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

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

9am on Tuesday 17th April 2018
Corporate Meeting Room, UHB HQ
University Hospital of Wales

QUALITY SAFETY AND EXPERIENCE COMMITTEE
9am on 17th April 2018
Corporate Meeting Room, HQ, University Hospital of Wales

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 13th February	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting - Approval of Medicines Management/Medicines Code EHIA	Oral *Chair*
Governance, Leadership and Accountability		
7	Patient Story	*CB Children & Women*
8	Children and Women Clinical Board Quality, Safety and Experience Assurance Report	*Clinical Board*
9	Community Health Council Report	*CHC*
10	Hot Topics – Update on 3 WAST Serious Incidents	Oral *Executive Nurse Director*
11	Quality Safety and Improvement Framework Update	*Asst Director Patient Safety & Quality*
12	Ethics Committee Terms of Reference and new Chair	*Medical Director*
13	Out of Date QSE Policies	*Executive Nurse Director*
Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)		
Theme 2: Safe Care		
14	Care of the Deteriorating Patient – Revised Risk Assessment	*Executive Nurse Director*
15	Revised Risk Assessment for Infection Prevention and Control	*Executive Nurse Director*
16	Patient Falls Exception Report	*Director of Therapies and Health Sciences*
17	Medical Outliers	*Chief Operating Officer*
Theme 3: Effective Care		
18	Cancer Peer Reviews – Cancer Pathways	*Medical Director*
Theme 4: Dignified Care		

19	HIW Activity Update	*Executive Nurse Director*
Theme 5: Timely Care		
20	Endoscopy – Serious Incidents and Lessons Learned	*Executive Nurse Director*
Theme 6: Individual Care		
Theme 7: Staff and Resources		
PART 2: Items to be recorded as Received and Noted for Information by the Committee Papers are available on the UHB website		
21	Nutrition and Hydration	*Director of Therapies and Health Sciences*
22	**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 – January 2. Mental Health – March 3. Primary, Community and Intermediate Care - January 4. Specialist Services – January 5. Medicine – January 6. Surgery – January 7. Children and Women – November 8. Dental – November and January	*Assistant Director, Patient Safety and Quality* *(Chief Operating Officer)*
23	Agenda for the Private QSE	
24	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
25	Review of the Meeting	Oral – *Chair*
26	Date of next meeting - 9am on Tuesday 12th June 2018 **Tutorial for Members on 30th May 9.30-12.30 in Hafan y Coed, UHL** **Dates for 2018/19** • 18 September • 16 October (Special Meeting) • 18 December • 19 February & 16th April 2019	

UNCONFIRMED MINUTES OF THE MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 13 FEBRUARY 2018 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

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Present:	
Susan Elsmore	Independent Member, QSE Chair
Akmal Hanuk	Independent Member – Community
Maria Battle	UHB Chair
Michael Imperato	Independent Member – Legal
In Attendance:	
Andrew Gough	Assistant Director of Finance
Angela Hughes	Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Caroline Bird	Deputy Chief Operating Officer
Clive Morgan	Deputy Director of Therapies and Health Science
Dr Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Observers	
Len Richards	Chief Executive
Alun Jones	Deputy Chief Executive, HIW
Dr Aarij Siddiqui	Chief Registrar Medicine
Dr Kathryn James	Welsh Clinical Leadership Training Fellow
Yvonne Hyde	Senior Nurse, IPC
Apologies:	
Abigail Harris	Director of Planning
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Salter	Staff Representative
Robert Chadwick	Director of Finance
Sharon Hopkins	Director of Public Health
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Steve Curry	Chief Operating Officer
Secretariat:	Julia Harper

QSE 18/001 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular, colleagues representing Executive Directors and several Observers. It was noted that colleagues from the Surgery Clinical Board would be attending from 9.30am – Dr Linda Walker, Clinical Board Director of Nursing, Mr Geoff Clark, Consultant Surgeon, Dr Richard Hughes, Consultant Anaesthetist and Mike Bond, Director of Operations.

QSE 18/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 18/003 DECLARATIONS OF INTEREST

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

QSE 18/004 MINUTES OF THE SPECIAL COMMITTEE HELD ON 6th DECEMBER 2017

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

QSE 18/005 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:

1. QSE 17/138 and 17/179 Nutrition and Catering Policy and Never Event NG Tube – The Policy was being considered at the Clinical Standards Group in March and following this would be available for consultation. It was anticipated for approval at Committee in June 2018. A timeframe for the completion of the Naso Gastric Tube Policy would be chased.
Action Dr Fiona Jenkins and Mrs Carol Evans

2. QSE 17/202 Patient Safety Walkrounds – Cllr Elsmore had written to Members about the importance of maintaining the programme for Walkrounds. These had started and were going well. The importance of writing a note of the visit was stressed to ensure actions could be followed through.

3. QSE 17/204 IPC Tier 1 – A Board Champion for Cleanliness and Hygiene would be considered at the Development Day next week.
Action – Miss Maria Battle

4. QSE 17/132 CHC Report – Work was ongoing about the role and function of the CHC. Their visit reports would be shared with the Committee to triangulate learning.

5. QSE 16/192 Critical Care Outreach/Care of Deteriorating Patients – A project structure had been put in place. No concerns had been identified from mortality figures. There were pockets of good practice and the NEWS system was used across the UHB but the response to a deteriorating score differed across the UHB.

It was agreed to consolidate the action log and provide a realistic time frame. It was also agreed to receive a short report at the next meeting, including the risk, priorities, mitigation and methodology.
Action – Dr Graham Shortland
The Resuscitation Team had managed successfully a call from the Llanfair Unit.

6. QSE 17/214 HIW Ophthalmology Thematic Review – The Executive Nurse Director advised that Management Executive had recently considered a report on waiting times and communication with patients. The Chief Operating Officer was streamlining a single plan and was personally overseeing progress, though it had to be recognised there were some very high risk areas. It was agreed to delay the update report to June so that the impact of these actions could be seen.

7. QSE 17/195 Specialist Services QSE Assurance Report – This was complete and the poem may also be used in the Annual Quality Statement.

The Chair expressed her concerns that timescales were often extended for work on items within the Action Log and this did not provide assurance. It was important for Executives to be open with the Committee and to commit to meeting the identified timeframes.

QSE 18/006 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

The Chair had nothing to report.

QSE 18/007 PATIENT STORY – SURGERY

Mr Geoff Clark, Consultant Surgeon delivered two patient stories that demonstrated both good and bad patient experience in emergency surgery.

As a result of a successful business case to support emergency general surgery, the UHB now had 2 surgical teams on call – one in theatre and one at the front door. In addition, the emergency CEPOD theatre had been enhanced. The teams covered upper GI and colorectal surgery.

The first case demonstrated that excellent communication between expert teams meant that a patient admitted in pain was diagnosed with advanced cancer very quickly, was supported when the bad news was broken, was discussed at a multi-disciplinary team meeting and was discharged with a care plan within 48 hours. All this care was provided by a consultant or specialist nurse.

The second case involved out of hours care which had not changed as a result of the business case. There was only one team with access to two theatres. A patient arrived via A&E and waited 11 hours for surgical review.

Knowing that a general anaesthetic was required, he was starved of food and drink. When it was known that he would not be able to access theatres he was discharged home, advised he could eat and was told to return in the morning. Due to poor communication, the surgeon was not aware that the second theatre was not available due to maintenance work. The first theatre was treating an emergency neuro case. The patient was finally taken to theatre at 5pm after starving all day and was "bumped" again due to another emergency neuro case. His operation finally took place at 3am the following morning. Overall the care was poor, yet the patient was so very grateful.

The Committee noted that weekend surgery was still a challenge and that there was no agreement for the SAU to open at weekends. In addition the constant need for 2 theatres was noted. The challenge was not all about money, but having sufficient staff. The establishment of 14 SPRs was running with 10 which left gaps in the rota.

The Chief Executive highlighted the need to make change easier in order to improve safety and quality and to change the culture to a "can do" attitude. This would also motivate staff and improve morale. Having just one extra pair of hands made a huge difference to performance, patient experience and morale. In terms of transforming emergency care, the key was training junior doctors in emergency surgery.

The Medical Director agreed to circulate a recent GMC case to Committee for information.
Action – Dr Graham Shortland

The Chair thanked Mr Clark for his excellent leadership and for sharing openly both good and not so good examples that focussed the mind and opened the debate across the organisation.

QSE 18/008 SURGERY SERVICES CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

The Chair invited comments and questions on the comprehensive report.

Dr Linda Walker commented on the action taken to improve infection rates, noting that "bare below the elbow" remained a challenge, but staff were talking about it. Refurbished areas had made a big difference to the environment.

A lack of interventional radiology was an issue out of hours. A consultant appointment had been made at Cwm Taf and it was anticipated that this would be resolved by the summer. Going forward, a regional partnership approach was needed to deliver an out of hours service with 2 serious incidents being investigated. It was agreed to receive a further report in June when progress was expected to be seen.
Action – Mr Steve Curry

Whilst the mortality review system had improved, there was still a need for more work on governance and assurance systems.

Dr Walker also answered questions on smoking cessation for pre-op patients, complaints response times and telephone assessment in the evenings. Nurse recruitment was doing well, but retention was harder and not helped by the number of medical outliers that damaged staff morale. This was being addressed in conjunction with the Medicine Clinical Board and the number had been reduced from 100 to 35 outliers. A business case was being prepared to address the requirements of the Nurse Staffing Act.
It was agreed to receive a separate report on outliers at the next meeting.
Action – Mr Steve Curry

In terms of medical negligence claims, it was noted that the number was not proportionately high.

The Chair thanked the Surgery Clinical Board for attending the meeting and answering the Committee's questions.

ASSURANCE was 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

The Quality Safety and Experience Committee:

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

QSE 18/009 COMMUNITY HEALTH COUNCIL (CHC) REPORT

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

QSE 18/010 POLICIES FOR APPROVAL

1. **PRESSURE ULCER RISK ASSESSMENT, PREVENTION AND TREATMENT**

ASSURANCE was provided by:

- Full consultation across the UHB to ensure staff implementation and its integration into UHB pressure ulcer training programmes
- The policy was in line with national and international guidelines.

- Report to Clinical Board Quality and Safety Sub Committee meetings bi-monthly where each Clinical Board investigated, via a Root Cause Analysis, 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:

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

2. MEDICINES MANAGEMENT

The Medical Director, Dr Graham Shortland explained that this Policy would overarch the procedures contained in the Medicines Code that was approved at the last meeting.

ASSURANCE was 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 Government's MARRS Policy.

