QUALITY, SAFETY AND EXPERIENCE COMMITTEE

9am on Tuesday 13th February 2018
Corporate Meeting Room, UHB HQ
University Hospital of Wales

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AGENDA

PART 1: Items for Action		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Committee meeting held on 6th December	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting	Oral - *Chair*
Governance, Leadership and Accountability		
7	Patient Story	*Surgery Clinical Board*
8	Surgery Clinical Board Quality, Safety and Experience Assurance Report	*Clinical Board*
9	Community Health Council Report – Scrutiny Overview January 2018	*CHC*
10 .1 .2	**Policies and Procedures for Approval** • Pressure Ulcer Risk Assessment, Prevention and Treatment • Medicines Management	*Executive Nurse Director* *Medical Director*
11	Review of Committee Terms of Reference	*Executive Nurse Director*
12	Committee Workplan for 2018/19	*Executive Nurse Director*
13	WAO Report on Discharge Planning	*Chief Operating Officer*
Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)		
Theme 2: Safe Care		
14	Achieving Compliance with Safer Patient Notice 24 – Patient Identification Bands	*Executive Nurse Director*
15	Revised Risk Assessment for Infection Prevention and Control	Report withdrawn
Theme 3: Effective Care		
16	Cancer Peer Re Reviews – Head and Neck	*Medical Director*
17	Clinical Audit Plan 2017-18 Progress Update	*Medical Director*
Theme 4: Dignified Care		
18	HIW Annual Report 2016-17	*Executive Nurse Director*
Theme 5: Timely Care		

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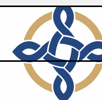

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19	Management of Outpatient Follow Ups and Endoscopy Surveillance	*Chief Operating Officer*
Theme 6: Individual Care		
Theme 7: Staff and Resources		
20	Update on Single Rooms, Isolation Rooms and Decant Facility	*Director of Planning*
21	Single Point of Entry for Children	*Chief Operating Officer*
PART 2: Items to be recorded as Received and Noted for Information by the Committee **Papers are available on the UHB website**		
22	Welsh Health Circular 045 2017 - Integrated Guidance On Health Clearance of Healthcare Workers and Management of Healthcare Workers Infected With Bloodborne Viruses (Hepatitis B, Hepatitis C And HIV)	*Medical Director*
23	Annual Quality Statement 2017-18	*Executive Nurse Director*
24	**Minutes from Clinical Board Quality Safety and Experience Sub Committees – Exceptional Items to be raised by the Assistant Director, Patient Safety and Quality** 1. Clinical Diagnostics and Therapeutics – October 2. Mental Health – November and December 3. Primary, Community and Intermediate Care - November 4. Specialist Services – October, November and December 5. Medicine – November 6. Surgery – September and November 7. Children and Women – October 8. Dental – *no Minutes since September*	*Assistant Director, Patient Safety and Quality* *Chief Operating Officer*
25	Agenda for the Private QSE	
26	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
27	Review of the Meeting	Oral – *Chair*
28	Date of next meeting - 9am on Tuesday 17th April **Dates for 2018/19** • 12 June • 14 August **or** 18 September • 16 October (Special Meeting) • 18 December • 19 February & 16th April 2019	

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UNCONFIRMED MINUTES OF THE MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 6 DECEMBER 2017 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:	
Susan Elsmore	Independent Member, QSE Chair
Akmal Hanuk	Independent Member – Community
Maria Battle (part)	UHB Chair
In Attendance:	
Angela Hughes	Interim Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Catherine Salter	Staff Health and Safety Representative
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Dr Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Steve Curry (part)	Interim Chief Operating Officer
Apologies:	
Michael Imperato	Independent Member - Legal
Stuart Egan	Independent Member – Trades Unions
Abigail Harris	Director of Planning
Fiona Salter	Staff Representative
Robert Chadwick	Director of Finance
Dr Sharon Hopkins	Director of Public Health
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Secretariat:	Julia Harper

QSE 17/188 WELCOME AND INTRODUCTIONS

The Chair, welcomed everyone to the meeting, in particular, two Management Trainees, Hattie Cox and Laura Jones who were observing the meeting.

It was noted that the attendance of the Specialist Services Clinical Board had been cancelled as part of the “7 Days No Delays” project.

QSE 17/189 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 17/190 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

QSE 17/191 MINUTES OF THE SPECIAL COMMITTEE HELD ON 17th OCTOBER 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED.**

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QSE 17/192 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log and **NOTED** the number of actions that had been completed. These would be removed. The action log was updated as follows:

QSE 17/132 Ward Bathroom Refurbishment – As there had been no correlation found, it was agreed to **close** this action.

QSE 17/056 Patient Safety Solutions Alerts and Notices – as no response had been received from the Community Health Council, it was agreed to **close** this action.

QSE 17/132 CHC Report – Mr Curry had provided details of repatriation difficulties to the CHC. **Complete.**

QSE 17/101 Cancer Peer Review – Action was in hand so this this item was **closed.**

QSE 17/176 Dental CB Assurance Report – Mandatory training was monitored at Performance Reviews and it was therefore agreed to **close** this action.

QSE 17/179 Never Event NG Tube – The Policy was anticipated for approval at Committee in February 2018.

QSE 17/152 Carers - A plan with dates would be available by February 2018. It was therefore agreed to **close** this action.

QSE 17/181 NatSSIPs – The Medical Director nominated Dr Tony Turley. **Complete.**

Critical Care Outreach/Care of Deteriorating Patients - Challenging and ongoing. New issues in Llanfair were emerging. A service was available but was not comprehensive. Agreed a full report to QSE with timeframe in February 2018.
Action - Mrs Ruth Walker and Dr Graham Shortland

QSE 17/132 – Trends and Themes in SIs (Patient Wristbands) – It had been difficult to release a member of the safety team to complete the work but the significance of the work was recognised. A report would be presented to BCAG in January for priority to be considered and included in the IMTP.
Action – Mrs Ruth Walker

QSE 17/017 HIW Ophthalmology Thematic Review – The Executive Nurse Director gave a breakdown of the number of concerns received as this had not been included in the report that was on the agenda.
April – November 180, average April – July was 18 per month with 40 in August. The figure fell in September to 26 as extra clinics were put on. This fell again to 21 in November. Concerns were mainly from glaucoma patients about the reasons for numerous cancellations. Of the 180 complaints, 72 related to cancelled appointments, 42 for waiting time and 19 about medical treatment.
It had been difficult to replace a consultant but 3 additional sessions were secured and more recently a further 2 had been made available. The post was currently out to advert.
It was anticipated that by the end of quarter 3, the UHB would clear the 36 week waiters but this would be hard to sustain. To meet the challenge in ocular plastics, a nurse appointment had been made.
Progress was being made with cataracts and 36 week waits should be cleared by the end of March.
Work was underway on improving the responses to complaints and the clinical pathways.
Independent Members requested a further update on waiting times and complaints at the April 2018 meeting to ensure no harm was being caused to patients.
Action – Mr Steve Curry and Mrs Ruth Walker

QSE 17/193 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

The Chair reiterated changes to the Committee Terms of Reference agreed at the last Board meeting.

QSE 17/194 PATIENT STORY – SPECIALIST SERVICES

In the absence of the Clinical Board, the Nurse Director, Mrs Ruth Walker delivered a story of the experience of a patient and his family following a serious road traffic accident. The themes highlighted were speed of treatment, distance from home, wonderful care of staff and communications. Overall, the patient's experience was positive but communication on general wards could have been improved. This was being developed by the Clinical Board and colleagues would ask staff at Walkrounds how challenges were managed by staff.

It was noted that the UHB was taking part in consultation on the major trauma network on which there was considerable clinical engagement. It was anticipated that a report would be prepared for the March Board meeting as there was considerable financial risk in becoming major trauma centre.
Action – Dr Graham Shortland

The Chair thanked Mrs Walker for delivering the patient story which reminded Board Members of their purpose in the UHB.

QSE 17/195 SPECIALIST SERVICES CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

The Chair invited the Executive Nurse Director to take comments and questions in the absence of the Clinical Board:

- The Director of Capital and Estates would be asked about the timescales for BMT, theatre capacity, bathrooms and Rookwood Hospital.
- The Committee often discussed the environment and as yet, no resolution had been found to many of the issues.
- There were robust quality and safety arrangements in place in Specialist Services with good clinical engagement and actions were embedded.
- Dr Sortland would enquire about arrangements for mortality reviews. **Action – Dr Shortland**
- The Comms Team would be asked to use the poem on social media. **Action – Mrs Carol Evans**

ASSURANCE was provided by:

- Internal Audit Risk Management Report 2016
- Leadership and management approach of the Clinical Board Core Team and Directorate Management Teams having open, inclusive and transparent multi-disciplinary team core business and processes
- Regular performance management
- Governance and quality, safety and patient experience priority within the Clinical Board and Directorates.

The Quality Safety and Experience Committee:

- **NOTED** the progress and approach taken by Specialist Services Clinical Board to date and its planned actions
- **APPROVED** the approach taken by Specialist Services Clinical Board.

QSE 17/196 COMMUNITY HEALTH COUNCIL (CHC) REPORT

In the absence of the CHC Chief Officer, Mr Stephen Allen, the report was **RECEIVED** and **NOTED.**

QSE 17/197 CHC REPORT: OLDER PEOPLE IN COMMUNITY HOSPITALS – AVOIDING BOREDOM AND LONELINESS

The Executive Nurse Director, Mrs Ruth Walker advised that this report was an update on the action plan that had previously been received by the Committee. It was a challenge to manage the CHC's expectations against what was reasonable with the finances and space available – eg the provision

of day rooms on all wards. The work of the volunteers in this agenda was commended and the Chair agreed to thank those involved in helping to alleviate boredom and loneliness.
Action – Cllr Susan Elsmore

ASSURANCE was provided by:

- Current status and future plans were reported through the Quality Safety and Experience Committee
- The Health Board had considered and formally responded to the Community Health Council.

The Quality, Safety and Experience Committee:

- **NOTED** the progress made to provide engagement and activities for patients
- **NOTED** the challenges in providing engaging activities for patients.

QSE 17/198 POLICIES FOR APPROVAL

1. **SAFETY NOTICES AND IMPORTANT DOCUMENTS MANAGEMENT POLICY**

Mr Peter Welsh, Director of Corporate Governance stressed the importance of getting a consistent approach and a robust audit trail in governance arrangements. In response to concerns, it was agreed that this policy would be taken to the Executive Assistants' Group to ensure corporate staff were able to take all necessary action.
Action – Mr Peter Welsh

ASSURANCE was provided by:

- The former Policy had been in existence for several years within the UHB and had been reviewed and updated with the support and contribution of key staff.
- The Equality and Health Impact Assessment for Admin-Type Policies agreed last year was relied on to support this Policy.
- Consultation had taken place across the UHB and following meetings, comments received were incorporated into the updated version.

The Quality Safety and Experience Committee:

- **APPROVED** the updated Safety Notices and Important Documents Management Policy and Procedure.
- **APPROVED** the full publication of the Policy and Procedure in accordance with the UHB Publication Scheme.
  Action – Mrs Julia Harper

2. **DNACPR ALL WALES POLICY REVIEW**

ASSURANCE was provided by:

- Dissemination of information across the UHB.
- Training of Staff.
- Audit of DNACPR (Annual).
- Audit of 2222 calls (ongoing).

The Quality, Safety and Experience Committee:

- **APPROVED** the revised Sharing and Involving – All Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
- **APPROVED** the full publication of the All Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy in accordance with the UHB Publication Scheme.
  Action – Mrs Julia Harper

3. THE MEDICINES CODE

The Medical Director, Dr Graham Shortland explained that this Code brought together a number of policies and procedures into one document and that it was hoped a primary care supplement would also be developed. The document had been in draft for a long time and wide consultation had taken place.

ASSURANCE was provided by:

- Aligning UHB Practice to the All Wales Policy for Medicines Administration Recording Review and Storage (MARRS 2015).
- Annual Medicines Audit completed by Clinical Boards and reported to UHB Medicines Management Group.

The Quality, Safety and Experience Committee:

- **APPROVED** The Medicines Code
- **APPROVED** the withdrawal of 13 policies/procedures on page 3.
- **APPROVED** the full publication of the Medicines Code in accordance with the UHB Publication Scheme.
- **AGREED** that Chair's action would be taken to approve the Equality and Health Impact Assessment that had unfortunately not been undertaken at the time of production.
  Action – Mrs Julia Harper

4. PRECEPTORSHIP FOR NEWLY QUALIFIED NURSES AND MIDWIVES POLICY AND PROCEDURE

The Executive Nurse Director advised that this policy had been refreshed to ensure nurses were safe and supported in transition from student to new registrant.

ASSURANCE was provided by:

- The policy and procedure were based on national guidelines, best practice and regulatory requirements and subsequent recommendations.
- Allocation of a trained preceptor to support and guide all newly registered nurses and midwives.
- Staff had access to education and training provided through the Nurse Foundation Programme or equivalent in-house training.
- Preceptors identified any new nurses or midwives who required additional support.
- Maintained staff training records and conducting PADR/Appraisal.
- Evaluation of preceptorship programmes and feedback.

The Quality, Safety and Experience Committee:

- **APPROVED** the Preceptorship for Newly Registered Nurses and Midwives Policy and Procedure.
- **APPROVED** the full publication of the Preceptorship for Newly Registered Nurses and Midwives Policy and Procedure in accordance with the UHB Publication Scheme.
  Action – Mrs Julia Harper

5. DISCHARGE POLICY AND PROCEDURE

Mrs Judith Hill attended to present this new Policy and Procedure. Committee noted that delayed transfers of care had improved but work continued on a daily basis and relationships with Local Authorities had improved.

The Director of Corporate Governance advised Committee that all Policies brought forward for approval had already been through the full engagement and consultation process as described in the Management of Policies and Other Written Control Documents Policy that had been agreed at the last meeting of the Board.

ASSURANCE was provided by:

- The implementation of a training and development programme to support the implementation of the Policy by ward based staff.
- Monitoring of compliance against the policy on a regular basis, supported by improvement plans to address recommendations

The Quality, Safety and Experience Committee:

- **APPROVED** the new Discharge from Hospital Policy and Procedure
- **APPROVED** the full publication of the Discharge from Hospital Policy and Procedure in accordance with the UHB Publication Scheme.
  Action – Mrs Julia Harper

QSE 17/199 QUALITY AND SAFETY IMPROVEMENT FRAMEWORK UPDATE

The Assistant Director, Patient Safety and Quality, Mrs Carol Evans gave an oral update. Meetings had been held with all Clinical Boards to embed requirements of the framework and reflect the position within their Integrated Medium Term Plans. All work was aligned with Health and Care Standards and a number of areas had been identified for further work. A full report would be prepared for the next meeting.
Action – Mrs Carol Evans

QSE 17/200 IMPLEMENTATION OF THE REFRESHED PATIENT EXPERIENCE FRAMEWORK

The Interim Assistant Director, Patient Experience, Mrs Angela Hughes was pleased to report activity in all four quadrants of the framework. In particular she cited the good work with schools to identify and support young carers. It was noted that the driver for the framework was 'what it was like to be a patient', as told by patients themselves. The UHB was on target to deliver the framework. It was agreed to share a recently prepared report with the Chair.
Action – Mrs Angela Hughes

ASSURANCE was provided by:

- The evidence of the progression of the Framework.

The Quality, Safety and Experience Committee:

- **NOTED** the progress of the implementation of the Framework

QSE 17/201 HEALTH AND CARE STANDARDS PROPOSED APPROACH FOR 2017 SELF ASSESSMENT

The Executive Nurse Director, Mrs Ruth Walker advised Committee that the Standards underpinned quality in all UHB business. Robust processes were in place to measure and deliver progress against the Standards and the report described the approach for the next self-assessment. As the timescales were tight, it was requested that dates for sign-off be added to the diaries now.
Action – Cllr Susan Elsmore and Lead Executive Directors

It was agreed to amend Lead Executives for Standards 2.8 and 3.4.
Action – Mrs Carol Evans

ASSURANCE was provided by:

- The progression of work to support continuous ongoing assessment against the standards
- Internal Audit Report 2017

The Quality, Safety and Experience Committee:

- **AGREED** the proposed approach for the assessment of compliance against the Health and Care Standards for the period 2017-2018.

QSE 17/202 PATIENT SAFETY WALKROUNDS

The Executive Nurse Director, Mrs Ruth Walker reiterated the rationale and proposals for Safety Walkrounds and encouraged Members to stick to the programme given the time spent planning and developing it and staff in all locations were well prepared and ready to receive Members to their areas. In this regard, the UHB Chair would be writing to all Board Members and it was agreed that the Committee Chair would do likewise, reiterating this was a concentrated one hour safety session and should not be used for other purposes.
Action – Cllr Susan Elsmore

The Committee **NOTED** the progress of WalkRounds.

QSE 17/203 NEONATAL IMPROVEMENT PLAN FOLLOWING ACINETOBACTER BAUMANNII OUTBREAKS

The Executive Nurse Director, Mrs Ruth Walker advised that the report described the progress made since the outbreak.

ASSURANCE was provided by:

- The development and ongoing monitoring of a robust improvement plan to address the recommendations made as result of the Independent Review.

The Quality, Safety and Experience Committee:

- **NOTED** the progress made in implementing the recommendations in the Improvement Plan.

QSE 17/204 INFECTION PREVENTION AND CONTROL (IPC) – TIER 1 INFECTION REDUCTION EXPECTATIONS FOR HEALTHCARE ASSOCIATED INFECTIONS

The Executive Nurse Director, Mrs Ruth Walker advised that the report covered the depth and breadth of the IPC agenda. A more detailed operational plan based on the driver diagram shared at the last Board meeting was also being developed. Discussion with the Chief Executive would take place to give greater consideration to the UHB's culture and communications as corporate branding of the IPC agenda was insufficient and action was not consistent, especially bare below the elbow.

The UHB Chair advised that she had not yet appointed a new Champion for hygiene and cleanliness and hoped that a greater impetus could be given to the agenda once an appointment was made.
Action – Miss Maria Battle

QSE 17/205 CLEANING UPDATE

The Capital Estates Director, Mr Geoff Walsh attended the meeting to represent the Director of Planning for this item. He began by answering the questions asked by the Committee earlier in the meeting (see item 17/195).

- BMT – it was anticipated that a business case would be submitted in September 2018 with full design and tendered costs.
- Rookwood Hospital – a business case had been submitted to Welsh Government but the process was being repeated because the contractor had withdrawn from the scheme. It was anticipated that a new business case would be submitted in January 2018 and work could start as early as May 2018, though funding was still a risk.
- T5 bathrooms – instead of just upgrading bathrooms, refurbishment of whole wards was being undertaken. Three wards had been completed, but due to winter pressures, work was on hold until Spring.
- Dementia Friendly – work on better use of colour was being actioned through the refurbishments.
- Theatre capacity – there was no timeline for any additional theatre capacity as the demand and capacity modelling had not yet been completed. However the development of a Business Justification Case for the first phase of the UHW theatre refurbishment programme was anticipated by July/August 2018.

In terms of cleaning, standards had been maintained in very high and high risk areas. The UHB had previously made a decision on financial grounds to invest resources in these areas at the expense of public areas such as corridors.

The Audit Committee had recently not been assured on the processes and systems for auditing cleaning - staff were not available to take measurements. The Committee was advised that the Limited assurance awarded related to processes and was not a reflection of cleanliness in clinical areas. However, Mr Walsh commented that following a review of the maintenance resource, a review of housekeeping would be undertaken and consideration was being given to the trial of cleaning robots.

LIMITED / REASONABLE ASSURANCE was provided by:

- Audit Report Draft Report – September 2017
- Actual Cleaning Scores for Very High & High Risk Area Scores vs Target

The Quality Safety and Experience Committee:

- **AGREED** that update content was appropriate and proportional.

QSE 17/206 HEALTH AND CARE STANDARD 2.9 MEDICAL DEVICES, EQUIPMENT AND DIAGNOSTIC SYSTEMS

Dr Fiona Jenkins, Director of Therapies and Health Sciences thanked Mr Clive Morgan for his work in this area.

ASSURANCE was provided by:

- The UHB's Medical Equipment Group as part of the Medical Equipment Management Governance Framework.

The Quality Safety and Experience Committee:

- **NOTED** assessment of corporate level compliance to Health and Care Standard: 2.9 Medical Devices, Equipment and Diagnostic Systems
- **SUPPORTED** the improvement actions to be included in the Medical Equipment Group (MEG) work programme for 2017/2018.

QSE 17/207 CORPORATE RISK AND ASSURANCE FRAMEWORK

The Director of Corporate Governance, Mr Peter Welsh advised Committee that there had been a reduction of the risk rating in the neonatal service.

The overall approach to risk was still under review and guidance had been produced in support of the new process which was being trialled on a small number of risks at Committees. It was agreed that this new method would be trialled on care of the deteriorating patient for the February Committee.
Action – Mrs Carol Evans

It was also agreed to engage with the IT team in terms of Cyber Security.
Action – Mr Peter Welsh

ASSURANCE was provided by:

- Assignment of risks to a Lead Executive and Committee
- The CRAF was a standard agenda item at Board and its Committees
- The review of the CRAF that was currently taking place recognised that this area could be strengthened to provide better assurance and was aimed at achieving this.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the CRAF Update Report and the potential for change to risk reference 6.4.12.
- **NOTED** the proposed next steps in the CRAF review.

4

QSE 17/208 UHB SELF ASSESSMENT AGAINST HEALTH AND CARE STANDARD 2.6 MEDICINES MANAGEMENT – MID YEAR UPDATE

The Medical Director, Dr Graham Shortland commented that the report was a mid-point review. A rating of 3 had been agreed because there was no consistency across the board to be able to progress to the next level.

ASSURANCE was provided by:
- Action plans were being managed via the corporate Medicines Management Group.

The Quality, Safety and Experience Committee:

- **NOTED** the mid-year update on self-assessment against Health and Care Standard 2.6 (Medicines Management).

QSE 17/209 SINGLE POINT OF ENTRY FOR CHILDREN

This item was taken earlier in the meeting when the Chief Operating Officer, Mr Steve Curry, was present. Mr Curry spoke about the clinical pathway variation by having two points of entry: the paediatric A&E unit and the children's assessment unit. A project team had been set up to scope how the two systems could be amalgamated as there were cost pressures to running two systems concurrently. The Management Executive would be considering the scoping exercise further in December and it was anticipated that a further report would be presented to Committee in February 2018.
Action – Mr Steve Curry

It was important to consider this in conjunction with geography and space issues that would arise as a result of the major trauma centre decision. It was confirmed that consideration would be given to the model for the multi-professional workforce required if any changes to the current system were made.

The UHB Chair reminded Committee that the thinking to close one entry point had originally been raised with her under the safety valve process.

ASSURANCE was provided by:
- The establishment of a multi-disciplinary project to develop a sustainable model for paediatric unscheduled care services
- The project was progressing as per the original plan with regular updates to Management Executive

The Quality, Safety and Experience Committee:

- **NOTED** the work being done to agree a model for a Single Point of Entry.

4

QSE 17/210 PATIENT SAFETY SOLUTIONS – ALERTS AND NOTICES – UPDATE ON OUTSTANDING AREAS OF NON COMPLIANCE

The Executive Nurse Director, Mrs Ruth Walker, by way of assurance, advised Committee that there were a number of actions involved in order to comply with each safety notice. In many areas several of the required actions may have been completed but until the UHB was complaint with all action required, the notice remained outstanding. However, the UHB was continuing to make progress.

ASSURANCE was provided by:

- The UHB was currently 90% compliant with all existing Patient Safety Solutions (PSS). Work was underway to address the requirements of recently issued PSS to declare compliance with historical alerts.
- The actions that were being undertaken to address the outstanding areas of non-compliance.

The Committee:

- **CONSIDERED** the update provided within the report.

QSE 17/211 CANCER PEER REVIEW – COLORECTAL CANCER

The Medical Director, Dr Graham Shortland advised that the UHB was now into its second cycle of peer reviews. In relation to the concerns expressed about endoscopic ultrasound, local health boards were working together to develop a centralised service within Cwm Taf University Health Board.

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the Peer Review assessment and Peer Review reporting process. Any concerns identified were addressed via an action plan and were regularly reported within the required process; at the Clinical Board performance reviews and by WG and the South Wales Cancer Network.

The Quality, Safety and Experience Committee:

- **NOTED** the report.
- **AGREED** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.
- **NOTED** that the NHS Wales Peer Review Framework WHC 17 037 had been received and would be considered by the QSE in February 2018.
  Action – Dr Graham Shortland

QSE 17/212 MORTALITY DATA AND MORTALITY REVIEW

The Medical Director, Dr Graham Shortland advised that mortality statistics were regularly reviewed and reports on trends/themes were brought to Committee eg 7 day working.

Internal Audit reports would advise if the UHB was using the information in a systematic way. Dr Shortland asked Committee to let him know if there were any particular areas on which a report was required.

In terms of the Medical Examiner role, implementation had been delayed to April 2019. This was welcomed given the number of deaths which occurred within the UHB as compared to availability of staff for greater investigation.

With regard to vulnerable patients, further work was being undertaken to ensure that the mortality reviews undertaken on patients with a learning disability, dementia or mental health problems, did not identify that these particular groups had been compromised or disadvantaged in terms of their clinical care.

ASSURANCE was provided by:
- Monitoring of Mortality measures reviews
- Mortality Data

The Quality, Safety and Experience Committee:

- **AGREED** the ongoing proposed plans for mortality reviews.

QSE 17/213 HIW PRACTICE INSPECTION REPORT – PRIMARY CARE GENERAL MEDICAL SERVICES AND DENTAL GOVERNANCE

The Executive Nurse Director, Mrs Ruth Walker, told Committee that this report demonstrated that processes were in place and that more work on assurance would be undertaken with the Primary, Community and Intermediate Care Clinical Board.

ASSURANCE was provided by:
- The processes in place to monitor the outcomes of HIW inspections in primary care
- Overall positive findings

The Quality, Safety and Experience Committee:

- **CONSIDERED** the report and the findings of the inspections.

QSE 17/214 HIW ACTIVITY UPDATE

The Executive Nurse Director, Mrs Ruth Walker had nothing to add to the report.

ASSURANCE was provided by:

- The development, implementation and monitoring of improvement plans to address recommendations.
- Progress reports through the Clinical Board Quality, Safety and Experience Sub Committee (QSE), as well as through the UHB QSE Committee.

The Quality, Safety and Experience Committee:

- **NOTED** the findings following the Children's Hospital for Wales inspection
- **NOTED** the level of HIW activity across a broad range of services
- **AGREED** that the appropriate processes were in place to address the recommendations and to receive future assurance reports as the findings of the thematic reviews were published.
- **AGREED** that a more detailed report, outlining the UHB position against the findings of the All Wales HIW report would be received at the February 2018 Committee.
  Action – Mrs Carol Evans

(The meeting was no longer quorate)

QSE 17/215 HIW OPHTHALMOLOGY THEMATIC REVIEW

The Executive Nurse Director, Mrs Ruth Walker presented the position paper. The gap in the action plan on page 455 had been updated by Mr Curry earlier in the meeting. A further report would be requested for April 2018.
Action – Mr Steve Curry

ASSURANCE was provided by:

- The development, implementation and monitoring of an improvement plan to address recommendations that resulted from the Thematic Review.

The Quality, Safety and Experience Committee:

- **NOTED** the progress made in implementing the recommendations in the Improvement Plan.

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

4

QSE 17/216 LEARNING DISABILITIES SPECIALIST, SECONDARY AND PRIMARY CARE SERVICES

ASSURANCE was provided by:

- Ongoing work to progress the integration and governance of Learning Disability Services.

The Quality, Safety and Experience Committee:

- **NOTED** the progress made against the joint Care and Social Services Inspectorate Wales and Health Care Inspectorate Wales Improvement Plan.

QSE 17/217 REMOVAL OF "STATUTORY" SUPERVISION OF MIDWIVES AND A NEW MODEL FOR WALES

The Nurse Director, Mrs Ruth Walker explained that the report detailed the UHB's process for supervision of midwives following the removal of the statutory element by the regulators.

ASSURANCE was provided by:

- The development and ongoing monitoring of a robust improvement plan to address the recommendations made as result of the Independent Review.

The Quality, Safety and Experience Committee:

- **NOTED** the progress made in implementing the recommendations in the Improvement Plan.

UHB 17/218 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The following Minutes were received and noted.

1. **CLINICAL DIAGNOSTICS AND THERAPEUTICS – AUGUST AND SEPTEMBER**
2. **MENTAL HEALTH – SEPTEMBER AND OCTOBER**
3. **PRIMARY, COMMUNITY AND INTERMEDIATE CARE - JULY**
4. **SPECIALIST SERVICES – JULY, AUGUST X 2 AND SEPTEMBER**
5. **MEDICINE – AUGUST AND OCTOBER AND ACUTE AND EMERGENCY WAITS – JUNE/JULY AND AUGUST/SEPTEMBER**

6. **SURGERY – JULY**
7. **CHILDREN AND WOMEN – AUGUST**
8. **DENTAL – SEPTEMBER**

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QSE 17/219 AGENDA FOR THE PRIVATE QSE MEETING

The private agenda was published as part of the culture on openness.

QSE 17/220 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

There was nothing to bring to the attention of the Board.

QSE 17/221 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 17/222 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 13th February 2018.

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ACTION LOG FOLLOWING QSE COMMITTEE DECEMBER 2017 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/088 QSE 17/132	20.6.17 12.9.17	CHC Report		Visit findings and feedback to be regularly shared with the Equalities Manager	CHC D Price	
QSE 17/138.3	12.9.17	Nutrition and Catering Policy		Update Policy again to include work on NG tubes when this is ready.	F Jenkins	Policy will be updated again once the recommendations of the working party have been agreed.
QSE 17/195	6.12.17	Specialist Services QSE Assurance Report		Ask CB about their arrangements for mortality reviews. Ask Comms Team to use poem on social media.	G Shortland C Evans	
QSE 17/021	6.12.17	Approach to Health and Care Standards Self-Assessment		Add deadline dates to diaries for signing off. Amend Lead Executives for 2.8 and 3.4.	All Lead Executives and Cllr S Elsmore C Evans	 **Complete**
QSE 17/202	6.12.17	Patient Safety Walkrounds		Write to Board Members about the importance of maintaining the visit programme	C Evans for Cllr S Elsmore	
QSE 17/204	6.12.17	IPC Tier 1		Appoint a Board Champion for Cleanliness and	M Battle	

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				Hygiene.		
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
QSE 16/192 QSE 17/048 QSE 17/099	18.10.16 18.4.17 20.6.17	Critical Care Outreach Team (Identifying and Managing the Deteriorating Patient)	*	Clinical Model for managing the deteriorating patient to be agreed. Finalise ongoing shape and purpose of services at UHL through the acute medicine review with the Planning Team.	Dr G Shortland A Harris	This item had been considered at Committee several times without agreement on a way forward for an action plan and timeline. Joint discussions taking place with Executive Nurse Director and scoping actions in place to take forward. Full discussion to be held at at QSE meeting in June 2017. Mrs Harris reported that the current arrangements will not change. A clinical services model was being developed. It was agreed to keep this on the agenda.
QSE 17/023	21.2.17	Care of Deteriorating Patient	*	Ensure all differing views are taken into account when scoping the way forward	Dr G Shortland	(Linked to the above work) Report with action plan and timeline to be provided for **QSE in September Deferred to Dec & again to February 2018.**
QSE 15/135 QSE 16/006	01.09.15 23.2.16	Corporate Risk and Assurance Framework	*	Business Case for Critical Care Outreach (CCO) and Hospital at	G Shortland	December 2016 update: Awaiting funding for Advanced Nurse Practitioners to address

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 16/202 QSE 17/023	13.12.16 21.2.17	Exception Report - Care of the Deteriorating Patient : Critical Care Outreach Service		Night to be considered at Investment Panel. Need to resolve Critical Care Service issues at UHL.	G Shortland	Hospital at Night February 2017 - Reported to HSMB in December that more work was required to make the plan resource neutral. Update agreed for **September 2017** (Linked to 2 items above)
QSE 17/192	6.12.17	Action on 3 boxes marked * above				Dec 2017 update: Challenging and ongoing. New issues in Llanfair emerging. Service is available but not comprehensive. Full report to QSE with timeframe in **February 2018**
QSE 17/207	6.12.17	CRAF		Trial new reporting method for care of deteriorating patients for February 2018.	C Evans	**QSE February 2018** The trial was changed to IPC instead
QSE 17/054 and QSE 17/055 QSE 17/199	18.4.17 6.12.17	Quality Safety and Improvement Framework		Receive monitoring report in October or December.	C Evans	QSE December 17 verbal update received. Deferred to **February and again to April 2018**
QSE 17/179 QSE 17/192	17.10.17 6.12.17	Never Event NG Tube		Timeframe for approval of revised policy.	C Evans	**QSE in February 2018**
QSE 17/194	6.12.17	Patient Story Specialist Services		Report on financial risks of becoming a Major Trauma Centre to March Board.	G Shortland	**Board March 2018**
QSE 17/098	20.6.17	CRAF		Comments to P Welsh	ALL Members and	Comments being considered as

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				on whether the risk descriptors and controls identified were adequate to provide assurance to the Committee by 20th July.	Attendees P Welsh to correlate.	an integral part of risk review to ensure risk descriptors are more meaningful and understood and controls more measureable. Anticipated by **April 2018**
QSE 17/139	12.9.17	Out of Date Policies		Plan to update all out of date policies within 6 months.	C Evans	**QSE April 2018**
QSE 17/017 QSE 17/192 QSE 17/214	21.2.17 6.12.17	HIW Ophthalmology Thematic Review		Progress report including complaints on waiting times and cancellations to be received in September	R Walker and S Curry	As regional Committee was also looking at the problems, it was agreed to receive a further update on waiting times and complaints in **QSE April 2018**
QSE 17/211	6.12.17	Cancer Peer Review		NHS Wales Peer Review Framework WHC 17 037 to be considered by QSE	G Shortland	**QSE February 2018.** This report had not been received in time for the February Meeting. **Defer to April 2018**
COMPLETED ACTION SINCE LAST MEETING						
QSE 17/024 QSE 17/048 QSE 17/084 QSE 17/132 QSE 17/192	21.2.17 18.4.17 20.6.17 12.9.17 6.12.17	Ward Bathroom Refurbishment		Analysis of comparative data – new bathroom - effect on falls and infection rate. Further work on impact of use of colour on falls and use of transportable toilet bags.	C Evans	No correlation to be found. Agreed at meeting the action could be **CLOSED**
QSE 17/56 QSE 17/192	18.4.17 6.12.17	Patient Safety Solutions Alerts and		Share with the UHB evidence obtained from	S Allen, CHC	This would be shared at a meeting on **15th September.**

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Notices		patients regarding wristbands.		As no response had been received from the CHC it was agreed to **Close** this action
QSE 17/088 QSE 17/132 QSE 17/192	20.6.17 12.9.17 6.12.17	CHC Report		To support the UHB, instigate national debate on repatriation.	CHC D Price	Impact of this on UHB to be provided to the CHC by Mr Steve Curry. **Complete**
QSE 17/101 QSE 17/192	20.6.17 6.12.17	Cancer Peer Review – Brain		Raise structure of the network with WHSSC Chair of Quality and Safety Committee (G Shortland to brief Chair). Undertake work on system rules on flows and collaboration	M Battle (Dr G Shortland) Dr G Shortland	Miss Maria Battle had been appointed as the Welsh Lead Chair on Cancer. Action was in hand and this could therefore be **Closed.**
QSE 17/135 QSE 17/176 QSE 17/192	12.9.17 17.10.17 6.12.17	Dental CB QSE Assurance Report		Raise with WOD Director concerns about mandatory training	M Battle	October update - a meeting had been set up. Monitored via Performance Reviews and therefore **Closed.**
QSE 17/152 QSE 17/192	12.9.17 6.12.17	Carers		Request Mrs Hughes liaise with LED to update mandatory training	A Hughes	A plan with dates would be available by February 2018. It was therefore agreed to **close** this action.
QSE 17/181 QSE 17/192	17.10.17 6.12.17	NatSSIPs		Nominate a Medical Lead	G Shortland	Dr Turley nominated. **Complete**
QSE 16/192 QSE 17/048 QSE 17/099	18.10.16 18.4.17 20.6.17	Critical Care Outreach Team (Identifying and		Discuss at Management Executive the options for strengthening on site	S Curry	Senior Clinical Lead appointed at UHL. **Complete**

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/192	6.12.17	Managing the Deteriorating Patient)		clinical and managerial support.		
QSE 17/057	18.4.17	Patient Falls		Undertake analysis of the data to identify hotspots, reasons for the fall and whether it was appropriate for the patient to be on that ward.	C Evans	Work is underway by Falls Delivery Group. Considered in general at the Special meeting of the **QSE in October 2017 –** included in Trends and Themes. Specific detail of action is ongoing. **Complete**
QSE 17/103	20.6.17	HIW Activity – Single Point of Entry for Children		Progress report	S Curry	**QSE September 2017.** Deferred to **December.** On Dec Agenda. **Complete**
QSE 17/197	6.12.17	CHC Report: Boredom and Loneliness in Hospitals		Letter of thanks to be sent to staff for all the initiatives to reduce boredom and loneliness.	S Elsmore	**Complete**
QSE 17/198	6.12.17	Policy approvals: Safety Notices Medicines Code		Publish 5 approved policies and advise authors. Share with EAs Group for implementation. Include list of withdrawn policies/procedures. Complete EHIA and obtain approval via	J Harper P Welsh G Shortland then J Harper	4 done, waiting on Medicines Code. See Medicines Management Policy on February agenda. Circulated to EAs See Medicines Management Policy on February agenda. **Complete**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				Chair's action.		
QSE 15/171 QSE 16/148 QSE 17/005 QSE 17/048 QSE 17/132 QSE 17/192	20.10.15 13.9.16 21.2.17 18.4.17 12.9.17 6.12.17	Trends and Themes in SI's		Revisit decision on patient wristbands. Case to be presented to BCAG in January 2018 and wristbands to be included in priority list for IMTP	R Walker	Feb 2017 - Solution agreed but funding yet to be identified for 2017/18. Present report for funding consideration to the Management Executive and provide more detail for the next QSE meeting in June. Business case now going to BCAG 13TH June 2017. Board advised it was anticipated for QSE in December 2017. This was taking longer to scope and at Chair's request, would remain on the agenda until a decision was made. Dec 2017 update - It had been difficult to release a member of the safety team to complete the work but the significance of the work was recognised. A report would be presented to BCAG in January for priority to be considered and included in the IMTP for next year. **QSE February 2018. On February agenda**
QSE 17/107	20.6.17	Single Rooms, Isolation Rooms		To be discussed at HSMB	A Harris	**To HSMB in November 2017** Deferred to **December 2017** and

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		and Decant				deferred again to **February 2018. On Feb agenda.**
QSE 17/105	20.6.17	Management of Outpatient Follow Ups and Endoscopy		Receive update report early next year.	S Curry	**QSE February 2018. On February agenda**
QSE 17/200	6.12.17	Refreshed Patient Experience Framework		Share report on young carers with QSE Chair	A Hughes	**Complete**
QSE 17/209	6.12.17	Single Point of Entry for Children		Update report for next meeting.	S Curry	**QSE February 2018** On February agenda
QSE 17/214	6.12.17	HIW Activity		More detail of UHB position against findings in all Wales report to be received in February.	C Evans	**QSE February 2018** On February agenda
QSE 17/207	6.12.17	CRAF		Engage with IT on cyber security.	P Welsh	Discussed as part of the review of corporate risk register **Complete**

SURGERY CLINICAL BOARD QUALITY, SAFETY AND PATIENT EXPERIENCE ASSURANCE REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 13th February 2018

Executive Lead : Executive Director of Nursing
Author : Surgery Clinical Board Director of Nursing Ext: 45258
Caring for People, Keeping People Well This report summarises a range of quality, safety and experience issues pertaining to patients and staff in the Surgical Clinical Board. Issues addressed in the report are aligned to the delivery of the quality components of the UHBs ten year Shaping our Future and Wellbeing Strategy (2015-2025). Key to this is working with our local and national population, communities and partner agencies to provide services a prudent approach to healthcare that maximize their health and wellbeing as well as make them fit for the future. All of which are to be delivered in the context of good governance arrangements and by appropriate staff and resources.
Financial impact : Not applicable
Quality, Safety, Patient Experience impact: This report provides assurance on the work of the Surgery Clinical Board on the range of quality, safety and experience issues. It is aligned to the NHS Outcomes Framework, focusing on quality, safety and patient experience. It describes the Clinical Board's governance arrangements for the promotion of safe, effective and dignified care and summarises key areas where there are plans to improve access to services.
Health and Care Standard Number: All standards 1 to 7
CRAF Reference Number: All, however Objectives 5, 6, 7, 8 and 9 are the areas of most activity demonstrated in this paper.
Equality and Health Impact Assessment Completed: Not Applicable

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ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The governance processes embedded in the core business of the Surgical Clinical Board and its Directorates
- Evidence of regular performance management reporting
- Independent review of the business of the Surgery Clinical Board by internal and external bodies such as Internal audit, CHC, HIW, Welsh Risk Pool, Welsh Government

RECOMMENDATION
The Quality Safety and Experience Committee is asked to:

- **APPROVE** the content of this report and the assurance given by the Surgery Clinical Board.
- **NOTE** the progress and approach taken by the Surgical Clinical Board to date and planned future actions.

SITUATION

This report provides details of the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety and Patient Experience agenda over the last 12 months. It will highlight the achievements, progress and planned actions of the Surgery Clinical Board in its aim to continue to improve and develop this very important agenda within the Clinical Board.

BACKGROUND

The Surgery Clinical Board has 5 Directorates which provide a significant number of emergency and elective services to Cardiff and Vale residents which include Trauma and Orthopaedics, General Surgery, Urology, ENT, Maxillo-Facial Surgery and Ophthalmology. The Clinical Board employs over 1800wte staff and has a budget of £120 million.

In addition to direct service provision for the local community of Cardiff the Surgery Clinical Board provides a significant number of services beyond the local population at both the University Hospital of Wales and University Hospital Llandough.

The Surgery Clinical Board supports the activities of all other Clinical Boards within the Health Board through the provision of services provided by the Perioperative care Directorate, which includes Anaesthesia, Pain Management, Operating Theatres, Pre-Assessment and Sterile Services.

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

The Surgery Clinical Board has a formal Quality, Safety and Patient Experience (QSPE) that meets bi-monthly which is co-chaired by the Surgery Clinical Lead Medical Advisor (Consultant Anaesthetist) and the Boards Director of Nursing. This structure is formally replicated in each of the Clinical Directorates. The QSPE group has two key sub-groups that report to it; a Health and Safety group and an Infection Prevention and Control group.
These meet bi-monthly, have formal terms of reference are formally minuted and have a range of different stakeholders who attend to ensure that there is wide engagement in the overarching quality and safety agenda.
The QSPE group report to the Clinical Boards formal business meeting which is held monthly and is chaired by the Clinical Board Director.

The formal board requires monthly assurance as to the quality, safety and effectiveness of the care it provides. The monthly assurance report to this group provides assurance of the activities and progress being made with regards to the Surgery Clinical Boards:

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- Quality and Safety agenda
- Infection Prevention and Control Annual work programme
- National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)
- IMTP
- Health and Care Standards
- Patient experience
- Financial and information governance
- Organisational Development and Workforce Planning
- The NHS Wales Quality Delivery Plans

ASSESSMENT AND ASSURANCE

The Clinical Board 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 eDatix 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 and through the Clinical Boards QSPE group and formal business meetings all of which have very strong medical, nursing and management representation and are fully minuted.

In summary the Surgery Clinical Board Quality, Safety and Patient Experience strives through strong leadership to:

- Ensure that there is a continuous review the quality and safety risks and take action to mitigate these on an ongoing basis.
- Continue to maintain a culture of improving quality, safety and patient experience throughout the Clinical Board.
- Continue to develop a culture of excellent staff engagement in the quality and safety agenda

ASSESSMENT

Governance, Leadership and Accountability
Quality, Safety and Patient Experience is the highest priority for the Surgery Clinical Board which has a robust and well attended quality and safety groups with strong representation from Management, Medical, Nursing and Allied Health Professional staff from both within and external to the clinical board.
An annual self-assessment against the Health and Care Standards continues and along with the Risk Register within the Clinical Board were used as the basis for the Clinical Boards 2016/17 IMTP draft submission.

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The Clinical Board Risk Register is monitored at Directorate and Clinical Board level on a regular basis locally. The top 4 risks on the Clinical Board risk register are:

Risks	Mitigation
Fabric and plant of the main theatre suite at UHW is of concern due to its age and the potential for there to be failures of the plant leading to cancelled operations.	Remedial works have been carried out on the theatres that posed the most significant concern. Plans have been drawn up with the Capital Planning team to address this issue in the longer term.
Fabric and plant of theatres 5 and 6 in main theatres at UHL is now becoming of concern due to its age and the potential for there to be failures of the plant leading to cancelled operations.	A modular theatre has been installed and commissioned in UHL to replace the activity lost in theatre 5. Remedial works have been carried out on theatre 6. Plans have been drawn up with the Capital Planning team to build two new theatres to address this issue in the longer term.
No out of hour's interventional radiologists available for two key clinical procedures which can only be carried out by an interventional radiologist – 1. Nephrostomies and 2. Renal vascular embolisation Nephrostomies are mainly needed to deal with obstructed infected kidneys. These are done under local anaesthetic and are safer than the alternative. Renal vascular embolisation for bleeding from the kidneys. This is again done under local anaesthetic with a good chance of renal preservation. The alternative is open surgical exploration which in the vast majority of case the patient ends up with the loss of a kidney.	To ensure patient safety an open procedure is carried out but with suboptimal outcomes.
Bank/Agency use increasing due to staff shortages which invariably leads to reduce levels of patient care	Micromanagement and contingency plans put in place on a daily basis by lead/senior nurses.

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as there is reduced continuity of that care.	Block booking of bank and agency as a way of integrating the agency and bank staff into a given area in order to help with continuity of care. Very proactive recruitment plan in place.

Healthy (Theme 1)

We promote the health of our staff and the wellbeing of our patients by proactively encouraging staff to take up the seasonal flu vaccine. As of the 31st December 2017 we had vaccinated 49.9% of our staff by a combination of using our own proactive flu champions and resources made available by the UHB. This is an improvement on the same time last year.

All patients who attend a pre-operative assessment are if required given advice on smoking cessation, safe alcohol limits and healthy weight management.

Health and safety group reviews themes of staff accidents and incidents and as part of the work the Clinical Board did a significant amount of work in relation of the roll out of introducing sharp free devices in place of traditional sharps such as hypodermic syringes. Where it was not possible to convert to a non-sharp device and these were mainly in the operating theatre environment then individual risk assessments have been completed and shared with the UHB Health and Safety department.

The Clinical Board has a dementia care plan and has some very proactive staff who embrace this agenda passionately. In the last 12 months we have seen the following pieces of work carried out;

- Roll out of the 'Read about me' initiative
- Investing in staff education about dementia with bespoke dementia training run by the Clinical Board
- Introduction of activity packs for use with patients on all Surgical CB wards.
- Introduction of blue crockery for sensory/cognitively impaired patients

Things being planned for this coming year;

- Open visiting for relatives of cognitively impaired patients
- Changes to ward routines to give the patients a routine that reflects their normal routine day which will mean significant changes to the working day of the ward.

Safe Care (Theme 2)

Sepsis
The sepsis 6 pathway has been rolled out across the Clinical Board.

There is a six month multidisciplinary project being undertaken between Surgeons, pharmacy and microbiology where all patients who have been prescribed antibiotics in the Surgical Assessment Unit are followed up at 48 hours to ensure that they have had the medication reviewed to ensure that it is still required. This project also extends to a follow up of all emergency surgical patients discharged from Critical care to a general surgical ward.

Skin bundle
Pressure damage is taken very seriously in the Clinical Board with all incidents being reported through the correct processes and the investigations are completed in a timely way. The Clinical Board Director of Nursing and the CB Lead Nurse facilitate a UHW wide group who look at this agenda on a monthly basis with a view to improving care in Cardiff and Vale but also seek to influence this agenda Wales wide.

Thromboprophylaxis
The Lead Nurse for Surgery Clinical Board has re-established the Surgery Clinical Board re-establish the multi-professional surgery Thromboprophylaxis and Anticoagulant Group. The mandatory Thromboprophylaxis risk assessment for all surgical patients has recently been reviewed and amended by members of the group

Serious Incidents and No Surprise Incidents reported to Welsh Government
Between 1/1/17 and 1/1/18 the Surgery Clinical Board reported 51 Serious Incidents and 2 No Surprise events to Welsh Government.

Never events
There were 2 reported never events in 2017.

All serious incidents are considered by the appropriate clinical teams and Quality and Safety Groups. Action plans are developed and progress and evidence of completion are reported to the Clinical Board Quality, Safety and Experience Group for assurance purposes.

