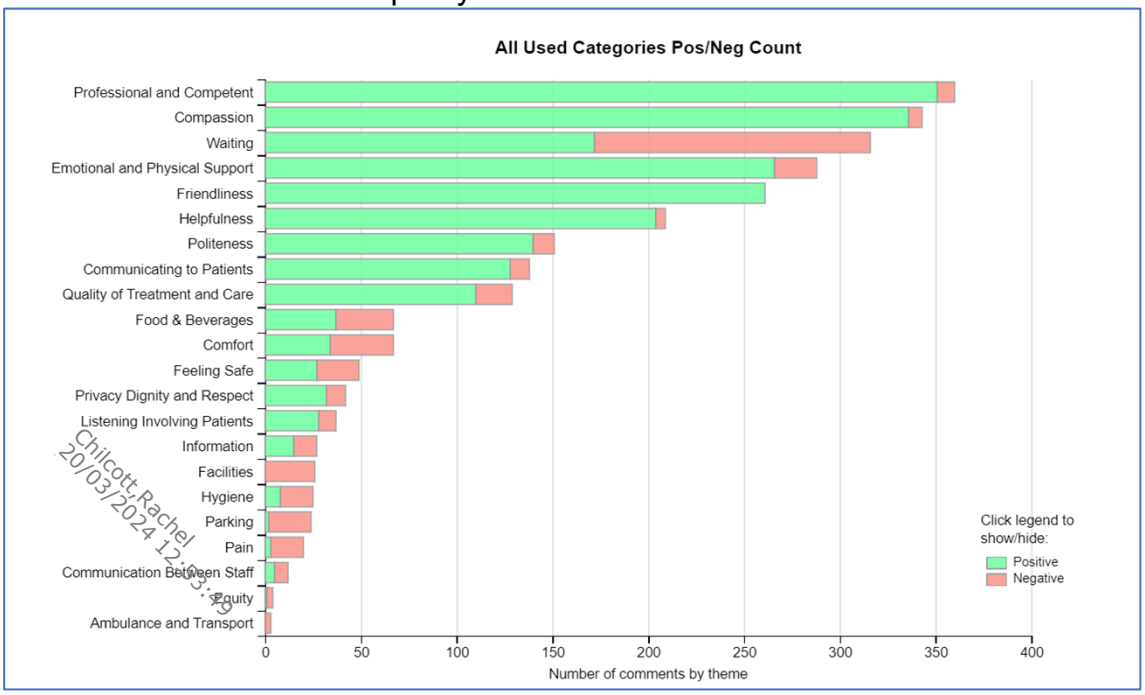
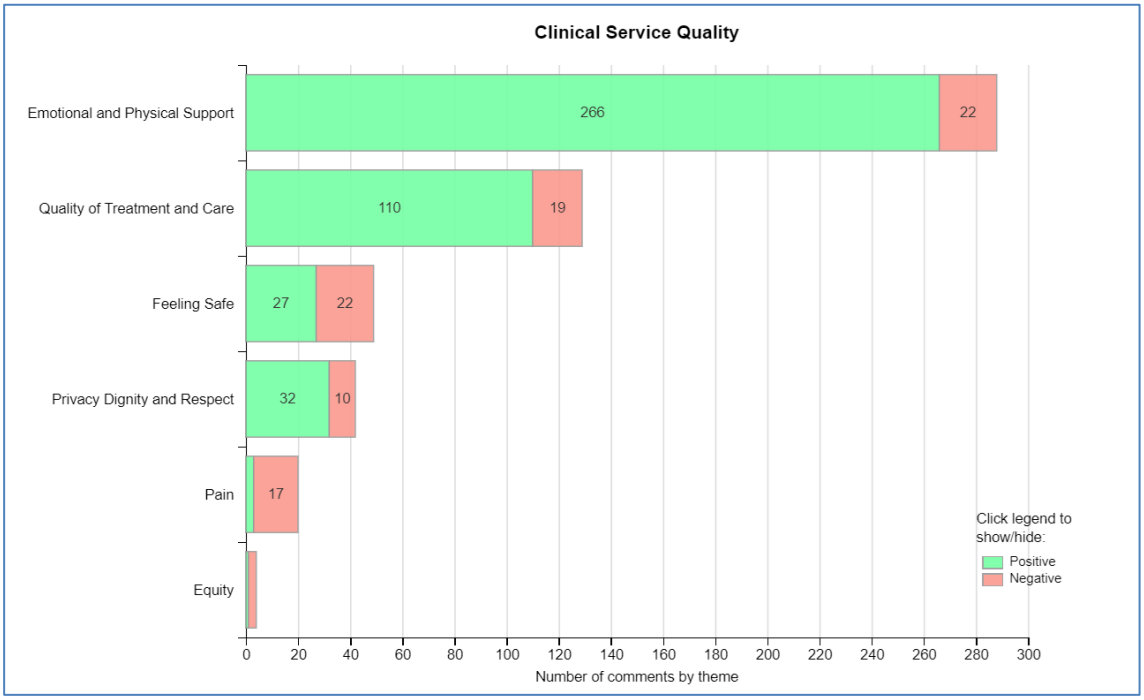


Patient Centred Care

Patient Experience

The graph below demonstrates comments by all themes from the Civica Once for Wales Patient Experience platform. Positive comments are shown in green and negative in red. The second table focuses on clinical service quality themes.

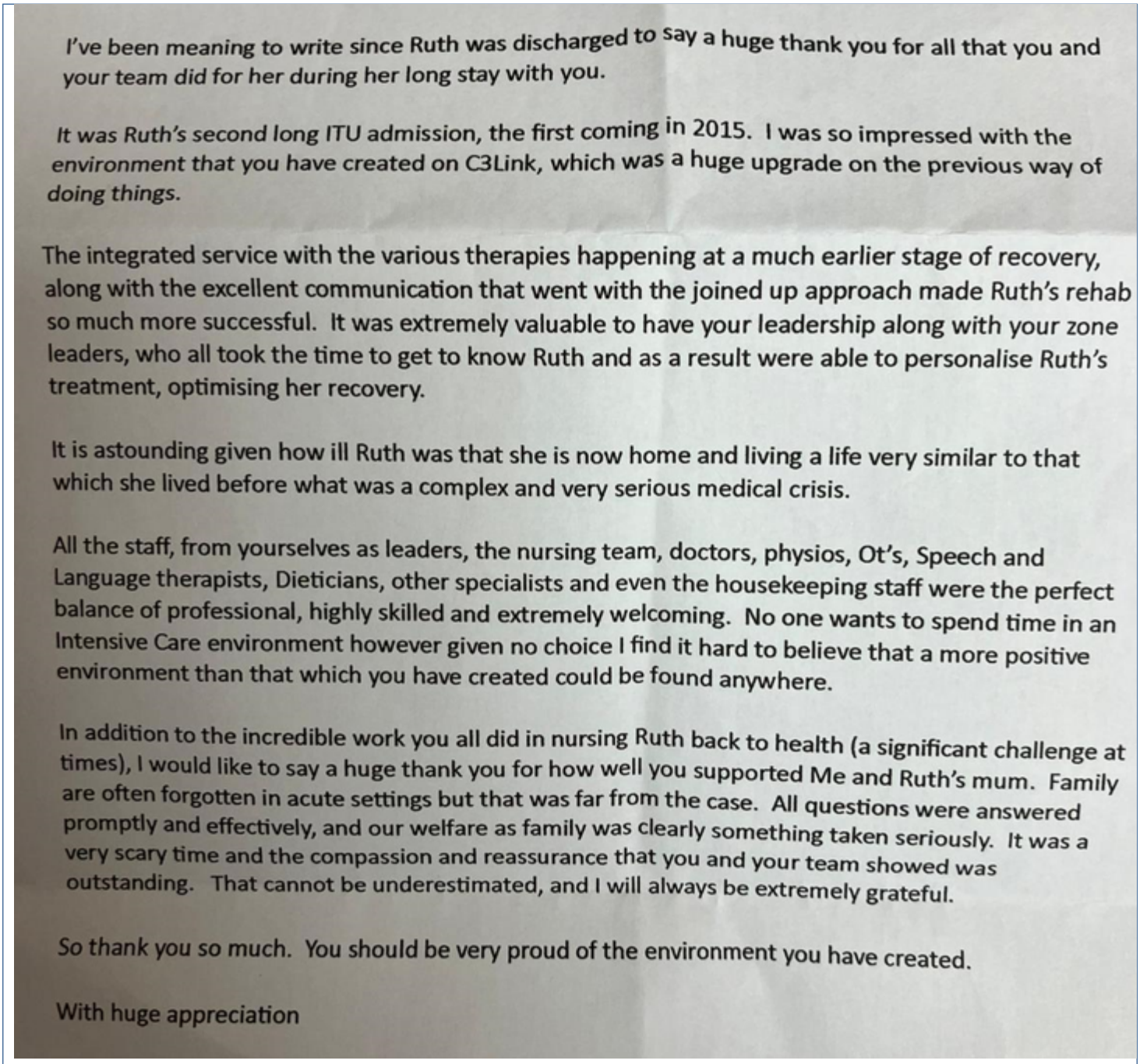




Compliments

A total of 29 formal compliments were received in 2023 to include:

- *"D received the very highest standard of care and consideration from every member of this most excellent ICU team. We as a family were supported in every way possible and we could not have asked for any more".*
- *"My grandson is under the care of the haemophilia department. I wish to highlight and praise the care the whole team have given and give his family. They are second to none for their compassion and professionalism. Over his 16 years N has received the best care possible from the whole team. He has had an injury and bleed this week. Again, we cannot fault the thorough and kind care he is receiving. Both their physical and psychological support is greatly appreciated. Please pass this onto to the health board CEO and the department. Thank you".*
- Most recent shared in 2024:



I've been meaning to write since Ruth was discharged to say a huge thank you for all that you and your team did for her during her long stay with you.

It was Ruth's second long ITU admission, the first coming in 2015. I was so impressed with the environment that you have created on C3Link, which was a huge upgrade on the previous way of doing things.

The integrated service with the various therapies happening at a much earlier stage of recovery, along with the excellent communication that went with the joined up approach made Ruth's rehab so much more successful. It was extremely valuable to have your leadership along with your zone leaders, who all took the time to get to know Ruth and as a result were able to personalise Ruth's treatment, optimising her recovery.

It is astounding given how ill Ruth was that she is now home and living a life very similar to that which she lived before what was a complex and very serious medical crisis.

All the staff, from yourselves as leaders, the nursing team, doctors, physios, Ot's, Speech and Language therapists, Dieticians, other specialists and even the housekeeping staff were the perfect balance of professional, highly skilled and extremely welcoming. No one wants to spend time in an Intensive Care environment however given no choice I find it hard to believe that a more positive environment than that which you have created could be found anywhere.

In addition to the incredible work you all did in nursing Ruth back to health (a significant challenge at times), I would like to say a huge thank you for how well you supported Me and Ruth's mum. Family are often forgotten in acute settings but that was far from the case. All questions were answered promptly and effectively, and our welfare as family was clearly something taken seriously. It was a very scary time and the compassion and reassurance that you and your team showed was outstanding. That cannot be underestimated, and I will always be extremely grateful.

So thank you so much. You should be very proud of the environment you have created.

With huge appreciation

Redress

There is 1 active case, a patient lost to follow up following incidental finding on CT scan.

Redress of £4000 has been offered and accepted for another case. The patient, under the care of Haemophilia Team, required dental treatment but there was a delay in referral. Unfortunately, the patient was left in severe pain whilst waiting for treatment.

Clinical Negligence

Neurosciences	**6**
Haematology	**3**
ALAS	**1**

Cardiothoracic	**4**
Critical Care	**3**
Major Trauma	**1**

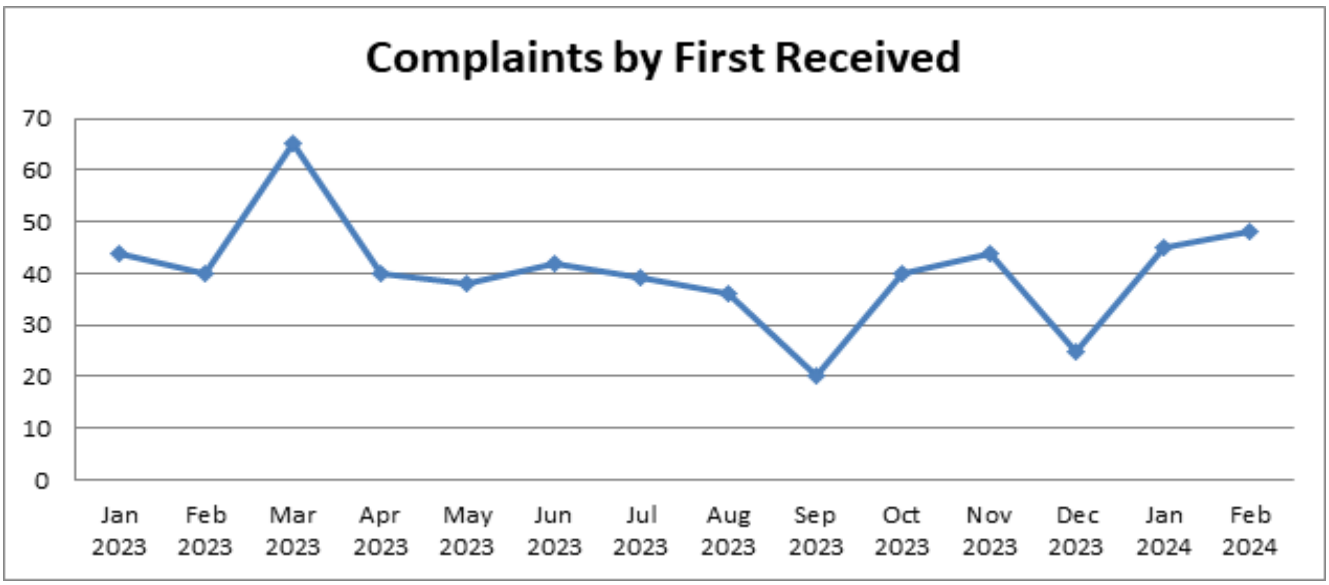
There are currently 50 active claims with 18 received in the last year as per above. The main themes relate to assessment, investigation and diagnosis.

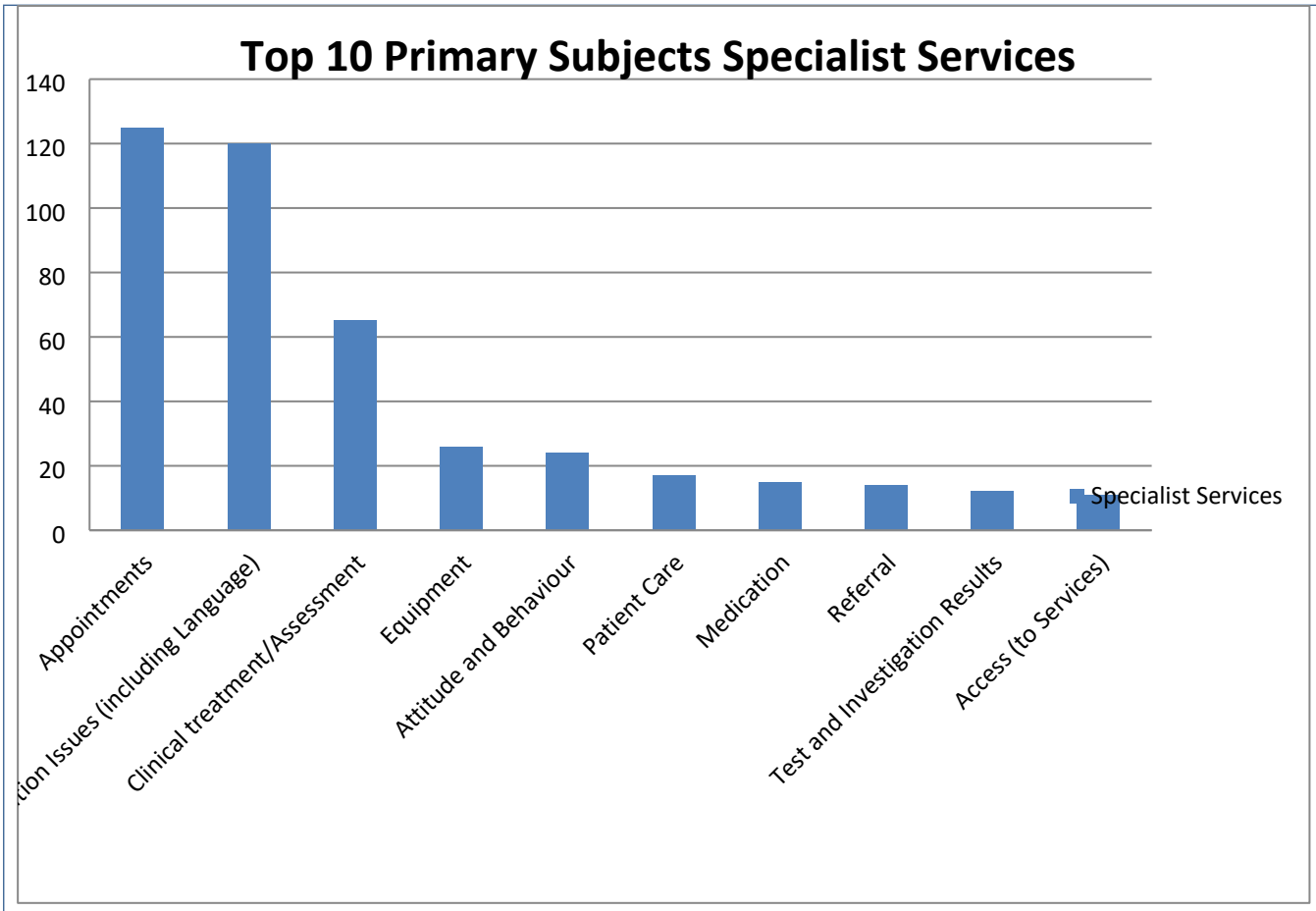
Inquests

SpS CB currently have 128 open inquests. It should be noted that the majority of open inquests recorded are for prognostication purposes. No themes and trends have been noted in relation to referrals to the coroner.

Concerns

The graph below details the number of concerns received each month over the last year.



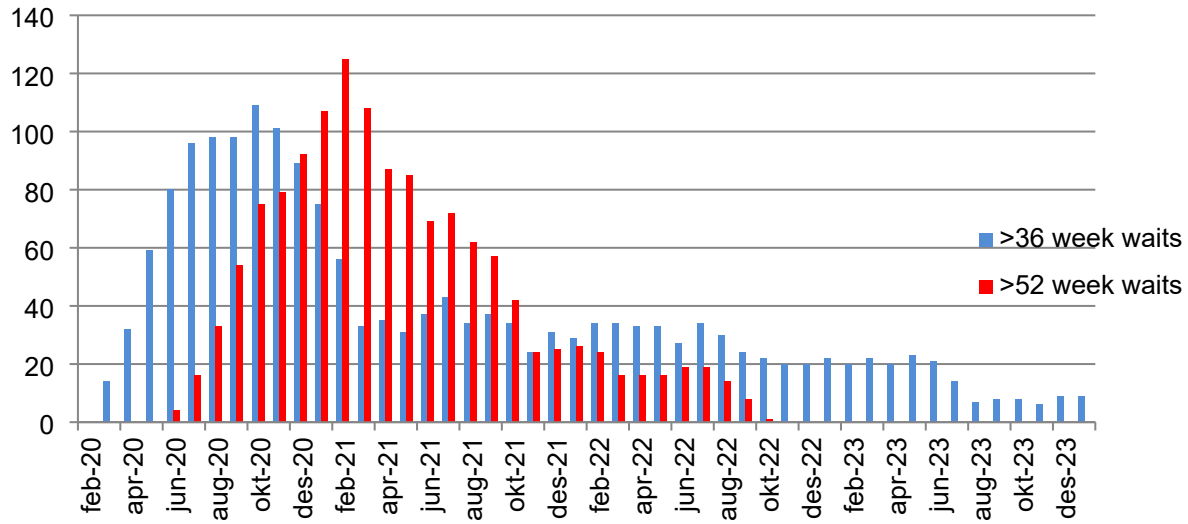


A key theme is appointment times, particularly in the Cardiac Services and Neurosurgery directorates.

For information, as per below, the cardiology outpatient waiting list is growing, as is length of wait, driven by switching off waiting list initiatives from November 203. The cardiothoracics inpatient waiting list is also growing slightly, driven by reduction in theatre activity secondary to workforce constraints and cardiac catheter laboratory activity

			2023/Apr	2023/May	2023/Jun	2023/Jul	2023/Aug	2023/Sep	2023/Oct	2023/Nov	2023/Dec	2024/Jan
CARDIAC SERVICE DIRECTORATE	3. Outpatient Waiting List	0-7 Weeks	1479	1373	1366	1440	1430	1342	1400	1282	1087	1304
		8-13 Weeks	774	846	816	739	812	785	746	768	723	730
		14-19 Weeks	523	690	702	725	750	714	743	676	699	661
		20-25 Weeks	340	221	347	350	436	490	422	611	589	583
		26-31 Weeks	83	117	75	84	99	91	80	160	385	511
		32-35 Weeks	15	10	21	18	11	24	24	13	17	157
		36-51 Weeks	9	8	6	6	17	9	8	12	12	14
		52-103 Weeks	2	2	2	0	0	0	0	1	0	2
		All Weeks Wait (Adjusted)	**3225**	**3267**	**3335**	**3362**	**3555**	**3455**	**3423**	**3523**	**3512**	**3962**
	4. Inpatient/Daycase Waiting List	0-7 Weeks	150	153	189	180	150	172	145	196	172	183
		8-13 Weeks	104	99	126	105	95	99	107	123	135	134
		14-19 Weeks	68	84	82	95	92	79	83	84	98	100
		20-25 Weeks	88	60	77	70	70	70	56	69	66	82
		26-31 Weeks	70	62	55	51	57	59	75	61	54	70
		32-35 Weeks	29	48	34	46	25	41	24	42	32	28
		36-51 Weeks	82	73	94	83	96	102	100	98	99	101
		52-103 Weeks	39	32	29	32	32	26	41	48	51	53
		104-155 Weeks	0	1	0	0	1	1	0	0	0	0
		All Weeks Wait (Adjusted)	**630**	**612**	**686**	**662**	**618**	**649**	**631**	**721**	**707**	**751**

In neurosurgery, the graph below clearly demonstrates the impact of COVID-19 resulting in extreme waits for neurosurgical intervention, at its height reporting 125 patients waiting over 1 year.



The service has implemented an improvement plan however and as a result there has been an 89% decrease in overall wait times over 36 weeks, across the neurosurgical inpatient waiting list.

It is also important to note that a high volume of these concerns received in relation to appointments are for routine appointments and the date received is within required timeframe but not deemed acceptable by patient.

The good news is that active concerns have dropped and performance improved in February 2024. These figures reflect a focus on concern management in 2024 to include drilling down the backlog and replacing generic concerns meetings with time slots for each directorate, with dedicated meetings and points of contact for each directorate.

No	Indicator	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Patient Experience																
7	Patient Satisfaction Score from any survey activity	**90%**	91%	91%	96%	93%	95%	93%	91%	94%	95%	92%	94%	94%	91%	
8	Active number of concerns	-	26	26	24	31	33	32	28	30	29	40	38	48	45	27
9	% formal complaints responded to within 30 days	**80%**	70%	77%	93%	80%	93%	75%	71%	96%	46%	70%	92%	81%	66%	76%

Safe, Timely, Effective, Efficient, Equitable and Person-Centred Care

This section of the report breaks down SpS CB into directorates and teams, detailing how each of them contribute to each of the 6 domains of quality.

Critical Care

Bed Expansion

The Intensive Care Unit (ICU) was funded for 31 beds and admits approximately 1,300 patients per year. Capacity often runs at over 100% which results in the service operating in a permanent state of escalation impacting on the team and services across the health board.

Following a successful phase 1 business case, investment was approved in Q2 2023/24 of an additional 3 beds which was a great start in closing the identified beds gap in C&VUHB secondary care provision. This prudent approach protected the 'dilution effect' on the workforce thus allowing us to retain current skill-mix and expertise. The service will continue with this incremental growth approach until we reach the required number of beds to maintain a safe and sustainable service.

Quality Improvement and Audit

The team have developed a strategy to learn from adverse event reporting via contributing factors and held a workshop for the 2nd year. There is a focus on multidisciplinary strategy methodology, promoting learning over a blame culture and using thematic analysis and staff experience to identify themes and improvements. As a result, multiple streams of improvement have developed to include:

- Working with microbiology to introduce rapid PCR for organism identification of positive blood cultures
- Introduction of neuron specific enolase with biochemistry
- Improving formal critical care communication, unit newsletter in trial stage
- Improving family feedback via family survey
- Improving handover documentation in response to adverse event
- Improving collection of pleural procedures and reporting of adverse events
- Initiate and maintain referrals database with focus on reporting delayed admissions via Datix
- Improving critical care IV access options and work with the Health Board IV access group to achieve vascular access clinic

Nurse Celebrations

It has been a year of high achievement for the nursing team. Amongst our many achievements, several of our internationally trained nurses have completed the 'Florence Nightingale Foundation, Developing the Leadership Potential for Internationally Educated Nurses' course. A number of nurses have also successfully completed the PG Certificate in Critical Care Nursing. A member of the team presented his poster at the Integrated Care Systems conference for work on driving pressures and another was runner up in the adult registered nurses' category at the RCN awards. There were 3 posters accepted for the HEIW Nursing conference. These were in relation to senior leadership in critical care, the Band 6 development programme and extending the system of staff support.

Patient at Risk Team (P@RT)

P@RT was set up in 2021 and has undertaken more than 10,000 ward reviews since its inception. Prior to P@RT, management of the deteriorating patient was delivered in a less structured way. P@RT offers support to ward teams by delivering hands on care to deteriorating patients when needed, providing bedside education, and in conjunction with the local clinical team will develop a robust, clinical management plan. This coproduction approach builds the skills and confidence of ward staff to deal with complexity; and has been particularly impactful in mitigating the risks associated with reduced ICU capacity. Staff satisfaction surveys have demonstrated excellent feedback.

P@RT support patient flow in and out of ICU. All ICU discharges are followed up by P@RT, which provides an additional tier of safety to these patients who are at higher risk of deterioration. Additionally, P@RT practitioners have a key role in supporting patients awaiting admission to ICU by providing enhanced monitoring and timely, specialised treatments that may be outside of the usual scope of practice of ward staff. It is important to note that the vast majority (>90%) of P@RT referrals do not require ICU admission, rather an enhanced level of clinical supervision and acute, specialised treatment facilitated by the P@RT. The team were finalists for this year's Health Service Journal Patient Safety Initiative Award for their work in redesigning outreach services.

In UHL P@RT has facilitated the continuation of specialised psychiatric care by the supervision and provision of treatment for nosocomial, medical complications in both Hafan-Y-Coed and the Mental Health Services for Older People wards. Prior to P@RT patients would have to be transferred to the emergency stream to safely meet their needs. P@RT also have had outstanding results and feedback for their provision of education around recognition and response to physical health in mental health services by providing study days to mental health trained professionals. This work aligns with the recommendations made in the Welsh Government Picture of Health document and supports the delivery of equitable care for all.

Following further investment, in October 2023, P@RT launched a 24/7 service across UHW & UHL, thus allowing all patients to receive timely, efficient and person-centered care regardless of the time of day or night.

Most recently P@RT have also expanded their remit to include 'Call 4 Concern', its response to national recommendations and Martha's Rule. This initiative offers a P@RT review to patients that have expressed concern either themselves or through relatives, that their clinical condition is deteriorating despite engagement from the ward team. The project went live on November 1st 2023 and was piloted on patients that have recently been discharged from ICU. Roll out across the UHW and UHL sites is currently being planned.

Major Trauma Centre (MTC)

Activity

The Major Trauma Centre (MTC) has seen 5709 patients from go-live up to the 14 February 2024. The Polytrauma Unit (PTU) has admitted/treated 1753 patients for the same period, breakdown by Health Board is below. Please note these are patients who were admitted to the PTU as their first destination.

UHB	Number of admissions
Aneurin Bevan UHB	324
Betsi Cadwallader	8
Cardiff & Vale UHB	593
Cwm Taf Morgannwg UHB	279
Hywel Dda UHB	209
Powys LHB	33
Swansea Bay UHB	145
Other	162

Overwhelmingly, a large majority of patients admitted to the MTC are subsequently discharged to their home/place of residence (61%), with approximately 27% repatriated back to their local health board/out of network. Whilst the MTC acknowledge the efforts made by neighbouring health boards in facilitating repatriations to support the flow of major trauma patients into the MTC, the South Wales Trauma Network (SWTN) data demonstrates that there has been a significant decline in adherence to the network repatriation policy which does pose a challenge currently.

The MTC continues to see a rising number of paediatric patients who require complex rehabilitation. The teams are continuing to develop the options appraisal for a specialist rehabilitation facility within the Children's Hospital for Wales. This is an ongoing piece of work with WHSSC. Scoping work has started alongside paediatric MTC's within National Health Service Executive to investigate the use of a standardised tool to assess the needs of a family, following admission to an MTC. Access to paediatric psychology remains a challenge.

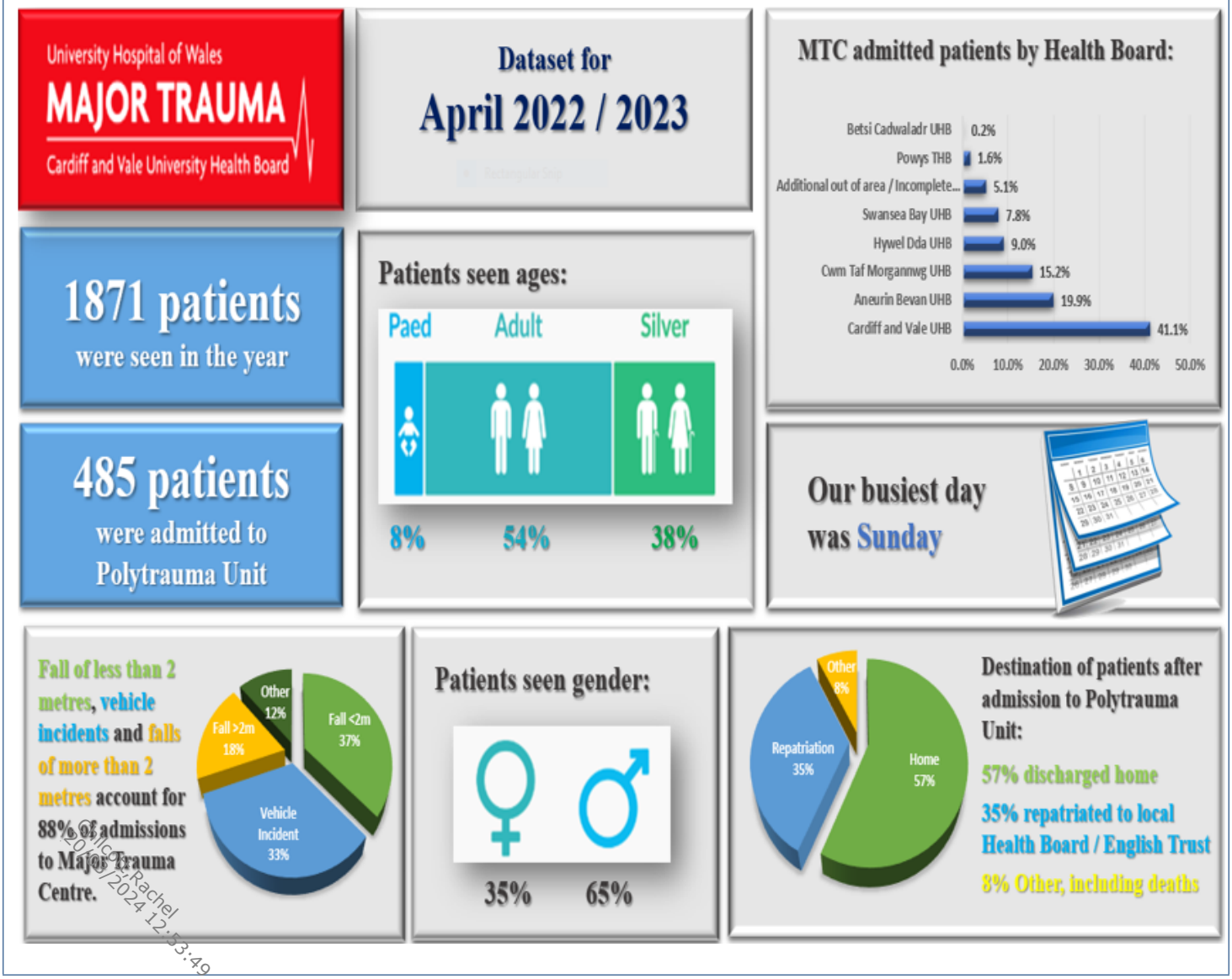
The MTC lead therapist is currently undertaking a project to improve the quality of rehabilitation prescriptions. The document has been tailored as an individualised patient-centric hand-held

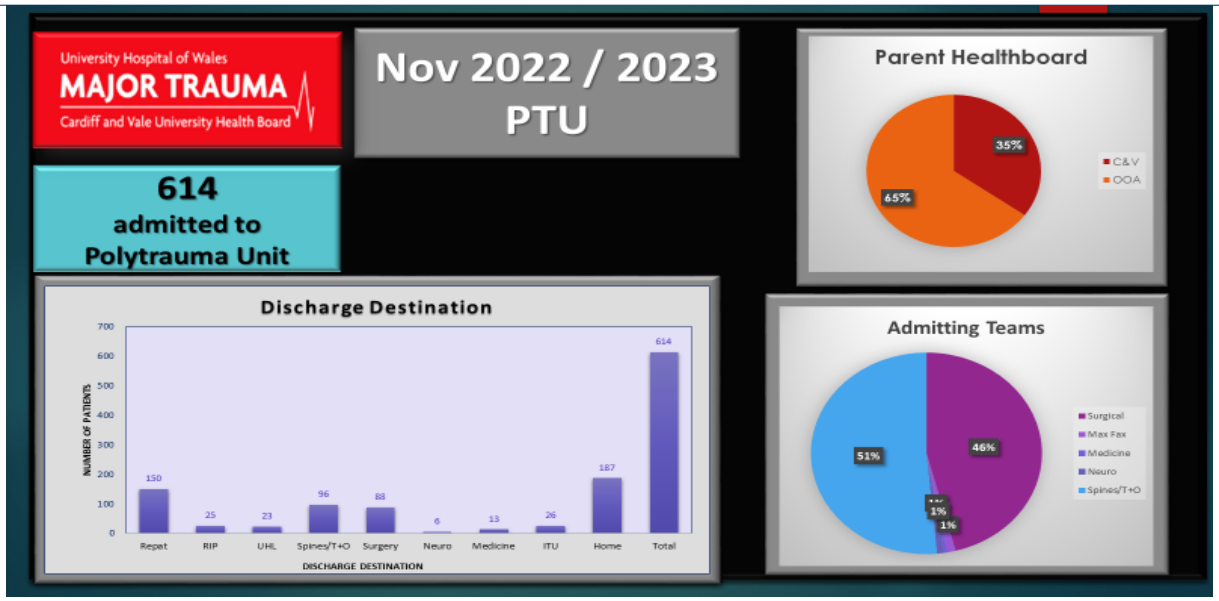
document is being provided to patients at the point of discharge or repatriation. There is a phased implementation plan to roll this out across the whole MTC pathway, starting with PTU.

