

<b>Agenda Item</b>
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<b>Quality Safety and Outcomes Sub-Committee</b>
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<b>Welsh Kidney Network Report</b>
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<b>Dyddiad y Cyfarfod / Date of Meeting</b>	23/02/2026
<b>Statws Cyhoeddi / Publication Status</b>	Open/ Public
	Not Applicable
<b>Awdur yr Adroddiad / Report Author</b>	WKN Quality and Patient Safety Lead WKN Head of Commissioning
<b>Cyflwynydd yr Adroddiad / Report Presenter</b>	WKN QPS Lead
<b>Noddwr yr Adroddiad / Report Sponsor</b>	Melanie Wilkey, Director of Commissioning for Specialised Services

<b>Pwrpas yr Adroddiad / Report Purpose</b>	For Noting Choose an item.
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<b>Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)</b>		
<b>Committee / Group / Individuals</b>	<b>Date</b>	<b>Outcome</b>
N/A	Click or tap to enter a date.	Choose an item.

<b>Acronyms / Glossary of Terms</b>	
AV	Arteriovenous (Fistula)
BCUHB	Betsi Cadwaladr University Health Board
CKD	Chronic Kidney Disease
CVUHB	Cardiff & Vale University Health Board
GMS	General Medical Services

GP	General Practitioner
KPIs	Key Performance Indicators
NRI	National Reportable Incidents
NWJCC	NHS Wales Joint Commissioning Committee
SBUHB	Swansea Bay University Health Board
UKKA	UK Kidney Association
WKN	Welsh Kidney Network

## 1. SITUATION/BACKGROUND

The purpose of this report is to provide a briefing on the current Quality Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

The WKN is a vehicle through which specialised kidney services are planned and developed on an all-Wales basis in an efficient, economical and integrated manner and provides a single decision-making framework with clear remit, responsibility and accountability.

The WKN continues to work with the Regions to develop and monitor KPI's using real time Welsh data reporting, this has been enabled by the production of audit dashboards for commissioned areas. The WKN also incorporates the National published reports from the relevant UK audit organisations into this work. Collaboration work also continues with the UK Kidney Association (UKKA) with continued representation on the UKKA Patient Safety Group.

## 2. SPECIFIC MATTERS FOR CONSIDERATION

### 2.1 New Incidents for Reporting

There is one new NRI for this reporting period.

Provider organisation	Incident reference and date	Reported into JCC
Cardiff & Vale University Health Board	ID-10129 11 <sup>th</sup> November 2025	25 <sup>th</sup> November 2025

#### Brief description

There have been two cases of patients in Cardiff & Vale University Health Board (C&VUHB) missing out on viable kidney transplant offers as a result of consultant workforce gaps leading to operating constraints. C&VUHB have reported this NRI under principle 4 of the National Policy on Patient Safety Incident Reporting & Management.

## The position of the JCC and WKN

JCC are aware that an investigation is underway to determine the detail and JCC/WKN representatives are attending the review meetings. NHSBT and Welsh Government have been informed.

In the interim the following measures have been put in place:

- JCC have asked C&VUHB for assurance that this will not reoccur – a copy of the plan and the mitigated actions they have put into place to provide a safe transplant programme in Cardiff
- JCC have also requested a business continuity plan - other service provider options.
- The risk is being added to the JCC CRAF risk register.

### **3. CLOSED INCIDENTS**

#### **3.1 NRI INC25-02-04 Carbapenemase Producing Organism (CPO) Outbreak**

##### Brief Description

B5 is a renal ward at the University Hospital of Wales (UHW), comprising of twenty-five inpatient beds and a dedicated three-bedded bay for acute dialysis treatment. An outbreak of E.Coli OXA-48 was identified on the ward, with the first confirmed case detected on 12th October 2024. In total nine patients were genome sequenced and confirmed to be linked, indicating a transmission event within the ward.

E.Coli OXA-48 refers to Escherichia coli bacteria that produce the OXA-48 enzyme, which is a type of carbapenemase, making the bacteria resistant to many common antibiotics, including carbapenems.

