Agenda Item
2.1

Quality Safety and Outcomes Sub-Committee

Welsh Kidney Network

Dyddiad y Cyfarfod / Date of Meeting	02/06/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	WKN Quality and Patient Safety Lead WKN Lead Nurse WKN Deputy Network Manager
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Noddwr yr Adroddiad / Report Sponsor	Melanie Wilkey, Director of Commissioning for Specialised Services

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
	Click or tap to enter a date.	Choose an item.

Acronyms / Glossary of Terms	
EWN	Early Warning Notifications
HARP	Healthcare Associated Infection & Antimicrobial Resistance Programme
NRI	National Reportable Incidents

NWJCC	NHS Wales Joint Commissioning Committee
WKN	Welsh Kidney Network
IMTP	Integrated Medium Term Plan

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 with continued representation on the UKKA Patient Safety Group, this has included a soon to be published document, which provides guidance on the management of behaviour that challenge dialysis services.

Work has also started on the National Kidney Conference, which is an opportunity for kidney care services throughout Wales to spread and share good practice to facilitate improvements in patient care and also highlight and discuss challenges to regional services.

2. SPECIFIC MATTERS FOR CONSIDERATION

2.1 New Incidents for Reporting

The following table provides an overview of new incidents reported, within the reporting period, to the WKN.

Incident date and reference	Reported to JCC	Brief Description
INC25-02-042 09/04/24 **NRI**	21/11/24	A patient with an arteriovenous fistula used for dialysis had a catastrophic haemorrhage at home and passed away. Investigation complete, awaiting outcome for lessons learnt.

Incident date and reference	Reported to JCC	Brief Description
INC25-02-040 31/01/25 **NRI**	17/02/25 as EWN NRI 17.03.25	Eight cases of Oxa 48 E-Coli infection have been identified on a kidney ward since November 2024. It has been identified recently that one positive patient has died, the death has not yet been investigated to understand whether the OXA-48 is considered a contributory factor or not.
INC70897 23.12.2024 **NRI**	4.03.25	Complex patient (oncology and kidney) accompanied to the bathroom in a dialysis unit, fell in the toilet, wound to above his left eye. Later found to have a subarachnoid haemorrhage and died on the 26.12.24. Investigation complete, no lessons identified.
INC84941 **NRI**	31.03.25	Delayed referral for further evaluation of suspicious findings, on a chest X-ray of a patient who had undergone Live Related Renal transplant. X-ray taken August 2024 and not actioned until December 2024, subsequent findings adenocarcinoma of the lung. Investigations into whether this was visible on other X-rays from August 2024.
INC84941 **NRI**	28.04.25	Error in plasma administration for a patient undergoing ABO incompatible plasma exchange, patient receiving compatible rather than incompatible plasma. The donor operation was stopped, and the patient was closed. Delaying the completion of donation. Reported as an NRI under the principle of learning opportunities.

Following the NRI INC25-02-04, the WKN has initiated national discussions with Healthcare Associated Infection & Antimicrobial Resistance Programme (HARP) with a view of standardising approach to kidney patients in Wales who are considered 'Out patients' but are regularly attending dialysis thrice weekly for 4 hours and will continue to do so until they no longer require Unit Dialysis. This piece of work will need to incorporate the whole patient pathway including transport, the implications for potential transplantation, managing hospital admissions and transfers between hospitals / specialisms, as the patients are complex and often comorbid. The WKN will continue to provide updates through Quality Safety and Outcomes Committee meetings and CPO will be added to the Commissioning Risk Register.

2.2 Closed Incidents

2.2.1 INC25-02-042 – Misuse of dialysis line

Complex Haemodialysis patient was admitted for treatment for a severe foot infection, requiring IV antibiotics. Past medical history including diabetes, hypertension, end stage kidney failure and declining mental health. The patient had a large bore central venous catheter (CVC) in his neck for haemodialysis, which had been in since March 2022.