As per the business case, National Major Trauma Quality Standards, NICE guideline on Major Trauma Service Delivery (NG40, February 2016) and the Peer Review recommendations, further work is required to progress the discussions surrounding the future expansion of the PTU.

The MTC and Critical Care Directorate have begun a modelling project to right size the phased expansion plan for the PTU. It is acknowledged that as the SWTN matures, the PTU has faced increasing constraints on capacity. Cardiff and Vale UHB are committed to addressing these challenges to provide assurance to our network colleagues that there is equity for patients from across the region in accessing the acute care and early rehabilitation model it was commissioned to deliver. This project will be supported by the NHS Wales Modelling Collaborative.

Performance data
The PTU has delivered care for SWTN patients at a greater proportion to Cardiff and Vale UHB patients (65% v 35%) over this most recent period. This demonstrates a shift in data from previous years, where patients from Cardiff and Vale UHB have been the predominant patient cohort on PTU. This may reflect the maturing processes of the SWTN and patient pathways towards a more equitable service across South Wales.



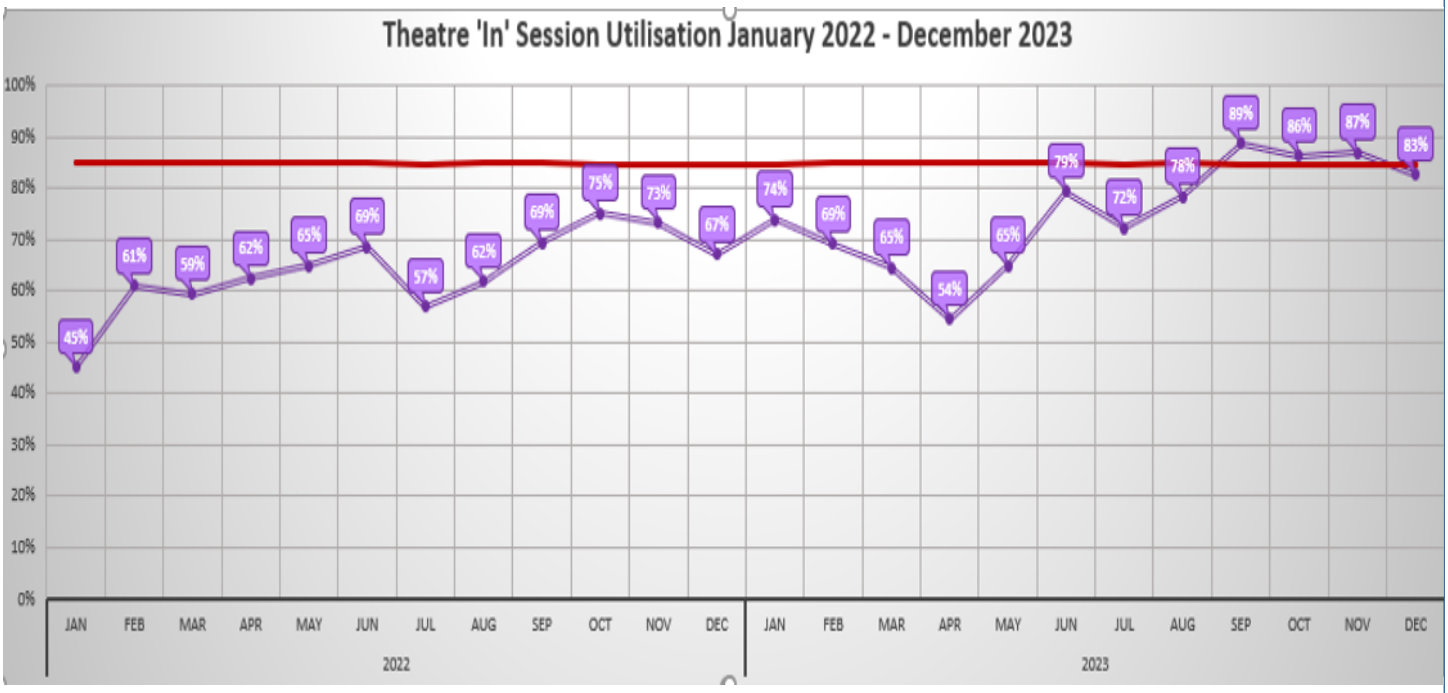


Trauma Audit and Research Network (TARN) data

TARN is an established national clinical audit for trauma care across England, Wales and the Republic of Ireland. Following a cyber-attack in June 2023, this data is not currently available however.

Cardiac Services

Theatre Efficiency



Cardiothoracic Services have made arrangements with Perioperative Care to reduce the length of theatre sessions from 08:00-18:00 to 08:00-17:00 Monday to Friday. There has been no reduction in cases, few lists overrun and financial gain from efficient use of the theatre team. Average 'in' session utilization from May 23 to August 2023 was 73% and from September 2023 to December 2023 86%

Other headlines

The planned return of Cardiothoracic Services from UHL to UHW in July. This will eliminate the significant risks associated with services over split sites. To support this move to UHW, interim footprint moves have been made to mitigate reduced capacity. The directorate have also acquired and refurbished the old Discharge Lounge, located adjacent to the Cardiac Day Case Unit to support our Treat and Repatriate (T&R) service which serves to increase our day case capacity.

The Heart Failure Team has had the opportunity for expansion. With support and investment from Value in Health Improvement, 3 additional nurses, and a senior nurse for the service have been appointed. This will support the future development of both the acute and chronic services and also community-based clinics.

A business case has been drafted for a 4th Cardiac Catheter Laboratory in response to pressure on services, capacity and environment. Cardiology bed capacity itself is also a current challenge. These constraints are also captured on the risk register.

Haematology, Clinical Immunology and Metabolic Medicine

Haematology

The Neuroendocrine Tumour Service (NETs) has been successfully integrated into the directorate structure with the development of nurse led hemochromatosis clinics and chemotherapy clinics at outlying sites. There has also been a significant review of roles and responsibilities across the patch by the senior nursing team to enhance service delivery, development of nurse led services and to support the medical team to deliver high quality care and promoting a service fit for the future.

In conjunction with Capital Planning and Velindre colleagues, a strategic outline case has been submitted this to Welsh Government for approval of construction of a new pioneering haematology, and bone marrow transplant research and development facility.

The DVT research nurse, Marilyn Rees, won the 'Unsung Hero' award at the Thrombosis UK Venous Thrombo-embolism (VTE) Awards in 2024.

Metabolic Medicine

A new project is planned in the Lipid Service to identify those with conditions such as lipoprotein disease and familial hypercholesterolemia. This will be a first in the UK and will be in conjunction with industry.

Clinical Immunology

Established insourced clinical activity has taken place to address the long waiting list for the Specialised Allergy Service, with patient waiting times reduced by approximately 12 months.
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Neurosciences

Highlights

The Joint Paediatric Spinal Dysraphism/ Neurogenic bladder Clinic is a multidisciplinary (MDT) highly specialised clinic that runs on a monthly basis. It comprises a number of specialities involved in the care of this complex and diverse patient group, including paediatric urology, paediatric neurology and paediatric neurosurgery, supported by both paediatric continence and neurosurgical clinical nurse specialists, with input from orthopaedic, orthotic and physiotherapy services.

It has children with a number of different conditions that neurologically affect their bladder function and lower limb function that also often have other associated conditions including skeletal and endocrine (hormonal) issues. This clinic not only manages a number of different but related issues, but also acts as an efficient ‘one-stop shop’ for patients and their parents/carers, saving both multiple visits to different clinics, but also allowing valued continuity of care across specialities. Although this service is not unique, it remains one of the few joint MDT clinic for spinal dysraphism/neurogenic bladder patients in the UK.

Workforce

Improvement work has been implemented and supported through a workforce review within the Spinal Rehabilitation Service to meet the recommended minimum national standards and to develop a more comprehensive therapeutic rehabilitation team for all aspects of care. The multidisciplinary team now consists of nurses, a rehabilitation consultant, a psychologist and number of therapists. This development benefits patients who access the Specialised Spinal Rehabilitation Service and those who do not meet the criteria for inpatient care but need support with management of their condition making it a more equitable service. Furthermore, the improved outreach capabilities have supported the wider health system as the specialist teams will support staff and patients in across the region, to avoid admission or whilst waiting for admission, to deliver optimum care to patients with significant spinal injuries in a more efficient and effective way.

Skull Base

Our Skull Base Neurosurgical Service provides a comprehensive and timely service for the patients of South Wales. Patients losing their vision due to various skull base pathologies from pituitary tumours to skull base meningiomas receive timely surgical intervention with good outcomes allowing return to driving and functional independence for many of them. The flexibility and good working relationship between the surgeons in our subspecialty mean that patients in need of timely specialised neurosurgical intervention are always able to receive it in optimal timeframe.

Our Acoustic Neuroma Service is pro-actively signed up to a national audit programme with centres in England and on the latest 3 yearly report we have been found to have a significantly lower 30-day complication rate than the national average. We form part of the pituitary MDT as well as lead the skull base MDT where we work closely and collaboratively with endocrinologists, neuroradiologists, oncologists, ENT surgeons, ophthalmologists, maxillofacial surgeons and audiovestibular medicine.

This close working relationship with other clinical specialties allows us to offer the best clinical advice and management for our complex group of patients. We have developed the role of a specialist nurse in skull base neurosurgery over the last 4 years who acts as a key worker from the point of diagnosis through to post-operative follow up for patients. This has dramatically improved the support we are able to provide to patients and families and improved the patient experience with those dealing with skull base pathologies who often have very complex and multi-factorial issues.

Neuro-Oncology

The Neuro-Oncology Service is going from strength to strength, having achieved the Tessa Jowell Centre of Excellence designation in 2022, and now preparing for reapplication. We form a close integrated partnership with the neuro-oncology teams in Velindre Cancer Centre and Singleton Cancer Centre, to offer the best care possible for our patients. We have a large research portfolio, including FUTURE-GB to assess the benefits of image-guided resections with tractography; and the oncologists themselves running studies. This is coupled with a good relationship with Cardiff University, via the Neuro-Oncology Multi-Disciplinary Research Group, to aid basic science research into brain tumours, such as 3D cell culturing.

This strong multi-disciplinary work is reflected in our exemplary monthly Low-Grade Glioma Clinic, where patients have direct access to surgeons, oncology, epilepsy nurses, speech and language therapy, and neuro-psychology. For patient communication, we have developed an individualised email for patients who are due to come for surgery, which provides answers to many logistical questions and references for support and further information. Many of our surgical consultations are now undertaken via video consultation, which means that we can see patients quicker and they do not have to travel great distances unnecessarily making the service far more efficient. Therefore, and due to the collegiate work sharing between the surgeons of the MDT, the vast majority of suitable brain cancer patients are operated upon within two weeks of MDT discussion.

Nephrology and Transplant

Efficiency

Following the Covid-19 pandemic, local anaesthetic (LA) and some general anaesthetic (GA) patients were moved to be bedded on Ward T5 for their procedures These procedures are day case admissions such as Tenckhoff insertions or removals or creations of fistulas. T5 supporting these admissions is now unsustainable and having a detrimental impact on patient experience with a number of cancelled procedures in recent months due to no available beds on T5.

The directorate have put a proposal of change to Perioperative Care in February 2024 for a change from 1 LA session to 1 GA session. This does have a requirement for day case beds however it would also release a session back to theatres and other services.

Other highlights

A Hepatitis B vaccination programme for all dialysis dependent patients and those planning to commence dialysis has been rolled out. This multi-centre, multiprotection immunisation programme will see Cardiff and Vale UHB patients receive vaccinations as per The UK Kidney Association Guidelines

A positive HIW inspection of B5 and T5 which solidified the use of AMaT within the directorate.

There has been a Value in Health based funding agreement for a Prehabilitation programme aimed at patients with Chronic Kidney Disease (CKD) with a view to improving access to transplantation and home dialysis for more equitable care.

There has been an increase in live donor numbers which has been achieved through an improved education programme lead by the CKD team and a streamlined process which has seen improvement pathway from time of identification to donation.

Artificial Limb and Appliance Service (ALAS)

Highlights

A Llais Visit Report following their visit to the Artificial Limb and Appliance Centre (ALAC) at Rookwood on 20th October 2023 reported, “Patient satisfaction with regards to all aspects of the ALAC service, including staff attitude and professionalism is high. “

On 18th December 2023 ALAS held a ‘Culture and Leadership away day’ at Cardiff City Stadium. The event was well attended and split into two main sessions. In the morning session each team in the directorate presented on the their speciality and the fantastic work they do to enable and support the lives of people across Wales. The afternoon workshop session, facilitated by the Education Culture and Organisational Development (ECOD) and People Services teams, worked through the

themes from the culture and leadership survey. ECOD are in the process of collating the information produced for publication.

'The Inseparable Sisters', as portrayed in a BBC documentary in February 2024 are longstanding patients at ALAS who provide their special seating and wheelchair and support them. This work and wonderful patient story has previously been presented in QSE.

Supportive Care

Value Based Healthcare | Project Summary Report

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

Project Name:	Supportive Care	**Date:**	Sept 2023
Project Team:	Dr Clea Atkinson	**Headline Outcomes:**	Significant Benefits to Patients Experience, symptom control, care planning , acute LOS

Background & Situation

Inequality of access to Palliative Care services.
- Around 88% of Specialist Palliative Care inpatient provision and 75% of outpatient/hospital support currently focused on cancer patients.
- In the last 1-2 years of life conditions such as heart failure, respiratory failure, kidney failure and liver failure have a similar symptom burden to metastatic cancer with equal levels of distress which palliative care input could help.
- Patients dying from non-cancer conditions are disadvantaged: only 20% ever receive Specialist Palliative Care.
- Numerous referral barriers need to be surmounted.

Initiative

Establish a Patient Centred Supportive Care service for to End of Life Liver, Renal and Respiratory ILD which is highly integrated with Referral Speciality Team and which overcomes referral barriers. Clarifying what matters to patients most and managing the patients' care together, re-empowering them in their healthcare. Where possible Providing Care in the setting Preferred by the Patient.
Significant opportunity to improve stewardship in last 1-2 years of life.
Aligning Service with Organisational Objectives of: Home First, Empowering the Person, Outcomes that Matter to the people, Avoid Waste Harm and Variation

Methods, Measurement & Learning

Bed days for all Emergency Admissions and disease cohorts
- Baseline data for 3 of the cohorts
- Pre and Post Referral Analysis.
- Linked to PLICs data
- PREMs and FROM datasets

Expected Benefits / Benefits Realisation

Dramatically increase the care being provided at home during last 1-2 years of life based on Patient Choice.
- Reduction in Emergency Admissions
- Reduction in Length of Stay
- Empowering the Person. Patient understanding the life-limiting Nature of the condition with Choices and the Potential Impacts of those Choices

Outcomes that Matter: Person Centred Goals, Symptom Control, QoL, Inappropriate Prolongation of Dying, Setting of Death, Avoid Waste Harm and Variation. Advanced Care planning, Empower patients to self-monitor, use services wisely, Limiting Chaotic Crises Admissions, using resources more efficiently.

Sustainable Value

Cost implications – Financial Value	Environmental & Social Value	Impact on health inequalities	Scalability
Total forecasted spend for 23/24 equals £412K. Anticipated Opportunity Cost Saving to exceed cost. Impact on WHSSC to be determined.	**Environmental Value** Significant reduction in CO2e with reductions in cute bed days **Social Value** Significant impact on Patient well being as demonstrate by PREMs. Significant impact on Family as demonstrated by FROMs. Qualitative data reveals a powerful impact of the service	Inequality of access is central to this programme of work. Many of our end of life patients, especially within the liver cohort, are within the socio-economic disadvantage population. Data is being collected to establish the impact by postcode. WCAT SpR is carrying out PhD on liver cohort.	Project scalable, pan Wales and pan UK. Current work - linking with Bristol trust on scalability, and with national liver audit (CAV is data collection site). SPR encouraged to attend Spread and Scale with the topic of possibly able to spread and scale the model to other respiratory conditions. Heart failure – very scalable (especially Rural areas) with interventions that support us to avoid hospital admissions, particularly when district nurses are in attendance. It provides innovative methods that require reduced nursing input (e.g. 7-day ambulatory infusion pumps).

There is huge inequity of access to palliative care in the UK, mostly on the basis of diagnosis, with around 88% of specialist palliative care inpatient provision and 75% of outpatient/hospital support currently prioritised to cancer patients. With an aging population and increasing impact of socio-economic disadvantage following the Covid-19 pandemic, this inequity gap will only continue to increase if unaddressed. Currently 32,000 people die in Wales every year and 3/4 of them could benefit from some form of palliative care input.

Over the last 6 years the Supportive Care Service has developed to better deliver palliative care input to patients dying from advanced heart failure. By focusing on person centered care and

working together in a highly integrated way with the referring team, clarifying what matters to patients most and managing the patients' care together; this approach has overcome many of the previous referral barriers, improved quality of life, lessened time spent in hospital away from loved ones, reduced in-hospital deaths and helped many more patients to die at home. This model of care has improved patient reported experience whilst simultaneously showing value-based outcomes. This approach has now also been adopted and adapted for patients with advanced renal failure, advanced liver failure and respiratory failure (interstitial lung disease) having received funding from the Welsh Government through Value Based Health Care.

Pharmacy and collaborative working to achieve quality

Critical Care Directorate (CCD)
A pharmacy technician and assistant technical officer has been funded as part of the CCD expansion project. Despite only having been in post for a few weeks, these individuals have done a great deal of work in improving the treatment rooms and have realised savings through reducing waste on the unit.

The critical care pharmacists have been working with the patient safety and practice development nurses in CCD to provide education sessions around medication errors due to the number of Datix reports in this area. There has been a reduction in the number of medication errors reported recently and this ongoing work will hopefully reduce the number of incidents further.

Nephrology and Transplant (N&T)

The N&T pharmacy team have recently set up a cardiorenal optimisation clinic, in conjunction with a consultant and chronic kidney disease nurse colleagues. This clinic is aimed at identifying patients within the Cardiff and Vale UHB nephrology cohort who may benefit from medicines optimisation, such as the addition of SGLT2 inhibitors and finerenone, as these agents have been shown to have significant renoprotective and cardioprotective effects in this group of patients. This project will result in more timely and increased access to these medicines, which have very strong evidence supporting their use.

Rob Bradley, Consultant Pharmacist for Nephrology and Transplant, has been appointed as the Lead Pharmacist for the Welsh Kidney Network.

Neurosciences

The MHRA have put in place further regulatory measures for patients prescribed Valproate medicines, extending the existing measures to introduce a risk assessment at the point of first prescribing for both female and male patients between the ages of 14 and 55 years old, as well as an updated annual risk assessment form for people of child bearing potential on long term treatment. The neurosciences directorate and pharmacy team inputted into the Valproate Clinical Working Group in order to ensure compliance with these new measures, as well as to highlight the challenges to clinical care that have resulted from their implementation. Work is ongoing in this area, with further updates to be expected as the evidence base for the safety of these agents, in men in particular, becomes clearer.

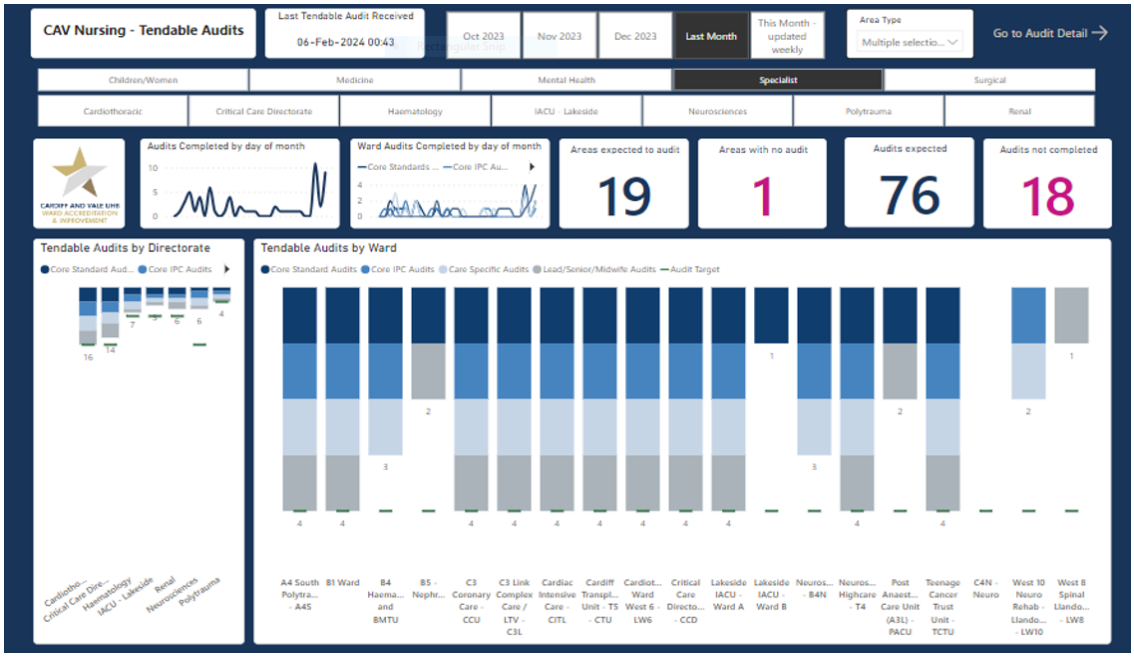
Heamatology

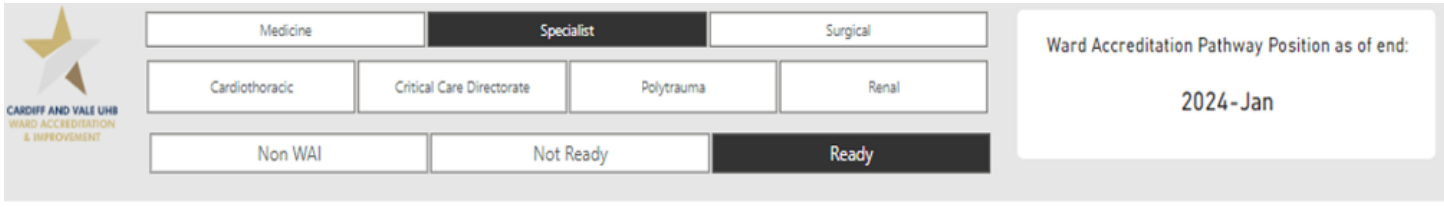
Collaborative working to establish chemotherapy delivery at other locations.

Nursing and Tendable
Tendable, the quality improvement and auditing app is used across specialist SpS CB to capture live data about quality standards, patient and staff experience and the care environment. To date, 19 inpatient areas and 12 outpatient areas have been set up on the system and use it for monthly or ad

hoc reporting, to meet the needs of the area. The content of the audit programme has been informed by practitioners within the clinical areas and specialist practitioners such as the DVT Service have contributed to content for UHB wide use around Venous Thromboembolism (VTE) as one example.

There are over 115 members of staff across the 31 clinical areas auditing. In conjunction with the whole of the wider team they contribute to action planning and issue resolution. SpS have notably high compliance as demonstrated by the figures for January below.





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 D
B1 Ward	100%	83%	100%	50%	83%	50%	93%	80%	Ready	01 January 2023	03 March 2023
Cardiff Transplant Unit - T5 - CTU	100%	83%	100%	50%	83%	50%	87%	80%	Ready		
Neurosurgery Highcare - T4	100%	83%	83%	50%	67%	50%	88%	80%	Ready		
A4 South Polytrauma - A4S	92%	83%	83%	50%	83%	50%	87%	80%	Ready		
B5 - Nephrology	92%	83%	83%	50%	83%	50%	93%	80%	Ready	28 September 2023	
Cardiothoraic Ward West 6 - LW6	92%	83%	100%	50%	100%	50%	89%	80%	Ready		

Furthermore, SpS CB have been front runners within Cardiff and Vale with Ward B1 being the first ward in the UHB to join the accreditation programme in January 2023. West 6 also joined the programme in September 2023 and there are currently another 4 areas eligible to join. Owing to the specialist nature of the services delivered within the CB, several will require an alternative accreditation programme to reflect the services that they deliver.

Workforce

The CB are committed to delivering the values and behaviours of the UHB to all of our staff.

The nursing workforce has been a priority over the last few years with a number of areas, to include the Critical Care and Nephrology and Transplant directorates, having recruited to establishment. The leadership and strategies used to achieve this are being rolled out to areas where nurse vacancies are more of a challenge. Work is also ongoing, focusing on looking at different roles and workforce models. IACU for example is an excellent example of a therapy-based team around the patient model.

Neurosciences is currently challenged with registered nurse vacancies. The team are actively seeking solutions and keen to be involved in the Nurse Retention Plan Launch work. We are very proud however to have successfully integrated Band 4 Assistant Practitioners (APs) within the Spinal Rehabilitation Setting. This area was facing significant recruitment and retention challenges following relocation from Rookwood Hospital, when funding for an increased registered nurse workforce of 8 whole time equivalent was approved to meet BRSM standards. At this time West 8 became one of the AP pilot wards within the UHB in an attempt to mitigate this risk and look at different ways of working. They have supported 9 APs, 3 of whom are just transitioning to registered nurses with the remaining 6 on a pathway to become registrants within 6-12 months. West 8 is the success story of the UHB with the AP model, with all of them wishing to remain on West 8 following a very positive experience.

The Band 5 registered nurses vacancy gap across the directorate is currently 22 whole time equivalents. The directorate has received positive feedback from overseas nurses and students respectively and there is a strong leadership team developing clear objectives and learning opportunities across the 4 inpatient environments. The directorate is not however on a trajectory that will see these posts appointed to in the next 12 months, therefore balancing and mitigating the associated quality and safety impact of these vacancies is a continued priority. Tracheostomy care is a notifiable risk that is directly linked to nurse staffing, skill mix and training. Neurosciences have 2 inpatient settings that deliver tracheostomy care however both are experiencing high vacancy rates meaning that the scope to take more patients with tracheostomy's is currently limited.

In Haematology where registered nurse vacancies are also a concern, the team have successfully appointed 9 streamlining registrants following a strategic investment in students.

In Cardiac Services their rotation programme for new starters is going from strength to strength, being constantly evaluated to ensure it is meeting the needs of clinical areas and new staff. It has now been offered to staff who have worked here a little longer and missed the opportunity at the start of their service with us. This programme is supporting the recruitment, retention and ongoing development of nursing staff within the directorate

Values Based Appraisals (VBAs)

There is a current organisational focus on VBAs and compliance which continues to drive the same within the CB. It is recognised that operational pressures and a focus on delivering clinical care does continue to add to this challenge.

Most areas are now close to or have exceeded 85%. The worst performing area stands at 36.81 % and has impacted on the average figures. This is currently an area where culture and leadership work are being undertaken however. All other areas have achieved 67% or above to date.

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Specialist Services	42.19%	46.44%	50.60%	53.36%	59.50%	64.90%	64.90%	64.04%	64.40%	65.45%	65.78%	65.85%	70.60%
UHB	53.64%	56.40%	58.43%	60.50%	64.89%	71.64%	70.98%	67.81%	67.00%	68.10%	68.00%	69.99%	74.03%

Sickness Absence

At the time of the last report, wellbeing initiatives had been implemented in response to an increasing sickness picture. These included, wellbeing champions, peer support, psychology support and debriefing, celebrating success and partnership working with union colleagues to listen to staff and develop improvements. In January 2023, sickness was at its lowest rate for over 12 months. This improvement continued before a gradual bounce, possibly associated with the time of year. An improved trajectory is now evident and a review of the position is currently being undertaken by the People Services Team who are looking at areas of concern, auditing and providing feedback and recommendations. It is also planned to initiate sickness surgeries if indicated.

Clinical Board	Specialist Services

Sum of % Sickness	Column Labels											
Row Labels	2023 / 04	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10	2023 / 11	2023 / 12	2024 / 01	2024 / 02	Grand Total
Add Prof Scientific and Technic	0.10%	0.00%	0.57%	1.93%	0.00%	5.93%	3.31%	1.57%	2.54%	2.83%	2.43%	1.98%
Additional Clinical Services	10.29%	8.66%	9.17%	9.51%	11.08%	9.94%	9.47%	9.45%	9.77%	10.83%	7.10%	9.58%
Administrative and Clerical	4.85%	5.03%	5.45%	6.69%	7.21%	8.51%	8.87%	10.23%	10.53%	11.26%	8.90%	7.98%
Allied Health Professionals	2.49%	3.23%	5.90%	3.40%	2.55%	3.24%	5.56%	8.34%	5.91%	6.84%	6.33%	4.93%
Estates and Ancillary	0.00%	0.00%	4.06%	17.87%	11.95%	0.00%	6.19%	1.15%	4.46%	13.66%	0.00%	6.11%
Healthcare Scientists	2.46%	2.58%	3.36%	5.10%	4.40%	4.95%	5.24%	3.45%	5.80%	5.19%	6.05%	4.41%
Medical and Dental	1.04%	1.02%	0.70%	0.42%	0.03%	0.00%	0.41%	0.84%	0.80%	0.63%	0.23%	0.56%
Nursing and Midwifery Registered	6.10%	5.60%	5.01%	5.77%	5.65%	6.57%	6.79%	7.14%	7.21%	7.71%	6.29%	6.37%
Grand Total	**5.94%**	**5.43%**	**5.36%**	**6.00%**	**6.18%**	**6.70%**	**6.84%**	**7.16%**	**7.34%**	**7.89%**	**6.15%**	**6.47%**

Resource

The Board has reported an overspend of £1.208m to month 10 of 2023/24. Directorate operational positions are £1.081m overspent with a CRP shortfall against target of £0.127m. Forecast to year end is to reduce the deficit to £0.433m

	Mth 10	Forecast *
	YTD £m	£m
Operational Variance	**1.081**	0.350
CIP Variance	**0.127**	0.083
Total	**1.208**	**0.433**

Headline Year to Date Issues:

·Medical £1.581m	Gaps and premium cover
·Registered Nursing £0.312m	Bank and agency usage to cover sickness and vacs
·LTA Performance £0.284m	Underperformance spread across all directorates
·Other vacancies (Net) (£1.128m)	Across most specialties
·IACU £0.287m	Funding capped at £4.3m
·Slippage against CRPs £0.505m	Offset by non-recurrent opportunity of £0.537m

Clinical Board Greatest Risks

The CB currently have x3 extreme risks scoring 20 that are held within the Corporate Risk Register. These are:

- Critical Care capacity
- Critical care clinical environment and estates
- Haematology and Immunology clinical environment

As noted earlier on in the report, sustainable measures to increase capacity are in progress Critical Care. There is also continued mitigation work to address estates and clinical environment challenges to include Haematology currently using capacity in an area that does not belong to the directorate.

There has however been a real focus on risk management in SpS CB in 2024. Historically each directorate holds their own local risk registers centrally. Every area has been asked to review and update these and all of the risk registers for SpS are now stored centrally. From early review it would seem that a number of new red risks have been added, themes to include capacity, clinical environment, workforce and specific services. Examples include the risks held in Cardiac Services, detailed earlier on in this report.

These newly identified risks across all directorates will be discussed in QSE Committee and directorate review meetings with the CB to achieve a rounded perspective in order to validate and support mitigation. The SpS CB risk register will then be reviewed and updated accordingly.

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

Recommendation:

The Quality Safety and Experience Committee is asked to:

1. NOTE the progress made by the Clinical Board to date
2. NOTE the content of this report and the assurance given by the Specialist Clinical Board

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

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

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

Prevention		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:

Report Title:	Quality Indicators Report			Agenda Item no.	2.2
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	26th March 2024
		Private			
Status *(please tick one only):*	Assurance		Approval	Information	
Lead Executive:	Executive Medical Director and Executive Nurse Director				
Report Author (Title):	Assistant Director of Quality and Patient Safety				

Main Report
Background and current situation:

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

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

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

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

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

- A significant rise in the number of Nationally Reportable Incidents has been observed since November 2023 as a result of revised guidance to report all Intrauterine deaths from 22 weeks gestation and neonatal deaths up to 28 days after birth.
- NRI reporting in ophthalmology, endoscopy and pressure damage continue to be the predominant theme.
- The UHB is currently has declared compliance with the patient safety alert associated with. prescribing of Calcium Gluconate and mitigation of associated hyperkalaemia; and the safe prescribing of Sodium Valproate.
- Positive verbal feedback was given following a recent HIW inspection in the Emergency Unit with two immediate assurance recommendations resulting both associated with safe medication storage.
- Inpatient mortality remains in line with the previous five-year average and all cause mortality demonstrates mortality rates inline with the five year average
- Progress of the Covid investigation programme is close to completion and all cases of nosocomial Covid will have been investigated by the end of March 2024
- 471 patient safety incidents were reported between October and December 2023. With the vast majority resulting in no harm or low harm.
- Tendable is being used across 200 clinical areas and 3 awards are currently working towards bronze accreditation and over 600 regular users across the UHB.
- During January and February 2024, the UHB received 982 concerns with 80% closed within 30 days and 35% closed under early resolution.
- 3753 full and partial patient experience surveys were completed on Civica in January and February 2024 and a further 1040 surveys undertaken in the Emergency Unit.

- 212 patient experience surveys were completed in Mental health services. 58% of patients felt that they always felt cared for.
- 86.9% of acute inpatient medical and surgical wards were compliant with safecare in February 2024.