The main themes for serious incidents are as follows:

Anaesthesia Care	2
Diagnostic Processes/Procedures	2
Infection Control Incident (Healthcare Associated Infection)	2

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Medical Devices, Equipment, Supplies	1
Medication/Biologics/Fluids	2
Patient Accidents/Falls	9
Pressure Ulcers	21
Service Disruptions (environment, infrastructure, human resources)	1
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	11
Total	51

Patient safety related incidents
Top 10 Patient Safety related incidents occurring within the Surgical Clinical Board during January 2017 to 31st December 2017 were;

Administrative Processes (Excluding Documentation)	82
Anaesthesia Care	36
Behaviour	36
Blood/Plasma Products	31
Communication	114
Diagnostic Processes/Procedures	64
Documentation	85
Exposure to Environmental Hazards	12
Infection Control Incident (Healthcare Associated Infection)	28
Injury of unknown origin	16
Maternity Care	2
Medical Devices, Equipment, Supplies	168
Medication/Biologics/Fluids	122
Nutrition Food/Meals from Kitchen	2
Nutrition Pharmacy Products	2
Other	20
Patient Accidents/Falls	588
Personal Property/Data/Information	10
Pressure Ulcers	291
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	93
Total	1802

Falls Prevention and Reduction
There were 9 injurious falls reported between 01.01.2017 – 31.12.2017 all of which have had an injurious falls RCA conducted. This is a much improved picture on previous years. So far the reviews have not identified any particular themes for the falls however they have given assurance that UHB policies, protocols and guidelines are being used in Directorates.

HM Coroner's inquests and regulation 28 reports
The Clinical Board has been involved in 5 inquests in 2017 (where Surgery was the managing Clinical Board). Of these, none received a regulation 28 report.

Relevant Coroner and Ombudsman reports and recommendations are considered by the Directorate and Clinical Board Quality and Safety Groups.

Concerns, compliments and claims

Formal concerns
This remains a challenging aspect of quality for the Clinical Board to manage efficiently and effectively. Between 1 Jan 2017 and 31 December 2017 the Clinical Board received a total of;

- 295 formal concerns which is a significant reduction (from 454) reported to the committee previously.
- 95% acknowledged within 2 days.
- 46% were responded to within the 30 day target which is acknowledged as being wholly inadequate. A focused piece of work is to commence within the Clinical Board to try and address this shortfall.

The Clinical Board also received 7 more complex concerns that required RCA investigations – 29% responded to in time.

Informal concerns
676 informal concerns which is a significant increase (from 190) reported to the committee previously.

The Clinical Board remains committed to being very proactive in contacting and meeting individuals who raise concerns at the informal stage in an attempt to achieve quick resolution for the patients and their carers, evidence of this work can be seen in the reduction of formal concerns.

The top four key themes from the formal and informal concerns in surgery are:

- Clinical Diagnosis and Treatment – (206)
- Cancellation of OPA (175 – Particularly Opthamology)
- Length of Outpatient waiting lists (174)
- Length of wait for admission date (98)

Compliments
The Clinical Board has received 200 compliments which have been logged formally. These are shared with staff appropriately.

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Claims

The Clinical Board has had (39) clinical negligence claims opened between 1/1/17 and 31/12/17

Which are split between the following:

(15) General Surgery and Urology
(4) Ophthalmology and Head and Neck
(3) Surgery Support Services
(17) Trauma and Orthopaedics

Key themes arising from claims received into the Clinical Board include:

- Substandard Surgical Technique
- Failure to diagnose and treat
- Inadequate Substandard care

There are 8 further categories. Some case have no category (Theme) yet as it is too early to determine.

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Infection prevention and control

Overview of position for this financial year (April to Dec 2017):

Clostridium difficile

On target to reach year end reduction target.
15 cases year to date (YTD) (target no more than 24)

Meticillin Resistant Staphylococcus Aureus (MRSA) bacteremia

Unfortunately the CB is not on target to reach year end reduction target of no cases.
3 cases YTD (which is the same number for 2016/17)

Meticillin Susceptible Staphylococcus aureus (MSSA) bacteraemia

Unfortunately the CB is not on target to reach year end reduction target of 12 cases.
17 cases YTD

Escherichia coli (E. Coli) bacteraemia

Unfortunately the CB is not on target to reach year end reduction target of 12 cases.
20 cases YTD (2016/ 2017 was 39)

Bare below the elbow and the virtual red line initiatives

The Clinical Board is very committed to this agenda and re invigorated its own bare below the elbow campaign in September 2017 which was aimed at re-focusing on this agenda. Staff within the Clinical board designed the yellow

posters that can be seen in all surgical areas asking for all who enter the clinical environment that they please be bare below the elbow and carry out appropriate hand hygiene. Badges were also designed by a member of staff which prompts patients to “ask me if I have cleaned my hands”.

Theatres at the same time launched their ‘virtual red line’. The adherence to this is currently being evaluated. Following some re-furbishment work in theatres the aim is to bring back the virtual red line in order to try and instil some discipline of ensuring staff are correctly attired and are bare below the elbow. All operating theatres will be visibly colour coded to denote the zoned red, amber and green areas and what is expected in terms of uniform and hand hygiene practices if an individual needs to cross the line from one zone to the next.

Aseptic Non touch technique (ANTT) roll out

The Clinical Board currently has 33 trained ANTT assessors and 21% of the nursing/ ODP staff are fully compliant with the full ANTT assessment. There is a robust ANTT action plan in place within the Clinical Board to ensure that this good progress continues and a plan has also been put in place to ensure that the Surgeons and Anaesthetists are also assessed whilst in the theatre setting.

Effective Care (Theme 3)

Emergency Surgery Business Case (EGS)

There have been three National Emergency Laparotomy Audit (NELA) which have not shown the Health Boards performance to be optimal in getting patients to the emergency operating theatre in a timely way. In 2015 the UHB was in the bottom 10% of all trusts/HB’s in our ability to get high risk patients access to emergency theatre within the recommended time frames Led by the Clinical Director for General Surgery it was felt that a radical new way of working was required in order to improve what was an unsatisfactory situation. The Health Board supported the Surgical Clinical Board to develop the Emergency General Surgery (EGS) business case, and the range of measures needed to be put into place in particular;

- Increased Emergency capacity on the main theatre suite at UHW to 2 theatres being available 24/7
- Dedicated Monday to Friday Consultant and Registrar cover for the Emergency Unit and the Surgical Assessment Unit.
- Development of a new role of a Peri-operative care physician which is currently being recruited to.

From the 1st October 2017 there has been two dedicated Emergency theatres running 24/7. Patients are receiving Consultant led care which is good for patient outcomes but is also excellent for the training of junior medical staff to be supported by senior surgeons.

The Surgical Assessment Unit whist predominantly a GP expected unit in times of high pressure are able to be more flexible and responsive to the needs of patients in the emergency unit.

The metrics for the first three month are currently being collated and will be presented at the relevant UHB groups and committees but anecdotal evidence from staff and patient flow would suggest that things 'feel' just so much better since the adoption of EGS. This model of care is now being looked at by other clinical specialities.

Nurse Led Research
The Surgery Clinical Board are working with Cardiff University on a Nurse Led research project that has been successful in gaining a research grant. This is the first time that nursing research of this classification has been carried out in the Surgery Clinical Board. It is hoped at the end of the trial that we will be able to effectively measure a patients' compliance with treatment. Where a patient is deemed not compliant for any reason e.g. manual dexterity they will be supported with a bespoke management plan to help them.

Audit
The Clinical Board has a formal audit plan in place, which includes both local and national audits. The results from these audits are fed back to Directorate and Clinical Board quality, safety and experience groups.

A new audit has replaced the Welsh Risk Pool audit is the Health Inspectorate Wales surgical inspection framework which has been launched and will be carried out across Wales on an unannounced basis. This audit will also encompass the work the UHB has done on the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards (LocSSIPS). In May 2017 the Surgery Clinical Board invited and hosted Dr Will Harrop-Griffiths, Chair of the national NatSSIPs group, to come and talk to staff within the UHB about the standards and what the requirements of the Health Board would be. This session was received well and was well attended by UHB staff from all Clinical Boards.

Dignified Care (Theme 4)
Dignified care inspections and CHC inspections carried out in 2017 have not identified any areas of significant concern specifically in relation to dignity. The newly developed Band 5 induction programme has the UHBs values and behaviours that underpin it and the delivery of dignified care is specifically addressed.

It is expected that all wards participate in the monthly Health and Care Monitoring System Audits on a monthly basis and these indicators are reviewed at the monthly Nursing Board meetings attended by the Director of Nursing, Lead Nurses, Senior Nurses and Practice Educators. They are also reviewed at the monthly confirm and challenge sessions with ward Sisters and Charge Nurses and action plans put in place as necessary.

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

The Clinical Board have looked at the Enhanced Care model completed in the Medicine Clinical Board Enhanced Care model to look after patients who have a cognitive impairment safely with the aim of preventing harm from falls. The pilot of this work will be commencing on A3L.

Clinical environments
There have been significant capital works that have taken place in the last 12 months to improve the environment and facilities for our patient's and staff.

Wards
At UHW wards B6 and B2 have had a total refurbishment essential for the client groups on these two wards who often have significant mobility and cognitive impairments and the environments have been adapted to facilitate these needs. Ward T2 Colorectal has moved across into Duthie ward housed in the old Duthie library which meets the new Health Building notes specifications for newly built and commissioned wards. Ward A3L in currently undergoing a refurbishment program to replace the floors and upgrade the toilet and shower facilities. There are plans to refurbish ward A2 in the summer of 2018.

At the University Hospital of Llandough there are plans to re-model CAVOC (John Radcliffe) ward.

Theatres
A new modular theatre has opened in the University Hospital Llandough following £1.7m worth of funding from the Welsh Government with plans to build two more theatres.

At UHW the changing room facilities for staff are being upgraded along with a fully refurbished admissions corridor. A robust planning process has been put in place to develop the business cases to refurbish the main operating theatres suite theatres as well as re-design the services offered by the operating theatres in the Short Say Surgery Unit (SSSU).

Day of surgery admission
The Perioperative Care Directorate are working with estates to provide a dedicated Day of surgery admission (DOSA) unit in SSSU which will enable all patients pre-surgery to be admitted in the same place which is known to all. This will allow the Surgeons and Anaesthetists to know exactly where the patients are. Currently it is possible that all patients on one operating list could be on several wards. This is very inefficient as the teams need to move about between wards to see the patients and that takes time and as a result it slows down the start of the operating list. With the new model of care it is anticipated that we will see a reduction in late starts and as we will have mapped the patient journey we will be able to facilitate the smooth flow of patients through inpatient beds and increase our performance against the national day case admission rates.

Timely Care (Theme 5)
Chequered flag initiative

This initiative commenced in General Surgery and has been introduced across the board. Its purpose is to ensure timely discharge of a patient whose discharge is complex. The ward staff identify a patient whose discharge is planned for the following day. This patient is clearly identified to the MDT and all staff focus on doing all they can to ensure that everything is in place for the patients' timely and safe discharge the following day utilising the discharge lounge as appropriate.

7 and 9 days 'no delays'
The Clinical Board were very pro-active in this UHB wide initiative. All senior managers and senior nursing staff were allocated a ward that they buddied for the period of this initiative (ward liaison officer). Its purpose was to help ward staff with any issue that felt were out of their control to enact a patient discharge. The aim was to achieve an earlier discharge for patients and as a result improve patient flow through the surgical in-patient beds. The results have been quite interesting. The data from this initiative were collected daily, with the teams updating a shared spreadsheet and shared with our Continuous Service Improvement colleagues. As a result we have been able to analyse this data and it has given us some hot spot areas that we need to focus on as part of our day-to-day core business. The key hot spot is that patients cannot be discharges as they need an ongoing investigation for a variety of reasons before they can be discharged safely. Therefore our focus will be on working with other Directorates and Clinical Boards to agree pathways for these investigations in order to reduce the waiting times and improve the patient experience and subsequently reduce the bed days occupied.

A very positive unintended consequence of the initiative is that senior staff have built new types of relationships with the ward staff due to their visibility. Staff are feeling that they know not only who is who, but feel more confident in asking question or asking for help, which has improved morale.

Hot clinics
On the back of the Emergency General Surgery business case the Surgical and Urology teams have set up hot clinics and a GP advice line in order to help manage patients care, so as they can remain in the community and avoid hospital admission.

Individual Care (Theme 6)
In implementing the National User Experience Framework service users are telling us we are in the main doing a good job but there is still work to do. We have a comprehensive action plan which carried out of the UHBs values into action initiative. We use all elements of the National User Experience Framework but we mainly use those in quadrant 1 and 4.

Real time – we carry out short surveys as part on the 'two minutes of your time' initiative and suggestion boxes on the wards. We have also have had patient kiosks in several of our clinical areas where the views of patients, their carers and staff are captured. The planned installation of Patient/Visitor Ward

Information Boards at the entrance to all ward areas across the UHB will help us significantly with this agenda.

Retrospective – Patient stories are shared at relevant groups within the Clinical Board

Proactive/reactive – Patient compliments are feedback to relevant staff. Also where concerns are raised by patients and their carers we do share the concerns with the relevant staff member/s in order that they can reflect on the patients' perception of the care they delivered and to make any changes that may be necessary.

Twice a year Medical students as part of their training interview patients to hear their stories. Patient story telling was undertaken as part of the RCN Clinical Leadership Programme and it is this methodology the students use. Once the interviews are carried out the student submits their report to the ward sister/charge nurse and action plans if required are developed from this information.

Balancing – Concerns, compliments, Clinical Incidents, Service user and family feedback are used to help the clinical board decide on its planning ideas such as redesigning its services.

8

Staff and Resources (Theme 7)

Finance

1. The financial position at the end of Month 9 is £0.283m deficit.

2. The Clinical Board savings target is £2.357m

3. Progress against this target is:

£2.401m green identified 102%

£0.118m amber identified 5%

£0m shortfall against target

4. The recurrent full year effect CRP position is a £0.196m surplus.

5. Year-end forecast £0.069m surplus

6. **Staffing**

Surgery Clinical Board Workforce Summary Report December 2017

Key Performance Indicator	Monthly Actual (Dec 17)	Comparison with Previous Month (Nov 17)	Comparison with Previous Year (Dec 16)	2017-18 target
Vacancy Rate (WTE)	7.22%	7.19%	5.07%	5.00%
Turnover Rate (WTE)	8.97%	9.37%	8.85%	7.0% - 9.0%
Sickness Absence Rate	4.89%	4.78%	4.62%	3.96%
PADR Rate	52.13%	57.83%	44.81%	85.00%
Statutory and Mandatory Training Rate	59.49%	57.32%	59.04%	85.00%
Medical Appraisal	81.17%	81.61%	80.62%	85.00%

8

Nurse Staffing Act

From April 2018 the nurse staffing act becomes statutory requirement and it will be applicable to and affect all acute surgical wards. In preparation for this the Clinical Board have done a significant amount of work on staffing establishments and triangulating this with professional judgment and other tools such as acuity data. The final guidance documentation on The Act is still to be published, but the Clinical Board is preparing itself as best as it can for receiving the final guidance. In terms of absolute numbers the wards in the Surgical Clinical Board meet the requirements of the Act except the proposal that all Ward Sisters and Charge Nurses need to be 100% supervisory and the financial challenge to the Clinical Board will be £459,072

Recruitment

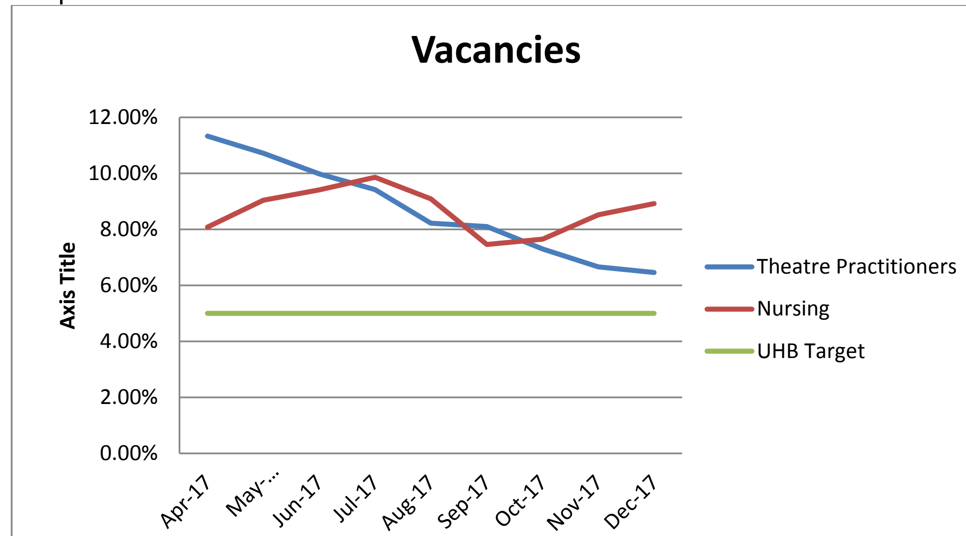
Nurse and AHP recruitment has been a significant challenge and a lot of work has been put into try and address this. The Clinical Board hold regular recruitment meetings underpinned by a robust action plan which has driven several different initiatives such as:

- Dedicated supported 4 week supernumerary time for all new registered staff joining a ward.

- Keeping in touch days where UHB staff contact staff who have been appointed but may not be commencing employment for a few months e.g. Student Nurses/ODPs who are a few months off qualifying, and invite them in to talk to them about new initiatives and give them opportunity to meet with staff in the team they are joining.

Whilst early in 2017 the staffing position for theatres was of concern at nearly 12% (Graph 1) this has reduced exponentially over 9 months to just over 6% with more staff still to join the team. The situation for the wards shows a different picture of more or less stagnation in terms of numbers (8-10%) with no improvement trajectory in sight. Whilst it has been relatively easy to appoint staff from the numerous recruitment initiatives such as recruitment evenings, the biggest challenge is now retaining these nurses.

Graph 1



Retention

Whilst we have a very comprehensive work plans and action plans to try and address nurse retention such as holding celebration events, trying to instil a feeling of being part of a bigger team such as via dedicated Facebook pages, it is proving to be inadequate. Anecdotal evidence would suggest that surgical nursing staff are very unhappy on the wards due to the emergency pressures on the organisation. In particular surgical nurses feel disenfranchised particularly in relation to the number of medical patients they are nursing on surgical wards. These nurses feel very strongly they are doing a job that they had not signed up for. They are specialised surgical nurses who want to care for surgical patients. As a result many are leaving to work in other clinical areas or hospitals. They say the stress and pressure that is being put on them feels untenable. As a result we have changed our strategy to conducting exit questionnaires which will now be conducted as a one-to-one interview by the Practice Education team who are felt to be impartial and whilst very senior are not seen as 'management'. We have also piloted clinical coaching sessions for Band 5 and Band 6 nurses/ ODP's which has been well received.

Medical staff can also be a significant challenge to recruit to particularly at Junior Doctor level. Some joint work will be undertaken by Directorates

working together to develop new and innovative ways to make such posts attractive.

Staff engagement
A significant amount of work has been carried out in the Clinical Board over the last 18 months to make this agenda a priority. The following are some of the highlights of the good work being done or being planned;

- Clinical Board and Directorate newsletters
- OD work ongoing in Theatres and HSDU to improve engagement
- Promoting the Health Board values and behaviours, including values based recruitment;
- Devising a HR Skills programme for managers;
- Team Development
- Each Directorate having a workforce plan that they can develop and own staff
- Succession Planning
- Talent Management
- Leadership & Development Programme ongoing in Theatres and HSDU
- Staff engagement week in September 2017
- Piloted clinical coaching sessions for Band 5 and Band 6 nurses/ ODP's

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Sickness absence
Whilst sickness absence is not at the UHB target levels all Directorates appear to be managing their sickness well.

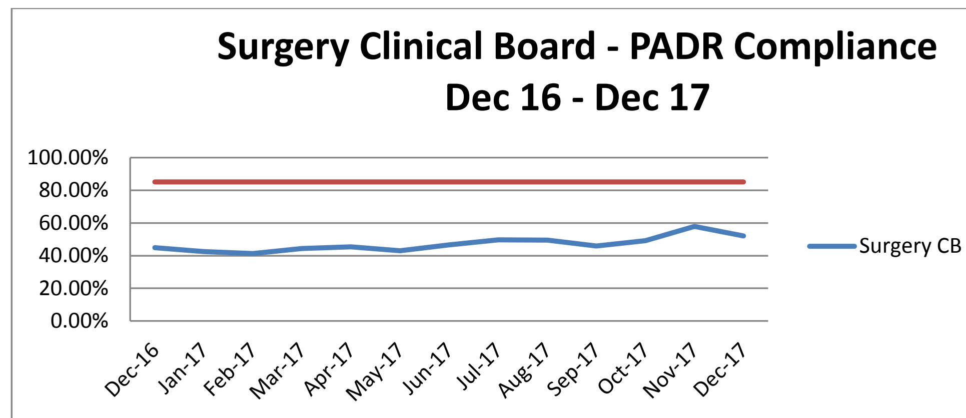
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
General Surgery & Urology	4.35%	4.38%	4.31%	4.28%	4.24%	4.64%
Urology					3.68%	1.98%
ENT/Oph	3.17%	3.27%	3.46%	3.66%	3.86%	4.30%
T&O	4.94%	5.03%	4.97%	4.97%	4.85%	4.73%
Peri-Operative Care	5.11%	5.21%	5.34%	5.37%	5.32%	6.38%
UHB Target	3.96%	3.96%	3.96%	3.96%	3.96%	3.96%

Actions that have been put in place to help support managers with this agenda are;

- Support for managers with both short and long term absence via: Bespoke training by the Workforce & OD Team Sickness Absence Surgeries with Line Managers, to discuss individual cases
- Compliance Against the Policy:
  Audit programme, focussing on hot spot areas to check;
  - Short and long term

- RTW Discussion compliance
- Accurate recording of reasons for sickness
- Health & Wellbeing Promotion via sickness surgeries and training

PADR compliance
PADR compliance has decreased to 59.21% in December against a UHB target of 85%. There are several areas that have completed PADRs to 100% and hot spot areas that the Clinical Board have focused on.



Actions to enable sustained improvement:
- Managers receive PADR ESR summary report from CB WOD on a monthly basis.
- Managers receive a detailed ESR PADR report from CB WOD, where they can see the details of each member of their team.
- Managers are now asked for projected dates of PADR's on a monthly basis
- CB WOD supporting managers with the use of ESR and how to upload PADRs once completed.
- CB WOD met with Senior Nurses and Clinical Leaders from Theatres in UHW to give a clear message regarding improvement. The same will happen with Senior Nurses and Clinical Leaders in UHL.
- CB SMT hold managers to account regarding performance with PADRs during performance reviews, confirm & challenge meetings, 1 to1 meetings, etc.

Awards and recognition

Many staff in the Clinical Board have received awards and recognition for the work they do to improve the lives for patients and their carers. Also many teams and individuals have had their work published or they have been invited to speak at conferences or present posters.

CAERDYDD A BRO MORGANNWG
CARDIFF AND VALE OF GLAMORGAN

9

Scrutiny Overview

Visiting Activity for the period:

08/09/17 – 27/10/17

January 2018

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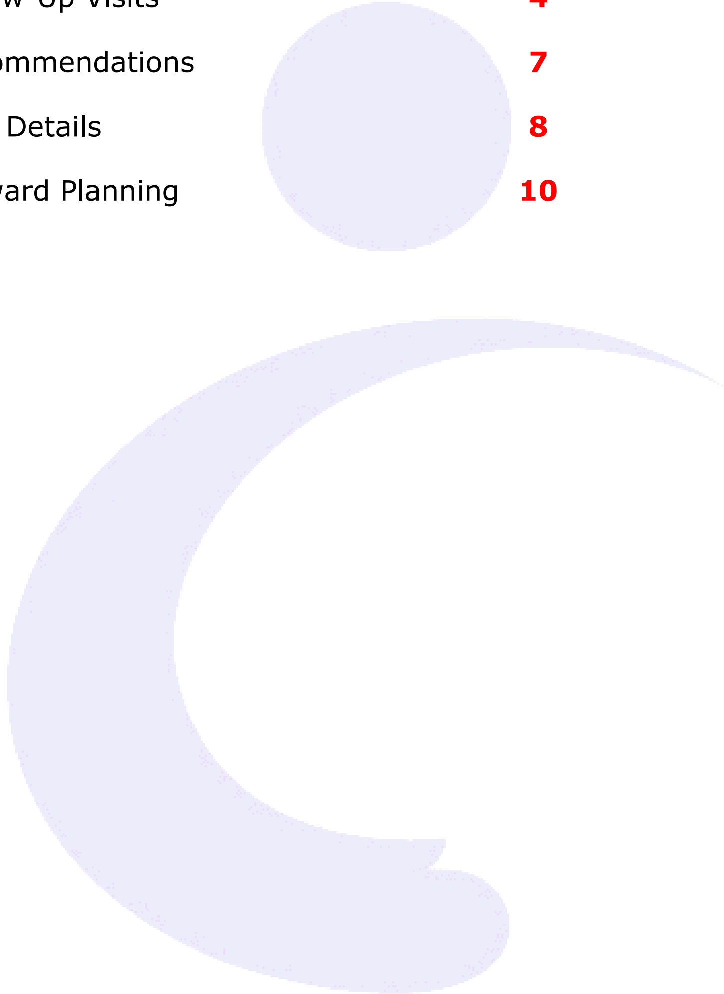

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Summary of Scrutiny Activity

Reporting Period – 08/09/17 to 27/10/17

This report is a considered overview of the scrutiny visiting activity from all visits undertaken between the 8 September 2017 and 27 October 2017. In total 6 visits were planned to be undertaken and all were completed. However, one visit report has been excluded as it wasn't submitted within the agreed timeframes.

The following reports, from outside the reporting period, have also been included:

- (**Visit Date 04/09/17**) Car Parking, Outpatient & Phlebotomy Facilities at Barry Hospital – Report not submitted to the UHB within agreed timescales for the November overview report.

Next Reporting Period – 28/10/17 to 05/01/18

The March Scrutiny Overview Report will incorporate all visit reports from the visits undertaken between the 28 October 2017 and 5 January 2018. In total 6 visits have been completed and are currently within the reporting process.

Looking Forward

The CHC has a schedule of visits planned until 31 March 2018 and each visit will be incorporated in to future overview reports.

In order to represent the views of the local community, we actively seek experiences in advance of, or during, our visits. We welcome all experiences, positive or negative. If you do wish to share your views/experiences on any of our planned visits, please contact us using the details below:

Telephone: 02920 750112
Email: cavog.chiefofficer@waleschc.org.uk
Address: Pro Copy Business Centre (Rear)
Parc Ty Glas
Llanishen
Cardiff
CF14 5DU

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Visiting Overview

Cardiff and Vale UHB

Concerns

Upon review of the visiting reports in the reporting period, the CHC has mapped the concerns and, due to the differing range of services visited, has been unable to identify specific themes. Therefore, we have highlighted the noteworthy issues only:

- **Support Staff** – In the visit report for Barry Hospital (Car Parking, Outpatients & Phlebotomy), members commented on the lack of staff at the hospital reception area, which impacts on the use of the parking terminal.
- **Planned Reduction in Parking –** Also in the visit report for Barry Hospital, members were concerned to hear of plans to reduce the number of parking spaces for patients, which currently appears to be working well. Should more services be provided from Barry Hospital, in line with the Shaping Our Future Wellbeing Strategy, this reduction will lead to access issues.
- **Equipment** – Issues were identified with the plan for replacing equipment, particularly in the UHL Endoscopy Unit, which is in contrast to the plan in place at UHW, which does not provide for consistency of service provision to patients.

Good Practice

- **Patient Support Groups** – In the visit to the Eye Clinics at UHW, members commended the establishment and continued support offered to the Cardiff Dystonia and Glaucoma Support Groups. This is no doubt supported by the partnership approach adopted at the clinics, with an Eye Clinic Link Officer being employed by the Cardiff Institute for the Blind, to offer front line support to visually impaired people and their carers.
- **Barry Hopsital** – Members specifically commented on the large range of services available at Barry Hospital, which ensures patients do not have to attend either UHW & UHL.

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Velindre NHS Trust

Concerns

The CHC visited only one area of the Velindre NHS Trust in this reporting period, that being the Chemotherapy Inpatient Unit located in the Velindre Cancer Centre. This segment provides a summary of the key points raised in the visit report, as opposed to a thematic overview.

- **Infection Control** – There were comments passed related to the lack of attention to cross infection policies by visiting staff.
- **Discharge** – Issues were identified with delays in discharge as a result of the time taken to provide large amounts of medication from Pharmacy.

Good Practice

- In order for the unit to maintain its priority of administering chemotherapy to patients, there are repatriation arrangements in place where existing inpatients may be transferred to their local District General Hospital.
- The provision of a patient area away from the ward environment, that is well equipped. Additionally, the use of volunteers to maintain the gardens.
- The provision of hand washing reminders at all sinks.
- The patient experience was extremely positive and this included comments about the food.

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Follow Up Visits

Resulting from our visits, members make recommendations for the improvement of the health service they have scrutinised. In turn, the Health Board/NHS Trust formally responds to these recommendations, identifying how they will action them and, in most cases, allocate a timeframe.

In order to sign off on these recommendations, the CHC undertakes follow-up visits a minimum of 6 months after the original visits, purely to determine whether recommendations have been actioned or not.

This report is a summary of the follow-up activity undertaken prior to the drafting period for this document, that being 15 December 2017. In total 7 follow-up visits were planned to be undertaken and 6 were completed, with 1 rescheduled.

UHB: Park View Health Centre, Cardiff (30 November 2017)

Date of Previous Visit: **1 August 2016**
Date of UHB Action Plan: **4 November 2016**

In total 1 recommendation was made during the original visit, which was provided an attributable action by the UHB and was subsequently agreed by Council. In regard to this recommendation, it was considered that it had not been achieved. The action(s) considered not to have been met are provided below:

- In the meantime, awaiting development of a new integrated cluster hub, the UHB would continue to undertake necessary urgent maintenance work, where this is needed for patients and staff safety. The following issues were identified to support the members aforementioned consideration:

  1) Although the roof had been repaired, there was still evidence of water leaks.
  2) Electrical cabling at the rear of the building remained exposed
  3) The door in the women's toilet had not been rehung causing an unnecessary obstacle
  4) The public toilets are not cleaned throughout the day, leaving facilities in a less than desirable state

5) There are no signs to assist patients in finding the disabled toilets
6) The building is now experiencing IT problems, which impacts service delivery
7) The window in the language centre requires repair

VELINDRE: Active Support Unit, Velindre Cancer Centre (4 December 2017)

Date of Previous Visit: **22 July 2016**
Date of UHB Action Plan: **5 October 2016**

In total 3 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 3 recommendations, it was considered that 2 were achieved in their entirety, with 0 being partly met. The action(s) considered not to have been met are provided below:

- The Trust would investigate ways in which they can provide a larger area to place toiletries in the vicinity of the shower (Now on First Floor Ward)

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VELINDRE: Radiotherapy Unit, Velindre Cancer Centre (4 December 2017)

Date of Previous Visit: **25 July 2016**
Date of UHB Action Plan: **5 October 2016**

In total 6 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 6 recommendations, it was considered that 5 were achieved in their entirety, with 1 being partly met.

VELINDRE: Outpatients Dept, Velindre Cancer Centre (4 December 2017)

Date of Previous Visit: **17 November 2016**
Date of UHB Action Plan: **23 February 2017**

In total 4 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 4 recommendations, it was considered that all 4 were achieved in their entirety.

VELINDRE: First Floor Ward, Velindre Cancer Centre (4 December 2017)

Date of Previous Visit: **20 February 2017**
Date of UHB Action Plan: **18 April 2017**

In total 2 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 2 recommendations, it was considered that all 2 were achieved in their entirety.

Summary of CHC Recommendation/Action Performance

Org.	Made	Achieved	Partly Achieved	Not Achieved	% Actioned
UHB	1	0	0	1	0%
Velindre	15	13	1	1	93%

* Please note, % actioned = sum of achieved + partly achieved

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Recommendations

Any recommendations made in this section of the report are additional to the recommendations made by members in regard to individual visits. They arise from thematic issues identified within this overview report, inclusive of the follow-up section.

Cardiff & Vale University Health Board (UHB) Visits

1. **UHB** – As part of the work around the 'Shaping our Future Wellbeing' Strategy, include central reception/information points in plans for the Locality Treatment Centres/Hubs.
2. **UHB** – Engage the CHC in regards to the changes to the parking at Barry Hospital and provide any related reports produced to date.
3. **UHB** – Following commendations on how well the two Endoscopy Units have been integrated, consider mirroring the replacement programme from UHW at the Llandough Hospital site.

Velindre NHS Trust (Trust) Visis

1. **VELINDRE** – To provide the CHC Velindre Oversight, Scrutiny & Performance Group with a briefing on the arrangements for existing patients who require transfers to local District General Hospitals and how well these arrangements are working.

Follow-up visits:

The **UHB & VELINDRE** are asked to provide an urgent action plan, within 2 weeks of the CHC Council meeting on **8th January 2018**, in regard to addressing their respective agreed actions that have yet to be completed following previous CHC visit reports.

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Visit Details

Reporting Period – 08/09/17 to 27/10/17

Type	Date	Service	Site	CHC Team	App.
Unannounced	04/09/17	Car Parking, Outpatients & Phlebotomy Facilities	Barry Hospital	Rob Henley (Lead) Gareth Williams	01
Announced	11/09/17	Endoscopy Unit	University Hospital of Wales (UHW)	Gareth Williams (Lead) Brenda Chamberlain	02
Unannounced	13/09/17	Endoscopy Unit	Llandough Hospital (UHL)	Gareth Williams (Lead) Moawia Bin-Sufyan	
Announced	25/09/17	Eye Clinics	University Hospital of Wales (UHW)	Eleri Jones (Lead) Bablin Molik	03
Announced	16/10/17	Community Dental Service	Barry Hospital	Lesley Jones (Lead) Matthew Wedlake	04
Announced	18/10/17	Ward East 6	Llandough Hospital (UHL)	Steven Place (Lead) Jane Jenkins	Excluded
Announced	27/10/17	Chemotherapy Inpatient Unit	Velindre Cancer Centre	Jane Jenkins (Lead) Leighton Rowlands	05
Type	**Date**	**Service**	**Site**	**CHC Team**	**App.**
Follow-up	30/11/17	Park View Health Centre	Ely, Cardiff South West	Eifion Pritchard (Lead) Matthew Wedlake Jane Jenkins	06
Follow-up	04/12/17	Active Support Unit	Velindre Cancer Centre	Eifion Pritchard (Lead) Christine Cave	07
Follow-up	04/12/17	Radiotherapy Unit	Velindre Cancer Centre	Eifion Pritchard (Lead) Christine Cave	08

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Follow-up	04/12/17	Outpatients Department	Velindre Cancer Centre	Eifion Pritchard (Lead) Christine Cave	09
Follow-up	04/12/17	First Floor Ward	Velindre Cancer Centre	Eifion Pritchard (Lead) Christine Cave	10

Next Reporting Period – 28/10/17 to 05/01/18

Type	Date	Service	Site	CHC Team	Stage
Unannounced	29/10/17	Ward B7	University Hospital of Wales (UHW)	Pat Matthews (Lead) Clare Clements Shirley Willis	
Educational	01/11/17	Radiology Department	University Hospital of Wales (UHW)	Rob Henley (Lead) Val Evans	
Unannounced	04/11/17	Emergency Unit	University Hospital of Wales (UHW)	Val Evans (Lead) Clare Clements	
Announced	15/12/17	Gwenwyn Ward	Llandough Hospital (UHL)	Alison Walker (Lead) Christine Cave	
Announced	18/12/17	Ward T2 Colorectal	University Hospital of Wales (UHW)	Eleri Jones (Lead) Leighton Rowlands	
Unannounced	20/12/17	Llanfair Unit & Wards East 14&16	Llandough Hospital (UHL)	Paul Davies (Lead) Eifion Pritchard	

Forward Planning

Date	Service	Site	Date	Service	
05/02/18	Physiotherapy Department	University Hospital of Wales (UHW)	28/02/18	Rainbow Ward	Childrens Hospital for Wales (CHfW)
08/02/18	Midwifery & Consultant Units	University Hospital of Wales (UHW)	05/03/18	Ward C4	University Hospital of Wales (UHW)
12/02/18	Restorative Dentistry	Dental Hospital @ UHW	09/03/18	Ward C1	University Hospital of Wales (UHW)
14/02/18	Island Ward	Childrens Hospital for Wales (CHfW)	14/03/18	Ward East 2	Llandough Hospital (UHL)
21/02/18	Ward East 4	Llandough Hospital (UHL)	19/03/18	Morfa Day Unit	Barry Hospital
23/02/18	Radiology Department	Dental Hospital @ UHW	26/03/18	Children's Kidney Centre	Childrens Hospital for Wales (CHfW)
26/02/18	Oral/Maxillo-Facial Surgery	Dental Hospital @ UHW	Quarter 4 TBC	Maggi Centre	Singleton Hospital (ABM UHB)

* Please note, unannounced visits are not publicised in advance

9

PRESSURE ULCER RISK ASSESSMENT, PREVENTION AND TREATMENT POLICY AND PROCEDURE

Name of Meeting Quality, Safety and Experience Committee

Date of Meeting 13 February 2018

Executive Lead : Executive Nurse Director
Author : CNS Wound healing -02921841591 kirsty.mahoney@wales.nhs.uk
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" and "Our service" elements of the Health Board's Strategy.
Financial impact : N/A
Quality, Safety, Patient Experience impact : • To reduce the risk of our patients developing pressure damage. • Promoting and implementing effective and consistent pressure ulcer assessment; • Ensuring that arrangements are in place to prevent pressure ulcers; and • Effective treatment of pressure ulcers should they develop.
Health and Care Standard Number :2.2 Preventing pressure and tissue damage
CRAF Reference Number :5.1.12
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION:

ASSURANCE is provided by:

- Full consultation across the UHB to ensure staff implementation and its integration into UHB pressure ulcer training programmes
- The policy is in line with national and international guidelines.
- Report to Clinical Board Quality and Safety Sub Committee meetings bi-monthly where each Clinical Board investigates, via a Root Cause Analyses, all category III, IV and un-stageable pressure damage.
- Continuing to identify the various causes of pressure damage and adopting appropriate preventative methods where possible
- Qualitative audit activity of compliance to inform risk assessments

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** The Pressure Ulcer Risk Assessment, Prevention and Treatment Policy and procedure

and

- **APPROVE** the full publication of the Pressure Ulcer Risk Assessment, Prevention and Treatment Policy and Procedure in accordance with the UHB Publication Scheme.

10.1

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SITUATION

The current Pressure Ulcer Risk Assessment, Prevention and Treatment Policy and Procedure was completed in 2012. Since completion of this document there have been changes to the recommendations on the management and treatment of pressure ulcers (European Pressure Ulcer Advisory Panel 2014) and the reporting mechanisms for all categories of pressure damage. It has therefore been necessary to update our Policy and Procedure to reflect these changes. In addition, our Policy and Procedure had to be separated to comply with the UHB's format. The Policy and Procedure documents underpin the Health Board's "Sustainability" and "Values" and "Our service" elements of the Health Board's Strategy. The guidance also reinforces compliance with Health and Care Standard Number 2.2 preventing pressure and tissue damage.

BACKGROUND

Pressure ulcers are painful and debilitating and, if left untreated, can lead to serious harm and death (National Patient Safety Agency, (NPSA) 2010; Whitlock et al, 2011). Every year up to 20% of patients in acute care in England and Wales are affected by pressure ulcers. Since 2005, the NPSA has received around 75,000 reports of patient safety incidents relating to pressure ulcers, yet a growing body of evidence suggests these are largely preventable (NPSA, 2010).

All national policies regarding pressure damage prevention, treatment and management are based on the recommendations within the International Guidelines (EPUAP- NPUAP- PPPIA, 2014).

ASSESSMENT

To ensure that Cardiff and Vale UHB is compliant with the Social Services and Well-being Act (Wales) 2014 and local and national guidelines it is necessary to develop clear rules on the assessment, treatment and management of pressure ulcers and safeguarding ensuring that the reporting process for pressure ulcers is consistent across the UHB.

A Task and Finish Group with representation from all Clinical Boards was established to address some of the inconsistencies in reporting, preventing and managing pressure damage across the UHB. The new Policy and Procedure were circulated for comments across all Clinical Boards and comments have been taken onboard and incorporated within document. The final document was taken back to the UHB Pressure Ulcer Task and Finish Group and contents were agreed prior to submission to the Nursing and Midwifery Board. The policy went out for consultation on 01/1/2018 on UHB intranet.

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Where appropriate comments were taken onboard and incorporated within the draft document. Only one comment was not taken onboard which requested sub-categories within the document - venous ulcers, arterial ulcers, neuropathic ulcers, incontinence-associated dermatitis/moisture lesions, skin tears, and intertrigo. This was not considered relevant for the policy which is pertaining to pressure ulcers only not other wounds types – this was fed back via email .

Compliance and monitoring will be done by:

- Each Clinical Board will monitor reporting of pressure ulcers through Datix and systems will be in place for ensuring learning is shared throughout the organisation so that similar mistakes are not being repeated in different clinical areas.
- Fundamentals of Care Audit to ensure that the procedure for risk assessment is being followed
- Prevalence audit due in January 2018 to monitor Pressure Ulcer prevalence
- The policy and procedure will by reviewed by the UHB Pressure Ulcer Task and Finish Group

The primary source for dissemination of this document within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: **Version Number:** 3	**Date of Next Review: 01/01/2020** **Previous Trust/LHB Reference Number: T/155**

PRESSURE ULCER RISK ASSESSMENT,PREVENTION AND TREATMENT POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently we will ensure that arrangements are in place to reduce the risk of our patients developing pressure damage.

Policy Commitment

This will be achieved by:-

- Promoting and implementing effective and consistent pressure ulcer assessment;
- Ensuring that arrangements are in place to prevent pressure ulcers; and
- Effective treatment of pressure ulcers should they develop.

Supporting Procedures and Written Control Documents

- This Policy is to be used in conjunction with supporting documents listed below: EPUAP (2014) –Pressure ulcer prevention quick reference guide
- AWTVN (2014) Essential elements of pressure ulcer prevention and management
- AWTVN (2013) All Wales reporting and investigation guide.
- NICE (2014) Pressure ulcers/prevention and treatment
- Social Services and Wellbeing Act (2014)

Scope

This policy and any supporting procedures and guidelines will be implemented by all employees, including those with honorary contracts, whilst providing care to adult and paediatric patients. It will apply in all care settings, including the community.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and found there to be little impact to the equality groups mentioned. Where appropriate we have taken or will make plans for the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation. ***Note: Policies will not be considered for approval without an EHIA***

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Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Nursing and Midwifery Board
Accountable Executive or Clinical Board Director	Executive Nurse Director

Disclaimer

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

Summary of reviews/amendments

Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	UHB 155 -The existing Policy and Procedure has been split into separate documents. Revision has been made to original document to reflect current international and national Guidance on Pressure ulcer assessment prevention and treatment Changes made to the Procedure include: Mental capacity Act added to documents to be read alongside. Minor amendments to the flow chart to reflect the changes in Barrier products on the UHB formulary
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Equality & Health Impact Assessment for

PRESSURE ULCER RISK ASSSESSMENT, PREVENTION AND TREATMENT POLICY AND PROCEDURE

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Pressure ulcer risk assessment, prevention and treatment policy and procedure
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Surgery Clinical Board/ PCIC Kirsty Mahoney/ Ceri Harris
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. We will ensure that arrangements are in place to reduce the risk of our patients developing pressure damage
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	• EPUAP (2014) • AWTVN (2014) . NICE (2014) **Pressure ulcer prevention: The prevention and management of pressure ulcers in primary and secondary care** *Clinical Guideline 179* at https://www.nice.org.uk/guidance/cg179/evidence/full-guideline-prevention-pdf-547610509

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	• list of stakeholders and how stakeholders have engaged in the development stages. This policy was sent for review to each Clinical Board • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	This states: **Be aware that all patients are potentially at risk of developing a pressure ulcer.** Neonates, infants, children and young people were also at risk of developing a pressure ulcer in a range of settings where NHS care is provided Neonates, infants, children and young people being admitted to secondary and tertiary care should receive a risk assessment. The Guideline Development Group (GDG) also felt that those receiving care in other situations, including those who receive on-going care in other NHS care settings such as primary care, community care or emergency departments may also be at risk. The GDG emphasised that neonates, infants, children and young people who are waiting to receive care, for example in an outpatient department may also be at risk. The prevention of pressure ulcers is becoming ever more important given an increase in the number of; older adults in the population, people with a disability and people being cared for in the community. People at risk of and who develop pressure ulcers exist within the entire healthcare framework, from people in their own home, to people in long term facilities such as residential and nursing home environments and those in acute care hospital settings. The below is taken from **Pressure ulcers: prevention and management of pressure ulcers -NICE guideline 2013** https://www.nice.org.uk/guidance/cg179/documents/pressure-ulcers-draft-nice-guideline-management-and-prevention2 All patients are potentially at risk of developing a pressure ulcer.

[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

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		However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity… Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards. (Here) in Wales, healthcare professionals should follow advice on consent from the Welsh Government. Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people at risk of developing or who have developed pressure ulcers. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care. This guideline covers people of all ages at risk of, or who have, a pressure ulcer. These terms are defined as follows: adults: 18 years or older neonates: under 4 weeks infants: between 4 weeks and 1 year children: 1 year to under 13 years Young people: 13 to 17 years.

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		• Health and Social Care Act (2015) **PART 7** refers to SAFEGUARDING which is applicable to: An adult/child who— • (a) is experiencing or is at risk of abuse or neglect, • (b) has needs for care and support (whether or not the authority is meeting any of those needs), and • (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The 2011 Census indicates that the population of Cardiff and the Vale is 474989, with 169,893 men and 176,197 women resident in the city[3]. 17.1% of the population is 0-14 years old, 69.8% of the population is 15-64 years old and 13.2% is 65+ years[3]. In terms of ethnicity, 84.7% of the population report being White, 2.9% of mixed ethnicity, 8% Asian, 2.4% Black, and 2% 'other' ethnic group[3]. The majority of the population report having a religious faith with 51.4% of the population Christian, 31.8% of no religion, 6.8% Muslim, 1.4% Hindu, 0.5% Buddhist, 0.4% Sikh, 0.4% other religion[3]. The largest proportion of the population report being single (45%), followed by married (38.5%), divorced (8.2%), widowed (6%), separated (2.1%) and in a civil partnership (0.2%) [3]. National pressure ulcer prevalence audit: The overall prevalence of pressure ulcers across Wales is 8.93% this is in line with data reported elsewhere, although higher than prevalence

[3] Cardiff Council (2015). Ask Cardiff: Cardiff and Vale profile. Available at: http://formerly.cardiff.gov.uk/content.asp?nav=2872,3257,6571,6572&parent_directory_id=2865&id=13784 [Accessed on 24th May 2016]

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		reported via Safety Thermometer from NHS England this audit reported all damage including category I whereas Safety Thermometer excludes Category I damage. Perhaps of greater significance the pressure ulcers identified as having occurred within the health boards (HAPU) are lower 4.02%, but this does equate to approximately 50% of the pressure ulcers recorded.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The Stake Holders include; All patients identified as being at risk of developing pressure damage All staff within the UHB Procurement in relation to TBM contract Industry in relation to TBM contract

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18;	The policy has a positive impact on patients Pressure damage can occur	No recommendations	

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
• between 18 and 65; and • over 65	and effect all age groups, however the very young and very old are at more risk of developing pressure damage (EPUAP 2014)		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	The policy has a positive impact as pressure damage could effect service users with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes. The positive impact is that individuals will receive high quality health care and will be protected from harm and neglect		

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.3 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	There appears to be no evidence to suggest that there has been a negative impact.		
6.4 People who are married or who have a civil partner.	There appears to be no evidence to suggest that there has been a negative impact.		