The Quality, Safety and Experience Committee:

- **APPROVED** the Medicines Management Policy subject to the provision of an Equality and Health Impact Assessment within 14 days (by 26th February) for Chair's approval.
  Action – Dr Graham Shortland
- **SUPPORTED** the provision of procedural guidance provided by The Medicines Code.
- **APPROVED** the full publication of the Medicines Management Policy and Code in accordance with the UHB Publication Scheme.
- **APPROVED** delegation of responsibility for the approval of Procedures (The Medicines Code itself) to the Medicines Management Group.
- **APPROVED** the withdrawal of a further 6 medicines management Policies/Procedures.
- **Action – Mrs Julia Harper**

QSE 18/011 REVIEW OF COMMITTEE TERMS OF REFERENCE

As part of the governance process, the Terms of Reference for the Committee were reviewed on an annual basis.

The UHB Chair advised that she had appointed two new Members to the Committee: Prof Gary Baxter as the new Committee Vice Chair and Dawn Ward.

ASSURANCE was 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:

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

QSE 18/012 COMMITTEE WORKPLAN FOR 2018/19

The Workplan was full, robust and aligned to the Health and Care Standards Framework, but hot topics would be added as and when necessary.

It was noted that the February Board Development session would be devoted to effective and efficient Board and Committee working and any changes made at that meeting would be incorporated as necessary.
Action – Mr Peter Welsh

ASSURANCE was 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:

- **APPROVED** the Committee Work Plan for 2018 -2019 subject to the inclusion of Patient Experience Framework and Claims and Concerns.
  Action – Mrs Carol Evans
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QSE 18/013 WAO REPORT ON DISCHARGE PLANNING

Mrs Judith Hill attended the meeting at the request of the Audit Committee for this item. She commented on the assessment of WAO findings and the 4 recommendations with the subsequent management response that was now somewhat out of date.

It was noted that the number of delayed transfers of care (DTOC) had reduced considerably from 157 in 2016 to 43. Weekly meetings were held with patients/families and each case was carefully scrutinized. It was clear

from these meetings that staff were very familiar with the needs of their patients and understood the need for timely information.

A new clinical dashboard had recently been shared with staff to help them monitor the situation and ensure patients were allocated to the correct pathway.

Timely discharge was a risk and it was important that staff understood this in terms of patient safety, community handover and patient flow. It was appropriate for Board Members to ask questions about this during Safety Walkrounds as it was a key part of the UHB's Strategy.

The Chair thanked Mrs Hill for all her work and commented that the Council was working closely with the UHB to ensure a seamless service for patients. The DTOC position was the best it had been in 12 years.

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

- **CONSIDERED** the main findings of the Wales Audit Office review.
- **AGREED** that the action plan addressed the recommendations made within the Wales Audit Office report.

QSE 18/014 SAFER PATIENT NOTICE 24 - PATIENT IDENTIFICATION BANDS

The Executive Nurse Director, Mrs Ruth Walker was delighted to inform the Committee that from April 2018, funding had been allocated for an electronic system and it was anticipated that this would also save money. Fortunately no correlation to patient harm had been found in the absence of a system whilst awaiting funding. It was also pleasing that the new bar code system would be able to offer further safety possibilities in the future. Mrs Walker thanked Mrs Carol Evans for all her work on this and for sourcing the system in order for the UHB to comply with the safety notice.

ASSURANCE was provided by:

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

The Committee **CONSIDERED** the update provided within the paper.

QSE 18/015 INFECTION PREVENTION AND CONTROL REVISED RISK ASSESSMENT

The report had been withdrawn.

QSE 18/016 CANCER PEER RE REVIEW – HEAD AND NECK

The Medical Director, Dr Graham Shortland advised that work had moved into the re review process. Good progress had been made and more learning had emerged. Work was underway with Surgery on ward staffing levels and skill mix, though there was a general recruitment issue in Pathology.

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 Welsh Government 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.
- **AGREED** that this, and future action plans, should be made more explicit and contain timescales.
  Action – Dr Graham Shortland

QSE 18/017 CLINICAL AUDIT PLAN 2017-18 PROGRESS UPDATE

Dr Graham Shortland, Medical Director, introduced the report and thanked Carol Evans and Alex Scott for the easy read dashboard for national audits. Post audit report, there was a 3 week window to report back to Welsh Government and a report was also taken to HSMB. It was agreed that there needed to be clarity and explanation of any areas where the UHB was classed as an outlier.

It was important that local audits aligned with the UHB agenda and addressed hot spot areas.

ASSURANCE was 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 was registered and ongoing.

The Quality, Safety and Experience Committee:

- **NOTED** the clinical audit activity undertaken in the Clinical Boards.
- **AGREED** to consider the clinical audit process for 2018 / 2019 on the June Agenda.
  Action – Dr Graham Shortland

QSE 18/018 HEALTHCARE INSPECTORATE WALES (HIW) ANNUAL REPORT 2016-17

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that as well as the Annual Report, separate individual reports from HIW were shared with Committee on a regular basis. This report addressed the action taken from the themes within the Annual Report.

ASSURANCE was 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:

- **NOTED** the Healthcare Inspectorate Wales Hospital Inspection Annual Report.
- **NOTED** the processes in place to monitor the required actions and improvements.

QSE 18/019 MANAGEMENT OF OUTPATIENT FOLLOW UPS AND ENDOSCOPY SURVEILLANCE

Mrs Caroline Bird, Deputy Chief Operating Officer advised the Committee that both areas were behind plan. Outpatient follow up had initially made good progress but this had slowed and action therefore needed to be refocussed. The PMS system was not designed to manage follow ups and staff were working with the IM&T team for other options. Unfortunately there was no clinical consensus on the management of follow ups due to the risk of the wrong patients being removed or left on the list. However, it was anticipated that a realistic view of the number of patients waiting would be available by the end of March. Following this, there would be a need to look at and change processes.

The number of patients waiting for endoscopic surveillance had deteriorated over the summer due to workforce issues. However, the opportunity had been taken to increase capacity through the use of two private hospitals and weekend insourcing at UHL. These lists appeared more efficient than the UHB's own lists and therefore there were lessons to be learned. The UHB was balancing the risk of patients waiting over 8 weeks and those awaiting surveillance.

Two further serious incidents had been received in the last week where delayed patients had been diagnosed with cancer. It was therefore important to receive a report on the lessons being learned and to ensure that risk was being balanced.
Action – Mr Steve Curry

It was noted that "spot purchase" was not helping. It would be more helpful if funding was recurrent in order to smoothly manage capacity and the growing demand.

In terms of streamlining administrative processes, it was suggested that lessons could be learned from Radiology where staff were very pleased with their booking system. It was also worth investigating DNA (did not attend) rates and whether they were lower at weekends when appointments were probably more convenient for working adults. It was agreed to look into DNA in greater detail to determine whether the service could make further improvements.
Action – Mr Steve Curry

As some patients were being failed, it was necessary for the Committee to be assured that the initiatives being taken were making a positive impact. In light of the gravity of the situation, it was agreed to receive a further comprehensive report in April.
Action – Mr Steve Curry

ASSURANCE was 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 had been an increase in the number of patients overdue their planned surveillance endoscopy, the UHB had secured additional in-year capacity to reduce the number of patients delayed.
- There was a clinically agreed risk scoring methodology in place for patients waiting for a surveillance endoscopy.

The Quality, Safety and Experience Committee:

- **NOTED** the current position and work ongoing in relation to the management of outpatient follow up care and endoscopy surveillance.
- **AGREED** to receive a further report at the April meeting.
  Action – Mr Steve Curry

QSE 18/020 UPDATE ON SINGLE ROOMS, ISOLATION ROOMS AND DECANT FACILITIES

In the absence of the Director of Planning, Mrs Ruth Walker advised Committee that it was recognized that the UHB had insufficient single rooms and this meant that patients sometimes spent longer in the Emergency Unit to

remain isolated. This was an ongoing challenge, but it was clear that more single rooms needed to be installed during the refurbishment process.

ASSURANCE was 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:

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

QSE 18/021 SINGLE POINT OF ENTRY FOR CHILDREN

Mrs Caroline Bird, Deputy Chief Operating Officer, advised Committee that the service model would need to change in the interim and longer term and commented on the mitigating action that had been taken to address the risk.

A working group had excluded a number of options and the choice was now down to two. Miss Battle advised that a regional planning meeting would be held later in the day and that Cwm Taf had reduced their figures downwards for paediatrics and maternity and this may affect the UHB's planning work for the service and its funding.

ASSURANCE was provided by:

- Plans for a Single Point of Entry were progressing in line with the project plan and were aligned to the developing plans for the Major Trauma Centre.
- These plans, and the interim options, were 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 had allowed the development of options which bridged the majority of the existing financial deficit.

The Committee:

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

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

The following items were **RECEIVED** and **NOTED** for information.

QSE 18/022 WHC 045 2017 INTEGRATED GUIDANCE ON HEALTH CLEARANCE OF HEALTHCARE WORKERS AND MANAGEMENT OF HEALTHCARE WORKERS INFECTED WITH BLOODBORNE VIRUSES (HEPATITIS B AND C, AND HIV)

ASSURANCE was provided by:

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

The Quality and Safety Committee **NOTED** Welsh Government Request and the Cardiff and Vale UHB response.

QSE 18/023 ANNUAL QUALITY STATEMENT 2017-18

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee **AGREED** the time frame for the development of the 2017 /18 Annual Quality Statement.

QSE 18/024 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The following Minutes were received and noted.

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**

The Committee found it unacceptable that no Minutes had been received from Dental since September and the Chair would write to the Clinical Board.
Action – Cllr Susan Elsmore

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QSE 18/025 AGENDA FOR THE PRIVATE QSE MEETING

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

QSE 18/026 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

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

QSE 18/027 REVIEW OF THE MEETING

There was nothing to add to the meeting and a review would be held following the private meeting.

QSE 18/028 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 17th April 2018.

ACTION LOG FOLLOWING QSE COMMITTEE FEBRUARY 2018 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/138.3 QSE 18/004	12.9.17 13.2.18	Nutrition and Catering Policy		Update Policy again to include work on NG tubes.	F Jenkins	Consultation to take place following March meeting of Clinical Standards Group.
QSE 17/204 QSE 18/004	6.12.17 13.2.18	IPC Tier 1		Appoint a Board Champion for Cleanliness and Hygiene.	M Battle	This would be actioned following Board Development Day in February.
QSE 18/012	13.2.18	Committee Workplan		Include any further changes following Board Development Day.	P Welsh	Discussed at the Board Development day in February 2018 and follow discussion planned for the development session in April.
QSE 18/019	13.2.18	Management of Outpatient Follow Ups and Endoscopy Surveillance		Investigate reasons for DNAs.	S Curry	
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
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 17/098	20.6.17	CRAF		Comments to P Welsh on whether the risk descriptors and controls identified were adequate to provide assurance to	ALL Members and Attendees P Welsh to correlate.	Comments being considered as an integral part of risk review to ensure risk descriptors are more meaningful and understood and controls more measureable.