Three patients who tested positive for OXA-48 in the outbreak, sadly passed away. One of these three patients was the 7th to have tested positive (patient 7). Patient 7 had OXA-48 producing E.coli present in a sputum sample. Patient 7's cause of death included pneumonia and the presence of OXA-48 is considered to have potentially contributed to their clinical deterioration and outcome. The deaths of the other two patients who had tested positive were not linked to OXA-48 in any way.

##### Conclusion

This structured review of the E. coli OXA-48 outbreak on the B5 nephrology ward at the University Hospital of Wales has examined the full timeline of patient admissions, screening results, and confirmed cases. The analysis focused on the sequence and overlap of patient stays, identifying clear opportunities for transmission and highlighting key contributing factors.

Three core issues were explored in depth: CRO screening compliance and technique, bed and mattress cleaning standards, and the ward layout and patient proximity. Each of these areas revealed gaps between expected infection

prevention and control (IP&C) practices and what occurred in practice. Inconsistent screening and poor screening technique delayed the identification of colonised patients, inadequate cleaning standards likely contributed to environmental contamination, and the ward's original layout—with multi-bed bays, limited isolation capacity, and cramped conditions due to dialysis equipment—was not fit for purpose.

A significant turning point came with the expansion of the B5 footprint into half of A5, which allowed for increased spacing between patients and improved the ward's ability to implement safe IP&C measures. This change underscored the importance of designing clinical environments that support infection prevention and control guidance, particularly in high-risk specialties like renal care.

The lessons learned from this outbreak reinforce the need for robust screening protocols, consistent environmental hygiene, and ward layouts that accommodate both patient care and infection control requirements. These findings will inform future planning, outbreak response, and service design across the UHB.

#### Recommendations

- Strengthen CRO screening protocols and screening technique.
- Improve environmental hygiene standards.
- Address ward layout and isolation capacity.
- Promote a culture of safety and learning.

The WKN will continue to follow up through the regional provider to ensure that the recommendations are addressed. A summary and learning outcomes report will be reported through the WKN Quality and Assurance meetings to ensure that wider learning is shared within the broader clinical teams in Wales.

NRIs under investigation are held on a log by the WKN. When NRIs are closed a summary and learning outcomes are shared by WKN with the Nephrology and Transplant clinical community in Wales.

## **4. KEY RISKS**

### **4.1 Risk Register**

The risk register for the WKN is reviewed through:

- Meetings between the regional providers and the WKN.
- The Welsh Kidney Network, Quality Patient and Safety (QPS) performance assurance meeting.
- Welsh Kidney Network Senior Leadership Group.
- Specialised Services Commissioning Team meeting.
- Welsh Kidney Network meeting.

There are in total seven risks on the current Welsh Kidney Network Commissioning risk register, with movement of 1 new risk compared to the last reporting period.

#### **4.1.1 Escalated risks**

No escalated risks in this reporting period.

#### **4.1.2 Reduced risks**

No reduced risks for this reporting period.

#### **4.1.3 Closed risks**

There are no closed risks in this reporting period.

#### **4.1.4 Emerging risks**

There is one emerging risk in this reporting period as a result of an NRI reported into JCC on the 25<sup>th</sup> November and reported through the JCC Quality Safety and Outcomes Sub-committee on 15<sup>th</sup> December 2025. As a result of the risk scoring this emerging risk will appear on the January 2026 update of the JCC Operational Risk Register.

Provider organisation Cardiff & Vale University Health Board.

WKN 25 – Service Sustainability of the National Transplant Programme in Wales.

The risk rating is currently at 20 (C5xL4) – High risk

If...Cardiff and Vale University Health Board do not develop and implement appropriate business continuity plans to ensure adequate and robust surgical arrangements for the provision of safe transplant services at UHW, including the provision of an on-call rota

Then...the service will not meet the UK National NHS Blood and Transplant Policies and Guidance and NWJCC contractual obligations with patients also being placed at risk of failing to receive viable transplants when expected

Resulting in:

- A risk that the NWJCC will be unable to commission consistent access to resilient services, which forms part of the 4 nation transplant sites.
- Patients having to continue with their existing dialysis modality with increased risk of poorer patient outcomes due to not receiving a transplant within the restrictive time-frame of opportunity and at an increased cost to the NWJCC.
- JCC being open to reputational risk.