Recommendation:

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

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
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Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration		Collaboration		Involvement	

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

Risk: Yes/No
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:

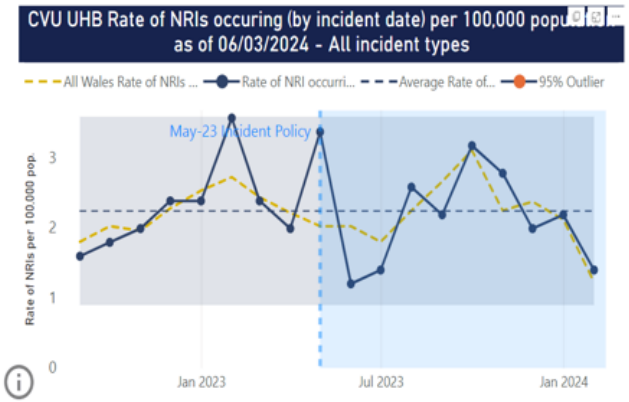
Quality Indicators Report

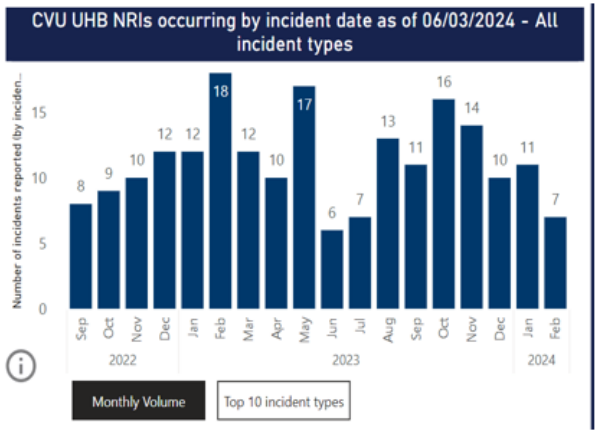
Quality Safety and Experience Committee

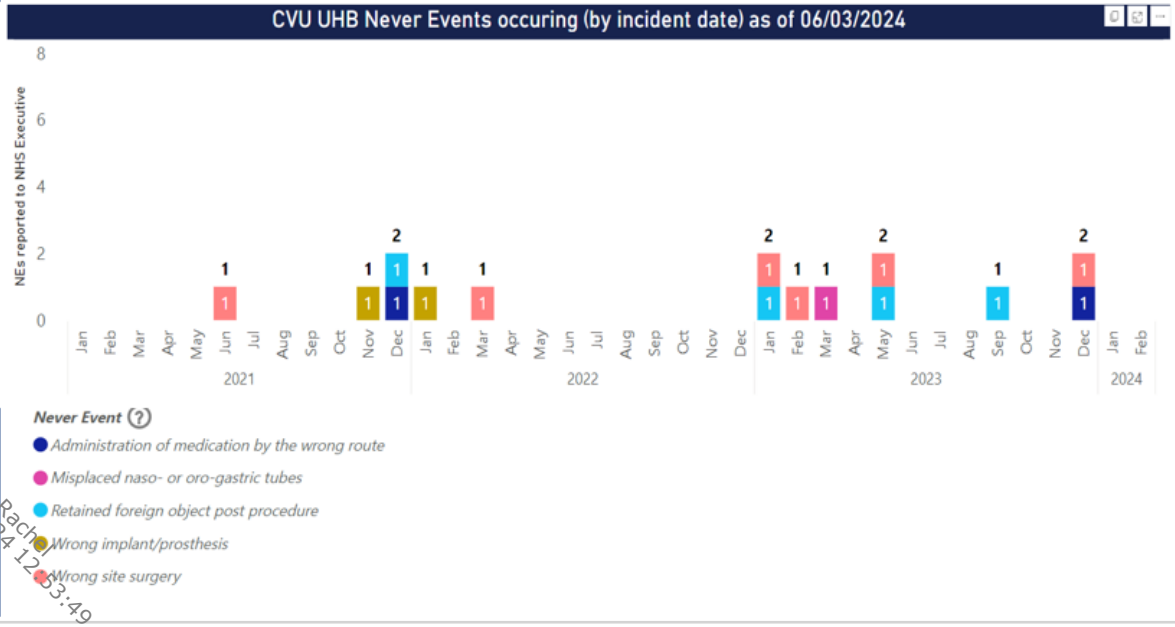
March 2024

Safe Care

National Reportable Incidents and Never Events







The change in NRI criteria include MBRRACE reported incidents (still births and intrauterine deaths with no care concerns) as well as the strengthened approach to reporting Health Care Acquired Infections has led to the increase in monthly NRI reporting from October 2023. This has led to an increased NRI position for Children and Women Clinical Board.

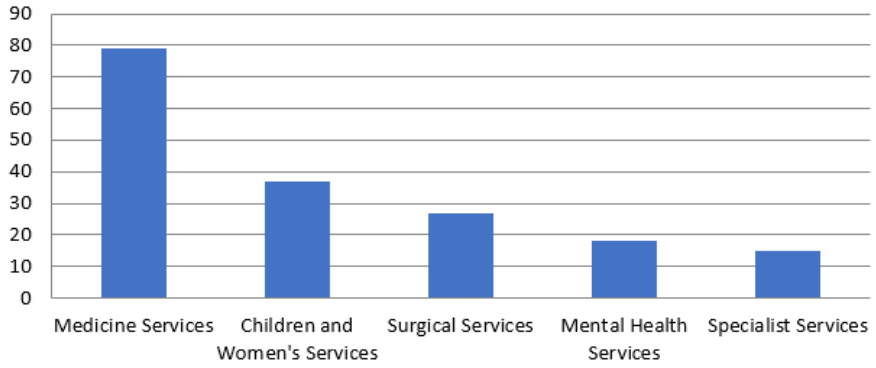
Medicine's increased NRI numbers are due in part to their increased pressure damage incidents. There is also a focus on supporting their gastroenterology service to review their lost to follow up incidents.

Never Events – 7 were reported in the year February 2023 to February 2024, wrong site surgery and retained foreign objects were the most commonly reported categories.

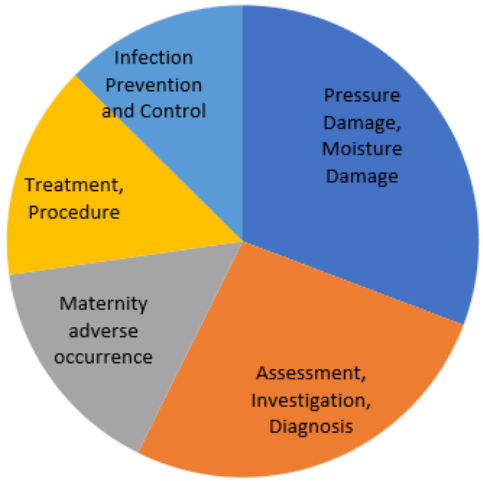
Safe Care

National Reportable Incidents and Never Events

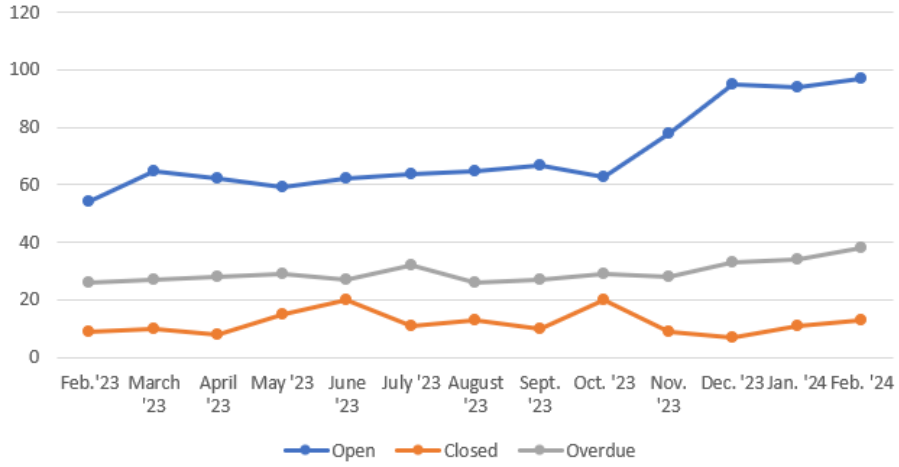
NRIs reported Feb 2023 - March 2024 by CLINICAL BOARD



NRIs by Classification - reported to NHS Exec 28.02.23 - 01.03.24 (N=202)



NRI position Feb.'23 - Feb. '24



Safe
Care

Infection Prevention and Control

Chart 4. Cardiff and Vale UHB cumulative monthly number of C. difficile

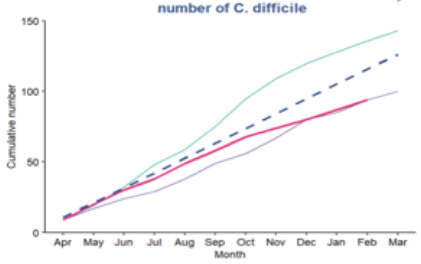


Chart 5. Cardiff and Vale UHB cumulative monthly rate of C. difficile per 100,000 population

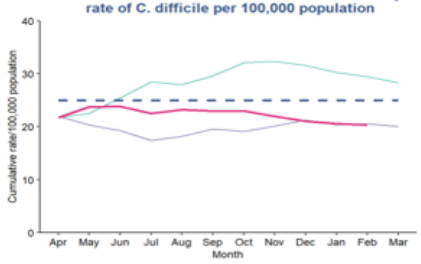


Chart 4. Cardiff and Vale UHB cumulative monthly number of S. aureus bacteraemia

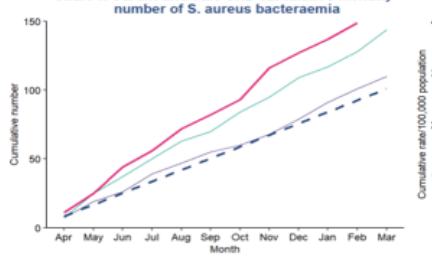


Chart 5. Cardiff and Vale UHB cumulative monthly rate of S. aureus bacteraemia per 100,000 population

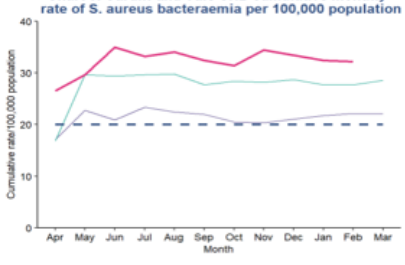


Chart 4. Cardiff and Vale UHB cumulative monthly number of E. coli bacteraemia

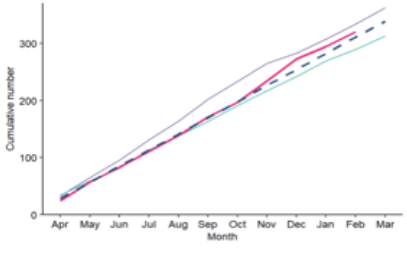
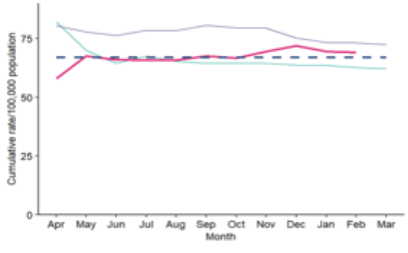


Chart 5. Cardiff and Vale UHB cumulative monthly rate of E. coli bacteraemia per 100,000 population

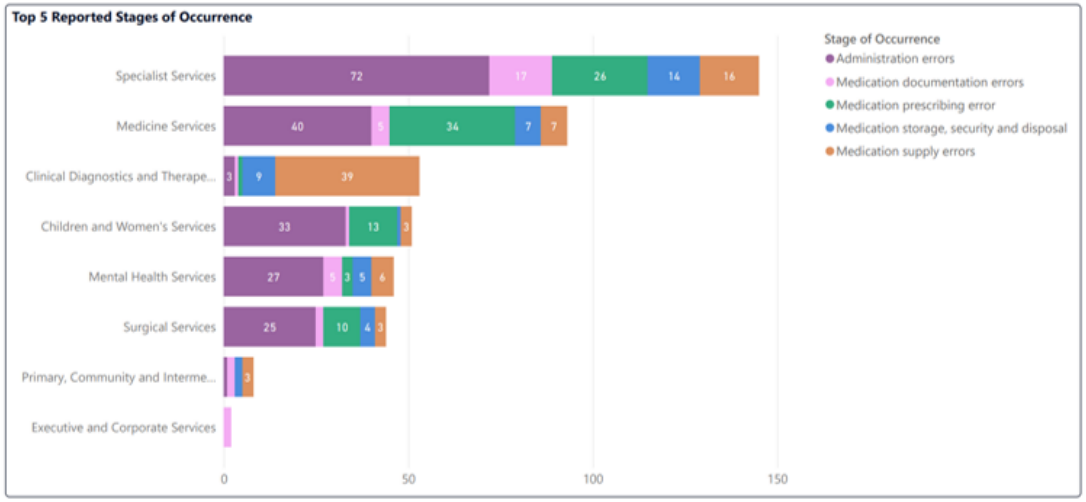


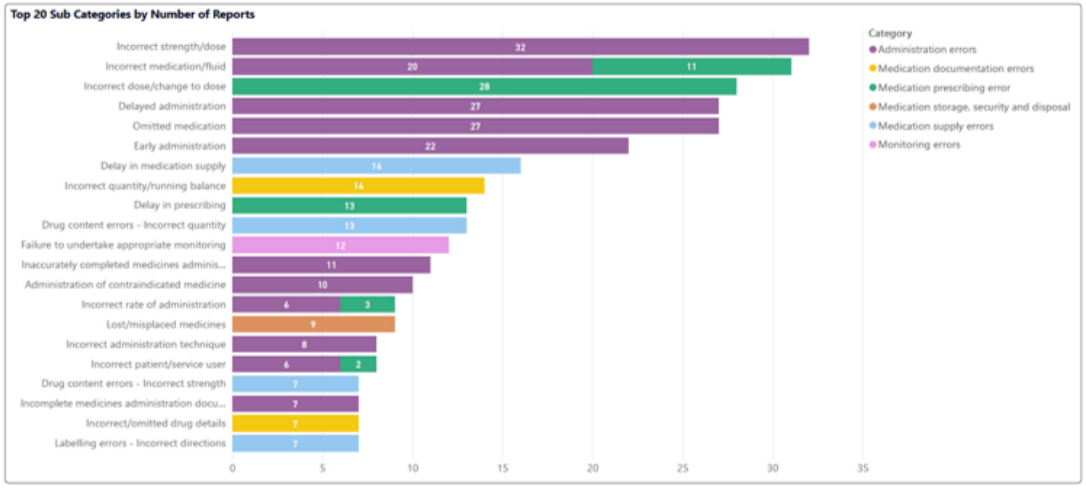
The Reduction Expectation for *C. difficile* for 2023/24 is no more than 25 cases per 100,000 population.At the end of February 2024, the rate in CAV is 20.54 cases per 100,000 population. We will be the only Health Board to achieve the reduction Expectation for 2023/24. The CAV rate is nearly back to the pre-pandemic rate and we strive to continue to reduce the number of cases further. Weekly MDT meetings are held attended by the . IPCN's, IPCD's, specialist scientist, IP&C scientist, microbiology registrar and AMR pharmacist.All patients are reviewed in person until resolved

The Reduction Expectation for SAUR bacteraemia for 2023/24 is no more than 20 cases per 100,000 population. At the end of February 2024, the rate in CAV is 32.20 cases per 100,000 population which is the 5th highest rate in Wales, CAV UHB will not achieve the required reduction. 64% of cases are community acquired, most of whom have had no interaction with healthcare providers. IP&C focus on SAUR bacteraemia for 2024/5 with Executive oversight. All new cases are discussed at the weekly MDT and have an in person review. ANTT is being reinforced across all clinical teams, and the IP&C team have presented to the Grand Round to outline to medical staff their responsibility to be ANTT compliant to undertake a procedure which requires asepsis. Work is commencing with the medical education department to develop a plan to increase ANTT assessments for medics.The CAVUHB have recommenced the ANTT working group and meet regularly, with the IP&C team supporting practice development nurses to undertake training and assessment for nurses

Safe Care

Medication Incidents 1/10/24 – 31/12/24





Yellow Card reporting data for CAVUHB 2023/24

Q1 = 94 Q2 = 84 **Q3 = 134**

General Practice = 22
Public = 82
Secondary Care 23
Community Pharmacy & other = 7

Highlights

471 medicines-related incidents were reported

- Highest number of reports (32%) – Specialist Services CB
- No/Low harm (as recorded by reporter) = 81%
- Medicine most frequently reported = oxycodone (n=20)

The most frequently reported (43%) 'Stage of Occurrence' was medication **administration** errors. Types of incidents reported:

- 1st = incorrect strength/dose (n=32)
- 2nd = Delayed administration (n=27)
- 2nd = Omitted medication (n=27)

The second most frequently reported (18%) 'Stage of Occurrence' was medication **prescribing** errors. Types of incidents reporter:

- 1st = incorrect dose/change to dose (n=28)
- 2nd = Delay in prescribing (n=13)
- 3rd = Incorrect medication/fluid (n=11)

8 new MHRA Drug Safety Updates, 1 new National Patient Safety Alert

Actions

In response to the concerns regarding omitted and delayed doses of medicines the UHB's Adrenal Crisis Task and Finish group are developing strategies (to cover education, communication, policy, prescribing/ePMA and self-administration) to reduce the number of incidents.

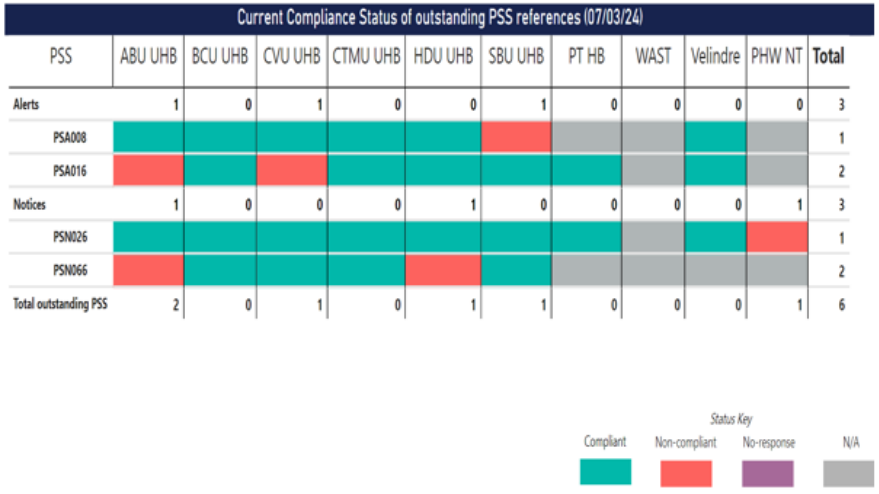
The CAV Valproate Clinical Working Group has been reconvened to implement the new regulatory measures (in place from 31st Jan 2024). Clinical teams are developing local action plans to ensure long-term sustainability of solutions. Input from the Improvement and Implementation team has been requested.

To improve awareness of medicines related-incident data, quarterly reports are prepared and shared with Clinical Boards. Feedback is being sought and discussions are being had with the UHBs Datix team to develop the medicines related incident Datix dashboards.

To provide greater assurance over actions taken in response to medicines related alerts and notices a database is being developed. It is hoped that this will also support organisational memory of such alerts and notices.

Safe Care

Patient Safety Solutions



PSA016 Potential Risk of Underdosing with Calcium Gluconate in Severe Hypokalaemia

The UHB declared compliance with PSA016 bit the national dashboard is yet to be updated to reflect this.

A policy has been developed and ratified that aligns with the Adult Renal Association Clinical Practice Guidelines and putting in place a procedure to extend support from the Critical Care Outreach Team to ensure time critical treatment for severe hyperkalaemia is implemented.

NatPSA/2023/013/MHRA - Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients

The UHB has declared compliance with this alert and has convened a UHB group to oversee the actions required to embed the regulations.
A separate paper has been taken to the March Committee to outline the actions undertaken to date.

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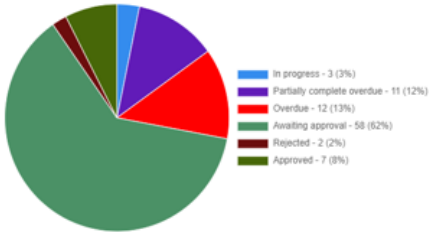
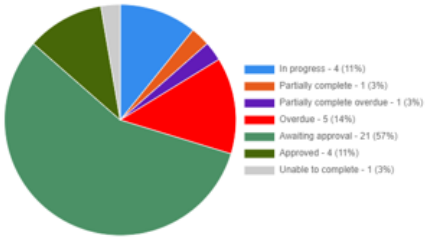
Safe Care

HIW

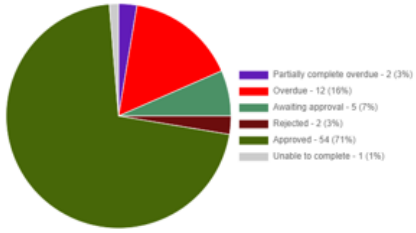
Children & Women



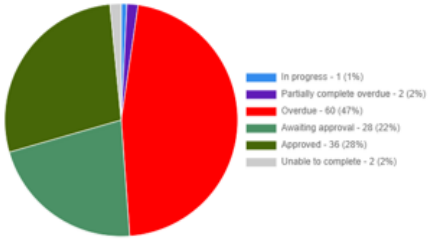
Clinical Diagnostics & Therapeutics



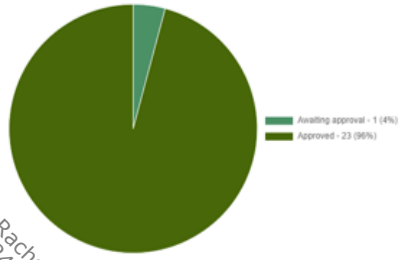
Medicine



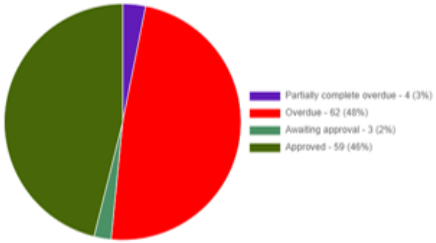
Mental health



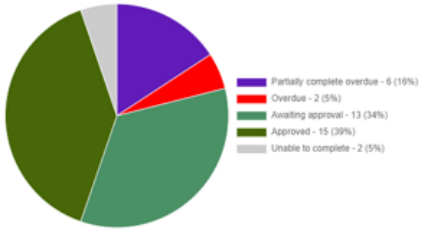
Primary Comm & Intermed Care



Specialist Services



Surgical



Island Ward Children's Hospital for Wales

An unannounced inspection was undertaken on 4 – 6th March 2024 within the Emergency Department. Immediate assurance has been submitted to HIW. Immediate assurances were required regarding fridge temperature checks and an updated maintenance log for medical equipment used within the department.

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

Improvements

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

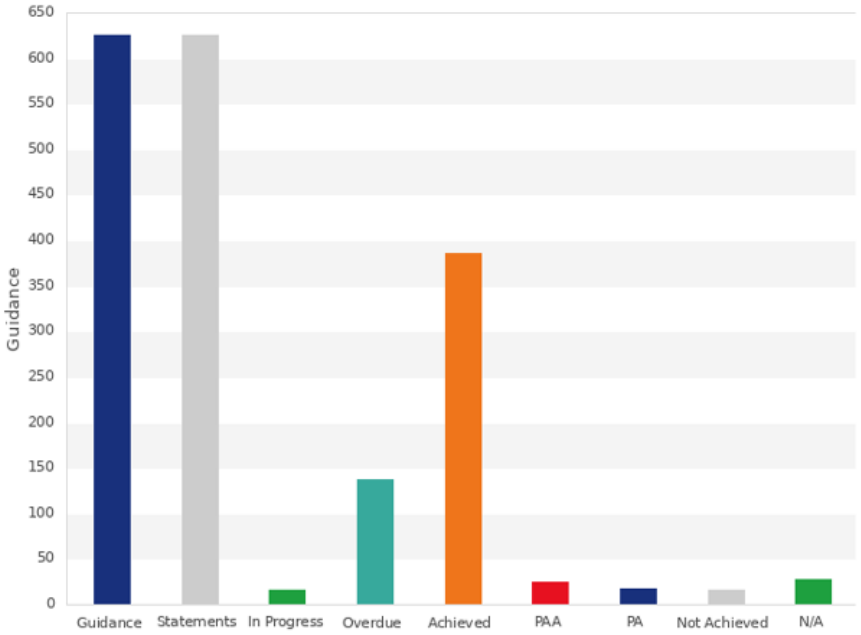
To support wider reaching actions to address these recommendations these will be discussed at the Medicines Safety Executive and the UHB Resuscitation Group.

Effeithiol Effective

Effective Care

Clinical Effectiveness

Guidance overview



- **Guidance (625)** - total number of guidance (that may contain one or more statements)
- **Statements (625)** - total of 'In Progress', 'Achieved', 'Partially Achieved', and 'Not Achieved' bars
- **In Progress (16)** - number of the trust's Guidance Statement entries that do not currently have a status
- **Overdue (137)** - number of the trust's Guidance Statement entries that are overdue
- **Achieved (386)** - number of the trust's Guidance Statement entries that have this status value
- **PAA (24)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Acceptable' status value
- **PA (18)** - number of the trust's Guidance Statement entries that have 'Partially Achieved' status value
- **Not Achieved (16)** - number of the trust's Guidance Statement entries that have 'Not Achieved' status value
- **Not Applicable (28)** - number of the trust's Guidance Statement entries that have 'Not Applicable' value

Circulated Guidance

Title

Circulated guidance January 2023 – March 2023

Devices for remote monitoring of Parkinson's disease (2023) *Updated and replaces MIB258

Artificial intelligence (AI)-derived software to help clinical decision making in stroke *This guidance replaces NICE MIB262 on RapidAI for analysing CT/MRI brain scans in people with suspected acute stroke.

Robot-assisted thoracic surgery

Sebelipase alfa for treating Wolman disease

Digitally enabled therapies for adults with depression: early value assessment (May 2023) *Updates and replaces MIB215

Early and locally advanced breast cancer: diagnosis and management [2018] *This guideline updates and replaces NICE guideline CG80 (February 2009), NICE technology appraisal guidance 107, 108, 109 and 112 (published 2006) and NICE evidence summary ES15

Caesarean birth [March 2021] *This guideline updates and replaces NICE guideline CG132 (November 2011).

Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients

Neonatal infection

Durvalumab with gemcitabine and cisplatin for treating unresectable or advanced biliary tract cancer

Olaparib with bevacizumab for maintenance treatment of advanced high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer *This guidance updates and replaces NICE technology appraisal guidance 693 on olaparib plus bevacizumab for maintenance treatment of advanced ovarian, fallopian tube or primary peritoneal cancer

Loncastuximab tesirine for treating relapsed or refractory diffuse large B-cell lymphoma and high-grade B-cell lymphoma after 2 or more systemic treatments

Ivosidenib for treating advanced cholangiocarcinoma with an IDH1 R132 mutation after 1 or more systemic treatments

Belumosudil for treating chronic graft-versus-host disease after 2 or more systemic treatments in people 12 years and over

Nivolumab–relatlimab for untreated unresectable or metastatic melanoma in people 12 years and over

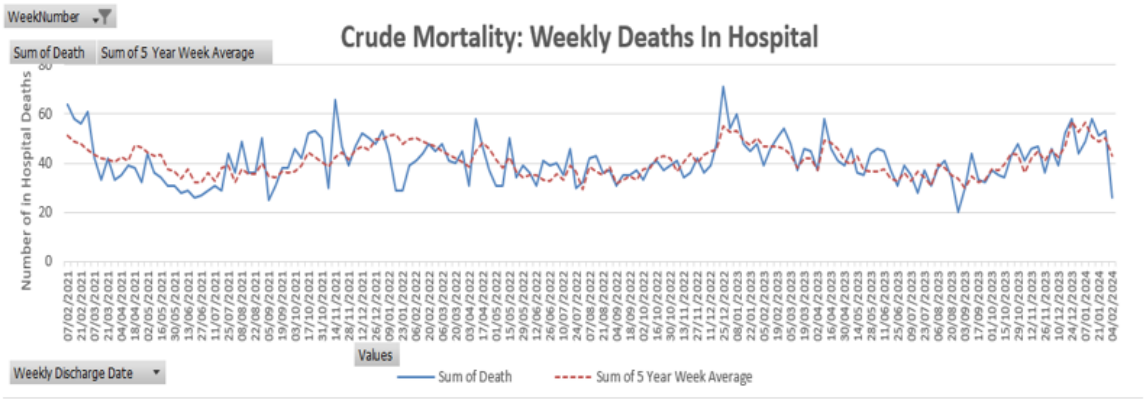
Olaparib with abiraterone for untreated hormone-relapsed metastatic prostate cancer

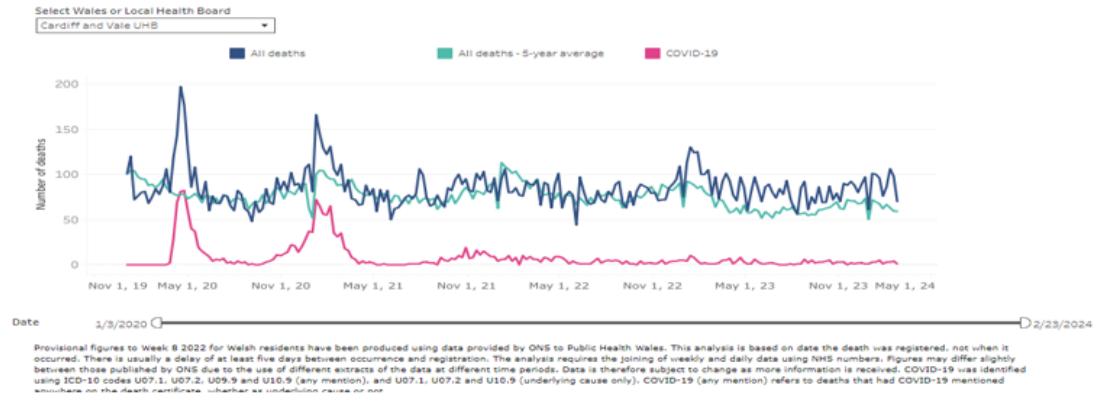
Talazoparib for treating HER2-negative advanced breast cancer with germline BRCA mutations

Effeithiol
Effective

Effective Care

Mortality





Provisional figures to Week 8 2022 for Welsh residents have been produced using data provided by ONS to Public Health Wales. This analysis is based on date the death was registered, not when it occurred. There is usually a delay of at least five days between occurrence and registration. The analysis requires the joining of weekly and daily data using NHS numbers. Figures may differ slightly between those published by ONS due to the use of different extracts of the data at different time periods. Data is therefore subject to change as more information is received. COVID-19 was identified using ICD-10 codes U07.1, U07.2, U09.9 and U10.9 (any mention), and U07.1, U07.2 and U10.9 (underlying cause only). COVID-19 (any mention) refers to deaths that had COVID-19 mentioned

Inpatient Mortality

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

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

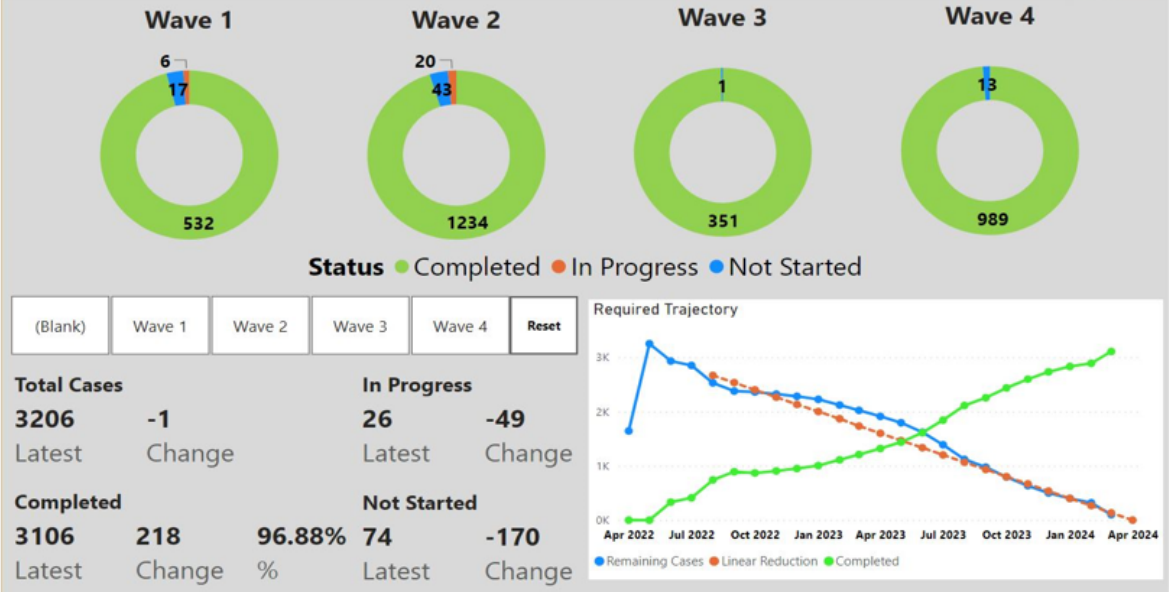
Effeithiol
Effective

Effective Care

Covid-19 Investigations

NNCP Data - Cardiff and Vale UHB

GIG CYMRU NHS WALES
National Nosocomial COVID-19 Programme



Covid Invetigation Programme

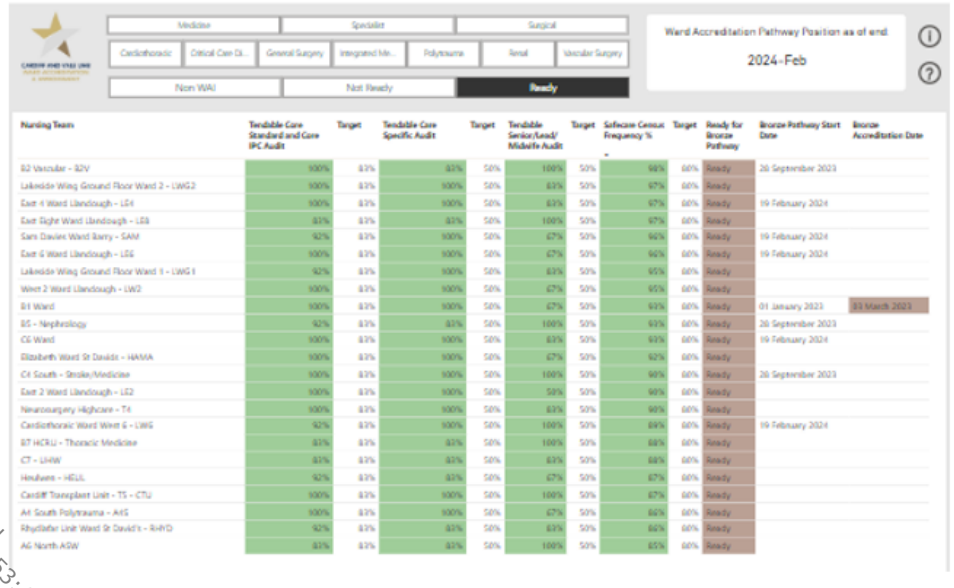
As of 15th March 2024, 32 cases remain outstanding-on trajectory for completion of investigation by 31 March

Effeithiol
Effective

Effective Care

Tendable

CARDIFF AND VALE UHB
WARD ACCREDITATION
& IMPROVEMENT



Tendable, the quality improvement and auditing app, is used across the UHB to capture live data about quality standards, patient and staff experience and the care environment.