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				the Committee by 20th July.		Anticipated by **April 2018**
QSE 17/017 QSE 17/192 QSE 17/214 QSE 18/004	21.2.17 6.12.17 13.2.18	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.** Given the recent work it was agreed to defer this update to **June** so the impact of initiatives could be seen.
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. Report Received April 2018 - to agree action plan June 2018**
QSE 18/008	13.2.18	Surgery QSE Report		Update on out of hours interventional radiology.	S Curry	**QSE June**
QSE 18/017	13.2.18	Clinical Audit Plan		Consider process for 18/19 at June meeting.	Dr G Shortland	**QSE June**
COMPLETED ACTION SINCE LAST MEETING						
QSE 17/021	6.12.17	Approach to Health and Care Standards Self-Assessment		Amend Lead Executives for 2.8 and 3.4.	C Evans	**Complete**
QSE 17/021	6.12.17	Approach to Health and Care Standards Self-		Add deadline dates to diaries for signing off.	All Lead Executives and Cllr S Elsmore	**Complete**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Assessment		Amend Lead Executives for 2.8 and 3.4.	C Evans	**Complete**
QSE 17/202 QSE 18/004	6.12.17 13.2.18	Patient Safety Walkrounds		Write to Board Members about the importance of maintaining the visit programme	C Evans for Cllr S Elsmore	**Complete**
QSE 17/195	6.12.17	Specialist Services QSE Assurance Report		Ask Comms Team to use poem on social media.	C Evans	**Complete**
QSE 17/088 QSE 17/132 QSE 18/004	20.6.17 12.9.17 13.2.18	CHC Report		Visit findings and feedback to be regularly shared with the Equality Manager	CHC D Price	Role and function of CHC was being reviewed. Visit reports would be shared with Committee. Issues of sensory loss and disability are shared with the Equality Manager. **Complete**
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** **Complete**
QSE 17/195	6.12.17	Specialist Services QSE Assurance Report		Ask CB about their arrangements for mortality reviews.	G Shortland	**Complete**
QSE 18/010.1	13.2.18	Pressure Ulcer Policy		Publish	J Harper	**Complete**
QSE 18/010.2	13.2.18	Medicines Management Policy		Only approved subject to receipt of EHIA within 14 days (26th Feb). Then	G Shortland	**Complete**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				obtain Chair's action. Then publish policy and remove out of date policies.	 J Harper	 **Complete**
QSE 18/012	13.2.18	Committee Workplan		Add Patient Experience Framework and Claims/Concerns. Include any further changes following Board Development Day.	C Evans P Welsh	**Complete**
QSE 18/016	13.2.18	Cancer Peer Re Review – Head and Neck		Make this action plan (and that of future reports) more explicit with timeframes.	Dr G Shortland	**Complete**
QSE 18/008	13.2.18	Surgery QSE Report		Report on Outliers to next meeting.	S Curry	**QSE April – on April agenda**
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 – on April agenda**
QSE 18/007	13.2.18	Surgery Patient Story		Bring a recent GMC Case to Committee	Dr G Shortland	Circulated to QSE on 4.4.18. Welsh guidance is anticipated. **Complete**
QSE 17/179 QSE 17/192 QSE 18/004	17.10.17 6.12.17 13.2.18	Never Event NG Tube		Timeframe for approval of revised policy.	C Evans	**QSE in February 2018.** This would is not a Policy as does not need approval at QSE. **Complete**
QSE 18/019	13.2.18	Management of		Endoscopy: Report on	S Curry	**QSE April. On Agenda.**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Outpatient Follow Ups and Endoscopy Surveillance		lessons learned and balance of risks.		**Complete**
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 Agenda April 2018 Completed**
QSE 18/024	13.2.18	Dental QSE Sub Committee		Write to Clinical Board – unacceptable to receive no minutes since September.	S Elsmore	The minutes had subsequently been received. **Closed**
QSE 16/192 QSE 17/048 QSE 17/099 QSE 17/023 QSE 15/135 QSE 16/006 QSE 16/202 QSE 17/023	18.10.16 18.4.17 20.6.17 21.2.17 01.09.15 23.2.16 13.12.16 21.2.17 6.12.17	Critical Care Outreach Team (Identifying and Managing the Deteriorating Patient) Care of Deteriorating Patient Corporate Risk and Assurance Framework Exception Report -	* * * 	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. Ensure all differing views are taken into account when scoping the way forward Business Case for	Dr G Shortland A Harris Dr G Shortland G Shortland G Shortland	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. 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. Programme of work in place to

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/192 QSE 18/004	13.2.18	Care of the Deteriorating Patient : Critical Care Outreach Service Action on 3 boxes marked * above		Critical Care Outreach (CCO) and Hospital at Night to be considered at Investment Panel. Need to resolve Critical Care Service issues at UHL.		confirm clinical model for acute and out of hours hospital services. Will be considered by the S&D Committee. (9/2/18 updated) (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.** December 2016 update: Awaiting funding for Advanced Nurse Practitioners to address 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) 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 – deferred to April.** Project structure had been put in place. Agreed to consolidate the

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
					R Walker	action log and provide realistic timeframe. **Revised Risk Assessment on April 2018 agenda. Complete**

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CHILDREN & WOMEN'S CLINICAL BOARD QUALITY, SAFETY & PATIENT EXPERIENCE REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting**: 17th April 2018

Executive Lead : Chief Nurse / Executive Nurse Director
Author : Director of Nursing, Children & Women's Clinical Board Ext 44787
Caring for People, Keeping People Well : This report summarises the quality, safety and experience key issues for Children and Women who use the services of the Clinical Board. It is aligned to the quality components of the UHB's ten year Shaping our Future and Wellbeing Strategy (2015 – 2025). Key to this is working with our stakeholders, our local and national population, committees and partner agencies. This report will focus on the Clinical Board's Governance arrangements and the delivery of safe, effective and dignified care.
Financial impact : Not Applicable
Quality, Safety, Patient Experience impact : This report provides assurance on the progress of the Children and Women's Clinical Board on a range of quality, safety and patient experience issues. It is aligned to the NHS Outcomes Framework focusing on the Clinical Board's Governance arrangements and the promotion of health, delivery of safe, effective and dignified care. Further it summarises key areas of improvement for access to services and plans to further improve access.
Health and Care Standard Number … All Standards
CRAF Reference Number 1:2,1:3,2:3, 2:4, 2:5, Objective 4;4:2, Objective 5; 5:1,5:1:6 and Objective 6
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Internal Audit Risk Management Report 2016
- Regular Performance Management
- Governance and QSPE priority within the Clinical Board and Directorates

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **NOTE** the progress and approach taken by the Children & Women's Clinical Board to date and its planned actions
- **APPROVE** the approach taken by the Children & Women's Clinical Board

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SITUATION

This report provides detail of the arrangements, progress and outcomes within the Children & Women's Clinical Board in relation to Quality, Safety and Patient Experience.

It identifies the achievements, progress and planned actions to maintain the priority of Quality, Safety and Patient Experience.

Children & Women's Clinical Board links with all elements of the strategy but in the past year has made strides to align specifically with avoiding harm, waste and variation and delivering outcomes that matter to people.

BACKGROUND

Children & Women's Clinical Board provides high quality, specialised clinical care to Women and Children with complex health needs and serious disease.

The Clinical Board has made progress with the implementation and monitoring of the Quality & Safety agenda in line with the NHS Wales Quality Delivery Plan, the Operational Plan, Quality & Safety imperatives, Infection, Prevention and Control Annual programme, Welsh Risk Pool and Healthcare in Wales priorities.

The Clinical Board has responsibility for universal services which support health, wellbeing, education, development and Public Health amongst the population of children, young people, parents, families, women and their partners. This includes partnership and safeguarding priorities.

Comprising 3 Clinical Directorates with associated clinical services and sub specialties, we provide services for the wider, regional and Welsh population to include Paediatric cardiology, nephrology and fetal medicine. The Clinical Board has a budget of 98 Million and a workforce of circa 1900 WTE.

Due to the high volume of activity and diversity of the services provided, risk in the Clinical Board is high and therefore there are robust risk management arrangements in place to mitigate any risk to our service users and staff.

In summary, the Children & Women's quality, safety and patient experience aims are:-

- To ensure that there is a process in place to continually review the quality and safety risks and take action to constantly mitigate that risk.
- To maintain a culture of improving quality, safety and patient experience across all teams.
- To ensure a positive culture of staff engagement, development and the understanding of everyone's responsibility for the delivery of safe effective care.

This report provides assurance of the progress being made within the Children & Women's Clinical Board with regards to:-

- The Welsh Government Quality Delivery Plan for the NHS in Wales
- The Clinical Board's Operational Plan
- Quality & Safety agenda
- Infection, Prevention and Control Annual work programme
- Health and Care Standards
- Patient Experience
- Organisational Development and Workforce Planning

ASSESSMENT

Governance, Leadership and Accountability

Quality, Safety and Patient Experience is the highest priority for the Children & Women's Clinical Board which has a robust and well attended quality and safety group with strong representation from Midwifery, Nursing and Allied Health Professional staff from both within and external to the Clinical Board.

Meetings are held every month with every third meeting dedicated to Health and Safety. The Clinical Board has also established a Serious Incident meeting where any open serious incident is discussed in detail, progress with individual investigations and action plans are widely shared. This meeting also serves as an additional forum for sharing outcomes and lessons learnt and detailing how responsive actions have been embedded into clinical practice.

All of the committees detailed have terms of reference which are reviewed regularly to ensure that they continue to be fit for purpose.

The quality, safety and patient experience group led on the self-assessment against the Health and Care Standards 2016-2017.

Key improvements identified for 2017/18 are:-

Health and Care Standard	Rating	Key Improvements
Health Promotion, Protection and Improvement	**AMBER**/Improving	• Maternity Safer Pregnancy Campaign has been embedded into practice • Highest influenza vaccination rates for staff our Children and our expectant mothers

Managing risk and promoting Health & Safety	Improving	• We have established multi-professional risk meetings within the Directorate • Development of Paediatric Surgery Improvement Plan following concerns raised 2017/18 • Stillbirth review group established • Multi professional skills and drills with prompt due for implementation
People's Rights	Improving	• The Clinical Board is in partnership with Cardiff Council and UNICEF developing Health framework to support Children's Rights approach. UNICEF will support the Clinical Board to develop policies which are Children's Rights focussed. • The Clinical Board will develop a Children's Charter in 2018 • We have developed a birth afterthoughts reflection service for women following their birth experience • Developed a Birth Choices clinic for women making decisions outside recommended guidance • Supported individual patients by development of blended diet protocol • Developed monthly governance sessions for maternity staff promoting women's stories and duty of candour • Use of women's stories for shared learning
Timely Access	Improving	• Improvements this year demonstrate more women

		are booked by 10 completed weeks for their antenatal care • Introduction of "Red Flag" events via Datix since June 2017 for monitoring / escalation of delayed activity in maternity services • The Clinical Board has demonstrated significant improvement in the delivery of referral to treatment time, with a reduction in the number of people waiting over 52 and 36 weeks for treatment

Each Directorate has a risk register which is based on robust risk assessment processes. In March 2018, the Clinical Board held a risk assessment and governance workshop to analyse and refresh all risk assessment processes. This has triggered a targeted piece of work with each Directorate to review its risks and mitigating action.