To mitigate the risk the WKN will seek assurance from the provider through a business continuity plan to include an alternative provider option and monitored through the provider WKN regional meetings, alongside continued attendance at NRI meetings.

#### **4.1.5 Risks above 15**

There is one risk above 15 and appears on the JCC Organisational Risk Register:

JCC 65, WKN 18 – Renal Dialysis Capacity across Wales, risk rating 16.

If...the number of patients requiring dialysis continues to grow annually at a rate of 3–4% (or higher based on some projections).

The demand will exceed current commissioned capacity across Wales for both unit-based and home dialysis, and there will be delays or limits on the number of patients accessing home dialysis, as the growing demand exceeds the capacity of the nursing workforce to provide timely training and ongoing monitoring.

Resulting in:

- The need to commission additional capacity, at financial risk to the NWJCC, to avoid population harm.
- Increased pressure on the commissioned NEPTS service to transport a greater number of patients to and from dialysis session 3 times per week at a financial risk to the JCC.

To mitigate the risk the WKN have introduced improvements within the Prevention pathway for Chronic Kidney Disease (CKD), through introduction of an All Wales Healthcare Pathway for referrals within Primary Care, a National Primary Care CKD optimisation project, which now forms part of the new GMS contract for all GP practices in Wales and includes a CKD e-learning module for Primary Care focusing on prevention. Additional investment, through securing Value in Healthcare monies, has increased the number of patients receiving a transplant and who are on a home dialysis modality. Funding has been allocated for additional dialysis stations in units, within BCUHB (Welshpool) and SBUHB (Bridgend and impending Neath Port Talbot).

## 5. ASSESSMENT

<b>Objectives / Strategy</b>	
<b>Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)</b>	Ensure Quality
<b>Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals</b> <a href="#">150623-guide-to-the-fg-act-en.pdf</a> <a href="#">(futuregenerations.wales)</a>	A Healthier Wales
	If more than one applies please list below:
<b>Dolen i Hwyluswyr Ansawdd</b>	Whole-systems Perspective

<p><i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i>  <b>Link to Enablers of Quality</b>  <i>(<a href="#">Duty of Quality Statutory Guidance (gov.wales)</a>)</i></p>	<p>If more than one applies please list below:</p>
<p><b>Dolen i Feysydd Ansawdd</b>  <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i>  <b>Link to Domains of Quality</b>  <i>(<a href="#">Duty of Quality Statutory Guidance (gov.wales)</a>)</i></p>	<p>Safe</p> <p>If more than one applies please list below:</p>
<p><b>Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)</b></p>	<p>No - Not Applicable</p> <p>If more than one applies please list below:</p>

<b>Impact Assessment</b>		
<p><b>Ansawdd</b>  <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i>  <b>Quality</b>  <i>Have you undertaken a Quality Impact Assessment Screening?</i></p>	<p>Yes: <input type="checkbox"/></p>	<p>No: <input checked="" type="checkbox"/></p>
	<p>Outcome:</p>	<p>If no, please include rationale below:</p>
<p><b>Cydraddoldeb</b>  <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i>  <b>Equality</b>  <i>Have you undertaken an Equality Impact Assessment Screening?</i></p>	<p>Yes: <input type="checkbox"/></p>	<p>No: <input checked="" type="checkbox"/></p>
	<p>Outcome:</p>	<p>If no, please include rationale below:</p>
<p><b>Cyfreithiol / Legal</b></p>	<p>There are no specific legal implications related to the activity outlined in this report.</p>	

<b>Enw da / Reputational</b>	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.
<b>Effaith Adnoddau</b> <i>(Pobl /Ariannol) /</i> <b>Resource Impact</b> <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.

## 6. RECOMMENDATIONS

The members of the Quality Safety and Outcomes Sub Committee are asked to:

- **Note** the report.