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There appears to be no evidence to suggest that there has been a negative impact.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears to be no evidence to suggest that there has been a negative impact.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a	There appears to be no evidence to suggest that there has been a negative		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
religious or philosophical belief	impact.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	There appears to be no evidence to suggest that there has been a negative impact.		
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	Service user/relative information has been translation into the Welsh language		

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There appears to be no evidence to suggest that there has been a negative impact.		
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	There appears to be no evidence to suggest that there has been a negative impact.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Non applicable		

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7. 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	Access equitable across all areas of deprivation	No recommendations	
7.2 People being able to improve /maintain healthy	The purpose of this policy is to prevent pressure damage	No recommendations	

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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
lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	and to empower patients and relatives to be actively involved in preventing pressure damage		

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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
7.3 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	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,	Overall the policy has a positive impact	No recommendations	

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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
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			
7.5 People in terms of social and community influences on their health: Consider the impact on	Overall a positive impact in prevention of pressure damage	No recommendations	

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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
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			
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	**This policy is influenced by Welsh Government programme to reduce to prevalence of pressure damage across Cardiff and Vale**	No recommendations	

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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			

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**

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	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?	Bi-yearly prevalence Audits to monitor prevalence Be-spoke education, consider mandatory education for Staff Dissemination across all Clinical Boards for comments, recommendations to enable ownership of policy	Lead Nurses CNS wound healing Podiatry	ongoing	
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?	Not required			

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	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	POD task and finish group Adherence to the policy will be be monitored through each Clinical Board Pressure ulcer prevalence To be monitored on a UHB level to observe Reduction in pressure ulcer Development Safeguarding referrals for Cat iii and IV pressure ulcer To be monitored which Should be reduced if Policy is adhered to.			

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8.5 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	POD task and finish group Adherence to the policy will be monitored through each Clinical Board Pressure ulcer prevalence To be monitored on a UHB level to observe Reduction in pressure ulcer Development Safeguarding referrals for Cat iii and IV pressure ulcer To be monitored which Should be reduced if Policy is adhered to.			

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	When this policy is reviewed, this EHIA will form part of that consultation exercise. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).			

10.1

Reference Number: **Version Number: 2**	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *T 185*

PRESSURE ULCER RISK ASSESSMENT, PREVENTION AND TREATMENT PROCEDURE

Introduction and Aim

Cardiff and Vale University Health Board (UHB) aims to reduce the risk of our patients developing pressure damage. This will be achieved by:-

- Promoting and implementing effective and consistent pressure ulcer assessment;
- Ensuring that arrangements are in place to prevent pressure ulcers; and
- Effective treatment of pressure ulcers should they develop.

This Procedure accompanies the Pressure Ulcer Risk Assessment, Prevention and Treatment Policy.

Objectives

The objectives of this document are:-

- To prevent avoidable pressure damage
- To inform and educate healthcare professionals in pressure ulcer risk assessment and prevention
- To ensure correct categorising/grading of pressure ulcers
- To ensure reliable delivery of the SKIN bundle
- To ensure provision of appropriate pressure relieving equipment

Scope

This procedure and any supporting procedures and guidelines will be implemented by all employees, including those with honorary contracts, whilst providing care to adult and paediatric patients. It will apply in all care settings, including the community.

Equality Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed. The EHIA found there to be a positive impact.
Documents to read alongside this Procedure	Equality , Diversity and Human rights Policy 2014 Consent to Examination or treatment policy 2016 Appendix a: Illustrative Clinical records- photography, video and audio

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	recordings Mental Capacity Act 2005 Protection of Vulnerable Adults Policy EPUAP (2014) Prevention Ulcer Prevention. Quick Reference Guide.
Approved by	Quality, Safety and Experience Committee
Accountable Executive or Clinical Board Director	Executive Nurse Director
Author(s)	Clinical Nurse Specialists – Wound Healing

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	*NA*	*11/09/2012*	NEW Procedure- UHB 155
2			The existing Policy and Procedure has been split into separate documents. Revision has been made to original document to reflect current international and national Guidance on Pressure ulcer assessment prevention and treatment Changes made to the Procedure include: Mental capacity Act added to documents to be read alongside. Minor amendments to the flow chart to reflect the changes in Barrier products on the UHB formulary

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Appendix 1: SKIN bundle

Appendix 2: Protocol for the Selection of Pressure Support Surfaces/Clinical Algorithm: Pressure Ulcers

References

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1. INTRODUCTION:

Pressure ulcer risk assessment and prevention is pertinent to all health care professionals and should begin as soon as the patient enters the health care system.

The purpose of the prevention recommendations is to guide evidence-based care to prevent the development of pressure ulcers. This procedure will apply to all vulnerable individuals of all age groups and is intended for the use of health care professionals who are involved in the care of patients and vulnerable people who are at risk of developing pressure ulcers, whether they are in a hospital, long-term care or assisted living at home regardless of their diagnosis or health care needs. It will also help to guide patients and carers on the range of prevention strategies that are available.

Pressure ulcers continue to be a significant complication of hospitalisation affecting all age groups and are costly in terms of resources and individual health outcomes which will result in patient harm, extended hospital stay and possible death. The financial implications of the treatment of pressure damage for the NHS are substantial.

The European Pressure Ulcer Advisory Panel (EPUAP) has agreed a definition and grading system for pressure ulcers. Ulcers can be categorised from I to IV with IV being the most severe. In 2014 EPUAP added unstageable and suspected deep tissue injury (SDTI). Cardiff and Vale University Health Board has adopted this approach. The cost of treating one Category/Grade 4 ulcer is £10,551 with a total cost for all category of ulcers approximately £1.4-2.1 billion annually in the UK, which equates to 4% of the total NHS expenditure (Bennett et al 2004).

It is envisaged due to an aging population that the number of patients with Pressure Ulcers will increase (European Pressure Ulcer Advisory Panel) (EPUAP 2014)

2. PROCEDURE STATEMENT AND AIMS:

Cardiff and Vale University Health Board (UHB) aim to reduce the risk of our patients developing pressure damage. This will be achieved by:-

- Promoting and implementing effective and consistent pressure ulcer assessment.
- Ensuring that arrangements are in place to prevent pressure ulcers; and
- Effective treatment of pressure ulcers should they develop.

3. SCOPE:

This procedure and any supporting procedures and guidelines will be implemented by all employees, including those with honorary contracts, whilst providing care to adult and paediatric patients. It will apply in all care settings, including the community.

4. OBJECTIVES:

The objectives of this procedure are:-

- To prevent avoidable pressure damage
- To inform and educate healthcare professionals in pressure ulcer risk assessment and prevention
- To ensure correct categorising/grading of pressure ulcers
- To ensure reliable delivery of the SKIN bundle
- To ensure provision of appropriate pressure relieving equipment

EPUAP PRESSURE ULCER DEFINITIONS AND CLASSIFICATION 2014

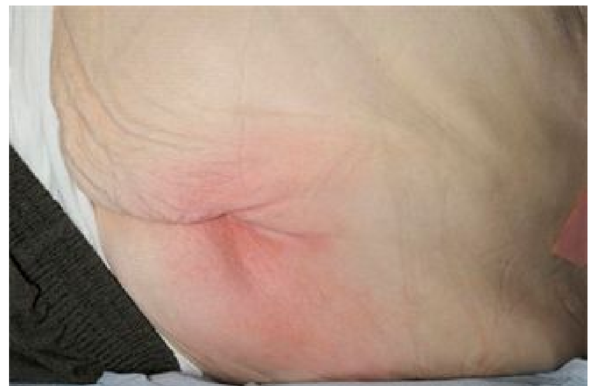
The UHB has adopted a common international definition and classification of pressure ulcers to document the level of tissue loss (EPUAP 2014).

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

Category I: Non-blanchable erythema of intact skin

Intact skin with non-blanchable erythema of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area

The area may be painful, firm, soft, warmer or cooler as compared to



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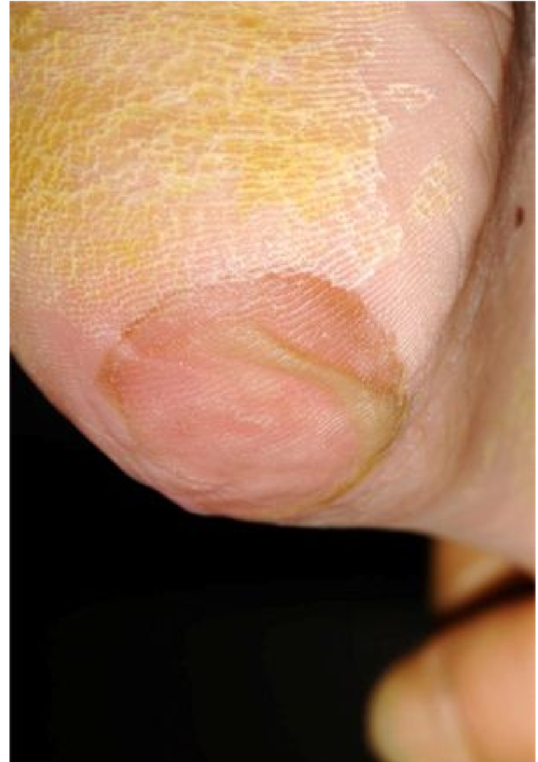
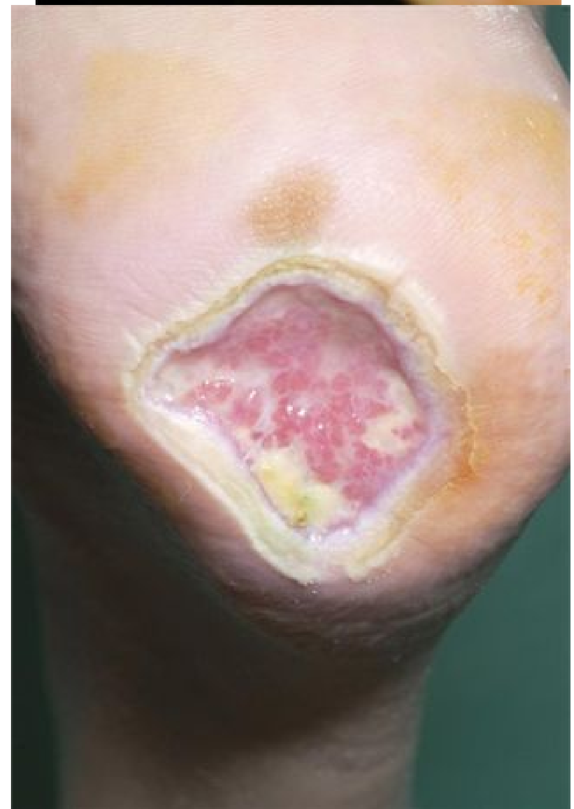
adjacent tissue. Category/ Stage I may be difficult to determine in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).

Category II: Partial thickness skin loss or blister

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured
serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category/ stage should not be used to describe skin tears, tape burns, perineal dermatitis, incontinence associated dermatitis, maceration or excoriation.

**Bruising indicates suspected deep tissue injury (SDTI)*





Category III: Full thickness skin loss

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.

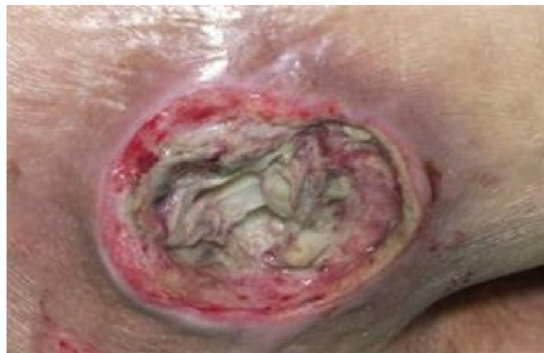
The depth of a category III varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have

subcutaneous tissue and Category III ulcers can be shallow. In contrast, areas
of significant adiposity can develop extremely deep Category III pressure ulcers. Bone/tendon is not visible or directly palpable.

Category IV: Full Thickness Tissue Loss

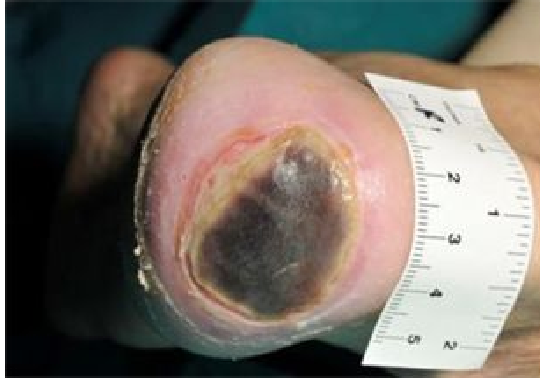
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling.

The depth of a Category IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/ tendon is visible or directly palpable.



Unstageable: Depth unknown
Full thickness skin loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.

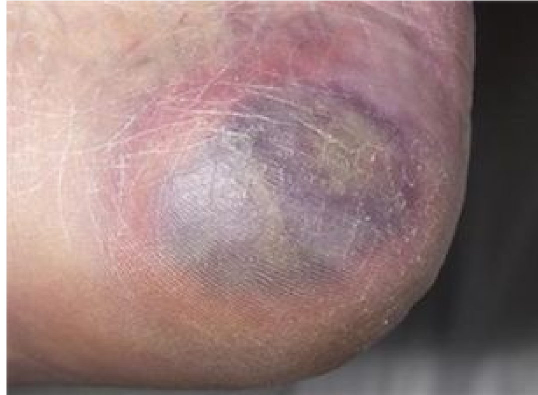
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore category cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance. Eschar on the heels serves as ‘the body’s natural (biological) cover’ and should not be removed.



Suspected Deep Tissue Injury (SDTI): Depth Unknown

Purple or maroon localized area of discoloured intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or sheer. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and may become covered with thin eschar. Evolution may be rapid exposing additional layers or tissue even with optimal treatment.



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SUMMARY OF THE RECOMMENDATIONS TO BE PUT IN PLACE TO ENSURE THE CLASSIFICATION OF PRESSURE ULCERS IS CORRECTLY PERFORMED

- Use a validated pressure ulcer classification system to document the level of tissue loss (EPUAP 2014).
- Educate healthcare professionals about special assessment techniques to be used in darkly pigmented individuals.
- Educate healthcare professionals on differentiating pressure ulcers from other types of wounds (e.g., venous ulcers, arterial ulcers, neuropathic ulcers, incontinence-associated dermatitis/moisture lesions, skin tears, and intertrigo).
- Educate professionals about the appropriate use of the classification system and the appearance of different tissue types at common pressure ulcer sites
- Do not use a pressure ulcer classification system to describe tissue loss in wounds other than pressure ulcers.
- Do not classify pressure ulcers on mucous membranes (EPUAP 2014).
- Consider adults and children with medical devices to be at risk of pressure ulcers; ensuring that medical devices are correctly sized and fit appropriately to avoid excessive pressure.

Key areas for consideration in pressure ulcer assessment and prevention are:-

- Risk assessment – assessing each patient's risk of developing a pressure ulcer and implement appropriate preventive measures.
- Identify intrinsic and extrinsic factors which may influence a patient's potential to develop pressure ulcers.
- Skin assessment to identify signs of pressure damage.
- Use of pressure relieving / reducing equipment and patient repositioning.
- Multi-disciplinary education and training.
- Provision of education and information to patients and carers

10.1

5. OUTCOMES:

The following provides the framework of assessment, prevention and treatment of pressure ulcers.

5.1 RISK ASSESSMENT AND PREVENTION

Practice Points:

- The Waterlow (adults) and Glamorgan (paediatrics) risk assessment tools are to be used in conjunction with clinical judgement and not as a tool in isolation from other clinical features.
- Risk assessment must be ongoing and frequency of re-assessment should be dependent on any change in the patient's condition.
- The following risk factors may influence the patient's potential to develop pressure ulcers. These must be considered when performing a risk assessment.

  - Reduced mobility or immobility
  - Spinal cord injury
  - Sensory impairment
  - Acute illness
  - Level of consciousness
  - Extremes of age
  - Vascular disease
  - Severe chronic or terminal illness
  - Previous history of pressure damage
  - Nutritional status e.g. Malnutrition and dehydration

Outcome statements:

5.1.1. All patients will have a risk assessment undertaken by a registered nurse using the Waterlow or Glamorgan Risk Assessment Tool.
5.1.2. All patients will have a risk assessment undertaken within the first **six** hours following the patient's admission to the acute care sector. Risk assessment must be ongoing and frequency of re-assessment should be dependent on any change in the patient's condition.
5.1.3. All patients will have a risk assessment undertaken on the **first assessment** visit in the Primary Care setting.
5.1.4. Date and time of initial assessment will be clearly documented in the patient care records.
5.1.5. All formal assessment of risk will be documented and made accessible to all members of the multi-disciplinary team.
5.1.6. All patients at risk of developing pressure ulcers will have an appropriate plan of care or implementation of the Skin bundle (appendix

1) prescribed by a registered nurse, which will be documented and evaluated as required.

5.1.7. Patients and carers will be involved in their plan of care as appropriate, patients who are willing and able should be encouraged, following education, to inspect their own skin.

5.2 SKIN INSPECTION:

Practice Points:

- Healthcare professionals will be aware of the following signs which may indicate pressure ulcer development:
  - Persistent erythema
  - Non blanching erythema
  - Discolouration
  - Localised heat
  - Pain
  - Localised oedema
  - Local induration
- Skin inspection will be based on an assessment of the most vulnerable areas of risk for each patient, typically, heels, sacrum, ischial tuberosities, femoral trochanters and occiput, early signs of pressure damage must be document on a body map.
- Patients with darkly pigmented skin pressure damage may present as: purplish / bluish localised areas on skin localised heat, localised oedema and localised induration.
- Studies have identified pain as a major factor for patients with pressure ulcers (Langemo *et al* 2000, Bale *et al* 2007). Several studies also offer some indication that pain over the site was a precursor to tissue breakdown (EPAUP 2014).

Outcome statements:

5.2.1. Educate professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response localised heat, oedema and induration (hardness).

5.2.2. Inspection of the skin (by a registered nurse) will be conducted at least every 8 hours or at every District nurse visit for patients who are at risk of developing pressure ulcers.

5.2.3. Changes in skin integrity will be documented immediately.

5.2.4. The condition of any existing ulcers will be categorised/graded using the European Pressure Ulcer Advisory Panel (2014) definition and classification and documented within the care notes and a body map completed. All entries should be signed, timed and dated by a registered nurse

5.2.5. Hospitalised patients will have anti-embolic stockings completely removed at **least once** daily and skin inspected **2-3 times a day** in accordance with the nursing care of patients wearing anti-embolic stockings (AES guidelines, 2015)
5.2.6 Observe the skin for pressure damage caused by medical devices (e.g., catheters, oxygen tubing, ventilator tubing, splints, semi rigid cervical collar, and pulse oximeter probes)
5.2.6. Ask patients to identify any areas of discomfort or pain that could be attributed to pressure damage.

5.3. PRESSURE ULCER PREVENTION:

Practice Points:

- Not all support surfaces are compatible with every care setting and should therefore not be based solely on the perceived level of risk for pressure ulcer development or the category of any existing pressure ulcers, nursing staff should take into consideration factors such as the patient's level of mobility within the bed, his/her comfort, the need for microclimate control, and the place and circumstances of care provision.
- Support surface use in a home setting requires consideration of the weight of the bed, the structure of the home, the width of doors, the availability of uninterrupted electrical power, and the ability to promote ventilation of heat from the motor. Smoking on dynamic a mattress is contraindicated due to the risk of combustion, patients that smoke in bed it may be necessary to complete a risk assessment and prescribe an alternative non- powered system to ensure patient safety.
- Patients who are at risk of pressure ulcer development should be re-positioned. The frequency of re-positioning must be determined by individual needs and skin inspection and not by a ritualistic schedule.
- Re-positioning should also take into consideration the patient's medical condition, their comfort and the overall plan of care.
- Repositioning frequency will be determined by the individual's tissue tolerance, his/her level of activity and mobility, his/her general medical condition, the support surface in use, the overall treatment objectives, and assessments of the individual's skin condition. Repositioning contributes to the individual's comfort, dignity, and functional ability.
- Assess the patient's skin condition and general comfort. If the patient is not responding as expected to the repositioning regime, reconsider the frequency and method of repositioning.

- Avoid subjecting the skin to pressure and shear forces. Use transfer aids to reduce friction and shear. Do not drag the individual while repositioning.

- Avoid positioning the patient onto bony prominences with existing non-blanchable erythema.

- Repositioning in the bed should be undertaken using the 30-degree tilted side-lying position (alternately, right side, back, left side) or the prone position if the individual can tolerate this and her/his medical condition allows.

- Avoid postures that increase pressure, such as the 90-degree side-lying position, or the semi-recumbent position.

- If sitting in bed is necessary, avoid head-of-bed elevation and a slouched position that places pressure and shear on the sacrum and coccyx.

- If limb elevation is required when sitting out of bed, ensure no additional pressure is applied to the heels, i.e. float heels off support surface.

- Record repositioning regimes, specifying frequency and position adopted, and include an evaluation of the outcome of the repositioning regime.

- Ensure that an appropriate manual handling risk assessment is completed and the repositioning regime documented as appropriate.

Education and Training about the role of repositioning in pressure ulcer and the correct methods of repositioning and use of equipment prevention should be offered to all persons involved in the care of patients at risk of pressure ulcer development, including the patient and significant others (where possible and appropriate).

Outcome statements:

All patients and their carers/family where appropriate, will be informed of their increased risk to pressure damage

5.3.1. All patients should be assessed and provided with a suitable support service according to their level of risk.

5.3.2. Re-positioning schedules will be agreed with the patient, recorded and established for each person at risk of pressure ulcers using the SKIN bundle, where implemented or an appropriate care plan.
5.3.3. Shear and friction damage will be minimised with correct use of manual handling devices and techniques.
5.3.4**.** After manoeuvring, slings and other parts of the handling equipment **will not** be left under the patient.
5.3.5. Water filled gloves, synthetic sheepskins or doughnut-type device **will not** be used as pressure relieving aids.
5.3.6. Patients or carers, who are willing and able, will be taught how to redistribute their weight.
5.3.7. Patients who are at elevated risk of pressure ulcers will restrict sitting time to less than 2 hours in a chair even with appropriate pressure relief.
5.3.8. Patients and carers will receive a full explanation and written information in the form of the Cardiff and Vale patient education leaflet on preventative measures to reduce the risk of pressure damage.
5.3.9 There should be clear documentation when a patient declines repositioning or appropriate support surfaces, following explanation and advice on the consequences. If cognitive impairment or mental capacity is questionable then mental capacity assessment should be considered.

5.4. PRESSURE RELIEVING DEVICES:

Practice Points:

- The positioning needs and support surface of all patients should be assessed and reviewed regularly.
- Re-positioning must still occur when individuals are on pressure relieving devices and documented using the repositioning charts or SKIN bundle communication tool.

Outcome statements:

5.4.1 The patient will be provided with the appropriate support system to correspond to their level of risk and will be in accordance with the UHB's Protocol for the Provision and Selection of Support Surfaces (Appendix 2).
5.4.2. Examine the appropriateness and functionality of the support surfaces on every encounter with the individual and verify that the support surface is being used within its functional life span, as indicated by the specific manufacturer's recommended test method (or other industry recognised test method).
5.4.3. All beds and dynamic mattresses will be delivered the same day if ordered before 15.00hrs by Medstrom (Acute Sector) depending on

availability. Community equipment will be provided within 5 working days depending on availability.
5.4.4. All patients assessed as being vulnerable to pressure ulcers will be placed on a Repose mattress/ cushion or wedge/ boots.
5.4.5. All patients undergoing surgery and assessed as being vulnerable will be placed on a high spec foam theatre mattress or other pressure re-distributing surface.
5.4.6. All patients with a category III or IV pressure ulcer will be nursed on a Duo 2 dynamic mattress.

5.5. PRESSURE ULCER MANAGEMENT:

Practice Points:

- Pressure damage must be categorised using the European Pressure Ulcer Advisory Grading system (2014).

- Nursing Documentation will include the following in line with the UHB Wound Assessment Chart:

  - Any changes in skin integrity
  - Site of Pressure ulcer
  - Category of Pressure ulcer
  - Dimensions of area/ulcer
  - Presence of pain, odour, exudate and infection

Outcome statements:

5.5.1. All patients with pressure damage will have details of the damage recorded and an incident form completed on DATIX. This will include an accurate recording of the location of the patient when the damage was first noted stating where and when damage occurred. The records will be checked to ensure that a DATIX entry has already been completed to avoid duplication. If the pressure ulcer deteriorates a new incident form is required.
5.5.2. All category III or IV pressure ulcers will be photographed by Medical Illustration / CNS Wound Healing in Primary care.
5.5.3. All patients with category III or IV pressure ulcers will be referred to the appropriate Clinical Nurse Specialist in Wound Healing who will liaise with other healthcare professionals as required.
5.5.4. All patients with Unstageable, category III or IV pressure ulcers will be reported to Safeguarding as a VA1. Health care acquired unstageable, grade III or IV pressure damage will also be investigated by a Senior Nurse using the All Wales RCA investigation tool.
5.5.5. Re-assessment of pressure ulcers will be performed at least weekly.

6. EDUCATION AND TRAINING:

All health care professionals will receive relevant training or education in pressure ulcer risk assessment and prevention, which will be structured, organised and comprehensive. Health care professionals with recognised training in pressure ulcer management will cascade their knowledge and skill to their colleagues. The implantation will be decided by each directorate. This forms part of the individual's overall professional development (Knowledge and Skills Framework 2004).

The Wound Healing Directorate has responsibility for training and educational programmes. The Learning, Education and Development Department will keep a record of staff that have undergone training and attended a study day.

There will be access to further departmental education as identified by audit or training needs analysis.

Patients who are vulnerable to or at an elevated risk of developing pressure ulcers and have capacity should be informed and educated about risk assessment, either verbally or with written information. Carers should be given NICE information booklet for carers and involved where appropriate (NICE 2014) by the Registered Nurse caring for the patient.

7. RESPONSIBILITIES:

The Board
The Board is responsible for ensuring that adequate provision is made to facilitate the implementation and monitoring of this procedure.

The Executive Director of Nursing
The Executive Director of Nursing has delegated responsibility for ensuring the Clinical Boards have the appropriate arrangements in place for the effective implementation of this procedure.

Clinical Board Management Teams

Clinical Board Teams are responsible for ensuring that this procedure is implemented within their Clinical Boards and Directorates/Business Units. Where there are difficulties in the implementation of this procedure they will bring this to the attention of the Executive Director of Nursing or Clinical Board Directors of Nursing.

Directorate Management Teams/ Business Units
Each Directorate/Business unit has a responsibility to ensure that staff are adequately supported and provided with the training to implement this procedure.

Ward/Departmental Managers
Individual managers and practitioners have the responsibility to promote standards of care as recommended by the procedure. Ward/Departmental Managers are responsible for enforcing compliance with the procedure and escalating any problems to their Directorate and Clinical board management teams as appropriate.

Employees
All health care professionals are personally accountable for their practice. Registered nurses have the prime responsibility for ensuring that the care given to the patient is focused on the assessment, planning and evaluations of the patient's needs in relation to pressure damage prevention.

Role of Wound Healing Team

The Wound Healing Team will be responsible for

- Ensuring specialist advice in relation to pressure ulcer risk assessment, prevention and treatment is available through the preparation of relevant policies and procedures
- Planning, measuring, reviewing and auditing pressure ulcer prevalence
- Assessing and devising a management plan for all patients with Category III and IV Pressure Ulcers
- Planning and delivering study days on pressure ulcer risk assessment, prevention and treatment.

8. RESOURCES:

Where many of the sections of the procedure are achievable within the existing resources, in order to facilitate multi-professional education and training there will be increased resource demands.

9. TRAINING:

Where it would be both impracticable and impossible to educate all staff in all aspects of care and management, as recommended by NICE (NICE 2005), it is recommended that members of the MDT have a basic level of knowledge in order to be NICE compliant (NICE 2005b) it is recommended that a basic level of knowledge related to the level of involvement of staff with patient care should be implemented.

This procedure represents existing practice within the UHB. Any costs associated with the implementation of this procedure will be met by the appropriate Corporate function or Divisions/Directorates as appropriate.

10. AUDIT:

The Wound Healing Directorate with the Preferred Supplier will undertake prevalence/ incidence audits to record accurate pressure damage data. The results of the audit will be used constructively to: -

- evaluate the effectiveness of prevention strategies
- evaluate the effectiveness of appropriate use of resources
- help to identify possible training and educational needs of staff
- identify any shortfalls in resources Utilise the Datix system to provide data to explore any opportunities for improvement in systems and process that support timely pressure ulcer prevention and management

In addition, the number of pressure ulcers will be recorded on the Health and Care Monitoring System (HCMS) monthly.

What audit requirements will there be for out of hospital care?

The number of hospital days between pressure damage will be recorded using the 1000lives Plus Safety Cross.

The findings of these audits will be reported to the Clinical Board/Directorate/Business unit Quality and Safety Groups as appropriate.

11. EQUALITY:

The UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Strategic Equality Plan and Equality Objectives. The responsibility for implementing the scheme falls to all employees and

UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB.

We have undertaken an Equality Impact Assessment and received feedback on this procedure and the way it operates. We wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was little impact to the equality groups mentioned. Where appropriate we have taken or will make plans for the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

12. IMPLEMENTATION AND DISTRIBUTION:

All members of the Multi-disciplinary Team should be aware of the Procedure and, ideally, have had basic education in pressure ulcer risk assessment. The Procedure will be made available on UHB Intranet, clinical portal and internet site. Where staff do not have access to the Intranet their line manager must ensure that a copy of this procedure is accessible

13. REVIEW:

This procedure will be reviewed every 3 years or sooner if appropriate.

Appendix 1

SKIN Bundle

Ascension Health in collaboration with the Institute for Healthcare Improvement developed the ‘SKIN’ bundle, that is a synergistic group of interventions to assist in the prevention of pressure damage (Gibbons et al 2006) .

The ‘SKIN bundle’ is a checklist of good practices for managing vulnerable patients, focusing on **S**urfaces, mattresses and cushions on which the patients lay or sit, the need to **K**eep the patients turning or moving, the need to manage **I**ncontinence and *i*ncreased moisture, and the importance of **N**utrition and hydration in preventing pressure damage.

Appendix 2

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THE PROTOCOL FOR THE SELECTION AND PROVISION OF SUPPORT SURFACES:

Every individual patient is at risk from tissue damage and requires assessment within 6 hours of admission into the health care setting. The Waterlow and Glamorgan risk assessment tools are used within the UHB. Risk assessment should be used as adjunct to clinical judgement and not as a tool in isolation from other clinical features.

The protocol is divided into two areas – prevention and treatment.

PREVENTION OF PRESSURE ULCERS:

- Patients at risk will be nursed on a high risk foam mattress.
- Patients with a high risk score, 15-20 on Waterlow, will be nursed on an appropriate overlay mattress in line with UHB bed contract.
- All patients with a very high risk score, 20+ on Waterow will be nursed on an appropriate overlay mattress or appropriate dynamic system when discussed and agreed by Medstrom Nurse Advisor.

TREATMENT OF CATEGORY I AND II PRESSURE ULCERS:

- Patients with category I and II pressure damage will be nursed on a Repose mattress as standard.
- Patients with category I and II pressure damage who are compromised and have other complications and consequently cannot be nursed on a standard Respose mattress may be nursed on a dynamic system after consultation with Medstrom Nurse Advisor.

TREATMENT OF CATEGORY III AND IV PRESSURE ULCERS/ SDTI/ UNSTAGEABLE:

- Patients with category III and IV pressure damage will be nursed on the appropriate dynamic system Duo 2 mattress after consultation with Medstrom Nurse Advisor.

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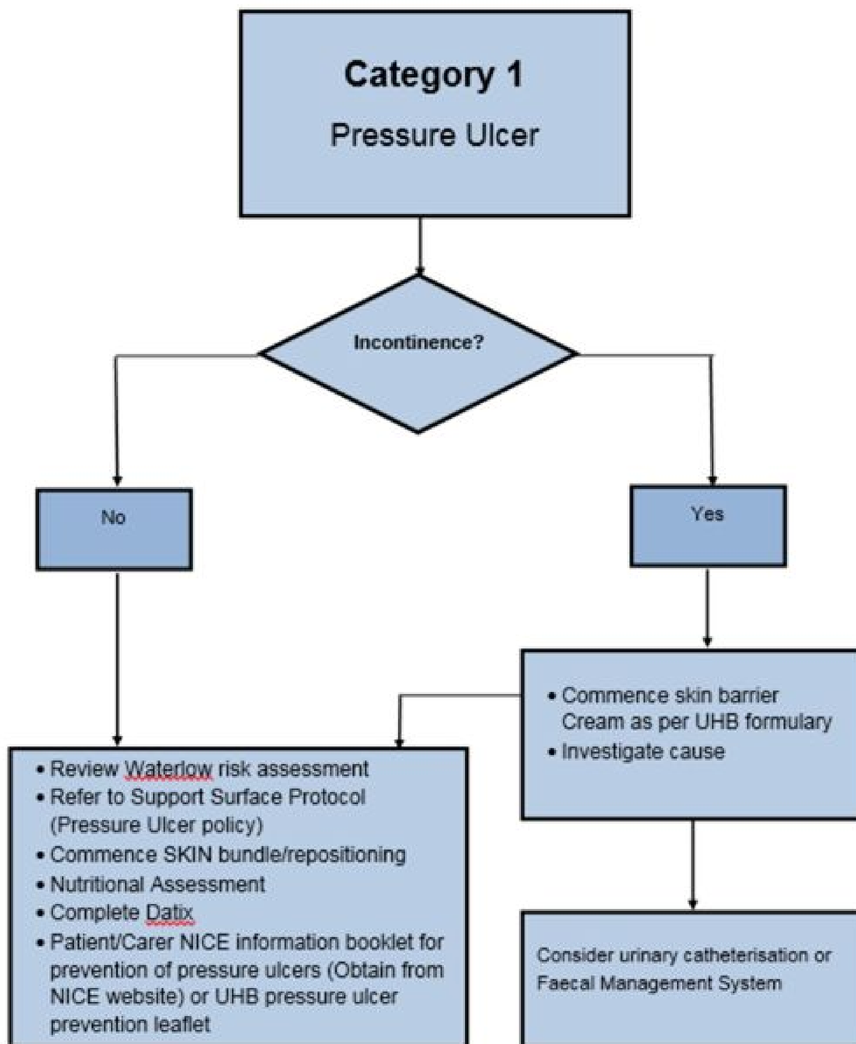

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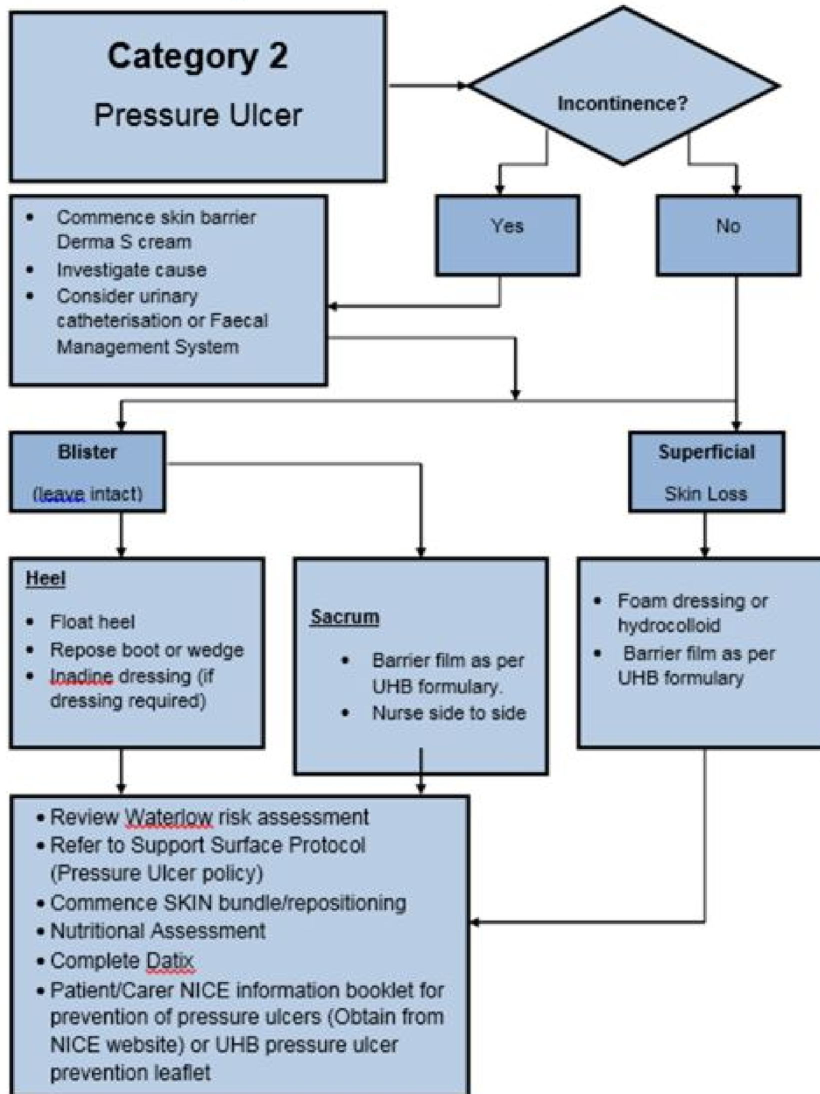

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Welsh Assembly Government (2003) *Fundamentals of Care. Guidance for Health and Social Care Staff*. Cardiff: Welsh Assembly Government.

Document Title: Pressure Ulcer Risk Assessment, Prevention and Treatment Procedure	25 of 25	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

MEDICINES MANAGEMENT POLICY
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 13th February 2018

Executive Lead : Medical Director
Author : Corporate Governance Manager and Nurse Advisor Medicines Management
Caring for People, Keeping People Well : Medicines Management Policy underpins the Health Board's commitment to avoid waste, minimise harm and avoid variation.
Financial impact : not applicable
Quality, Safety, Patient Experience impact : The Medicines Management Policy will provide members of the multidisciplinary team involved in all or part of the medicines management process, with a clear understanding of the Health Board's commitment to medicines management.
Health and Care Standard Number : 2.6 Medicines Management – people receive medication for the correct reason and receive the right medication, at the right dose and the right time.
CRAF Reference Number : 5.1 Deliver safe, effective and efficient care - Patient harm resulting from inadequate management of medication
Equality and Health Impact Assessment Completed: An EHIA is being prepared

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Aligning UHB Practice to the All Wales Policy for Medicines Administration Recording Review and Storage (MARRS 2015).
- Monthly Medicines Metrics Audit completed by Pharmacy and reported to the Clinical Boards.
- Annual secure storage of medicines audit, reported to Clinical Boards and UHB Medicines Management Group.
- Self-Assessment against Welsh Governments MARRS Policy.

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Medicines Management Policy.
- **SUPPORT** The provision of procedural guidance provided by The Medicines Code.
- **APPROVE** the full publication of the Medicines Management Policy and Code in accordance with the UHB Publication Scheme
- **APPROVE** delegation of responsibility for the approval of Procedures (The Medicines Code itself) to the Medicines Management Group

10.2

SITUATION

Cardiff and Vale UHB needs to ensure alignment to and implementation of The All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS). The Medicines Management Policy will set out the UHB's commitment to safe effective medicines management practice. Procedural guidance will be delivered via the Medicines Code.

BACKGROUND

Following the publication of the Trusted to Care Report (2014), subsequent Welsh Government spot checks of hospitals throughout Wales and the introduction of the Medicines Administration, Recording, Review, Storage and Disposal (MARRS) work stream, Cardiff and Vale University Health Board has conducted a full review of its medicines related policy and procedures. Trusted to Care and the MARRS work demonstrated a lack of knowledge of medicines policy and procedure within health care staff groups. Welsh Government produced the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS Policy), this policy was ratified in November 2015. Welsh Health Boards were subsequently required to review all their medicines related policies and procedures and align to the all Wales document.

ASSESSMENT AND ASSURANCE

In December 2017 the Committee approved the introduction of the Medicines Code which set out procedural guidance on medicines related practice and the subsequent withdrawal of 13 Policies/Procedures. On reflection, it was determined that the Medicines Code would in fact replace more than the 13 Policies/Procedures stated at the last meeting, these being:

- UHB 152 Inpatient Prescription Monitoring Endorsement and Supply Procedure
- UHB 204 Complimentary Medicines Guidelines
- UHB 226 Use of Unlicensed Medicines and Medicines Used Outside their Product License Procedure
- UHB 266 Non-Medical and Dental Prescribing Policy
- Ref 270 Use of Bedside Medicine Cabinets for Wards Without a POM Service Medicines Management Procedure
- Ref 242 Writing Prescriptions Policy

All out of date documents are listed in Appendix 1 of the Medicines Code and will be withdrawn from circulation once final approval is obtained.

It is acknowledged that, in line with UHB standards, an overarching Policy should be produced to support the safe management of medicines. The large document approved by the Committee in December, The Medicines Code, should be treated as a Procedural document and the Medicines Management Group be given responsibility for keeping the document up to date and in line with changing standards.

In addition the following policy/procedure documents will be reviewed in February 2018.

- UHB 233 Prescribing, Dispensing and Administration of Oral Methotrexate Procedure
- Ref 246 Pre Printed Prescription Labels Procedure
- Ref 268 Monitored Dose Systems
- UHB 225 Take Home Medication (TTH) on Adult Short Stay Surgical and Gynaecology Areas Procedure

10.2

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

The Medicines Management Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will uphold the Health Board's commitment to avoid waste, minimise harm and avoid unwanted variation.

The Health Boards Medicine Code sets out procedural guidance to facilitate implementation of these policy principles.

Policy Commitment

The UHB will ensure that people receive medication for the correct reason and receive the right medication, at the right dose and the right time. Procedural guidance to support this is presented as The Medicines Code.

Supporting Procedures and Written Control Documents

- The Medicines Code

Other supporting documents are:

- All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal.
- Cardiff and Vale Good Prescribing Guide.
- Management of Parenteral Cytotoxic Chemotherapy.
- Extravasation Policy
- NMC Standards for Medicines Management.

Scope

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

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) is being completed
Policy Approved by	UHB Quality Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	UHB Medicines Management Group

10.2

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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

Document Title: *Insert document title*	2 of 2	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Accountable Executive or Clinical Board Director	Medical Director.

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	This is a new overarching Policy to support the procedural guidance contained within the Medicines Code.
2			

10.2

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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

REVIEW OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE TERMS OF REFERENCE
Name of Meeting Quality Safety and Experience Committee **Date of Meeting** 13th February 2018

Executive Lead: Executive Nurse Director
Author: Corporate Governance Manager, 029 2074 3111
Financial impact NA
Quality, Safety, Patient Experience impact
Health and Care Standard Number: Governance Leadership and Accountability
CRAF Reference Number 8 Governance
Equality and Health Impact Assessment Completed: No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Regular annual review of the Terms of Reference as well as adjustments made by the Board in November 2017.

The Quality Safety and Experience Committee is asked to:

- **APPROVE** the revised Terms of Reference of the Quality, Safety and Experience Committee for 2018 -2019.

11

SITUATION

The purpose of this paper is to provide a revised Terms of Reference which set out the purpose, authority, membership and function of the Quality, Safety and Experience Committee for 2018-2019

BACKGROUND

The University Health Board (UHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

In line with standing orders (and the UHB Scheme of Delegation), the Board has established the Quality, Safety and Experience Committee. This Committee's focus is on ensuring patient and citizen quality, safety and experience including activities traditionally referred to as 'clinical governance'.

ASSESSMENT

In November 2017 the Chair, in consultation with the Independent Members, reviewed and finalised membership of the Committees. As an integral part of this work, the opportunity was taken to review the Terms of Reference for a number of Committees. As such, the Board agreed the following changes to the Terms of Reference for the Committee to take effect from 1st January 2018:

- A reduction in the minimum number of Independent Members from 5 to 4. The quorum remains 3 members with the need for the Chair or Vice Chair to be present.

  Membership of the Committee is currently:

  - Cllr Susan Elsmore, Chair
  - Akmal Hanuk
  - Michael Imperato
  - Maria Battle
  - A N Other - *to be confirmed*

- The removal of the need for the Audit Committee Chair to be a member of the Committee. However, a member of the Audit Committee would still need to be a member of the Quality, Safety and Experience Committee. This member is, as yet, to be identified.

The Chair of the Committee is awaiting finalization of membership before selecting a Vice Chair of the Committee.

The Board was also advised that a further review of Committee working was scheduled for the Board Development Day later in February, when it was anticipated that two new Independent Members (Trade Union and Cardiff University) would have joined the Board.

It is recommended that the Terms of Reference be amended to reflect the changes agreed by the Board.

Quality, Safety and Experience Committee

Terms of Reference and Operating Arrangements

Approved at QSE on 21st February 2017
Updated at Board on 30th November 2017
Considered for approval at QSE on 13th February 2018

11

1. INTRODUCTION

1.1 The University Health Board (UHB) Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders (and the UHB Scheme of Delegation), the Board shall nominate a Committee to be known as the **Quality, Safety and Experience Committee**. This Committee's focus is on ensuring patient and citizen quality and safety including activities traditionally referred to as 'clinical governance'. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Experience Committee "the Committee" is to provide:

- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to quality, safety and experience of health services;
- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality, safety and experience of public health, health promotion and health protection activities;
- ***assurance*** to the Board in relation to the UHB arrangements for safeguarding and improving the quality and safety of patient and citizen centred health improvement and care services in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales;
- ***assuranc***e to the Board in relation to improving the experience of patients, carers citizens and all those that come into contact with our services including those provided by other organizations or in a partnership arrangement

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its ***provision of advice*** to the Board:

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- oversee the initial development of the UHB plans for the development and delivery of high quality and safe healthcare and health improvement services consistent with the Board's overall Strategy and any requirements and standards set for NHS bodies in Wales;

- consider the implications for quality, safety and experience arising from the development of the UHB Strategy, Integrated Medium Term Plan or plans of its stakeholders and partners, including those arising from any Joint Committees of the Board;

- consider the implications for patient and citizen experience arising from internal and external review/investigation reports and actions arising from the work of external regulators;

- consider the outcomes for patient feedback methodologies in line with the National Service User Framework

- review achievement against the Health and Care Standards in Wales to inform the Annual Quality and Annual Governance Statements;

- consider and approve policies as determined by the Board.

- monitor implementation of the Quality, Safety and Improvement (QSI) Framework

3.2 The Committee will, in respect of its ***assurance role***, seek assurances that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and improvement services across the whole of the UHB activities and responsibilities.

3.3 To achieve this, the Committee's programme of work will be designed to ensure that, in relation to all aspects of quality, safety and patient and citizen experience:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;

- the organization, at all levels has a citizen centred approach, putting citizens, patients and carers, patient safety and safeguarding above all other considerations;

- the care planned or provided across the breadth of the organization's functions is consistently applied, based on public health principles, sound evidence, clinical effectiveness and meets agreed standards;

- the organization, at all levels has the right systems and processes in place to deliver, from a patient, carer and citizen perspective - efficient, effective, timely and safe services;
- the organization has effective systems and processes to meet the Health and Care Standards;
- the workforce is appropriately selected, trained, supported and responsive to ensure safe, quality and patient centred services ensuring that regulatory arrangements, professional standards and registration/revalidation requirements are maintained;
- there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organization;
- there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;
- risks are actively identified and robustly managed at all levels of the organization;
- decisions are based upon valid, accurate, complete and timely data and information;
- there is continuous improvement in the standard of quality and safety across the whole organization – continuously monitored through the Health and Care Standards in Wales;
- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that:
    - sources of internal assurance are reliable, e.g., internal audit and clinical audit teams have the capacity and capability to deliver;
    - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
    - appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims, known collectively as ‘concerns’, (noting that concerns information is routinely included in the standing item on the Board agenda (Patient Safety Quality and Experience Report) and will not be duplicated in Committee)

3.4 The Committee will advise the Board on the adoption of a set of key indicators of safety, quality and patient and citizen experience against

which the UHB performance will be regularly assessed and reported on through the Annual Quality Statement.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee, Sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Board has approved the following sub-Committees:

- 8 Clinical Board Quality and Safety sub-Committees

3.8 The Committee has authority to establish short life working groups which are time limited to focus on a specific matter of advice or assurance as determined by the Board or Committee.

4. MEMBERSHIP

Members

4.1 A minimum of four (4) members, comprising:

Chair Independent Member of the Board

Members 3 other Independent Members of the Board, to include a Member of the UHB Audit Committee.

The Committee may also co-opt additional independent ‘external’ members from outside the organization to provide specialist skills, knowledge and expertise.

Attendees

4.2. The following officers **are required to be in attendance**:

- Executive Nurse Director (Lead Executive)
- Medical Director
- Director of Therapies and Health Sciences
- Chief Operating Officer
- Director of Public Health
- Director of Finance
- Director of Planning
- Board Secretary/Director of Corporate Governance
- Assistant Director of Patient Safety and Quality
- Assistant Director of Patient Experience

Key Directors should be represented if they are unable to attend a meeting.

Other Executive Directors or deputies should attend from time to time as determined by the Committee Chair.

4.3. By invitation:

The Committee Chair may extend invitations to attend Committee meetings as required from within or outside the organization to whom the Committee considers should attend, taking account of the matters under consideration at each meeting.

- 2 x Staff Representatives and
- the Cardiff and Vale of Glamorgan Community Health Council.

Secretariat

4.4 Secretary: as determined by the Board Secretary/Director of Corporate Governance.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board,

based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair and, where appropriate on the basis of advice from the UHB Remuneration and Terms of Service Committee.