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Each Directorate performs a monthly review of its clinical risk register which is then aligned to the Clinical Board Risk Register.

Currently the highest risks within the Clinical Board:-

Risk	**Action to Manage or Mitigate**
Imminent increase in activity associated with the South Wales Alliance in Obstetrics, Paediatric and Neonates. Insufficient capacity, workforce and process to manage this activity and escalation.	Full engagement with SWA meetings and process. Work programme remains a high priority for C&W Clinical Board.
Insufficient PICU capacity particularly over winter months. Not currently commissioned to most recent PICU standards.	Nursing resource is used flexibly where possible to ensure adequate staffing to meet demand. Transfer out of UHB is available if no available beds following clinical assessment where appropriate Business Case has been submitted to WHSSC for 18/19.

Insufficient cot numbers to meet the needs of critical care and Special Care Baby Unit babies for the South Central Region	Escalation procedure has been reviewed and implemented in Neonatal and Maternity Units. Nursing vacancies filled to ensure all available cots are staffed to BAPM standards. Future proofing of additional cot capacity available to be commissioned.
Lack of Senior Medical Cover of Obstetrics Assessment Unit	Consultant cover provided from Delivery Suite where possible. Risks are assessed and staff moved as necessary. Plans in place through South Wales Alliance.
Quality of Care – Paediatric Surgery • Escalated through increased concerns and incidents. • Insufficient M&M process • Vacancies and sickness at Paediatric Consultant Surgeon level. • Poor standard of Ward Round and handover.	External Review undertaken by Royal College of Surgeons. Paediatric Surgery Improvement Plan developed to address areas of concern Recruitment to vacancies

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Staying Healthy (Theme 1)

Each winter, flu vaccinations are a priority for the Children & Women's Clinical Board for its staff and service users. This year the Clinical Board achieved an outstanding 8290 of staff vaccinated. This demonstrated a substantial increase on 2016/17 figures.

For our service users, the Clinical Board continues to drive forward improvements with targeted services in areas of deprivation. This ensures the effective delivery of immunisation programmes for those families who are less likely to engage with core services.

This delivered an increase in the percentage of children who received all their scheduled vaccinations at age 4 in this particular population group, which may well have impacted on our low admission rate of children with flu this winter.

Within Maternity Services the 'safer pregnancy campaign has been embedded into everyday practice. This campaign promotes a healthy lifestyle for pregnant women including diet, exercise, vaccinations, awareness of fetal movements, alcohol, importance of attending antenatal appointments etc.

Within Obstetrics & Gynaecology the Clinical Board has invested in additional carbon monoxide monitors for our antenatal women. This has contributed to our ability to undertake enhanced monitoring in pregnancy. We are currently seeing circa 37 per month stopping smoking. There is still more to do to reach the Public Health Wales target of 55 per month.

- **% of women who smoke during pregnancy**

	2015/16	**2016/17**
Co Monitoring	n/r	45.5%
Smoking in pregnancy	14.6%	13.6%
Gave up during pregnancy	7.2%	21.4%

In addition in 2017, the Healthy Pregnancy Clinic was launched following completion of a LIPS service improvement project. The aim of this project is to provide a safe, equitable, women centred service for women with a BMI of over 35 (and no underlying co-morbidities) to labour outside an Obstetric Unit. This adheres to NICE (2010) Weight Management in Pregnancy Guidance.

Each year the Clinical Board is required to report against a number of key performance measures in accordance with the Maternity Indicator dataset. Breastfeeding rates at Cardiff and Vale are currently 70%.

In addition to this, Maternity and Neonatal services have recently had their reassessment of BFI status, early results for renewed accreditation are promising and the full report is expected by the end of March 2018.

In 2017, following a parental concern being raised regarding the late diagnosis of a malignant tumour, a new protocol has been developed for Health Visitors in collaboration with the UHB Orthoptic department. The emphasis is on Health Visitors seeking early advice from orthoptics and increased training. The protocol is now available on the portal.

Future developments for 2018 include:-

- Compact Nutrition training (including Making Every Contact Count)
- Audit of Women with BMI 35 – 39.99 who start their labour outside an Obstetric Unit
- Implementation of recommendations from "You Birth, We Care" survey.
- To finalise and implement plans with partners to deliver targeted services to prevent/support those affected Adverse Childhood Events (ACE).

- Establishment of pilot Children's zones in deprived neighbourhoods in C&V bringing together services across statutory and 3rd sector partners, Flying start and Families First to provide seamless support for Children and Families.

In addition, the generic Health Visitor service has developed a Supported Observation Tool which is the first such tool that quality assures a Health Visitors' professional practice.

It is being piloted currently and will be introduced across the workforce, both at a senior level, with Band 7 Health Visitors and with those staff who are newly qualified. So far, staff are finding it helpful and there are recommendations for both practitioners and managers alike. It is being supported by operational managers currently, but will be used by Community Practice Teachers and peers in due course. We hope it will be an early indication for staff who may have required a capability process and can be used as a supported process to action any training and development needs but also quality assures practitioners. The tool will be shared via the All Wales Head of Health Visiting Group.

Health and Safety:-

In the period 2016-2017, there have been a total of 9 staff RIDDORS.

Since November 2017, there have been two:-

One caused by a faulty bed which exacerbated a staff members existing back condition and the other due to uneven flooring.

Safe Care (Theme 2)

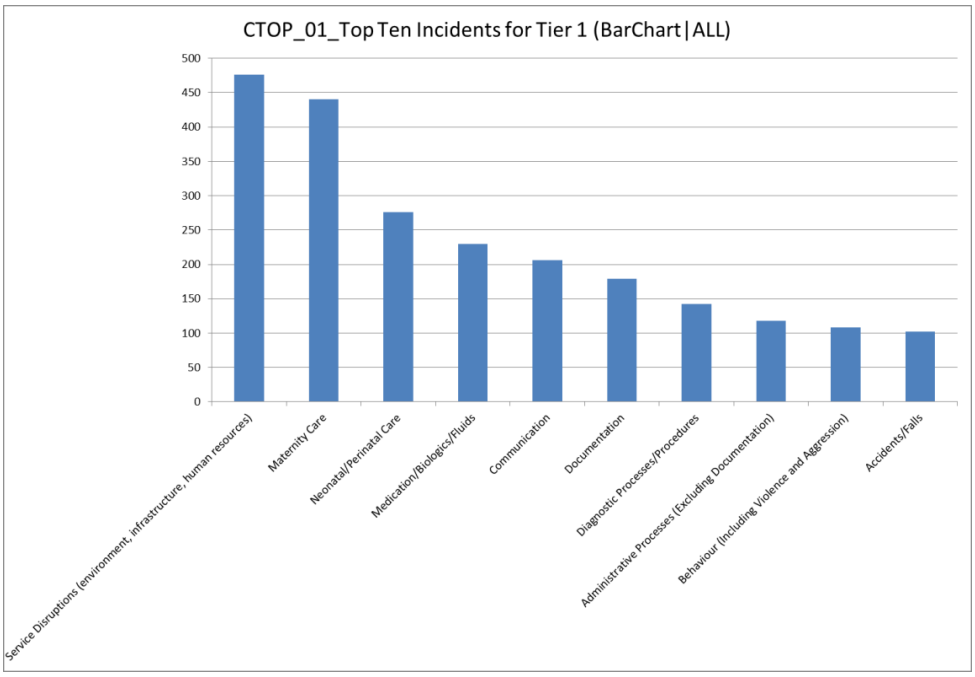
Safety Alerts
With regard to management of safety alerts, the Clinical Board has a robust management system in place for patient safety alerts working in conjunction with the Patient Safety Team. All patient safety alerts are disseminated widely and further discussed at Directorate and Clinical Board QS&PE Meetings.

Patient safety Incidents

For the period 2017-2018, the Clinical Board reported a total of 2457 incidents of these 1683 were patient incidents.

Patient incidents (excl. rejected)b	01: No harm	02: Minor	03: Moderate	04: Major	05: Catastrophi	Total
Acute Child Health	382	180	35	8	1	606
Community Child Health	93	38	7	1	0	139
Obstetrics and Gynaecology	473	409	54	2	0	938
Total	948	627	96	11	1	1683

Of these, the top ten patient safety incidents categories for Tier 1 targets are detailed in the bar chart below:-



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Serious Incidents

In 2017, The Clinical Board reported a total 16 SI's/no surprises. There are currently 5 serious incidents open to the Clinical Board which cover all 3 Directorates. There are no similar themes identified within the 5 incidents and within the same time period there have been 21 closure forms submitted.

SBAR's are prepared following all ratified RCA investigations and are used for shared learning within teams.

RCOG triggers for Clinical Risk are discussed at both Maternity and Gynaecology Risk Management meetings where a multi-professional review is held and recommendations made in relation to further root cause analysis/serious incident reporting.

The Clinical Board works closely with the Maternity Network Wales to develop and implement evidence based care and improve safety culture.

The Obs Cymru management and reduction of post-partum haemorrhage work, which was developed in Cardiff and Vale has been recognised as an example of good practice and implemented across Wales.

The Clinical Board is also fully engaged with the UHB initiatives of:-

- NATSSIPS
- ANTT
- Reducing Sepsis.

Following a serious incident when a child sadly died in the care of Children's Community Nursing Service, several changes have been implemented in response.

A "Memorandum of Understanding" has been developed between UHB Legal Services and the CCNS/ Directorate. This will be launched with families shortly. Families have been consulted regarding the level of monitoring for their child in the home and individual risks assessed and shared with families. All nurses have access to baseline clinical observation kits and net books have been provided so that nurses can access electronic records in the home.

We have a lead Senior Nurse/Therapist representative for Safeguarding, Falls Management and Pressure Ulcer Prevention.

Safeguarding

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The Director of Nursing has a monthly meeting with the Head of Safeguarding to keep updated with developments and discuss cases where appropriate, in addition to this:-

- Staff attend face to face mandatory level 2 updates as well as on line training
- Staff working with vulnerable women and children undertake level 3 training
- Routine enquiry in the antenatal period is audited annually
- There is a designated Safeguarding Specialist Nurse for Flying Start
- Currently working with Cardiff Children's Services and Police to develop protected pathway for professionals to escalate safeguarding concerns regarding Gypsy Traveller children.