The haemodialysis CVC (permacath) was inconsistently identified within the notes, and there was a missed opportunity to seek advice of the Vascular Access Outreach Team for support in the management of the haemodialysis CVC. The line was being used by staff on the ward for intravenous medications, the patient was found in a deteriorated condition with an uncapped and unclamped line, which had led to some blood loss.

Education and training has been undertaken in the Health Board with a safety alert going out to clinical areas. Advice provided was to identify venous access devices on admission within notes and on patient boards and ongoing work to amend vascular access policies within the Health Board.

Through WKN attendance at the National Patient Safety Group of the UK Kidney Association, a similar scenario in NHS England was reported, resulting in an air embolism and fatality through a misused dialysis line (uncapped and unclamped). Changes have since been made to MHRA advice, which states that large bore dialysis lines should not be used by untrained and inexperienced staff.

The UKKA are currently starting a piece of work with patient groups to ensure that patients are informed of the risk of central venous catheter to increase arterio-venous fistula numbers. This would mitigate the general risk. They are also working with industry partners to produce line stickers which could be used in renal centres to go on patient's line dressings to identify dialysis lines.

The WKN has started work with Welsh Government and the NHS Executive to develop a Patient Safety Notice for disseminating through NHS Wales University Health Boards and Trusts to mitigate the risk of any further incidences and patient death related to misuse of dialysis lines. The WKN will continue to provide updates through Quality Safety and Outcome Sub-Committee meetings.

3. KEY RISKS

3.1 Risk Register

The Risk Register for the WKN is regularly reviewed through the following WKN groups:

- WKN Regional meetings with the three Welsh providers; Betsi Cadwaladr University Health Board (BCUHB), Cardiff & Vale University Health Board (CVUHB), Swansea Bay University Health Board (SBUHB)
- WKN Quality Patient and Safety Performance Assurance meetings; and
- The WKN Board.

The WKN currently holds 6 risks on the Commissioning Risk Register. Within this reporting period 1 additional risk has been added to the WKN Risk Register:

- WKN 22 - Management of CPE/CPO for kidney patients in Wales. The risk rating is currently at 9 (Medium risk).

- Of the 6 risks, one is >15 (currently 16) and therefore sits on the NWJCC Risk Register Risk Ref 65 (WKN 18). Kidney Dialysis capacity across Wales. This risk has been included within NWJCC IMTP submission for 2025/2026 covering growth including the Independent Service Providers (ISPs).

Controls in place include Value in Health Care funding, which has been secured to increase the number of transplant and home dialysis patients. Monitoring is through Regional meetings and the WKN commissioning performance dashboard.

Action plan:

- Appointment of a Prevention Clinical Lead for the WKN has provided clinical leadership for the strategic development of Primary and Secondary Care prevention, to include the design of an All Wales Healthcare Pathway for referral to Primary Care.
  - **Update**: The Community Healthcare Pathways - Chronic Kidney Disease in Adults page provides guidance on disease screening, monitoring and management inclusive of referral information has been added to the all Wales draft site (awaiting transfer over to public facing page). The GMS has recently been allocated £4.5M to support practices to undertake their own QIP in 3 mandatory areas, including CKD optimisation. Practices will undertake screening of their patient population, to identify patients "at risk", ACR screening and BP target compliance, and those eligible for pharmacological optimisation. In addition there a CKD e-module targeted at primary care users that may also be completed to obtain points. Completion by Qtr 1, 2025/26
- Development of Regional actions plans for increasing patient numbers for home dialysis and transplantation.
  - **Update**: The WKN is working with the Regions on action plans where targets are not being met. This is being picked up as part of the WKN/Regional performance meetings. Completion by Qtr 1, 2025/26.
- Increased unit dialysis capacity includes additional investment into Welshpool (operated by BCUHB) and a Dialysis Unit in Bridgend with 21 stations (operated by SBUHB).
  - **Update**: The Bridgend Unit is commissioned and operational. Additional unit capacity is currently being commissioned in Neath Port Talbot (will be operated by SBUHB). Completion by Qtr 1 2026/27.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)	Ensure Quality

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Quality Safety and Outcomes Sub Committee is asked to:

- **Note** the report.