To date, over 200 areas across inpatient, theatres, outpatient and the community have been set up on the system with the roll out ongoing.

The content of the audit programme has been informed by practitioners within the clinical areas and specialist practitioners such as the DVT service, have contributed to content for UHB-wide use around Venous Thromboembolism (VTE). There are now over 65 different audits written, each tailored to the needs of individual wards/departments/ theatres etc. The audit content is aligned with national standards, local policy and procedures. The Health and Safety Team is also due to set up their audit programme on Tendable this year.

There are over 600 users regularly using the system to audit with many more registered who contribute to action planning and issue resolution. The ease of reporting via the app and through the dashboards (pictured) has contributed to high levels of compliance across the Clinical Boards and many wards becoming eligible to enter the Ward Accreditation and Improvement programme. Dashboard (pictured).

There are currently eight wards undertaking the Bronze programme, with a waiting list of teams eligible to join. Teams are assessed against five pillars; Quality and Safety, Resource, Patient Experience, Staff Experience and Leadership. Digital data is collected via Tendable, SafeCare, Health Roster, CIVICA and Welsh Nursing Care Record to support the Accreditation process.

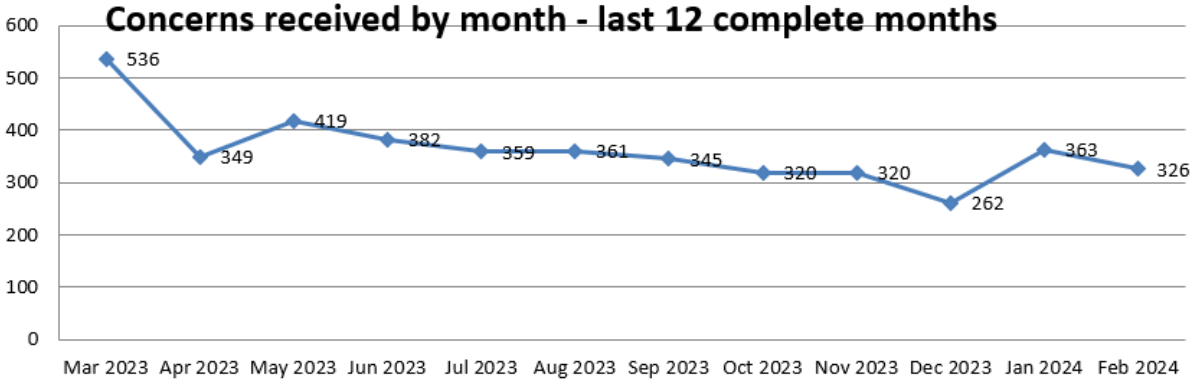
Person Centred Care

Patient Experience

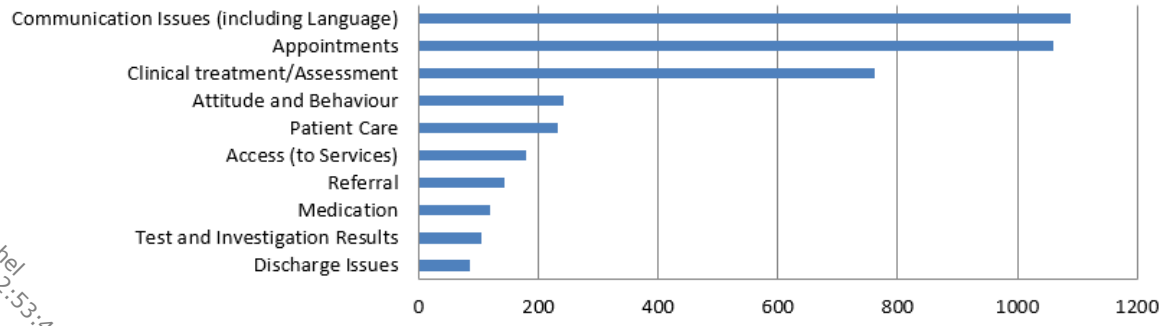
CONCERNS

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

Concerns received by month - last 12 complete months



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



During December 2023, January and February 24, the Health Board:

- Received 982 Concerns
- Closed 987 concerns
- 80% Closed within 30 working days (including Early Resolution)
- 35 % closed under Early Resolution (within 2 days including day of receipt)
- 337 Enquiries
- 167 Compliments

We currently have 283 active concerns

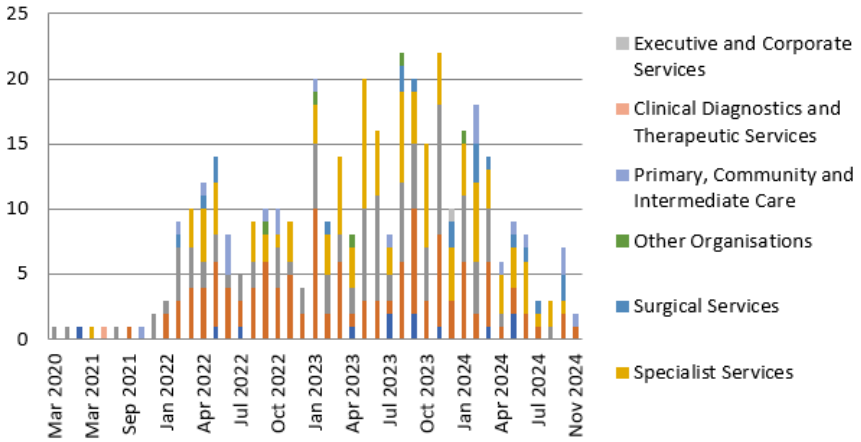
Top 3 themes and trends

- Communication
- Concerns around appointments (waiting times/cancellations)
- Clinical Treatment and Assessment

Person Centred Care

Patient Experience

Inquests by hearing date and Clinical Board



We have 377 Inquests managed through Patient Experience

Focus upon

- Focus on learning –we share a lesson learned at all inquests
- Staff support pre and post inquest
- Weekly meetings with Legal and Risk
- Use of teams channels for complex inquests
- Preparation of information for the coroner in a timely manner
- Alignment to Redress where appropriate

The numbers of inquests is increasing and the complexity is challenging

The focus is upon staff support and ensuring that wherever possible the family's questions are addressed before the inquest

A focus of the team has been on the compilation of lessons learned to reassure the families and HMC in cases where we have identified any concerns regarding our systems, processes or care delivery

Person Centred Care

Tell Us in 2 Survey

SMS sent: 8205

Survey responses: 1497

Response rate: 18%

Bedside responses: 182

90% were satisfied with their overall experience.

National Survey

SMS sent: 10968

Survey responses: 2074

Response rate: 19%

87% were satisfied with their overall experience.

Patient Experience - CIVICA

Tell Us in 2 Survey results (combined SMS and bedside)

Based on **1,679** partial/full survey completions (1st December 2023 – 31st January 2024 discharges/attendees).

- Whilst in our care did you feel safe? **84%** of respondents answered 'Always'.
- Were staff kind and caring? **82%** of respondents answered 'Always'.
- Did you feel involved when decisions were made about your care and/or treatment? **72%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- **90%** were satisfied with their overall experience.

National Survey results

Based on **2,074** partial/full survey completions (1st – 31st January 2024 discharges).

- Did you feel that you were listened to? **69%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **28%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- Did you feel well cared for? **71%** of respondents answered 'Always'.
- If you asked for assistance, did you get it when you needed it? **69%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- **87%** were satisfied with their overall experience.

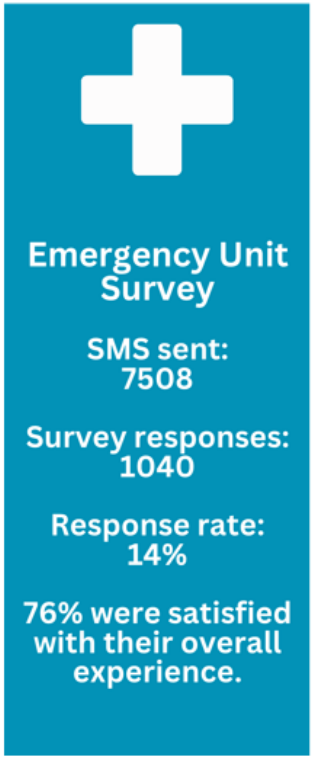
We aim to send up to 600 text message survey links per day to patients using our general services to gather feedback.

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

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

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

Person Centred Care



Patient Experience - CIVICA

Emergency Unit Survey results

Based on **1,040** partial/full survey completions (1st December 2023 – 31st January 2024 discharges).

- Did you feel that you were listened to? **70%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **40%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **63%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **67%** of respondents answered 'Always'.
- If you asked for assistance, did you get it when you needed it? **66%** of respondents answered 'Always'. (based on those who answered with a response other than 'Not applicable').
- Did you feel you understood what was happening in your care? **69%** of respondents answered 'Always'.
- **76%** were satisfied with their overall experience.

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

To alleviate people feeling anxious and stressed while waiting, the Patient Experience Team have introduced mobile loaning library trolleys, stocked with books, magazines and patient activity packs for all levels of cognitive impairments to provide distraction. Personal radios and DVD players and DVDs are also available from the trolleys for patients to loan while on our wards to take their minds away from their problems. This project is now in the initial stages to be rolled out at UHL in the new financial year.

The team will be implementing the roll out of feedback kiosks/desktop machines across the Health Board to enable us to receive real time feedback from patients in our care. Reports generated will be circulated to staff leads within the appropriate Clinical Boards.

Person Centred Care

Mental Health Survey

SMS sent: 2677

Survey responses: 212

Response rate: 8%

74% were satisfied with their overall experience.

Patient Experience - CIVICA

Mental Health Survey results

Based on **212** partial/full survey completions (1st December 2023 – 31st January 2024 discharges).

- Did you feel that you were listened to? **57%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **38%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **62%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **58%** of respondents answered 'Always'.
- If you asked for assistance, did you get it when you needed it? **46%** of respondents answered 'Always'. (based on those who answered with a response other than 'Not applicable').
- Did you feel you understood what was happening in your care? **45%** of respondents answered 'Always'.
- **74%** were satisfied with their overall experience.

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

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

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

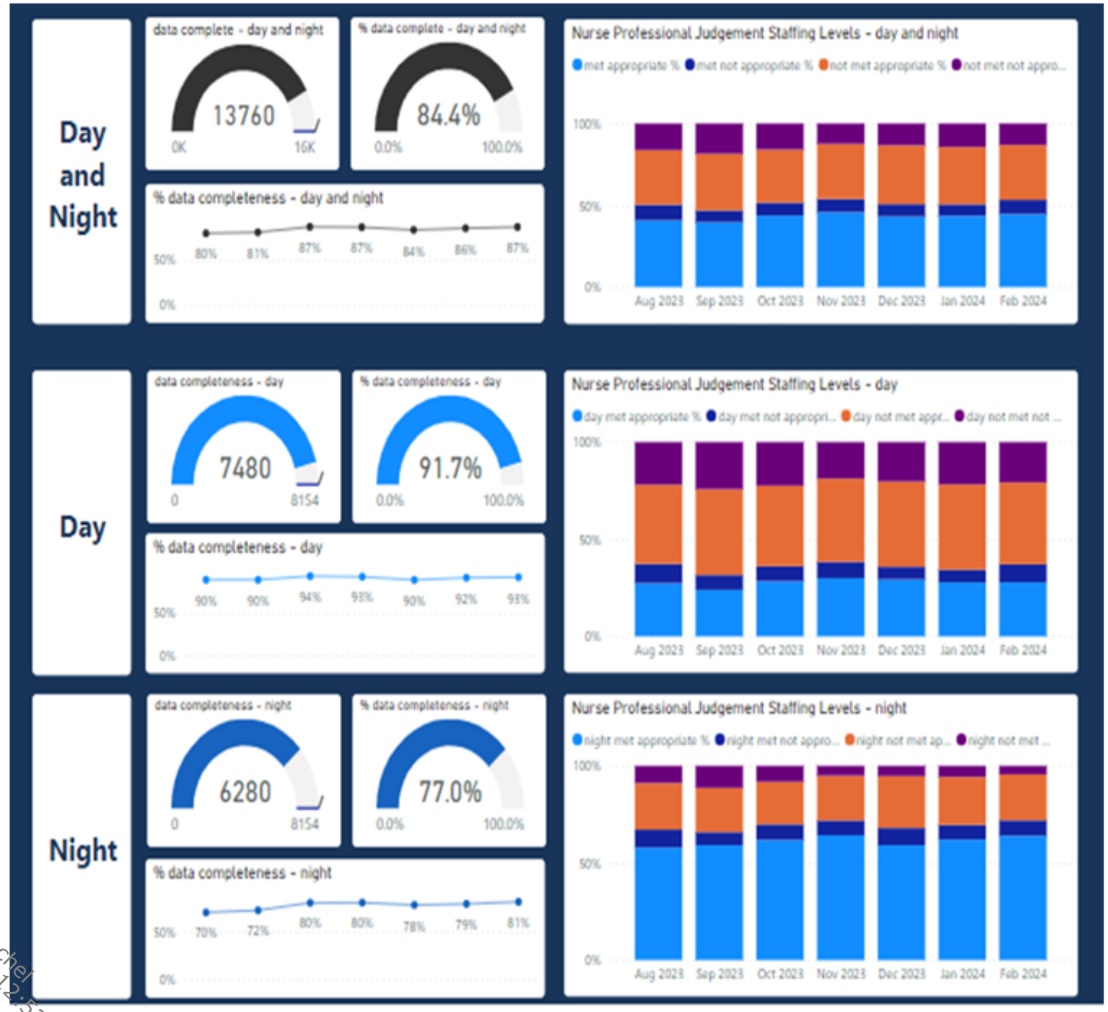
For those requiring special assistance in completing the questionnaire, a dedicated telephone helpline is available from 10am - 1pm, Monday – Friday and a dedicated email address has been created to manage feedback enquiries.

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

Effeithlon
Efficient

Efficient Care

Safe Care



- SafeCare is being used in over 90 clinical areas across the UHB.
- Mental Health and Maternity are now using SafeCare. This has required some adaptions to the system, such as developing 'Red Flags' and using different acuity tools specific for these clinical areas.
- Using professional judgement, the Nurse-in-Charge on each shift records if the nurse staffing level is appropriate. A further dashboard has been created to meet the reporting requirements of the Nurse Staffing (Wales) Act 2016. Reporting on four key metrics:

  i. Shifts where planned roster **met** and **appropriate** *(based on professional judgement of Nurse-in-Charge).*
  ii. Shifts where planned roster **met** but **not appropriate**.
  iii. Shifts where planned roster **not met** but **appropriate**.
  iv. Shifts where planned roster **not met** and **not appropriate**.

- This reporting is required for acute inpatient medical and surgical wards for adults and paediatrics *(25B Wards in the 2016 Act)*. February **SafeCare compliance was 86.9%.**
- The infographic on the left highlights that in the last six months a total of 77.9% of shifts have been recorded as appropriate by the Nurse-in-Charge. On nearly 15% of occasions the planned roster was not met and not appropriate *(purple block in graph)*.
- This information is broken down into days and nights providing the opportunity to review nurse staffing levels and develop effective rostering practices.

Report Title:	Sodium Valproate			Agenda Item no.	2.4
Meeting:	Quality, Safety and Experience Committee	Public	x	Meeting Date:	26th March 2024
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Executive Medical Director				
Report Author (Title):	Assistant Directror of Quality and Patient Safety				

Main Report
Background and current situation:

On 28 November 2023 the Medicines and Healthcare products Regulatory Agency published a National Patient Safety Alert, Valproate**: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.** The alert can be accessed at National Patient Safety Alert: Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients (NatPSA/2023/013/MHRA) - GOV.UK (www.gov.uk)

The MHRA required organisations to put a plan in place to implement new regulatory measures for sodium valproate, valproic acid and valproate semisodium (valproate). This follows a comprehensive review of safety data, advice from the Commission on Human Medicines and an expert group, and liaison with clinicians and organisations.

Due to the known significant risk of serious harm to a baby after exposure to valproate in pregnancy, these measures aim to ensure valproate is only used if other treatments are ineffective or not tolerated, and that any use of valproate in women of childbearing potential who cannot be treated with other medicines is in accordance with the Pregnancy Prevention Programme (PPP). Given these and other risks of valproate, these measures also aim to reduce initiation of valproate to only in patients for whom no other therapeutic options are suitable.

The regulatory change in January 2024, for oral valproate medicines, means that:

A. Valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply.

B. At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes.

Health organisations were required to implement a group to coordinate the implementation of the new regulatory measures by 31st January 2024 with an appointed chair with delegated responsibility for the actions in the alert, with representation from clinical leads in all specialties and to agree a mechanism by which the group can involve and be informed by patients with lived experience.

An initial meeting was convened by the Executive Medical Director on 9th January 2024 chaired by the Assistant Medical Director for Quality and Patient Safety and a follow up meeting was held on 26th January 2024. The group comprised clinical leaders from adult and paediatric neurology, mental health, primary care and pharmacy. It was agreed at the first meeting that representation form Epilepsy Action would be sought to represent the patient view.

Acute Child Health

All new prescriptions of Valproate will be independently considered by the Consultant Paediatric Neurologist. Correspondence to GPs and parents will document this, naming the two prescribing clinicians.

Mental Health
There is a relatively small cohort of patients currently prescribed valproate who require annual risk acknowledgement form (ARAF) to be completed to demonstrate compliance with Prevent (Pregnancy Prevention Programme). Specialist secondary authorisers are being identified within the community mental health teams with consideration given to providing independence by referring to staff for other CMHT.

Adult Neurology
Consideration is being given to providing virtual or multi-disciplinary team processes to support secondary consideration of valproate initiation or completion of ARAF forms.

Recognizing that the impact of the regulations on workload of specialist prescribing teams will increase as patients are initiated on Valproate in coming years there is a need to process map valproate prescribing and to understand the required resource. The Improvement and Innovation team have agreed to support this work with all three specialist areas in the coming months.

The attached improvement plan (appendix 1) provides oversight of actions underway or planned to meet the requirements of the patient safety alert.

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

From 31 January 2024 health organisations are required to ensure that valproate is not started in new patients younger than 55 unless two specialist independently consider and document that there is no other effective treatment.

In addition, women of child bearing potential should have a revised annual risk acknowledgement form at their next annual review, which includes the need for a second independent specialist signature.

The UHB has convened a group to oversee the implementation of the regulations and the wider assurance.

Recommendation:

The Board / Committee are requested to: **NOTE** the assurance provided by the actions undertaken to date and the ongoing program of work.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
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:

Appendix 1

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

Improvement Plan

Datix reference / WG SI reference / other reference:	NatPSA/2023/013/MHRA
Date Approved:	
Date Approved:	
Executive Director(s) Responsible:	Executive Medical Director
Monitoring Arrangements:	Valproate Task and Finish group

Recommendation number	Recommendation	Actions to Support the Recommendation	Is the Action Strong / Medium / Weak? (See hierarchy of interventions)	Designation of Person Responsible for the Action	Timeframe for Action – Immediate (within 1 month) Medium term (1 – 6 months) or Long term (6 months plus)	Date Completion of the Action Due	Evidence of Progress and Completion

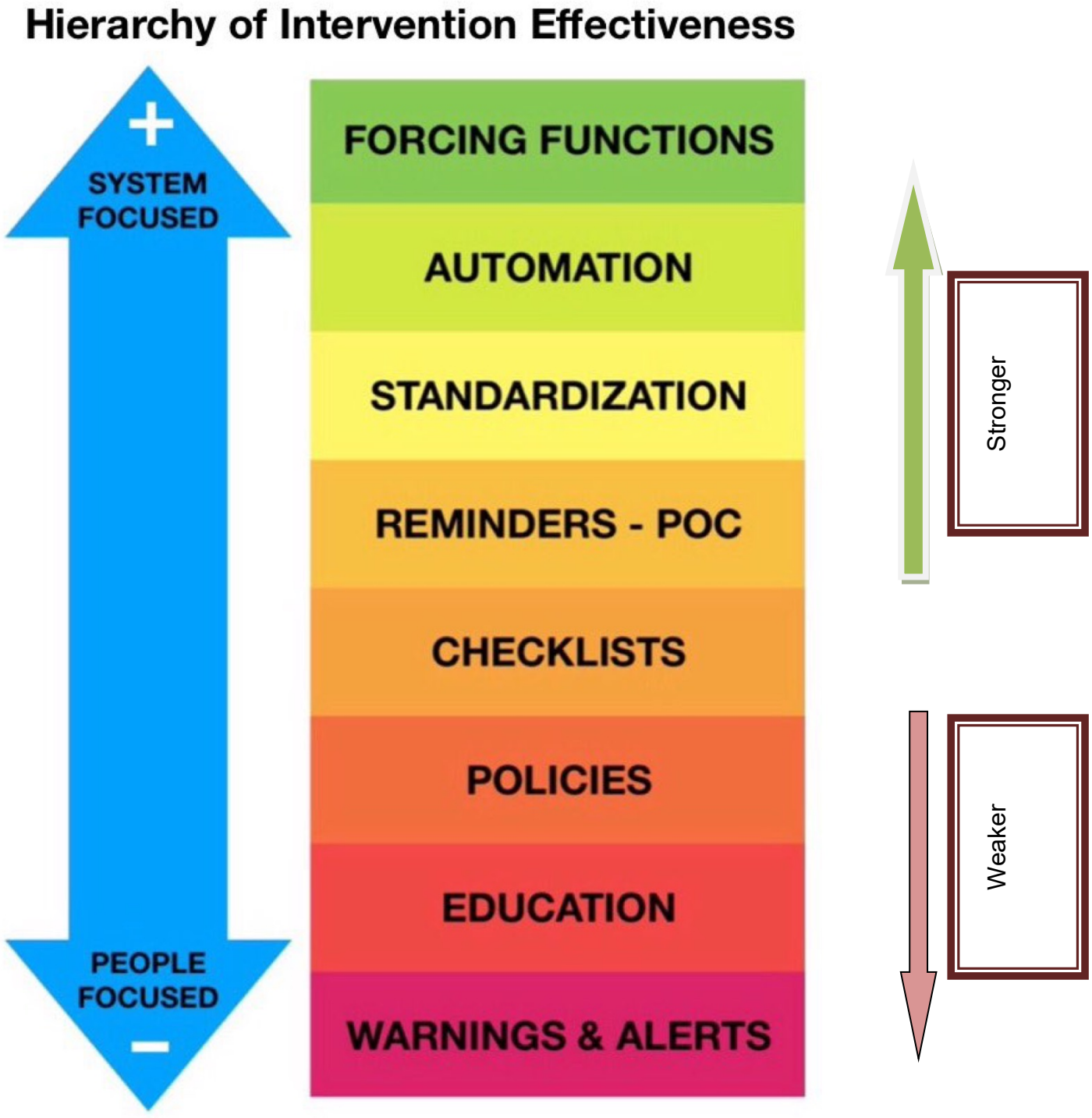
1.0	Implement a system to ensure that Valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply.	1.1 <u>Acute Child Health</u> Agreement in ACH that the Consultant Paediatric Neurologist will provide a specialist secondary opinion for all newly initiated valproate prescriptions. This will be documented in correspondence to both GPs and Parents identifying the names of both prescribing clinicians. 1.2 <u>Adult Neurology</u> Agreement that for all existing women of child bearing potential that require annual risk acknowledgement forms will have either virtual or MDT secondary consideration. 1.3 <u>Mental Health</u> Community Mental Health psychiatrist will provide cross cover to other CMHT. Consideration is being given to allocating some sessional resource from a current academic contract to support.		CD for Acute Child Health CD for Adult neurology CD for Community Mental Health	Complete Complete		

		1.4 Develop a health board wide alert and communication tools to make all staff aware of the new Valproate prescribing requirements. 1.5 Scope a review of Valproate dispensing within the inpatient setting to understand if it is initiated in any non-specialist areas.		AD for quality and Patient Safety CD of Pharmacy	March 2024 April 2024		
2.0	At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes	As above 1.1 - 1.6					

3.0	Updating all local guidance and protocols relating to prescribing of valproate to reflect the new regulatory position, including definitions of the roles and responsibilities of clinicians and provider organisations, and the recording of compliance with the risk forms	Valproate prescribing protocol to be developed with development of an EQIA		Patient Safety Lead for Pharmacy	June 2024		
4.0	Commissioning work if necessary to understand the needs of the affected population, including those people most at risk of health inequalities.	Consider population health measures to understand the impact of regulations on patient outcomes including seizure management, SUDEP and patient experience.			January 2025		

5.0	Reviewing the results of local audit(s) of compliance with the existing PPP measures for girls and women of childbearing potential prescribed valproate	Recruit into the Epilepsy Database coordinator post Validation exercise to establish that all women of child bearing potential who are prescribed valproate are included in the database. Quarterly Monitoring of PPP compliance from the central database through directorate quality and patient safety meetings Explore the opportunities for the development of a digital ARAF form to include working with DHCW around any potential national solution		Lead Nurse for Neurology Clinical Directors of Adult Neurology, Mental Health and Acute Child Health Quality and safety lead for Adult Neurology, Acute Child Health and Mental Health Chair of Valproate prescribing group	May 2024 May 2024 May 2024 April 2024		

6.0	Commissioning/determining the local pathways of care for women of childbearing potential and girls in relation to the prescribing and review of valproate.	Review of existing prescribing pathway for Valproate in women of child bearing potential with completion of an EQIA		Valproate Group in partnership with specialist prescribers	June 2024		
7.0	Planning for and identification of clinical resource to meet the identified needs of the population and implement the new regulatory measures.	1.4 Process Map pathways for Valproate prescribing and PPP in each specialist directorate with support from the I&I team to support development of a clinical pathway adequately resourced to meet the regulations.		I&I	April 2024		



- This applies to skill-based errors and device use
- It is not a model of human factors
- Weaker actions can be important, depending on the circumstances

Appendix 1

Report Title:	Looked After Children – Assessment Backlogs			Agenda Item no.	2.5
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	26th March 2024
		Private			
Status *(please tick one only):*	Assurance	X	Approval		Information
Lead Executive:	Executive Nurse Director				
Report Author (Title):	General Manager, Children, Young People and Family Health Services				

Main Report
Background and current situation:

The purpose of this report is to provide Committee Members will an updated position regarding assessments for Children looked after.

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

The Children Looked After (CLA) team are an integral part of the Children, Young People and Family Health Directorate and deliver statutory health requirements. It is well known that children in care have adverse health outcomes so the assessments are aimed at improving health outcomes and reducing health inequalities, as well as ensuring identified health needs are actioned and monitored.

The service is provided by a small staffing team of 1.1 WTE Consultant sessions, 1 Speciality Doctor session, and 7.30 WTE Specialist Nurses. The nursing team was increased in March 2023 in response to the number of children waiting for a statutory health assessment.

In January 2024 a Joint Inspectorate Review of Child Protection Arrangements (JIPCA) was undertaken in CAV as part of an All Wales review. The CLA service was reviewed and although it was noted that additional capacity had already been put into place to address the backlog of statutory assessments, further action was requested for CLA in line with the JIPCA Assurance Improvement Plan. The Directorate have reviewed the process in place for CLA health assessments ensuring they take place within statutory timescales, concluding with the required report. A number of actions are ongoing and being closely monitored as this paper describes below.

Performance against Statutory Regulations

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

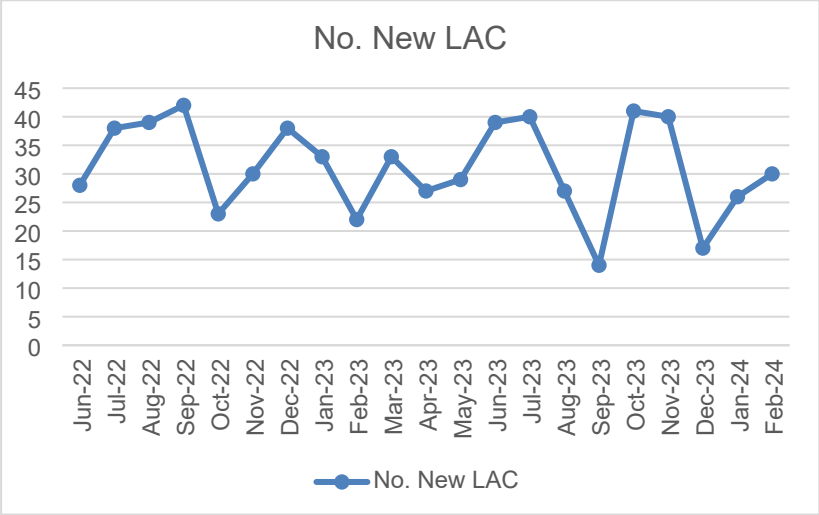
Growth

As previously reported there has been a consistent increase in children in care in Cardiff and the Vale of Glamorgan. There are currently 1,633 children on the CLA database in February 2024. Included within this are 386 children from Cardiff and Vale, who are looked after out of area. Therefore, there are 1,210 children living across Cardiff and Vale that the CLA team have statutory obligations around the new initial health assessment, and review health assessment. Health assessments for children placed out of area remain our responsibility, but are undertaken by the Health Board / Trust where the child is placed.

The increase in numbers of Looked after have a significant impact on the number of Initial & review Health Assessments required each year. However, capacity had remained the same until recently, resulting in a backlog of both new and review health assessments.

The graph below shows the number of new CLA cases per month. In 2023 there were 362 new cases referred into the service. This is an average of 30 new children every month.

Graph 1 - Number of new LAC referrals



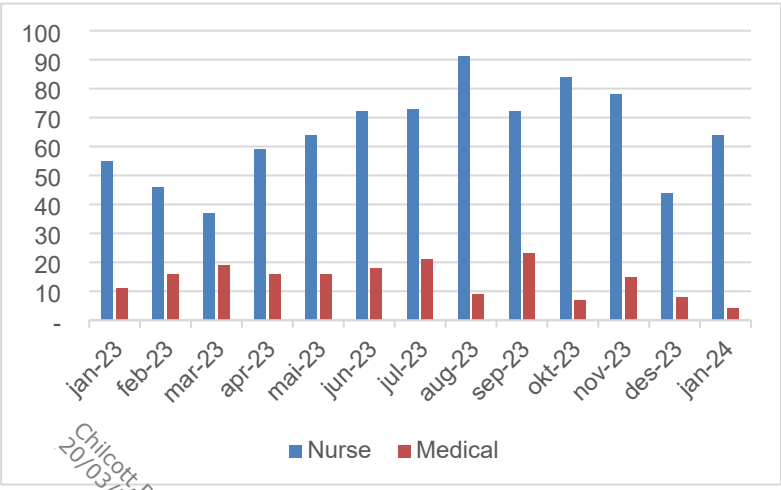
Impact of actions taken

An additional 2.90 WTE nurses have been appointed to increase the nursing workforce to 7.30wte.

Nurses are now undertaking all initial and review health assessments for children over 5. Prior to March 2023 medical staff were undertaking all health assessments for children under 10.

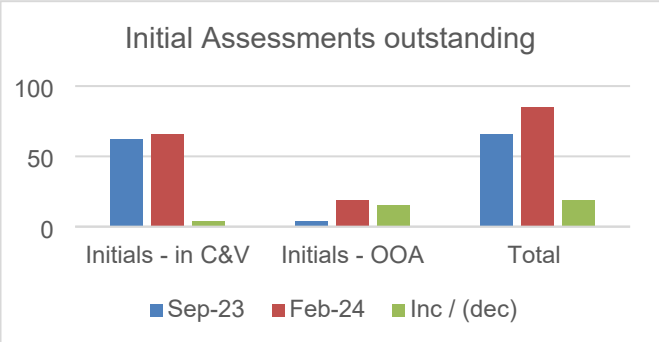
The graphs below demonstrate the fluctuation in Heath Assessments undertaken up to December, but despite the fluctuation in numbers of assessments we have seen an overall reduction in the backlog of Health Assessments.

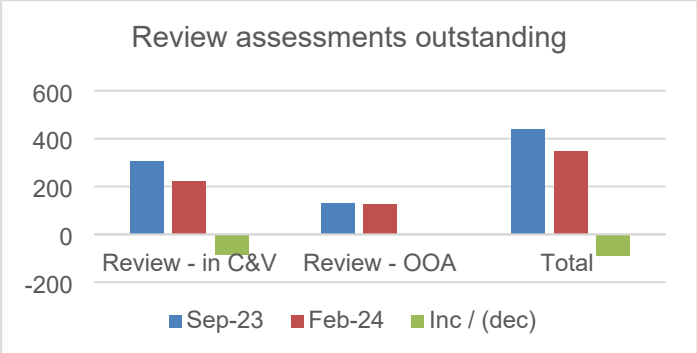
Graph 2 - Number of Health Assessments undertaken



There was a seasonal reduction in activity in December. Medical capacity is reduced due to maternity leave at present.

Graph 3 & 4 Number Health Assessments outstanding Sept 23 to Feb 24





The number of children awaiting an initial health assessment have increased overall, whereas the backlog of review assessments has reduced overall.

The number of children within Cardiff and Vale awaiting an initial health assessment has increased slightly since September 23, due to a reduction of capacity associated with maternity leave, and the number of new referrals in October and November were the highest two months, with 81 new cases (see graph 1). Capacity was also lower in December due to the Christmas period. Additional medical capacity has been secured commencing March 2024 to support initial health assessments.

There has been an overall reduction in the number of children awaiting a review assessment.

Whilst there has been a significant improvement in the numbers waiting, meeting these regulations continues to be a challenge.

We have recruited 4.20 WTE Specialist Health Visiting roles to contribute to review Health assessments for the under 5s review assessments. This is a pilot project with C & V UHB being the first health board in Wales to implement. This will clear the back log of the under 5s Health assessments and ensure they continue to be completed bi-annually as per statutory guidance.

Additional hours to be offered to the nurses to help clear the backlog of health assessments to be completed for over 5s.