Support to Committee Members

4.7 The Board Secretary/, Director of Corporate Governance on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for Committee members in conjunction with the Director of Workforce and Organizational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held bi-monthly, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB Annual Plan of Board Business.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the

quality and safety of healthcare for its citizens. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organization, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the UHB values, corporate standards, priorities and requirements, for example, public health, equality, diversity and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of the Annual Quality Statement.

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example, AGM, or to community partners and other stakeholders, where this is considered appropriate, for example, where the Committee's assurance role relates to a joint or shared responsibility.

7.3 The Board Secretary/Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

9. REVIEW

9.1 These Terms of Reference and operating arrangements shall be reviewed on a biennial basis by the Committee with reference to the Board.

The Board will keep under review the need for the 8 Quality and Safety Sub-Committees to ensure an alignment with accountabilities and responsibilities of the Clinical Board organizational model.

COMMITTEE WORKPLAN 2018-19
Name of Meeting Quality Safety and Experience Committee **Date of Meeting:** 13th February 2018

Executive Lead: Executive Nurse Director
Author: Assistant Director Patient Safety and Quality
Financial impact NA
Quality, Safety, Patient Experience impact
Health and Care Standard Number: Governance Leadership and Accountability
CRAF Reference Number 8 Governance
Equality and Health Impact Assessment Completed: No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Inclusion of items identified in the CRAF, Health and Care Standards as well as recommendations from external reports.

The Quality Safety and Experience Committee is asked to:

- **APPROVE** the Committee Work Plan for 2018 -2019.

SITUATION

The purpose of this paper is to provide a revised Work Plan for the Committee until March 2019.

The UHB has a significant and challenging Patient Quality, Safety and Experience agenda to progress across the organisation. The Board has delegated the monitoring and scrutiny of these arrangements to the Quality, Safety and Experience Committee. In order to inform the development of this work across the UHB, the Committee needs to consider and approve an Annual Work Plan in order to structure the work of the Committee over the coming year. As part of its approval, the Committee needs to agree to review the appropriateness of the programme in light of the changing quality and safety agenda for NHS Wales.

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ASSESSMENT

The publication of the Francis Report in Mid Staffordshire NHS Foundation Trust, The Berwick Review in to Patient Safety and the report by Sir Bruce Keogh into quality of care and treatment in England all highlighted the need for transparency and rigour in identifying and addressing quality and safety issues. The Quality Delivery Plan for NHS Wales sets national direction and Organising for Excellence provides the UHB strategic direction, while Safe Care, Compassionate Care – A National Governance Framework to enable high quality care in NHS Wales 2013, sets out the NHS Wales response to the Francis report with a pledge to build on the progress made and to ensure that the system is:

- Providing the highest possible quality and excellent patient experience
- Improving health outcomes and reducing health inequalities
- Getting high value from all our services

The delivery of safe, high quality care is not just about systems, but also the culture, values and behaviours that organisations and staff exhibit which are equally important. It is this which has the greatest impact in ensuring all patients and service users get the very best standards of care. It is the responsibility of the Board to ensure an appropriate culture exists and is cultivated within the organisation, reflecting the core values of NHS Wales:

- **Putting quality and safety above all else:** providing high value evidence based care for our patients at all times
- **Integrating improvement into everyday working** and eliminating harm, variation and waste
- **Focusing on prevention, health improvement and inequality** as key to sustainable development, wellness and wellbeing for future generations of the people of Wales
- **Working in true partnerships** with partners and organisations and with our staff
- **Investing in our staff** through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively

The Quality, Safety and Experience Committee Annual Work Plan for 2018-2019 is attached as Appendix 1. The Programme attempts to capture the 'core' quality and safety related business of the UHB as outlined within the Committee's Terms of Reference. The Committee has also agreed that the work programme would be subject to periodic review in order to ensure it remained 'fit for purpose'.

In developing its work programme, in addition to national strategic drivers, the Committee has also considered the Corporate Risk Assurance Framework.

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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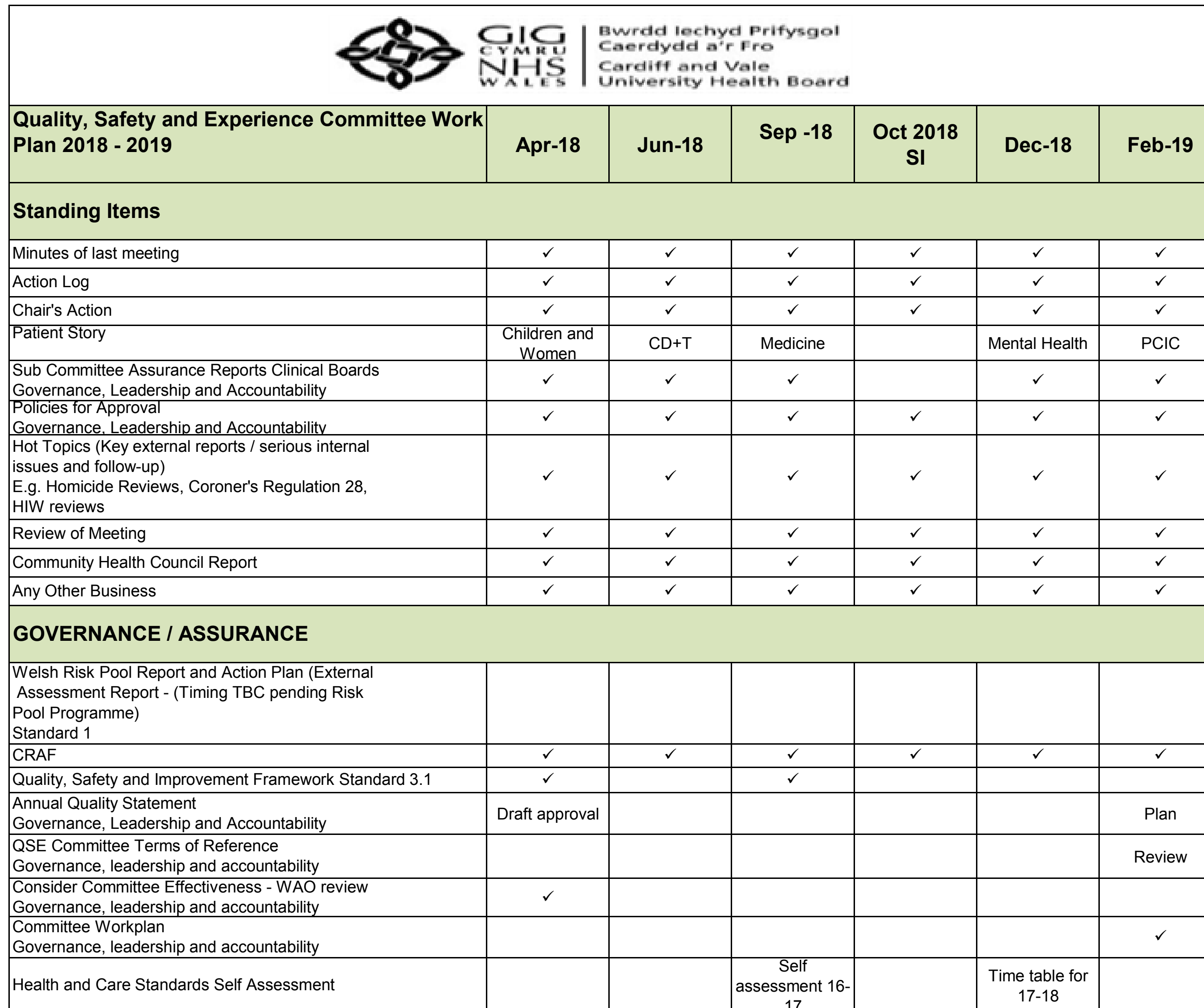
Cardiff and Vale University Health Board



Quality, Safety and Experience Committee Work Plan 2018 - 2019	Apr-18	Jun-18	Sep -18	Oct 2018 SI	Dec-18	Feb-19
Standing Items						
Minutes of last meeting	✓	✓	✓	✓	✓	✓
Action Log	✓	✓	✓	✓	✓	✓
Chair's Action	✓	✓	✓	✓	✓	✓
Patient Story	Children and Women	CD+T	Medicine		Mental Health	PCIC
Sub Committee Assurance Reports Clinical Boards Governance, Leadership and Accountability	✓	✓	✓		✓	✓
Policies for Approval Governance, Leadership and Accountability	✓	✓	✓	✓	✓	✓
Hot Topics (Key external reports / serious internal issues and follow-up) E.g. Homicide Reviews, Coroner's Regulation 28, HIW reviews	✓	✓	✓	✓	✓	✓
Review of Meeting	✓	✓	✓	✓	✓	✓
Community Health Council Report	✓	✓	✓	✓	✓	✓
Any Other Business	✓	✓	✓	✓	✓	✓
GOVERNANCE / ASSURANCE						
Welsh Risk Pool Report and Action Plan (External Assessment Report - (Timing TBC pending Risk Pool Programme) Standard 1						
CRAF	✓	✓	✓	✓	✓	✓
Quality, Safety and Improvement Framework Standard 3.1	✓		✓			
Annual Quality Statement Governance, Leadership and Accountability	Draft approval					Plan
QSE Committee Terms of Reference Governance, leadership and accountability						Review
Consider Committee Effectiveness - WAO review Governance, leadership and accountability	✓					
Committee Workplan Governance, leadership and accountability						✓
Health and Care Standards Self Assessment			Self assessment 16-17		Time table for 17-18	

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Quality, Safety and Experience Committee Work Plan 2018 - 2019	Apr-18	Jun-18	Sep -18	Oct 2018 SI	Dec-18	Feb-19
HEALTH PROMOTION PROTECTION AND IMPROVEMENT						
Reports as and when required (to be determined)						
SAFE CARE						
Serious Patient Safety Incident report Standard 2				✓		
Patient Safety Solutions Compliance Standard 2	✓		✓			
Blood Management Standard 2.8			✓			
Safety Walkrounds Standard 2.1 CRAF 5.1			✓			
Infection Prevention and Control (Tier 1) Exception Reports Standard 2.4 CRAF 5.1 / 5.2 (high risk)		✓			✓	
Cleaning Standards Standard 2.4 CRAF 5.2 (high risk)		✓			✓	
Patient Falls Exception Reports Standard 2.3 CRAF 5.1.9 (high risk)	✓			✓		
Medication Standard 2.6 CRAF 5.1.8		✓			✓	
Nutrition and Hydration Standard 2.5 CRAF 5.1.9	✓		✓			
Safeguarding QOF Annual Self Assessment - time tbc						
Safeguarding **(in private)** Standard 2.7 CRAF 5.4	✓	✓	✓	✓	✓	✓
Protecting Patients from Pressure Damage Standard 2.2 CRAF 5.1.12		✓			✓	
POCT		✓			✓	
Care of the Deteriorating Patient (NEWS) Exception Reports Standard 3.1 CRAF 5.1.2 (high risk)			✓			✓

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Quality, Safety and Experience Committee Work Plan 2018 - 2019	**Apr-18**	**Jun-18**	**Sep -18**	**Oct 2018 SI**	**Dec-18**	**Feb-19**
Medical Devices Standard 2.9 CRAF 8.1.8			✓			

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Quality, Safety and Experience Committee Work Plan 2018 - 2019	Apr-18	Jun-18	Sep -18	Oct 2018 SI	Dec-18	Feb-19
EFFECTIVE CARE						
Mortality and Harm Standard 3.1 CRAF 5.5.1		✓			✓	
UHB Clinical Audit Plan 2017 - 2018 (and Progress) Standard 3.1	2018/2019				Progress update	
Cancer Reviews (as reported) Standard 3.1	✓	✓	✓		✓	✓
Research and Development update Standard 3.3			✓			
LIPS Standard 3.3 CRAF 5.1					✓	
NICE Guidance Standard 3.1 CRAF 5.1			✓			

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Quality, Safety and Experience Committee Work Plan 2018 - 2019	Apr-18	Jun-18	Sep -18	Oct 2018 SI	Dec-18	Feb-19
DIGNIFIED CARE						
HIW activity update; primary care inspections as requird Standard 4.1	✓	✓	✓		✓	✓
Carer Measure Standard 4.1 CRAF			✓			
TIMELY CARE						
Outpatient Follow up and survelliance processes Standard 5.1 CRAF		✓			✓	
INDIVIDUAL CARE						
Sensory Loss Standard 6.2 People's Rights		✓				

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WALES AUDIT OFFICE REPORT ON DISCHARGE PLANNING
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 13th February 2018

Executive Lead : Chief Operating Officer
Author : Head of Integrated Care ***Phone/ Ffôn:*** *ext 43694* ***Email: Judith.A.Hill@wales.nhs.uk***
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" ,"Values" and Delivering Outcomes that Matter to People elements of the Health Board's Strategy.
Financial impact : Not Applicable
Quality, Safety, Patient Experience impact: External audit provides valuable feedback and assurance in relation to the quality and safety of services and how well organisations work together to affect the Patient experience. It also provides opportunity to consider the patient, family and carer experience, as well as providing staff the opportunity to input their views into the report.
Health Care Standard Number : Standard 3.1 5.1,6.1
CRAF Reference Number: 2.1.1, 6.2.1, 11.2.5.1.
Equality and Health Impact Assessment Completed: Not Applicable

RECOMMENDATION

ASSURANCE is provided by:

- The development, implementation and monitoring of improvement plans to address recommendations
- Confirmation from the Wales Audit Office that Health Board has robust discharge improvement plans, strong performance management arrangements and performance overall is improving but there is scope to improve ward staff training and awareness of policies and community services.

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the main findings of the Wales Audit Office review
- **AGREE** that the action plan addresses the recommendations made with the Wales Audit Office report.

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SITUATION

This report is intended to inform the committee of the recommendations made following a Wales Audit Office (WAO) review entitled – Discharge Planning – Cardiff and Vale Health Board which was reported in August 2017 and made

available to the public in December 2017 and is available for viewing at https://www.wao.gov.uk/publication/cardiff-and-vale-university-health-board-discharge-planning

The review sought to examine whether the Health Board has sound governance and accountability arrangements in relation to discharge planning. The work focused specifically on whether the Health Board has;

- A sound strategic planning framework in place for discharge planning;
- Effective arrangements to monitor and report on discharge planning; and
- Taken appropriate action to manage discharge planning and secure improvements.

The paper seeks to assure the Committee that action is being implemented in response to the findings of the review and that appropriate monitoring of progress against the actions is in place.

BACKGROUND

In 2007 and 2009, the WAO undertook audits of Delayed Transfers of Care (DToCs). The findings from those reviews highlighted challenges across the whole system and recommended a more integrated approach to promoting older people's independence. It was recognised that if there was to be long-term improvement this would have to be supported by focussed attention from all partner organisations.

In 2016 the NHS Wales Delivery Unit undertook a review of discharge planning processes across Wales. The findings of that review for Cardiff and Vale Health Board showed that the patients discharge process was variable and largely poor when assessed against expected practise.

Since the Delivery Unit report, the Delayed Transfers of Care Operational group has been established, along with the development of the Home First plan which specifically focussed on reducing the number of patients experiencing delays in the transfer of their care and addressing the issues raised within the Delivery Unit report.

This most recent review undertaken by the WAO was in response to the Auditor General's sense that there was little evidence of improvement despite the recognition of common themes for many years.

Assessment

The overall conclusion of the review was that the Health Board has robust discharge improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services.

Four recommendations were made and an action plan developed in conjunction with Partners has been developed to address the recommendations

Main Findings of the Review
The review concluded that there had been significant improvements in the discharge planning process but there remained scope for improvement in staff training and staff awareness of polices.
However, there were strong performance management arrangements and robust discharge improvement plans in place.
The main reasons cited in the report for this conclusion were as follows as follows:

Planning:
The Health Board has clear plans for improving discharge planning supported by comprehensive polices and pathways. There are clear plans for improving discharge planning, which have been developed with partners.

The Health Board has a well-developed draft discharge policy, reviewed with Partners, however patient and carers have not been involved in its review. The recently revised discharge pathways are comprehensive and form part of the draft discharge policy.

Arrangements for supporting discharge:
Multiagency and multidisciplinary teams are available to support discharge but only during the week;
There is scope to improve staff training and raise awareness of policies, pathways and access to information about community services.

Monitoring and reporting:
Overall, performance is improving; the Health Board has strong scrutiny arrangements for discharge planning and is taking positive steps to capture more meaningful information.
There are clear lines of accountability and regular scrutiny of discharge planning performance, which includes partners.
Board members generally feel informed about discharge planning performance, with action being taken to develop further the range of information available.
Performance is improving but it is too early to comment on whether this is linked to improvements in discharge processes.

WAO Recommendations

Four recommendations were made following the WAO review and include:

1. Information on Community Health and Social Care Services
The Health Board should develop a system where ward staff are able to access up to date information about community health and social care services ; and review the range and frequency of data collated about community health and social care services

2. Policy Review
The Health Board should seek to involve patients and carers when the next policy revisions are due.

3.Staff Awareness of Policies and Pathways:
The Health Board should undertake training and raise awareness once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.

4.Discharge Planning Training:
The Health Board should explore developing an e-learning course for discharge planning which ward staff may find more accessible. Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.

ASSURANCE
The attached management response action plan has been submitted by the Health Board in Partnership and accepted by Wales Audit office (Attachment 1).

The Regional Partnership Board will monitor the implementation of the actions agreed and receive regular reports in relation to the number of reported DToCs.

The Health Services Management Board will also continue to receive the performance monitoring reports which reflects the overall patient flow through the system.

The multiagency Get Me Home work stream, as a sub group of the Unscheduled Care Programme will continue to scrutinise DToCs and support an improvement programme which is aimed at reducing delays and improve Patient flow.

Management response

Attachment 1

Report title: Discharge Planning – Cardiff and vale University Health Board

Completion date: September2017

Document reference: DRAFT

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1a	Develop a system where ward staff are able to access up-to-date information about community health and social care services.	Wider and up to date information on community services to help patients on being discharged.	YES	YES	The Integrated Discharge Service is the first point of contact within the Health Board and provide a signposting service for all UHB staff in relation to any queries they may have in relation to community service provision . An Intranet Website is available currently and information how to access and the content is included within training programmes Web site address for DEWIS is also available First Point of Contact and Single Point of Access both ICF funded projects		Chief Operating Officer / Head of Integrated Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					assisting with the provision of information and advice to patients, their families and to staff as part of the overarching compliance with the Social Services and Wellbeing Act 2014. Additional Discharge Support Officers and IDS team are in place to offer advice and to act as a point of contact . A review of the web site is planned to ensure that information is current and accessible to all UHB staff. Reinforcement of available information sources will continue to be included in ongoing training programmes.	Ongoing December2017 Ongoing	
R1b	Review the range and frequency of data collated about community health and social care services. For example waiting times for some services and the frequency data on	Ward staff are better informed and know where to find information about community services.	NO	YES	Information relating how to access community services is available on the UHB intranet site . The UHB is participating in the All Wales development of an integrated Community and Social Care information system which when developed will provide a platform for sharing of		Chief Operating

Draft version Sept17

DRAFT

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Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	services available through other NHS bodies and housing options is collated.				information and data. How staff can access the current information on the UHB website and its content will be reinforced during training programmes	Ongoing	Officer / Head Of Integrated Care
R2	The Health Board should seek to involve patients and carers when the next policy revisions are due.	Patients and carers have a say in policy reviews and development meaning they are an equal partners in the process.	YES	YES	The draft Choice Protocol and Discharge Policy are currently out for consultation The current draft Discharge Policy and Choice protocol has been provided to South East W ales Carers Trust, Engagement Project for comment	End October 2017	Chief Operating Officer / Head of Integrated Care
R3	The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.	Staff are well informed, leading to a consistent application of the discharge policy and pathways across the Health Board.	YES	YES	There is now a well developed training and development plan in place (attachment 2). **Short term Plan** **Discharge Planning** Weekly training sessions of 1-1 ½ hrs on both UHW and Llandough Topics: Discharge Policy Choice Protocol simple/supported complex. Integrated discharge Service. Care Homes. CRT. CWS and its use purpose. (20 session completed to date	Ongoing	Chief Operating Officer / Head of Integrated Care

DRAFT

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					64 staff attended) **"Get me Home"** 3 Monthly workshops have been held which focus on the Home First principles The HB has also embarked on an organisation wide De- conditioning campaign which aims to maintain Patient independence in order to reduce avoidable harm, improve the Patient experience and expedite discharge (2 workshops held to dates with 2 further dates agreed 120 staff attended) **SNAP Training** Daily for 2 weeks -30min sessions, ward based Topics: Discharge Policy Choice Protocol simple/supported complex. Integrated discharge Service. Care Homes. CRT. CWS and its use purpose., Fast Track CHC (160 session delivered to date	Campaign Launch October2017 Ongoing	

Draft version Sept17

DRAFT

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					280 staff attended) **Longer Term Plan** Work ongoing with Learning and Development department to facilitate Discharge Planning within undergraduate Therapy and Nurse training programmes Work is progressing with LED colleagues to formalise the monthly multidisciplinary training programme . Work is ongoing to include discharge planning in Induction programmes for all professional staff Arrangements are in place to include specific discharge planning in the foundation course for newly qualified nurses Collaborative work is ongoing with Cardiff University to support the inclusion of discharge planning as part of	November 2017 November 2017 October 2017 December 2017	

Draft version Sept17

DRAFT

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					the academic curriculum for undergraduates.		
R4a	Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Better discharge planning because staff are well trained, offered regular refresher courses and the Health Board has a record of training compliance.	NO	YES	Work is ongoing with LED colleagues to develop a discharge planning focused E learning resource	TBC	Chief Operating Officer / Head of Integrated Care
R4b	Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.	Training delivery method, which is convenient for ward staff with limited time.	YES	YES	Each Staff member now has the ability to register their own academic achievement and course attendance on ESR, whilst the IDS team are now maintaining a record of all those attending training. Formal workshops are also recorded on the ESR system.	Ongoing	Chief Operating Officer / Head of Integrated Care/ Clinical Boards

DRAFT

ACHIEVING COMPLIANCE WITH SAFER PATIENT NOTICE 24 – PATIENT IDENTIFICATION BANDS
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 13th February 2017

Executive Lead : Executive Nurse Director
Author : Patient Safety Manager – 029 2074 6387 Patient Safety Facilitator – 029 2074 6548
Caring for People, Keeping People Well: This paper underpins the 'reducing waste, variation and harm' element of the University Health Board's strategy.
Financial impact: Approximate saving of between £2,000 and £50,000 over 3 years, depending on options chosen.
Quality, Safety, Patient Experience impact: The work outlined within this report reflects the significant activity taking place to improve patient safety through technology, leading to improved quality and care outcomes for patients.
Health and Care Standard Number 2.1, 3.1, 3.3
CRAF Reference Number 5.1, 5.1.5, 5.6, 5.7
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- This update on progress to address non-compliance of the UHB with Safer Practice Notice 24.

The Committee is asked to:

- **CONSIDER** the update provided within the paper.

SITUATION

The purpose of this paper is to inform the Quality, Safety and Experience Committee of the progress in regards to 'Safer Practice Notice 24 – Standardising wristbands improves patient safety'.

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BACKGROUND

In 2007, the National Patient Safety Agency issued a Safer Practice Notice which required NHS organisations to implement patient identification wristbands which met a number of requirements. One of these requirements is that all wristbands must be generated and printed from the hospital demographic system.

The UHB currently uses a system where patient details are handwritten on a small card which is inserted into a pocket on the wristband. Alternatively, it is common practice to affix an addressograph (a label which contains the patient's details) to the card insert.

Due to the lack of an electronically printed wristband solution, the UHB is unable to declare compliance with the Safer Practice Notice. Cardiff and Vale is the only Health Board in Wales reporting non-compliance. The UHB is also unable to declare compliance with the related 'Patient Safety Notice 026 – Positive patient identification' issued in April 2016.

ASSESSMENT

A number of groups have worked on implementing a printed wristband solution within the UHB since the notice was issued. Previous work had progressed to the business case stage, but investment was not secured.

In recent months, the UHB's Patient Safety Team has made visits to view the wristband solutions used in other Health Boards and talk to clinical staff who use the systems on a daily basis. An information session with representatives from a major manufacturer of wristbands and printers was held in January 2018. This gave an overview of the options currently available on the market. Procurement are contacting suppliers of wristband solutions in order to progress the project.

Wristband technology has continued to develop, with increasingly comfortable and durable options available on the market. In addition the cost of wristbands and the associated printers has reduced in recent years. This presents the UHB with a potential saving as the electronically printed wristbands are significantly lower in cost than the type currently in use. Due to the volume of wristbands used, it is likely that the saving will offset the cost of purchasing the dedicated printers required. More detailed costings have been developed with input from procurement and there has now been agreement to release capital funding to take the forward the project on an 'invest to save' basis and it is anticipated that the UHB can start to introduce the system in Quarter 1 of 2018-2019.

Additional benefits to implementing a new wristband solution include increased patient comfort as well as improved legibility and longevity of the patient details.

The use of an electronically printed wristband across the UHB will also create the foundation for a number of potential future safety developments. One of the options being explored is GS1 compliant barcoding of wristbands. This forms part of the 'Scan 4 Safety' project which is underway in NHS England (www.scan4safety.nhs.uk). Through standardised barcoding, Scan 4 Safety brings together the correct patient, product, place and process. The six English NHS Trusts which are demonstrator sites for the project have reported significant benefits in releasing nursing time for patient care, reducing waste and variation in stock procurement as well as increased efficiency.

Other healthcare organisations are using barcoded wristbands to improve safety in areas such as blood sampling and labelling, blood transfusion, medicines administration and recording of observations. Our existing wristband solution would not be compatible with this emerging technology. It is therefore prudent to ensure that any electronically printed wristband solution implemented within the UHB meets future requirements.

Ongoing support from the Information Management & Technology department is vital for the project to succeed as the wristband printers will have to interface with the Patient Management System and/or other Health Board IT systems. The Patient Safety Team is already working with IM&T to take the project forward.

CANCER PEER RE-REVIEW HEAD AND NECK
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 13th February 2018

Executive Lead : Medical Director
Author : Lead Manager Cancer Services, Telephone 02920 746682
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact : The financial impact needs to be assessed as part of the action plan going forward and implementation by the Clinical Board recognizing and in the context of the UHB's overall financial position
Quality, Safety, Patient Experience impact : The work outlined within this paper reflects the significant activity taking place to improve patient experience for patients with cancer leading to improved performance, quality and care outcomes.
Health and Care Standard Number … 3.1Safe and Clinically Effective Care
CRAF Reference Number …… 5.1 Deliver safe, effective and effective care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The level of scrutiny applied internally and externally to the Peer Review assessment and Peer Review reporting process. Any concerns identified are addressed via an action plan and are regularly reported within the required process; at the Clinical Board performance reviews and by WG and the South Wales Cancer Network

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report
- **AGREE** that appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.

SITUATION

The purpose of this report is to present the Committee with an analysis of the findings and actions required following the Peer Review processes reported to Welsh Government and the South Wales Cancer Network following the review, re-review of each of the cancer tumour sites within the Health Board. This report outlines the findings of the re review of Head and Neck cancers, the initial review having taken place in 2014.

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BACKGROUND

Peer review of cancer services in Wales is a quality assurance programme that reflects the quality of the service being delivered against a framework of standards of care, by multi-disciplinary teams and health boards in Wales. It combines self- assessment with independent expert review to ensure structures and processes are in place to deliver high quality care, and that clinical teams are working effectively together with the aim to improve service delivery, treatment outcomes and patient experience. In Wales, peer review of cancer services began in 2012 and is delivered by the Cancer Networks in partnership with Health Inspectorate Wales (HIW). A three yearly re-review process has been developed by the cancer network. Actions plans are expected to be developed and implemented to address the concerns raised at each peer review and re-review.

It is pleasing to note the good practice and significant achievements. These include the well-functioning team and the documented improvement in a number of areas against the previous action plan following the re-review.

ASSESSMENT AND ASSURANCE: Summary of Peer Re-review Report for Head and Neck Cancers

Good Practice/Significant Achievements:

- A well-functioning team
- Dental assessment pre-op and access to post op dental rehabilitation
- Ultrasound access daily for neck lump assessment
- Improvement since last review as evidenced by the action plan
- Improved radiology input to the MDT
- Key worker copied into letters

No Immediate Risks noted:

No Serious Concerns noted:

Concerns noted were:

Staffing level and skill mix on dedicated head and neck ward
Pathology service
Outpatient service / survivorship
USC pathway
Wound care
Oncology cover

Further detail is provided in the full action plan appendix 1.

APPENDIX 1

Head and Neck Peer Review Action Plan September 2017

Health Board Name – Cardiff and Vale University Health Board

	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
1	Staffing level and skill mix on dedicated head and neck ward A5 The number of experienced staff has significantly reduced in the past 18 months on the dedicated ward. This has resulted in a reported increase of near miss incidents.	• The Health Board needs to explore the correlation of ward staffing levels and increased risk reported where identified through the quality and safety structure.	High	MDT Lead (SQ) / Director of Nursing Surgical Clinical Board	2018	Recruitment to posts under discussion.
2	Pathology service Retirement of the specialist oral pathologist who supports the local MDT but also provides a tertiary second opinion for Wales. There is a concern regarding the lack of succession planning for filling the resultant gap when the current specialist oral pathologist retires. This post supports the local MDT but also provides a tertiary second opinion for Wales. In addition there is also a recognised lack of a dedicated ENT pathologist within the team.	• Succession planning needs to be undertaken in order to continue a seamless service of oral pathology for both local and tertiary patients.	High	MDT Lead (SQ)	2018/19	Under discussion as this will become an issue when current pathologist (J.P) retires. As yet the date for retirement is unknown
3	**Outpatient service / survivorship** No service provision post-surgery for specialist outpatient physiotherapy available.	• The Health Board to explore service gaps and provision of care in relation to implementing interventions from within the recovery package and supporting survivorship.	Medium	MDT Lead	April 2018	Nil

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	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
4	USC pathway The Health Board / MDT are below target and show a decrease in achievement since the review of 2014.	• The service needs to look at ways of improving their performance against the cancer targets. ? Increased input from consultant staff, supported by directorate team, in identifying patients who are near to breaching.	High	MDT Lead	2018	Ongoing
5	Wound care Dedicated expert nursing time for specialist wound care for complex head and neck reconstructive cases is currently inadequate.	• As specialist wound care is an essential part of the recovery package for patients this needs to be embedded in the specialist service provided.	Medium	MDT Lead	2018	Ongoing
6	Oncology cover Single handed oncologist providing oncology input into the MDT with no cover arrangements for absence.	• Cover arrangements for oncology input to the MDT for discussing systemic anti-cancer treatment and radiotherapy options for each patient needs to be explored by all HBs and Velindre Cancer Centre.	High	MDT Lead SQ/Oncologist (M.E)	2018	Ongoing

CLINICAL AUDIT PLAN 2017-2018 – PROGRESS UPDATE
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 13th February 2018

Executive Lead : Medical Director
Author : Patient Safety and Quality Assurance Manager Alexandra.scott2@wales.nhs.uk
Caring for People, Keeping People Well : Offer services that deliver the improvement in health that our citizens are entitled to expect
Financial impact : None
Quality, Safety, Patient Experience impact : Clinical audit is a cornerstone of quality assurance and quality improvement.
Health and Care Standard Number 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation
CRAF Reference Number 7.2
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Progress against the clinical audit plans
- The assurance processes in place around the National Clinical Audits
- The additional Local Clinical Audit activity that is registered and ongoing

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the clinical audit activity undertaken in the Clinical Boards
- **AGREE** the clinical audit process for 2018 / 2019 on the June Agenda.

SITUATION

Clinical audit is a quality improvement process designed to measure care delivery against a defined set of criteria. Clinical audits should be part of a structured programme designed to meet the safety and quality priorities of individual departments. The purpose of this paper is to present an overview of clinical audit activity within the Clinical Boards and compliance with the agreed local clinical audit plan for 2017-2018.

BACKGROUND

In September 2017 the Clinical Board's annual clinical audit plans were submitted to the Quality Safety and Experience (QSE) committee for approval. It was acknowledged that there would continue to be significant clinical audit activity undertaken in directorates and localities that were not included in the clinical audit plans.

It was anticipated that as the processes embedded there would be greater scrutiny of clinical audit activity by the Clinical Boards and that future clinical audit plans would incorporate all audit activity.

ASSESSMENT AND ASSURANCE

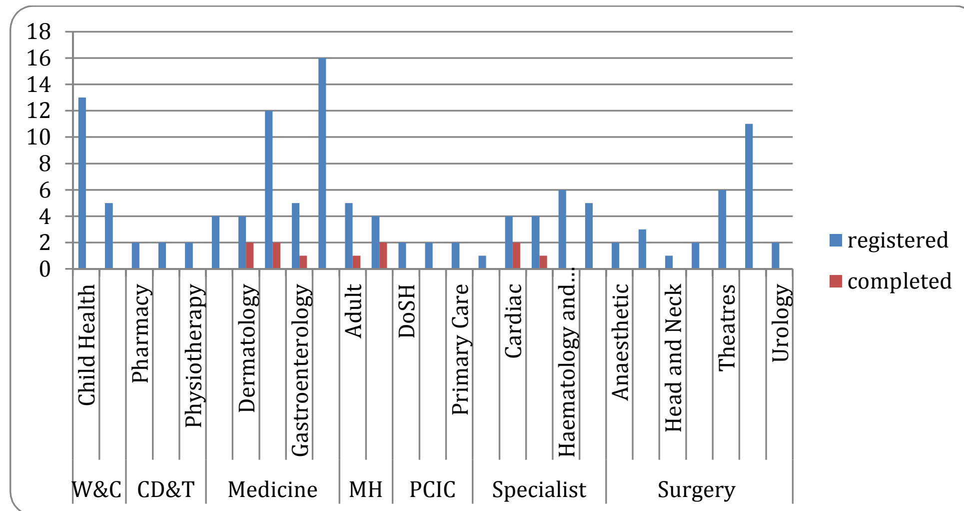
Clinical Boards were asked to propose a minimum of 1 clinical audit per Directorate or Locality to include in the clinical audit plan. It was recognised that there would be significant additional audit activity undertaken throughout the year. Those audits included in the clinical audit plans were predominantly mandated national clinical audits. There is a robust process embedded around the reporting of results and development of actions plans associated with the national audits which has been in place since September 2016. The Clinical Audit Leads are required to complete a two part assurance pro forma; Part A specifies the relevant findings of the audit and Part B details the improvement actions. The pro formas are reported to Clinical Boards, to the Health Service Management Board and to Welsh Government. Progress with each of these audits is detailed in a dashboard in Appendix 1. This dashboard will continue to be updated and provides a very useful overview and high level scrutiny as to the progress of the UHB with National Audits. This information forms part of the wide range of governance information collected by the UHB for patient safety, quality and experience and further informs other areas such as the monitoring of mortality rates.

Since April 2017 the Clinical Boards have registered 127 clinical audits in addition to those that were specified in the clinical audit plan. It is recognised that the requirement to undertake clinical audit will arise throughout the year and will be dependent on a number of factors including capacity, the release of new clinical guidelines or evolving patient safety and quality themes.

The majority of the additional clinical audits remain ongoing however 11 have been completed and have been reported (figure 1). These results are sent back to the Clinical Boards to review and to consider taking through the QSE agenda.

Figure 1

2017/2018 Local Clinical Audits



To reflect a prudent and targeted programme of audit while recognising the value of the additional audit activity it is proposed that in 2018 / 2019 there will be a 3 tiered system of audit. There Is an expectation that all Tier 1 and where possible Tier 2 audits will be planned in advance and will be included in the 2017 / 2018 clinical audit plans. There is not an expectation that all Tier 3 audits will be included in the clinical audit plans, however the requirement to register and have approved all audits and to report and escalate the results remains imperative.

- **Tier 1** Audits included on the National Clinical Audit and Outcome Review Programme.
- **Tier 2** Local clinical audit that are undertaken to address the patient safety and quality agenda, it is anticipated that they will be in response to Serious Incident, Never Events, Regulation 28 and patient safety incident themes. These audits will be supported with notes collection whenever possible.
- **Tier 3** Local clinical audit of best practice guidelines.

The 2018 / 2019 clinical audit plans will be brought to the QSE committee in June 2018.

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Appendix 1

National Clinical Audit Dashboard

	Overdue
	In progress not yet due
	Complete

NAME OF AUDIT	Link to National Report	Lead Clinical Board	SIGN OFF A	SIGN OFF B	OULIER (Y/N)	WHEN NEXT DUE
SSNAP	Link	Medicine			No	29.11.17
MINAP	Link	Specialist / Medicine			No	TBC
Peadiatric Diabetes	Link	W&C			No	TBC
Diabetes Transition Audit	Link	W&C			No	TBC
MBRACE Perinatal mortality	Link	W&C			No	TBC
Peadiatric Diabetes: Hospital admissions	Link				No	TBC
National Insulin Pump	Link	W&C			No	12.04.18
Diabetes Complications & Mortality	Link	PCIC			No	TBC
National Ophthalmology Database Audit: Year 2	Link	Surgery			No	08.02.18
National Audit of Breast Cancer in Older Patients: 2017	Link	Surgery			No	TBC
National Heart Failure Audit Annual report 2017	Link	Specialist			No	TBC
National hip fracture 2017	Link	Medicne			No	TBC
National Audit of Percutaneous Coronary Intervention	Link	Specialist			No	TBC

Appendix 1

National Clinical Audit Dashboard

National Confidential Inquiry into Suicide and Homicide	Link	Mental health			No	TBC
Dementia	Link	Medicine / Public Health			No	TBC
National Pregnancy in Diabetes Audit Report 2016	Link	W&C			No	TBC
National Diabetes Foot Care Audit: Hospital Admissions Report (2014-2016)	Link	CD&T			No	TBC
National Prostate Cancer Audit	Link	Surgery			No	TBC
National Vascular Registry	Link	Surgery			No	TBC
Falls and fragility fracture audit	Link	Medicine			No	TBC
National lung cancer audit	Link	Medicine			No	TBC
National bowel cancer audit	Link	Surgery			No	TBC
National oesophago-gastric cancer audit	Link	Surgery			No	TBC
National COPD Audit Programme: Primary care audit (Wales) 2015–17	Link	PCIC			No	TBC
National Chronic Kidney Disease Audit	Link	PCIC			No	TBC

HEALTHCARE INSPECTORATE WALES ANNUAL REPORT 2016-2017
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 13th February 2018

Executive Lead : Executive Nurse Director
Author : Patient Safety and Quality Assurance Manager. Alexandra.scott2@wales.nhs.uk
Caring for People, Keeping People Well : Offer services that deliver the improvement in health that our citizens are entitled to expect
Financial impact : None
Quality, Safety, Patient Experience impact : External inspections provide valuable feedback and assurance in relation to the quality and safety of services. It also provides opportunity to consider the patient, family and carer experience, as well as providing staff to input into the report.
Health and Care Standard Number . All Standards
CRAF Reference Number 5.1 and 5.1.6
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The development and monitoring of improvement plans to address both local and national recommendations
- Reporting and monitoring through the UHB committees

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the HealthCare Inspectorate Wales Hospital Inspection Annual Report
- **NOTE** The processes in place to monitor the required actions and improvements

SITUATION

The purpose of this report is to provide the Quality Safety and Experience Committee with an overview of the All Wales HealthCare Inspectorate Wales (HIW) Hospital Inspections Annual Report 2016-2017. The report can be accessed here.

The paper seeks to assure the committee that the themes that have arisen from the national inspection programme are acknowledged by the UHB and where necessary the appropriate actions are being implemented.

BACKGROUND

HIW is an independent inspectorate and regulator for health care in Wales. The core role is to review and inspect the NHS and independent healthcare organisations in Wales.

The Dignity and Essential Care inspections (DECI) undertaken are a means of providing assurance that a patient's dignity is being maintained whilst in receipt of care. It is a structured inspection and supports the views of Francis (2013) who emphasised the importance of undertaking direct observations of care.

In 2016-2017 HIW undertook 16 hospital inspections in health boards across Wales. Three inspections were undertaken within Cardiff and Vale UHB

- Ward C6 and C7 UHW
- Follow up inspection in E10 E18 E1 and E4 UHL
- Emergency Unit UHW

ASSESSMENT

A number of themes were identified as a result of the national inspections:

Patient Identification wristbands
HIW sought immediate assurance from three health boards relating to an absence of patient identification wristbands. There were no actions required following inspections undertaken within the UHB, however there has been significant work undertaken in relation to providing a robust resolution to the provision of patient identification wristbands. A funding solution has been agreed and it is anticipated that an electronic solution will be implemented in the first quarter of 2018-2019. A separate paper detailing the patient identification wristband solution has been brought to this meeting of the QSE committee.

Mental Capacity Act and Deprivation of Liberty
HIW identified the need for staff in all health boards to fully comply with Mental Capacity Act (2005) Legislation. Since 2017 all staff have been required to complete mandatory training relating to the Mental Capacity Act. Compliance is reported in the monthly Clinical Board Performance Reviews. The UHB compliance in December 2017 was 50.79% this is reported into the Mental Health and Capacity Legislation Committee.

It was noted that across health boards that staff awareness of the use of Deprivation of Liberty Safeguards (DoLS) was variable. A planned programme of training delivered on a monthly basis continues within the UHB as well as training delivered to wards on request. There is a correlation between the training attendance and the number of DoLS applications; in the year prior to Cheshire West judgment (2014) the UHB and Cardiff and the Vale of Glamorgan Local Authorities processed 91 applications, this number now exceeds 3000 applications per annum. There is an Internal Audit review of the

UHB DoLS arrangements underway at present which will be reported to the Audit Committee.

Boredom
HIW identified the need to ensure that patients, particularly those who have a diagnosis of dementia and those who are confused, received significant support from staff to prevent boredom.

A recent paper presented to the QSE committee in December 2017 detailed the work underway within the UHB to combat boredom, isolation and loneliness. This work has included the development of a lending library of equipment to support activities, numerous musical activities; visitor and befriending programs are in place in conjunction with Student Volunteering Cardiff.

Dignified Care
HIW identified that almost without exception, patients and relatives experience of healthcare was positive. People explained that they were treated with kindness, courtesy and politeness. The Health and Care Monitoring Audit was undertaken in October and November 2017 by 95 wards and departments across the UHB, 98.56% of patients who responded felt that they were treated with dignity and respect.

Improvements to emergency units was identified as a result of the national inspections. In particular the need for better flow and monitoring of patients, specifically the need to prevent the delivery of care to patients on trolleys in corridors. Following the Inspection of the UHB Emergency Unit a comprehensive improvement plan was developed that has been monitored by the Medicine Clinical Board.

Patient Information
HIW identified that the provision of bilingual information and the ability for patients to be able to discuss their health needs in Welsh was inconsistent across health boards.

Cardiff and Vale UHB cumulative data from the National Surveys demonstrated that 72% of patients (n=5497) were always given all of the information that they needed. Welsh speaking staff are identified by the Welsh Language icon and work to ensure the provision of the bilingual patient information is in progressing in line with the Single Welsh Language Plan and was reported to the Resource and Delivery Committee in January 2018.

Nutrition and Hydration
Inspections across the health boards were positive in relation to nutrition and hydration with adequate staff available to support patients to eat and drink and a suitable choice of meals provided.

Continued progress has been made in relation to the overall food quality and meal service provided to patients, with continued compliance to the All Wales food and fluid nutritional standards. There is an ongoing programme of nurse

and catering training and education which incorporates nutrition and hydration service improvement at ward level. The UHB has begun a phased introduction of new coloured crockery to further support an improved patient eating and drinking experience.

The UHB continue to maintain its focus on implementing the action plan of 2017, to include the implementation of a new UHB menu in Feb. 2018. The UHB also continues to focus on compliance with use of the nutrition and hydration bed plan which supports the patient safety agenda, The UHB has undertaken a pathfinder model ward project on Nutrition and Hydration practices and the success of this pathfinder has encouraged the Health Board to seek charitable funding for a larger scale trial on four wards in the UHB.

Medicines Management

The health board inspections demonstrated comprehensive management arrangements in place, however, the following issues were identified:

- Absence of audit activity regarding medicines management
- Unlocked medicines fridges and inadequate monitoring of temperatures
- A number of medication storage rooms were left unlocked
- Some patient medication charts failed to contain staff signatures

The UHB has a comprehensive programme of audit undertaken by pharmacy staff on every ward each month. The audit includes the recording of patient allergy status, Venous thromboembolism risk assessment and prescribing and audit of signatures on medication charts.

A programme of Observations of Care inspections incorporating all clinical areas is ongoing and medication charts, medication fridges, and medications storage rooms are checked routinely as part of the inspections.

MANAGEMENT OF OUTPATIENT FOLLOW UPS AND ENDOSCOPY SURVEILLANCE
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 13 February 2018

Executive Lead : Chief Operating Officer
Author : Assistant Chief Operating Officer – Tel: 02920 744120
Caring for People, Keeping People Well : Timely follow up care underpins the care and sustainability elements of the Health Board's strategy
Financial impact: The cost of the plan to reduce endoscopy waits and elements of the Outpatient Follow-Up Improvement Plan form an integral part of the Health Board's Planned Care Plan. The Health Board has received additional in-year funding from Welsh Government to improve diagnostic waiting times.
Quality, Safety, Patient Experience impact: Timely follow up is integral to the delivery of safe clinical care and good patient experience. The potential consequences of a follow up appointment past the clinically agreed dates are a poor patient experience and adverse patient outcomes.
Health and Care Standard Number: 5.1 and 3
CRAF Reference Number: 5.3
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Outpatient Follow-Up Improvement Plan was revised in July 2017, revising governance arrangements and re-focusing actions to increase the pace of improvement.
- Whilst there has been an increase in the number of patients overdue their planned surveillance endoscopy, the UHB has secured additional in-year capacity to reduce the number of patients delayed.
- There is a clinically agreed risk scoring methodology in place for patients waiting for a surveillance endoscopy

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the current position and work ongoing in relation to the management of outpatient follow up care and endoscopy surveillance

SITUATION

Timely access to follow up care is integral to delivering the Health Board's strategy "Caring for people, keeping people well". The purpose of this paper is to provide an update on progress

over the last seven months in relation to the management of outpatient follow ups and endoscopy surveillance.

BACKGROUND

The Quality, Safety and Patient Experience Committee received a report at its meeting on 20th June 2017 on the management of outpatient follow ups and endoscopy surveillance. This, along with previous reports to the Board and other committees, had been submitted against the backdrop of general concerns that patients are waiting too long and governance concerns arising from reported Serious Incidents in Endoscopy. Following receipt of progress in June 2017, the Committee requested a further update in February 2018.

ASSESSMENT AND ASSURANCE

Outpatient Follow up care

As reported at the last meeting, the UHB had developed a Follow-Up Care strategy comprising of a number of components. This included identifying specialties and clinical conditions of higher risk; improving the quality of our data and transforming outpatients. Whilst good progress had been made in both identifying clinical conditions across all specialties where there is a potential for harm through delays in follow up appointments and reducing the backlog in recent years (from over 600k open pathways to just under 300k follow-ups in April 2017), it was acknowledged in July 2017 that progress had slowed and a revised approach was required.

The next phase of the plan included a revision of some of the strategies already used (particularly data quality improvement) along with some new measures. The design principles for the revised plan included the need to avoid increasing potential harm and to deliver an improvement on a cost neutral basis. The Welsh Government target for outpatient follow-up is 'continuous improvement'. Alongside the revised actions, the governance arrangements were also reviewed and aligned to the key actions. These recognised the need for clinical oversight and sign off up to Medical Director level. Appendix 1 details the revised plan, approved by Management Executive. The plan was also presented to the LMC.

As at 31 December 2017, the UHB had 196K patients on the following up waiting list with no clinically agreed target date and 126K patients delayed past their clinically agreed target date. Of these 47K previously could not attend or did not attend their last appointment. Given the high volumes and associated risk, the focus of the in-year plan is to improve the quality of data – in particular assigning a target date and offlisting patients who should not be on the list. It is important to note that there is potential risk in both taking action and not taking action. Significant efforts are being made to ensure that that only clinically appropriate adjustments will be made to pathways – in line with approved national guidance and Health Board policies. However, there is existing risk in not further validating the list, given the estimated volume of inappropriate pathways is likely to lead to further delay in finding solutions for patients that do require a follow-up.

A number of the actions in the revised plan have now been completed. The key one in progress that will make a significant impact is automated validation. A number of proposals were presented by the Information Team to Clinical Boards in October 2017 to implement further algorithms to either add target dates or off-list patients, with the proposals requiring

clinical signoff at a specialty and Clinical Board level. The majority of the Clinical Boards have now confirmed their agreement (or non-agreement) to the proposals or have proposed further revisions. The final stage is for the algorithms to be re-written to incorporate the agreement reached for each specialty and for these to be applied against the current waiting list. It is anticipated this will be completed February to March 2018.