Further developments include:-

- The post natal wards at UHW are upgrading its infant abduction alarm system with work to be completed by spring 2018.
- To complete a clinical pathway for all Health Visitors to support looked After Children and newly adopted children.

Falls management

A "Babies Don't Bounce" falls prevention project within post natal areas has been introduced. This project standardised care for neonates who sustained falls within the Maternity Ward.

A falls prevention programme was also developed for children and has been trialed on Jungle Ward. This will now be rolled out further to other clinical areas within the Children's Hospital for Wales.

Inquests/Regulation 28

The Clinical Board has received a section 28 report following a coroner's inquest held in October 2017. Three recommendations were made:-

- Consideration should be given to increase the support for Junior staff
- Improve standard of leadership of Obstetric staff
- Enhance and improve effectiveness of fetal monitoring

This case has been shared with multi-disciplinary teams at Clinical Audit and outside of the organisation at Heads of Midwifery Wales. In response to this incident, a fetal surveillance care bundle has been developed which is due to be implemented from 1st April 2018.

Infection Prevention Control

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The Clinical Board has made improvements on its incidence of HCAI when compared to the same period last year. We have worked closely with colleagues in Microbiology and have ensured that RCA's have been completed in a timely manner. Within the Neonatal Unit we have developed a multi-disciplinary task force to develop enhanced surveillance and initiatives to drive down incidence.

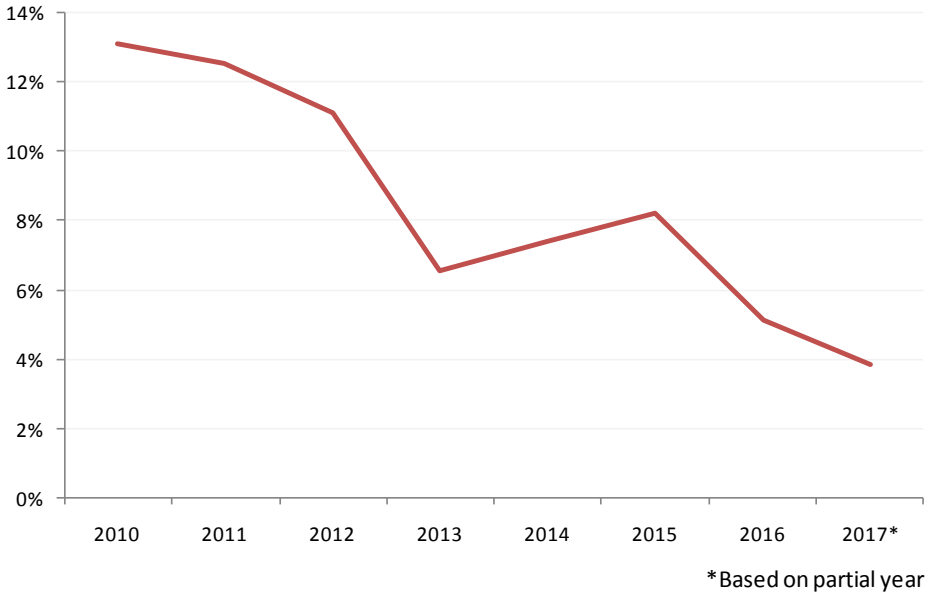
This year the Clinical Board has successfully reduced its incidence of *CDifficule* by over 50%. Where we have seen incidence this has been amongst our most complex children with multiple co-morbidities. As a Clinical Board we work closely with our IP&C colleagues and the Director of Nursing meets regularly with the IP&C lead to identify any areas of concern and to review completed RCA's. We have had zero cases of MRSA reported this year and our incidence of MSSA has reduced by 60%. In March 2018 our hand hygiene scores were 95.5%

Caesarean Section Surgical Site Infection (CSSSI) Rate:-

Through a focused and effective work plan, the Clinical Board has successfully reduced it caesarean section surgical site infection rate. This has been achieved through a number of actions:-

- Changed antibiotics given at induction
- Benchmarked with other similar units in England
- Explored and audited environmental temperatures
- Decreased use of inappropriate suture material

This considerable improvement is evidenced below:-



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Effective Care (Theme 3) – Research

The Clinical Board has a healthy portfolio of open research studies, funded studies set up with colleagues from Cardiff University and other HEI's studies in development or awaiting decisions on funded applications.

In the current year 2017/18, Health and Care Research Wales professional data indicates that 709 women have been recruited to portfolio studies in Cardiff and Vale. This places us as the highest recruiting Health Board in Wales for this specialty. We had 21 studies recruited in the last year and already have 15 studies for 2018.

Current studies include:-

- Pregnancy and weight monitoring study
- Anode:-prophylactic antibiotics for the prevention of infection following operative delivery.
- The Pool study: A cohort study to establish the safety of Water birth for mothers and babies.

Our clinical audit plan is established and regularly audited through Quality, Safety and Patient Experience arrangements in addition to this NCEPOD reports and NICU guidance is circulated widely throughout the Directorates and discussed at Directorate and Clinical Board QS&PE committees.

The Clinical Board can also demonstrate effective care through its Clinical Board Medicines Management group.

Improvements for the forthcoming 12 months will be to formally capture and share all “pockets” of research activity being undertaken throughout the Clinical Board.

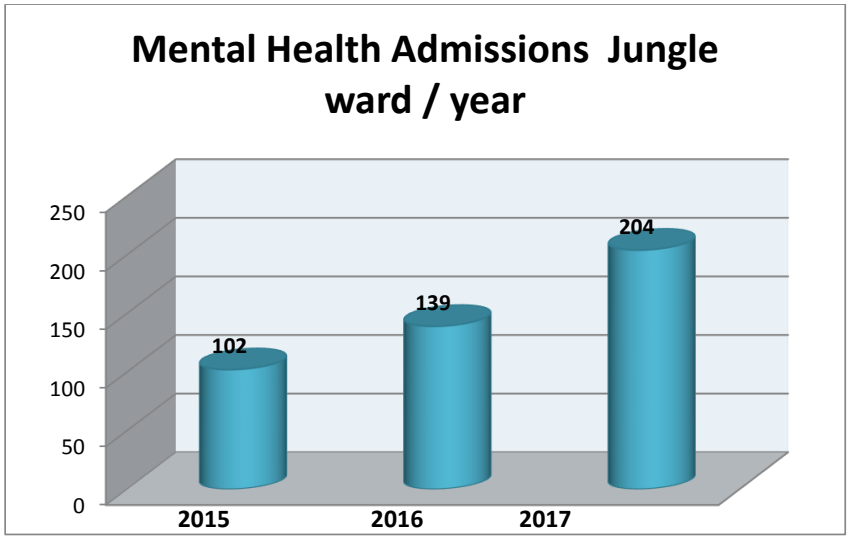
The Clinical Board is supporting 3 members of staff to undertake Professional Doctorate studies. Each will include a Pathway or Portfolio study which will be relevant to the Clinical Boards priorities.

Dignified Care (Theme 4)
Within the Clinical Board a second bereavement suite is being developed within the main delivery unit at UHW to support women who have experienced a pregnancy loss but require further monitoring and assessment of their clinical condition post-delivery.

In addition a part time bereavement midwife will become full time from the end of March to support the launch of a “Rainbow Baby” clinic for next pregnancy following a loss.

Dementia champions are in place and dementia awareness compliance is improving.

In 2017, the Children’s Hospital for Wales saw a marked increase in the number of children admitted in crisis with mental health. This is demonstrated below:-



In response, the Children & Women’s Clinical Board signed a pledge to support the Mental Health and Wellbeing of young people and positively change the organisations policy and practice towards mental health.

The signing of the pledge was achieved in partnership with Gofal, Hafal and MIND Cymru. An action plan has been developed to include staff training, mental health awareness days and looking at resilience training for staff, in addition Mental Health Champions will be identified in all clinical areas.

Dignity/Essential Care Inspections

Within the preceding 12 months the Clinical Board has had inspections/reviews from HIW, CHC as well as internal inspections.

The HIW inspection was held in June 2017, which was largely positive with the finding that the service provided safe and effective care. The recommendations for improvement included:-

- The availability of sufficient theatre time for surgical procedures
- Aspects of Medicines Management
- Recording of care in patients notes

HIW noted that almost without exception, that the parents they spoke to during the inspection praised the care provided by staff and were positive regarding food options available, cleanliness and the support the children received from play therapists.

Unannounced CHC inspections are demonstrating that patients are receiving compassionate, individualized and dignified care. The feedback is also very positive following the move to the Children's Hospital for Wales. Recurring issues pertain to documentation and regular Audits to monitor progress are embedded.

Timely Care (Theme 5)

The Children and Women's Clinical Board have had a successful 2016/17 and will continue to work collaboratively to maintain this trajectory. We have demonstrated significant improvement in the delivery of referral to treatment times, and have eliminated all patients waiting more than 52 weeks for both Gynaecology and Paediatric Surgery services. The establishment of a pre-admission clinic for children had also supported improvement and reduced on the day cancellations

In 2018 we will aim to have a planned care system in place where demand and capacity are in balance where we reduce waste, harm and variation and sustainably make the best use of resources available to us. We will continue to work collaboratively with WHSSC to secure additional resource where appropriate to deliver specialist services.

With regard to unplanned care we will aim to have a system that provides the right care, in the right place first time. The Clinical Board has plans for a range of both community and secondary care based service improvements which it is anticipated will provide increase capacity.

Work in 2018 will include the delivery of the Children's Acute Theatre Service and also progression in the agreement and planning for the Single Point of Entry collaboratively with the Medicine Clinical Board.

Significant progress has been made towards compliance with the PMH (part1) target which states that 80% of Mental Health assessments must be undertaken within 28 days of the receipt of referral. Compliance with this target has risen to 85% and we continue to work with the clinical teams to ensure that delivery is sustainable.

The C&W Clinical Board remain compliant with all cancer targets and these rarely provide cause for concern.

The Community Child Health Directorate and Clinical Board have worked hard to improve the waiting times for paediatric therapies and to ensure that they are effectively managed. This work has resulted in a reduction in the number of children waiting more than 14 weeks for access to these important services and it is anticipated that at the end of March 2018 there we be no paediatric therapy patients waiting more than 14 weeks for their appointment

Individual Care (Theme 6)
National surveys are used for gaining feedback from service users in both Maternity and Gynaecology services.