In addition to the demand and capacity gap the increase in the number of children looked after has resulted in nurses carrying significant numbers of children on their caseload, in excess of the recommended 100. Based on the current over 5 caseloads this would require 10.30 wte (inc 0.80 WTE manager case holding all children placed (OOA), an increase of 3.20 WTE.

Summary of impact

- Additional CLA specialist nurses appointed, and will undertake HA for all children over 5. This has increased capacity by c 36 a month.
- Specialist HV will undertake review Health Assessments for all children under 5, currently 150 children
- Medical capacity will increase by c 14 initial assessments a month for under 5s by the end of Quarter 1 in 2024/25
- Medical capacity will further increase by c 7 initial assessments for under 5s when medical staff returns from maternity leave (exact date unknown)

Further actions to consider / complete

- Immediate review of role of trainee doctors and their contribution to health assessments for under 5s with a target activity of up to 2 clinics a month.

- Consideration of skill mix to be introduced to the team with named LAC health visitors and the potential recruitment of 2 Band 4 Assistant practitioner posts, which will support the nurses on delivery of healthcare. This aims to provide short term intervention which will alleviate pressures from other child health services. Funding would need to be secured or re purposed from alternative source.

- Review of outcomes from an Audit of quality of Health Assessments and information sharing. The audit will look at the quality and how differences information shared has an impact of the time the assessment takes, which will have a direct impact on the number of assessments that can be completed.

Recommendation:

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

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

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

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

Prevention	√	Long term	√	Integration		Collaboration		Involvement	

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

Risk: Yes
This has been risk assessed and entered onto the Risk Register
Safety: Yes
In the main body of the report
Financial: Yes
Immediate financial risk has been mitigated by redirecting resource to CLA service due to risk being held.
Workforce: Yes
Detailed in body of the report

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

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

Report Title:	MBRRACE-UK Neonatal report 2021 and National Neonatal Audit Programme			Agenda Item no.	2.6
Meeting:	QSE Committee	Public	x	Meeting Date:	26/03/2024
		Private			
Status *(please tick one only)*:	Assurance	X	Approval		Information	
Lead Executive Title:	Executive Medical Director				
Report Author (Title):	Dr Ian Morris (Clinical lead – neonatal medicine)				

Main Report

Background and current situation:

The Mothers and Babies : Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

The aim of the MBRRACE-UK programme is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

The most recent report, published in September 2023, relates to 2021 mortality data. CAV neonatal data is adjusted for similar units across the UK. These are level 3 NICUs that provide surgery, of which there are 26 such units in the UK. The latest published report can be accessed at MBRRACE-UK_Perinatal_Surveillance_Report_2020.pdf (ox.ac.uk)

Key summary for CAV 2021 data:

- MBRRACE includes deaths of babies born in Cardiff and Vale, at or above 24 weeks' gestation, and who died within 28 days of birth.
- 15 babies included in MBRRACE-UK criteria. An additional 14 deaths occurred in 2021 that do not meet MBRRACE-UK criteria; 5 babies born between 22-24 weeks' gestation, 4 outborn, 5 post-neonatal deaths.
- Stabilised neonatal mortality was 3.00 per 1000 live births (95% CI 2.05-4.43)
- This compares to 2.62 deaths per 1000 live births in similar UK units
- This is >5% above average for comparator group (level 3 NICU with surgery)
- When excluding congenital anomalies, CAV UHB rate is 1.81 per 1000 live births (95% CI 1.11, 2.88), which compares to 1.48 for similar UK units
- Internal data and other benchmarking databases suggest we are not an outlier for mortality, but consistently higher than average and not where we want to be

Neonatal mortalities are reported to MBRRACE-UK by designated reporters in the neonatal team. All deaths undergo a clinical review by a senior clinician who has had no or minimal involvement in the care of the infant, using the standardised Perinatal Mortality Review Tool (PMRT).

There were 15 reviews of deaths occurring on the neonatal unit at the University Hospital of Wales (UHW) and 1 review of death occurring in Great Ormond Street Hospital for Children, London.

The number and proportion of neonatal deaths reviewed where the perinatal mortality review group identified issues which they considered were likely to have made a difference to the outcome for the baby (Category D for maternal care): 1 (6.3%). This was related to severe perinatal hypoxic ischaemic encephalopathy.

The number and proportion of neonatal deaths reviewed where the perinatal mortality review group identified issues which they considered may have made a difference to the outcome for the baby (Category C for neonatal care): 3 (18.8%). Two cases were related to thermal management at delivery and after admission to the unit, where the infant was noted to have a low admission temperature outside the normal range. One case was related to severe perinatal hypoxic ischaemic encephalopathy.

Provisional 2022 data:

There is local unit data for 2022 that has been released in the last week. The full National report is expected in autumn 2024, which will inform our annual review of mortality in CAV. Key data can be seen below. Most crucially, the rate excluding congenital anomalies is revealing and once again demonstrates the profound effect that this group of babies have on our mortality rate. In 2022, 60% of neonatal deaths were attributed to congenital abnormalities. It is also important to consider that changes in stillbirth rates are likely to impact neonatal and perinatal mortality rates and that improvement plans must include a perinatal approach.

Perinatal mortality (all deaths)

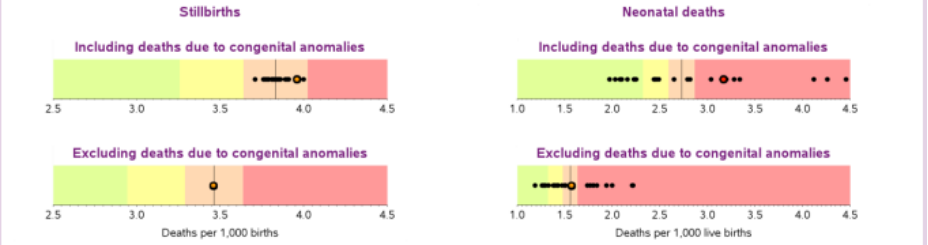
Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	30	5.76	3.96	(3.23 to 5.14)	Up to 5% higher or up to 5% lower
Neonatal	15	2.89	3.17	(2.04 to 4.75)	More than 5% higher
Extended perinatal	45	8.63	7.10	(6.05 to 9.37)	More than 5% higher

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	26	5.00	3.46	(2.93 to 4.33)	Up to 5% higher or up to 5% lower
Neonatal	6	1.16	1.57	(0.98 to 2.35)	Up to 5% higher or up to 5% lower
Extended perinatal	32	6.16	5.03	(4.38 to 6.38)	Up to 5% higher or up to 5% lower

Comparisons with similar Trusts and Health Boards

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



Internal data and reviews as to important areas to focus on improving following 2021 report:

- High nosocomial infection / late onset sepsis – 2023 saw an extensive action plan developed in response to this.
- Improvements needed in admission temperature, delayed cord clamping, breastfeeding rates – QI projects were initiated and these were all areas we performed well on in the 2022 National neonatal audit programme (NNAP)
- During 2021, several old incubators on NICU had serious failures where they failed to maintain temperature and humidity in the incubators, especially during procedures. This issue was identified even before the mortality reviews were completed, and a significant investment was put in to buy new efficient incubators.
- Infection peaks with high acuity and low staffing – ongoing action plan around nursing workforce, including recruitment of international nurses, enhanced overtime and new resources for nurses for practice education and transitional care units.
- Risk/governance processes for NICU were inadequate – 2023 has seen investment with the appointment of an 8a lead for governance and 1 consultant session for risk.

There has also been a change to a perinatal governance mode and a review and restructure of neonatal and maternity governance meetings to enhance collaborative efforts on perinatal morbidity and mortality.

- Lack of beds and staff leading to high acuity patient load. This means that the highest risk patients are prioritized in CAV and *may* influence our data. This will be ongoing until network cot reconfiguration plans are finalized alongside additional funding required for workforce expansion.
- Consultant presence – shift monitoring and departmental reviews suggest that on-site consultant presence needs to be expanded to include evenings (now resident until 22:00) and nights as a result of patient acuity and declining skills and experience of the junior doctor workforce. This will require significant investment as 24-hour consultant cover would need an addition of at least 4 WTE consultants. A business case is in early stages.
- Recommendations specific for mortality review processes:

    - Improve timeliness of reviews - recommended within 6 months, we are now just achieving this having improved in each of the last 5 years
    - Involvement of a wider MDT: Lead neonatal nurse for mortality reviews and bereavement (funding agreed, not recruited). Dedicated nursing support for governance (agreed, appointed December 2023). Wider involvement of obstetricians, fetal medicine consultants and midwives (not yet achieved). Involvement of surgeons, cardiologists for specialist input review (not yet achieved)

The National Neonatal Audit Programme (NNAP) is a national clinical audit run by the Royal College of Paediatrics and Child Health (RCPCH). It is commissioned by the Healthcare Quality Improvement Partnership (HQIP). Data is in the public domain and units are identifiable. The latest report can be accessed at NNAP-Summary-report-on-2022-data-VERSION-2.pdf (hqip.org.uk).

When reviewing 2022 NNAP data that has been adjusted for treatment affect (i.e. case mix variations between units) where appropriate, we see that there are areas of good performance including normothermia on admission, deferred umbilical cord clamping, and breast-feeding during admission and at point of discharge. These were all areas identified for improvement previously.

However, we do see performance below comparative average for timely administration of antenatal corticosteroids and magnesium sulphate, and timeliness of Retinopathy of prematurity screening. Note that in 2023 and 2024 we have instigated quality improvement work in these areas.

We have a statistically significant, higher than average incidence of blood stream infections.

The rates of infection among preterm infants cared for at UHW have been an ongoing issue, although worsened in 2022. A separate benchmarking exercise that we contribute to, the Vermont Oxford Network (VON), also suggests our infection rates are higher than expected for preterm babies when compared with other, similar, international units for each of the last 5 years.

In the first half of 2023, we continued to see an increase in our infection incidence. Noting this the neonatal senior team wrote to the executive team in August 2023 highlighting concerns regarding infection rates and key contributory factors, including:

- Inadequate nursing staffing levels and proportion of ‘qualified in speciality’ on a significant majority of shifts. We have identified an association between our infection outbreaks and periods of increased infection incidences, with times of high acuity and insufficient nursing staff for the number of infants on the unit.
- Year-on-year critical care cot occupancy levels exceed those recommended by the British Association of Perinatal Medicine (BAPM).
- Medical workforce gaps and failure to staff according to national recommendations.

Alongside these over-arching factors, a departmental working group was convened to review all aspects of infection prevention on the neonatal unit. Over 30 actions were identified, grouped in to 4 key themes: environmental, equipment, workforce, and clinical practice. All actions have identified responsible teams and timescales. Regular executive review meetings were held and now continue in the newly formed monthly exec chaired MatNeo oversight group.

Some successes have been seen, including the development of a departmental infection prevention team, 100% compliance of medical staff in ANTT training, consistent excellent performance in IPC audits for hand hygiene and 'bare below the elbow', and audits and QI work around antibiotic stewardship, feeding practice and central line care.

Ongoing work continues with storage across the unit, workforce recruitment strategies and dedicated time for IPC education and training. There is also ongoing collaboration with the 'Releasing Time to Care Team'.

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

- Stabilised neonatal mortality was 3.00 per 1000 live births (95% CI 2.05-4.43)
- This compares to 2.62 deaths per 1000 live births in similar UK units
- This is >5% above average for comparator group (level 3 NICU with surgery)
- When excluding congenital anomalies, CAV UHB rate is 1.81 per 1000 live births (95% CI 1.11, 2.88), which compares to 1.48 for similar UK units
- In 2022, 60% of neonatal deaths were attributed to congenital abnormalities
- We have a statistically significant, higher than average incidence of blood stream infections.
- In the first half of 2023, we continued to see an increase in our infection incidence. Noting this the neonatal senior team wrote to the executive team in August 2023 highlighting concerns regarding infection rates and key contributory factors.
- The development of a departmental infection prevention team, 100% compliance of medical staff in ANTT training, consistent excellent performance in IPC audits for hand hygiene and 'bare below the elbow', and audits and QI work around antibiotic stewardship, feeding practice and central line care have been observed in 2023
- Ongoing work continues with storage across the unit, workforce recruitment strategies and dedicated time for IPC education and training. There is also ongoing collaboration with the 'Releasing Time to Care Team'

Recommendation:

The Committee is requested to **NOTE** the results of both the MBRACE and NAP audits and the improvement work underway to address the requisite improvements and are asked to:

a) Support ongoing work around medical and nursing workforce recruitment strategies
b) Support existing executive oversight of infection action plan
c) Support any recommendations and actions that arise from the RTTC team collaboration
d) Support national cot reconfiguration programme in increasing capacity, with appropriate funding of additional resources that will be required in collaboration with WHSSC.

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	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	

3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		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	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category.* ***If yes please provide further details.***
Risk: No
Safety: No
Financial: Yes
Workforce investment will create additional cost. For nursing, the strategy includes overseas recruitment, specialist enhanced overtime rates and protected non-clinical time for education and training. A business case for additional medical workforce is required. There will be a small financial ask for visual aids for IPC messaging on the unit.
Workforce: Yes
As above
Legal: No
Reputational: Yes
MBRRACE-UK data and NNAP data are in public domain. The high incidence of infection is in the public domain. This creates a reputational risk if not improved. Mitigations are the existing, extensive action plan. Communication with parents and the neonatal network and WAG have been produced for infection outbreaks.
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Several actions should positively contribute to UHB decarbonization strategies including the reduction of surplus stock ordering and reduction in use of non-sterile gloves for patient care.

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

Chilcott Rachel
20/03/2024 12:53:49

Report Title:	Optimising Outcomes Policy - update			Agenda Item no.	*3.2*
Meeting:	Quality, Safety and Experience Committee	Public	X	Meeting Date:	26th March 2024
		Private			
Status *(please tick one only):*	Assurance		Approval	✔	Information
Lead Executive Title:	Executive Director of Public Health				
Report Author (Title):	Consultant in Public Health Medicine				

Main Report
Background and current situation:

Background

The Optimising Outcomes Policy (OOP) was adopted by Cardiff and Vale University Health Board (UHB) in 2013. The aim of OOP is to systematically embed supportive management of smoking cessation and weight management in elective surgical pathways. The OOP identifies action to be taken as part of elective surgical pathways in order to deliver effective behaviour change support to people who smoke and/or people with a Body Mass Index of 40 or above.

The last review of the policy was approved in February 2020 and a further review is now due.

Current situation

A small working group reviewed the policy, its accompanying procedure and the associated EQIA/HIA.

No changes have been made to the policy statements.

Significant service development has taken place in Cardiff and the Vale of Glamorgan in response to, and following, the COVID-19 Pandemic. Changes have been made to the supporting documents which make appropriate links with current Optimisation, Prehabilitation and Rehabilitation Services.

The revised aims of the Optimising Outcomes Policy are therefore to:

- Support best optimisation and prehabilitation practice by ensuring the lifestyle risk factors of smoking and living with obesity are appropriately managed in elective surgical care pathways.
- Introduce a systematic approach to supporting patients to access smoking cessation and weight management support, with the aim of reducing the risk of post-operative complications for the patient.
- Actively promote and support health and wellbeing via the Keeping Me Well Website.
- Ensure patient centred care and a compassionate approach to lifestyle change remain at the heart of this policy.

Policy monitoring arrangements ceased during the COVID-19 pandemic. Governance arrangements have been updated to take account of new oversight and proposed monitoring arrangements.

No significant changes have been made to the EQIA and HIA assessments; both assessments found the policy to have an overall positive impact.

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

Maximising health is a critical element in achieving a sustainable health service into the future. The Optimising Outcomes Policy enables a systematic approach to addressing the lifestyle risk factors of smoking and living with obesity in elective pre-operative patients. The policy remains a relevant part of preoperative care that supports best practice around prehabilitation, ensures that preventative action is considered and teachable moments utilised, and contributes to reducing the risk of inter and post operative complications and thus an optimal post-operative outcome.

Recommendation:
The Committee is requested to: a) APPROVE the updated Policy documentation

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

Five Ways of Working (Sustainable Development Principles) considered *Please place an "X" in the below boxes 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: [redacted]/No
No new risk assessments were undertaken in updating the policy documents
Safety: Yes/[redacted]
This Policy aims to improve patient safety by ensuring that appropriate support is offered to manage the risk factors of smoking and a BMI of 40 + in the pre-operative period.
Financial: [redacted]/No
No additional financial considerations
Workforce: [redacted]/No
No additional workforce considerations
Legal: [redacted]/No
Legal advice was sought when the Policy was originally developed, but not for this update
Reputational: Yes/[redacted]
There is a reputational risk in not offering support to people who are on waiting lists for elective surgical care, to ensure they are as fit as possible to receive treatment.
Socio Economic: Yes/[redacted]
An Equality Impact assessment has been undertaken.
Equality and Health: Yes/[redacted]
An Equality Health Impact Assessments (EHIA) was conducted when the Policy was initially developed, and has been revised as part of this update.
Decarbonisation: Yes/[redacted]
This Policy aims to prevent ill health, utilises community based services and encourages self-management. It therefore supports action to reduce carbon emissions.
Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Reference Number: Version Number: FINAL	Date of Next Review: Previous Trust/LHB Reference Number: UHB 224

OPTIMISING OUTCOMES POLICY

Policy Statement

To ensure the Health Board delivers its statutory responsibility for improving the health of the population of Cardiff and the Vale of Glamorgan as well as providing individual patient centred care for promotion, prevention, diagnosis, treatment and rehabilitation, we have adopted an Optimising Outcomes Policy.

The policy contains two statements (relating to smoking and weight management) that must be applied in the context of a patient's individual clinical need which is ultimately to be determined by the clinician responsible for their care.

1 Smoking[1]

Anyone being referred or listed for an elective intervention who is recorded as a smoker is expected to have been offered, accepted and completed smoking cessation support prior to their surgery.

2 Weight management[2]

Anyone being referred or listed an elective intervention who has recorded a BMI of 40 or above is expected to have been offered, accepted and completed weight management support prior to their surgery.

[1] Smoking cessation support includes the following services: Community or hospital based NHS Smoking Cessation Services.

[2].Weight management support includes one of the following services: Community Dietetic Service, National Exercise Referral Scheme, commercial weight management programmes. Whilst non-NHS provider weight management programmes are an option they currently lie outside of the NHS resourced referral pathway

Policy Commitment

Maximising health is a critical element in achieving a sustainable health service into the future. The Optimising Outcomes Policy enables a systematic approach to addressing the lifestyle risk factors of smoking and living with obesity in pre-operative patients. It enables people to be given appropriate support, with the aim of helping them to experience an optimal post-operative outcome. In supporting best practice around prehabilitation, the policy will therefore ensure that the appropriate management of lifestyle risk is a routine part of elective surgical care pathways.

This policy supports the Cardiff and Vale University Health Board Smoke Free Policy, the Public Health (Wales) 2017 Act and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 which make it illegal to smoke on hospital grounds. It also supports the Welsh Governments Healthy Weight, Healthy Wales Strategy, and the Cardiff and Vale Move More Eat Well Strategy and Plan.

Supporting Procedures and Written Control Documents

This Policy and the Optimising Outcomes Policy Supporting Procedures describe the following with regard to the Optimising Outcomes Policy.

- Background
- Aims
- Objectives
- Roles and responsibilities
- Application of this Policy
- Training
- Communication
- Resources
- References
- Definitions

Other supporting documents are:

- Keeping Me Well patient information resources for preparing for surgery, stopping smoking, eating well and weight management
- Clinician information sheet – smoking cessation
- Clinician information sheet – weight management
- Frequently Asked Questions for Clinicians
- No Smoking and Smoke Free Environment Policy
- Compassionate Conversations (UHB Sharepoint link only)
- Making Every Contact Count (UHB Sharepoint link only)

Scope

The Policy applies to all patients aged 16 years and above who are residents of Cardiff or Vale of Glamorgan local authority areas, with the exception of the exclusions listed below. Patients who receive surgical treatment with Cardiff and Vale UHB but do not live within these two local authority areas will not be included in the Policy.

People who smoke and have a BMI of 40 or above will need to complete both pathways.

Anyone being considered for an elective intervention should be referred to smoking cessation services at the earliest opportunity, preferably within primary care, so the intervention is most effective in improving outcome. A 'second offer' of support should be made at the first secondary care outpatient appointment if initial offer was not made or not already undertaken.

Similarly, anyone being considered for an elective intervention should be referred to weight management services or signposted to a preferred commercial slimming club at the earliest opportunity, preferably by primary care at the point of referral, as this will maximise outcomes. A 'second offer' of support should be made at the first secondary care outpatient appointment if initial offer was not made or not already undertaken.

Completion of a programme can include:

- Attendance at 4 out of 6 Smoking Cessation sessions (clarify treated smokers)
- Attendance at initial assessment appointment for Weight Management and uptake and completion of intervention offered:
  - Minimum of 4 one-to-one sessions
  - 7 out of 10 Eating For Life sessions
  - 6 out of 8 Foodwise sessions
- A minimum of 2 sessions a week for 16 weeks of National Exercise Referral sessions
- Accessing on line tools and resources – eg Keeping Me Well website.

Exclusions

Exclusions apply primarily to enable access to urgent care. However, all patients should be offered access to smoking cessation and/or weight management at the same time, regardless of urgency at the earliest opportunity.

Exclusions include:

- Patients requiring emergency surgery
- Patients receiving surgery for the treatment of cancer
- Patients who have a BMI of 40 and above with specific endocrine conditions which make them medically unsuitable for this pathway (weight management exclusion only)

No specific definition of elective and urgent care is provided, as it depends on the specific case of the individual patient and the type of procedure being advised.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in the EqIA/HIA document
Health Impact Assessment	A Health Impact Assessment (HIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in the EqIA/HIA document.
Policy Approved by	
Group with authority to approve procedures written to explain how this policy will be implemented	Quality, Safety and Experience Committee
Accountable Executive or Clinical Board Director	Executive Director of Public Health

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	29/10/2013	17/04/2014	New policy introduced • Statements on the smoking cessation and weight management support required in Cardiff and Vale University Health Board elective surgical care pathways
2	13/05/2014	16/06/2014	Amendment to policy statements
3	28/07/2016	18/08/2016	• Policy reformatted into new UHB style. • Operational detail transferred into procedures document
4	18/02/2020	03/03/2020	• Information added to reflect expected changes in legislation effecting smoking on hospital sites • Update to service referral details and current versions of information resources

			• Additional evidence added to evidence in appendix 1 of procedures document
5	To be added	To be added	Reviewed to take account of the development of prehabilitation within the UHB since 2020: • Policy updated to ensure all links and reference to services and supporting materials are up to date • Additional referral details added for weight management support • Service contact details updated • Additional detail added to recommend earliest possible referral • Update governance and reporting arrangements

Reference Number: **Version Number:** FINAL	**Date of Next Review:** **Previous Trust/LHB Reference Number:** UHB 224

Optimising Outcomes Policy Supporting Procedures

Introduction and Aim

This document outlines the supporting procedures for the optimising outcomes policy in order to achieve consistent implementation across the Cardiff and Vale University Health Board (UHB)

Objectives

- Outline the background, evidence and rationale for the policy
- Provide details of the policy statements, aims, objectives, scope and exclusions
- Provide guidance on the implementation of the policy in practice
- Provide details of the resources available to support implementation
- Summarise the finding of the EqIA
- Outline plans for monitoring and audit
- Identify recommended review period

Scope

These procedures apply to all staff in all locations, including those with honorary contracts, who manage patients that may need to access elective surgical pathways.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in the EqIA/HIA document
Health Impact Assessment	A Health Impact Assessment (HIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in the EqIA/HIA document.
Documents and online resources to read alongside this Procedure	• Keeping Me Well patient information resources for preparing for surgery, stopping smoking, eating well and weight management • Clinician information sheet – smoking cessation • Clinician information sheet – weight management • Frequently Asked Questions for Clinicians • No Smoking and Smoke Free Environment Policy • Compassionate Conversations (UHB Sharepoint link only) • Making Every Contact Count (UHB Sharepoint link only)
Approved by	Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	Executive Director of Public Health
Author(s)	Consultant in Public Health Medicine
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	28/07/2016	18/08/2016	• Contents previously contained in policy. Transferred to separate document in line with revised UHB style. • Operational details of services update • Literature review updated
2	18/02/2020	03/03/2020	• To reflect expected changes in legislation effecting smoking on hospital sites • Update to service referral details and current versions of information resources • Additional evidence added to evidence in appendix 1
3	To be added	To be added	Reviewed to take account of the development of prehabilitation within the UHB since 2020: • Policy updated to ensure all links and reference to services and supporting materials are up to date • Additional referral details added for weight management support • Service contact details updated • Additional detail added to recommend earliest possible referral

			• Update governance and reporting arrangements

CONTENTS

1. INTRODUCTION

In July 2013, the UHB Board approved the Optimising Outcomes Policy statements relating to Smoking Cessation and Weight Management. The Policy was approved by the People, Performance and Delivery Committee (PPDC) on 29th October 2013 and the Policy became operational from 1st December 2013. Amendments to the Policy were made in the light of feedback received during early implementation and accepted by the PPDC on 13th May 2014. Policy reviews were conducted in 2016 and 2019, in accordance with UHB governance arrangements, when minor amendments were made to supporting information. A further update was carried out in 2023/24 to take account of the new services and structures put in place during and after the COVID-19 pandemic. These procedures support the amended version of the Policy and now links with Optimisation, Prehabilitation and Rehabilitation Services, details of which can be found at Keeping Me Well.

2. GUIDANCE AND EVIDENCE

This information is attached as Appendix 1.

3. AIM

The aim of this policy is to:

- Support best optimisation and prehabilitation practice by ensuring the lifestyle risk factors of smoking and living with obesity are appropriately managed in surgical care pathways.
- Introduce a systematic approach to supporting patients to access smoking cessation and weight management support, with the aim of reducing the risk of post-operative complications for the patient.
- Actively promote and support health and wellbeing via the Keeping Me Well Website.
- Ensure patient centred care and a compassionate approach to lifestyle change remain at the heart of this policy.

4. OBJECTIVES

The objective of the Policy and the supporting procedures is to improve health by promoting action to limit risks associated with smoking and living with obesity prior to, during and after surgery to protect and promote the health of the patient.

In order to achieve this, the following will be implemented:

- Provide effective communication processes to ensure compliance and adherence to the policy in Primary and Secondary Care.
- Provide effective communication processes to ensure the public are aware of the policy and understand the policy aim.
- Ensure Primary Care practitioners offer timely referral to smoking cessation and/or weight management support for those patients who smoke and/or live with a BMI of 40 or above that may require a surgical intervention.
- Ensure smoking cessation and weight management services are able to provide timely support for identified patients.
- Ensure that appropriate arrangements are in place for monitoring of the policy
- Ensure a 'second offer' of support is made at the first secondary care outpatient attendance if not already offered or undertaken.
- Ensure full UHB commitment and reinforcement of support from all independent members, executive directors, senior clinicians and managers.
- Ensure appropriate information (including patient information leaflets, digital resource and accessible formats) are available for staff and patients.

If a patient does not accept the offer of referral, or complete the support programme, the surgical clinician responsible for the patient's care should determine whether surgery will go ahead based on an assessment of all relevant operative risk factors.

5. DEFINITIONS

A full list of definitions used in this policy are listed in Appendix 2.

6.ROLES AND RESPONSIBILITIES

6.1 The UHB Board

The UHB Board has agreed the policy statements, and the Quality, Safety and Experience Committee will be responsible for monitoring the policy on behalf of the UHB Board.

6.2 Chief Executive

As Accountable Officer the Chief Executive is ultimately accountable for the effective management of the UHB's business and in particular for ensuring that policies are adhered to.

6.3 Executive **Director of Public Health**

The Executive Director of Public Health is responsible for ensuring the appropriate policy with regard to optimising outcomes is in place on behalf of the Chief Executive of the UHB. The Executive Director of Public Health advises and supports the commitment to this policy.

6.4 Directors and Clinical Board Directors

Directors and Clinical Board Directors have responsibility for compliance with the Optimising Outcomes Policy at Primary and Secondary Care level.

They should ensure that everyone in their Clinical Board/Directorates understands their responsibilities in ensuring compliance and this is reviewed and promoted at regular intervals.

6.5 Clinical Governance Leads

Leads on Clinical Governance in each Directorate will ensure that presentations on the policy (including smoking cessation and weight management) feature at least annually in their audit sessions with reference to the Optimising Outcomes Policy.

6.6 Clinical Service Managers

Clinical Service Managers in relevant Clinical Boards have a responsibility to ensure that their staff are aware of the policy and patients are referred in compliance with the policy.

6.7 All Employees

All UHB employees and independent contractors commissioned by the UHB for its population have a responsibility to inform patients about the policy and to offer referral to relevant services prior to their surgery. They also have a responsibility to promote the health and wellbeing of our population.

7. APPLICATION OF THIS POLICY

7.1 Patient information

Patients will be informed about the policy by their GP in a Primary Care setting and also by a member of staff at their first outpatient appointment at hospital and provided with a patient information and signposted to Keeping Me Well website

7.2 Non-compliance

The commitment to enforcing this policy should not just be a formal statement but be evident in the day to day activities of the UHB, so that it is readily known and understood by all staff. Where managers become aware of deficiencies in adherence to the policy they are required to take action to address this through promotion of the policy and relevant training.

See Compassionate Conversations and MECC.

Managers and staff are jointly responsible for ensuring that:

- Patients are aware of and understand this policy
- The policy is monitored in their own areas and contraventions are identified and managed.

7.3 Referral to relevant services for patients

Smoking Cessation
NHS Smoking Cessation services are available to support patients to stop smoking. People who smoke tobacco are four times more likely to successfully quit smoking with NHS stop smoking support, than going it alone. For all groups, quitting smoking will increase life expectancy, reduce the risks of ill health and optimise surgical outcomes. Pregnant smokers are more likely to have a healthier pregnancy and a healthier baby.

Help Me Quit community based smoking cessation services.

Help Me Quit (HMQ) is the NHS stop smoking service in Wales and offers people who smoke the greatest chances of success by providing structured, tailored and expert support, carbon monoxide monitoring and access to free licensed stop smoking medication .

Patients can choose one-to-one or group weekly sessions. These sessions are available across Cardiff and Vale of Glamorgan in community venues, and at different times of day (morning, afternoon or evening). Telephone support is also available for patients if they prefer this option. All patients will receive expert behavioural support and free no-smoking medication.

People who smoke can self refer by calling 0800 085 2219, Texting HMQ to 80818 (to get a call-back) or by visiting: www.helpmequit.wales/quit-now to request a call-back

Professionals can refer people who smoke by: Telephone (with client permission) on 0800 085 2219 or by using the professional referral short-form: www.helpmequit.wales/professional-referrer/

Hospital in-house smoking cessation services

Contact details: Helen Poole, Smoking Cessation Counsellor
02921 843582 (University Hospital Wales, Cardiff)
helen.poole@wales.nhs.uk

A hospital in-house smoking cessation service exists for all staff and patients (and their families) accessing Cardiff and Vale UHB. The service can be accessed either by self-referral or referral 'in house' (such as from a Clinician/GP) within the UHB. The programme incorporates elements from various behavioural therapies to allow flexibility, tailoring support to each individual. The first month consists of an intensive phase of weekly advice and support sessions, which includes a discussion of the various kinds of treatment available, such as Nicotine Replacement Therapy (NRT) and the newer stop-smoking aids that do not contain nicotine such as Buproprion (Zyban). The in-house service is also able to prescribe NRT patches/lozenges (signed by an

appropriate consultant). Follow up sessions take place at 3, 6 and 12 months, with telephone support at 2, 5 and 9 months.

Community Pharmacy Smoking Cessation Service

An Enhanced Level 3 Smoking Cessation Service for Community Pharmacists operates in specific locations across Cardiff and Vale UHB.

Smokers wishing to quit can access the participating Pharmacy directly and are offered one-to-one weekly support in the Community Pharmacy and free NRT.

Alternatively, some GP Practices offer smoking cessation support either as a routine appointment or in a dedicated smoking cessation group or one to one meeting.

See Smoking Cessation Health Pathway for more information.
https://cardiffandvale.communityhealthpathways.org/

Weight Management
Weight management services are available to support patients to lose weight; following an initial assessment with a dietitian patients may choose either group or one-to-one support. One-to-one support is available over four to six sessions, held two weeks apart, depending on patient preference. All options are listed below

- Eating for Life – group intervention
- One to one dietetic support –
- Diabetes programmes (if relevant)
- Foodwise for life – self referral available through Keeping Me Well website
- Level 3 weight management service referral
- Sign posting

See Primary Care weight management Health Pathway for further information
https://cardiffandvale.communityhealthpathways.org/

Contact details: GP e-referral to Community Dietetic Service.
https://cardiffandvale.communityhealthpathways.org/
Tel: 02920907681 Email: Dietitian.Reception.UHW@wales.nhs.uk

Patients can also self-refer by e-mailing dietitians.cav@wales.nhs.uk or via Tel: 02920668089

Peer support sessions are being piloted by the weight management service and if successful will be rolled out as a permanent feature of the weight management service. One-to-one appointments are offered to people where a group education programme is not suitable.

Details of weight management service referral pathways can be found on the UHB Sharepoint site
Weight Management Services sheet (1).pptx (sharepoint.com)

- National Exercise Referral Scheme (NERS)

NERS is an evidence-based health intervention incorporating physical activity and behavioural change techniques, to support referred clients to make lifestyle changes to improve their health and wellbeing.

Once referred, patients that meet the criteria are invited to their local leisure centre for an initial assessment with a qualified exercise referral professional. They will be offered a tailored, supervised exercise programme for 16 weeks and their progress will be reviewed at key points.

Health care professional can refer patients via the NERS New Patient Management System - Public Health Wales (nhs.wales)

Once patients have completed the programme they can access a discounted NHS leisure centre membership.

Alternatively, patients can refer themselves to commercial weight management programmes, however this option will not be funded by the NHS.

8. TRAINING and resources for staff

Issues related to smoking cessation, weight management and public health will be included in the following:

- Cardiff and Vale UHB Induction
- Making Every Contact Count training (MECC) Level 1 and Level 2 (raising the issue of lifestyle behaviour change, including smoking and weight management, with a patient)
- Compassionate Conversation Cards
- Keeping Me Well Website
- Bespoke training available on request from Community Dietetics dietitians.cav@wales.nhs.uk

9. COMMUNICATION

9.1 Communication to staff

This policy will be communicated to staff via the internet, Sharepoint, clinical portal and bulletins.

Leads on Clinical Governance in each relevant Directorate will ensure that presentations feature at least annually in their audit sessions with reference to the Optimising Outcomes Policy.