Whilst the main focus of the revised plan is about in-year improvement, it also references the need for outpatient follow-up to form part of the overall Health Board outpatient transformation plan as, even with extensive validation, there will still be a backlog of patients. This also aligns to the work being driven at a national level through the National Planned Care Board, both through Specialty Specific Boards and also the Outpatient Transformation steering Group. This includes implementation of a number of nationally agreed priorities and pathways to reduce and manage follows-up appropriately – ENT follow-up guidelines; Glaucoma pathway for ophthalmology; Prostate pathway in urology; and Patient Recorded Outcome Measures in Orthopaedics.

Endoscopy Surveillance

Reducing waiting times for endoscopy surveillance forms part of the wider Health Board plan to improve patient experience and access to endoscopy services for all categories of patients – urgent, routine and surveillance. Whilst it was reported at the last Committee that the UHB's actual position of waits greater than 8 weeks for all categories of patients was on plan, this went off track late summer. The volume and risk profile (a clinically agreed risk scoring methodology based on the planned interval date and the amount of time the patient is delayed beyond the planned date) for surveillance patients has, therefore, deteriorated since the last committee, as follows:

Endoscopy Surveillance	Current	Last Committee	Intro of risk profile
Risk rating	**Volume Dec 2017**	**Volume April 2017**	**Volume July 2016**
300% or more	24	13	62
200% - 300%	32	4	54
100% - 200%	71	32	140
75% - 100%	98	52	86
50% to 75%	205	145	169
25% to 50%	302	259	258
0% to 25%	321	333	251
Total > 8 weeks overdue	**1053**	**838**	**1020**

The specific issue impacting on the overall plan, including surveillance, was a loss of endoscopy capacity in August to October, with the service adversely impacted by a number of workforce issues – operator availability, nursing gaps and unplanned absences the administration team. This resulted in the inability to run and staff the fourth endoscopy theatre at UHL. This was escalated to Executive Level and a number of recovery actions were implemented. Operator availability and administration issues have resolved and the nurse staffing position is improving. The number of lists running in the fourth theatre has steadily improved since October and is currently running at a minimum of three days (or more where nurse bank staff have been secured). February is an improving picture with new nurse appointments completing their training. Subject to further and full recruitment to the nursing gaps, it is anticipated the fourth theatre will be fully operational again by the end of March.

In addition to the above, the UHB has also received in-year funding to improve waiting times. The UHB agreed with Welsh Government that any additional capacity would need to be balanced across clinical priorities and would, therefore, be used to both reduce the volume of urgent and routine patients waiting greater than eight weeks and also patients overdue their surveillance endoscopy. The additional capacity has been secured through our existing private providers on an outsourcing arrangement and also a new provider on an insourcing arrangement. The outsourcing capacity commenced at the beginning of January 2018 and the insourcing arrangement commenced on 27th January 2018. With this additional in-year activity in place, it is anticipated that waiting times across all categories of endoscopy patients, including surveillance, will reduce significantly by the end of March 2018. It should be noted, however, that the number of Serious Incidents as a result of long waiting times in endoscopy will increase as the backlog is reduced.

WG target = Improvement

OUTPATIENT FOLLOW UP IMPROVEMENT PLAN

Appendix 1

6 to 9 months

	Action	Clinical Board or Corporate	Expected outcome	Governance	Key resource	Potential impact - 000's
						Starting position: 296
Improving Data Quality: List additions	Review Clinical Outcome codes & update PMS functionality	Corporate	Reduce volume of patients being added onto the OPFU list incorrectly	1. Outpatient Follow up Improvement Group 2. Data Quality Group	ACOO / Clinical Boards / IMT	TBC
	Development of retrospective weekly report for clinics not cashed up	Corporate		Information only - governance forum not applicable	Information (BIS team)	
	Development of 'live alert' for clinics not cashed up	Corporate		Information only - governance forum not applicable	Information and IMT	TBC
Improving Data Quality: List removals	Automated validation: Identification and implementation of further algorithms to offlist patients	Corporate & Clinical Boards	Reduce the volume of recorded OPFUs	Sense check and sign off by: 1. Clinical Board Directors of Operations and Assistant Chief Operating Officer 2. Clinical Board Directors	Information / IMT/ ACOO / Clinical Boards / Medical Director	1. Algorithms - Up to 84K 2. CNA / DNA rule application - Up to 37K 3. Manual validation - 15% discharged & 16% target date entered
	Review and update the UHB's Patient Access Policy re. OPFU CNAs and DNAs	Corporate	1. Clear rules for treatment of CNAs and DNAs for patients on an OPFU pathway 2. Updated & approved Patient Access Policy	Approval by: 1. Clinical Board Directors of Operations and Assistant Chief Operating Officer 2. Planned Care Board	ACOO & Senior Manager Performance and Compliance	
	Continue manual validation for clinically prioritised specialties / conditions	Corporate	Reduce the volume of recorded OPFUs	Application of agreed policy and existing rules	Validation Team	-75
Development of Clinical Board plans	Clinical Boards to develop and implement specialty specific OPFU improvement plans	Clinical Boards	1. Clinically prioritised specialty specific plans 2. Reduction in OPFU volumes	Executive Performance Reviews with Clinical Boards	Clinical Board Directorate teams	25K reduction target -25
Outpatient Transformation	Identify programme of work to transform outpatients and reduce volumes of OPFUs					Sustainability: demand and capacity balance -196

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UPDATE ON THE PROVISION OF SINGLE ROOMS, DECANT FACILITIES AND ISOLATION ROOMS AT UHW
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 13th February 2018

Executive Lead : Director Strategy & Planning
Author: As above
Caring for People, Keeping People Well: This report underpins the Health Board's "Our Service Priorities" and "Sustainability" elements of the Health Board's Strategy.
Financial impact : Not Applicable
Quality, Safety, Patient Experience impact:
Health and Care Standard Number: 2.4
CRAF Reference Number: 5.2 & 6.4.8
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- NWSSP – Specialist Estate Services Isolation Room Ventilation Inspection Report March 2017
- Prioritisation of discretionary capital programme
- Scrutiny at the Capital Management Group
- Development of the UHB's estates strategic plan, the outline of which was discussed in the Strategy and Engagement Committee

The QSE Committee is asked to:

- **NOTE** the position in relation to the identification of a decant ward area that would enable a rolling proactive ward refurbishment programme to be implemented.

- **NOTE** the plans for an estates strategic plan which will set out the programme for development of our estates – both our hospitals and our community facilities in order to deliver our strategy and ensure facilities are fit for purpose and sustainable

SITUATION

At its meeting in June 2017, the QSE received a report on work being progress in the short term to improve the environment on the wards, particularly at UHW and to create space to provide decant areas to facilitate

the ward refurbishment programme and to support infection, prevention and control measures. The report also confirmed that an estates strategic plan was being developed to address the risks associated with the current estate over the medium to longer term.

This report provides an update on that work.

BACKGROUND

1. The condition of our estate and resources available

The UHB has identified the condition of the estate as one of the highest risks facing the organisation, and there are plans to mitigate the risk as much as possible (which does mean tolerating conditions which are not as we would like them) whilst the longer term plans for the development of facilities that are fit for purpose are developed and implemented.

The UHB completed an assessment in 2014 which indicated that in the order of £1.2b would be required over the next 10 – 15 years to make all of our facilities fit for purpose and that the current level of investment was not keeping pace with the upkeep of our existing buildings which were continuing to deteriorate.

The discretionary capital programme is approved by the Board each year and reflects the most pressing priorities to be addressed in the shorter term. The annual allocation is just under £15m. This funds all of the smaller UHB capital schemes including all of the estates statutory compliance issues and backlog maintenance, IT infrastructure and backlog and medical equipment replacement.

2. Operational issues

The main hospitals, UHW and UHL, operate with occupancy levels about 95% meaning that it is difficult to schedule time for general ward refurbishments and to provide space to support the prevention of infection.

In an ideal situation, decant wards areas should be available to enable patients to be moved to allow a deep clean of an area where there has been an infection. The availability of single rooms with en-suite facilities assists with preventing the spread of infection. At the time UHW and UHL were build, very few single rooms were built into the design, and often it is difficult to provide further single rooms in the current ward configuration without major structural work, which has a significant cost implication and would impact on bed capacity.

Single rooms are often confused with isolation rooms. These are negative pressure rooms that meet a very high technical specification, and are used only in the most severe cases, where a patient has, for example, multi drug

resistant TB. The UHB is fully compliant with the isolation room requirements with negative pressure rooms in the following areas:

- Emergency Unit
- Ward A7 (Medical Ward) X 2
- Children's Hospital
- Ward A3 (Critical Care)

The above facilities meet the requirement of the WG directive on the provision of negative pressure isolation rooms on acute sites.

ASSESSMENT AND ASSURANCE

Since the last report, the follow action has been taken to improve the position in the short term:

- The ward refurbishment programme has progressed at UHW during the last
  12 months with the following works completed:
    - Wards B4 North & South complete refurbishment
    - Wards B2 North & South refurbishment excluding bathrooms. (bathrooms done within last 5 years).
    - Wards B6 North & South refurbishment excluding bathrooms. (bathrooms done within last 5 years).
    - Wards A4 North & South bathroom refurbishment only.
    - Wards A5 North & South bathroom refurbishment only.

  This has been possible by closing half the ward at a time on a rolling programme, when activity levels allowed this reduction of beds over a number of months.

- The creation of an additional ward over winter by bringing forward the conversion of the Duthie Library into the colorectal ward, freeing up T2 as a winter ward prior to the work to create additional obstetric capacity required to support the increased flow of patients from the Cwm Taf area following the implementation of the South Wales Programme.
- Approval of plans to improve the management of emergency surgical patients which will result in a reduction of beds, creating decant capacity. The current option is to relocate the Liver Ward into the main hospital from Heulwen and relocate the Pre-Operative Assessment Unit into what was previously the Lakeside Ophthalmology facility. These moves would free up both Heulwen and the Old Paeds South ward for use for decant and winter pressures. The timescale to deliver these proposals have yet to be determined.
- Completion of the first phase of the neonatal development so that the UHB is now up to its previous cot capacity, with the necessary space to meet standards and reduce the risk of spread of infection.

- Capital work at UHL to create a new corridor as part of the medical assessment unit to enable patients to be transferred more appropriate to other clinical areas. The works have commenced on site and will be completed in March 2018, following which works to the Medical ward adjacent to MEAU with commence. This will provide additional wc/shower facilities for the patients. This phase of works is due for completion in May 2018.

This work has been funded from the 2017/18 discretionary capital budget. The plan for 2018/19 discretionary capital works has been drafted and is being considered by the Capital Management Group and Management Executive before being submitted to the Board for approval. Further prioritisation of the programme of work is needed as the budget is over-committed by 50%. At present an allocation is proposed for the continuation of the ward refurbishment programme.

In relation to the medium to longer term, the estates strategic plan is in developed and will be considered by the Board and its relevant committees early in the financial year. It will set out longer term plans for the replacement of UHW, the further development of UHL, the completion of the health and wellbeing hubs in the community to support our locality health and care model, and the expansion needed in primary care to accommodate the Cardiff population growth over the next decade.

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UPDATE ON SINGLE POINT OF ENTRY FOR CHILDREN
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting** 13th February 2018

Executive Lead: Chief Operating Officer
Author: Programme Manager – Single Point of Entry for Children Project
Caring for People, Keeping People Well - This report underpins the Health Board's "For Our Population", "Sustainability" and "Values" elements of the Health Board's Strategy
Financial impact : Final model to be determined but expected to be cost neutral; cost of interim model reduced to a maximum of £62k per annum, £140k below the current costs
Quality, Safety, Patient Experience impact: Delivering a single point of entry for children will improve patient experience, safety and the quality of care provided.
Health and Care Standard Number – Governance, Leadership & Accountability, Standard One – Seven.
CRAF Reference Number
Equality and Health Impact Assessment Completed:

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Plans for a Single Point of Entry are progressing in line with the project plan and are aligned to the developing plans for the Major Trauma Centre
- These plans, and the interim options, are being developed with the full engagement of medical, nursing and managerial teams from the Children and Women and Medicine Clinical Boards and in consultation with the other affected Boards and services
- The alignment of the interim plans with the SWP paediatric changes has allowed the development of options which bridge the majority of the existing financial deficit

The Committee is asked to:

- **NOTE** the progress with the plans for a Paediatric Single Point of Entry and the options developed for the interim arrangement.

SITUATION

This report is presented to the committee to provide assurance that the Single Point of Entry for Children project is progressing to time and developing a robust interim and long term model that will ensure unscheduled care for children is sustainable, delivered safely, aligned to professional standards and recognises that all children deserve a high quality service and a positive experience of care within UHW and the NACHfW.

BACKGROUND

Emergency and urgent care of children for the Cardiff and Vale area is provided at the University Hospital of Wales (UHW), within two geographically separate areas – the Paediatric Emergency Unit (PEU) and the Children's Assessment Unit (CAU). They are the only such units within Cardiff and serve a paediatric population of approximately 100,000 children. In addition secondary and tertiary services provided at UHW attract paediatric patients from the wider South Wales area.

The PEU operates 24 hours a day, seven days per week and is situated adjacent to the main adult emergency department. Attendances within the department currently exceed 30,000 per year with all attendees self presenting via the ambulatory or emergency stream or brought by ambulance.

The CAU is located within the Noah's Ark Children's Hospital for Wales. It currently receives an average of 6,700 primary care referrals per year, but demand is rising at typically 10% per year (over the past 4 years). These patients have been assessed by their GP and require assessment by the specialist paediatric team.

In addition there are in excess of 200 children who have been given 'open access' to the CAU following previous acute admissions or as part of their complex need / chronic condition care pathway. The unit is funded for operation between 08:00 and 22:00 seven days per week, but has been open 24 hours since 2013 at financial risk in response to significant seasonal demand pressures within CAU and PEU.

Two distinct streams of patients and several referral pathways exist within both departments. These are not always easy to define or navigate for patients, doctors referring patients into hospital and the ambulance / transport service as children with particular conditions may in practice present through either stream.

It has been recognised since at least 2013 that the current arrangements for the management of children's unscheduled care, based upon operating two separate clinical models is sub-optimal, both in terms of clinical effectiveness and resource efficiency. A Single Point of Entry (SPoE) for paediatric unscheduled care patients would offer a number of advantages for the child, their families and the Health Board.

ASSESSMENT AND ASSURANCE

Future Model

It has been recognised that an opportunity exists to align plans for a Single Point of Entry for Children with those to develop and implement a Major Trauma Centre at UHW.

The principles of the proposed service model have been agreed by the project board and will be progressed as an integrated service that will receive GP referrals, children presenting with minor injuries and illnesses and those brought to the hospital suffering major and life threatening conditions. For some patients requiring specialist tertiary care, direct admission to the respective ward will continue.

It is proposed that all patients are assessed and streamed according to their clinical needs and managed accordingly within a single unit that will be co-located with the main Emergency Unit at UHW. It is acknowledged that by reviewing current service models and developing robust clinical pathways, the quality, safety and efficiency of care provided within a single department and the resulting patient experience can be improved.

The current project plan is on schedule to deliver a detailed service model that will inform the development of a formal business case as required during 2018. Work is continuing to establish the physical space requirements for the new setting, the workforce model required and the systems that will be necessary to ensure that it is managed effectively within the agreed structure and financial envelope.

Interim Model – During the interim period it is necessary to review the way in which the current services for paediatric unscheduled care are delivered within UHW ensuring that they are safe, sustainable and provided within the agreed governance frameworks.

In order to achieve this, a workshop was held in December 2017. Representatives of the Children & Women Clinical Board, Medicine Clinical Board and respective directorate teams were invited to explore the options that would enable the UHB to deliver a revised model within the resources available. In total the workshop identified twenty one options and following an agreed selection process, four final options were developed in more detail and formed the basis for the development of an options appraisal.

On the 24th January the SPE Project Board was extended to include all those who attended the December workshop. This included medical, nursing and managerial representation from the two Clinical Boards and Directorates. The group received and discussed an options appraisal document developed following the workshop and incorporated the impact of additional paediatric activity resulting from the planned changes to the paediatric service at Cwm Taf (expected to occur from August 2018).

The four options developed for the interim model are described below. Each of these is affordable within the anticipated revised budget, accounting for the additional funding from Cwm Taf.

Options
1. CAU closed overnight and open four additional paediatric beds to accommodate additional paediatric activity from Cwm Taf.
2. CAU Open 24/7. No change to ward capacity or PEU capacity. [i.e. absorb Cwm Taf activity within existing assessment/bed capacity]
3. CAU open 24/7 with new short stay unit (4 beds) and reduce surgical capacity (by 4 beds) at weekends (to offset the costs)
4. CAU closed from 2am Saturday to 9 am Sunday with new short stay unit (4 beds) open Monday – Friday.

Each option was discussed in detail and the advantages and disadvantages debated.

The project board acknowledged that significant progress had been made in narrowing the gap between the existing funded model and the minimum required to provide a safe paediatric service in the intervening period (before the Single Point of Entry is developed).

In addition, the board considered the proposal of a short stay unit would bring significant advantages, minimising the number of unnecessary admissions, thereby improving patient experience and the efficiency of the service.

All representatives were of the view that Option 1 would not adequately meet the level of demand, placing significant pressure on the PEU in particular, and was a sub-optimal solution due to its emphasis on more inpatient beds rather than assessment capacity. Option 1 was therefore discounted.

Option 2 is, in effect, the default option as it is the status quo in respect of service provision but requires the additional Cwm Taf activity to be absorbed within this. Whilst this option cannot be entirely discounted – it does at least secure the current arrangements - it was considered less preferable due to the additional pressures it would put on the existing services and concerns regarding its long-term sustainability.

Options 3 and 4 were favoured, at least in part due to the introduction of a short stay unit into the model, but opinions were split on which was preferable – acute paediatrics favouring option 4 and EU preferring option 3.

The two directorates and Clinical Boards are now working together to determine if there is a way in which, between them, a short stay unit can be opened without the need to close either the CAU or inpatient beds (the deficit is approximately 2wte Band 5 nurses). This outcome would provide for the additional activity from Cwm Taf, be the most sustainable interim model and enhance the existing service.

INTEGRATED GUIDANCE ON HEALTH CLEARANCE OF HEALTHCARE WORKERS AND MANAGEMENT OF HEALTHCARE WORKERS INFECTED WITH BLOODBORNE VIRUSES (HEPATITIS B, HEPATITIS C AND HIV) WELSH HEALTH CIRCULAR 045 2017
Name of Meeting : Quality, Safety and Patient Experience Committee **Date of Meeting:** 13th February 2018

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Executive Lead : Medical Director
Author : Head of Employee Health and Wellbeing Services, Senior Nurse Occupational Health Service Tel: 02920 7 43264
Caring for People, Keeping People Well: This paper supports the sustainability element of the UHB strategy by making the best use of its clinical resources and staff.
Financial impact: No financial implications
Quality, Safety, Patient Experience impact: Improving the appropriate advice to staff and protecting patients.
Health and Care Standard Number **3.1:** Safe and clinically effective care
CRAF Reference Number **5.1:** Deliver safe, effective and efficient care **5.15:** Compliance with professional standards and best practice
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Awareness of the Welsh Health Circular and actions taken to implement necessary changes.

The Quality and Safety Committee is asked to;

- **NOTE** Welsh Government Request.
- **NOTE** Cardiff and Vale UHB response.

SITUATION

The document brings together the current guidance on the management of blood-borne viruses in healthcare workers (HCW); it includes guidance on clearance and monitoring of healthcare workers who undertake exposure-

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

WHC 045 2017 Guidance on Health Clearance of Workers and Management of Workers Infected with Bloodborne Viruses

prone procedures and advice on the investigation and management of any healthcare workers found to have a blood-borne virus.

https://www.gov.uk/government/publications/bbvs-in-healthcare-workers-health-clearance-and-management

Welsh Government have advised that HCWs performing exposure prone procedures (EPPs) must be contacted to remind them of their duty of care regarding Blood Borne Viruses and the need seek professional advice if they may have been exposed, please see attached Welsh Health Circular (WHC)

BACKGROUND

It remains policy that all new HCWs are required to have the standard health clearance checks. Additional health clearance is required for all new HCWs performing EPPs in all health care settings including primary care (medical practice and dental practice), secondary care and other community settings.

All HCWs, are under ethical and legal duties to protect the health and safety of themselves and of others, such as colleagues and patients, and must have understanding of, and co-operate in health and safety matters.

Patient safety and public confidence are paramount and dependent on the BBV positive or potentially infected HCWs observing their duty of self-declaration to an occupational physician. This means HCWs are under an ongoing obligation to seek professional advice about the need to be tested if they have any reason to believe that they may have been exposed to infection with a serious communicable disease either through a specific occupational incident or outside their work environment. Failure to do so may breach the duty of care to patients.

ASSESSMENT AND ASSURANCE

In order to comply with Welsh Governments request, the duty of care template letters in the Welsh Health Circular have been amended for Cardiff and Vale UHB purposes and have been sent to the following for dissemination across the UHB:

- Heads of Workforce and OD for each Clinical Board
- Ceri Hill – Medical Education Manager
- Eleri Jeffries – Senior HR Officer Dental
- UHB Communications Team

In addition, all new EPP workers attending Occupational Health will be notified of their ongoing duty of care

ANNUAL QUALITY STATEMENT 2017-2018
-Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 13th February 2018

Executive Lead : Executive Nurse Director
Author : Patient Safety and Quality Assurance Manager Alexandra.scott2@wales.nhs.uk
Caring for People, Keeping People Well : Offer services that deliver the improvement in health that our citizens are entitled to expect; Join up what we do for the people we serve and strive for operational excellence making the best use of the resources we have.
Financial impact : an approximate cost of £1500 to produce hard copies of the AQS
Quality, Safety, Patient Experience impact : The AQS provides an opportunity for the UHB to lets its local population know in an open and honest way how it is doing to ensure all of its services are meeting local needs and reaching high standards.
Health and Care Standard Number All standards
CRAF Reference Number 4.2, 4.3
Equality and Health Impact Assessment Completed: Not Applicable

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ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The plan of work to support the development of the Annual Quality Statement

The Quality, Safety and Experience Committee is asked to:

- **AGREE** the time frame for the development of the 2017 /18 Annual Quality Statement.

SITUATION

The requirement for NHS organisations to produce an Annual Quality Statements represents a key step forward in meeting the commitment set out in *Together for Heath* for transparency on performance, and specifically, action 10 of the Quality Delivery Plan.

BACKGROUND

NHS bodies are required to publish Annual Report and Accounts. An important element of this will be the publication of the Annual Quality Statement (AQS). Welsh Government has re-issued published Guidance on production of the Annual Quality Statement. The UHB has published AQS' since 2012-2013.

The AQS is intended to provide an opportunity for the organisation to inform the public about what and how it is doing, including how it is making better use of resources to provide and deliver safe, effective care that is dignified and compassionate.

The AQS should:
- Provide and assessment of how well the UHB is doing across all services
- Promote good practice to spread and share more widely
- Confirm any areas that require improvement
- Report on progress year on year
- Account on the quality of the services

The AQS is not intended as a Board assurance document, although the Board must assure itself through internal assurance mechanisms, including its internal audit function, of the accuracy and triangulation of data and evidence to ultimately sign off the AQS. Development of the AQS is subject to Internal Audit assessment.

The AQS for 2017/2018 is required to be published by no later than 1st June 2017.

ASSESSMENT AND ASSURANCE

Development of the AQS will be undertaken in line with the Welsh Health Circular 2017 and provides an opportunity to engage meaningfully with members of the public and patients, pass on public health information and to demonstrate the range of services provided by the University Health Board through from services provided in the community and primary care to specialist and tertiary services provided in acute hospital settings.

Development of the AQS will be carried out in partnership with the Community Health Council and also through engagement with the Stakeholder Reference Group which has proved to be very beneficial in the past. In addition to this there will also be wider public and staff engagement including contributions from patients and staff from the Paediatric Diabetes Service.

The following timeline is proposed:

Date	Task	Lead
January 2018	Engagement with Stakeholder Reference Group to influence early thinking of contents/design the 2017-2018 AQS	Patient Safety and Quality Assurance Manager
22nd January 2018	Engagement with Community Health Council (CHC) to influence early thinking	Patient Safety and Quality Assurance Manager

	of contents/design the 2017-2018 AQS	
End March 2017	Development of Chapters	Corporate Leads
End March 2018	Introductory Chapter	Chief Executive and Chair
End March 2018	Review and introductory chapter by Chief Officer Community Health Council	CEO Community Health Council
Mid April 2017	Collation of chapters	Patient Safety and Quality Assurance Manager
17th April 2018	Draft to QSE	Patient Safety and Quality Assurance Manager
May 2017	Consistency check between Annual Report and AQS	Patient Safety and Quality Assurance Manager
27/04/1/-18/05/18	Design and formatting	Media Resources
31st May 2015	Presentation to Board	Executive Nurse Director
1st June 2018	Publication of AQS	
26th July 2018	AGM	Executive Director of Nursing

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD QUALITY SAFETY AND EXPERIENCE SUB-COMMITTEE

MINUTES OF THE MEETING HELD ON 17TH OCTOBER 2017

24.1

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Alun Morgan	Professional Lead for Quality, Safety and Experience/ Assistant Director of Therapies and Health Sciences
Paul Harrison	In attendance for Sue Dayananda
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Rhodri John	Assistant Head of Workforce
Robert Bracchi	Consultant, Toxicology and Therapeutics Directorate
Bolette Jones	Head of Media Resources
Maria Jones	Senior Nurse, Outpatients

Apologies:

Matthew Temby	Clinical Board Director of Operations
Mike Bourne	Clinical Board Director
Stuart Egan	Independent Member
David Lewis	Head of Finance
Ceri-Ann Hughes	Head of Workforce and OD
Sarah Jones	Quality and Safety Lead, Pharmacy
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Lisa Griffiths	Quality Manager, Laboratory Medicine
Rebecca Pettit	Medical Physics Quality and Safety Lead
Rachael Daniel	Health and Safety Adviser

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 17/352 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

The Clinical Board commenced the meeting by launching its Beat the Flu campaign.

CDTQSE 17/353 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 17/354 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 13th September 2017 were **APPROVED.**

CDTQSE 17/355 Matters Arising/Action log

The action log was **RECEIVED** and it was noted that a number of actions had been completed. The outstanding actions were updated as follows:

CDTQSE 17/238 Foot Assessment Tool

Update on the way forward to be discussed at the next meeting.

Action: Mike Bourne

CDTQSE 17/257 Surgery IP&C Poster

Mike Bourne to advise if this is being taken forward at the next meeting.

Action: Mike Bourne

CDTQSE 17/261 Recommendations of the Lung Nodule Follow Up

Mike Bourne to provide an update on presenting this to the LMC at the next meeting.

Action: Mike Bourne

CDTQSE 17/333 Medical Air Terminal Units

Confirmation needed of whether Radiology has any medical air terminal units.

Action: Rebecca Vaughan-Roberts

CDTQSE 17/344 Retention Schedule

Sion O'Keefe has circulated a link to the retention schedule.

The retention schedule is aligned to the 2016 NHS Code of Practice but is not yet ratified through the new UHB Strategy and Engagement Group, however there is every indication that this will be adopted.

The new Records Management Policy is also due for ratification.

Sion O'Keefe emphasised that it is important to retain records as long as should be as well as undertaking timely destruction.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 17/356 Patient Story

There was no patient story presented at today's meeting.

CDTQSE 17/357 Feedback from UHB QSE Committee June 2017

The Clinical Board provided a report to the UHB QSE Committee on its regulatory and accreditation visits. The report was well received and it was commented that the report was positive, demonstrated robust governance and showed lessons had been learned. The Chair agreed to write a letter of thanks to the Clinical Board.

The Human Tissue Authority (HTA) has undertaken an inspection of the Mortuary and Cellular Pathology Laboratories. This was a difficult visit and the work to address the actions that came out of the visit has been very challenging. The main issue highlighted by the inspectors was that tissue has been held that has not been destroyed in a timely fashion. Major shortfalls were identified relating to standard operating procedures and risk assessments, training and competency assessments. Estates issues were also identified. The Senior Clinical Board Team have implemented a Gold Command Management Group to oversee the action plan to address the issues raised.

Health Inspectorate Wales visited the Cardiology Service in relation to IRMER Regulations and this was a very successful inspection with positive feedback. The main comment related to training records and the requirement for more robust documentation.

Sue Bailey raised her concerns that recording of training and in particular refresher training is emerging as a common theme of inspections.

The Health and Care Standards annual assessment that was undertaken by Clinical Boards and Committees was presented. It was noted that there will be a move away from self-assessment in future years in favour of constant monitoring by Committees.

It was reported that Cleaning Standards was discussed at the Health Systems Management Board and concerns were raised that some of the public areas not deemed high risk have not been prioritised. An internal audit will be carried out in the near future. This Clinical Board has received negative feedback around housekeeping in some of its areas and Alun Morgan noted that he is meeting with housekeeping next week to discuss use of resources.

Action: Alun Morgan

CDTQSE 17/358 Health and Care Standards

Nothing further to report.

CDTQSE 17/359 Risk Register

The Clinical Board has not yet received a risk assessment from Therapies relating to its concerns around staff safety in retrieving records in the record archive facility in Treforest. Alun Morgan will follow this up.

Action: Alun Morgan

The level of risk needs to be identified and the Clinical Board can then consider the mitigation required.

Therapies need to map where they are placing records so that the notes most likely to require retrieval should be stored in a location where they can be retrieved more safely and easily.

Sion O'Keefe referred to the action plan around the environment of libraries at UHW and advised that going forward there is an option to utilise the Treforest facility. The Clinical Board Health and Safety Meeting is being held next week and records storage at the Treforest facility will be added as an agenda item.

CDTQSE 17/360 Exception Reports

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 17/361 Initiatives to promote Health and Wellbeing

This month the influenza vaccination is available for staff. The Chief Executive has announced a large cash prize for the Clinical Board with the highest uptake from frontline staff and for the most improved Clinical Board. Sue Bailey iterated that the main incentive is for staff to receive the vaccination to protect themselves, patients, their families and the community and this Clinical Board will willingly vaccinate staff from the other Clinical Boards. If there are any areas that are off site and would like a flu champion to come out to vaccinate staff to contact Maria Jones.

CDTQSE 17/362 Falls Prevention

Alun Morgan reported that a report has been submitted for the next UHB QSE Committee on falls. There has been a reduction in Serious Incidents relating to falls over the last few months however falls are still the main cause of SIs.

It is now almost a year since the Falls Delivery Group was introduced. A Falls Lead has been appointed who is due to commence in post within the next month. The main issue identified is the lack of a clear pathway for referrals of falls. Particular concern is falls that occur in Primary Care. The UHB is also working with WAST as falls is their main reason for calls.

It was noted that there is good engagement across the UHB and there is representation on the Falls Delivery Group from this Clinical Board.

SAFE CARE

CDTQSE 17/363 Concerns and Compliments Report

In September 2017, the Clinical Board reported 7 formal concerns. There was 1 breach in response times relating to an ongoing concern within Media Resources.

There have been 7 breaches against response times since 1st April 2017.

0 AM concerns were reported this month and 7 AM concerns have been received since 1st April.

The Clinical Board received 10 compliments in September. To date the Clinical Board has received 35 formal concerns and 46 compliments. The key theme for formal concerns relates to clinical diagnosis and treatment.

Sarah Cornes-Payne, Concerns Team Coordinator was welcomed to the meeting. The Concerns Team are working to improve response times and the quality of responses. The team have identified that some staff being asked to investigate concerns have not received any training and therefore the Concerns Team is planning to develop a training package. They would welcome any feedback and ideas from Clinical Boards on how best to deliver training and education prior to developing a package.

It was suggested that the training should include engagement across Clinical Boards i.e. where a Clinical Board investigating a concern requires comments from another Clinical Board that these are requested in a timely fashion so that the response can be submitted within the timeframe. Also that efforts are made to submit the comments back to investigating Clinical Boards timely to the deadlines where possible.

It was commented that the new process around asking patients what questions they specifically want answered is helpful for departments in providing a response.

It was requested that examples of good and poor responses would be of benefit within the training.

Sion O'Keefe also requested for an education package to flag the need for directorates to appropriately track out casenotes where they are being used to investigate a concern.

The issue was raised that staff are sometimes afraid to admit a breach in duty of care. It would be helpful if a training package could explain what a breach of duty of care means and what constitutes as appropriate redress.

It was generally agreed that both individual learning via an e-learning package and study days for learning together would be of benefit.

24.1

CDTQSE 17/364 Ombudsman Reports

Nothing to report.

CDTQSE 17/365 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 17/366 Patient Safety Incidents

Serious Incident Report

The Clinical Board is reporting 2 Serious Incidents:

In20895 Lupus Incident – Sue Bailey has written a closure form for Cardiff and Vale patients to be signed off by Patient Safety Team.

In51407 – misidentification incident in Cellular Pathology. The RCA is complete and with the Patient Safety Team for review. Processes and the procedure around identifying patients with same and similar names has now been strengthened.

CDTQSE 17/367 New SI's

There are no new SI's to report.

CDTQSE 17/368 RCA/Improvement Plans

Nothing to report.

CDTQSE 17/369 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 17/370 Regulation 28 Reports

Nothing to report.

CDTQSE 17/371 Patient Safety Alerts

MDA 2017 029 Lung Ventilators

The alert has been circulated across the Clinical Board but is not relevant to any of its departments.

PSN035 Risk of death and severe harm from ingestion of superabsorbent polymer gel granules

The notice has been circulated across the Clinical Board for awareness.

CDTQSE 17/372 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 17/373 IP&C Issues

The action plan was approved at last IP&C Group with one amendment relating to flushing procedures.

Directorates were requested to review the membership of the IP&C Group to check that their IP&C leads are correct.

Action: Directorates

In terms of ANTT training, Maria Jones has asked the Learning and Education Department for an update of their training database. The Clinical Board needs to consider how to collate a training database into a single response for the Clinical Board.

A meeting to consider issues around implementing ANTT in Phlebotomy has been arranged.

2 bacteraerium have been reported in Radiology which has highlighted the importance of rolling out ANTT in Radiology.

CDTQSE 17/374 Key Patient Safety Risks

Safeguarding/ Mental Capacity Issues

Maria Jones reported that the last UHB Safeguarding Group was held at the end of September.

There are a lot of details on its webpage around female genital mutilation (FGM).

An increase in POVAs across the Health Board has been reported. More referrals are due to the Social Services and Wellbeing Act.

Safeguarding Week is being held on 13-17 November.

Alun Morgan reported that is attending an event on Friday with other UHB colleagues – ‘walking in her shoes’, a campaign to eliminate domestic violence.

For Older Persons Day, it was reported that the Physiotherapy department held a session where children from a local nursery attended to undertake activities with older persons.

CDTQSE 17/375 Health and Safety Issues

The next Clinical Board Health and Safety Group will be held next week.

CDTQSE 17/376 Regulatory Compliance and Accreditation

Nothing further to report

CDTQSE 17/377 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 17/378 Clinical Audit

Nothing to report.

CDTQSE 17/379 Research and Development

Sion O'Keefe reported that the Clinical Board is to consider taking forward WG initiative to bid for time for R&D.

A key issue from the Clinical Board R&D Group is the need for departments to evidence where they are undertaking R&D activities.

Discussions were held around looking at income opportunities for R&D and exploring options around the 60 day cycle service improvement work.

CDTQSE 17/380 Service Improvement Initiatives

8 different 60 day cycles have been identified. This is a good mechanism for directorates to achieve exposure. The Clinical Board will be hosting a showcase event towards the end of the financial year.

CDTQSE 17/381 NICE Guidance

Nothing to report.

CDTQSE 17/382 Information Governance

The Information Governance survey has been circulated across the Clinical Board.

CDTQSE 17/383 Data Quality

There is recognition in the UHB of the need to undertake improvement work. Surgery Clinical Board is taking forward a project linked to 1000 Lives where patients can update their information.

DIGNIFIED CARE

CDTQSE 17/384 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

CDTQSE 17/385 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

TIMELY CARE

CDTQSE 17/386 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 17/387 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Nothing to report.

INDIVIDUAL CARE

CDTQSE 17/388 National User Experience Framework

A 41% response rate was received in September, however Sue Bailey acknowledged that this does not reflect the response rate in the Outpatients department which was much higher.

The Clinical Board received 91% for a score of 8 or more from patients in how satisfied they were with their experience.

A portable touch screen is available in Outpatients that can be used by other departments if they wish to use it to gain patient feedback on any specific questions that they would like to ask.

An Action Planning Workshop is available at UHL based on developing action plans. Good feedback has been received from the workshop held at UHW.

STAFF AND RESOURCES

CDTQSE 17/389 Staff Awards and Recognition

Nothing to report.

CDTQSE 17/390 Monitoring of Mandatory Training and PADRs

Rhodri John reported that the Clinical Board is reporting a PADR compliance rate of 69%. The Clinical Board understands the reasons for those departments with low compliance.

Mandatory training compliance is 77%. The Workforce and OD team will be circulating spreadsheets next week showing individuals' compliance against the mandatory training modules for managers to validate.

It was noted that the My ESR app is available for staff to download.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

There were no items to receive.

ANY OTHER BUSINESS

Sue Bailey reported that she received a telephone message around staff involved with a patient who attempted to commit suicide. The Clinical Board has recognised that staff within its directorates are exposed to difficult situations and it has been advised by the Mental Health Team that debrief is the best tool to use as a coping mechanism. The Clinical Board will look to develop skills within the Clinical Board to take this forward.

Alun Morgan commented that Equality and Diversity should be a standing item on this agenda. Sue Bailey will find out under which section this would be best placed.

Action: Sue Bailey

DATE AND TIME OF NEXT MEETING

8th November 2017 at 2pm in Room 1.13 Ty Dewi Sant UHW

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING
16th November 2017
Seminar Room, Hafan y Coed, Llandough Hospital

24.2

Present:
Jayne Tottle, Director of Nursing Mental Health (Chair)
Will Adams, Specialist Nurse Liaison Psychiatry
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Philip Ball, Deputy Senior Nurse Manager, CMHTs
Owen Baglow, Clinical Lead for Quality, Safety & Governance
Gemma Budge, Clinical Psychologist, Gabalfa CMHT
Lisa Crump, ANP Adult In-patient
Jazmin Dicker, Student Nurse
Ann-Marie Dunsby, STR South CRHTT
Catherine Evans, Patient Safety Facilitator
Emily Harrington, Consultant Psychiatrist
Sarah Howell, CMHN Gabalfa CMHT
Peter Murray, Integrated Manager, Gabalfa CMHT
Bala Oruganti, Consultant Psychiatrist Crisis Team
Kelly Panniers, ANP Adult In-patient
Clare Quinn, Clinical Psychologist MHSOP
Darren Robinson, Substance Misuse Liaison Nurse, EU UHW
Tara Robinson, Interim Senior Nurse Manager Rehab & Recovery
Darren Shore, Team Lead North CRHTT
Sara Spray, Integrated Manager, East Vale CMHT

Apologies:
Jayne Bell, Lead Nurse Adult Mental Health
Jane Boyd, Clinical Director Psychology & Counselling
Dan Crossland, Occupational Therapy Clinical Lead
Adeline Cutinha, Consultant Psychiatrist, Gabalfa CMHT
Mark Doherty, Lead Nurse MHSOP/Neuro
Alison Edmunds, Concerns Co-ordinator
Gail Evans, ANP MHSOP Community
Nicola Evans, Professional Head MH Nursing, Cardiff University
Ruth Evans, Lead CPN Links CMHT
Louise Flynn, Senior Nurse Manager, MHSOP In-Patient
Paul Howells, Lead CPN Pentwyn CMHT
Claire Humphries, Safeguarding Nurse Advisor
Jayne Jennings, Ward Manager, Willow Ward
Isabella Jurewicz, Consultant Psychiatrist,Pentwyn
Robert Kidd, Consultant Psychologist
Lisa Lane, Senior Nurse Manager, MHSOP Community
Mary Morgan, Senior Nurse Manager Adult MH
Helen O'Sullivan, Senior Nurse Manager Adult Community
Annie Procter, Director Mental Health
Jayne Strong, ANP Rehab & Recovery
Natalie Williams, Lead CPN Gabalfa CMHT
Suchitra Sabari, Clinical Director Adult MH
Dave Williams, Ward Manager, Beech Ward
Jo Wilson, Directorate Manager MHSOP
Lowri Wyn, Ward Manager, Cedar Ward

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting and introductions were made.
Chair said the idea of this forum is to learn from incidents, to identify areas of good practice, have a debate and exchange ideas.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

Complex Cases Forum

Chair informed the Group that Complex Cases Forum meetings are held every two weeks on a Thursday from 2.00-4.00pm in Hafan y Coed. The Forum provides an opportunity for teams to refer service users with highly complex needs who present significant challenges. The Forum is a multi-professional advisory group to help support the management of risks presented by service users. Philip Ball will circulate the referral process.

Intermittent Observations

Chair said that the policy on intermittent observations varied in Health Boards but have the same meaning at All Wales level.

There was much discussion regarding intermittent observations. The opinion was that intermittent observations do reduce risk and that qualified staff should support newly qualified staff especially when asking the patient difficult questions.

It was stressed that there is a difference between predictability and preventability.

There is currently a working group (Will Adams, Natalie Hulbert and Lisa Crump) auditing the case notes and documentation surrounding implementation and reduction of observations, and the discussion around these risks. Once the audit is completed they will meet up with Ward Managers to discuss the themes and how improvements can be made.

PART 3 : GOOD PRACTICE

3.1 PT

Sadly, PT was found deceased. He had left a suicide note and is then thought to have inhaled an unknown substance.

PT had a history of depression. An Autistic Spectrum Disorder (ASD) assessment was completed and the assessment was consistent with Autistic Spectrum Disorder on the milder form. PT was referred for ASD post diagnostic counselling and signposting to appropriate services but sadly died before the counselling appointment.

Good Practice

The Review was very clear and easily readable, showing areas of good practice and realistic recommendations.

PT was seen within guidelines and all paper work completed to a high standard.

Issues identified:

Waiting times for ASD referrals are 8 weeks. The establishment of the new Integrated Autism Service (IAS) will significantly increase the provision of pre and post diagnostic support and intervention.

TO CLOSE.

3.2 JC

JC was found unresponsive at the family home, paramedics attended but sadly JC died.
JC was known to the Substance Misuse Liaison team as he had been frequently referred to Liaison Services for alcohol/substance misuse since 2013.

A Multi Agency meeting had been held and a Management Plan was in place for frequent attendance in the Accident and Emergency department (A&E).

Since 2016, JC had frequent admissions to hospital for physical health reasons (usually associated with ongoing excessive alcohol intake). During these admissions assessments were undertaken by Liaison Psychiatry and the Substance Misuse Liaison nurse with follow up care from Addictions Services being arranged prior to discharge.

JC was identified as not engaging with services to stop alcohol use or with organisations who offered harm minimisation/motivational interviewing work. There were no identified serious mental health problems requiring ongoing support.

Good Practice

Good practice throughout as all Services tried to engage with him. There was consistent, clear evidence of communication between all teams. Co-ordination of services never failed, was always maintained.

Risk assessments were regularly updated and reflected historic and current risks.

There is clear evidence of the Community Addictions Unit and Substance Misuse Liaison Services on-going attempts to engage with JC since the first referral via EDAS in 2013 continuing through to most recent (physical health) hospital admission in May 2017. Assessments by the Crisis Resolution & Home Treatment Team, Adult Liaison and the Community Mental Health Team identified alcohol as the predominant issue and offered appropriate and consistent advice.

The Desktop Review is an excellent, clear example.

Chair said that the whole team had done a marvellous job.

Issues identified:

The Frequent Attendee Management Plan is difficult to locate on PARIS.
The PARIS team said to put the Management Plan as an Alert or an Attachment on PARIS

Noted that A&E has a hard copy of Cas Card and this follow the patient’s notes.

Will Adams said he has completed the Train the Trainer Blue Light Change Resistant Alcohol Users training.

TO CLOSE.

3.3 AG

AG is a 44 year old man. His GP referred him to Hafan Dawel Community Mental Health Team (CMHT) with concerns around suicide risk as AG presented to the GP with suicidal ideation due to his recent split from his girlfriend and homelessness (AG was staying with family and friends), and feeling that he couldn't go on. Hafan Dawel accepted the referral from the GP and arranged to see him immediately. AG agreed to leave the GP Surgery and go straight to the CMHT.

However, after AG left the GP Surgery, he rang his ex partner and informed her that he had taken an overdose of 30 tablets and threatened to take 69 more. The ex-partner contacted Hafan Dawel CMHT by phone and informed them. The Integrated Manager reassured the ex-partner and took a description of AG and vehicle details. The Police were informed. The Integrated Manager then contacted the GP to inform him of developments (also faxed the case note to the GP), and asked for the details of the latest medication prescription that may be the ones used in the overdose. The Integrated Manager informed police that the medication is considered a significant risk in overdose. AG was found unconscious by police and was taken to A&E in UHW where is he admitted to Critical Care with Amitriptyline overdose

AG had social issues rather than a Mental Health illness.

Addendum:

He is alive, has a new flat and is working. He has sent a "thank you" letter to staff.

Good Practice

Throughout this incident staff at the CMHT followed all guidance. At the point of referral from the GP the client was offered an immediate appointment. Within an hour or so of not arriving for the appointment they were aware of the overdose and appropriately dealt with the situation. The communication between the CMHT and the GP was excellent with both parties working in collaboration. The discussion with the ex-partner reassured her. The level of detail given to the police was of high quality allowing them to locate AG and hence get him the medical intervention he needed.

Whilst AG ended up in Critical Care, there is no indication that this was as a result of failings on any part of the referral / treatment pathway into mental health services. Communication was excellent and all parties were aware of what was happening.

TO CLOSE.

3.4 PD

PD was known to Addiction Services for alcohol and substance misuse.

Mental Health Services were advised by police that a PD's body had been discovered in the River Taff, near Western Avenue. He could not be resuscitated and was declared deceased. His death was reported to the Coroner.

No serious mental illness had been identified at his assessments. There were intermittent psychotic symptoms which were probably related to substance misuse/withdrawal.

Good Practice

Evidence of proactive attempts to engage/re-engage PD with substance misuse services to address his alcohol dependency.

Excellent communication between Alcohol Services, CMHT, Crisis Services and Tenant Support Worker.

The case notes are comprehensive and demonstrate high quality assessments, clinical consideration of risk and appropriate management planning. There were no missed opportunities.

Issues Identified:

There is one particular issue, the issue of PD having obtained 2 weeks supply of medication a couple of weeks prior to his death (when he was supposed to be limited to weekly to reduce the risk of overdose). This event did not directly contribute to his death. The exact reason he was able to access this is unclear but may well have been a backlog of his usual repeat prescription which had not been stopped or collected whilst he was in hospital.

Wendy Davies, MH Pharmacist, had been asked about the issue of communication between the hospital, GPs and pharmacies to ensure not double prescribing, and about communicating changes. Wendy's comments were:

- Currently on admission medicines are reconciliation by the Pharmacist within 24 hours. Can check what they are being prescribed to ensure continued appropriate medication.
- Would not as a matter of course notify GPs
- We cannot currently electronically send discharge advice letters to GP as Paris does not currently communicate with the general hospital system. On discharge, will write meds on the notes and fax to the GP

Another issue is that of patients on extended leave. How would we know if they had repeat prescriptions set up with a pharmacy which were accumulating?

Wendy Davies had agreed to raise these issues at Medicines Management Group.

PART 3 : CLOSURES

3.5 SG

SG was a 43 year old woman well known to the West Vale Community Mental Health Team (CMHT) with a severe and enduring mental illness. SG presented to the CMHT with breathlessness and anxiety. Her presentation was treated as a panic attack and she was given Lorazepam and advised to return home. However, as her clinical condition deteriorated in the CMHT this decision was changed and an ambulance was called. Very sadly, SG was diagnosed with a pulmonary embolus and died after a spell of treatment on ICU.

This incident is considered a "near miss" as the action of sending the patient home (rather than calling an ambulance) nearly happened.

Issues Identified:

SG was overweight and smoked, which increased her risk of venous thromboembolism.

The Locum Consultant Psychiatrist did not have any personal knowledge of SG and it may have been that the information that SG had been seen by her GP who ruled out physical cause and that she was suffering from anxiety lead to him coming to the conclusion that her presentation was due to a panic attack. (It should be noted that the Locum is no longer working in the UHB to clarify his view of the events).

The Locum was care co-ordinating a large number of patients (240) and having to work across two teams.

The CMHT did not have full medical staffing. There are still posts not filled. Jayne Tottle will raise the significant lack of medical staff at West Vale CMHT with Senior staff.

Discussion regarding monitoring oxygen levels in blood and the accuracy of equipment used to monitor stats. Jayne Tottle said any decision regarding the equipment for monitoring physical health needs to be a multi-disciplinary decision.

Good Practice:

Roisin Budina, Social Worker, decided to seek the advice of her CPN colleague. The CPN looked at SG and saw that she looked unwell with a strange skin colour and advised Roisin Budina to call an ambulance.