Maternity services also undertake '2 minutes of your time questionnaires' for women when leaving the service. A 'You Said We Did' feedback mechanism is in place and shared on newly developed 'hot boards' in all areas. Challenges around facilities for women and families for access to hot food and drink whilst on the ward remains. A beverage bay is planned for Delivery Suite along with the completion of a patient kitchen within the ante and postnatal ward.
Women's stores are shared via mandatory learning, led by the women's experience midwife who is the main point of contact for concerns and compliments. An active Maternity Services Liaison Committee is embedded within maternity services. The committee meets quarterly but also has a 'Parent Voices' Facebook group which is used for sharing parent education class details, guideline development and listening to feedback from women. A recent project in development as a result of patient feedback is improving induction of labour processes and information. Virtual tours of the unit are available for all areas. Birth Choice and Birth Afterthoughts clinics are in place for women making choices outside of evidence based recommendations and for women who may need a 'de-brief' following their birth.

Within the Childrens services we have developed age appropriate questionnaires which gives the Clinical Board more meaningful feedback on how the children view their stay with us and their view of the services provided.

We have also utilised the 'happy or not' machines as a method of establishing real time feedback of children's services.

Concerns

The management of concerns remains a key priority for the Clinical Board. The Clinical Board holds weekly tracker meeting with the concerns team which allows interrogation of the database and ensures responses are issued within agreed targets. In December 2017, the Clinical Board achieved 100% compliance with the 30 day response target. The Clinical Board actively attempts to resolve all complaints informally, however due to the complex nature of some of the concerns received this does not always prove possible.

Informal concerns:-
Between the period of January 2017 to 31st January 2018, the Clinical Board received 163 informal concerns:-

DIRECTORATE	TOTAL
Acute Child Health	77
Community Child Health	25
Obstetrics and Gynaecology	61
Total	163

Formal Concerns:-
For the same period detailed above the Clinical Board received 152 formal concerns in total:-

DIRECTORATE	TOTAL
Acute Child	54
Community Child Health	35
Obstetrics and Gynaecology	63
Therapy services	0
Total	152

The reasons of formal concerns remain primarily:-

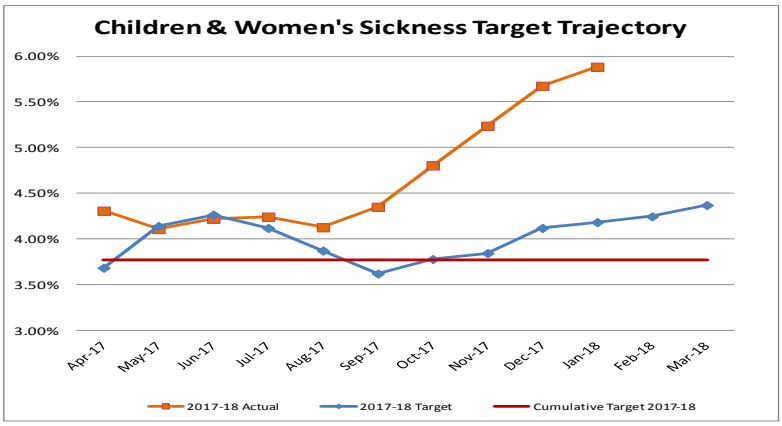
- Clinical Diagnosis and treatment
- Communications between staff and patients

Staff and Resources (Theme 7)

Workforce information and performance metrics provide key data to support the Organisation's goal of providing, high quality, safe services to our patients.

High Levels of sickness and temporary staffing may have an adverse impact on patient experience, safety and quality if not appropriately managed. Non-compliance to compulsory training and in annual performance appraisal and development review may adversely impact safety and quality in care as well as a lack of productivity and appropriate performance management.

Sickness Absence:



The cumulative sickness absence rate for the Children and Women Clinical Board as at January 2018 was 4.66%, this is lower than the UHB rate of 5.01%.

The Clinical Board recognises the importance of annual appraisals for all staff and has set a target of 90% compliance. Unfortunately this has not been achieved but good progress is being made.

At the end of January 2018, 70.75% of staff within the Clinical Board had received their PADR. The Directorates have nominated "proxy users" in order to ensure that PADR information is input in a timely manner.

In respect of individual Directorates, performance is as follows:

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Directortate / Department	Number of Reviews	Staff in Post	% Compliance (December)	Change from Previous Month
Acute Child Health Services Total	468	588	79.59%	
Community Child Health Services Total	314	522	60.15%	
Obstetrics & Gynaecology Total	345	479	72.03%	
Women & Children MGMT Total	5	11	45.45%	
Children & Women Clinical Board	1132	1600	70.75%	

Vacancies and Turnover

The Clinical Board recognises the importance of managing its vacancies and the impact that the use of bank and agency staff and expensive agency locums has on variable pay. The Clinical Board's vacancy factor as at January 2018 was 2.39%. This remains within the 5% target set by the UHB.

The Clinical Board turnover rate for January 2018 was within the acceptable range of 7%-9% at 8.19%.

The Gynaecology ward is staffed as per CNO Safer Staffing Principles and is working with the UHB, undertaking acuity audits. Within maternity services, there is a requirement that 'Birthrate plus compliance is achieved with sufficient midwifery staffing. Plans are in place for recruitment and to become Birthrate plus compliant by June 2018.

Acute Child health held a recruitment event in February 2108 which was attended by 65 qualified and student nurses attending from within and outside Wales. Of the 65 applicants interviewed, 60 are suitable for appointment. Further work is ongoing to predict the number of leavers between now and November 2018, so that posts can be offered. Further discussions will need to take place concerning the implications of the South Wales Plan and the timing of Paediatric, Obstetric and Neonatal activity flow from Cwm Taf to UHW. This is now predicted to be March 2019 rather than August /September 2018.

Staff Engagement

Staff Engagement is extremely important to the Clinical Board. As such the Clinical Board has developed a three year Staff Engagement Plan which sets out our commitment to our staff and staff organisations and our undertaking to continue to develop the Clinical Board as one that we can be proud of. Staff Engagement is therefore a key Organisational Development priority for the Children and Women's Clinical Board.

In developing the plan, employee feedback has been gathered and analysed from various sources including the Staff Survey, Focus Groups and Health and

Wellbeing Surveys. Recurrent themes included a lack of communication, not feeling supported by management, lack of recognition, senior management not being visible in clinical areas and employees not understanding how their roles relate to overall Clinical Board Priorities.

The aim of the plan is to ensure that staff are involved in defining what a great work experience is, helping to shape the systems and processes that deliver it, and living the values of our organisation.

The Clinical Board also has active Local Partnership Forum which meets every two months. The forum is an opportunity to discuss the progress and development of the Clinical Board, key priorities and initiatives within Directorates as well as Organisational and service change issues.

The Clinical Board's Staff Celebration and Recognition event took place in January 2018 and was a huge success. The theme for the event was "Working Together" with award categories for;

- Inspiring Leader
- Team triumph
- Bright Beginning Award.

The "Caring for you" work in Maternity services with the Royal College of Midwifery continues to develop. Staff meetings within the area are now well established.

Awards.
The Children's and Womens Clinical Board has had a very successful year, this has been recognised with a number of our staff winning national awards.

- 17 nominations for RCN Wales Nurse of the Year Awards.
- Emma's Diary RCM UK Midwife of the Year 2018.
- RCN Wales Leadership Award 2017
- RCN Wales Mental Health and Learning Disability Nurse of the year Award 2017.
- Caring for You Award 2018, UK RCM Awards.
- Winner of Staff flu incentive 2018.
- Presentations and Posters accepted and shared at national and International conference

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

CAERDYDD A BRO MORGANNWG
CARDIFF AND VALE OF GLAMORGAN

9

Scrutiny Overview

Visiting Activity for the period:

18/10/17 – 05/01/18

March 2018

Index

Summary of Scrutiny Activity

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

This report is a considered overview of the scrutiny visiting activity from all visits undertaken between the 28 October 2017 and 5th January 2018. In total 5 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:

- Ward East 6 at Llandough Hospital – Report not submitted within agreed timescales for the January overview report.

Next Reporting Period – 06/01/18 to 09/03/18

The May Scrutiny Overview Report will incorporate all visit reports from the visits undertaken between the 6 January 2018 and 9 March 2018. In total 4 visits have been completed and are currently within the reporting process, with a further 2 planned to be undertaken following the collation of this report.

1 date allocated during this period for scrutiny activity, was utilised as part of the new follow-up process in operation. This was due to a lack of opportunities to follow-up as an addition to a general visit.

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

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 and their specialities, has been unable to identify many specific themes. Therefore, we have highlighted the noteworthy issues only:

- **Sensory Loss 01** – In the visit report for Ward East 6, UHL, members identified a lack of staff awareness, of a patient with hearing difficulties.
- **Sensory Loss 01** – During the visit to the recently reopened Radiology Unit, it was noted that there was no hearing loop available. Whilst acknowledging that the Unit has been redesigned in line with the Royal National Institute for the Blind (RNIB) Visibly Better Cymru Scheme, it is disappointing that other elements of Sensory Loss have not been addressed fully in the refurbishment.
- **Service Capacity** – Issues were identified during the visit to Gwenwyn Ward, in relation to the admission of general medical patients at periods of high demand and the reversion of the 6 bay ward to a single gender. It was noted that this impacts on the ability of poisons patients to access the expert care and facilities provided within this ward, at a time when demand for said services is increasing.

Good Practice

- **Patient Experience/Staff** – As ever, members were able to provide positive comments related to the high level of patient satisfaction experienced and the level of care provided by UHB staff, in all 5 of the visit reports.
- **Environment** – Members specifically commented on the ward/departments environments in all but 1 report, albeit there were no adverse comments included either. Comments incorporated the décor, cleanliness, impressions given and lack of clutter.
- **Gwenwyn Ward** – The visit team who conducted the visit to Gwenwyn Ward commended the development of the service into a

specialist unit and the perceived effective and excellent care delivered to poisons patients over the years. This incorporated comments on the approach and commitment by staff, arrangements with other services and the unique resources that expand UK wide.

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 23 February 2018. In total 5 follow-up visits were planned to be undertaken and 4 were completed, with 1 rescheduled.

UHB: Ward West 1, Llandough Hospital (18 October 2017)

Date of Previous Visit: **5 August 2016**
Date of UHB Action Plan: **26 September 2016**

In total 5 recommendations were made during the original visit, with each provided an attributable action by the UHB and subsequently agreed by Council. One of the recommendations was allocated an additional 3 action points by the UHB, taking to total number of follow-up issues to 8. Of these 8 recommendation action points, it was considered that 7 were achieved in their entirety, with 0 being partly met. The action(s) considered not to have been met are provided below:

- Ensure the ward has ample supply of cleansing wipes for the toilets and there is a constant availability for patients to comply with notices

UHB: Whitchurch Crisis Unit, Whitchurch Hospital (29 January 2018)

Date of Previous Visit: **11 July 2016**
Date of UHB Action Plan: **1 November 2016**

In total 2 recommendations were made during the original visit, with each provided an attributable action by the UHB and subsequently agreed by Council. One of the recommendations was allocated an additional 3 action points by the UHB, taking to total number of follow-up issues to 5. Of these 5 recommendation action points, it was considered that all 5 were achieved in their entirety.