All induction for relevant staff must refer to this policy.

9.2 Communication to Patients

Patients will be informed about the policy at the point of GP engagement and encouraged to access smoking cessation and/or weight management services prior to engagement with Secondary Care services. Patients will also be reminded about the policy at the first point of engagement with Secondary Care.

Patients ideally need to be referred from all initial assessment opportunities.

Patient information leaflets and resources will be available containing advice as to how to access smoking cessation and/or weight management services via the Keeping Me Well website.

Patients and visitors can access the full policy on the UHB Internet site.

9.3 Consultation

The 3 Ps Group maintains oversight of implementation of the policy.

During initial development (2012/13), the policy statements were raised at the following meetings:

- Public Health Steering Group
- Community Health Council
- Cardiff 3rd Sector Council Network
- Practising Public Health Organisation
- Tobacco Free Cardiff and Vale Group
- Vale 50+ Forum
- Directors of Public Health meetings
- Local Medical Committee

Support to the policy was also gained from:

- Tobacco Control Leads, Public Health Wales
- Obesity Leads, Public Health Wales
- Directors of Public Health

10. RESOURCES

10.1 Patient information leaflets

Patient information leaflets on smoking cessation and weight management are required to ensure patients can access information on the policy and what is required of them. These are available in English (Home - Keeping Me Well) and Welsh (Adref - Cadw Fi'n Iach (keepingmewell.com))

Clinician information sheets are available for Primary Care and Secondary Care, along with a frequently asked questions sheet was written to address commonly raised operational issues.

10.2 Relevant support services

Smoking cessation and weight management services are outlined in section 7.3 above.

11. REFERENCES

Details of the documents referred to in the development of this Policy are shown in Appendix 3.

12. MONITORING AND AUDIT

12.1 The 3Ps Delivery Group will monitor the progress of the policy via regular meetings, and report to the Planned Care Strategic Programme Board

12.2 The UHB's Quality, Safety and Experience Committee will receive updates as required.

12.3 The following indicators will be used to monitor the effectiveness of the policy:

- The number of patients accessing smoking cessation support and weight management support will be monitored.
- Revised monitoring data to be developed

Appendix 1

Optimising Outcomes Policy Guidance and Evidence

SITUATION

The NHS Wales Act 2006 places a target duty on the Welsh Health Minister, passed down to Health Boards by the Statutory Instruments that establish them, to promote the health of the people within the population it serves.

Healthcare professionals routinely manage clinical risks such as hypertension in people undergoing surgery. Lifestyle factors can increase clinical risk, with evidence suggesting that smoking cessation and weight loss (if required) improve post-operative outcomes.

The Optimising Outcomes Policy introduced a systematic approach to supporting patients to access smoking cessation and weight management, with the aim of reducing the risk of post-operative complications for the patient. The literature reviews conducted over time to support policy development are summarised in the background section below.

BACKGROUND

2012/13 - POLICY DEVELOPMENT
Pre-operative Smoking Cessation

In the policy published in 2013, the following guidance and evidence existed to support the policy:

- People who smoke are more likely to have lung, heart and infectious complications; have reduced bone fusion after fracture and impaired wound healing; be admitted to an intensive care unit; have an increased risk of in-hospital mortality; and remain in hospital longer[2, 3].

- Patients can reduce their risk of a wide range of complications if they stop smoking eight weeks before elective surgery, with improved recovery and outcomes[2, 3], including reduced wound related, lung and heart complications; decreased wound healing time; reduced bone fusion time after fracture repair; reduced length of hospital stay; in the long term reduced risk of heart disease, cancer and premature death[2, 3].

- Specifically for Cardiff and Vale, modelling suggests the following potential savings per year[4]: Based on 9,371 elective admissions being current smokers, approximately 10-30% of people who smoke are likely to give up through a Pre-operative Smoking Cessation programme (as calculated by London Health Observatory[4]), this would result in

approximately 754 – 1,574 quitters, resulting in 124 – 1,299 bed days saved and an estimated £41,941 - £437,650 saved per year.

A literature search was conducted to update the evidence base for the OOPs policy review in 2016. Emerging evidence since adoption of the original policy included the following:

Smoking

- People who currently smoke are at an increased risk of a range of postoperative complications following a range of surgical procedures compared to non smokers (including abdominal, head/neck, breast, orthopaedic, plastic, thorax, transplantation and general surgeries)9. The systematic review and meta-analysis concluded that smokers have a:
    - 1.52 fold higher risk of general morbidity post operatively
    - 2.15 fold higher risk of wound complications
    - a 1.54 fold higher risk of general infections
    - a 1.73 fold higher risk of pulmonary complications
    - a 1.38 fold higher risk of neurological complications
    - and a 1.60 fold higher risk of admission to intensive care unit
- People who smoke receiving general anaesthesia for major elective surgery have a 4.40 fold increased risk of peri-operative respiratory complications and a 1.86 fold increased risk of post-operative morbidity compared to non smokers[10]
- People who smoke are 1.45 times more likely to experience respiratory events (pneumonia, unplanned intubation, or ventilator requirement) following major surgery and 1.65 times more likely to experience an arterial event (myocardial infarction or cerebrovascular accident)[11]
- People who currently smoke are 2.21 times more likely to experience organ/space surgical site infections (SSI) and surgical wound complications in orthopaedic surgery with implants[12]
- People who currently smoke are 1.47 times more likely to have wound complications following primary total hip or knee athroplasty compared to non smokers[13]
- People who currently smoke are 2.37 times more likely to experience deep infection and 1.78 times more likely to need an implant revision after primary total hip athroplasty or total knee athroplasty compared to non smokers[14]
- People who currently smoke have an increased risk of post-operative morbidity by 1.3 fold and mortality by 1.5 fold for all types of major colorectal surgery (elective major colorectal resection for colorectal cancer, diverticular disease, or inflammatory bowel disease)[15]

- Women who currently smoke are 1.16 times more likely to experience venous thromboembolism in the first 12 postoperative weeks than never-smokers[16]
- People who currently smoke are 2.41 times more likely than non-smokers to have post-operative pulmonary complications after coronary artery bypass grafting surgery[17]
- Smoking is associated with wound dehiscence after cesarean delivery (46.7% vs. 21.1%, smokers vs non-smokers)[18]
- Smoking is associated with increased wound complications and 30-day mortality after laparotomy (32% vs 23%, smokers vs non-smokers)[19]
- People who currently smoke are 1.28 times more likely to develop wound complications after an open cholecystectomy and 1.20 times more likely after a laparoscopic cholecystectomy compared to non smokers[20]

Pre-operative Weight Management

Living with Obesity is a recognised risk factor for a wide variety of peri-operative complications. Research highlights that patients living with obesity are likely to experience:

- A nearly 12-fold increased risk of a post-operative complication after elective breast procedures[21]
- A 5-fold increased risk of surgical site infection (SSI)[22]
- A two fold increased risk of SSI risk in orthopaedics[23]
- An increased risk of SSI as much as sixty percent (60%) when undergoing major abdominal surgery[24]
- A higher incidence of SSI (up to 45%) when undergoing elective colon and rectal surgery[24]
- An increased risk of bleeding and infections after abdominal hysterectomy[25]
- A 2.1 fold increased risk of any complication after elective spine surgery[27] [29] including:
    - a 1.2 - 3.11 fold higher risk of SSI [28, 29, 30, 31, 32, 37]
    - a 1.21 fold increase in risk of SSI for every 5-unit increase in BMI[36]
    - A 2 - 3.15 fold higher risk of venous thromboembolism [28,31,32,33]
    - a 1.43 fold higher risk of revision[28]
    - a 28.89 fold higher risk of blood loss during surgery [28,29,30]
    - a 14.55 fold higher risk of longer surgical time [28,30,37]
    - and 2.6 fold higher risk of mortality[28]
- A 1.67 fold increased risk of superficial wound infection and a 1.52 fold increased risk of deep wound infection following orthopaedic trauma surgery[35]

Research indicates that people living with obesity are likely to experience:

- A 1.6 – 1.84 fold increased risk of any complication following spinal surgery[37 38] including:
    - a 2.5 – 3.22 fold increased risk of SSI[32,37]
    - a 2.5 fold increased risk of venous thromboembolism[32]
    - a 1.7-2.43 fold increased risk of urinary complications[32,37]
    - a 15.3 fold increased risk of acute renal failure[32]
    - a 1.7 fold increased risk of sepsis[32 34]
    - a 2.18 fold higher risk of pulmonary complications[37]
    - a 2.3 fold higher risk of re-admission[38]
    - a 1.8 fold higher risk of return to the operating room[38]
- A 2.51 fold increased risk of deep wound infection and a 2.29 fold increased risk of wound dehiscence following orthopaedic trauma surgery[35]

- An increased risk of restrictive pulmonary syndrome, including decreased functional residual capacity (for people living with obesity)[26].

It is understood that around 50 percent of patients who live with obesity have a poor outcome following joint replacement surgery compared to less than ten percent of patients with a healthy Body Mass Index (BMI) for the following reasons:

- A significantly higher risk of a range of short-term complications[7]
- A less likely outcome of surgery improving symptoms[8]
- A higher risk of the implant failing, requiring further surgery[8]
- A higher incidence of weight gain following joint replacement surgery[7].

This weight management pre-operative intervention should be seen as a basic component of evidence based commissioning for elective surgery.

2017 – EVIDENCE REVIEW

In 2017, two rapid evidence reviews were conducted by Cedar to explore the effects of smoking[39] and obesity[40] on primary hip or knee replacement. The conclusions were as follows:

Smoking

Although some studies did not show an association between smoking and poorer outcomes, there seems to be some evidence that smoking is an independent risk factor for poorer outcomes in patients undergoing total hip or knee arthroplasty. Based on current evidence, patients who smoke appear to be at increased risk of both local and systemic complications and have an increased risk of implant failure and revision compared with patients who do not smoke.

Obesity

Hip Arthroplasty

There is evidence that patients who live with obesity have an increased risk of complications following primary hip replacement surgery including major complications such as deep infection, dislocation, osteolysis and/or aseptic loosening and minor complications such as superficial infection, wound healing and/or haematoma.

The evidence indicates that people living with obesity have a higher risk of dislocations.

The evidence suggests that although people living with obesity have significantly lower pre-operative and post-operative patient reported outcome scores compared with people who do not live with obesity, the difference in the change of scores from pre to post-op follow-up is not significant at 2 year follow-up suggesting that the magnitude of benefit or obese and morbidly obese patients is similar to that of non-obese patients. One study however did report a significantly lower patient reported outcome score in obese and morbidly obese patients at 5 year follow-up compared with non-obese patients suggesting that it is possible that although obese and morbidly obese patients benefit from surgery initially, this benefit is not maintained in the longer term. It is not possible to say whether the lower score at 5 years is the result of increased BMI and primary hip surgery however; there are other factors which impact on a patient's score.

Knee Arthroplasty
There is evidence to suggest that patients living with obesity have an increased risk of both superficial infection and deep wound infection following primary knee replacement, however there is some uncertainty around the robustness of the results relating to deep infection and it is possible that the risk of deep infection does not differ between obese and non obese patients.
Patients living with obesity appear to have a greater risk of undergoing a revision procedure for any reason when compared with non-obese patients.

Patients living with obesity do not appear to have a greater risk of intra-operative complications such as intra-operative fracture, tendon/ligament rupture or nerve damage compared with non-obese patients and there also appears to be no difference in the risk of post-operative deep vein thrombosis.

Patients living with obesity record lower patient reported outcome scores preoperatively compared with patients who are not obese and the evidence suggests that patient reported outcome scores in obese and morbidly obese patients are lower at 6 and 12 months post-operatively. However information was not provided on the change in patient reported outcomes from pre-operative scores to post-operative scores, so it cannot be assumed that the obese/morbidly obese patient group did not achieve an improvement in functional outcomes compared with their pre-operative scores of a magnitude similar to non-obese patients.

2019 – POLICY UPDATE

No additional literature searches were completed as part of the 2019 policy review. However, it was noted that both smoking cessation and weight management featured in national guidance for effective pre-operative care published by the Royal College of Anaesthetists[41].

ASSESSMENT

2023 – POLICY UPDATE

This most recent update has seen the Policy align to the development of prehabilitation services within the UHB and the Keeping Me Well resource, all of which are informed by the evolving evidence base. No additional literature reviews were conducted as part of the review, but the following were noted:

- Further development of 'Fitter, Better, Sooner', including patient information resources on 'preparing your body' which reference smoking, exercise and diet/weight
- A rapid review by Public Health Wales, on behalf of the Wales COVID-19 Evidence Centre (WCEC) whose findings showed 'the benefits of exercise, education, smoking cessation, and psychological interventions for patients awaiting elective surgery'[42]

RECOMMENDATION

The continuation of the Optimising Outcomes Policy to offer smoking cessation and weight management advice in pre-operative patients enables a systematic approach to addressing lifestyle risk factors with the aim of supporting action to ensure optimal post-operative outcomes for patients.

Appendix 2

LIST OF DEFINITIONS

BMI	Body Mass Index
CHC	Community Health Council
Completed programme	A completed programme is defined as a patient having attended the following number of sessions for each programme: 4 out of 6 smoking cessation sessions 5 out of 8 Eating for Life sessions (or equivalent individual sessions) 10 out of 16 Exercise Referral sessions
EqIA	Equality Impact Assessment
Listed	For the purposes of the Optimising Outcomes Policy, listing is defined as 'given a date to come in for surgery'. This means the patient can be added to the waiting list for an elective procedure in the normal way and the waiting time clock will continue.
LMC	Local Medical Committee
Smoking Cessation Services	Includes NHS community and hospital based Smoking Cessation Service
UHB	University Health Board
UHW	University Hospital of Wales, Cardiff
Weight Management Services	Includes Dietetic Services and National Exercise Referral Scheme

Appendix 3

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Equality & Health Impact Assessment for

Optimising Outcomes Policy

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

Please note:

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

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive Director of Public Health, Cardiff and Vale University Health Board
3.	Objectives of strategy/ policy/ plan/ procedure/ service	**Optimising Outcomes Policy** The Optimising Outcomes Policy aims to ensure appropriate smoking cessation and/or weight management support is given to patients prior to surgery in order that they experience an optimal post-operative outcome.

		Two statements (revised June 2014) outline the policy. These statements must be applied in the context of a patient's individual clinical need which is ultimately to be determined by the clinician responsible for the patient's care. 1. Smoking Cessation Anyone being referred or listed for an elective intervention who is recorded as a smoker is expected to have been offered, accepted and completed smoking cessation support[2] prior to their surgery. 2. Weight management Anyone being referred or listed for an elective intervention who has recorded a BMI of 40 or above is expected to have been offered, accepted and completed weight management support[3] prior to their surgery.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages	Mid year population estimated for 2022 suggest 505,581 people are resident in Cardiff and Vale UHB area, 48.8% of whom are male[6].18.2% of the population is aged 0-15 years and 16.5% are aged 65 years and older. The ethnic diversity of the populations of Cardiff and the Vale of Glamorgan vary significantly, with Cardiff being more diverse and the Vale having a profile similar to Wales as a whole. Estimates suggest that in Cardiff, 79.2%% of the population identify as White (compared to 94.6% in the Vale), 4.0% of mixed ethnicity (Vale 2.3%), 9.7% Asian/Asian British/Asian Welsh (Vale 2.1%), 3.8% Black/Black British/Black Welsh/Caribbean/African (Vale 0.5%), and 3.3% 'other' ethnic group (Vale 0.5%)[7]. At the last Census (2021) the majority of people in the region reported either having no religion (Cardiff 42.9%; Vale 47.9%) or did not answer (Cardiff 6.3%; Vale 5.7%). The most commonly reported religions were Christian (Cardiff 38.3%; Vale 44.1%), Muslim (Cardiff

[2] Smoking cessation support includes one of the following services: NHS community or hospital based Smoking Cessation Services.
[3] Weight management support includes one of the following services: Community Dietetic Service, National Exercise Referral Scheme, commercial weight management programmes. Whilst non-NHS provider weight management programmes are an option they currently lie outside of the NHS resourced referral pathway
[6] Stats Wales. Local health boards (gov.wales) [Last accessed 10/2/24]
[7] Office for National Statistics: Census 2021. Accessed at Census - Office for National Statistics (ons.gov.uk) [Last accessed 10/2/24]

	Population pyramids are available from Public Health Wales Observatory[4] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[5].	9.3%; Vale 0.9%), Hindu (Cardiff 1.5%; Vale 0.3%) and 'other religion' (Cardiff 0.6%; Vale 0.5%). In Cardiff, 48.6% of people aged 16 years and over reported that they were never married/registered a civil partnership, 36.8% were married/in a registered civil partnership, 7.8% divorced/dissolved civil partnership and 5.0% widowed/surviving civil partner; the equivalent proportions for the Vale of Glamorgan are 33.5%, 47.4%, 10.1% and 7.0%. Most recent estimates (2021-22 & 2022-23) show that 13% of the population in Cardiff and the Vale of Glamorgan smoke[8]. Smoking prevalence in Wales (2022-23) is highest in the 16-44 age group (16%) and the 45-64 age group (13%) but thereafter the prevalence of smokers declines to 7% by 65+ years. The prevalence of smoking in males aged 16+ in Wales is 13% compared to 12% in females. The following information is copied from 'A Smoke Free Wales – Tobacco Control Delivery Plan 22-24' (Pgs 9-10)[9], and provides insight into smoking prevalence among different population groups: "As identified in our strategy, A Smoke-free Wales, there are groups and communities in Wales for who have higher smoking prevalence, have a higher risk of taking up smoking, or experience increased health impacts from smoking. These priority groups are defined as pregnant women, children and young people, people from socio-economically deprived backgrounds, people in routine and manual occupation, people who are unemployed, people living in social housing, people engaged with mental health services, people from ethnic backgrounds which have a higher smoking prevalence, and people from the LGBTQ+ community. A cohesive, community-led approach is required to

[8] StatsWales Accessed at Adult lifestyles (gov.wales)Last accessed 10/2/24
[9] A Smoke Free Wales: Tobacco Control Delivery Plan 2022-2024 Accessed at https://www.gov.wales/sites/default/files/consultations/2021-10/tobacco-control-delivery-plan-2022-to-2024.pdf [Last accessed 12/2/24]

		prevent uptake and reduce smoking prevalence in people who belong to one or more of these groups." "We have good data which shows smoking rates vary amongst different groups in our society. Smoking rates amongst people living in the most socio-economically deprived areas of Wales are over twice as high as the rates for people living in the least deprived areas[10]. People in routine and manual occupations are 2.5 times more likely to smoke than those in professional occupations, whilst people who are unemployed are 2.8 times more likely to smoke.[11] People living in social housing are twice as likely to smoke compared to those living in other housing tenures.[12] Higher smoking rates contribute to existing equalities and health inequalities in these disadvantaged groups." "We also know, prevalence of smoking and use of other tobacco products varies between people from different ethnic backgrounds. In Great Britain, smoking rates are higher for men and women of mixed ethnic backgrounds, compared to people from white ethnic backgrounds, and lower for most other ethnic groups.[13] . There are also strong links between gender and smoking for people from different ethnic minority groups, with smoking rates being much higher in men from Black, Asian or Chinese ethnic backgrounds compared to women from those groups.[19] - There are also differences in the types of tobacco products used by people from different ethnic groups, such as use of smokeless tobacco by people from South and South East Asian ethnic backgrounds.[19] It is important that our tobacco control actions consider these differences to provide appropriate support to people from a wide range of ethnic backgrounds."

[10] Public Health Wales. 2020. Smoking in Wales. Available at: https://publichealthwales.shinyapps.io/smokinginwales/

[11] Office for National Statistics (ONS). 2020. Adult smoking habits in the UK 2019 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2019

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[13] ASH. 2019. Tobacco and ethnic minorities. Available at: https://ash.org.uk/wpcontent/uploads/2019/08/ASH-Factsheet_Ethnic-Minorities-Final-Final.pdf

		"Smoking rates are higher in lesbian, gay and bisexual people compared to heterosexual people.[14] Surveys also show that transgender people are more likely to smoke.[15] The relationship between members of the LGBTQ+ community and higher smoking rates is also seen from a young age, with 40% of 15-16-year olds who do not identify as either male or female smoking at least weekly. [16] Despite these higher rates many LGBTQ+ people report that they can feel excluded from healthcare by non-inclusive language and policies.[21] Further work is required in Wales to support LGBTQ+ people to reduce smoking rates amongst these communities." **Pre-operative Weight Management** In the most recently available data, 57% of the population in Cardiff and the Vale of Glamorgan report living with overweight or obesity (BMI 25+), with 21% reporting living with obesity (BMI 30+)[17]. The prevalence of living with overweight or obesity in Wales peaks in the 45-64 age group at 68%, declining to 59% in the 65+ age group[18]. Prevalence is lowest in the 16-44 age group at 57%. The prevalence living with obesity by age group are 25% (16-44 yrs), 31% (45-64 yrs) and 21% (65+yrs) respectively. The prevalence of living with overweight and obesity in males 16+ in Wales is 65% compared to 57% of females. The proportion of males who report living with obesity is 25% compared to 27% of females.

[14] National Institute of Economic and Social Research. 2016. Inequality among lesbian, gay, bisexual and transgender groups. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/539682/160719_REPORT_LGBT_evidence_review_NIESR_FINALPDF.pdf [Last accessed 22/2/24]

[15] ASH. 2020. Smoking: LGBT People. Available at: https://ash.org.uk/wp-content/uploads/2019/09/HIRPLGBT-community.pdf

[16] SHRN. 2021. Student Health and Wellbeing in Wales: Report of the 2019/20 School Health Research Network Student Health and Wellbeing Survey. Available at: https://www.shrn.org.uk/wpcontent/uploads/2021/03/SHRN-NR-FINAL-23_03_21-en.pdf

[17] National Survey for Wales (2023/22 and 2022/23 combined) Accessed at Adult lifestyles by local authority and health board, 2020-21 onwards (gov.wales) [Last accessed 11/2/24]

[18] National Survey for Wales (2022-23) Accessed at Adult lifestyles by age and gender, 2020-21 onwards (gov.wales) [Last accessed 11/22/24]

		No recent data is available on prevalence of living with obesity by ethnic group in Wales. Data from England, where the prevalence of living with overweight and obesity in adults over 18 is 62%, suggests that black adults were the most likely out of all ethnic groups to be living with overweight or obesity (72.8%)[19]. White British adults were also more likely than average to be living with overweight or obesity (62.9%), whereas adults from the Chinese ethnic group were least likely to be living with obesity (34.5%). The percentage of adults in the Asian, Other White, Mixed and Other ethnic groups was also lower than the national average (57%, 57.8%, 58.5% and 58.3% respectively) The prevalence of people living with overweight or obesity (BMI 25+) in Wales varies with fifths of deprivation. It is highest (66%) in quintile 1 (most deprived) and lowest (56%) in quintile 4 (second least deprived)[20]. The prevalence of living with obesity (BMI 30+) shows a gradient from most to least deprived, with a prevalence of 32% in quintile 1 (most deprived) and 22% in quintile 5 (least deprived).
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The stakeholders include:- • Patients on elective surgical pathways (with the exception of the exclusions outlined in the policy). • Any referrer e.g. General Practitioners, Surgeons, AHPs, Outpatient Nurses, prehab services etc. • Primary Care – General Practices, Community Directors, Local Medical Committee (LMC) • CVUHB, Clinical Boards • CVUHB IT Department • Cardiff and Vale Public Health Team • Community Health Council (CHC) • Help Me Quit (HMQ) community based NHS smoking cessation service

[19] Gov.UK *Overweight Adults* (2017-18). Accessed at https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-adults/latest [Last accessed 31/12/19]

[20] National Survey for Wales (2020-21 onward). Accessed at Adult lifestyles by area deprivation, 2020-21 onwards (gov.wales) [Last accessed 22/02/24]

		• Hospital in-house Smoking Cessation Service • Level 3 Pharmacy • CV UHB Nutrition and Dietetic services • CV UHB Level 3 Specialist Weight Management service • National Exercise Referral Scheme (NERS) • Local Leisure Services • Commercial companies • Third Sector • Public Health Wales • Welsh Government

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 Chilcott Rachel 20/03/2024 12:53:49	**Smoking Cessation** The policy does not apply to people under the age of 16, however, there are options available to access smoking cessation services. The UHB's in-house smoking cessation service is able to provide 1-2-1 support to those under 16 years although the service can only prescribe to those 12+. Help Me Quit community based services are able to provide support to under 16s in a one to one context or by telephone. It would not be appropriate for them to access a group of mixed ages. Overall, access to smoking cessation services will have a positive impact for people of all ages and no negative impact was identified. **Weight Management**	**Smoking Cessation and Weight Management** No recommendations.	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	The policy does not apply to people under the age of 16. Young people aged 16-18 would access childrens service. The NERS service also delivers the service to individuals 16+. Overall, access to weight management services will have a positive impact for people of all ages and no negative impact was identified for young people aged 16-25 years. The policy does not apply to under 16s.		
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	**Smoking Cessation** Smoking cessation services are provided in easily accessible venues enabling access for those with physical impairments. HMQ conduct an accessibility assessment of each of the venues they use.	**Smoking Cessation** Provision for clients with visual impairment, learning disability and mental health diagnoses (in the community) will continue be considered as part of any service developments.	HMQ in the community to consider service developments for clients with visual impairment, learning disability and mental health diagnoses

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
	HMQ cessation support can also be accessed via telephone and online. Those with learning disabilities would need to access one to one provision. Carers are invited to attend appointments. For those with hearing impairments, HMQ are able to provide the hearing loop system and a British Sign Language interpreter. For those with visual impairments, no specific adaptations are provided by any of the services. HMQ does not offer a formal one to one support programme for community based mental health patients, but will see clients with low level mental health issues. Services are in place for mental health in-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
	With regard to access for those with a learning disability, HMQ assess on an individual basis and support offered in the most appropriate way. Overall no negative or positive impacts were identified for the majority. HMQ strive to support client needs as required. **Weight Management** Venues that deliver the weight management service are accessible to people with disabilities. Housebound patients are offered a dietetic domiciliary visit or virtual appointment. Patients' carers are invited to attend all appointments at the patient request. Equipment to support people with hearing impairments is available. For those with visual impairment, the service can still	**Weight Management** Consider development of a specialist weight management service for housebound patients, Mitigation - virtual appointments are available.	Weight management teams to consider services for housebound 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
	be provided as consultations are provided verbally. Certain resources can be produced in an audio version. The dietetic service for individuals with a severe learning disability is offered by Swansea Bay UHB. Individuals with less severe learning disabilities who require general lifestyle support would be offered support locally in a 1-2-1 context as the groups would not be suitable. Mental health patients - If the mental health condition is the primary issue they would access the community mental health team. The management of their mental health would be prioritized initially NERS relies on family members/carers to support individuals with sensory impairments.		

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
	Overall no negative or positive impacts were identified for the majority		
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 Chilcott Rachel 20/03/2024 12:53:49	**Smoking Cessation and Weight Management** There is currently no service data available to assess whether males and females are accessing smoking cessation services in a way which is proportional to the prevalence of smokers who are male or female in the local population. The same is true of weight management services. Patients would be eligible for referral to the Welsh Gender Service if required. The multi-professional group conducting the EQIA considered that, as the policy is applied equally to all individuals needing surgery, there should be no differential effect in relation to gender. No negative impacts were identified.	**Smoking Cessation and Weight Management** Continue to monitor the data collected and recorded on the UHB systems with a view to better understanding access to services by gender and to determine if any mitigation is required.	UHB to improve data collection related to protected characteristics

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
6.4 People who are married or who have a civil partner.	**Smoking Cessation and Weight Management** Data on access to services by marriage and civil partnership is not collected. The services are set up so that all individuals needing surgery can access them. The services do not discriminate by marriage and civil partnership, therefore, no negative impact was identified.	**Smoking Cessation and Weight Management** Continue to monitor the data collected and recorded on the UHB systems with a view to better understanding access to services by marriage and civil partnership and to determine if mitigation is required.	UHB to improve data collection related to protected characteristics
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. Chilcott Rachel 20/03/2024 12:53:49	**Smoking Cessation** A question about pregnancy is asked in the assessment telephone call with HMQ at the start of the 6 week programme. HMQ provide a specific service for pregnant women. All pregnant women, on booking with maternity services, are carbon monoxide monitored (via a breath test) and offered a referral to HMQ if found to be a current smoker.	**Smoking Cessation and Weight Management** No recommendations.	

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
	Weight Management A dedicated service has been established in Cardiff and Vale via the midwife led healthy pregnancy clinic. A maternal specialist dietitian is in post. Foodwise in Pregnancy is now delivered along with an App on-line resource. The National Exercise Referral Scheme excludes women in the first 12 weeks of pregnancy. Overall, a positive impact was identified on pregnant women in terms of smoking cessation and weight management services.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers Prescott Rachel 20/03/2024 12:53:49	**Smoking Cessation** Services can be provided in other languages through the use of an interpretation service and language line. Some HMQ resources are available in different languages, in addition to English and Welsh.	**Smoking Cessation and Weight Management** No recommendations.	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	Patient leaflets can be translated in to other languages on request. Overall, no negative or positive impact was identified. **Weight Management** One to one service can be provided in other languages through the use of an interpretation service and language line. The group is not offered in different languages, but family members are invited to support. The consultations and nutritional advice provided is culturally specific. A lot of work has been done previously to achieve this and the team has good links with communities. Resources are available in different languages. Resources can be provided that are pictorial.		

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
	Overall, a positive impact was identified, however group access is limited to individuals who are confident to communicate in English or Welsh.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	**Smoking Cessation** No negative impact was identified. **Weight Management** All staff in the weight management service have an awareness of cultural issues through staff training. The consultations are adapted to meet the individual's religious and cultural needs. They are person centred. Overall, a positive impact was identified.	**Smoking Cessation and Weight Management** No recommendations.	
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	**Smoking Cessation and Weight Management** The impact of the policy on sexual orientation was	**Smoking Cessation and Weight Management** No recommendations.	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)	discussed and no positive or negative impacts were identified.		
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	**Smoking Cessation and Weight Management** OOPs policy resources are available in Welsh. Patient information for HMQ is available in both Welsh and English. HMQ can provide consultations in Welsh with the assistance of language line. In terms of the weight management services, 1-2-1 consultations and group sessions can be undertaken in Welsh (if a request has been made in advance of the appointment). Overall, a positive impact.	**Smoking Cessation and Weight Management** No recommendations.	
6.10 People according to their income related group:	**Smoking Cessation**	**Smoking Cessation and Weight Management**	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health Chilcott Rachel 20/03/2024 12:53:49	All smoking cessation services are free to access and prescriptions for Nicotine Replacement Therapy are free. Telephone support is available for people unable to travel to appointments **Weight Management** Community Dietitian led Weight Management Services are free. Virtual appointments and groups are available for people unable to travel to appointments. NERS has a mandatory cost of £2.50 per session which may have an impact on those on lower incomes. Commercial organisations will charge for their services. Overall, the impact is generally positive, although there may be some negative impact for those without phone/internet access.	No recommendations.	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Provision of smoking cessation and weight management services (HMQ, Level 3 pharmacy, Weight Management Service) are aligned with areas of deprivation and therefore there are more services in these areas. Level 3 pharmacies are situated in area of high deprivation. Overall, a positive impact was identified.	**Smoking Cessation and Weight Management** No recommendations.	
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Health Inclusion Groups may experience issues with access to services in general, but both HMQ and dietetic led weight management services strive to offer a variety of options to meet individual needs. Overall, no specific impact was identified	**Smoking Cessation and Weight Management** Access for health inclusion groups will be kept under review and action taken as required	

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 Chilcott Rachel 20/03/2024 12:53:49	**Smoking cessation** The policy promotes access to several smoking cessation services in the community at venues across Cardiff and Vale. If choosing to access HMQ, there is the flexibility for individuals to choose to access a group that is convenient for them, for example, they could access a group near to work or home. Smoking cessation services are available face to face, online and telephone support. Individuals can self-refer to smoking cessation services. The quality of services is monitored and reported on	**Smoking cessation** We will continue to develop information via Keeping Me Well, on smoking cessation and weight management.	3Ps Group to develop a monitoring framework alongside other data development for planned care

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
	regularly i.e. by the number of individuals accessing each service and the number of smokers quitting at 4 weeks. Building knowledge, skills and confidence to help individuals change their behaviour is a key component of the support provided by the smoking cessation services. Overall, a positive impact on access to services. **Weight Management** The policy promotes access to weight management services in each locality of Cardiff and Vale. Professional referral is required for weight management services highlighted in this policy and for NERS, although self-referral for Community Dietetics has been recently introduced. All health care providers are provided with information to refer to the service.	**Weight Management** The All Wales Healthy Weight Healthy You on-line platform is available and will be promoted	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
	The weight management service is regularly evaluated and clinical outcomes recorded. Education is intrinsic to the support offered by the weight management service and NERS. Resources in relation to both smoking cessation and weight management are now available via the UHBs Keeping Me Well website Overall, a positive impact on access to services.		
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	The purpose of this policy and the smoking cessation and weight management services promoted within it are to empower individuals to make decisions that support healthy lifestyles. The weight management services would signpost to	**Smoking Cessation and Weight Management** No recommendations.	

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
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	relevant preventative services such as alcohol services. Overall, a positive impact on access to lifestyle support.		
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	The policy will help improve clinical outcomes, which may help support individuals to return to work or to gain employment. For example, evidence suggests a higher level of absenteeism in smokers compared to non-smokers and this may have an impact on their employment, income and job security and therefore, quitting smoking is likely to have a positive impact on an individual's income, employment and work. Weight management interventions provide holistic	**Smoking Cessation and Weight Management** No recommendations.	

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
	lifestyle support, to enable all people (including those on a budget) to have the ability to adopt a healthy diet. Overall, a positive impact.		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental 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 policy aims to support individuals to give up smoking pre-operatively. Individuals who stop smoking will have improved air quality in their living environment. There may also be a reduction in passive smoking by other individuals living in that environment and therefore their exposure to pollutants will be reduced. Weight management services actively encourage movement and physical activity including walking and cycling where possible. This encourages a reduction in car/motor transport use. Overall, the policy has a positive impact.	**Smoking Cessation and Weight Management** No recommendations.	

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 smoking cessation and weight management services empower individuals to manage the social and community influences on their health. Relatives are encouraged to attend weight management sessions thereby helping to build support for lifestyle changes in the family. The group sessions may help to build social networks and social support through shared behaviour change of the individuals attending the groups. Overall, a positive impact.	**Smoking Cessation and Weight Management** No recommendations.	
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	The policy aims align to Welsh Government policies in relation to improving population health (e.g. Tobacco Control Strategy; Healthy Weight Healthy Wales) and sustainability. Weight management advice takes into consideration the	**Smoking Cessation and Weight Management** No recommendations.	