Roisin Budina then went back to the Locum to tell him an ambulance had been called; the Locum advised physical observations should be taken.

Example of good team working. Roisin Budina felt able to approach another member of the team who was in the building who easily agreed to assist her in the situation. As a team they felt able to reverse the decision made by the Locum Consultant (that no ambulance was needed and the patient could return home).

Roisin Budina kept communicating with the team, informing the Locum of the decision to call an ambulance.

3.6 HS

HS was to be transferred back to the area he was from as he was an out of area patient; this was explained to HS on admission. Transport was arranged from a private patient transport & nursing Agency. The private patient transport agency attended the ward and full handover was completed; HS was placed in their care. Two members of Cedar ward staff and the private patient transport agency staff escorted HS off the ward into the Emergency Assessment Suite car park. Whilst in the car park HS's relatives turned up. The relatives became obstructive to the transfer and were highly confrontational and verbally abusive towards staff. The private patient transport agency staff attempted to guide HS into their vehicle; whilst this was happening Cedar ward staff observed that the relatives were filming staff. Cedar staff went to speak to the relatives to ask them to stop filming but at the same time the private patient transport agency staff let go of HS and he ran behind the vehicle and out of the car park towards the main entrance.

The Police were immediately called and patient reported as AWOL. HS was found safe and taken to the area he was from.

Issues Identified:

Nobody took charge of the situation, at the time there was a lack of communication.

The gate Emergency Assessment Suite car park was broken – if gate was closed the family would not have had access to where the handover of patient was taking place. The gate is still not fixed. E mails have been sent to Maintenance requesting repair of the gate. Maintenance department are liaising with the company who installed the gate.

4.0 <u>DATE OF NEXT MEETING</u>

18th January 2018 at 9.30am in the Seminar Room, Hafan y Coed.

24.2

MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE
13th December 2017
SEMINAR ROOM, LLANDOUGH HOSPITAL

Present: Jayne Tottle, Director of Nursing Mental Health (Chair)
Owen Baglow, Quality, Safety & Governance Lead
Jayne Bell, Lead Nurse Adult Mental Health
Arpita Chakrabarti, Assistant Clinical Director MHSOP & Neuro
Mark Doherty, Lead Nurse MHSOP/Neuro
Catherine Evans, Patient Safety Facilitator
Mike Ivenso, Clinical Director MHSOP & Neuro
Robert Kidd, Consultant Psychologist
Sarah Lloyd, Directorate Manager Adult MH
Mark Warren, Senior Nurse Manager, Criminal Justice Service

Apologies: Wendy Davies, MHCB Pharmacist
Mick McGeoch, Clinical Audit Co-ordinator
Annie Procter, Clinical Board Director, Mental Health
Suchitra Sabari, Clinical Director Adult Mental Health
Andrew Vidgen, Assistant Clinical Director Adult Mental Health
Ian Wile, Head of Operations & Delivery Mental Health

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting.

Presentation – Re-using Patients Own Medicines

Lucy Nelson, Pharmacist and Claire Mazey, Pharmacy Technician presented the LIPS project "Re-using Patients Own Medicines (POMs)".

Problem when patients do not routinely bring in their own medication when admitted to Hafan y Coed and particularly when the pharmacy is closed. There is also the risk of the patient stock piling at home. There would be a cost saving if patients brought in their own medicines and reduce wastage.

The Implications are:

Delay in receiving correct medication

Drug out of stock

Drug history ambiguity

List of solutions:

Involve Carers

Involve Pharmacy

Involve the Crisis Team

Give Leaflets to staff and patients

The results of the project were good – before the project only 5% of patients had their own medication on admission; after the project 54% of patients had their own medication on admission

Lucy said she would like to see more ward based pharmacists. MHSOP will be trialling a ward based pharmacist for a period of time. It was noted that care homes are completing a project regarding patients own medicine with Pharmacy.

1.2 Apologies for Absence

24.2

Apologies for absence were noted.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on18th October 2017 were accepted as an accurate record.

1.4 ACTION LOG/MATTERS ARISING

The Committee received the Action Log and noted the actions that had been completed; these would be removed from the Log:

Hospital at Night Plan

This is on-going and an update will be given at the next meeting. **Action: Annie Procter**

Risk Assessment/Risk Management Plan

There has been a LIPS project looking at the link between risk assessment and risk management plans, the work on this project concluded that the design of Form 4 plays a significant part in the failure to link the assessment to the management plan. Therefore, the form needs to be re-evaluated or re-designed.

Rob Kidd is considering Form 4 as part of his project. On-going – remove from Action Log.

Mental Health Medication whilst an in-patient on Physical Health Wards

There are issues with mental health services users receiving prescribed mental health medications whilst an in-patient on physical health wards. Issues are mental health medications not being administered, as well as duplicate administration of antipsychotic medication including long acting depots. It has been identified that physical health pharmacists have no access to mental health prescribed medications through any systems, including GP records.

Wendy Davies' report:
Wendy is trying to arrange a meeting with key individuals to address this but it is not straight forward due to the variety of computer systems that exist. **Action: Wendy Davies**

Carer's Assessment

Carer's should be offered a 'Carer's Assessment. Jayne Tottle stated that the assessments should be noted in the dedicated section on PARIS. It was noted that this is not mandatory.

Policy Group

Jayne Bell, Chair of the Mental Health Services Policy Group had asked for assistance with the review of policies and procedures as she is not receiving the due updates despite many reminders to the people concerned.

Jayne Tottle said that she and Annie Procter would meet in the new year to nominate a multi-disciplinary group to organise the updating of policies. The Group would include Medics, Occupational Therapy, Pharmacy and Psychology. It was noted that there is no system to identify when policies are due for review. **Action: Jayne Tottle/Annie Procter**

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 UHB Quality, Safety and Experience Committee

The Chair noted the Minutes of the Special Annual meeting of the UHB Quality, Safety and Experience Committee dated17th October 2017:

QSE17/178 Analysis of Trends and Themes in Serious Incidents and Never Events

The Executive Nurse Director, Mrs Ruth Walker advised the Committee that this was a Special Annual Meeting to provide assurance around actions taken on serious incidents (SIs) and ensure they were managed robustly.

The UHB had been somewhat slow in closing SIs because of the need to demonstrate thorough investigation, analysis, solution and action but the position of 282 open SIs last year had improved and now stood at 80.

(Since January 2017 Mental Health have submitted 109 closure forms to WG)

2.2 Health and Care Standards

Jayne Tottle is meeting Carol Evans on 21st December. An update will be provided at the next Quality & Safety meeting.

2.3 Regulatory compliance and external accreditation - No report.

2.4 Risk Register

Manual Handling

Owen Baglow said there were issues with manual handling. Currently patients in Hafan y Coed are on fixed level beds that are fixed to the walls so cannot be moved out. In this position, during CPR, it is not possible to obtain access to all four limbs (for IV/IO access) and the head (for airway management). There have been discussions with the Resuscitation Team and Manual Handling to address this issue. In the initial meeting with Manual Handling no solutions were arrived at to achieve the objectives of getting the patient to a hard, flat surface with access to all four limbs and head. The technique arrived at was just to get the patient to the floor as quickly as possible by sliding. Manual Handling had several concerns about this as the patient's entire weight was

transferred to the floor by the team moving the patient. There were also concerns about injuring the patient as they were transferred. Manual Handling did suggest using a device used for evacuating patients down stairs. It was felt that this was inappropriate as there was considerable time where effective chest compressions could not be performed. Further meetings with Manual Handling will be held to resolve this issue.

There is no approved method of moving a patient to the floor so that effective CPR can be performed. Whilst we are awaiting an approved method of transfer, we are addressing the risk associated with the unapproved method as we are unable to mitigate the risks associated with the transfer. The discussions with the Resuscitation Team and Manual Handling are on-going although we will be heavily guided by the Resuscitation Council (UK) 2015 publication for Guidance for Safer Handling During Cardiopulmonary Resuscitation in Healthcare Settings.

Psychological Therapies

Rob Kidd said a new 26 week wait referral to treatment target in psychological therapies was being introduced from April 2018 which is likely to cause a breach in traumatic stress services. Jayne Tottle advised that Martin Ford, Directorate Manager Psychological Therapies, should include this in his risk register.

2.7 Directorate QSE Groups

The **Adult Directorate Quality & Safety** Minutes dated 23rd November 2017 were noted:

Patient Story

The story of patient who was recently discharged from Phoenix was presented. The patient had a long standing history of mental illness and a diagnosis of paranoid schizophrenia.

The patient was at Llanarth Court for a period of over 10 years and had not left the ward during this time. The patient was admitted to West 2 in Whitchurch Hospital (now Hazel Ward, Hafan y Coed) from Llanarth and then transferred to the Phoenix Community.

At Phoenix the patient started to have unescorted leave for the first time in many years and started using buses, visiting barbers and other general day to day activities. The patient continues to do well with the support of recovery services.

Hazel Ward, Phoenix and the rehab teams involved in his care were commended for their support.

Post Incident De-briefing meetings

Staff were supported post incident through debriefing meetings. Robert Kidd had stated that there was a risk of re-traumatising staff by having debriefing meetings as some may not want to meet and the debrief will not help them and might re-open stressful issues for others. However, it was agreed that some form of support was needed. Currently there is no incident review for involved staff so discussion is taking place on how to support staff following an incident.

Smoking Cessation

A smoking ban in Mental Health premises may come into effect from the 1st January 2018.
A training session was held recently for Band 6's and 7's. Smoking Cessation Meeting held on 7th December 2017.

Rehab & Recovery

Tara is looking into the issue surrounding finances for patients and highlighted that the current budget for food for service users is £4 per day, which has not increased for some time. There is also a lack of consistency across rehab areas regarding activities money.

Olanseni Lewis – "Seni's Law"

A new law to improve oversight over force used in mental health units has been given initial approval, after a man died when he was restrained in hospital. Olaseni Lewis, 23, died in 2010 soon after being restrained by 11 officers in Bethlem Royal Hospital, Beckenham. The Mental Health Units (Use of Force) Bill, known as "Seni's Law", passed its second reading in Parliament earlier this month. Under the new legislation, hospitals will be required to publish data on how and when physical force is used. The bill would also make sure any non-natural death in a mental health unit triggers an independent inquiry.

The bill now moves on to committee stage in the House of Commons, where detailed line by line scrutiny is carried out by a committee of MPs.

135/136 Amendments

Section 135/136 amendments come into effect on 11th December 2017.

It is unlawful to use a police station as a place of safety for anyone under the age of 18 in any circumstances therefore they will be brought to Hafan y Coed.

Simon highlighted that nobody will be taken into custody under the Mental Health Act. Hafan y Coed is the only designated place of safety in the Cardiff area. The new Act states if a patient is taken to police cells they have to be monitored every 30 minutes by a health professional (not specifically our mental health professional) but the police do not have the manpower to do this. Cwm Taff have agreed that all patients even when violent can go to their place of safety and the police are pushing for us to do the same. However the Mental Health Clinical Board has refused.

Anyone on a 136 needing medical treatment should be taken to A&E as physical health comes first.

CMHT CTP Compliance

Phil Ball has completed an audit on Care and Treatment Plan (CTP) compliance in CMHT's.

Breakdown in order of compliance as of 9th October 2017 (i.e. these are the percentage of people allocated under the CMHT's who had a CTP carried out (new or review) within the last 12 months)

1. Gabalfa -85%
2. Links -58%
3. Hamadryad -56%
4. Pendine -48%
5. Amy Evans – 48%
6. Pentwyn – 47%
7. West Vale – 44%
8. East Vale -35%

The breakdown across nursing caseloads

1. Gabalfa -97%
2. West Vale -90%
3. Amy Evans -84%
4. Pendine -80%
5. Hamadryad -79%
5. Links -79%
7. Pentwyn -70%

It was noted that has not been a Part 2 Mental Health Measure Lead since Dave Semmens left. The Department are looking to fund a Lead.

The **MHSOP/Neuropsychiatry Quality & Safety**

The Meeting was held on 11th December 2017, therefore no Minutes available as yet.

Clinical Director MHSOP

Dr Mike Ivenso has been appointed Interim Clinical Director of MHSOP and Aripa Chakrabarti as Interim Deputy Clinical Director of MHSOP.

Ward Moves

Iorwerth Jones closed on 26th October 2017. Coed y Felin moved to East 14 and Coed y Nant moved to East 16, Llandough Hospital.

The ward moves went very well.

Staffing

High sickness levels. Services are stretched thinly and are monitored on a regular basis.

REACT Team Review

The REACT team review is on-going.

Psychology & Counselling Quality & Safety – The meeting was held on 6th December 2017, therefore no Minutes available as yet

Effective Care:

Rob Kidd said that the purchase of a new audit toolkit had not progressed as hoped.

Complaints:

Rob Kidd stressed that if there is a complaint regarding a psychologist, then Jane Boyd, Clinical Director of Psychology and Counselling Services, should be informed.

Vacancies:

Rob Kidd said that psychology staff vacancies are taking a long time to process.

24.2

Matrics Cymru*:*

Matrics Cymru, published by Public Health Wales, is a Guide to Delivering Evidence Based Psychological Therapy in Wales Mental Health Services for adults, older adults and children.

"Live reporting in April. 2018. Evidence based therapy should be a choice but do not know what is on offer. Andrew Vidgen and Andy Lodwick are looking at this.

Rob Kidd said he would present Matrics at the next MHCB Quality & Safety meeting.

Emotion – Community Mental Health Team 26 week programme. Work in progress.

Pharmacy - No report

Primary Mental Health Support Service (PMHSS) – No report.

Mental Health Act - No Report

Infection, Prevention & Control - No Report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

3.1 Initiatives to promote health and wellbeing

Smoking

The Group were asked to receive and ratify the Patient Group Direction (PGD) for the supply and administration of Nicotine Replacement Therapy by registered nursing staff for smoking cessation in Mental Health and the Poisons Unit. The PGD had been circulated previously.

The PGD was approved.

The non smoking pilot in Hafan y Coed will commence week beginning 8th January 2018. No smoking will also be enforced in Park Road Houses and Phoenix Community.

It was noted the PGD criteria was for smokers over the age of 18 who are admitted to Mental Health wards who require and wish to receive nicotine replacement therapy to manage nicotine withdrawal/ dependence. Smokers under the age of 18 years should be referred to GP or the responsible clinician's team to receive NRT therapy.

SAFE CARE

4.2 Patient Safety Incidents

1) Jayne Tottle referred to a death by hanging incident at Hafan y Coed. The patient had not been identified as suicidal. The patient's diagnosis was psychosis, not depression. Jayne is arranging WARRN (Wales Applied Risk Research Network) training for newly qualified staff. The training covers risk assessment and risk management. Owen Baglow is looking at suicides over the last year to see if there is a theme.

2) A recent inquest issued a Regulation 28 to South Wales Police in relation to advice given by call handlers in respect of a person found hanging.

3) Recent Coroner's Court for a MHSOP patient. No short coming by Mental Health Services. The Coroner was assured by the Multi-disciplinary Case Review (MCR) and subsequent recommendations.

4.3 Patient Safety Alerts

None

4.4 Key Patient Safety Risks

Wound Dressing

At a recent Band 5 induction, the newly qualified nurses requested training in wound dressing. MHSOP staff currently receive this training; Adult Directorate will also provide this training.

Clozapine Prescribing

Sentinel events meetings have identified a number of deaths in people who were prescribed Clozapine. People who are prescribed Clozapine are more prone to developing infections.
At each consultation, a patient receiving Clozapine must be reminded to contact the treating physician immediately if any kind of infection begins to develop.
A study has recently been undertaken looking at Immunoglobulin levels (antibodies) in those who take Clozapine. Immunoglobulin levels were all significantly reduced in Clozapine treated patients.

24.2

Phillip Ball, Senior Nurse, has completed a SBAR on infection reporting.

Action: To invite Philip Ball to next MHCB Quality & Safety meeting

EFFECTIVE CARE

5.1 Audits

Clinical Audit results circulated:

- Re-audit of Benzodiazepine and Hypnotic Prescribing in Older Adult Mental Health Acute In-Patient Units
- Audit of Primary Care Referrals for Secondary Mental Health Routine Assessment of Patients Presenting with Depressive Illness
- Audit cycle of Physical Health Monitoring of Forensic Out-Patients
- Local Audit to determine adherence to the NICE Guideline CG142 – Autism Spectrum Disorder in Adults: Diagnosis and Management dated 27 June 2012

Action: Ask Mick McGeogh/Bala Oruganti to attend next meeting to discuss audits

DIGNIFIED CARE

6.1 HIW

The HIW Annual Report 2016-2017 Hospital Inspections had been circulated.

During visits, HIW were concerned about the number and quality of Care Treatment Plans (CTPs). It was found that some patients did not have CTPs. There was a discussion on who should perform CTPs. **Action: Jayne Tottle to take to Senior Team**

6.2 Initiatives to improve services for people with Sensory Loss

Mollie Kearns, Graduate Management Trainee, and Ian Wile, Director of Operations, would be asked for a report on access and services for our service users with a sensory loss.

Action: Mollie Kearns/Ian Wile

TIMELY CARE

No report.

INDIVIDUAL CARE

8.1 Feedback from Surveys

Patient Experience Survey

Jayne Bell met with the Patient Experience Team in relation to improving survey return rates. Feedback kiosks will be in place on all wards in Hafan y Coed from January 2018.

8.2 Compliments

Compliments received for:

Focussed Outreach Recovery Team (FORT) – Praise of the service from a Specialist Substance Misuse Worker at the Salvation Army.

MHSOP – Plaudit Report.

Focussed Outreach Recovery Team (FORT) – thank you letter from a patient.

REACT Team - thank you letter from a relative of a patient

Complaints are on-going.

STAFF AND RESOURCES

9.2 Staffing Levels

Jayne Tottle said there was an advertisement for Band 5s and that both Directorates had been authorised to over recruit to Band 5s and Band 2s.

Rob Kidd said that a 0.2 psychologist was commencing soon.

The Mental Health Work Stream latest data collection had been completed for wards across Wales and will be feedback in January 2018.

Joanna Doyle, All Wales Nurse Staffing Programme Manager, Public Health Wales is arranging a meeting with the CNO, Ruth Walker and Jayne Tottle in the new year.

PART 2 : ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

Policies and Procedures

The Group were asked to receive and ratify the following:

10.0 Community Treatment Order Policy

10.1 Community Treatment Order Procedure

10.2 Hospital Managers' Scheme of Delegation Policy

10.3 Hospital Managers' Scheme of Delegation Procedure

10.4 Section 5(2) Doctors' Holding Power Policy

10.5 Section 5(2) Doctors' Holding Power Procedure

10.6 Section 5(4) Nurses' Holding Power Policy

10.7 Section 5(4) Nurses' Holding Power Procedure

The policies/procedures were approved subject to them being circulated to Adult Directorate Medics and any comments incorporated in the next two weeks.

10.8 Thank you

Jayne Tottle extended her gratitude to Sarah Lloyd, Directorate Manager Adult Mental Health, who was leaving the Mental Health Clinical Board at the end of December 2017. Jayne said that Sarah's support had been invaluable to Mental Health Services.

DATE OF NEXT MEETING

14th February 2018 at 9.30am in The Seminar Room, Hafan y Coed.

(next Clinical Board Q&S Lessons Learned Meeting is on 15th March 2018 (18th January cancelled) in the Seminar Room, Hafan y Coed)

Item 4

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 1.30, 14th November, 2017 IN ROOM 1, CRI

Present :	Gareth Hayes (GH) (Chair)	Clinical Director Clinical Governance
	Kay Jeynes (KJ) (Vice Chair)	Director of Nursing PCIC
	Sue Morgan (SM)	Director of Operations
	Nicola Evans (NE)	Head of Workforce and OD
	Nicky Hughes (NH)	Lead Nurse S&E Locality
	Helen O'Sullivan (HO)	Quality and Safety Manager
	Denise Shanahan (DS)	Consultant Nurse Older Vulnerable Adults
	Anna Mogie (AM)	Lead Nurse, North and West Cardiff
	Helen Earland	Senior Nurse PC
	Maria Dyban	
	Sarah Congreve	
	Fiona Walker	
	Ian Stuart	

Preliminaries		**Action**
11/17/001	**Welcome and Introductions** All present introduced themselves and were welcomed by Kay Jeynes.	
11/17/002	**Apologies for absence** Matthew McCarthy, Anna Kuczynska, Rhian Bond, Karen May & Ceinwen Frost	
11/17/003	**Declarations of Interest** GH asked for any declarations of interest – none noted.	
11/17/004	**Minutes of the previous meeting held 09 May 2017** Minutes are recorded as accurate.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
11/17/006	**PCIC CB Quality and Safety Group Action Log** The Clinical Board Quality and Safety group action log was reviewed. Members noted the content. Some actions requiring further work:	

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	Cold Chain SI Audit has been completed, **On going action - Primary care to confirm the audit results and present to PCIC QS&E Committee in January then close the action** **Quality Dashboard** Draft dashboard tabled and discussed; noted that some information was not accurate but work in progress. NE informed the group that PADR was a tier 1 target and should be on dashboard. KJ advised the committee on the development of a corporate clinical dashboard which should be available in 2018. **Information Governance** DN teams have undertaken audit and results and action plan already fed back to the committee; CRT audit and action plan to be presented in January 2018 **Older People Commissioner Report** On agenda for discussion. **Action can be closed** **DOLS Guidance** In patients with challenging behaviour, the level of restriction when the DOLS assesment is undertaken is sometimes is not sufficient, which means that MDTs will sometimes request that a court of protection application is made to properly assess the level of restriction – this was an issue as a flurry of applications came in causing delays but has since settled down. **Action to be closed** **MCA Compliance** Current backlog for HB & local authority around court of protection applications; going through as above. **Action to be closed** **POCT** NH advised – database is held by POCT team that identifies the equipmemt allocated to staff and has been forwarded to localities with relevant information. This needs to be sent out to all the team leads to check that staff have all completed the necessary training; also for recording as per UHB guidance**. Lead Nurses are asked to ensure that systems are in place for both Glucometers and Coagucheck machines and feed back in 2018 to provide assurance.** **Review TOR** KJ has reviewed the TOR; some members who often don't turn up will be moved to the category of invitation only or to receive the meeting papers for information only. **Update on service model and staffing for CHAP** Service model redesign is on hold whilst we await the appointment for the Clinical Director and Senior Nurse for vulnerable groups to come into post. **Action: Update March 2018**	

Item 4

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Procurement Log
Procurement log in place to identify schemes that need supporting and monitoring. Action – CHC Framework to be added to the Log

CRT Audit
Action Update in January

C. diff Trends
Process is being reviewed as complaince has not been as rigorous due to staffing gaps. HO'S is undertaking some review work with Dr A Jain, CD Lead for Meds management. Action – Update January 2018 meeting

AMR Plan
Formal plan to be completed and brought to the group; the focus is on E.coli reduction in community settings which will involve pilot testing of improvement cycles for the revised UTI pathway (awaiting sign off ffrom WG). Full support is being provided by Dr Eleri Davies (PHW). Central Vale cluster & GP OOH will be the designated pilot site.

HCS Action
Overarching action plan is on the agenda. Action – some further work is required before disseminating to the buisness units.

Radiological Tests
SBAR that was produced by radiology has been reviewed by Dr AK; no further actions required by the clinical board . Action completed.

HIW/Branch surgery recommendations
There have been no GP reports since last meeting. HO'S and RB met with Carol Evans, Asst Director Patient Safety and Quality, to go through all HIW reports and action plans. Action - KJ to oversee a review of the HIW process for independent contractors with the asssistant HOD, and revised process to be in place by Jan 2018 (KJ/CD)

OOH IT Issues (put on log)
Action plan is in place to work through the persistent issues in the GP OOH service. Action – update for the next meeting is required. Things have not progressed. Callum Davies, Graduate Management Trainee, is supporting and monitoring progress.</td><td></td></tr>
<tr><td>11/17/
007</td><td>Patient Story

NH read a story to group that described a patient with kidney problems who was cared for by the District Nursing team for over 5 years, describing the impact that the nursing team has had on her life over that period of time, especially since the patient's husband passed away. The DN team also cared for the patient's husband at end of life. The story touched on themes of good communication, positive relationships with staff and consistency of care. The feedback on staff was very positive.</td><td></td></tr>
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11/17/ 008	**Risk Register** **QS&E 000214 OOH** Maintaining risk level 3 through the good work of the team and good use of skill mix, hoping that IR35 implications do not have significant impact. KJ thanked the team for all the hard work. **QS&E 000113 Independent Sector** Remain at current level no change. **QS&E 020714 CHAP** Still a fragile service, although patient numbers are low. Still working with locums, two nurses still on temporary contracts and one of the permanent nurses still on long term sick. New senior nurse & Clinical Director are in the process of being recruited. **QS&E 160714 Patient Flow** Risk remains the same. Some planning required for the "Perfect Week" which is will be piloted in the first week of December, first week of January and Easter week. **QS&E 160714 Equipment/JES** Section 33 is out to consultation. **PCIC 110914 Complex Packages of Care** New domicillary care providers available within the community setting which may have a positive impact on greater availability. **PCIC 0814 Local Development Plan** Update required for January meeting. **PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainabilty** There are a number of fragile practices at the moment; full discussion has ben held at PCIC SDG. PCIC has also received 2 applications under the sustainability framework. A recent Practice merger involving 2 S&E Practices has gone smoothly with no real issues flagged. A formal risk escalation report has been completed in relation to the N&W locality Practice which has handed its contract back. A procurement exercise is ongoing; there have been various issues and impacts on other local stakeholders and Clinical Boards with services working with GPs as a a result of patient choice. As a result of this Practice closure other Practices are requesting to close their lists. Patients are opting to approach Practices rather than transferring to the allocated Practice which is casuing significant disruption and additional work for the local GP Practices in the area and for the PC team. The CHC has been involved and engaged in the tendering processes but not supportive of Practices wishing to close branch surgeries to ensure they remain sustainable,which is an additional concern. **PCIC 10.03.16 Pressure Ulcer Prevalence** Still waiting for the revised guidance. All Clinical Boards are required to report all grade 3 and 4 pressure ulcers as potential Sis, whether there is	**KE** **RB**

Item 4

	any suggestion of negligence or not; this will potentially cause a big impact on staff workloads in completing additional paperwork/meetings. This conern has been discussed with the corporate patient safety team and Executive Nurse Director. **S&E 05.12.16 HMP Cardiff – Prescribing, Staff Stress, Environment** The risk has improved but environment of care is still fragile. Staff member redeployed due to stress in relation to Spice incidents and there are approximately 5 code blues a day due to Spice incidents. **S&E 06.01.17 HMP MH Provision** Remain the same. **N&E 10.01.17 Cardiff CRT Medication Administration Procedure** Still remains a risk; medication policy not signed off yet – being held up in local authority. **N&W 15.03.17 DN Workload Allocation** Can come down in risk due to improved process that has been introduced– to come off PCIC RR and be monitored through the locality risk register. **VL 29.07.17 Change of phone lines** Reduced risk, first change has taken place, second change yet to take place – waiting on final allocation of space. Update in January 2018 **CHC 11.08.17 CHC Commisioning group** KJ has met with internal audit department, who are coming to undertake a repeat audit. KJ has flagged that there is still no revised heads of service agreement in place and the joint FNC contract has not progressed, which will help develop CHC contract. **PCIC 05.11.14 District Nursing Risk** A POD in IMTP has been developed to specifically address the demand in over night care for the NVS and Western Vale District Nursing staffing. The IMTP also needs to reflect the new District Nursing principles that Welsh Government have made statutory as part of the Nurse Staffing Act. Ruth Walker has requested KJ to discuss with senior team to put together a case for potential additional resources to demonstrate compliance with the District Nursing principles.	
11/17/ 009	**SI Log** **Current SIs** 2 current SIs – HMP and S&E Locality relating to PU damage **Medication Errors** 7 incidents reported – 6 district nursing and 1 prison – all reviewed and appropriate actions taken; nothing of concern to note. **Sexual Health PDG** For noting.	

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Item 4

	QS & E Audit Report KJ advised the group that the Clinical Board had received substantial assurances from the internal audit dept for the QS&E processes in place within the Board; some additional work is required to support improved processes and assurances for independent contractor services, which will be part of the next phase of work that CD will lead on behalf of KJ & RB (concerns process, HIW reporting and interface incidents). KJ thanked all the teams for their hard work.	
	IMTP Update and QS&E Priorities KJ to circulate priorities that were agreed for IMTP.	**KJ**
	Datix Management KJ advised that the Clinical Board still has an issue with reviewing incidents within 7 days; colleagues were requested to make sure that they look at incidents and process as soon as they are able. This is a very important KPI and provides assurance that we are reviewing and ensuring that services and are staff are as safe as possible. AM concerned as teams are sending off the incidents to relevant teams/departments and either no or a poor response is received. KJ to arrange meeting with Matt to discuss and identify a solution.	**KJ**
	Risk Escalation Reports • Fragile practice Covered off in risk register discussion • DN Procedure packs Major issue with the procedure packs that district nurses use to undertake their clean techniques. Packs are not the usual ones and staff are having issues with gloves breaking and items are not included to safely undertake procedures. This has been flagged to Procurement as this could potentially cause issues in relation to patient safety staff. S Yellan and Procurement and K Mahoney (TVN) are attempting to resolve this issue.	
	Information Governance Group Minutes To note minutes from the meeting October 2017. Main issue to note is the archiving of the patient notes and Treforest site being available in the transfer of records. The committee was asked to note the significant work and coordination this is requiring. Also a number of audits have been undertaken in DN and CRT's. CD produced an SBAR following the meeting to address issues in the communications hub, which has been dealt with. Potential breach in CHAP which has been dealt with, which was reported as a non-breach following investigation. IT Issues with the clusters have been identified and an action plan is in place. Can all staff please prioritise IG training, which is mandatory. SM emphasised the importance of the training and ensuring things are in place to make sure everyone does their training	

Item 4

HEALTH PROMOTION PROTECTION AND IMPROVEMENT		Action
11/17/ 010	**Quality Dashboard** Covered off in action log **National Point Prevalence survey of healthcare – associated infections & antibiotic use in Welsh long term care facilities** Awaiting feedback	
SAFE CARE		**Action**
11/17/ 011	**HCAI Report** Covered on dashboard discussions, *E. coli* reduction discussed; MSSA template and RCA work required for 2018 onwards. **Antimicrobial Delivery Plan** Discussed earlier within the agenda. **HCAI Update** Covered earlier in the agenda. **HCS Standards** KJ has developed action plan and will send out to everyone for an update in what they are required to focus on for the HCS doing in terms of progress. It is a good opportunity to show the improvements made in each standard. **Locality Pressure Ulcer Report** Difference in reporting in each locality, LN's were asked to share the learning on producing reports for this meeting and make sure every Locality is undertaking the same process; to bring back to next meeting. All grade 3 and 4 pressure ulcers are now SIs and we will need to be able to provide some information and assurance of what we are doing. **Concerns Report** Discussed as part of the dashboard , the numbers within PCIC are low, but our performance in relation to the timescales are poor. KJ advised that all staff are responsible for responding to concerns in a timely manner and an improvement was required and needed to be sustained going forward. **POCT Update** **Glucometer/Coagucheck process** KJ fed back from the minutes of the UHB POCT group, the group identified a Surgery in Cardiff that was not compliant with the EQA. KJ was not sure that PC was made aware of this. Re Equipment and training logs, KJ asked LN's to bring back logs for assurance at next meeting. **Medicines Audit September 2017(DOSH/CHAP/Prison/GPOOH/ART)** Audit went straight back to Louise Williams; no issues picked up and systems seemed compliant with requirements. **Patient safety alert NG tubes** KJ circulated document out to the teams regarding the safety notice, Dietetics were leading on the changes required, this is for information	**KJ** **LN's** **LN's**

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<u>SBAR DN Insulin Meds Charts</u>
CF not at meeting, update next meeting.</td><td>CF</td></tr>
<tr><td></td><td>EFFECTIVE CARE</td><td>Action</td></tr>
<tr><td>11/17/ 012</td><td><u>Cariad Research study – Marie Curie – exploring informal Carers administering EOL meds to Family members</u>
No Update

<u>CCAMA Study</u>
KJ advised that the DN teams were taking part in a community catheter audit as part of a UK national audit supported by the IPC team.

<u>Implementation of key NICE Guidance</u>
Evidence-based recommendations on faecal immunochemical tests (OC Sensor, HM-JACKarc, FOB Gold and RIDASCREEN) to guide GP referral for colorectal cancer.
For information.

<u>Nutrition and catering group action plan</u>
KJ has advised the nutrition and catering group that PCIC will not be attending this group unless there is a specific issue relating to PCIC. The Chair will send minutes and actions to KJ for information.

<u>Management of Simple Ovarian and Other Adnexal Cysts Imaged on Ultrasound</u>
For information.

<u>Patient Experience</u>
An assurance paper has been completed for the Executive team which will be presented tomorrow regarding our patient engagement and feedback work. KJ reminded the locality teams that they need to respond to the requests for updated information to ensure we can keep the data base up to date.</td><td></td></tr>
<tr><td colspan="2">DIGNIFIED CARE</td><td>Action</td></tr>
<tr><td>11/17/ 013</td><td><u>HIW Reports - General Practice and Dental action plan</u>

H O'S & RB have met with Carol Evans to go through all HIW reports and action plans; no GMS reports have been sent through since the last meeting. The GDC action plan needs more work. Carol Evans has assisted in updating the report for the Executive Board in December; hopefully an improved process will be agreed and signed off for 2018.

<u>Dental Suspension (MR)- Review of action plan</u>

Reviewed the action plan in relation to the incident that occurred in Splott Road Surgery (Dentist suspended). Assurance was provided that all of the actions have been completed. Dentist now removed from the GDC register and case concluded with GDC.</td><td>H O'S/RB</td></tr>
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	Fragile Practice Update (GMS) Already discussed **Older Person's Commissioner** SM informed group that the older person's commissioner had asked all Health Boards to review the published report in relation to access to GP services. An action plan has been developed which will need to updated in the new year. The OPC will be expecting an update from PC directors group in the new year and is expecting to see progress Action SM to send action plan to KJ **GMS Branch Surgery Visits – Nov/Dec 2016 Action Plan** Action plan not available to bring back for next meeting **Palliative Care SBAR** KJ needed to make the group aware that within the End of Life Care Decisions Document that is used within acute in patient areas, there is a NEWS chart (early warning scores chart) which identifies when people become unwell. Mel Lewis identified a number of wards that were using this chart when patients were not EOL or did not have a DNA CPR in place, which is a concern. M Lewis has spoken to KJ & S Harrison, Assistant Executive Nurse Director, completed a risk assessment and agreed an action plan to ensure patients are not put at risk. **Guidance for Minimal Consciousness/ Persistent Vegetative State** KJ informed group that all Boards were asked to respond to the National Clinical Guidance of Prolonged Disorder of Consciousness to ensure we were compliant with the guidance. KJ has fedback to the Medical Director. The Clinical Board currently supports 5 patients; some required review as a result of the guidance.	**SM** **RB**
TIMELY CARE		**Action**
11/17/ 014	**Safeguarding Update** KJ informed the group that it was national safeguarding week. KJ asked the group to ensure all staff have undertaken e-learning specifically relating to safeguarding. **Safeguarding Meeting** Judy Hunt was unable to attend the meeting, therefore no update was available	
INDIVIDUAL CARE		**Action**
11/17/ 015	**Mental Capacity Act Training** KJ flagged that this is again a mandatory requirement; we need to ensure that staff are undertaking this and dementia awareness. Mandatory training within the board has significantly improved, so KJ again thanked everyone present for all of their hard work. KJ also thanked Dr Dyban for arranging some awareness sessions for GPs through CPET.	

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	Dementia Awareness/Dementia Champions update KJ informed the group that next year one of the priorities for IMTP quality and safety is to agree a consistent approach towards dementia for the Clinical Board, including, dementia champions and dementia training. Denise Shanahan has agreed that she will assist KJ and lead on this as the Clinical Board champion.	
STAFF AND RESOURCES		**Action**
11/17/ 016	**PCIC Staff Turnover/Recruitment and Retention Issues** NE advised that there is still an issue with turnover, currently 13%, month on month, October being latest data. The Clinical board has had 7 starters and 8 leavers, always having more leavers than starters, not necessarily in the same areas. The Clinical Board has developed a recruitment and retention plan in response to the turnover of staff, some of which will be around staff engagement. Staff should be aware of the plan as they have been actively involved in the development of it. We are hoping to see an improvement in retention going forward. **Consent Annual Audit** KJ informed group that the required MCA audit was not undertaken due to a misunderstanding in communication. Carol Preece is going to review the audit pro forma and undertake a repeat correct audit during the first week of December for feedback in January 2018. **GDC Letter** KJ informed the group that a letter has been sent out to Dentists detailing CPD requirements in relation to radiography and radiation training which is required through a 5 year cycle and could potentially be 10 years if managed well. The letter has been sent to all Practices and will be reviewed as part of the annual QAS.	**NH**
SUB-GROUP REPORTS		**Action**
11/17/ 017	**Cardiff North and West Locality** AM continuing to have judicial review application for very complex gentlemen who has been an inpatient for 18 months. Nursing Care home of concern has now been sold to the new provider so the risk of closing has been negated. There has been an issue with a nursing agency, in terms of competency and training of staff; the agency has now been temporarily suspended from the all Wales agency contract. A small number of community patients have had to be reviewed and new providers sought; this is still ongoing due to the complexity of the packages of care **Cardiff South and East Locality** NH Butetown is still fragile, had a meeting to see how the LMT can support this; going to move extra staff in to support. Incident in CHAP involving a gentlemen released from remand in June into the care of CHAP with no restrictions. He had previously been violent within the service and restrictions were supposed to be put in place. A professional meeting has taken place to see how the service can provide care going	**SM/HE**

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	forward and looking at options. DOSH wished to communicate a new service out to the public via Twitter; however there was an issue around sensitivity but is now resolved. **Vale Locality** SC updated that western vale phone coverage and plan to trial the pager for lates and weekend shifts. Issue with continence and wound waiting list, some dialogue re possible solution for further exploration. Safeguarding and vulnerable adults activity is increasing particularly between August and September relating to pressure damage **Out of Hours** Some Individual Health Record and IT issues – ongoing, to be followed up via the action plan. **Medicines Management** No additional update other than report **Palliative care** No additional update other than report	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		**Action**
11/17/018	**WELSH HEALTH CIRCULAR and CMO Updates** **4 Sept 2017. CEM/CPhA/2017/8:** Drug Alert Class 4 – Focus Pharmaceuticals, Pregabalin Oral Solution 20Mg Per Ml PI 20046/0301: Trazodone 100 Mg Capsules PI 20046/0290: Nefopam Hydrochloride 30Mg Film Coated Tablets PI 20046/0296: Nortriptyline **29 September 2017 CEM/CPhA/2017/9/2017/4** Drug Alert Class 2 : (action within 48 hours); Strathclyde Pharmaceuticals Ltd; Eu/1/08/472/018 **17 October 2017 CEM/CPhA/2017/10** Drug Alert Class 4 : B Braun, Sanofi, Hospira,Zentiva, Amdipharm, Wockhardt; Injectable Gentamicin Shortage of Hepatitis B Vaccine – update **2 October 2017 WHC (2017) 046** Amendment to the Human Medicines Regs 2012 – Supply and use of Adrenaline Auto Injectors in Schools **16 October 2017 WHC (2017) 048** Attaining the WHO targets for eliminating hepatitis (B&C) as a significant threat to public health **12 September 2017 WHC (2017) 027** Clinical Musculoskeletal assessment Treatment Service (CMATS) **Medical Device Alerts**	

Item 4

	13th September 2017 MDA/2017/029: Lung ventilators: Astral 100, 100SC and 150 – potential power loss due to faulty battery **21st September 2017 MDA/2017/30 7th** All Accu-Chek Insight insulin pumps – risk of alarm failure **3rd October 2017 MDA/2017/033(WALES)** Professional use HIV test: Alere HIV Combo – risk of false positive results **INTERNAL SAFETY NOTICE** **PSN035/August 2017-11-06** Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	
	ANY OTHER BUSINESS	
11/17/ 019	Nil Noted	
DATE OF NEXT MEETING		**Action**
Date and time of next meeting : January 9th 2018		

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MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 12th October 2017
Venue: Critical Care Resource Room

In Attendance:
Carys Fox (CF), Director of Nursing (Chair)
Jessica Castle (JC), Director of Operations
Navroz Masani (NM), Clinical Board Director
Keith Wilson (KW), Haematology Consultant
Helen Scanlon, Service Manager, Haematology
Fiona Kear (FK), Assistant Service Manager, Haematology, TCT, Clinical Immunology & Medical Genetics
Gareth Jenkins, Service Manager, Haematology, Immunology & Medical Genetics
Martyn Read (MR), Consultant, Critical Care
Hywel Roberts, Consultant, Critical Care & Medical QSE Lead for Specialist Clinical Board
Kevin Nicholls (KN), Service Manager, Cardiothoracics and Critical Care
Beverley Oughton (BO), Senior Nurse, Critical Care
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Rachel Barry (RB), Lead Nurse, Neurosciences & ALAS
Suzie Cheesman, Patient Safety Facilitator & Lead for the Clinical Board
Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology & Medical Genetics
Peter O'Callaghan, Clinical Director, Cardiothoracics
Richard Wheeler, Consultant, Cardiology
Sian Williams, Senior Nurse, Cardiothoracics
Vince Saunders (VS), IP&C
Mark Jones (MJ), Directorate Manager, Nephrology and Transplant

Present:
Gemma Williams (GW), PA Specialist Services Clinical Board (Note taker)
Owain Evans, Cardiology SHO
Joseph Pasquale Merola, Registrar, Neurosurgery
Tom Woodhouse, Locum SHO, Neurosurgery
Julia Barrell, Mental Capacity Act Manager

PART 1: PRELIMINARIES		**Lead**
1.1	Welcome & Introductions The group introduced themselves one by one. CF noted that the focus of the meeting would be consent, noting that there would be two presentations related to this.	
1.2	Apologies for absence Maria Roberts, Tom Hughes, Ceri Philips, Mark Jones, Jennifer Proctor, Colin	

	Gibson, Claire Main and Lisa Evans.	
1.3	To review the Minutes and action log of the previous meeting 22nd September 2017 Matters Arising 1.3/2.4 – NM not present at the meeting at this time. NM was to discuss NCEPOD and the NIV Service outside of the meeting with Gemma Ellis, Nurse Consultant, Critical Care. 1.3/4.1 – MR updated the group on the protocol for clearing cervical spines – document present and live since 2012 seems to be available but not used. **Action**: MR will pick this up with the Critical Care team. 1.3/5.1 – work ongoing regarding the wet bathrooms on T5. 1.3/2.1 – GW noted that Nicola Robinson, Assistant Head Of Workforce And OD, would be looking at the Clinical Board newsletter in November and would include the Learning Disability (LD) information. LE not present at the meeting for feedback regarding whether the LD information had been included in the Critical Care newsletter. **Action:** GW to follow this up. 2.1 – JC confirmed that Gemma Ellis would be presenting at the following Q&S Clinical Board meetings; Children & Women, Medicine and Surgery. 2.4 – GW noted that she had been informed from Deborah Powell, Senior Nurse, Haematology, that she had circulated the old version of the VAD guidelines and that the new version needed to be circulated. Jen Proctor was going to discuss in the meeting but had to send apologies. **Action:** GW to pick this up with Jennifer Proctor outside of the meeting. 3.1 – MRR to provide UHB Q&S update at the next meeting. 3.2 – **Action**: Formal review of the Risk Register at the next meeting. GW to include on Agenda. 3.3 – HR confirmed that he had started conversations with the relevant parties and informed the core team of the discussions on the use of antimicrobial stickers. HR meeting with Federica Faggian next week. HR has spoken to Gemma Elis and Paul Morgan as well regarding the stickers and Sepsis. NM noted that the approach looks good. Admin office space needed for the Haematology Consultants - no unused office space that Directorates are aware. 4.1 – Audit plans included on the agenda for this meeting. 6.1 – MH noted that Flu Vaccinations would be available at the end of the meeting for staff who had not yet been vaccinated. MH to follow up the issue of lack of flu vaccination training availability urgently. MH confirmed that if the vaccinators have previously been trained then they just have to complete the e-learning module and don't require a face to face training session. The Directorates were reminded of the importance of ticking the box on the VTE documentation when a VTE risk assessment has been carried out. **Action**: Directorates to go back to their areas and destroy the old copies of the VTE drug charts and replace with the new copies (new copies show the tick box on the inside page top right hand side). Directorates to engage with medical	 **MR** **GW** **GW** **GW** **Dirs**

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	staff/receptionists to ensure that this is actioned. 8.1 – Directorates invited Junior Drs to attend this consent focused meeting.	
1.4	Patient Story – Peter O'Callaghan POC presented a patient story to the group entitled "a case of mistaken identity". The story focused on a patient and what procedure she thought she was having done compared to what the patient actually had done. The patient was potentially going to raise a complaint however POC suggested she write a letter that can then be used as a patient story so that others can learn from her experience. POC commenced the patient story by providing some back ground information on Injectable loop recorders compared to Implantable loop recorders. Injectable loop records are 87% smaller than the implantable versions however there is a cost implication of moving over to injectable of £90,000. POC read out the letter that the patient had written detailing her experience of the procedure she received. In summary: - The patient was not aware of the procedure that was undertaken as the wrong procedure had been described to her by the Consultant prior to surgery. - The patient was very distressed during the surgery but staff made no attempt to find out why or stop. - The patient has been in extreme pain since the surgery and traumatised by the whole experience. No written information available on ILRs. Currently work ongoing around producing information leaflets detailing all procedures. KW noted that the attitude of the staff was wrong in that no one stopped the procedure even though the patient was very distressed. POC noted that they are trying to empower staff to be able to say "stop" if there are any concerns like this in future. RW noted that there was currently some work going on in Cardiac in relation to consent procedures. Looking at using pre-printed consent forms completed in advance. NM noted that loose terms when describing the procedure can be extremely misleading to a patient. Information sheet needs to be given to the patient at the time of discussion and not when they come for the procedure. Endoscopy has a robust informed consent process which works well. RW noted that the consent process in endoscopy uses a significant amount of staff for this approach so there may be logistical problems doing this. Accurate information is needed along with the appropriate person giving the information. KW noted that in Haematology the patient signs a declaration stated that they have understood what has been discussed and then the consent form is signed when they come in for the procedure based on the previous conversation. It was agreed that honesty was key when informing patients of a procedure. JB agreed that patient autonomy was key. The patient must decide what is happening to them on an informed basis. Evidence suggests that more people op out of having the procedure if informed. JB raised concern that some of the patient leaflets she has seen are actually hard to understand. RW will look to produce pre-printed forms for all their procedures within	

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	Cardiology with the help of JB. Important to get this right. NM congratulated POC on his approach to this case and defusing the situation before it escalated any further. **Action:** POC will draft a response letter to the patient which he will send to CF for sign off.	**POC**
PART 2: SAFE CARE		
2.1	Open Inquests SC updated the group. Closed two this month. Target is 4. 8 open in total. Closure Forms: IN39876 A diabetic patient who underwent a combined kidney and pancreas transplant had an unusually poor outcome resulting in admission to the Critical Care Unit post operatively. The transplant graft thrombosed following surgery and had to be removed on the same day. The patients circulation to her leg was also compromised and has since resulted in a below knee amputation of the patients left leg. Large scale investigation. Action plan produced. RCA has gone to Welsh Government. CF confirmed that Welsh Government have now closed this case. IN47316 Renal patient who had a fall in the dialysis satellite unit. Patient fell on her left side which was her fistula arm. An x-ray revealed a fracture to the head of the left humerous. The patient was transferred to ward B5 and had 4 hours of dialysis as prescribed but her condition deteriorated and she became unstable and the patient's family decided to stop the treatment. The patient sadly passed away. An action plan on how to manage falls at satellite unit has been produced. WAST involved as there was a significant delay in getting the patient. Investigation completed. Welsh Government has been sent the closure form and it has been signed off. Open Serious Incidents **Action:** CF and SC to meet and go through the incidents individually outside of the meeting. CF noted that there has been 1 more pressure damage case - 1 patient with x 2 pressure damage sores which occurred in Critical Care and Neuro.	**CF/SC**
2.2	Patient Safety Alerts None circulated.	
2.3	Healthcare Associated Infections VS provided an update to the group. - 5 MRSA bacteraemia already to date – we only had 5 last year in total. - Averaging 3-4 C.Difficile cases a month. - Averaging over 3 MSSA cases per month. One case of C.Difficile in Specialist Services for October. CF referred to the MRSA cases noting that one was in the Cardiff Transplant Unit and one on B5. Not linked. VS noted that they were not all line related. In 2016/17 there were 39 cases in total and currently at 15 up until October.	