UHB: Ash Ward, Llandough Hospital (21 February 2018)

Date of Previous Visit: **1 February 2017**
Date of UHB Action Plan: **22 May 2017**

In total 6 recommendations were made during the original visit, all of which were provided an attributable action by the UHB and were subsequently agreed by Council. Of these 6 recommendations, it was considered that 5 were achieved in their entirety, with 0 being partly met. The action(s) considered not to have been met are provided below:

- Install an accessible bath in the empty shower room

UHB: Short Stay Surgical Unit, UHW (23 February 2018)

Date of Previous Visit: **13 February 2017**
Date of UHB Action Plan: **19 May 2017**

In total 1 recommendation wa 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 was achieved in its entirety.

Summary of CHC Recommendation/Action Performance

Org.	Made	Achieved	Partly Achieved	Not Achieved	% Actioned
UHB	20	18	0	2	90%

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

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. **CHC** – As part of the on-going work around the Sensory Loss Agenda, and following the latest focussed activity in January 2018, the CHC will add a specific element to the routine visiting programme.
2. **UHB** – Explain the rationale for incorporating sight loss in the redesign of the Radiology environment, but excluding other elements of Sensory Loss. Additionally, provide assurances that any future area redesigns will address the full range of the Sensory Loss agenda.
3. **UHB** – Inform the CHC of the appropriateness of utilising what is a specialised service, for general medical patients and the associated risks caused to patients who are then unable to access these expert services.

Follow-up visits:

The **UHB** is asked to provide an urgent action plan, within 2 weeks of the CHC Council meeting on **12th March 2018**, in regard to addressing their respective agreed actions that have yet to be completed following previous CHC visit reports.

Visit Details

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

Type	Date	Service	Site	CHC Team	App.
Announced	18/10/17	Ward East 6	Llandough Hospital (UHL)	Steven Place (Lead) Jane Jenkins	1
Educational	01/11/17	Radiology Department	University Hospital of Wales (UHW)	Rob Henley (Lead) Val Evans	2
Unannounced	04/11/17	Emergency Unit	University Hospital of Wales (UHW)	Val Evans (Lead) Clare Clements	3
Announced	15/12/17	Gwenwyn Ward	Llandough Hospital (UHL)	Alison Walker (Lead) Christine Cave	4
Unannounced	20/12/17	Llanfair Unit & Wards East 14&16	Llandough Hospital (UHL)	Paul Davies (Lead) Eifion Pritchard	5
Type	**Date**	**Service**	**Site**	**CHC Team**	**App.**
Follow-up	18/10/17	Ward West 1	Llandough Hospital (UHL)	Steven Place (Lead) Jane Jenkins	6
Follow-up	29/01/18	Crisis Unit (Park Lodge)	Whitchurch Hospital	Alison Walker (Lead) Christine Cave	7
Follow-up	21/02/18	Ash Ward	Llandough Hospital (UHL)	Judith Simove (Lead) Jane Jenkins (Lead)	8
Follow-up	23/02/18	Short Stay Surgical Unit	University Hospital of Wales (UHW)	CHC Officer Completion	9

Next Reporting Period – 06/01/18 to 09/03/18

Type	Date	Service	Site	CHC Team	Stage
Announced	08/02/18	Antenatal & Consultant Led Unit	University Hospital of Wales (UHW)	Bablin Molik (Lead) Jane Jenkins	Awaiting Report
Announced	14/02/18	Island Ward	Children's Hospital for Wales (CHfW)	Julie Williams (Lead) Pat Matthews	Awaiting Report
Educational	19/02/18	Dental Hospital	University Hospital of Wales (UHW)	Pat Matthews Brenda Chamberlain Alison Walker Eleri Jones Jane Jenkins	Awaiting Report
Announced	21/02/18	Ward East 4	Llandough Hospital (UHL)	Jane Jenkins (Lead) Judith Simove	Awaiting Report
Announced	28/02/18	Rainbow Ward	University Hospital of Wales (UHW)	Shirley Willis (Lead) Eleri Jones	Planned

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Forward Planning

Date	Service	Site	Date	Service	
05/03/18	Ward C4	University Hospital of Wales (UHW)	21/03/18	Physiotherapy	University Hospital of Wales (UHW)
14/03/18	CHAP Service	Cardiff Royal Infirmary	26/03/18	Children's Kidney Centre	Children's Hospital for Wales (CHfW)
14/03/18	Ward East 2	Llandough Hospital	29/03/18	Restorative Dentistry	Dental Hospital @ UHW
15/03/18	Oral/Maxillo-Facial Surgery	Dental Hospital @ UHW			

The Visiting Plan for the 18/19 year, starting on 1st April 2018, is yet to be signed off by the Executive Committee. At this point, it will be publicised.

* Please note, unannounced visits are not publicised in advance

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QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK 2017 – 2020 - PROGRESS UPDATE

Name of Meeting: Quality, Safety and Experience Committee
Date of Meeting: 17th April 2017

Executive Lead: Executive Nurse Director

Author: Assistant Director Patient Safety and Quality.
Carol.A.Evans2@wales.nhs.uk

Caring for People, Keeping People Well: The Quality, Safety and Improvement (QSI) Framework has been specifically written to deliver the following elements of the UHB Strategy – Delivering Outcomes that matter to people; avoiding waste, variation and harm.

Financial impact: Delivery of the QSI framework has the potential to reduce costs that are incurred when patients are harmed as a consequence of their care. There are costs associated with some of the actions required to deliver the necessary improvements e.g. to achieve full compliance with Patient Safety Solutions requires an investment in the region of 100k.

Quality, Safety, Patient Experience impact: The QSI framework has been written to deliver improvements in key areas of the Quality, Safety and Experience agenda based on what we understand to be our current risk profile.

Health and Care Standard Number: This covers implementation of all Health and Care Standards.

CRAF Reference Number: 5.1

Equality and Health Impact Assessment Completed: No but it is anticipated that full implementation of the QSI Framework would lead to positive equality and health impacts.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The range of achievements during 2017-2018
- Identification of particular areas for focus during 2018-2019

The Quality, Safety and Experience (QSE) Committee is asked to:

- **CONSIDER** progress with implementation of the Quality, Safety and Improvement framework.
- **NOTE** the main high level achievements for 2017/2018
- **AGREE** to monitor the implementation of the framework and to receive a more detailed outcome based report in June 2019.

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SITUATION

The purpose of this report is to present the Committee with a high level update on implementation of the Quality, Safety and Improvement Framework 2017 - 2020. The Framework is summarised in the diagram in **Appendix 1.**

Progress on implementation of the Framework during 2017-2018 will be reported through the UHBs Annual Quality Statement which will be published at the end of July 2018 and annually thereafter.

A more detailed, outcome based progress report will be provided to the Committee in June 2019, which will allow time for the validation of outcome data for the 2018- 2019 period. .

BACKGROUND

The Quality, Safety and Improvement (QSI) Framework was approved by the Committee in April 2017. Since that time the Patient Safety and Quality team have been working with Clinical Boards and specialist leads within the organisation to support implementation.

It supports, and is integral to delivery of our Integrated Medium Term Plan and embraces the philosophy of Caring for people, Keeping People Well; supporting the broad organisational objectives of our overall UHB strategy – Shaping our future Wellbeing Strategy – that is, to deliver outcomes that matter to people and avoid waste, variation and harm.
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ASSESSMENT AND ASSURANCE

Our priorities are aligned with some of the key domains within the Health and Care Standards framework 2015, recognising that our colleagues in Public Health and in Workforce and Organisational development will be taking forward their own work to support the embedding of Standards within other domains. The Framework is also aligned with the UHB Patient Experience Framework for 2017 - 2020.

Key achievements to date in each domain include:

Aim 1 - Governance, Leadership and Accountability

Main achievements:

- The **standardised QSE agenda** is well embedded across the organisation and Clinical Boards continue to provide assurance reports to QSE Committee on a rotational basis.
- Work is progressing to provide a more focused **integrated QSE report** to Board that drives discussion around our QSE priorities.
- The **Annual Quality Statement** was published in line with WG requirements at the end of September 2017.

- **Leading Improvement in Patient Safety (LIPS)** - two cohorts delivered taking the total number of people who have undertaken LIPS to 750 and the number of QI projects to around 150. LIPS continues to attract international attention and a presentation has been accepted to the International Health Institute (IHI) conference in Amsterdam in May 2018.
- There has been specific investment in the development of a cohort of UHB staff with skills in human factors
- A set of generic quality indicators have been identified for all commissioned services

Areas for focus for 2018-2019:

- Safety culture survey of UHB staff
- Embedding of a human factors training programme
- Embedding of a multi-disciplinary QSE network - first meeting 27th April 2018
- Further strengthening of governance around QSE in our commissioning arrangements with external organisations
- Strengthening of reporting arrangements for relevant regulatory compliance to the QSE Committee

Aim 2 - Safe Care

Main achievements:

Same cause serious incidents - Overall there has been a reduction in the number of reported serious incidents from 238 to 232

- the number of incidents of self-harming behaviour (suicide, serious self-harm, drug and alcohol related deaths) has reduced from 35 in 2016/2017 to 23 in 2017/2018
- the number of injurious falls has fallen from 74 in 2016/2017 to 48 in 2017/2018
- serious medication errors have reduced from 7 in 2016/2017 to 3 in 2017/2018
- the number of IR(ME)R breaches where patients have had unnecessary exposure to radiation has reduced from 10 in 2016/2017 to 4 in 2017/2018
- the number of never events has reduced from 7 in 2016/2017 to 4 in 2017/2018 and overall there has been a reduction in the number of same cause never events, most noticeably in relation to retained swabs. The number of never events related to dental extraction remains the same.

- **Pressure damage prevention and management** – a well embedded Pressure Ulcer group, Chaired by the Director of Nursing in Surgery has enjoyed excellent engagement throughout the year. The UHB policy has been approved during 2017/2018. A £3 million Total Bed Management contract has been secured and a 'Mattress Selection' algorithm has been implemented and embedded. A considerable amount of work has been undertaken to improve the quality and the reporting of pressure damage and the UHB has moved from being an outlier of reported pressure damage in in-patients to a position where it is now comparable with peers across wales.

- **Falls prevention and management –** a well embedded multi-disciplinary and multi-agency Falls Delivery Group has met regularly during 2017/2018 and an award winning Falls Strategy implementation lead has been appointed.