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

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	The overall impact was determined to be a positive one.

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?	HMQ in the community to consider service developments for clients with visual impairment, learning disability and mental health diagnoses Weight management teams to consider services for housebound patients 3Ps Group to develop a monitoring framework alongside other data development for planned care	HMQ in the Community Service Lead Weight Management Service Lead 3P Delivery Group	By Marc 2025 By March 2025 By March 2025	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No further assessment required			

	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
	Policy to continue unchanged			

Appendix 1

Equality & Health Impact Assessment

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

Guidance

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

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)[21]

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:

21 http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)[22]
- Equality Act 2010[23]
- Well-being of Future Generations (Wales) Act 2015[24]
- Social Services and Well-being (Wales) Act 2015[25]
- Health Impact Assessment (non statutory but good practice)[26]
- The Human Rights Act 1998[27]
- United Nations Convention on the Rights of the Child 1989[28]
- United Nations Convention on Rights of Persons with Disabilities 2009[29]
- United Nations Principles for Older Persons 1991[30]
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance[31]
- Welsh Government Health & Care Standards 2015[32]
- Welsh Language (Wales) Measure 2011[33]

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

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

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (ie their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues.

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22 http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en
23 https://www.gov.uk/guidance/equality-act-2010-guidance
24 http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
25 http://gov.wales/topics/health/socialcare/act/?lang=en
26 http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782
27 https://www.equalityhumanrights.com/en/human-rights/human-rights-act
28 http://www.unicef.org.uk/UNICEFs-Work/UN-Convention
29 http://www.un.org/disabilities/convention/conventionfull.shtml
30 http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx
31 http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf
32 http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en
33 http://www.legislation.gov.uk/mwa/2011/1/contents/enacted

They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

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

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

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

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

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[34]
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide[35]

[34] http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf (accessed 4 January 2016)
[35] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782 (accessed on 4 January 2016)

Appendix 2 – The Human Rights Act 1998[36]

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

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, 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 travelers, 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 travelers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person solely because of their age, patients presented with health options without the use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home
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

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

Appendix 3

Tips

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

Minutes of the Medicine Clinical Board
Quality, Safety & Experience Committee Meeting
Held on 16 November 2023 14:30 – 16:00, Via MS Teams

Present:	
Barbara Davies	Deputy Director of Nursing (Chair)
Sian Rowlands	Head of Quality and Clinical Governance
Kath Prosser	Quality & Governance Lead, Medicine
Aneurin Buttress	Consultant, Integrated Medicine (IM)
Catherine Evans	Interim Deputy Head of Patient Safety, Patient Safety Team
Derek King	Clinical Nurse Specialist, Infection Prevention & Control
Angela Jones	Senior Nurse, Resuscitation Service
Jenna McLaren	Senior Nurse, Acute & Emergency Medicine
Rachael Maiden	Senior Nurse, Integrated Medicine
Gill Spinola	Senior Nurse, Integrated Medicine
Beth Jones	Senior Nurse, Specialised Medicine (SM)
Liz Vaughan	Professional & Practice Development Nurse
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Jane Murphy	Director of Nursing
Alun Tomkinson	Clinical Board Director
Lyndsey MacDonald	Consultant, Emergency Medicine
Louise Platt	Director of Operations
Ceri Martin	Lead Nurse, Acute & Emergency Medicine
Ceri Richards-Taylor	Lead Nurse, Integrated Medicine
Wayne Parsons	Lead Nurse, Integrated Medicine
Dave Pitchforth	Lead Nurse, Specialised Medicine
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Niki Turner	Service Manager, Stroke, Integrated Medicine

Item No	1. Standing Items	Action
MCBQSE/ 2023/0173	**Welcome & Introductions** – were undertaken. **Declarations of interest** – none raised.	
MCBQSE/ 2023/0174	**To receive the minutes of the previous meeting held on 21/09/23** The group resolved: the minutes were agreed and accepted.	
MCBQSE/ 2023/0175	The Action Log following the meeting held on 19/10/23 was updated.	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2023/0176	**Patient Story** The group resolved: no patient story was shared. **Actions from discussion**: none.	
3. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2023/0177	**Compliments - West 2** 'It is always a very traumatic time when losing a family member, but Hannah (Ward Manager) and her staff made it as comfortable as it could have been for us and 'K'. The time, care, kindness and respect given to 'K' in his last days will always be treasured. Special thanks to HCSW Jo, who went over and beyond to support us and gave 'K' so much care and attention. We really could not have asked for better care. Hannah, again very professional, kind and really showed that she cared. Also 2 HCSW's who were finishing their long day shift came to say their goodbyes. What a team to be proud of'. **Concerns** – there are a number ongoing. There is an increase in the complexity of the concerns being received. It is a significant amount of work addressing this situation.	

	The group resolved: to keep noting compliments and share with teams. **Concerns responses** – Investigating Officers are struggling with their clinical demands to ensure responses are within the expected timeframe. **Actions from discussion:** none.	

MCBQSE/ 2023/0178	**Infection Prevention and Control up-date**
	55 days since last MRSA bacteraemia (UHL W2)
	83 days since last MSSA bacteraemia (UHL E8)
	16 days since last *C difficile (UHW LSGF2)*
	18 days since last E. *Coli* bacteraemia (UHL W1)
	55 days since last Pseudomonas bacteraemia (UHW A7)
	25 days since last Klebsiella bacteraemia (UHW A7)
	There are currently 0 outbreaks within the MCB. There are only 3 Covid cases in UHW.
	• DMT scores – all wards within MCB are compliant for the last 4-week period.
	• HCAI reduction goals, MCB position based on same period 2022-2023:
	  ○ 10% increase with *C. difficile.*
	  ○ 31% increase with *E. coli.*
	  ○ No increase / reduction with *Pseudomonas.*
	  ○ 33% reduction with SAUR Bacteraemias.
	  ○ 8% increase has been seen *with Klebsiella*
	• There are 4 outstanding RCA's for September, all for UHW.
	• IP&C teaching will continue at induction next year.
	• COVID cases have decreased consistently throughout the MCB over the past month. Covid 19 cases in the community continue to fall.
	• Norovirus - none in the UHB.
	• Influenza activity is currently below baseline activity and described as stable, but the rate has increased.
	• BBE compliance and hand hygiene audits have improved significantly, both anecdotally and identified by audit. Need to maintain consistency.
	• ANTT – LV has run five sessions to train assessors for wards and attendance has been low. There are now assessors across MCB. LV is running sessions where staff can go direct to her to be assessed.
	
	The group resolved: to note the above. **Actions from discussion**: none.	

MCBQSE/ 2023/0179	**Safeguarding** There are safeguarding components regarding a patient on A7. In conjunction with Mental Health Services, an external company have been brought in to assist with this individual's needs. The group resolved: an invitation has been sent to the Safeguarding Team, however, no attendance to date. **Actions from discussion** – none.	
MCBQSE/ 2023/0180	**SSNAP – the Sentinel Stroke National Audit Programme – roll over to next month.** The group resolved: the presentation will be moved to a future meeting. **Action from discussion** – none.	
4. ITEMS FOR APPROVAL/ RATIFICATION		
MCBQSE/ 2023/0181	**National Reportable Incidents (NRIs)** There are currently 26 NRI's, 7 of which are ongoing Covid investigations. From April 23, Covid investigations moved from the Covid Investigations Team to the relevant Clinical Board. Four NRI's are progressing to closure. In addition, there are three IRMERs. It was noted as with the concerns the demands of the Investigating officers to undertake the PSLR's in a timely manner is challenging secondary to operational pressures. **MCB Patient Safety Learning Review (PSLR) Draft Approval Process** - it has become difficult over the last few months ascertaining what the procedure is regarding taking the patient safety learning review through the closure improvement plan process and then sharing the review with agencies and individuals outside C&VUHB. This has	

	been shared with the Patient Safety Team and has been signed off by JM and BD. There are several stages to go through prior to sharing the outcome with families. **Duty of Candour –** all is going well. The group resolved: when an NRI is identified, the Patient Safety Team Administrator sends out a Duty of Candour reminder form to be completed. **Actions from discussion:** none.	
MCBQSE/ 2023/0182	**HIW / HEIW Reports and Improvement Plans:** • **HSE Inspection** – there was a recent inspection by the Health and Safety Executive in the Emergency Department. Thanks to Jenna McLaren and the team for their work around this. • **HEIW Targeted Visit Report Gastroenterology revisit 24/7/23** - included for completeness. Discussed at MCB Formal Board yesterday. Responses have been submitted. HEIW are content with the governance and action plan submitted. A revisit will take place in 6 months-time. • **HEIW Targeted Visit Report** - General Internal Medicine revisit 18/9/23. • **NHS Executive visited A1 link** - clinical governance concerns have been raised by email. Clarification has been sought as to the process/actions required. • **Llais** *(previously CHC)* **Visit St David's Hospital, Lansdowne Ward 25/10/23** Unannounced visit on 25/10/23. Feedback was provided swiftly. Clear areas of learning have been identified. Support is being given to provide an action plan for the area. The formal report from the visit has not been received to date. The group resolved: to note the above. **Action from discussion**: none.	
5. ITEMS FOR NOTING AND INFORMATION		
MCBQSE/ 2023/0183	**Patient Safety Alerts/MDAs/ISNs: no issued raised.** The group resolved: no issues raised. **Action from discussion**: none.	
MCBQSE/ 2023/0184	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions, for noting:** • Emergency and Acute; Integrated Medicine; Specialised Medicine. Jane Morris (JM), Senior Nurse for the Patient at Risk Team (PART) and Angela Jones (AJ) meet regularly. PART is now a 24/7 service. JM and AJ are looking at effectively utilising resources, particularly for education and training provisions. As a result, have confirmed the areas of responsibility and primarily separated it across the management of deteriorating and deteriorated patients. Any changes will take place from 1/1/24. Additionally, JM and AJ are looking at the increased double 2, double 2 calls particularly in relation to failure to recognise and escalate news scores. **Resuscitation** – add to future agendas for updates/findings. **Emergency Unit** – transition from paper to digital has been good. Compliance is now higher and more effective. The plan is to transition all check lists onto the digital system. The group resolved: note the action below. **Actions:** Directorate QSE minutes must be shared with KP on a regular basis.	All Directorates
MCBQSE/ 2023/0185	**Minutes from QSE Sub Groups:** • **MCB IP&C** – have a robust structure on how the meetings are run. Two meetings have been held to date. • **MCB H&S** 04.10.23 – minutes for noting. This was the first meeting held in MCB for quite some time. Champions per directorate have been identified. • **MCB Medicines Access and Governance Group** – next meeting takes place on 17/11/23. The group resolved: all three of these meetings are fairly new in their re-establishment. **Actions from discussion:** none.	
MCBQSE/ 2023/0186	**Feedback from UHB QSE Committee dated** The group resolved: all to read. **Action from discussion**: none.	
MCBQSE/ 2023/0187	**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.	
6. ANY OTHER BUSINESS		
MCBQSE/ 2023/0188	**Asthma Clinic** – received a bequest from a deceased patient who was known to them. **Charitable Trust Applications** – have resulted in two areas being upgraded which are: the Sam Davies Ward with the purchase of some bespoke chairs for their day room; the other was the Daphne Programme which is a diabetes education programme for patients and the area will be upgraded to meet the needs of patients. **GPs Report** – GP's indicate there is a lack of correspondence from hospitals regarding diagnosis and treatment regarding *C. difficile*. Discharge advice letters state that information is sent out electronically via Welsh Clinical Portal, not via post. The group resolved: thank you to all for attending. **Action from discussion**: none.	
7. DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2023/0189	21/12/23 at 14:30-16:00 via MS Teams	

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

Held on 22nd January 2024 Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Director of Nursing/Multi Professional Teams
Adam Christian	AdC	Clinical Board Director
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
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
Paul Williams	PW	Clinical Scientist, Medical Physics
Melissa Melling	MM	Head of Medical Illustration
Rhys Morris	RM	CD&T R&D Lead
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Alison Lewis	AL	Patient Safety Coordinator
Mark Saunders	MS	Representing Biochemistry
In attendance:		
Caroline Sutton	CS	Chief Pharmacy Technician and Operation Site Lead
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Debra Woolf	DW	Sister, Outpatients
Sarah Lloyd	SL	Director of Operations
Marie Glyn-Jones	MG-J	Deputy General Manager, Radiology & Medical Physics/ Clinical Engineering
Susan Beer	SB	Public Health Wales Representative
Jamie Williams	JW	Senior Nurse, Radiology
Mathew King	MK	Head of Podiatry
Becca Jos	BJ	Deputy Director of Operations
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Sian Jones	SJ	Directorate Manager, Laboratory Services
Hadas Reshef	HR	Head of Occupational Therapy
Elaine Lewis	EL	General Manager, Pharmacy
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Timothy Banner	TB	Clinical Director, Pharmacy

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 24/001	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 24/002	**Apologies for Absence** The apologies for absence were noted.	
CDTQSE 24/003	**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 24th November 2023 were accepted as an accurate record.	
CDTQSE 24/004	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 23/133 Pharmacy R&D Lead* No nomination has been received yet. CS to follow up with EL. *CDTQSE 23/144 HTA Inspection* SG to provide feedback from the inspection at the next meeting. *CDTQSE 23/231 Equipment Causing an Obstruction by SDEC* JD noted that the area has improved. There are items that still need to be removed but they are not causing an obstruction. *CDTQSE 23/323 Booking Lab* SO noted that the system is not yet live and it was agreed that a demonstration will be provided at a future meeting. **The Group resolved that:** a) The update on the actions outstanding from the previous meeting were noted.	**CS** **SG** **SO**
CDTQSE 24/005	**Terms of Reference Review** The terms of reference have been updated. Any final comments to be submitted in the next 2 weeks and they will be signed off at the next meeting.	**All**

6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 24/006	**Concerns and Compliments Report** In December 2024, the Clinical Board received 27 concerns; 3 formal and 24 early resolution concerns. There were 2 breaches in response times. 4 compliments were received. The top 3 reasons for concerns relate to: • Difficulties cancelling/arranging appointments – 56% • Waiting times - 11% • Waiting times for test results/scan reports – 11% It was noted that the early resolution timeframes are challenging to meet. **The Group resolved that:** a) The concerns report was received. The report also provides a breakdown of the individual departments' data.	
CDTQSE 24/007	**National Reportable Incidents** The Clinical Board has 2 open NRIs. One is being managed as part of a local review as the level of harm to the patient is relatively low. The other relates to a referral for an ultrasound scan where the follow up was not timely. The incident relates to 3 Clinical Boards and when the investigation is concluded the findings will be discussed at this meeting. **Presentation on Pharmacy Incident** CS reported that the incident occurred in late 2022. The patient was seen in Paediatric Outpatients for their epilepsy which was not under full control. Their sodium valproate was maximised and the consultant paediatrician consulted with neurology on other treatments they could try. It was recommended that Lamotrigine was added. The consultant wrote a prescription for a titrating dose of Lamotrigine which was then posted to the parents. There were a few weeks delay between the prescription being posted and the parents presenting with the prescription at UHW Pharmacy. The prescription was for Lamotrigine 2mg, 5mg and 25mg. At the time there was only 5mg in stock and the 2mg and 25mgs were ordered. The parents came back a few days later and collected the 25mg but the 2mg was still unavailable so the titrating dose did not commence as there were not the right quantities available at this point. The prescription should have been placed in the Owens folder but was misfiled with the daily prescriptions. The Owens file is	

	checked on a daily basis and it would have been noted that the 2mg was still outstanding and the parents would have been informed that this was in stock. This did not happen as it was incorrectly filed. The patient suffered a seizure at home and was admitted to paediatric critical care and it was noted that the Lamotrigine had not commenced. Had this commenced at the right time, the patient would still not have been on the maximum dosage so would still be going through the titration procedure. A recommendation from the investigation was that the department strengthened its Owens procedure and a checklist is incorporated on to the follow up slip. The procedure is now more robust and the checklist is in place. Staff at UHW and UHL have been made aware of this. A further recommendation was that the Pharmacy system allows for an automatic or a manual reorder. In this case this was on a manual reorder. As it was a critical time medicine, this should have been an automatic reorder and this has been reviewed for all critical time medicines. **The Group resolved that:** a) In hindsight this case probably didn't meet the threshold for a nationally reportable incident given there was low harm to the patient but the investigation was a useful exercise as it highlighted processes that needed to be made more robust that will prevent a future reoccurrence.	
CDTQSE 24/008	**New NRIs** **The Group resolved that:** a) There were no new NRIs to report.	
CDTQSE 24/009	**Duty of Candour Cases** **The Group resolved that:** a) There are no cases to report.	
CDTQSE 24/010	**Risk Register Updates** RB reported that the Academic Centre lift has been shut down due to a flood. The lift needs to be completely dry before it can be repaired. SO noted that the suspended flooring in Health Records at UHW is perishing and the tiles are causing a trip hazard. Options around replacement are being considered with the Estates team. JF raised an issue relating to the closure of the Radiopharmacy and the impact on the nuclear medicine service. The service at UHW has had to house dispensing in a scanner room that has taken a scanner out of action. The department is struggling to	

	identify alternative storage options. A risk assessment has been completed and JF will send this to HL. EC noted that the risk assessment with challenges with staffing to undertake planned maintenance is being completed. EC will forward to HL when completed. Dietetics are experiencing waiting times challenges within the weight management service. KA will ask Dietetics to produce a risk assessment and send the risk rating to HL. **The Group resolved that:** a) The updates relating to risks were noted.	**JF** **EC** **KA**
CDTQSE 24/011	**Patient Safety Alerts** **NatPSA/2023/013 Valproate** Due to the known significant risk of serious harm to a baby after exposure to Valproate in pregnancy, from January 2024, new regulatory measures will be put in place for oral Valproate medicines. These measures will reduce initiation of Valproate to only patients for whom no other therapeutic options are suitable. **Supply Issues with Sando-K and Phosphate Sandoz** There are intermittent supply issues with Sando-K and Phosphate Sandoz. The notice suggests recommendations to be considered when exploring alternative options. **Safety Notice Tramadol and Warfarin** A safety notice has been circulated advising that co prescription of Tramadol and Warfarin can result in significant increases in INR and bleeding risk. SS are looking at putting this into their drug interactions information for INR training for end users. RB noted that AWMSG has developed patient information leaflets where it advises that patients should discuss this with their doctor if they are taking Warfarin. RB to share the link to the leaflet. **Safety Alert Samsung Mobile System** Radiology has received safety alert relating Samsung mobile system and the additional actions required on this. Service engineers have been contacted to replace a part on all the units. A further safety alert received in Radiology was received in relation to potential loss of imaging functionality which requires a software update.	**RB**

	National Patient Safety Alert re Bed Equipment KA noted that this work is ongoing and a detailed plan is being produced in Occupational Therapy. **The Group resolved that:** a) Two Groups have been set up in the Health Board for Clinical Boards that have patients who receive Valproate to implement the regulatory measures.	
CDTQSE 24/012	**Medical Device/Equipment Risks** EC noted that a meeting was held in January relating to the national alert on the bed equipment and a further meeting is to be scheduled in February. Actions arising from the meeting will be captured. **The Group resolved that:** a) Whilst this is a major piece of work, good progress is being made.	
CDTQSE 24/013	**Point of Care Testing** SS has been raising poor connectivity issues and discussions are now being held with the IM&T team to identify a solution. A risk has been placed on the POCT risk register relating to a cohort of haematology based POCT devices within the POCT team. A request has been made to haematology consultants for support, evaluation and maintenance of these devices which is outside of the expertise of the POCT team. **The Group resolved that:** a) SS to submit the latest version of the POCT risk register to HL.	**SS**
CDTQSE 24/014	**IP&C/ Decontamination Issues** **UK Health Security Agency 2024/001 Recall of Infant Formula Product Due to Possible Contamination** There are recalls of two infant formula products as a precautionary measure due to concerns of possible contamination with Cronobacter sakazakii. The products must not be fed to infants. SR advised that at the last IPC meeting there was further discussion on MSSA bacterium infections relating to line infections. This work is coming to an end. A Venous Access Group has been set up looking at improvements and standardisation of the pathways across the Health Board.	

	She noted that ANTT compliance in this Clinical Board has improved. Training has been secured for 2 assessors to undertake assessor training. Currently training an individual in lymphoedema and an individual in Radiology. The Decontamination Group was held in December. No specific issues were raised relating to this Clinical Board. The UHB Ventilation Group is seeking representation from each Clinical Board however, this Clinical Board has good representation on this group. The Water Safety Group has also recently been held. The main risk within this Clinical Board is the hydrotherapy pool however there are currently no issues to report. In terms of other IPC issues, there is still availability the of Covid and Flu vaccinations for staff. Staff are also being asked to receive the measles vaccination. The Tendable system is being used more widely for capturing IPC audits. If anyone requires training on the system to contact SR or HL. The Outpatients department received feedback from a Llaith visit undertaken last year. Whilst the department conformed with UHB IPC guidance around removing unnecessary signage, magazines etc. issues were raised around the lack of information on display. The inspection also raised the issue that there is no water cooler in place. The response to Llaith will include justification that the department was complying with IPC guidance. JF noted that Radiology will be trialling a cleaning product, Spill Kit in the Radiology rooms that are not able to use Achtichlor. JF will feedback on the outcome. YH has been involved in the discussions. **The Group resolved that:** a) The IPC update was noted.	
CDTQSE 24/015	**Safeguarding Update** A notice relating to challenges with current staffing levels in the Safeguarding Team has been circulated. **The Group resolved that:** a) The level of service provision the team can currently provide was noted.	

CDTQSE 24/016	**Health and Safety Issues** JD reported that the Health and Safety Operational Group shared feedback from the HSE inspection but there were no issues relating to this Clinical Board. HL issued a reminder that if a work incident occurs which results in staff being off for 7 days, this will result in a RIDDOR investigation. There has been a change in the reporting of patient injurious falls and if they were unavoidable they are now treated as a RIDDOR. A patient injurious fall occurred on Glan Ely Ward and this has been reported. SR to advise AL when the investigation is completed. Learning will be shared at a future meeting. **The Group resolved that:** a) The Health and Safety update was noted.	**SR**
CDTQSE 24/017	**Regulatory Compliance** HL reported that the All Wales Quality Assurance Pharmacist has undertaken an inspection at UHL Aseptic Unit. The team are compiling a response to the findings. The ageing estate was raised as an issue. UKAS have inspected the Biochemistry department. Positive feedback was received and the department maintained its accreditation against the 2012 Standard with a recommendation that they are also accredited against the 2022 standard. **The Group resolved that:** a) The minutes of the Regulatory Compliance Group will be shared for information.	
TIMELY		
CDTQSE 24/018	**Initiatives to Improve Access to Services** Nothing to report.	
CDTQSE 24/019	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** SO reported that the number of patients waiting for Therapies 14 weeks or more is 1066. A large proportion relates to the weight management service in Dietetics. Podiatry is also reporting breaches and plans are in place to mitigate this by February. Pelvic Health Physiotherapy service is also under pressure due to staffing issues. The number of patients in Radiology waiting 8 weeks or more is 8943. The Community Diagnostic Centre has been implemented at UHL and the CT and MRI backlog will reduce	

	significantly over the next few months. Ultrasound remains a challenge. It was noted that the recent Industrial Action has had an impact on the waiting lists. **The Group resolved that:** a) The waiting time position was noted.	
EFFECTIVE		
CDTQSE 24/020	**Feedback from UHB QSE Committee** **The group resolved that:** a) The minutes of the meeting held on 19th December 2023 are not yet available.	
CDTQSE 24/021	**NICE Guidance** **The Group resolved that:** a) There was no new guidance to share.	
CDTQSE 24/022	**Research and Development** RM reported that the next Clinical Board R&D Meeting is being held on Wednesday. The Clinical Board R&D Forum is being held on 7th February. Speakers include an individual from Speech and Language Therapy providing a talk on First into Research Fellowship and Nia Jones and Cedar will be discussing patient empowerment tools. A new R&D Lead has been appointed for Therapies. No leads yet identified in Laboratory Medicine and Pharmacy. A Research Investigators meeting was held last week. A presentation was provided from Siemens on their MR scanners and Cardiff University presented and getting their Mathematics Masters student involved in work with the Health Board. There was a short discussion about the role of R&D Leads having more input into high risk projects. The issue was raised that there is no funding for R&D Leads and this should be factored into job planning, however as there is only 1 R&D lead in this Clinical Board that is a clinician, this is not applicable to the majority of R&D Leads in this Clinical Board. **The Group resolved that:** a) The Clinical will need to monitor the workload of the R&D Leads over the coming months, given there is no resource allocated to them.	

CDTQSE 24/023	**Service Improvement Initiatives** Cancer Pathway work is being resumed with the All Wales Medical Genetics Service and Cellular Pathology looking at respiratory and lung cancer pathways and widening this. SO and AC will be discussing support from Kate Blower ,Clinical Board I&I Lead for teams that are looking to take on local improvements. AA stated there are 3 post Registration Pharmacists due to commence service improvement initiatives related to: • Cold Chain • Renal stock and wastage • Adverse Drug reporting and increasing engagement in this process. **The Group resolved that:** a) These initiatives will be presented at a future meeting when the projects end.	
CDTQSE 24/024	**Information Governance/Data Quality** Digital Front Door for Subject Access Requests has started in Health Records. This currently requires double entry with the previous process whilst the new process is being trialled and embedded. This is a robust system that will tighten quality controls and there will be efficiencies for the Health Records team. KA asked if there is a timeframe for this to become a standard approach. It was noted that the system was developed by the Information Governance Team and they will advise other teams. The first part is dealing with requests in a standard way and the messaging given back to patients and the timeliness of responses. The next stage is dealing with general and unique questions relating to the requests and SOPs will be strengthened around this. There will be differences between different services but there will be general guiding principles for all teams. **The Group resolved that:** a) It was noted that at present the existing practice stands.	
CDTQSE 24/025	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** The draft report from the HIW inspection of Radiology has been received. The department has provided its feedback and the associated improvement plan. Positive feedback was received relating to the protection of patient's privacy and dignity. Patients who attended their appointments did not have to wait long in waiting areas to be seen. Information on patient journeys was displayed well.	

	There has been an improvement in Employers Procedures since the last meeting and it was commented that they were well written. It was commented that the entitlement process was clear and there were good lines of accountability. Staff demonstrated that they were aware of how to act in an incident or concern and they show good compliance with policies and procedures within the department. There was positive management and governance structures in place and training, documentation and mandatory training compliance was good. Shared learning of incidents with staff was highlighted as an area of good practice. Positive comments were received in relation to the department's participation in Project Search. Areas for improvement were made in relation to introducing a standard template for all audits. The department is standardising its process and ensuring audits are uploaded onto the AMAT system. There were a number of outstanding estates works that need ot be completed in a more timely manner. Entitlement letters for radiologists from other Health Boards who work within the department need to be included on the entitlement matrix. It was also recommended that a consent form for carers and comforters is developed. Compliance with Values Based Appraisals also need to be improved. An issue was also raised relating to Paediatric Radiologist provision where there are not adequate numbers to provide a rota'd on-call service. This risk is highlighted on the risk register. **The Group resolved that:** a) The feedback from the Radiology HIW Inspection Formal Report was noted.	
CDTQSE 24/026	**Policies and Procedures** **The following policies out to consultations include:** • Welsh Language Choice for Inpatients Policy • Intraoperative Cell Salvage Policy • SOP for CF Special Infection Patients **The Group resolved that:** a) Members of the group will review any of the policies that are relevant to their areas.	
EFFICIENT		
CDTQSE 24/027	**Exception Reports from Directorates** Therapies submitted an Exception Report.	

	The Group resolved that: a) A reminder was issued to other directorates to either share their QSE Group minutes or submit exception reports.	
CDTQSE 24/028	**Health and Care Quality Standards** **The Group resolved that:** a) There were no updates to report.	
CDTQSE 24/029	**Clinical/Internal Audits** EC noted that Clinical Engineering received their BSI audit recertification visit in October 2023 and Clinical Engineering received their recertification. **The Group resolved that:** a) Departments are encouraged to use the AMAT system for any formal audits. Training can be provided by the Patient Safety Team.	
CDTQSE 24/030	**Waste and Sustainability** The UHB Green Group received a presentation on the Therapies Decarbonisation Action Plan. The plan received positive feedback and will be replicated in a number of other departments across the UHB. A presentation was also received from the IT department on the shutdown of PCs overnight. The UHB has produced a monthly Sustainability Pledge SharePoint site where staff can sign up to make personal pledges against a specific topic each month that will have a positive impact on reducing their carbon footprint. The Clinical Board Green Group now meets seasonally. It has produced a sustainability action plan which sets the group 'Green' objectives relating to a specific topic, which the group are asked to try to achieve by the following meeting when the results are discussed. The current objective is on reducing printing. EC noted that the UHB is no longer permitting the purchase of diesel or petrol fleet cars. He recommended that departments consider submitting a request if they are planning to procure electric vehicles and require charging points. KA advised that therapies have experienced difficulties trying to procure electric lease vehicles. EC advised that lead times are challenging. **The Group resolved that:** a) The updates from the UHB Green Group and Clinical Board Green Group were noted.	

EQUITABLE		
CDTQSE 24/031	**Feedback from Clinical Board Inclusion Ambassadors Group** **The Group resolved that:** a) The Inclusion Ambassadors Meeting is being held later in January.	
CDTQSE 24/032	**Equality and Diversity Issues** **Equity, Equality, Experience and Patient Safety Equity Framework** The document was circulated for information. **The Group resolved that:** a) The document will be discussed at the next meeting.	
PERSON CENTRED		
CDTQSE 24/033	**Patient Story** A compliment was received for a phlebotomist from a patient who has regular bloods taken. The patient perceives that they are difficult to bleed and experiences anxiety before appointments. The phlebotomist took them to a quiet area away from where bloods are normally taken to a room with a reclining chair and reassured and calmed the patient prior to taking their bloods. The patient noted that this made a huge difference. A compliment was also received for a Podiatrist around the time they had taken and the adaptations that they made to provide individual care to support the needs of an autistic child. **The Group resolved that:** a) Taking time and making small changes to support patients can have a big impact.	
24/034	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** As discussed earlier, vaccinations are available to staff at the Mass Vaccination Centres. **The Group resolved that:** a) The MMR vaccination is also now available to staff.	
CDTQSE 24/035	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	

CDTQSE 24/036	**National User Experience Framework/Feedback from Patient and Service User Surveys** Civica feedback is now being received. Whilst not tailored specifically to this Clinical Board, relevant information is contained within the report. JF stated that a Radiology survey undertaken for Outpatients and GP patients generally received good feedback. An issue was raised whereby patients felt they did no receive enough information prior to their procedure or examination and this is being addressed. A survey is now being planned for inpatients. **The Group resolved that:** a) HL will share the Civica Reports.	**HL**
CDTQSE 24/037	**Staff Awards and Recognition** The Clinical Board Monthly Staff Recognition Scheme is continuing in 2024. The category for January is the Individual Living our Values Award. **The Group resolved that:** a) Nominations are to be submitted by the deadline for the end of January.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 24/038	Therapies QSE Exception Report	
ANY OTHER BUSINESS		
CDTQSE 24/039	There has been a call out for staff to undertake training for NRIs and locally reported investigations. Individuals need to receive approval from their line managers prior to signing up for the training. There is also a request for managers to look at new incidents on Datix and reduce the number of open incidents.	
CDTQSE 24/040	**Date & time of next Meeting** 16th February 2024 at 9am via Teams	

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

Held on 16th February 2024 Via MS Teams

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

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 24/041	**Welcome & Introductions** SL welcomed everyone to the meeting.	
CDTQSE 24/042	**Apologies for Absence** The apologies for absence were noted.	
CDTQSE 24/043	**Minutes of the previous meeting** The minutes of the previous meeting were received. **The Group resolved that:** a) The minutes of the previous meeting held on 22nd January 2024 were accepted as an accurate record.	
CDTQSE 24/044	**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 Lead Pharmacy* TB is in discussions with an individual in the Pharmacy Team who may potentially take on this role. *CDTQSE 23/244 HTA Inspection* SG to provide feedback on the HTA inspection and an update on actions being taken at the next meeting. *CDTQSE 23/323 Demonstration on Booking Lab* SO to provide a demonstration when the system is live. *CDTQSE 24/010 Risk Assessment on Staffing in Clinical Engineering* EC to complete a risk assessment based on the SBAR relating to the challenges with staffing in Clinical Engineering and submit to HL. *CDTQSE 24/013 Point of Care Testing Risk Register* SS to send the latest version of the risk register to HL and HJ.	**TB** **SG** **SO** **EC** **SS**

	CDTQSE 24/016 Investigation of Fall on Glan Ely Ward SR to advise AL when the investigation of the patient fall has been completed. **The Group resolved that:** a) The update on the actions outstanding from the previous meeting were noted.	**SR**
CDTQSE 24/045	**Terms of Reference Review** The updated terms of reference document was approved by the Group. **The Group resolved that:** b) The document will be submitted to Formal Board for final ratification.	**HL**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 24/046	**Concerns and Compliments Report** In January 2024, the Clinical Board received 15 concerns in total; 3 formal and 12 early resolution concerns. There were 0 breaches in response times and 4 compliments were received. The top 3 reasons for concerns in January related to: • Difficulties cancelling/arranging appointments • Waiting times • Waiting times for test results/scan reports Concerns relating to difficulties in cancelling and arranging appointments relate to Physiotherapy, Radiology and Health Records and this is mainly due to pressures within their booking teams due to vacancies. **The Group resolved that:** a) The concerns report was received. The report also provides a breakdown of the individual departments' data.	
CDTQSE 24/047	**National Reportable Incidents** The Clinical Board has 3 open NRIs currently under investigation. **The Group resolved that:** a) The incident report was noted.	