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	CF noted that the renal association published expected Streptococcal infections which was 2.5 per population. 1 MRSA per 100 HD population over a 2 year period. Looking at these over a two year period to see if in or outside renal guidelines. Nationwide figures could be useful. Ongoing meetings with the C.Jeikeium patients. Rates have slightly dipped again. Various discussions ongoing around this. It has been suggested that some baseline data is taken. Only in Haematology.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Neurosurgical Consent Audit JPM presented to the group the findings of a recent consent audit that he had undertaken in Neurosurgery. Principles of consent based on the latest Welsh Health Circular which is from 2008. All elective admissions over a 2 week period in September were reviewed. Results: 31 patients had 33 procedures (94%) consent forms analysed. Failing to document consent in the patient notes. Can only assume that patient information leaflets are not being used. Currently trying to produce some patient information leaflets that can be given to patients. JPM referred to an Australian consent form noting that that was a very good section entitled “notes to talk to my Dr about” which could be useful to include in newer versions of the consent form. RW will utilise the slides from JMP and carry out an audit using the same methodology. **Action:** GW will circulate when received. 76% return rate actually very high. JB referred to the EIDO patient information leaflets which could be a first point of call. Could use these as a starting point. JMP noted that there were very limited EIDO leaflets for their area. HR noted that professional societies are another source that could have some of this information readily available. JB noted that the whole consent policy doesn’t need to be read as this would be very time consuming but that the document was hyperlinked and to use the summary headings as and when needed. Discussion took place around 16-18year olds and consent. JB confirmed that 16 is the cut off for consent. **Actions** agreed: Cardiac – will look to produce consent information leaflets Neuro – will do the same Renal – already doing this once the patient enters the service. No treatment is now an option. SG noted that there would be implications of adopting the “stop” approach – re activity and possible financial implications. CF noted that each Directorate has identified actions and that consent will be discussed again in 6 months at this meeting – **Action:** GW to arrange.	**GW** **Cardiac** **Neuro** **GW**

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3.2	WPOCT Project Implementation of the All Wales Point of Care Connectivity Solution (WPOCT). CF noted that this document was circulated ahead of the meeting for information and action where necessary.	
3.3	Feedback from UHB QSE Committee Deferred to next meeting.	
3.4	Risk Register – review and revision CF noted that Haematology had 4/5 risks that score at 25 on the risk register. There are some that can now be reduced. **Action:** Haematology will review and feed back to CF. **Action:** All Directorates were requested to do the same.	**Haem** **Dirs**
3.5	Exception reports and escalation of key QSE issues from Directorate QSE groups Flu Training for Vaccinators MH noted that the vaccinations started from last week. There have been difficulties in getting vaccinators trained. MH noted that if vaccinators have previously been trained then they can complete the e-learning and do not need to wait for the face to face training session. **Action**: CF requested that MH follow up the training issue and ask to utilise other Directorate sessions or access via occupational health.	**MH**
PART 4: EFFECTIVE CARE		
4.1	Directorates to give a brief oral update on previously submitted audit plans Deferred to the next meeting.	
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business Nephfederpine Never Event Directorates confirmed that this wasn't an issue in their areas. SC will feed this back to whoever is leading on this within Patient Safety.	
PART 6: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
6.1	Received and noted for information	
PART 7: DATE OF NEXT MEETING		
7.1	Friday 3rd November 2017, 8am, in the Critical Care Resource room, UHW.	

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24.4

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 23rd November 2017
Venue: Critical Care Resource Room
MINUTES

HCAI FOCUSED

In Attendance:

Carys Fox, Director of Nursing (Chair)
Hywel Roberts, Consultant, Critical Care and Medical QSE lead for the Clinical Board
Maria Roberts (MRR), Patient Safety Manager, Patient Safety
Vince Saunders, IP&C Lead for the Clinical Board
Beverly Oughton, Senior Nurse, Critical Care
Ceri Phillips, Lead Nurse, Cardiothoracics
Sian Williams (SW), Senior Nurse, Cardiothoracic Services
Martyn Read (MR), Consultant Intensivist, Critical Care
Steve Gage (SG), Clinical Board Lead Pharmacist
Anne-Marie Morgan, Directorate Manager, Haematology, TCT, Immunology and Medical Genetics
Rafael Chavez, Consultant, N&T
Fiona Kear (FK), Assistant Service Manager, Haematology, Immunology & Medical Genetics
Gareth Jenkins, Service Manager, Haematology, Immunology and Medical Genetics
Mary Harness, Senior Nurse, Haematology
Mathew Price, Assistant service Manager, Neurosciences
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Colin Gibson, Clinical Engineer, ALAS
Claire Main (CM), Lead Nurse, Nephrology & Transplant
Dale-Charlotte Moore, Directorate Manager, Critical Care

Present:

Gemma Williams, PA for the Specialist Services Clinical Board (Note taker)
Malisa Pierri, Clinical Nurse Specialist, Neurosciences

PART 1: PRELIMINARIES		
		ACTION
1.1	Welcome & Introductions	
1.2	Apologies for absence Received from; Rachel Barry, Jennifer Proctor, Tom Hughes, Paula Goode, Navroz Masani, Keith Wilson, Mark Jones and Suzie Cheesman.	
1.3	To review the Minutes of the previous meeting 3rd November 2017 CF noted that the minutes couldn't be signed off at the meeting today as MRR needed to add to the content. **Action:** MRR will send to GW to circulate once	**MRR**

	finalised. Matters Arising Item 2.1 Open Serious Incidents (SIs) – all Directorates were to review the open SI spreadsheet and provide updates as appropriate. SI's will be discussed further on in the meeting. Item 2.2 Patient Safety Alerts – LD to feedback to NM regarding service transition (paeds to adults) in Neuro relating to the Valproate alert. CF noted that she had received a very comprehensive response from MP in relation to the Epilepsy service. MP noted that work was ongoing on a C&V response to this alert. Item 3.2 Risk Register – GW confirmed that updated risk registers had been received from; Haematology, N&T, Medical Genetics and ALAS. Cardiac and Critical Care confirmed that they would send their registers across today. **Action:** CF requested that Directorates ensure that they have a documented risk assessment built into the risk register.	**Dirs**
1.4	Patient Story – Malisa Pierri MP presented to the group, a case relating to a male who attended EU with a suspected first seizure. Witnessed convulsive collapse, cyanosis, slow gradual recovery. Referred to first seizure service – next available appointment given (7 weeks from initial presentation). Before that appointment he experienced a further convulsive event. Waited 30 minutes for ambulance as seizures had stopped. At hospital witnessed generalised tonic clonic seizure in waiting area. Glutteral breathing for around 15 seconds. The gentleman then experienced a full cardiac arrest. The patient was successfully resuscitated after 2 minutes of CPR. An MRI, EEG, ECG, and Echo all came back as normal. NICE guidelines for epilepsy - All individuals with a recent onset suspected seizure should be seen within 2 weeks by a specialist. MP noted the work that had taken place following this case: - In working hours pathway and out of hours pathway reviewed. - Established a weekly epilepsy referral MDT. Ensuring all referrals through the department were discussed. - Patients marked with a red flag at WAST in case of any future episodes. - Introduced telephone follow ups and answer machine – better for patients who are unable to drive, reduces DNA rate as patients only tend to want contact when they are symptomatic. Since July 2016 100% of patients with a suspected first seizure have been reviewed within 2 weeks. Looking at cluster clinics in the community but doesn't seem to be a lot of ability to facilitate this at the moment. Electronic referral system is building – currently ~ 50% CF thanked MP for attending and congratulated her on this work.	
PART 2: SAFE CARE		
2.1	Open Serious Incidents MRR fed back to the group. Currently 9 open SIs for the Clinical Board. MRR listed the Open SIs to the group: - Two chest drain incidents with MRR.	

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- Lady on B5 who had a renal biopsy. The report is with MRR regarding for amendment.
- Man from B5 with MSSA bacteraemia recorded on death certificate Closure form in draft with Patient Safety.
- Gentleman from Neuro with pressure damage (second for this patient). Due into Welsh Government by 1st December 2017. Aiming to be in by end of the week.
- Gentleman with pressure areas that deteriorated on B5. Report is in draft.
- Cardiothoracic pressure damage patient – 2 pressure damages. New one reported from Neuro.
- Gentleman who deteriorated 2 days post surgery and died suddenly on ward. Concerns regarding response of medical staff. Out for statements etc on this case.
- Old case which Welsh Government have been trying to get us to close down since 2012. Relates to pancreas transplantation issues with access to CEPOD theatre. Needs to go to surgery for information to allow us to close this. MRR to follow up with Tony Turley.

<u>Open Inquests</u>
MRR noted that she has an inquest meeting next week to gather more information on these cases.

<u>Closure Forms</u>
One closure form has been submitted so far this month for November – several others are in draft.

CF confirmed that the closure target for the Clinical Board has now been reduced from 4 to 2 a month, therefore one more needs to be completed and submitted this month.
BO provided information on the closure form submitted. Patient obtained Grade 3 penile pressure sore whilst on Critical Care. The patient had experienced a traumatic brain injury and underwent neurosurgery and went back to theatre. Sedated and ventilated for period of time. A temperature probe urinary catheter was inserted and a Statlock was not used because of presence of Arctic Sun pads. Patient sustained grade 3 pressure sore, transferred to T4 and pressure sore did fully heal. Teaching has taken place regarding the importance of regular pressure area assessment. Critical Care have trialled some new Statlocks which are softer.; they are in the process of collating the evaluations of this. Action: Discussion regarding temperature control catheter – to be discussed in Critical Care.

CF referred to the previous action log from the 12th October meeting and asked MR for an update regarding the clearance of cervical spine policy in Critical Care so that patiebts don’t spend longer than necessary in a collar. MR confirmed that updated guidance would be published in the near future. Action: MR will feed back when published.
</td><td>HR/MR

MR</td></tr>
<tr><td>2.2</td><td>
<u>Flu Vaccinations</u>
MH provided feedback to the group.

Approximately 50% of front line staff have been vaccinated so far. Now need a push on any groups of staff that need to be targeted. Looking at the data, additional clinical staff and technical staff are not being vaccinated. Action: CF suspects that this includes HCSWs so requested that Directorates focus on getting this group vaccinated where possible. N&T were flagged as having low figures. CM noted that they had no flu trainers and also that there was a delay in
</td><td>Dirs</td></tr>
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	getting on the training programme. They now however have 3 people fully trained and more vaccinators have now been signed off. The figures are now likely to have doubled. MH noted that the Board has to reach the target of 60% vaccinated by the end of season would means another 200 people need to be vaccinated. CF noted that she had discussed with the nursing group about re-visiting the Louise Williams patient story where Louise had spent a month in Critical Care with flu. Her message was that if you don't do it for yourself do it for your family. HR flagged that we mirror Australasia which is currently experiencing very high numbers of flu cases.	
2.3	Patient Safety Alerts • Patient Safety Notice – PSN038/October 2017 – Risk of severe harm and death from infusing Total Parenteral Nutrition too rapidly in babies. For information only. • Traceability non compliance for October – CF noted that within the Board there was no areas where they were completely unable to confirm the transfusion. This is a much better position than it was 12 months ago. • ISN: 2017/003 Safety Notice – an incident occurred in October 2017 in C&V UHB where a patient received a blood transfusion that was intended for another patient. Two patients in the same clinical area required blood transfusions. The nurse asked an agency nurse to check the unit of blood with her. They then checked the blood with the prescription chart and then the patients ID wristband. The blood label and the patient's wrist band were never checked together and therefore it was not identified that the blood was going to be given to the wrong patient. Pre-transfusion observations were undertaken and the transfusion was commenced. The error was identified by chance and the transfusion was stopped. Every area needs to review competence assessments. Individual areas to keep own records, some do but this is not consistent or robust. LED are looking at starting central records. • Welsh Health Circular – WHC (2017) 051 – Raising awareness of Carbon Monoxide Poisoning and Action required by Health Professionals. CF noted that the only area within the Board where this could occur is in Critical Care. HR had no concerns regarding this. Circular for information.	
2.4	Healthcare Associated Infections Clinical Board HCAI Review to end of October VS updated the group. No cases of C.Difficile to date this month. The UHB won't meet targets for MSSA and MRSA but may still meet target for C.Difficile. October was a bad month for C.Difficile with 5 cases. There were also 3 MSSA and 2 E. coli's. This month 1 MSSA bacteraemia and 1 E. coli. RCAs Sarah Matthews, Senior Nurse, N&T, presented at Big Room 2 weeks ago regarding the actions taken by B5 after recent C.Difficile cases. The actions taken need to shared with other areas. B5 introduced a different way of cleaning their beds which is to be rolled out everywhere. Haem RCA raised issue in terms of getting HPV cleaning into cubicles versus the pressure of trying to get patients into beds. B5 book a different space to target each weekend. CF noted that a rolling HPV programme would be useful on Haem. **Action:** MH to pick this up. CF noted that there have been a couple of	**MH**

	cases of C.Difficile lately on C5 which is unusual. CP noted that they had reviewed their hand hygiene audit results and they were always good. They also looked at staffing as they have been using band and agency. RCAs have been completed for the 2 cases reported. **Action:** CF raised concern that she has been made aware of 3 Consultants who are repeatedly not complying with bare below the elbow and requested that Directorates let her know of any others that need to be flagged. They will be picked up on an individual basis. CF informed the group that there has been an issue with staff wearing stoned rings which has been picked up in audits. CF suggested that staff are checked at the beginning of each shift. Navroz Masani, Clinical Board Director and CF to meet with Eleri Davies, Acting Director – WHAIP and VS again. LD commented that Navroz Masani had said that he would be sending out a second letter reinforcing the first one. **Action:** CF will follow this up with him. <u>Use of Antibiotic stickers to improve compliance</u> HR confirmed that he will be meeting with Federica Faggian, Antibiotic lead for the UHB, in relation to the All Wales prescription chart changing to possibly include a permanent sticker. Trying to clarifying when the antibiotic chart will be changed. Pharmacy are carrying out some more baseline audits before Critical Care carry out any interventions. After that pilot there will be zero tolerance approach to antibiotic management and recording etc.	**Dirs** **CF**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u> Deferred to next meeting.	
3.2	<u>HTA Disposal of Organs</u> RC confirmed that they have a robust system in N&T for the disposal of organs that do not get transplanted. Once agreed that the organ is not suitable for a patient in Cardiff it is offered via the fast track system. If an organ is unsuitable to be transplanted at all the organ is passed over to Histopathology for disposal, this is a robust process. The transplant service supervised very closely by NHS Blood and Transplant Service (NHS BT) who in turn report to the Human Tissue Authority (HTA), who audit regularly. The only time an organ is kept is if it arrives late on a Friday it will have to stay with N&T until transferred to Histopathology on Monday, there is a protocol for this. CF thanked RC for clarifying the processes and protocols in place. The current documents may need some updating, CF has passed the information onto RC to action	**RC**
3.3	<u>Risk Register Formal Review</u> Discussed under matters arising. Once CF receives all updated Risk Registers from Directorates she will amend the Clinical Board Risk Register.	
3.4	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Medical Equipment Bids</u> CG noted that Claire Salisbury has emailed all Clinical Boards informing them that the bids have to be submitted by the 4th December. The bids will be prioritised according to risk. Need to get bids in quickly. **Action:** CF requested that Directorates look into this and submit their forms.	**Dirs**
PART 4: EFFECTIVE CARE		
4.1	<u>Directorates to give a brief oral update on previously submitted audit plans (deferred from previous meeting).</u>	

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	To Note: Medical Genetics contributes to National (UK) Audits in Clinical Genetics but there is no ongoing audit for now – seems to have lapsed. N&T CM working through all audits on list – next one up is audit of concern process in surgery. Nothing else is an issue at the moment. CM will need to update CF further. Critical Care DCM noted that they have a new audit lead so plan to sit down with them next week to discuss. New audit lead will be Paul Morgan, DCM to update Clinical Board Haematology CF noted that Keith Wilson, Consultant, Haematology, had emailed an update to her as not available to attend today's meeting. Haematology are up to date except for lymphoid and myeloma audits. Neurosciences MP informed the group that Ravindra Nanapaneni has agreed to take over as audit lead. CF requested that he updates the audit plan and feeds back at this meeting. MP will pick this up with him. ALAS Update previously supplied by CG – no further information to add. Cardiac NG confirmed that they had a robust audit programme which he will send to CF. **Action:** All Directorates to send their updated audit plans to CF if they haven't already done so.	**CM** **DCM** **MP** **NG** **Dirs**
PART 5: INDIVIDUAL CARE		
5.1	2 minutes/National Report – October 2017 **Action:** reports for information and to review within Directorates particularly comments made by patients. CF provided an update on Rookwood. They have had 3 new boilers that were due to be functioning before last Christmas – 2 of these are still not fully functional as hoped so there is still an issue with the heating. The old house where some patients are still seen, has received money for new roof as water pouring through offices, only part of roof has been replaced. One of the offices does have fungus and mould growing on the walls. Some concerns that this could be affecting patients and staff due to spores – **Action:** VS has a planned visit to RW to review	**Dirs** **VS**
PART 6: ANY URGENT BUSINESS		
6.1	Any Urgent Business None.	
PART 7: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
7.1	Received and noted for information	
PART 8: DATE OF NEXT MEETING		
8.1	Friday 15th December 2017, 8am, in the Critical Care Resource room, UHW.	

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Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 15th December 2017
Venue: Critical Care Resource Room

MINUTES

In Attendance:

Carys Fox, Director of Nursing (Chair)
Paula Goode, Interim Director of Operations
Navroz Masani, Clinical Board Director
Hywel Roberts, Consultant, Critical Care and Medical QSE lead for the Clinical Board
Hywel Pullen, Head of Finance
Suzie Cheesman, Patient Safety Facilitator
Beverly Oughton, Senior Nurse, Critical Care
Sian Williams (SW), Senior Nurse, Cardiothoracic Services
Martyn Read (MR), Consultant Intensivist, Critical Care
Steve Gage (SG), Clinical Board Lead Pharmacist
Gareth Jenkins, Service Manager, Haematology, Immunology and Medical Genetics
Mary Harness, Senior Nurse, Haematology
Mathew Price, Assistant service Manager, Neurosciences
Colin Gibson, Clinical Engineer, ALAS
Claire Main (CM), Lead Nurse, Nephrology & Transplant
Dale-Charlotte Moore, Directorate Manager, Critical Care
Keith Wilson, Haematology Consultant
Tom Hughes, Clinical Director, Neurology
Rachel Barry, Lead Nurse, Neurosciences
Helen Scanlon, Service Manager, Neurosciences
Emma Wilkins, Perfusion, Cardiothoracics

Present:

Gemma Williams, PA for the Specialist Services Clinical Board (Note taker)
Sally Jones, Sister Home Therapies Unit
Bethan Ingram, Advanced Nurse Practitioner, Haematology
Clare Rowntree, Consultant Haematologist

PART 1: PRELIMINARIES		**Action**
1.1	Welcome & Introductions The group introduced themselves one by one.	
1.2	Apologies for absence Mark Jones, Gemma Ellis, Lorraine Donovan, Anne-Marie Morgan, Fiona Kear and Jen Proctor.	
1.3	To review the Minutes of the previous meeting 23rd November 2017 The minutes were agreed as an accurate record.	

	Matters Arising Item 1.3 – **Action:** MRR to send GW the amended minutes from the 3rd November meeting to circulate. It was re-iterated that Directorates need to have a documented risk assessment for every item on the risk register. Item 2.1 MR confirmed that the temperature control catheter had been discussed in Critical Care. MR confirmed that the cervical spine policy had been discussed in Critical Care but that there were differences in opinion. Work ongoing around this. Item 2.2 Flu Vaccinations – MH confirmed that the Board should now have reached the target of 60% of staff vaccinated. Next audit will show exact figures. Some Directorates have increased figures and will supply the information to MH. It was confirmed that if a staff member has received their vaccination somewhere else i.e. another Health Board then they need to fill in a form so that this data is captured. Item 2.4 HCAI – MH noted that they try to target a specific area every week for HPV cleaning. Housekeeping do this every week in the Day Centre. More difficult on the wards as never have an empty cubicle. Work ongoing around this. CF bare below elbow – **Action:** NM will complete second letter this week and circulate. TH noted that he had dealt with two cases within Neurosciences yesterday. **Action:** GW to arrange for CF and NM to meet with Eleri Davies, Acting Director WHAIP and Vince Saunders again. Item 3.2 HTA Disposal of Organs – current N&T documents need updating. **Action**: RC to action. Item 3.4 CF confirmed that Directorates have submitted their medical equipment bids. Item 4.1 – **Action:** All Directorates to send their updated audit plans to CF if they haven't already done so. **Action:** CM will follow this up with Vinod Ravindran for N&T. Item 5.1 reports were for information and reviewing in Directorates. CF asked if Vince Saunders had visited Rookwood regarding the mould etc in offices. **Action:** RB will check and feed back at the next meeting.	**MRR/SC** **NM** **GW** **RC** **ALL** **CM** **RB**
1.4	Patient Story – N&T SJ presented the patient story to the group. Patient has end stage kidney disease and has been on home dialysis for 7 years. The lady dialyses independently without the need for a carer/partner. Diagnosed in May with papillary carcinoma. Treatment required the administration of radioactive iodine and isolation for 4-5 days. Due to renal failure could not anticipate how long she would need to be isolated. In order to safely manage her treatment the team needed to facilitate her doing her haemodialysis in the isolation unit in Velindre hospital. This involved using a portable dialysis machine recently introduced to service and the patient had to be trained to use it. Several meetings with med physics, infection control and nursing team in Velindre took place to ensure safe	

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	management of this lady. Identifying any risks, safe disposal of waste and developing emergency connect/disconnect guidelines for staff were some of the issues that needed to be addressed. The lady dialysed on the morning of her treatment and then the following day. Radioactivity levels were monitored and she was deemed safe to go home on day 3. Treatment was successful and will require further sessions at 6 monthly intervals. The patient was positive about the experience. It was a learning curve for the renal team, they are now in a better position to support patients in similar settings in the future.	
PART 2: SAFE CARE		
2.1	Open Serious Incidents (SIs) SC fed back to the group. Open Serious Incidents for the Board = 12. 7 within Welsh Government timescale. 2 new SIs to date in December which both relate to pressure damage. Signed one off to date this month which has gone to Carol Evans, Asst Director Patient Safety And Quality, which relates to a patient on Cardiac ITU who developed 2 pressure sores. Need to close one more to reach target of two a month. CF raised concern regarding some sitting with Patient Safety Department. SC to follow up CF noted that there had been a significant increase in SIs over the last few months mainly relating to pressure damage. CF noted that this is a Health Board wide issue. Previously grades 3 and 4 reported but didn't have to report all cases and now it is mandatory to report all cases. CF has spoken to Linda Walker, Director of Nursing, Surgery Clinical Board, re this as she leads on pressure damage for the Health Board. Issue regarding pressure sores graded as 2's in the community and then upgraded to 3's in hospital. Could be an issue with new TVNs or education on the wards. TVNs are reviewing a lot by photos and not in person which is an issue. It was felt that reviewing in person was a much more reliable way to grade pressure sores. LW will be raising these issues at the pressure damage group. Lorraine Donovan, Senior Nurse, Neurosciences, represents the Board at this group. Discussion took place on a recent incident on B4N where a man post op became unwell, nurses were concerned and escalated to the Doctors but the Doctors wouldn't look at the ECG as on ward round. Patient had cardiac arrest and died that day. ECG showed acute heart attack. NM raised concern that the ECG wasn't looked at when requested. HR has agreed to investigate this, not reported as SI to date. Open Inquests Inquest meeting cancelled last week. SC only familiar with one - initials JO. Waiting for RCA to be completed.	**SC**
2.2	Patient Safety Alerts Field Safety Notice – Important Medical Device Information Vascutek Gelsoft is used in Cardiac Surgery – it is recommended immersing the prostheses/patches in sterile saline prior to implantation for 5 minutes. CF confirmed that she had emailed Indu Deglurkar, Cardiothoracic Consultant re this but hadn't as yet had confirmation that this is done in all cases. **Action:** KN will follow this up with Miss Deglurkar.	**KN**

	Unbranded LED decorative lighting chains, model CL100: risk of electric shock due to inadequate construction – remove from use For information particularly due to the amount of Xmas lights in use.	
2.3	Hoist Repairs CF informed the group about the issue with hoists. Issue in Neuro as no hoist for available for some months. Estates are responsible for repairing them if they can. If parts are required then delivery time is 4-6 weeks as a minimum, so for that period of time there is no hoist in the area. There are no spares in the UHB to cover a broken hoist; in some cases patients have had to stay in bed. Looking to lease one or borrow one from St Davids. No process in place to deal with this. **Action:** CF will meet with Lee Wyatt and get a view on exactly what the process is.	**RB** **CF**
2.4	Healthcare Associated Infections CF noted that November was a much better month compared to previous months. One MSSA and one E-coli in month. No C.difficile. Noted that as numbers are small there is not one specific reason for improvement although attention to detail, HH and BBE are key and need to be constantly reiterated Ongoing meetings regarding C.Jeikium in Haematology. MH noted that there had been an improvement but had a few cases in November. Now doing RCA for each case. CF referred to a Hep B case in Cardiac Surgery possibly Health Care acquired. Waiting for results back from blood transfusions and other possibilities. Currently no evidence that it was acquired in health care. **Action:** CF requested that Directorates make sure that staff in their areas that are exposure prone seek professional advice about the need to be tested if they have any reason to believe that they may have been exposed to infection and ensure they are assessed regularly. HR referred to the letter from Occupational Health circulated by Nicola Robinson, Assistant Head of Workforce, regarding duty of self-declaration for healthcare workers performing exposure prone procedures. **Action:** Directorates to review this information.	**ALL** **Dirs** **Dirs**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee None.	
3.2	CMP Annual Quality Report MR presented two slides to the group. • Risk adjusted acute hospital mortality – previous report identified 20% more deaths than the model was predicting. Thought to be issues with coding, infrastructure or sub cohort patients that we don't do well with. • Quality indicator dashboard – above the 1.0% mark so in the acceptable range. All scores pretty much in normal range. Big change from previous figures. HR noted that coding of every single patient is now reviewed by the consultant body. HR noted that coding the same as other units is important.	
3.3	Risk Register Formal Review Deferred to next meeting. **Action:** CF will update the Clinical Board Risk Register to include any recent changes within Directorates that she has been made aware of.	**CF**
3.4	Exception reports and escalation of key QSE issues from Directorate QSE groups None.	

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PART 4: EFFECTIVE CARE		
4.1	<u>Ambulatory Care – Review of the new Initiative</u> BI discussed some documents that needed ratifying with the group: Ambulatory Care Operational Group Ambulatory Care Admission Booklet (for nurses) Patient Information – full Patient information – brief overview Daily nurse assessment for AC patient (based on CTCAE) AC Referral form The information outlines the procedures for patients receiving post stem cell transplant chemotherapy within the haematology ambulatory care service currently being piloted. The ambulatory service aims to improve the patient experience whilst improving treatment capacity by allowing eligible patients to receive their treatment in an outpatient setting. Documents have gone through Haematology QSE. MR suggested that the documents could be electronic instead of paper based and could be added to Welsh Clinical Portal. KW noted that they are looking at having a page – work ongoing around this. PG referred to the investment proposal from the Directorate noting that the Clinical Board hadn't yet received it. BI noted that they are reviewing internally and that it will be with the Board very soon. Pilot started the summer. The documents were validated by the group	
PART 5: INDIVIDUAL CARE		
5.1	<u>National Report – November 2017</u> For information.	
PART 6: ANY URGENT BUSINESS		
6.1	<u>Any Urgent Business</u> <u>Pacing Theatre – Pipe Leaking</u> KN informed the group that a pipe was leaking into the electronics in Pacing Theatres. KN noted that it was currently being dried out and hoping that it will work when switched back on. Will update the CB <u>Celebration of Practice Event (COPE)</u> CF noted that the COPE took place on Tuesday which was an excellent event. Huge thanks to all who participated, the standard is improving every year. Congratulations to all the winners. Paul Twose was the overall prize winner for his Physiotherapy in Critical Care poster. Execs that attended were very impressed. Critical Care had their Celebration event yesterday which was very impressive and the approach was different. Staff delivered patient stories, thank you cards for this year and photographs were displayed. CC was congratulated on the event <u>New Beds</u> HR noted that some of the new beds were being used in Critical Care (as a temporary measure, won't be staying there) and that concern had been raised as	**KN** **Dirs**

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	to their suitability e.g. breaks not working. CF confirmed that there is a new bed contract in place. **Action:** CF requested that any issues with these beds are sent to her to escalate. CG raised concern that this was a whole system problem and that there was lack of engagement from estates and procurement. CF noted that there had also been issues with new mattresses. CF stated that usual hard mattresses are to be used for unstable spines as there is no evidence that the new promats are suitable. Audits CF confirmed that mental capacity audits will need to be completed in January and documentation audits in February. **Action:** GW to email out to the group.	**GW**
PART 7: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
7.1	Received and noted for information	
PART 8: DATE OF NEXT MEETING		
8.1	Thursday 11th January 2018, 8am, in the Critical Care Resource Room, UHW.	

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AGENDA
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 16th November 17 14:00 – 16:30
Venue: Classroom 1

Attendees:	Ian Dovaston
Jennie Palmer	Suzie Cheesman
Kath Prosser	Sian Brookes
Sharon Parkhouse	Derek King
Sharon O'Brien	Sam Barrett
Mudassir Pasha Gillian Spinola Leslie Price(F1)	Jason Roberts (Chair) Tara Cardew Rebecca Aylward

24.5

		Actions
A1	**Welcome & Introductions** JR welcomed all those present.	
A2	**Apologies for absence** Debbie Hendrickson, Angela Jones, Dr Aled Roberts, Delyth Jones, Dr Jo Mower, Lisa Graham, Lisa Harwood and Gemma Murray.	
A3	**Lying and Standing Audit** Dr Leslie Price presented an audit that was completed on West 1 at UHL on the completion of lying and standing blood pressure compliance and falls. The audits identified that there are continued improvements required for the completion of lying and standing blood pressures in line with NICE 2015 guidelines.	
A4	**To receive the Minutes of the previous meeting** The minutes of the meeting held on 19th October were accepted. **Matters Arising** SC shared at Octobers Clinical Board QSE meeting the YALE Swallowing Screen Tool which was preferred above the existing HEADS Tool. Since this meeting it has been agreed that the HEADS Tool will be implemented across all Wales therefore the YALE Tool will not require agreement and ratification. An existing member of staff has been allocated to work with the procurement team to review under or over stocked areas within the Clinical Board. The Clinical Boards Enhanced Supervision Framework report has been submitted to the UHB. Two other Clinical Boards are currently trialling this framework. Further work is ongoing, particularly around changing the UHB Clinical Workstation that would support the electronic recording of patients under Enhanced Supervision and the risk assessments associated with this. It has been noted that there has been a significant culture change around specialling since the Enhanced Supervision Framework has been implemented and patient/staff/relative feedback continues to be monitored.	
1.1	**Patient Story**	

	Gastroenterology, Hepatology and Endoscopy TC shared a story for a young lady who had to be admitted for the treatment of her Crohns Disease which was complicated by the fact that she was a new Mum with a 10 week old baby who was being breast fed. There were governance concerns around how the baby could be safely managed on the ward whilst the patient received the care she required, this resulted in the patients relative having to stay and the patient and relative advised of the risk around this. TC shared the difficulties experienced by the ward is obtaining the required equipment such as a breast pump and cot from Obstetric colleagues. JR asked that TC speak to Children and Womens Clinical Board and their Obstetric colleagues to share the wards experience and how closer joint collaboration can we maintained.	**TC**
1.2	Feedback from UHB QSE Committee http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee- All present were advised of the above link to access UHB QSE committee paper	
1.3	**Directorate QSE minutes – exception reporting** Nothing noted that required further discussion. JR commended Gastroenterology, Hepatology and Endoscopy on the quality of their QSE agenda and minutes.	
1.4	**Health and Care Standards Monitoring audits** KP clarified that these audits should be ongoing and completed by the end of November.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**Flu Plan 2017** KP shared with the group that the Clinical Board were currently at 57% uptake across the Clinical Board and thanked everyone for their ongoing commitment in supporting the Board achieve the expected 60% target. This is an impressive achievement in protecting our patients and staff. S OB raised the Point of Care testing for Flu which MEAU in UHL were keen to trial. JR to raise at the next Point of Care Testing meeting.	**JR**
2.4	**Tissue Viability Task and Finish Group update** KP circulated the new mattress selection tool to support staff identifying the correct mattress selection which has recently been agreed at the UHB Tissue Viability Task and Finish Group along with the new training dates from Medstrom for Primo mattresses. Concerns continue to be raised around the Primo mattress and the lack of flat fitted sheets. This is being picked up by Linda Walker Chair of the Task and Finish Group. All Aero spacer mattresses are to be removed from the clinical areas.	
2.5	**LIPS update** SP provided an up-date on the LIPS project being undertaken at St Davids Hospital and falls prevention. It was identified that the majority of the falls occurred whilst mobilizing to the toilet. Slipper socks have been trialled but discussions are ongoing with Consultant K Davies and D Shannahan Older Persons Consultant Nurse regarding their appropriate use. Further suggestions to support patients whilst mobilizing included 'pimp my Zimmer' which entails making the patients Zimmer frame personal to each patient to encourage them to use this whilst mobilizing and potentially reducing the risk of falls. Further activities have been and continue to be undertaken with the patients as a means of preventing de-conditioning and thereby reducing the risk of falls, such as Karoke and currently making Christmas decorations. RA suggested contacting the Communications Team to invite them to take some photographs on Elizabeth Ward of these activities being undertaken.	**SP**

	SB provided an up-date on the LIPS project that she is involved with which focuses on how we can improve the movement and management of older mental health patients into acute care. Mental health colleagues have undertaken NEWS training to support the patients remaining in the care of mental health. Other areas of work included training and education for nurses on IV fluids and anti-biotics and the identification of Sepsis. A sepsis quiz has been distributed to the ward areas. Support is also being provided by Infection, Prevention and Control colleagues.	
3.1	**Serious Incidents** In October the Clinical Board reported 6 Serious Incidents to Welsh Government, 3 Injurious Injuries, 1 hospital acquired pressure damage, 1 incorrect blood transfusion (never event) and 1 delayed surveillance follow up. WG closure forms for discussion and shared learning: In55493 – An unwitnessed fall relating to a patient in the Assessment Unit which resulted in a fractured neck of femur. The patient was identified as being confused on admission and was placed in an observable area of the unit. Risk assessments were completed in line with best practice. The patient shuffled to the end of the trolley and attempted to mobilize independently resulting in the fracture. The Hover jack was used in line with UHB best practice and NICE 2015 post falls guidelines however, neurological observations were not completed in line with NICE guidelines. All staff were reminded of the importance of complying with NICE 2015 guidelines, this has been shared via the Assessment Units social media website and an SBAR has been recirculated to all staff. In52714 – Hospital acquired Grade 3 pressure damage. The All Wales Pressure Damage RCA identified that the patient had several risk factors that increased the risk of pressure damage including poor dietary intake, poor mobility, Diabetes and incontinence. The RCA identified that the patient was extremely reluctant to be repositioned despite encouragement and that there was a delay in the patient being referred to the Tissue Viability Team when the pressure damage was identified. All staff have been reminded of the importance to ensure that patients/relatives/carers are explained the risk of not repositioning and the potential risk of pressure damage occurring and ensuring that this is accurately documented within the patient's notes. Further education and training continues for all staff around pressure damage. In55870 – Hospital acquired Grade 3 pressure damage. The All Wales Pressure Damage RCA identified that the patient had several risk factors that increased the risk of pressure damage including Parkinsons Disease, a CVA, incontinence and poor mobility. The patient was also being fed via an NG tube and that they would frequently remove this which left the patient nutritionally compromised. The investigation found that whilst risk assessments had been completed, they had not been up dated in line with best practice to reflect any changes in the patient's condition. The investigation also found that the patients individual care plan was not up dated to capture the deterioration from Grade 2 – Grade 3 damage and the actions required. Patient information as in the 'keep moving leaflet' was not provided to the patient or next of kin. All staff were reminded immediately at Safety Briefings for the requirement to ensure that all risk assessments are up dated to reflect any changes in line with UHB and NMC best practice. Spot check documentation audits as well as monthly audits are undertaken to ensure standards are maintained and actions agreed. Nursing staff were reminded that whilst patients with cognitive impairment may not be able to clearly understand and rationalise the requirement to be repositioned, continued encouragement and engagement with relatives/carers are required. The Clinical Board in conjunction with the UHB Tissue Viability Task and Finish Group are re-launching a pressure damage prevention leaflet that can be shared with patients/relatives/carers. These will be shared within all clinical areas of the board	

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	In55105 – Unwitnessed fall resulting in a sub dural haematoma. The Injurious Assessment identified that the patient was not a high risk of falls and had attempted to mobilize and fell. A CT head scan was requested in line with UHB and NMC best practice which reported the sub dural haematoma, however, when the CT report was validated this injury was identified as a chronic sub dural haematoma rather than acute so this was not as a result of this fall. In terms of learning however the Hover jack was not utilised and neurological observations were not completed in line with UHB and NICE 2015 guidelines. All staff were advised immediately that these actions are required in line with UHB best practice. Internal Medicine: 55105 – Unwitnessed fall resulting in haematoma, patient wasn't identified as a fall risk, patient stood up and fell. Ct head scan was done– revalidated chronic haematoma but we submitted the SI before just in case – the hover jack wasn't used but staff were reminded immediately.	
3.2	**Patient Safety Alert** Internal PSN 2017/003 – disseminated for circulation.	
3.3	**Health Care Associated Infections** HCAI rates**:** 240 days since the last case of MRSA 13 days since last case of MSSA 12 days since last Clostridium *Difficile* C. *Difficile* reported 2 cases in October. The target for the Clinical Board this year is 24 so we will not achieve the expected reduction figures. Work is ongoing within the Clinical Boards IP&C sub group around how KPI standards can be improved. MSSA – The Clinical Board is currently on target to achieve the expected reduction target. E Coli reported 4 cases in October. The Clinical Board will not achieve the expected target for this year. RCA's have identified that the main source of these are urinary device related. Congratulation to Ward A7 for their excellent IP&C audit results.	
3.4	**MDRO procedure** This is being reviewed in the Clinical Board IP&C sub group and will feedback concerns into the next Clinical Board QSE in December.	
3.5	**Up-date on blood transfusion competencies following Never Event** There are dates for training scheduled for 2018 along with the ongoing on line training. Practice Educators are facilitating new IV study days. JR requested detail on the number of staff that require training or not had their competencies signed and that this should be easily recordable and available within each clinical area. Information has been shared with the Patient Safety Team for those staff who have received training and had their competencies signed in order to identify the overall UHB requirement for training.	**ALL** **KP**
3.6	**Recommendations from SI In43070 RCA** It has been identified that there have been a number of themes in investigations around NEWS scores not being completed in line with UHB guidelines with the NEWS score being incorrectly calculated. One of the recommendations for consideration from this RCA is that any patient who scores greater than 5 should only have their observations and NEWS score completed by a Registered Nurse	

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	and not a HCSW. RA asked that should the Clinical Board consider implementing this for any patient who scores 3 or above. JR suggested a small task and finish group meeting to scope this recommendation. ID advised that NEWS training forms part of the HCSW induction programme and that e-learning is available. JR requested that ID scope out training within the Clinical Board and to feedback at the QSE meeting in January 2018.	
EFFECTIVE CARE		
4.1	**Director of Nursing Quality & Safety reports** Nil to raise – shared for noting.	
4.2	**Johns Campaign** To carry forward to Decembers meeting.	
DIGNIFIED CARE		
5.0	**HIW report and improvement plans: verbal up-date Emergency Medicine** Action plan for Emergency Medicine remains ongoing. The oxygen tick box and mental capacity has been added to the 'cas card'. S OB to discuss with JR the outstanding actions which sit corporately so that we can close this from the Clinical Board QSE agenda.	**S OB/JR**
5.1	**Read about me campaign up date** ID advised that costing has been completed and it is hoped that this will be funded centrally. Training has been arranged for wards.	
TIMELY CARE		
6.1	**Waits within Emergency/Acute Medicine** SB provided some detail on the overall position for November. To date there were 23 12 breaches in November which are being reviewed. Incomplete E-discharge summaries were raised as a concern in that there are 152 outstanding and should this be noted within the Clinical Board Risk Register. KP advised that this is currently not within the Emergency Medicine Risk Register, to be picked up outside of this meeting.	
INDIVIDUAL CARE		
7.1	**National User Experience Framework** Positive and negative feedbacks were shared. Positive comments continue to be centred around caring nursing staff and care received. Negative comment themes were noted to be around patient food, cold and noisy wards particularly at night.	
7.2	**Complaints and trends** JR advised that the current concerns response rate for the Clinical Board has continues to improve from 44% to 45%. **Compliments** Compliments were shared that had been received for the IBD nurses who expressed that staff were very helpful in making the patient feel at ease, creating a comfortable environment where an open discussion can be undertaken. A compliment was received around the care of a patient in UHL which was shared on the Paul O'Grady Radio programme.	

	Jo Mower wants us to raise the medical staffing in EU. It was discussed at Executive Review yesterday. – AU/EU is biggest risk at the moment as there is a big gap in the Rota and doctors will lose out with the new CAP rate. This will be escalated to Richard as to whether he breaks the cap and agrees a rate. Graham Shortland is pulling together a process for out of hours decisions re breaking the cap.	
8.1	**Staffing levels** Chair/Group The Clinical Director of Emergency Medicine raised concerns around medical staffing. Discussions are ongoing with the Clinical Board Director and UHB Medical Director.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		

Date and time of next meeting: 21st December 2017 Classroom 1

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24.6

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 12th September 2017, 08:00-10:30 hours
Haematology Seminar Room, A7, UHW

CONFIRMED MINUTES

Present:

Richard Hughes	Chair, Consultant Anaesthetist	RH
Linda Walker	Nurse Director, Surgery Clinical Board	LW
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Ophthalmology	AJ
Susan Mogford	Senior Nurse, SSSU/Pain Services	SM
Sally Finley	Dietition	SF
Claire Mahoney	CNS, IP&C	CM
Ceri Chinn	Interim Lead Nurse, Perioperative Services	CC
Mark Bennion	Clinical Governance Facilitator, Perioperative Services	MB
Rafael Baraz	Consultant Anaesthetist	RB
Clare Wade	Lead Nurse, Surgery Clinical Board	CW
Gillian Edwards	Lead Nurse, Trauma & Orthopaedics	GE
Carole Kyte	Service Manager, Trauma & Orthopaedics	CK
Catherine Evans	Patient Safety Facilitator	CE
Adrian Turk	Pharmacy	AdT
Lee Evans	DM, Urology	LE
Graham Roblin	Consultant ENT Surgeon	GR
Mark Wise	Safeguarding Nurse Adviser	MW
Chris Williams	Consultant Ophthalmologist	ChrW
Barbara Jones	Perioperative Care	BJ

<table>
<tr><td colspan="2">17/055 Patient Story: Wrong Site Surgery, Trauma & Orthopaedic Directorate
Highlighted in clinic post operatively, correct side (hand), wrong site. The key findings that contributed to the incident were;
Legibility of the consent form and abbreviations used.
Patient did not see surgeon immediately in the Pre-Operative period.
Anaesthetist marked the operation site.
The WHO Surgical safety checklist was not completed.
The usual theatre team were not present in theatre at the time.