CDTQSE 24/048	**New NRIs** **The Group resolved that:** a) There are no new NRIs to report.	
CDTQSE 24/049	**Duty of Candour Cases** **The Group resolved that:** a) There are no duty of candour cases to report.	
CDTQSE 24/050	**Risk Register Updates** MM reported that the slit lamp in Medical Illustration is at end of life and in need of repair. This is used for magnification of images of the eye. EC advised her to contact John Maisey in the Clinical Engineering team who may be able to provide maintenance and repair. EC will send her a capital bid form to complete to request a replacement. KA reported that the Physiotherapy team are producing a capital bid for bariatric plinths. There are issues with vermin in the roof space at Barry Hospital which has resulted in cancellation of some appointments. Dietetics have reported issues with nasogastric pH strips whereby the wrong products are being identified on wards. Work is underway to reduce the number of options available to order to reduce the risk. The physiotherapy neuro gym is experiencing temperature control issues where the environment has been too cold for this cohort of patients, resulting in a number of cancellation of appointments. EL reported that a drug storage fridge at UHL is at end of life. Whilst it is currently working and will remain operational as long as possible, this will be discussed with the Capital Management team as a replacement will involve major capital work. A review will also be undertaken of all the other fridges within Pharmacy. EC reported that following a change in guidance, desflurane needs to be removed from vaporisers before they are sent back to the company. EL advised that Fiona Brennan is taking this forward with an external company and EL and EC will discuss with her outside of this meeting. BJ raised the risk around the resources needed for the ongoing build and implementation of the new LIMS system. The deployment is scheduled for May 2025. A lot of work is required in a short timescale and there are few staff available with the necessary skills to undertake this work. A risk assessment	**EC**

	needs to be undertaken to identify the level of resource that will be needed. AC noted that the Swansea IR service is fragile and late last year their service was paused due to lack of staffing. Temporary arrangements were instigated with the SE Wales Network, where Consultant Interventional Radiology colleagues from Cardiff and Vale and AB Health Board provided on-site support, in addition to support with MDT meetings. In terms of out of hours support, patients were transferred to Cardiff and Vale to receive treatment that was required on an urgent or time sensitive basis. There have been lots of discussions at Executive level between the Health Boards and going forward the out of hours arrangements will remain in place. This will be monitored in terms of volumes to review any impact on Cardiff and Vale and whether any changes are required to this model. In-hours on-site support to Swansea Bay Health Board will cease and instead there is a request for Cardiff and Vale to undertake elective work on their behalf during March. Radiology are in the early stages of developing this arrangement. It was noted that any reliance on the Radiology service that runs into the new financial year will overlap with the capital replacement work in the IR rooms in Cardiff and Vale. The implementation plan is being worked through to map out the risks relating to this. There may be a need for neighbouring Health Boards to undertake cases to help manage demand across the region. It was agreed that when the operating model is produced, AC will present the risks to a future meeting. **The Group resolved that:** a) The updates relating to current risks within departments were noted.	**AC**
CDTQSE 24/051	**Patient Safety Alerts** EC reported that in December 2023 a product notice was received relating to the Phillips Azurion system that could affect performance of the equipment. A new software update has now been completed and this safety alert is now closed. A product information received from GE Healthcare on the Mac VU360 software version V1.02 SP05, indicated that where after performing a 12 Lead ECG acquisition, a filter is applied post-acquisition on the preview screen or print out report. There is potential that the amplitude could be slightly reduced for QRS waves. The interpretation software is unaffected, however a software update will be released in the near future. A letter from Welsh Government and the National Clinical Lead for Frailty has been circulated to Health Boards relating to	

	movement sensors and fall detectors. There is a recommendation to discontinue the use of movement sensors as an option for falls prevention. They should only be utilised on an individual basis following an MDT discussion and daily reviews should be routine and patient independence should not be compromised. An updated Field Notice from Phillips has been received relating to Mobile Diagnostic wDR expiration of software certificate validity preventing users from system log in. A software solution has now been identified and released to address this issue. An urgent Cerabase Product Recall notice has also been received. This affected Interventional Radiology and action has been taken in the department to isolate the products**.** **The Group resolved that:** a) The update on the Safety Notices was noted.	
CDTQSE 24/052	**Medical Device/Equipment Risks** **The Group resolved that:** a) There were no further updates to be received.	
CDTQSE 24/053	**Point of Care Testing** **The Group resolved that:** a) There were no updates to note.	
CDTQSE 24/054	**IP&C/ Decontamination Issues** There has been no IPC Group held since the update provided at last month's meeting. The UHB Decontamination Group was held this week. All Clinical Board Directors of Operations are to ensure their Clinical Boards are represented on the UHB Ventilation Group. This Clinical Board and theatres were raised as particular areas, given they have a high number of air handling units in their services, however SR has noted that this Clinical Board has good representation on the Ventilation Group. The first draft of the review of the UHB Decontamination Policy has been circulated for comments from the Decontamination Group. The UHB has been undertaking sustainability projects such as moving from wrap to sterilisation containers; a Green theatre has been set at UHL and is trialling reusable linen, gowns and masks, macerators as opposed to bed pan washers on the ward and reusable galley pots.	

	A new Endoscopy User Group has been set up and the first meeting has taken place. There have been changes to Ultrasound decontamination and a Trophon machine has been secured which uses hydrogen peroxide for a high-level disinfection of ultrasound probes. The Standard Operating Procedure has been amended to reflect a key change in in terms of the wipes process, which has been agreed with the IPC team. **The Group resolved that:** a) The update from the Decontamination Group was noted. There were no issues raised from this report.	
CDTQSE 24/055	**Safeguarding Update** Physiotherapy Paediatrics have raised an issue relating to safeguarding information that is recorded on one UHB patient record system not linking across into other UHB systems**.** **The Group resolved that:** a) The issue is being discussed with the UHB Safeguarding Team.	
CDTQSE 24/056	**Health and Safety Issues** EL noted that following a serious fall on the internal stairwell in Pharmacy, legal services are now involved. There has been a suggestion that that stairs are closed on a permanent basis, however this would result in the only access for drugs to be taken upstairs is via the concourse which is not appropriate. RB reported that the high level of heating on the second floor of the Academic Building at UHL is causing discomfort for staff. SL advised that Medical Records staff have decanted from the department at UHW to allow for works to commence to the flooring. **The Group resolved that:** a) EL to obtain an update from Estates on the plan for the stairwell. b) RB to check that staff affected by the heating in the Academic Building have submitted a maintenance request to Estates.	**EL** **RB**
CDTQSE 24/057	**Regulatory Compliance** An unannounced inspection was undertaken in Blood Bank by the MHRA. There were no Critical findings but a number of Major actions to be addressed. Positive feedback was received,	

	particularly in terms of their risk assessment documentation where it was noted that this should be an example to other units. **The Group resolved that:** a) Given the staffing gap within the quality team in this department, the staff are to be commended for receiving a positive inspection.	
TIMELY		
CDTQSE 24/058	**Initiatives to Improve Access to Services** **The Group resolved that:** **a)** There were no initiatives to report.	
CDTQSE 24/059	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** The diagnostic hubs implemented for MR and CT at UHL and the additional ultrasound lists are having a positive impact in supporting the Radiology waiting list position. Whilst the department is still reporting a high level of breaches at 8507, this has reduced by 436 this month. In term of patients waiting 14 weeks or more for therapies there are issues with weight management demand in dietetics and a plan is being devised to mitigate those breaches within paediatrics. The issues are driven by a resource gap and a lack of specialist skills. Physiotherapy breaches have increased in Pelvic Health. This also relates to a resource gap in a skilled specialist service. Podiatry have been working on their templates to address their waiting list position and reported 22 breaches at the end of January and aiming for 0 breaches at month end. Speech and Language Therapy breaches have increased largely due to demand and complexity of cases in the transgender service. **The Group resolved that:** a) The waiting time position was noted.	
EFFECTIVE		
CDTQSE 24/060	**Feedback from UHB QSE Committee** The minutes of the meeting held on 10th January 2024 noted that a limiting factor impacting on the ability to progress the Covid investigations is the availability of Health Records. The Health Records team are trying to locate health records that have not been returned to file and are providing the level of oversight this	

	work requires. The issue highlights failures in the system where records could be held anywhere across multiple sites. **The group resolved that:** a) Discussions are being held with the Patient Safety Team to determine what can be undertaken to conclude the investigations by the end of March.	
CDTQSE 24/061	**NICE Guidance** **The Group resolved that:** a) There was no new guidance to share.	
CDTQSE 24/062	**Research and Development** The R&D Leads Research Forum held last month was well received. RM requested nominations for speakers at the next forum. It was noted in the R&D Leads Meeting that the R&D Team will be looking for R&D Leads to input into risk assessing new trials, which involves providing advice on the level of risk associated with a trial. This further highlights the issue that there are no R&D Leads in Pharmacy and Laboratory Medicine. RM has also escalated the issue to R&D that there is a lack of funding for R&D Leads within this Clinical Board, as the model HCRW has implemented is that clinicians have R&D sessions built into their job plans. This does not apply to the non-medical R&D Leads within this Clinical Board as they do not have job plans. RM reported that there is a positive development where the R&D team have been in discussions with Cellular Pathology, Pharmacy and Radiology relating to funding from the Cardiff Cancer Research Hub. **The Group resolved that:** a) SJ to provide an update on Laboratory Medicine identifying an R&D Lead.	**SJ**
CDTQSE 24/063	**Service Improvement Initiatives** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/064	**Information Governance/Data Quality** KA reported on an IG breach in Therapies which is a recurring issue relating to blind copying in multiple individuals who might be attending a group into emails. Work is being undertaken with the Information Governance team to address this issue.	

	The Group resolved that: a) The Information Governance Team may wish to share learning from this incident with other Teams that may be experiencing similar IG breaches.	
CDTQSE 24/065	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** It was noted that there was a recent visit from Laith to the Outpatients department. Comments were made relating to the tired environment needing an update and suggestions around materials that could be made available for patients. **The Group resolved that:** a) Laith is a new organisation, formerly the CHC, and departments that receive a visit are requested to feedback at this meeting on their visits and to help identify if there are any differences in their approach.	
CDTQSE 24/066	**Policies and Procedures** **The Group resolved that:** a) There were no policies or procedures to be received.	
EFFICIENT		
CDTQSE 24/067	**Exception Reports from Directorates** Therapies and AWTTC submitted exception reports. **The Group resolved that:** a) A reminder was issued to other directorates to either share their QSE Group minutes or submit exception reports.	**All**
CDTQSE 24/068	**Health and Care Quality Standards** **The Group resolved that:** a) There were no updates to report.	
CDTQSE 24/069	**Clinical/Internal Audits** There were no audits to be received. **The Group resolved that:** a) Departments are encouraged to use the AMAT system for any formal audits. Training can be provided by the Patient Safety Team.	

CDTQSE 24/070	**Waste and Sustainability** There were no updates to report this month. **The Group resolved that:** a) The UHB Green Group is meeting next week. b) The Clinical Board Green Group is next meeting in March.	
EQUITABLE		
CDTQSE 24/071	**Feedback from Clinical Board Inclusion Ambassadors Group** Sarah Clements presented on an initiative in Speech and Language Therapy to embrace the inclusion agenda without the need for additional resources. SL suggested that this work is presented to a future meeting of this group. **The Group resolved that:** a) HJ will invite Sarah Clements to a future meeting.	**HJ**
CDTQSE 24/072	**Equality and Diversity Issues** **Equity, Equality, Experience and Patient Safety Equity Framework** The document was circulated for information. It was noted that Alun Williams, Welsh Language Officer is leading on a consultation relating to this work. **The Group resolved that:** a) Members who would like to feedback on the framework to contact Alun Williams.	
PERSON CENTRED		
CDTQSE 24/073	**Patient Story** **The Group resolved that:** a) There was no patient story presented at today's meeting.	
24/074	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** HN has been involved in ongoing discussions around the challenge of implementing the healthy offer for staff within the UHB restaurants. Dietetics are also involved in discussions between the ICU department and catering services to address an issue where there is no catering provision for jug changes for non-sterile water to patients.	

	The Group resolved that: a) The future of catering services is under review and SL will check that HN is aware of this work.	**SL**
CDTQSE 24/075	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 24/076	**National User Experience Framework/Feedback from Patient and Service User Surveys** There was no feedback from surveys to report. **The Group resolved that:** a) Civica information will be shared when it is available.	
CDTQSE 24/077	**Staff Awards and Recognition** The Clinical Board Monthly Staff Recognition Scheme is continuing in 2024. The category for February is the Outstanding Team Award. **The Group resolved that:** a) Nominations are to be submitted by the deadline for the end of February.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 24/078	Therapies QSE Exception Report AWTTC Exception Report Regulatory Compliance Group Minutes February 2024	
ANY OTHER BUSINESS		
CDTQSE 24/079	KA noted that there are still places available for the AHP and Health Science Conference. She requested any final submissions for the brochure KA also noted that the ECOD team are planning a Staff Recognition Event for practice placement education on a multi-professional basis.	
CDTQSE 24/080	**Date & time of next Meeting** 15th March 2024 at 2pm via Teams	

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

Safeguarding Steering Group Meeting
Thursday 25th January 2024
MS Teams Meeting

Present:
Rebecca Aylward – Deputy Executive Nurse Director
Linda Hughes-Jones Head of Safeguarding
Helen Whalley- Deputy Lead for Bereavement Service
Chloe Laws – Safeguarding Midwife
Judith Cutter- Consultant Midwife
Annette Blackstock- Designated Nurse for Safeguarding Public Health Wales
Nick Howard – South Wales Police
Katina Kontos – Safeguarding Doctor
Pippa Johnson – MCA
Jasmine Jones – LATCH
Carly Simpson – Neuroscience
Melanie Bostock – MCA
Bethan Williams – LAC / Adoption Doctor
Fiona Sullivan – Spire
Faye Protheroe – Bereavement Lead
Anna Mogie – PCIC

PART 1: PRELIMINARIES *(Chair)*		**Document**
1.1	**Welcome** Rebecca Aylward welcomed everyone to the meeting.	
1.2	**Apologies for Absence** Apologies were received from: Ceri Lovell, Mark Doherty, Bev Oughton, Chris Frayne	
1.3	**Approval of SSG Minutes from the previous meeting** The minutes of the previous meeting were agreed as an accurate record.	
1.4	**Action Log** Please note updates documented on the Action Log	
PART 2: STRATEGIC DIRECTION AND SERVICE IMPROVEMENT		
2.1	**Update from Joint Inspection Review of Child Protection Arrangements (JICPA) with Cardiff Children Services presented by Linda Hughes-Jones:** The JICPA interviews was completed on the 19th January 2024. The inspection was a joint review with HIW, CIW, Police and Education reviewing child protection arrangements in Cardiff for children up to the age of 11 years old. 16 cases were selected by the inspectors, 6 of those being a deep dive review and 10 cases were reviewed by considering "front door" arrangements. The inspectors would be considering information from each organisation for those children. There were two	

	children of health visiting age and remainder for the Deep Dive were school aged children. It was demonstrated that there was good partnership working within the agencies to provide the information in a tight deadline. There were a number of health staff interviewed as part of the inspection to identify roles and processes in place. The inspectors reported that they received 120 completed surveys by UHB staff, the overwhelming overview is that staff feel that they are able to access the UHB Corporate Team, they feel that good advice is provided and that they are satisfied by the service offered to them. Initial interim feedback from the HIW inspectors includes: • Attendance at Level 3 safeguarding training will need to be improved. • CLA health assessments and the delay in receiving those assessments to be reviewed. • School Health Nurses completing Health Assessments when they are preparing for an Initial Child Protection conference. • A QSE report to the Board was identified by the inspectors, the report detailed pressure damage reporting in Paediatric Intensive Care Unit. The UHB are awaiting an interim report from JICPA. The full report is expected at the end of February 2024.	QSE PICU Pressure Damage - Septembe
2.2	**Safeguarding Midwife Role, FGM Update presented by Judith Cutter:** Chloe Laws has commenced as the Interim Safeguarding Midwife (replacing Alice Fairman) within the Safeguarding Team. The current post is a secondment, the post is advertised and will be progressing through recruitment. The Executive Nurse Director Jason Roberts, is the strategic lead for FGM with C&V UHB. A SBAR has been developed and is enclosed. Discussions held at the meeting regarding risk assessments for women who disclose or are identified as having FGM. Judith presented a recent case identified at the CRI, Well-being Clinic where a discussion was held with a woman around completing a MARF in respect of her female child. The woman did not want a MARF completed as she felt able to protect her child from being a victim of FGM. There is a FGM pathway in place with agreed pathways for agencies within the Cardiff and Vale region. It was felt one isolated case of not consenting to the MARF should not change the process that is in place. An evaluation had previously taken place with women from the Somalian community with the outcome that, although they disagreed with the FGM pathway they understood why it was needed. **Action: Chloe to scope with other health boards in Wales, regarding their process for FGM reporting.** **Action: Consider the case discussed to be shared at the All Wales FGM group**	SBAR FGM 180124.doc
2.3	**CAMHS Update:** Deferred	
2.4	**Safeguarding Training Update presented by Linda Hughes-Jones:** A number of Level 3 training sessions have been cancelled during 2023-2024. This is due to resources within the team, poor attendance and	Nov 2023 - MCA L2 training Compliance

	booking the session. There is also a significant issue around “no show” on the training day with up to 50% non-attendance. An example given is a recent VAWDASV session delivered by a Safeguarding Nurse Advisor and an IDVA as per Welsh Government guidelines, 51 staff initially booked the session and 15 people attended. Safeguarding does not have the capacity to contact the line managers of those who have not attended. **Action: Rebecca Aylward to raise with the Directors of Nursing the non-attendance at safeguarding training** There has been an issue in booking outside speakers for the Level 3 training to enhance the presentations and knowledge gained on the day. Level 2 training compliance is set by the health board as 75%. The recent inspection (JICPA) felt that it should be 85% as set by the National Guidance **Compliance from November / December 2023** Level 2 Adult: - November - 77.2%, December – 78% Level 2 Children – November - 75.6%, December – 76% VAWDASV – November - 72% - December – 72%	
PART 3: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
3.1	**Safeguarding Activity Update:** **Safeguarding Run Rate:** **Adult Health Safeguarding referrals AS1s** November 29, December 21 **Child Safeguarding referrals MARFs** November – 533, December 490 **Action: Future audit of referral quality to be undertaken** **DoLS Assessments** November – 43 Requested, 11 completed December – 39 Requested, 2 completed **Update of the safeguarding team interim measures presented by Linda Hughes-Jones:** The corporate safeguarding team are in currently in considerable extreme measures. There have been two experienced staff resignations at the same time. There are team establishment is: 11 SNA’s, eight of the staff work part time hours. The Safeguarding Midwife post is currently out to advert and the Senior Nurse for Safeguarding has been appointed and will be commencing her post in March 2024. There are considerable Multi-Agency commitments through the RSB and reviews which are commissioned. A new review the Offensive Weapons	Corporate Safeguarding Team

	Homicide Review is currently in a pilot stage, this is a new review process. An Interim Safeguarding Action Plan has been developed to prioritising the main areas of safeguarding within the UHB. The plan will be in place from February to August focusing on, Mandatory Training and Level 3 training, Safeguarding Supervision for specific roles, ensure that the advisory and supportive role is maintained and staff are available to speak with UHB practitioners, Regional Safeguarding Board (RSB) meetings and commitments, provide mentorship to new Safeguarding Nurse Advisors (SNA). **Action: Feedback the Interim Action Plan to be completed within 2 weeks** **Action: Interim Action Plan to be placed on Safeguarding Risk Register**	
3.2	**Safeguarding Reviews Updates shared by Linda Hughes-Jones:** There are 13 safeguarding reviews ongoing: Five CPR Two APR Five MAPF (multi-agency professional forums) One SUSR. There is one DHR in the Vale which is due to be completed Two new DHR's in the Vale which are due to commence The SNA are panel members for all of the reviews. The pilot SUSR in C&V region has been ongoing since January 2023. A draft report is expected by March 2024. The SUSR will be introduced across Wales from April 2024. There have been two homicides in the region during December 2023. Due to the usual area of residence it has been determined that one review will be undertaken in Cwm Taff and one in Cardiff.	Cardiff and Vale Regional Safeguard
3.3	**SMM Implementation Plan shared by Linda Hughes-Jones:** Safeguarding Maturity Matrix plan to be considered by Clinical Boards **Action: Feedback to be sent within 2 weeks.**	SAFEGUARDING MATURITY MATRIX II
3.4	**MAPPA Update:** Defer to next meeting **Action: Linda Hughes-Jones to discuss with Chris Frayne**	
PART 4: GOVERNANCE		
4.1	**Liberty Protection Safeguards (LPS)/ DoLS Assessments presented by Pippa Johnson:** The MCA team shared a six-month summary update from July – December 2023. They team provide advice, support and training to staff. 438 staff have been trained over 28 sessions. **Action: Newsletter to be shared with members for dissemination**	6 Month Newsletter.pdf
4.2	**Consent Lead role presented by Mel Bostock:** The consent peer review group has been introduced since 1st September 2023. The team have reviewed over 206 patients records. The outcome	

	has identified that documentation is poor and patient information leaflets are not shared consistently. A workplan is in place to improve the IDO leaflets, developing pathways and guidelines on how to produce patient specific consent forms and leaflets. Consent training needs to be mandatory across Wales. This work is on-going and will involve over 8000 UHB staff identified as requiring training. The first consent group meeting took place on 25th January 2024 with 20 members in attendance. **Action: Presentation slides to be shared with CBs for dissemination** **Action: Mel to meet with Linda to discuss mandatory training for safeguarding and consent**	Presentation1 Consent update.doc
PART 5: REPORTS/ MINUTES FROM OTHER GROUPS/COMMITTEES		
5.1	**RSB update presented by Linda Hughes-Jones:** A Regional Safeguarding Board away day has recently been held. The priorities for the RSB for the coming year are identified as: - Safeguarding fundamentals - Effective reviews - Themes – Child sexual abuse and exploitation being the main focus. VAWDASV is another. - Transitional safeguarding – the journey of CLA or on the CPR and reaching 17years of age- what happens next? - Self Neglect – Tool kits for children and adults are developed. - Prevent agenda **Spire** Fiona discussed on-going work regarding a patient safety incident review (PSIR). If there is a clinical incident at their hospital, a meeting will take place within the week.	
5.2	**NHS Safeguarding Network presented by Annette Blackstock:** The last meeting held in November 2023. Areas discussed at the meeting were:- • Prevent Duty – The training and learning subgroup are looking at whether the training should be mandated. • Rapid response to suspected suicide a presentation from Claire Cotter at the meeting • Louise shared work around quality assurance framework for safeguarding • Sexual Safety in Health settings • School Nursing work and how children on the CPR are supported. Progressing plans around quality principles • SMM workplan being delayed • Welsh nursing care record in paediatric inpatients. • ICD to be revised **Action: Annette will speak to her Welsh counterparts regarding Spire accessing the Welsh nursing care records**	
PART 6: FOR INFORMATION		
6.1	Papers for sharing from this meeting are saved on the Safeguarding Intranet Page	

	 Safeguarding Steering Group Meetings / Publications nhswales365.sharepoint.com The Safeguarding Steering Group (SSG) has been established to support the Health Board Executive Lead for Safeguarding in the provision of assurance to the Board on all matters relating to safeguarding children and adults at risk . If there are any difficulties obtaining papers please contact natalie.clemett@wales.nhs.uk	
PART 7: ANY OTHER BUSINESS		
7.1	Members to consider amendments to the Safeguarding Steering Group Terms of Reference **Action: any comments to come back in two weeks** An internal safeguarding audit will be undertaken during 2024/25	
PART 8: KEY MESSAGES FROM MEETING		
PART 9: NEXT MEETING OF THE UHB SAFEGUARDING STEERING GROUP		
	Thursday 21st March 2024	9.30-11.30

ACTION LOG

MINUTE POINT	ACTION 25th January 2024	PERSON RESPONSIBLE	TIMESCALE
2.2	**Action: Chloe to scope with other health boards in Wales, regarding their process for FGM reporting.** **Action: Consider the case discussed to be shared at the All Wales FGM group**	**Chloe Laws**	**March 2024**
2.4	**Action: Rebecca Aylward to raise with the Directors of Nursing the non-attendance at safeguarding training**	**Rebecca Aylward**	**March 2024**
3.1	**Action: Feedback the Interim Action Plan to be completed within 2 weeks** **Action: Interim Action Plan to be placed on Safeguarding Risk Register**	**CB's**	**March 2024**
3.3	**Action: Feedback to be sent within 2 weeks.**	**CBs**	**March 2024**
4.2	**Action: Presentation slides to be shared with CBs for dissemination** **Action: Mel to meet with Linda to discuss mandatory training for safeguarding and consent**	**MB & LHJ**	**March 2024**
5.2	**Action: Annette will speak to her Welsh counterparts regarding Spire accessing the Welsh nursing care records**	**AB**	**March 2024**

Rolled over from previous meetings

MINUTE POINT	ACTION 23th November 2023	PERSON RESPONSIBLE	TIMESCALE
2.2	Contextual Safeguarding: Consider feedback from practitioners, what difference does the process make to the lives of the young people involved?	**Linda H-J to discuss with partner agencies**	**April 2024**
2.5	RR to return in May to update SSG on the pilot	**Rachel Rowlands**	**May 2024**
	ACTION 28th September 2023		
3.2	Dr Bethan Williams to work together with Dr Zoe Roberts and Adele around amalgamating the health care needs form and the acute emergency care form	Bethan Williams/ Zoe Roberts/ Adele Watkins	In process

	ACTION 28th JULY 2023		
3.1	Safeguarding to consider monitoring the AS1 referrals and feedback to MH Clinic Board in November through SSG.	**Safeguarding Team**	January 2024

MINUTE POINT	ACTION 17th March 2023	PERSON RESPONSIBLE	TIMESCALE
2.1	Undertake rolling programme of evaluation of training on a 6-12-months basis. (Feedback on training)	**NJ/ SJ safeguarding team**	**Annual update**

3.6	CB to update MCA/ DoLS at the Q&S meetings assurance required	**CB's**	January 2024

MINUTE POINT	ACTION 26th January 2023	PERSON RESPONSIBLE	TIMESCALE
3.3	Emergency Department Safeguarding Meetings Update: Action: Lisa to share an update at the next meeting on a complex case following discharge	**Lisa Green**	**March 2024**
3.4	Update to be brought back to SSG when situation resolved: **Close Action**	**Mark Doherty & David Pitchforth**	**Agreed with MH no further update required**
7.1	Residential placements for C&Y people that are commissioned by the NHS where there are concerns LHJ to feedback at next SSG	**Linda HJ/ Laura Hutchinson**	**January 2024**

MINUTE POINT	ACTION 25th November 22	PERSON RESPONSIBLE	Timescale
3.6	BW to feedback to the SSG the continuity of records for adopted children when resolved	Bethan Williams	With National Safeguarding Service

MINUTE POINT	ACTION 28th July 22	PERSON RESPONSIBLE	TIMESCALE
3.2	**SBAR: Internal Pressure Damage Audit findings** Felt another audit would be useful re health boards position regarding reporting G3,4 & unstageable.	Linda HJ	Consider CB Scrutiny Panel approach: March 2024

Annual Report of the Quality, Safety and Experience Committee 2023/24

1.0 INTRODUCTION

In accordance with best practice and good governance, the Quality, Safety and Experience Committee ("the Committee") produces an Annual Report to the Board setting out how it has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

The Committee membership is a minimum of four Independent Members, one whom must be a member of the Audit and Assurance Committee. During the financial year 2023/24 the Committee comprised five Independent Members. In addition to the Membership, the meetings are also attended by the Executive Nurse Director and the Executive Medical Directors (Joint Executive Leads for the Committee), the Executive Director of Therapies and Health Sciences, the Chief Operating Officer, the Executive Director of Public Health, the Director of Corporate Governance, the Assistant Director of Patient Safety, Quality and Improvement, and the Assistant Director of Patient Experience. The Chair of the Board is not a Member of the Committee but attends at least annually after agreement with the Committee Chair. Other Executive Directors are required to attend on an ad hoc basis.

3.0 MEETINGS & ATTENDANCE

The Committee met ten times during the period 1 April 2023 to 31 March 2024. This is in line with its Terms of Reference.

The Committee achieved an attendance rate of 86.7% (80% is considered to be an acceptable attendance rate) during the period 1st April 2023 to 31st March 2024 as set out below:

	11.04.23	09.05.23	18.07.23	30.08.23	26.09.23	25.10.23	28.11.23	19.12.23	13.02.24	26.03.24	Attendance
Ceri Phillips (Chair)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	tbc	**tbc**
Rhian Thomas (Vice Chair)	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	tbc	**tbc**
Mike Jones	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	tbc	**tbc**
Keith Harding *	Yes	Yes	Yes	Yes	No	No	Yes	n/a	n/a	n/a	71.40%
Akmal Hanuk	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	tbc	**tbc**
Total	**100%**	**80%**	**80%**	**80%**	**80%**	**60%**	**100%**	**100%**	**100%**	**tbc**	**tbc**

**Keith Harding left the Organisation on 30.11.2023*

A meeting was scheduled to take place on the 6th June 2023, but was stood down due to Industrial Action taken.

4.0 TERMS OF REFERENCE

The Terms of Reference and annual Work Plan are reviewed and approved on an annual basis. The Terms of Reference for the year 2023/24 were reviewed by the Committee on the 10th January 2023 and were approved by the Board on the 30 March 2023.

5.0 WORK UNDERTAKEN

The purpose of the Committee is to provide advice and assurance to the Board with regards to the discharge of its functions and responsibilities around the quality, safety and experience (QSE) of health services within the Health Board. During the financial year 2023/24, the Committee considered the following:

- **Clinical Board Assurance Reports**

The Committee received and discussed Clinical Board Assurance reports and Patient Stories from each of the Clinical Boards. These reports provided details of the clinical governance arrangements within the Clinical Board in relation to QSE. The reports identified the achievements, issues, progress and planned actions to maintain the priority of QSE which had arisen during the previous 12 months.

- Children & Women's Clinical Board – 11.04.2023
- Clinical Diagnostics and Therapeutics Clinical Board – 18.07.2023
- Primary, Community and Intermediate Care (PCIC) Clinical Board – 26.09.2023
- Medicine Clinical Board – 28.11.2023
- Mental Health Clinical Board – 19.12.2023
- Surgical Clinical Board – 13.02.2024
- Specialist Clinical Board – 26.03.2024

- **Quality Indicators Report**

At every other meeting, the Committee received an overview of the Health Board's current performance against a range of agreed quality indicators which included National Reportable Incidents and Never Events, Medication Incidents, Patient Safety Solutions, Health Inspectorate Wales (HIW) Activity Reports, Infection Prevention and Control, Mortality, Clinical Effectiveness, COVID Investigations, Tendable, Patient Experience, and Safe Care.

In the alternate meeting, the Committee were presented with a Deep Dive on the following topics:

- Peri-Natal Mortality
- Complaints
- Infection, Prevention & Control
- Mortality
- Medication Safety

The Committee also considered adherence to the requirements of the Duty of Candour and Duty of Quality legislation introduced in April 2023.

- **Board Assurance Framework – Patient Safety**

At its meetings, the Members of the Committee was provided with the opportunity to review the Patient Safety risk on the Board Assurance Framework (BAF) and to ensure that the same were being appropriately managed.

- **Policies and Procedures**

A number of policies and procedures were discussed & approved at the Committee as follows:

1. Mental Health Clinical Risk / Risk Mitigation Management Policy (UHB 119)
2. Clinical Audit Policy (UHB 509) and Procedure for Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group (UHB 510)
3. Labelling of Specimens submitted to Medical Laboratories Policy (UHB 017) & Labelling of Specimens submitted to Medical Laboratories Procedures (UHB 452)
4. Nutrition and Catering Policy (UHB 221) & Procedure for Inpatients (UHB 367)
5. Laser Risk Management Policy and Procedure
6. Consent to Examination or Treatment Policy (UHB 100)
7. Medicines Code 2023 (UHB 389)
8. Staff Winter Respiratory Vaccination Policy and Procedure (UHB 494)
9. Intraoperative Cell Salvage Policy and Procedure (UHB 403 & 030)
10. Swab Instrument and Needle Count Policy & Procedure (UHB 191)
11. Inpatient Welsh Language Policy (UHB 513)
12. Individual Patient Funding Request (IPFR) Policy
13. Optimising Outcomes Policy & Procedure (UHB 224)

- **Minutes from Clinical Board QSE Sub-Committee Minutes**

A number of minutes from Clinical Board QSE Sub-Committee minutes were noted at the Committee meetings, which included:

- Children & Women's Clinical Board
- Mental Health Clinical Board
- Medicine Clinical Board

- Primary, Community and Intermediate Care (PCIC) Clinical Board
- Clinical, Diagnostic & Therapies Clinical Board
- Surgical Clinical Board
- Specialist Clinical Board

Additional minutes noted by the Committee included:
- WHSSC Patient Safety Minutes
- Safeguarding Steering Group (SSG) Minutes

- **Other matters of business discussed during the year, included**: -

- Pressure Damage Collaborative Work Plan
- Quality of Care Assurance in Commissioned Services in response to the Operation Jasmine & the Flynn Report
- Committee Self-Effectiveness Survey
- Ward Accreditation & Improvement
- Radiation Protection Group Chairs Report
- MBRRACE Report
- Clinical Audit Strategy
- Unpaid Carers Annual Report
- Cardiff and Vale of Glamorgan Winter Respiratory Vaccination Plan 2023/24
- Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25
- Quality, Safety & Experience Terms of Reference
- Executive Summary of Child and Adult Practice Reviews
- Stroke/Stroke Performance
- Cardiff and Vale of Glamorgan Childhood Immunisation Action Plan
- Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan
- Welsh Risk Pool Final Assessment Report
- Introduction to the Public Health Wales Safeguarding Service, Self-Assessment Safeguarding Maturity Matrix (SMM) for Health Boards and Trusts
- Looked After Children – Assessment Backlogs
- COVID Investigation Programme Update
- Transition to NRFit for Neuraxial Procedures
- Paediatric PICU Pressure Damage
- Bi-Annual National Clinical Audit
- NG Tube Patient Safety Notice
- Radiation Protection Group – Chair's Report
- Children & Women's Waiting List Update
- Maternity Thematic Review
- Outstanding Actions from the Ombudsman's Annual Letter
- Healthy Eating Standards for Hospital Restaurant and Retail Outlets
- Child Practice Review Report
- Learning Committee Update
- Quality, Safety and Experience Framework – effectiveness review
- Research Update
- Health Protection Plan
- Healthcare Inspectorate Wales Annual Report (2022-23)
- Consent to Examination and Treatment
- Patient Safety Solutions – Valproate
- National Neonatal Audit
- Community Health Council Reports (Transport to Health Services)

All of the items discussed were reported to the Board via the formally agreed minutes and Chairs Reports.

6.0 REPORTING RESPONSIBILITIES

The Committee reported to the Board following each of its meetings by presenting a summary report of the key discussion items at the Committee. The report is presented by the Chair of the Committee.

7.0 OPINION

The Committee is of the opinion that the draft QSE Report 2023/24 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Ceri Phillips

Committee Chair

Chilcott Rachel
20/03/2024 12:53:49