Robust action plan in place including:
- Team Brief reinforced.
- Support given to consultant
- Learning from the incident to be shared widely.</td><td>Actions</td></tr>
<tr><td colspan="2">PART 1: PRELIMINARIES (Chair)</td><td></td></tr>
<tr><td>17/056</td><td>Welcome and Introductions
Colleagues were welcomed to the meeting and introductions made around the table.</td><td></td></tr>
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17/057	**Apologies for Absence** Received from Angela Jones, Denis Williams, Edwina Shackell.	
17/058	**Declarations of Interest** None declared.	
17/059	**Approval of the minutes of meeting held 18th July 2017** Agreed as an accurate record.	
17/060	**Matters Arising:** Minute 2.1.3 17/5/2011. Pregnancy before surgery – ongoing. No update. 16/182 Consent Audit Perioperative Assurance of distribution of Patient Safety Notice to be provided by General Surgery, ENT, Ophthalmology, Urology. **Action: Andy Jones** 17/014 Alerts and Safety Notices: CG80 (March 2017) Early and locally advanced breast cancer: diagnosis and treatment. For General Surgery. **Action: AJ to follow up with Helen Sweetland.** DG27(Feb 2017) Molecular testing strategies for Lynch syndrome in people with colorectal cancer **Action: AJ to follow up with Colorectal Surgeons.** MTG30 (Dec2016) – XprESS multisinus dilation system for treating chronic sinusitis. Mr Roblin to complete the response form and send to Clinical Audit. Completed**, CLOSED**. **17/015** Key Messages from Board/Committees/Groups: Safeguarding Steering Group 22 March 2017 *Safeguarding Steering Group 22nd March 2017.* It was suggested that the Domestic Violence Adviser be invited to a future meeting. Invitation issued. **CLOSED**. **17/022** SBAR Blood Glucose Monitoring Training and Assessment 7/2/17. *Lead Nurses to inspect wards and provide assurance of competency.* RH reiterated the message. **Assurance received from Lead Nurses. CLOSED.** **17/037** Standing Item: NatSIPPS Progress Report. Directorate Lead names for General Surgery, Urology, ENT, Ophthalmology to be provided to CW. **Action AJ**. **17/038** Director of Nursing Reports. Ward staff to be reminded to open existing Datix report for patients re pressure damage, not open new report. Action: Lead Nurses. **17/042** Alerts and other Safety Notices: 11. WHC (2017)025 Guidance on Cyber Security and Information Governance requirements relating to suppliers and the supply chain. **Assurance to be provided. CG Leads/DMS/Lead Nurses**	
17/061	**Clinical Board Annual Work Plan review**	
17/062	**Future meetings – alternative days/times** It was concluded that an alternative day/time would not suit all. The decision was taken to continue with the current schedule.	
PART 2: PATIENT SAFETY AND QUALITY		
17/063	**Standing Item: NatSIPPS Progress report** The UHB Task and Finish Group had been held on Monday 11th September. There was recognition that by September 2017 a scoping exercise should be completed. Discussion took place concerning the definition of an invasive procedure. **Action: MB to share the flow chart.** ENT Lead – Mr Graham Roblin Ophthalmology Lead – Mr Chris Williams General Surgery Lead – Mr David Scott-Coombes.	**MB**

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	Once scoping is complete, individual Task and Finish Groups will focus on individual procedures.	
17/064	**Director of Nursing Q&S Report** **August 2017** LW reviewed the Report.	
17/065	**Directorate Assurance Reports:** 2.3.1 General Surgery, Urology, Ophthalmology – on shared Drive, not discussed. 2.3.2 ENT – not submitted 2.3.3 Perioperative Services – summarised by MB 2.3.4 Anaesthetics – summarised by RB 2.3.5 Trauma & Orthopaedics – summarised by GE	
17/066	**Exception reports from Directorates/Working Groups** ▪ General Surgery, Vascular , Wound Healing: ▪ Head & Neck, Maxillo Facial and Ophthalmology ▪ Urology ▪ Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: o RCA into lack of WHO checklist o RCA into 139 images for facet joint injection ▪ Trauma and Orthopaedics	
17/067	**Policies and Procedures** Nil received.	
17/068	**Alerts and other Safety Notices** . NICE guidelines: 2.6.1 Surgery CB summary spreadsheet – received and noted. 2.6.2 *IPG581 (June 2017) – Infracoccygeal sacropexy using mesh to repair vaginal vault prolapse*. **Action: AJ to chase assurances from General Surgery** MDA 2.6.3 – *MDA/2017/019, Issued 11 July 2017: Unomedical high concentration oxygen masks (specific lots) – risk of hypoxia as the tubing can disconnect from the oxygen masks*. None within Surgery Clinical Board. 2.6.4 *MDA/2017/022, issued 17 August 2017: DePuy Synthes Impactor for PFNA (Proximal Femoral Nail Anti-rotation) Blade: risk of infection*. None within Surgery Clinical Board 2.6.5 *MDA/2017/027, issued 24th August 2017: Intra-aortic balloon pump (IABP):CS100, CS100i and CS300 – risk of hemodynamic instability to patients with critical conditions due to a delay in or sudden interruption of therapy.* Not applicable to Surgery Clinical Board. Patient Safety Notice 2.6.6 *PSN036, issued November 2016: Reducing the risk of oxygen tubing being connected to air flowmeters*. Addressed by Clinical Engineering. 2.6.7 *PSN036, Medical Air SBAR* Addressed by Clinical Engineering. 2.6.8 PSN025*, Briefing Paper: Achieving compliance with Patient Safety Notice 025 – Risk of death or severe harm due to inadvertent injection of skin preparation solution. Safe Practice reminder, issued July 2017 – For all staff involved with invasive procedures.* **Risk to be reduced by writing a Standard Operating Procedure. Action: MB** **SOP to be taken to Policy Group. Action: BJ** **To be added to Risk Register. Action: MB**	**AJ** **MB** **BJ** **MB**

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	2.6.9 *ISN 2017/002,: Risks associated with confusion between Ketamine 10mg/ml injection and Eskatamine injection 5mg/ml.-* 2.6.10 *ISN 2017/001: Risk of written consent forms being illegible, incomplete, abbreviated and not dated correctly*. Welsh Health Circulars: 2.6.11 *WHC (2017) 029, Issued 26 July 2017: All Wales Guidelines for the Management of Devastating Brain Injury*. **Received and noted.** 2.6.12 *WHC (2017)034. Issued 12 July 2017: Policy on the Management of Point of Care Testing (POCT), What, When and How?* **Received and noted.** Highly relevant to Surgery Clinical Board. 2.6.13 *WHC (2017)036, issued 24 July 2017: Guide to Consent for Examination or Treatment* – Revised Guidance. National Group. Document to be revised, based on Montgomery. Ophthalmology have a device to magnify consent forms, which can be used on all font sizes.	
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
17/069	Key Messages from Board/ Committees/ Groups 3.1.1 UHB Medicines Management Group Minutes 20th July 2017 & 17th August 2017. Papers summarised by AdT: - Clexane: Change over in November/December 2017 to new supplier. T&O using Fragmin. There may be a financial penalty. No risk of supplies running out. 3.1.2 UHB Decontamination Group Draft Minutes 10 August 2017. Received and noted. National Audit happening. 3.1.3 Research Governance Group Minutes 11 July 2017 – Received and noted. 3.1.4 Clinical Board H&S Group Draft Minutes 7 June 2017 – Received and noted. 3.1.5 Clinical Board IP&C Group Draft Minutes 24 July 2017: - ANTT discussed. Surgeons/Junior doctors need to complete ANTT. All to escalate via Directorate Quality and Safety and Audit meetings. **Action: ALL** The following items were received and noted: 3.1.6 UHB Water Safety Group update 3.1.7 Blood Transfusion Committee update – Minutes 6/9/17 - Zero Tolerance Report July 2017 3.1.8 UHB Patient Safety Quality and Experience Report July 2017 3.1.9 Notification of Critical, Urgent, and Unexpected Significant Radiological Findings SBAR. 3.1.10 Out of areas GI bleeds – Letter to staff 3.1.11 All Wales Sterile Services Departments Decontamination Survey – letter 5 July 2017 3.1.12 Saying Sorry leaflet	**ALL**
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
17/070	**IP&C RCA database** Noted.	
17/071	**LIPS Progress Report – Trauma & Orthopaedics** T&O sisters and charge nurses completing a project on The Ideal Ward.	
17/072	**QUAD Audits**	

	Findings: poor WHO checklist compliance.	
17/073	**Team Briefing Compliance** Further work required.	
17/074	**VTE Thromboprophylaxis Audit July 2017** This needs to be repeated, and the tool adapted. Findings: Various drug charts in use. Old Care Plans in place for VTE.	
PART 5: GOVERNANCE		
17/075	**Concerns (Clinical Incidents, Complaints, and Claims)** 5.1.3 Open SIs, No Surprises,: 14 open SIs. Four remain open from 2016. .5.1.4 Regulation 28 report & Open Inquests Nil 5.1.5 Serious Incidents: Closure forms sent to WG since 1/7/17: 6 closure forms submitted to WG in the previous month. Target of 5 closure forms per month remains a challenge to achieve 5.1.6 Falls Report: 1 unavoidable, 1 partially avoidable. 5.1.7 Pressure Damage Report 6 Pressure damage SIs. 5.1.8 Complaints, Claims and other Concerns (i) All New Clinical Negligence claims opened 15/7/17 – 6/9/17 (ii) All Clinical Negligence Claims Settled 15/7/17 – 6/9/17 (iii) Personal Injuries Negligence Claims settled 15/7/17 – 6/9/17 (iv) New Personal Injuries Negligence Claims opened 15/7/17 – 6/9/17 Noted. 5.1.9 Ombudsman's Reports received: nil	
17/076	**Review HIW Ophthalmology Thematic Report Improvement Plan** (Deferred previous meeting) DW had not attended. ▪ The majority of actions were complete and had been presented to the Chief Executive. ▪ CE discussed an incident on e-datix regarding allegation of harm. Update required from Ophthalmology. ▪ ChrW raised the issue of lack of Glaucoma consultant and advised colleagues to report on e-datix any incidents that are causing patient harm. Asked to take back to Ophthalmology Q&S to report harm. ChrW's view was that e-datix is not easy to use. ▪ RH clarified that clinicians must report potential and actual harm. ▪ RB confirmed that the system is robust if incidents are reported.	
17/077	**Patient Surveys:** 5.5.1 - National Survey Report for Surgery (July 2017) – Received and noted.	
17/078	**Research & Development** Nil reported.	
PART 6: DATE OF NEXT MEETING **Tuesday, 21st November, 08.00 – 10.30, Haematology Seminar Room, A7, UHW**		

PART 7: URGENT BUSINESS		
17/079	1. Roll out of new pumps: RH raised the issue of new pumps that are due to be rolled out soon. Concern had been raised regarding the lack of a robust plan. **Action: CWade to contact Clinical Engineering re Roll out plan.** 2. Capital Equipment Bids. RH suggested that colleagues prepare their bids in readiness should there be funding made available. 3. Staff Engagement Week 11 – 15 September. Facebook page refers. 4. Safeguarding Nurse Adviser. Mark Wise introduced himself and explained that VA1s go to MASH as discussed at the Safeguarding Strategy meeting. Mark is the Lead for the Surgery Clinical Board. AJ advised that Safeguarding training would be delivered at the next Audit session for clinicians 5. Nursing Times Awards AJ shortlisted and to present to the panel in London later in the week.	**CWade** **ALL**
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
17/080	**Recent Reports & Communications** The following were received for information: 8.2.1 TARN Report – Clinical Report Issue 2 – July 2017 8.2.2 Cessation of Tonsillectomy Surveillance 8.2.3 Enhanced Microbiology Service 8.2.4 Ministerial Ratification of AWMSG Recommendations June 2017 8.2.5 CMO Update 88 8.2.6 Violence against Women, Domestic Abuse & Sexual Violence E-learning training module 8.2.7 Information and guidance on domestic abuse: Safeguarding older people in Wales 8.2.8 Public Health England: Hepatitis B vaccination in adults and children: temporary recommendations 8.2.9 RCS: Consent: Supported Decision Making – A Guide to good practice.	
17/081	**Directorate Q&S Minutes** 8.3.1 Anaesthetic Q&S Minutes 13 June 2017 8.3.2 Perioperative Care Q&S Minutes 28th July 2017	

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SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 21st November 2017, 08:00-10:30 hours
Haematology Seminar Room, A7, UHW

CONFIRMED MINUTES

24.6

Present:

Richard Hughes	Chair, Consultant Anaesthetist	RH
Linda Walker	Nurse Director, Surgery Clinical Board	LW
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Ophthalmology	AJ
Susan Mogford	Senior Nurse, SSSU/Pain Services	SM
Sally Finlay	Surgical Lead Dietician	SF
Yvonne Hyde	CNS, IP&C	CM
Ceri Chinn	Interim Lead Nurse, Perioperative Services	CC
Mark Bennion	Clinical Governance Facilitator, Perioperative Services	MB
Rafael Baraz	Consultant Anaesthetist	RB
Clare Wade	Lead Nurse, Surgery Clinical Board	CW
Gillian Edwards	Lead Nurse, Trauma & Orthopaedics	GE
David Scott-Coombes	Clinical Governance Lead, General Surgery	DSC
Adrian Turk	Pharmacy	AdT
Oleg Tatarov	Clinical Governance Lead, Urology	OT
Judith Smith	Senior Nurse, Perioperative Care	JS
Robin Clark	Main Theatres (observing)	RC
Chris Williams	Consultant Ophthalmologist	ChrW
In attendance:		
Edwina Shackell	PA, Surgery Clinical Board	ES
Sarah Richards	Independent Domestic Violence Adviser	SR
Karen Lewis	Claims Manager	KL
Suzanne Wickes	Clinical Negligence Claims Manager	SW

Patient Story: MDT working across different Health Boards: A patient story of where care went wrong

LW provided an overview of the care of a patient whose care had been shared between Aneurin Bevan (AB) and Cardiff and Vale (C&V) Health Boards. The patient had been seen and worked up at AB; a specific stent needed to be designed for endovascular surgery. An MDT was convened, comprising an interventional radiologist and consultant surgeon for each Health Board. The key findings:

- C&V could not see any radiological images, or blood tests as these were on the AB system and this did not ‘talk’ to the C&V system.
- All correspondence in planning for the surgery was carried out via email but not in a consistent way as not all parties were always copied in to all correspondence
- Two days prior to surgery, AB advised that their surgeon could not do the procedure. Care of the patient was handed over to the C&V consultant surgeon on the day of surgery. Also the C&V anaesthetist who was involved with the patient’s Pre-Operative work up was not going to be present on the day.
- The patient needed a spinal drain inserted as part of the procedure, normally done by an anaesthetist.

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- The C&V surgeon did not know the patient. The consent form was completed, and the procedure carried out on the same day. The Montgomery principles were not evidenced in this case. Due to the extensive nature of the procedure it took approximately 7 – 8 hours. The ward staff had expected the patient back in 3 hours; the family consequently became very anxious.
- Normal procedure is if the patient had had a drain inserted by an anaesthetist, they would have gone to HDU. However, the requirement for the drain was missed, it was not inserted and so the patient returned to the ward. The physiotherapist noted the patient had slight deterioration in movement of the lower limbs at about 24 hours post procedure, but the full extent that the patient had an infarcted spinal cord was not picked up until 48 hours post-surgery. Unfortunately this was too late and the damage irreversible. Over the following weeks the patient's condition worsened and sadly he subsequently died.

Learning points:

- MDT – information was not shared between Health Boards in a robust way. Welsh Clinical Portal now addressed this.
- The consent process was poor – new process have been put in place to address this.
- The arterial observation chart does not specifically ask that movement of limbs are checked. – A new document has been designed an implemented.

Actions

- The service was suspended with immediate effect.
- A detailed action plan has been put in place and is reviewed regularly. Once the action plan has been fully implemented a discussion on the plans to re-introduce the service can be progressed.

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<tr><td colspan="2">PART 1: PRELIMINARIES (Chair)</td><td></td></tr>
<tr><td>17/082</td><td>Welcome and Introductions
Colleagues were welcomed to the meeting and introductions made around the table.</td><td></td></tr>
<tr><td>17/083</td><td>Apologies for Absence
Received from Catherine Evans, Graham Roblin, Jayne Thain, Simon White, Clare Mahoney, Barbara Jones, David Owens, Angela Jones, Helen Robertson and Guy Blackshaw</td><td></td></tr>
<tr><td>17/084</td><td>Declarations of Interest
There were no declarations of interest.</td><td></td></tr>
<tr><td>17/085</td><td>Independent Domestic Violence Adviser, Sarah Richards
SR explained that this role sits within the Safeguarding Team based at UHW. The role includes supporting patients and staff experiencing domestic violence. Referrals are received via EU, Maternity and Mental Health.
SR can meet with patients, undertake a risk assessment, and complete immediate safeguarding referrals. Support can be given with emergency accommodation, or informing the police if the client wishes.
Support in hospital is by its nature short term, with referral on to the appropriate third sector organisation.
Forms and information are available on the intranet.

LW explained that it had been difficult to access training for a perpetrator.
SR advised of a 24 week programme, Choose to Change, offered for males in the Vale of Glamorgan. Clients could self-refer or be referred by a professional. A female partner would be offered support by the same charity.

SR was not aware of an equivalent charity in Cardiff but this may mean that Cardiff residents can refer to the Vale organisation.

RESPECT – can give advice on all perpetrator services across Wales.</td><td></td></tr>
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	There is currently a lack of specific support for a perpetrator in a same sex relationship or a female perpetrator, but all of the above mentioned will support those in same sex relationships.	
17/086	**Approval of the minutes of meeting held 12th September 2017** The Minutes were approved, subject to the following amendments: Highlighting to be removed throughout **Minute 17/055**: "Highlighted in clinic by wrong thumb" to be amended to read: "Highlighted in clinic, correct side (hand), wrong site."	
17/087	**Matters Arising** To receive Action Log from the above meeting Minute 2.1.3, 17/5/2011. Checking pregnancy before surgery. Ongoing. Policy written, sits with Children & Women. All Surgery Clinical Board wards are affected, particularly Llandough. The Policy had been taken via Children & Women QSE, and needed to go to a UHB ethics Committee but that was the situation up to a year ago; there has been no feedback. There is currently no further action the SCB can take. 16/182 Consent Audit Perioperative Care. Consent forms are still not being completed to a good standard. RH asked all colleagues to emphasise this message across the Clinical Board. Assurance was **RECEIVED** that this had been recirculated to General Surgery, Urology, ENT, Ophthalmology, and discussed at Anaesthetic Quality and Safety. 17/014 Alerts & Safety Notices CG80 (March 2017) Early and locally advanced breast cancer: diagnosis and treatment. A response had been received from the Lead Clinician for Breast Cancer and submitted to Clinical Audit. **CLOSED**. DG27 (Feb 2017) Molecular testing strategies for Lynch syndrome in people with colorectal cancer. A response had been received and submitted to Clinical Audit. **CLOSED.** 17/037 Standing Item: NATSIPPS Progress Report– **AGENDA ITEM** 17/038 Datix reporting. Assurance to be provided that ward staff were to be reminded to amend existing Datix report re pressure damage, not open a new report. Assurance **RECEIVED. CLOSED.** 17/046 In38815. Incident closed with WG. **CLOSED.** 17/046 Claims report – Agenda Item. **CLOSED.** 17/063 NATSIPPS – definition of invasive procedure. The flow chart had been circulated. **CLOSED.** 17/068 IPG581 (June 2017) Infracoccygeal sacropexy using mesh to repair vaginal vault prolapse AJ had sent out another request. *Post meeting: submitted by Mr Tatarov to Clinical Audit 21/11/17.* ***CLOSED.*** 17/068 – PSN025 Briefing paper: Achieving compliance with PSN025 – Risk of death or severe harm due to inadvertent injection of skin preparation solution. Safe Practice reminder, issued July 2017. A Standard Operating Practice had been written, which had been taken to Policy Group, circulated for comments in readiness to take back to the next Policy Group. Added to the Risk Register. **CLOSED.**	

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	17/069 Roll out of ANTT. Surgeons and Doctors in Training need to complete ANTT training. It was explained to clinical colleagues that this was an All Wales decision, designed to capture clinical staff who had not covered this in their training. Perioperative Care – Dr Balachandran is leading. The Education Leads are happy to support if there are insufficient assessors locally. 5 minute assessment. E-learning is published. **Action: CW to circulate the link to e-learning.** 17/079 – roll out of new pumps. Clinical Engineering will be implementing their roll out plan over the next few months. **CLOSED.**	**CW actione d 21/11/17**
PART 2:	**PATIENT SAFETY AND QUALITY**	
17/088	**Standing Item: NatSIPPS Progress report** - Definition of Invasive Procedures This paper, produced by Patient Safety, had been helpful for ENT, as nasoendoscopy is not defined as an invasive procedure. Update on progress: - Perioperative – 95% compliant - Bed holding directorates submitted their gap analysis. **Action: Invite Matt McCarthy, UHB NATSIPPS Lead, to next meeting**. Assurance had been submitted to Welsh Government. - Next steps: to address issues highlighted in the gap analysis.	**ES actioned 28/11/17**
17/089	**Director of Nursing Q&S Report** October 2017 Key issues: SIs – the Clinical Board is required to close 6 SIs per month; target of 20% improvement by January 2018. Good progress had been made on closure forms. Directorates to share learning from SIs and their own Q&S meetings. Sepsis 6 Bundle. Dean Whittle, Pharmacy, and Federica Faggian, Consultant Microbiologist are to undertake work on 48 hour antibiotic review across general surgery, including those patients stepping down from Critical Care. Virtual Red Line. This has been implemented in Theatres ahead of schedule. Colleagues' feedback was noted, in particular that there were currently no adequate changing facilities outside of the red line in some of the theatre suites making this difficult to fully adhere to. The Perioperative Care Directorate are working to reconfigure the floor footprint in main theatre UHW to provide changing facilities but for the other suites it was acknowledged this was a challenge. As the point of principle the Virtual Red Line is at the Anaesthetic room doors, the orange zone just back from this which is a bare below the elbow area. The Virtual Red Line and the different zone areas would be formally re-launched when the refurbishment of changing rooms at UHW was complete. Modular theatres UHL. Work was nearing completion. A commissioning date is to be confirmed.	
17/090	**Directorate Assurance Reports:** 1. General Surgery, Urology, Ophthalmology – Report on Shared drive. 2. ENT – Report on Shared drive. 3. Perioperative Care: - A Governance Group had been established. - Cardiac had declined the use of Theatre 10, now utilised for CEPOD service. - Modular Theatre UHL handover 13/11/17. Delay in opening due to work on the floor below; the revised date of 29/11/17 is unlikely to be met due to a recent leak. - UHL Theatre 5 is not in use; Theatre 6 in use for non-joint surgery. - CHFW – feedback from the recent major incident table top exercise had been positive.	

<table>
<tr><td></td><td>4. Anaesthetics
- M&Ms presented in October, including misplaced central line at UHL, where the X-ray was not reviewed in a timely manner.
- Line insertion – it was unclear to MB why the Anaesthetic service was offering this service, particularly with the volume of cases going through emergency theatre. The difficulty of this was acknowledged by LW, with the need for clear UHB guidelines for each type of line. A UHB lead was needed, but this was not deemed to lie with the Surgery Clinical Board.
UHL did not offer a line insertion service; patients were therefore transferred to UHW, then returned to UHL.
An updated flow chart for line insertion had been presented at Anaesthetic audit.
Action: LW to discuss with Carol Evans, Assistant Director for Patient Safety.
- Consent legibility – discussed at Audit.
- Drug Error, sub-Lingual Nifedipine. Dr Baraz and Adrian Turk had jointly presented at Anaesthetic Q&S Sept 2017. Action: AdT to send bulletin to RB.

5. Trauma & Orthopaedics:
- Julia Barrell had presented on the Mental Capacity Act.
- 7 SIs, 6 of which pressure damage. RCAs being finalised, will be closed.
- Increase in SSI post elective hip surgery at UHL. No predominant organism, no single point of source of infection. A review had been undertaken of theatre discipline, hand hygiene, hip protectors, alcohol gel, and traffic to store room at rear of Theatre 4. Nil specific found. It had been agreed to review data via repeat audits. Consideration was being given to pre-operative showers or wipes. YH advised wipes were not deemed suitable and that IP&C were considering trialling a new wash solution (in use at Velindre).
JS advised that the 5 patients transferred from UHW to UHL as emergencies, post trauma, rather than electives. The CD for Trauma & Orthopaedics had raised concern regarding the mix of elective and emergency patients. JS had requested locks to be fitted to prevent traffic through theatre and was chasing Estates.
- YH advised that there will be a Public Health Nurse appointed for Infection Prevention and control. There had been a blip in SCB hand hygiene compliance, which had improved to 100%. BBE and HH generally much improved.
- T&O MRSA patient. LW cited this case where a patient was screened in pre-assessment and was already known as MRSA negative on arrival for surgery and was counted against SCB. Elective surgery UHL, MRSA screened negative, then arrived at UHW, screened MRSA positive, now attributed SCB. YH explained that criteria had to be set to determine where cases were attributed; she would review this recent case.</td><td>LW

AdT</td></tr>
<tr><td>17/091</td><td>Exception reports from Directorates/Working Groups
1. <u>General Surgery, Vascular , Wound Healing</u>:
General Surgery and Radiology SI, identified communication issues between the two services which is being looked at.

2. <u>Urology</u>
Patients requiring interventional radiology. Mr Tatarov cited examples of 2 cases in recent weeks where an out of hours interventional radiologist was not available. Mr Tatarov had consistently raised this issue, and explained the serious implications for patients. In particular where had there been an interventional radiologist available, kidneys could have been saved. This issue had been escalated to the Medical Director.

Mr Tatarov envisaged an increase in these cases should the Trauma Centre be located at UHW. The Trauma Centre working group is aware. The long term issue would take several years to resolve, considering recruitment, retention and rotas.

LW confirmed that the matter is with the Medical Director and Executive Director of Nursing. This had been placed on the CB Risk Register, 25 score, since 2011. It was likely that a paper for Management Executive would be required in due course.</td><td></td></tr>
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	Mr Scott-Coombes explained that for Vascular surgery, an interventional radiologist rota is standard care across the UK. It was extremely concerning that C&V was in this position, particularly in light of Mr Richard Whiston's work over a period of 7 years to establish a SE Wales Vascular Service. Recommendations: 1. Specialties to log incidents. Mr Tatarov confirmed this was being actioned going forward. 2. It is suggested that Urology has a formal weekly report, whereby any incidents can be captured. 3. Head & Neck, Maxillo Facial and Ophthalmology – nil reported 4. Urology – nil reported. 5. Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: - Drug error, Main Theatres. Internal review in progress. - Loss of specimen in SSSU – report complete. - Diabetic chart – RH explained that a Diabetic Nurse presented this to SSSU nursing staff. Staff are now confused as to what they should be doing for patients. This had been escalated to the diabetes team. AdT confirmed that specialised diabetic fluid is a stock item on wards but that there was not wide awareness. RH was unsure whether this had been disseminated to surgical teams; AdT advised that this was in the process of being embedded. CW had met with Aled Roberts, CD for Medicine, who was happy to attend Audit meetings. RH explained that management of an emergency diabetic patient was not straightforward; they should either be given sugar and electrolytes as part of modern diabetic management. AdT referred to a drug chart, which it was acknowledged was not easy to read. It was agreed that the change of management of these patients should be embedded in education for F2s, F1s etc. AJ confirmed that there was lack of assurance that staff knew what the process was, as it was too confusing. A Diabetic Specialist Nurse is available 5 days, not 24/7. It was suggested by LW that focus be given to SSSU and SAU initially – that diabetic nurses could be asked to support these areas. CW had met with diabetic nurses, who reported a lack of resources for education. DSC observed that managing the insulin dependent diabetic in the emergency stream should be standard sliding scale care. It was suggested that clarification should be sought from Aled Roberts on the correct modern fluid management to follow. **Action: AdT** 6. Trauma and Orthopaedics - nil 7. IPC YH was aware of reduction targets. The UHB cannot now achieve its Staph aureus target E coli – possible to achieve target C diff – can achieve target. HCAI – there had been an increase since the 2011 review. The recent study had had better access to patient data, giving a more accurate picture. The increase shown was therefore anticipated. Antimicrobial data summary - report out today, 21/11/17. Flu vaccination. There had been flu on ITU, very low levels at present. YH asked all colleagues to drive the vaccination uptake forward.	**AdT**
17/092	**Policies and Procedures** Nil received.	
17/093	**Alerts and other Safety Notices** 1. Shortage of litmus paper for NG fluid testing	

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	This had caused anxiety. MERC pH strips withdrawn nationwide. There were plans to change to an alternative supplier. WG now wants a non CE strip, and have stocks ready to go. However, the reading of the strips uses a colour code that is opposite to that of MERC, therefore significant training will be required. Agreement from WG awaited. C&V has fed back to WG that it is not happy to adopt a non CE strip, and was hoping for support from other HBs. **Action: CW to add to the Risk Register.** In the meantime, stocks of MERC will continue to be used, pending a decision before these run out. *Update received post-meeting:* *At present we have obtained a similar product to the current one, therefore there will be no training requirements on how to read the pH strips and it will be a straight swap on the ward.* *The new stock is due to arrive within the hospital 24/11/17* *There may still be changes in the future but this will be disseminated out as and when required.* MDA 2. MDA/2017/029, issued 13 September 2017: Lung ventilators: Astral 100, 100SC and 150 – potential power loss due to faulty battery. **Not applicable to SCB** **3.** MDA/2017/030, issued 21 September 2017: All Accu-Check Insight insulin pumps – risk of alarm failure None held in Perioperative Care. **Not applicable to SCB.** 4. MDA/2017/032, issued 3 October 2017: Intra-aortic balloon pump (IABP): Maquet/Datascope CS100, CS100i and CS300 – potential for interruption or delay to therapy of critically ill patients. **Not applicable.** NICE Guidance 5. Surgery CB summary spreadsheet – outstanding notices: IPG 575 – *Trabecular stent bypass microsurgery for open-angle glaucoma*. ES **Resent to Prof Morgan/Denis W 31/10/17.** CG65 – *Hypothermia: prevention and management in adults having surgery*. UHB non-compliant as indirect measurement thermometers used **ES resent to Richard Hughes 21/11/17** IPG579 – *Irreversible electroporation for treating pancreatic cancer*. **AJ to chase General Surgery.** 6. NG51 – *Sept 2017: Sepsis: recognition, diagnosis and early management* 2.6.6.1 Sepsis 6 Pathway – Sepsis Screening Toolkit – **Gemma Ellis attending next meeting.** 7. IPG 591 – *Sept 2017: Ab externo canaloplasty for primary open-angle glaucoma*. Actioned and **CLOSED.** 8. IPG592 – Sept 2017: *High-intensity focused ultrasound for symptomatic breast fibroadenoma.* Post-meeting: response received from Miss Sweetland. **CLOSED.** Patient Safety Notice 9. *PSN035, issued August 2017, re-issued 28 September 2017: Risk of death and severe harm from ingestion of superabsorbent polymer gel granules.* Relaunched. Advice from SCB QSE Group had been for the Nutrition team to approach the supplier for tamper proof lids, which the supplier had advised was not feasible. On the Risk Register. **CLOSED.** 10. *Compliance with Human Tissue Act 2004, HTA Standards and Codes of Practice. WG letter dated 13 September 2017* **NOTED**: for adherence/action. 11. ISN: 2017/003- Blood Transfusion Safety All directorates to provide assurance.	**CW** **AJ**

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<table>
<tr><td></td><td>Assurance RECEIVED from: Perioperative Care.
Action: All other directorates to respond direct, cc ES, embedding copies of the assessments or database. Assurance to be provided at the next meeting.

<u>Welsh Health Circulars:</u>
12. WHC/2017/043, Issued 20 September 2017. Policy for Managing babies born on the threshold of survival. Not applicable.

13. WHC (2017) 046, Issued 2 October 2017. Amendment to the Human Medicines Regulations 2012 – Supply and Use of Adrenaline Auto Injectors I Schools. – Not applicable.

14. WHC/2017/048, Issued 16 October 2017: Attaining the WHO targets for eliminating hepatitis (B and C) as a significant threat to public health. Hep B Vaccine Shortage.
It was noted that the UHB would not achieve this target.

15. WHC/(2017) 051, issued 15 November 2017: Raising Awareness of Carbon Monoxide Poisoning and Action Required by Health Professionals. For awareness and dissemination to directorate Q&S</td><td>ENT, OPHTH, T&O,GEN SURG, UROL

ALL</td></tr>
<tr><td colspan="3">PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT</td></tr>
<tr><td>17/095</td><td>Key Messages from Board/ Committees/ Groups

1. <u>UHB Medicines Management Group Minutes 19th October 2017</u>
Antimicrobial Medicines Management Group. Being taken forward via the IMTP process. A strong Antimocrobial lead is still needed in Surgery.
Enabling Medicines Management project: the current work plan includes local implementation of the 5 “low value medicines”.

Clexane – current status. AdT advised that the UHB was allowed a maximum quota it was able to purchase. The UHB had passed the first predicted shortage. The next 2-3 outage would be at the beginning of December, with no further supplies to the UK. Management would comprise likely exploration of a biosimilar drug for Obs and Gynae. Trauma continues to use Fragmin. It is hoped that Clexane supplies will return to normal in the New Year.

2. <u>UHB Decontamination Group meeting 17th Oct</u>, Minutes awaiting ratification
Key issues:
Decontamination audit September 2017. Action plan for Surgery in place.
Cardiac heater/coolers in theatres – removed.
Decontamination records – there had been discussion on location of records, and retention duration. A working group is to be set up.
Laryngocosope handles/blades – ongoing issue.

3. <u>Research Governance Group</u> – feedback from meeting 17th October 2017
Nil for SCB.

4. <u>Clinical Board H&S Group Draft Minutes 18 October 2017</u>
Key issues:
Corporate decision to charge for non-attendance at Manual Handling courses where no notice is received.
Fire service – core hours, one crew only will attend. Out of hours 3 crews as normal.

5. <u>Clinical Board IP&C Group Draft Minutes 9th October 2017</u>
Flu 36% compliance to date.

6. <u>UHB Water Safety Group update</u>
Key issues:</td><td></td></tr>
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	Reminder to adhere to flushing policy for showers used and unused. Estates will no longer carry out flushing at UHL. 8. Blood Transfusion Committee update – Feedback from meeting 20th October 2017 o Zero Tolerance Report October 2017 Noted. MB advised that the report does not specify which particular area in SSSU was implicated; it has therefore not been possible to follow this up. 9. UHB Vulnerable Adults & Safeguarding Children – meeting next week. Successful training had been undertaken for medical and other Ophthalmology staff. A community paediatrician is happy to come out to deliver a 2 hour session condensed from 4 at local audit meetings so long as there is adequate attendance. 10. UHB Safeguarding Team Newsletter Autumn 2017 – Noted 11. TAAG Group This had been reinstated. There were potential changes with regard to VTE and Trauma in light of draft NICE guidelines. Meeting in January.	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
17/096	**IP&C RCA database** C.difficile – 14 to date. More timely testing is needed, to identify potential community sources. MRSA – 3 (2 potentially not attributable to SCB) MSSA – 14 – over expectation. Themes: complex patients, antibiotic use.	
17/097	**LIPS Progress Report – update from Perioperative Services** MB advised that 5 staff had embarked on a project 12 months previously; however, 4 had been pulled for clinical commitments. The remaining member of staff had joined another group working with ID bracelets – no update yet available. RH underlined the need for the CB to support staff to attend courses. It is anticipated that due to an improved staffing position in theatres, it should be possible to release staff.	
17/098	**Audits** 1. Internal Quad Audits, September 2017 - UHL Theatres September 2017 - SSSU Theatres September 2017 - Main Theatre UHW September 2017 - CHfW Theatres September 2017 Some results disappointing. Actions completed: Results shared across all directorates Action plans – monitored by ongoing governance Groups. 2. Perioperative Uniform Procedure Audit October 2017 Action plans as above. 3. Perioperative Bare Below the Elbow Audit October 2017 Main culprits are surgeons and anaesthetists Teams are asked to continue with the audits and 'challenge' where required in order to assure that discipline is in place. **ALL** 4. Virtual Red Line Zone – Bare Below the Elbow and Hygiene Initiatives Discussed above. CW noted that this should be raised at team briefs every day.	

<table>
<tr><td>17/099</td><td><u>HIW Surgical Services Inspections</u>
All Wales Annual Report has been circulated for information.
LW had been in touch with a Health Board who had been inspected by HIW. It is likely that C&V will be inspected sooner rather than later.
Theatres systems and processes are robust. However, ward areas are vulnerable. LW strongly suggested that colleagues read the HIW report. The Executive Nurse Director requires assurance from each Clinical Board on their status. It was advised that the inspectors rely heavily on staff comments. Action: ALL</td><td>ALL</td></tr>
<tr><td>17/100</td><td><u>Healthcare Standards</u>
Will be reviewed early in the New Year.</td><td></td></tr>
<tr><td colspan="3">PART 5: GOVERNANCE</td></tr>
<tr><td>17/101</td><td>Concerns (Clinical Incidents, Complaints, and Claims)

1. <u>Open SIs, No Surprises,</u>:
19 currently open. Target is to close 5 per month. Last month 6 were closed, but 6 new were reported. Several longstanding complex SIs, cross CB/HB.

2. <u>Regulation 28 report & Open Inquests</u> - nil

3. <u>Serious Incidents</u>:
Closure forms sent to WG since January 2017: 41

4. <u>Falls Report</u>: 4 since April.

5. <u>Pressure Damage Report</u> – 14 Sis, 2 WG.

6. <u>Complaints, Claims and other Concerns</u>
(i) All New Clinical Negligence claims opened 12/3/17– 14/11/17:20 new since March, range of categories
(ii) All Clinical Negligence Claims Settled 12/3/17 – 14/11/17
(iii) Personal Injuries Negligence Claims settled 12/3/17 – 14/11/17
(iv) New Personal Injuries Negligence Claims opened 12/3/17 – 14/11/17: 6 new

Karen Lewis explained the context of her role and introduced Suzanne Wicks.
A brief overview of the claims process was provided.
Reports identify total payments on closed cases, which includes costs of C&V solicitors. Costs can therefore be quite excessive.
New Personal Injury claims over £25k can be reclaimed from Welsh Risk Pool. The new WRP lead was exploring new ways of producing reports, with more focus on lessons learning and governance issues going forward.

Claims must be submitted to WRP within a set timeframe. It is anticipated that in future reclaims may be submitted earlier which may improve the timeliness of lessons learned.

Financial reports are produced quarterly.

It was explained that major claims arise from Obstetrics, with a few spinal cases. These can include retrospective loss of earnings and/or care costs. It may be prudent to concede claims if it is deemed inappropriate to proceed due to trial costs.

SW explained that contributory negligence on the part of a claimant is mitigated for. Clinical colleagues noted the responsibility of a patient to read all information provided before giving consent. SW confirmed that the burden of proof is on the claimant; however the UHB could not defend an incomplete or incorrect consent form.

The Newsletter was recommended for an overview of topical issues.

7. <u>Ombudsman's Reports received</u>:</td><td></td></tr>
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	Ombudsman's Fact Sheet received. Two reports had been received from the Ombudsman, one not upheld, the other partially upheld which was a consent issue not dissimilar to that of the patient Story above.	
17/102	**Patient Surveys**: National Survey Report for Surgery (October 2017) Received and noted.	
17/103	**Research & Development** Nil to report.	
PART 6: DATES OF NEXT MEETING **Tuesday, 16th January 2018, 08.00 – 10.30. Seminar Room B, UGF, A Bl, UHW.**		

PART 7: URGENT BUSINESS		
17/104		
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
17/105	**Alerts and Other Safety Notices** See above.	
17/106	**Recent Reports & Communications** 1. National Hip Fracture Database (NHFD) Annual Report 2017 2. CMO Update 89 3. Legal and Risk Services, Clinical Negligence Newsletter October 2017	
17/107	**Directorate Q&S Minutes** **1.** Ophthalmology: Minutes of Clinical Governance Meeting 19th May 2017 Minutes & Action Log of Clinical Governance Meeting 12th July 2017 2. Trauma & Orthopaedics: Minutes of Clinical Governance meeting 13 October 2017 with accompanying papers and M&M 13 October 2017 3. Anaesthetics: Q&S Minutes September 2017 + powerpoint Q&S Minutes October 2017 Management of Acute APH	

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MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 17th October 2017
8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		**Action**
1.1	**Welcome & Introductions** Jenny Thomas, Clinical Board Director (Chair) Rachel Burton, Director of Operations Sarah Evans, Head of Workforce & OD Cheryl Evans, Directorate Head of Operations & Delivery Suzanne Hardacre, Head of Midwifery Judith Cutter, Clinical Supervisor for Midwives, Obstetrics & Gynaecology Annie Burrin, Clinical Supervisor for Midwives, Obstetrics & Gynaecology Anthony Lewis, Clinical Board Pharmacist Bev Thomas, Assistant Directorate Head of Operations & Delivery Jane Maddison, Interim Head of Therapies Michelle Abel, Infection Prevention Control Nurse Diane Rogers, Interim Directorate Head of Operations, Acute Child Health Laura Bassett, Risk Manager, Obstetrics & Gynaecology Donna Newell, Safeguarding Nurse Advisor **In Attendance** Kirsty Hook, Board Secretary Gemma Ellis, Consultant Nurse Critical Care (item 2.1 only)	
1.2	**Apologies for absence** Rose Whittle, Mary Glover, Heather Gater, Rim Alsamsam, Cath Heath	
1.3	**To receive the Minutes of the previous meeting 22nd August 2017** The minutes of the meeting held on 22nd August 2017 were agreed to be an accurate record.	
1.4	**QSE bring forward action log / Matters Arising** Actions and updates following the meeting are noted in the action log dated 22nd August 2017.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Sepsis Update Presentation** Gemma Ellis, Consultant Nurse for Critical Care was welcomed to group to provide an update on Sepsis. The background was provided on the "Sepsis Six" care bundle that has been introduced across the Health Board. The data is provided to Welsh Government on a monthly basis and it was noted that Sepsis mortality across UHW has significantly reduced as a result of the introduction of the tool. Work is ongoing in order to improve across UHL also. There is a medical and nursing lead for Sepsis within the Health Board. A Sepsis Webpage has been developed with all resources available through this webpage - http://nww.cardiffandvale.wales.nhs.uk/pls/portal/url/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/SEPSIS/WHAT_IS_SEPSIS . It was noted that the Nottingham Feedback tool	

	is being implemented within Critical Care which will feedback to all healthcare professionals involved prior to the admission of the patient, which will enhance communication and feedback. Discussion ensued as to how all processes can be aligned across the health board. It was noted that a separate piece of work is being undertaken within Maternity services, however links are being taken forward by Rachel Collis in order to align processes with the rest of the UHB. The scoring system for children is ongoing.	
2.2	**Patient Story – Eliose's Journey** Deferred to the next meeting due to technical issues with the story.	**SH**
2.3	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **Acute Child Health** The report was noted for information. There were no specific concerns to note for this meeting. **Obstetrics & Gynaecology** • Healthy Pregnancy Clinics have been implemented as part of a LIPS Project. JC provided a presentation on the work that has been taken forward. It was noted that this clinic was formally known as the BMI clinic, and following investigation it highlighted that there was an inequality of maternity service provision for patients with a BMI between 35-39.9 delivering outside of the obstetric unit. It is hoped that through the implementation of this service, the numbers of maternity deliveries can increase. Discussion ensued with regards to referral to exercise clinics and it was agreed that options would be reviewed with a view to have a drive with Public Health. JC agreed to follow up options outside of the meeting. • In Obstetrics -there are currently 5 ongoing RCA's and 1 chronology (2 of which are SI's). In Gynaecology - there is 1 RCA ongoing in Gynaecology and 1 case review. • Neonatal SOP has been developed for baby falls/drops, with input from Maternity. • CSSI infection rates have been significantly reduced following the implementation of the Service Improvement methodology and small changes being implemented within the service. There is a 20% reduction plan in place with a 34% improvement noted. • The Facebook Page has been a big success and it was acknowledged that this has been a very good way of communicating with staff. Due to the success of this, a maternity staff group page has now been created. • Maternity lift issues continue and it was noted that there is an action plan in place, however it was acknowledged that this cannot continue. Clinical Board to raise again with Estates. Discussion ensued with regards to Antimicrobial leads for the Clinical Board and whilst it difficult to have one lead, it was suggested that this be split into two halves. The group were asked to consider who could lead this within their areas and feedback to the Clinical Board. **Community Child Health** • Mandatory Training has improved across the Directorate for September 2017 • 31 children waiting over 14weeks within OT and work is being taken forward with Service Improvement Team in order to review options to improve pathways.	**JC** **RB** **DMT's**
2.4	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** **Acute Child Health** • Chemotherapy Administration within the Community is being reviewed for inclusion within ACH Risk Register. • CHANTS Service is a WHSSC commissioned service and the need for support to provide a 24hour service – ACH Risk Register	**DR** **DR**

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2.5	**Paediatric Surgery Update** The formal report has now been received from the Royal College of Surgeons, however it is not yet available for sharing. An action plan is being developed in order to outline required actions that need to be completed and implemented. A new rota will be implemented by January 2018 which will help on call, handover etc. Discussion ensued and it was agreed that the action plan, when complete will be shared with the meeting for information. Work continues with the Executive Team and Chief Executive in order to support the ongoing improvements within the service. Discussion ensued with regards to handover process and it was noted that there is a requirement for a set ward round with face to face reviews of patients. A trial of rolling handover is being taken forward in order to review continuity of care.	
2.6	**Quality, Safety and Improvement Framework 2017 -2020** The framework was noted for information. The group were asked to review and feedback any specific issues with maintaining compliance or an exception reporting to note.	**ALL**
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients/Staff** • Health & Wellbeing Week being taken forward in December within Maternity Services • Clinical Psychology Service are providing Mindfulness Sessions for all staff as part of a rolling programme.	
SAFE CARE		
4.1	**Update on Serious Incidents / RCA's** **SARC cold chain failure report** An update was provided to the meeting with regards to concerns associated with the monitoring of the fridge within SARC and the storage of Hep B Vaccine. It was noted that following review, it was confirmed that the fridge is fine to use in the interim and a new fridge is in the process of being monitored. The drugs that were quarantined were agreed as fine to be used. Discussion ensued with regards to some anomalies noted on the temperature recording form. CE agreed to gain clarity regarding the recordings that had been included to ensure that there is reassurance of the appropriate temperature recordings. There was general discussion with regards to fridges within other departments and SH noted that replacements are taking place on Maternity and 1st Floor to ensure that there are robust monitoring processes in place. It was acknowledged that external probes should ideally not be used. The group were asked to review to ensure that there are robust monitoring procedures in place for all fridges.	**CE** **DMT's**
4.2	**Closure Forms** **241466/873431MARCH17 – Retained Swab** Noted for information. There is an action plan in place and lessons learnt have been shared.	
4.3	**Infection Prevention Control Update** The report was noted for information. • The new CJD Policy is available on the intranet for comments • No C Diff, No MRSA, x3 MSSA, 1 E Coli reported. • All environmental audits are being undertaken again as there was concern regarding the original audit scores. • De-cluttering is being undertaken across a number of areas, however it was noted that there were no specific issues to note. • No concerns were noted with regards to Bare Below the Elbow • FIT Testing is being undertaken across all areas	

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<tr><td>4.4</td><td>Safeguarding
RCN Guidelines – Modern Slavery
The report was noted for information. Training is being delivered and can be accessed via the ED prospectus. Discussion ensued and it was noted that this is also covered as part of Audit days.

MARF updated Multi Agency Referral Form – Vale of Glamorgan
The form was noted for information. This has been noted at the CCH Q&S meeting. The group were asked to ensure that this is taken through ACH and O&G Directorate Q&S Meetings for assurance.</td><td>DMT's</td></tr>
<tr><td>4.5</td><td>Patient Safety Alerts (internal/external)/Welsh Health Circulars
• Welsh Health Circular 2017 046 - Amendment to the Human Medicines Regulations 2012 – Supply and Use of Adrenaline Auto Injectors in Schools
• Welsh Health Circular 2017 043 - Managing Babies Born on the Threshold of Survival
• Welsh Health Circular 2017 034 - Policy on the Management of Point of Care Testing (POCT). What, When and How?

The patient safety alerts and circulars were noted for information.

With regards to WHC 043, confirmation is required by the Executive Nurse Director of assurance that all Directorates are in line with guidelines. The group were asked to ensure that procedures are reviewed and any exception reporting highlighted if necessary.</td><td>DMT's</td></tr>
<tr><td colspan="3">EFFECTIVE CARE</td></tr>
<tr><td>5.1</td><td>Clinical Audit Results to note
• Neonatal MRI image quality
• The use of Antiplatelet agent Aspirin 75mg to reduce the risk of hypertensive disorder in pregnancy
• Audit Of Neonatal Pneumothoraces In Tertiary Neonatal Units In Wales
• Croup Management
• IV fluids in critically ill children
• <u>EU Audit</u> safeguarding referrals for children who are victims of community violence

The results of the recent audits noted above were circulated for information and sharing. It was agreed that the Directorate Audit leads would attend future meetings on an adhoc basis or provide updates to feed into the meeting for information. Discussion ensued where it was suggested that a future Audit day would be used as a "Clinical Board" Audit Day in order to share information, lessons learnt, and areas of good practice.

It was also noted that Alex Scott, Patient Safety and Quality Assurance Manager will be attending future Clinical Board QS&PE meetings in order to provide information about NICE guidance and clinical audit and will also provide updates about health and care standards.</td><td>JT</td></tr>
<tr><td colspan="3">DIGNIFIED CARE</td></tr>
<tr><td>6.1</td><td>Latest Cleaning Scores Report – for information
The scores report was noted for information. There were no specific issues to highlight from the report.</td><td></td></tr>
<tr><td colspan="3">TIMELY CARE</td></tr>
<tr><td>7.1</td><td>Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes – for information
The latest update has been received following circulation of the papers for this meeting and it was agreed that this would be shared for information to all. Work continues in order to further improve all areas, whilst acknowledging that there has been significant improvements made across a number of areas. Thanks were expressed to all for their continued hard work.</td><td></td></tr>
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INDIVIDUAL CARE		
8.1	**Update on latest 2 minutes of your Time feedback** **ACH** Information boards have been implemented across all wards. Patient Stories have decreased recently and it was agreed that further work would be undertaken to look at options for increasing receipt of patient feedback.	
Staff and Resources		
9.1	**Feedback on current position for PADR / Sickness** Detailed discussions have taken place with all Directorates as part of recent Directorate Performance Reviews with regards to plans for management of sickness and PADR performance. It was noted that short term sickness has increased for September and SME agreed to review and share the detail for information outside of the meeting. The drive for increasing PADR compliance is required and it was noted that the Asst HWOD has agreed to help with inputting of data in order to ensure that anomalies highlighted with reporting figures can be resolved.	**SME**
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
10.1	**Paediatric Clinical Research Facility Terms of Reference & Governance Structure** The official opening of the Paediatric Clinical Research Facility took place on 11th October 2017 which was very well attended and was opened by the Health Minister, Vaughan Gething. The Governance structure was shared and noted for information, and it was agreed that feedback on the research undertaken will come through the Directorate and Clinical Board Q&S structure. Commendation was noted to Rhian Thomas-Turner, Operations Manager for all the hard work that has taken place to get this unit up and running. Discussion ensued and it was agreed that there would be some minor amendments made to the structure with regards to required pharmacy support and once complete this would be noted at a future meeting for final ratification.	**AL**
10.2	**Enhanced microbiology service** The changes to the microbiology service was noted for information. The pilot is being taken forward and it was noted that this will have a significant impact for transitional care and neonatal unit specifically.	
ANY OTHER BUSINESS		
11.1	**Regulation 28** Formal action plan will be shared with the meeting in December.	
11.2	**National Safeguarding Week** National Safeguarding Week is being taken forward 13th November 2017.	
11.3	**Antimicrobial Awareness Week** World Antibiotic Awareness Week is taking place between 13th - 19th November 2017.	
11.4	**Medication Errors Bulletin** This was noted for information. A monthly bulletin is being developed and will be shared with all prescribers with regards to an acknowledgement that there is a “zero tolerance” approach for all.	

	The medications code is in development and it was noted that this should be available for sharing shortly. AL agreed to link with Gillian Body to ensure that medication errors is part of the induction programme within Paediatrics for medical staff, which follows the same process as the nursing policy. It was noted that a database has been developed within Obstetrics & Gynaecology in order to monitor all medication errors.	**AL**
11.5	**Water Group Meeting** Representation is required at the IPC Water Group Meeting and it was agreed that MA would approach Mallinath Chakraborty, Neonatal Consultant as a possible representative.	**MA**
11.6	**Medical Education Governance** Discussion ensued as to how the medical education governance training programmes are noted and managed within the Clinical Board. It has been suggested that this be shared and noted as part of the Clinical Board governance structure. The group were asked to share the most up to date reviews in order for sharing of best practice, lessons learnt etc. JT suggested that the January QS&PE Meeting be used to focus on Educational Training and Governance in order to provide and share all feedback.	
11.7	**Locum Doctor IT Access** Queries were raised in relation to concerns for access to patient results, patient information etc for locum doctors which would require Ad Hoc access. It was noted that a generic account is available within midwifery which allows staff to access results, however does not include access to Welsh Clinical Portal. It was agreed further discussions would take place with the AMD for IT security as to the options available as this very much needed. JT also agreed to discuss with the Medical Director outside of the meeting.	**JT**
DATE AND TIME OF NEXT MEETING		
The next meeting is scheduled for **Tuesday 28th November, 8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW (HEALTH & SAFETY FOCUS)**		

24.7

PRIVATE QUALITY SAFETY AND EXPERIENCE COMMITTEE

13th February 2018
Corporate Meeting Room, HQ, University Hospital of Wales

AGENDA

1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Private Committee held on 6th December 2017	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting	Oral *Chair*
7	Safeguarding Update	*Executive Nurse Director*
8	Services for Transgender Patients	*Medical Director*
9	Winter Pressures – Safety of Patients Letter from Minister for Health and Social Services	*M Battle*
10	Paediatric Surgery	Oral *Executive Nurse & Medical Directors*
11	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
12	Review of the Meeting	Oral – *Chair*
13	Date of next meeting Tuesday 17th April 2018	