- **Healthcare acquired infections –** the WG target for Clostridium difficile has been achieved. While good progress has been made against targets for e-Coli and for MRSA, the WG targets were not met. The following have been achieved:

  - Multi-drug resistant organism procedure has been ratified and is being implemented

  - Roll out of aseptic non touch technique (ANTT) – 259 facilitators have been trained to support the roll out; 1531 relevant staff completed the e-learning (44%); 1372 relevant staff attended the face to face learning (39%); 1072 (31%) competency assessed.

  - Primary care based RCA tool for staph aureus is currently being trialed.

  - An E-Coli work-stream and steering group established. Pilot GP practices identified.

- **Sepsis – a** Clinical Fellow for Sepsis appointed and a Sepsis 'star' has been developed for the clinical workstation to assist with data capture and prompting the process.

- **Safeguarding** – the UHB has:

  - secured funding for another band 7 post within the team and have also secured a full -time Independent Domestic Violence Advocate (IDVA) within the Safeguarding team which is the only team in Wales to have such a post.

  - agreed an occupation agreement with the Multi-Agency Safeguarding Hub as well a Wales Accord on the sharing of personal information (WASPI)

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- advanced the Female Genital Mutilation (FGM) agenda significantly, with Cardiff the highest referrer in Wales. An FGM clinic has been established and this is seen as leading work in Wales.

- worked with both Local Authorities to deliver the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 strategy in line with the Act.

- **Nurse Staffing levels (Wales) Act 2016** – considerable progress has been made to ensure that the UHB is compliant with requirements of the Nurse Staffing Wales (Act 2016) and this includes the identification of clinical indicators and the development of a live ward based nursing dashboard.

Areas for focus for 2018-2019:

- Continued monitoring of endoscopy improvement plan
- Prevention of further same cause never events in the dental setting
- Improved quality of reporting of pressure damage in line with awaited, revised WG guidance with specific focus on community healthcare acquired pressure damage
- Compliance with WG targets for healthcare acquired infections
- Implementation of the electronic wristband system
- Strengthening reporting of mortality and morbidity data in relation to Sepsis and care of the deteriorating patient
- Prevention of Hospital Acquired Thrombosis

Aim 3 - Effective care

Main achievements:

- **Patient Safety Solutions** - increase in compliance from 81% in January 2017 to 91% in March 2018. The UHB has secured capital investment to introduce an electronic wristband system which will achieve compliance with an historical alert that the UHB has been non-complaint with for over 10 years.

- **Mortality reviews -** The interface between Datix and the Business Intelligence System (BIS) has been achieved. Reported incidents can now be seen at individual patient level. Reported incidents for the final episode of care will automatically trigger a second stage mortality review. This is a significant step forward.

- IT development is under way to capture LD information and to trigger an automatic second stage mortality review for these patients.

- 80% of in-patient deaths have been subject to Universal Mortality Review (UMR)

Areas for focus for 2018-2019:

- Roll out of the electronic wristband system to ensure full compliance with NPSA notice 24 – July 2007 - Standardising wristbands improves patient safety and PSN 026 Positive Patient Identification
- Introduction of an electronic clinical audit system
- Standards for record keeping and audit
- Increasing the % of in-patient deaths subject to UMR

Aim 4 - Dignified care

Main achievements:

- **Mouth care** –three has been a trial of and amendment of the current assessment documentation and an over-arching action plan has been signed off and will be monitored by the Clinical Standards and innovation Group (CSIG)

- **Learning disabilities** - The 1000+ lives guidance for improving general hospital care for people with Learning Disabilities has been rolled out.

  - A regional commissioning group has been established with C&V representation and there are work streams focusing on
    - Finance
    - Performance and quality measures
    - Service specifications
    - Needs assessment

  - National work is underway to review the Enhanced service for Annual Health Checks with a view to improving and incentivising engagement of primary care and uptake.

  - A specific symbol is now being used on the Patient Administration System to identify in-patients with a known Learning disability

The Committee should be advised that have been no serious incidents reported this year in relation to the care of a patient with Learning Disabilities. Previously this has been identified as a theme in our Serious Incidents

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End of Life care – there has been increased funding/ workforce for the CVUHB/Marie Curie Hospice at Home Team to improve length of stay and patient experience. In addition:

- the UHB is imminently recruiting two Macmillan Advance Care Plan Facilitators to support preferred place of care
- national data demonstrates that our specialist palliative care referrals are higher than other comparable areas in Wales with excellent response rates
- there is evidence of improving numbers of Advance Care Plans and Community Anticipatory End of Life prescribing to support a reduction in admissions – supported by improved guidance and processes

Continence care – the UHB responded fully to the Older People's Commissioner in relation to continence care and the Clinical Standards and Innovation Group (CSIG) has agreed a pathway for the use of appropriate continence aids. There has been an increase in referrals to the continence service and there has been less spend on continence products because assessment of the patients' needs is considered to have improved.

Quality of sleep –the CSIG has approved and is monitoring an over-arching action plan in relation to the promotion of sleep. There have been no themes identified this year from our patient surveys which relate to sleep, in contrast with previous years.

Areas for focus in 2018/2019

- Sensory loss plan
- Exploring the experiences of our service users with Learning Disabilities
- End of life care – outcome measures

Aim 5 - Timely care

Main achievements:

- There has been a reduction in the number of patients waiting longer than 8 weeks for diagnostic tests to less than 1000 compared to this time in 2017
- There has been a 32 % reduction in the number of patients waiting longer than 36 weeks for elective treatment, compared to this period in 2017
- There has been a reduction of 49% for patients waiting longer than 52 weeks for elective treatment, compared to this period in 2017

- No patients are waiting longer than 14 weeks for therapy services at this point in time

- Overall there is an improving trajectory during 2017-2018 in relation to the number of patients whose care has been delayed in hospital

- Throughout the year there has been an improving picture in relation WG targets for compliance with the Mental Health Measure. In March 2018 the Board was advised that:

    - 83% of service users seen in January 2018 were assessed by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of referral, against the Welsh Government's minimum standard of 80%. Both the adult and older people's services achieved the standard of 80%, delivering 93% and 88% respectively
    - Overall 79% of service users started a therapeutic intervention following assessment by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of their assessment against a standard of 80%.
    - 90.1% of LHB residents had a valid Community Treatment Plan completed at the end of November. Performance remains above the standard of 90%.
    - 100% of former users assessed under part 3 of the measure were sent their outcome of assessment report within 10 days.

Areas for focus in 2018/2019:

- Implementation of the Single Cancer Pathway
- Ambulance handover times
- Reduction in the number of 12 hour waits in EU
- Access to Out of Hours General Practitioners
- Continued reduction in the number of patients whose discharge is delayed
- Referral for psychological therapies
- Access to Children and Adolescents' Mental Health Services

Aim 6 - Individual care

An update against this domain will be covered in detail in a report to the committee scheduled for June 2018 on implementation of the Patient Experience Framework.

Main achievements:

Patient Experience Framework - the UHB can demonstrate achievements and activity in all four quadrants of the

- the UHB has maintained very good patient satisfaction scores throughout out 207-2018

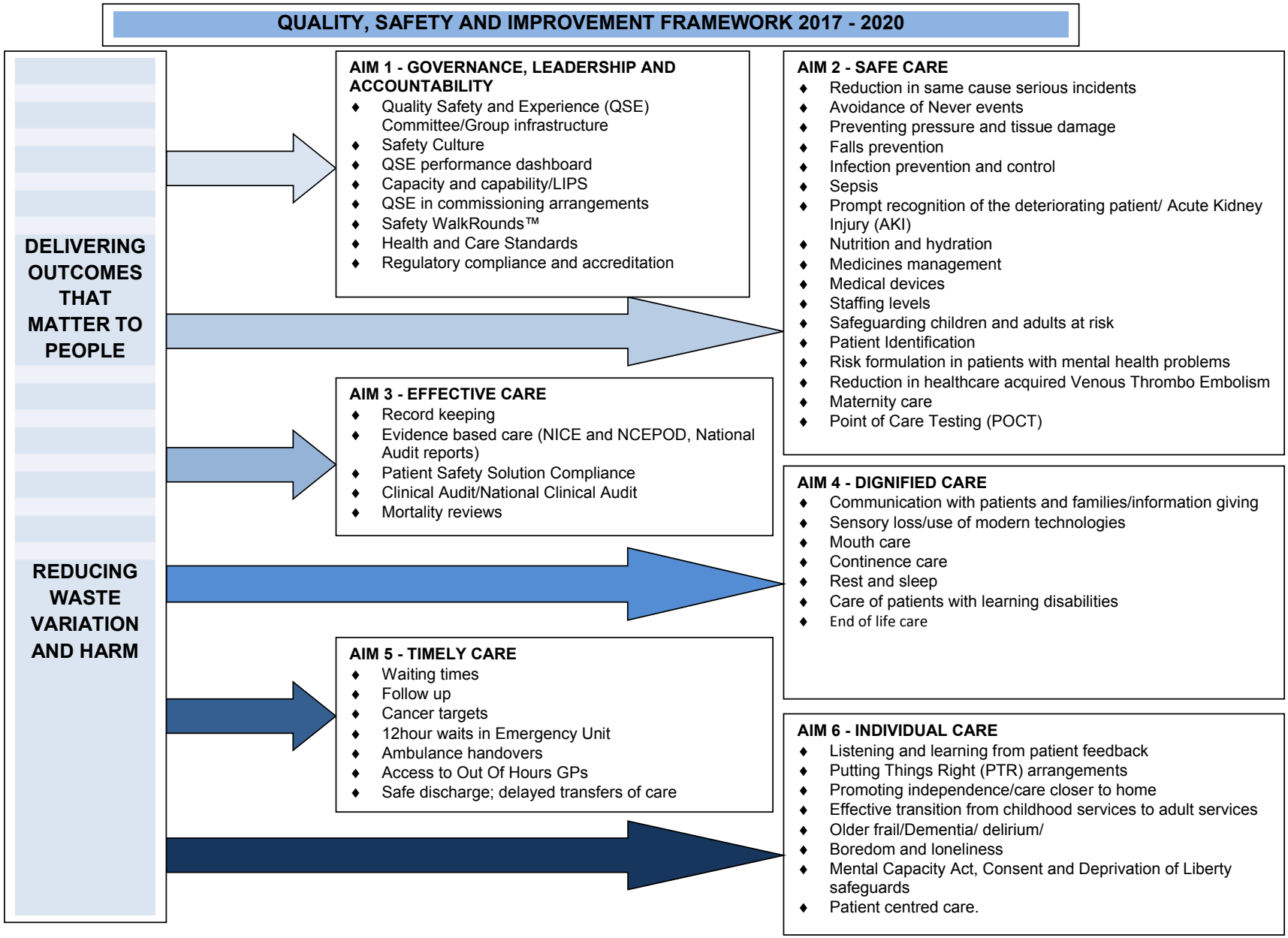
- there has been an increased % of Concerns managed informally and a sustained improvement in the formal response times

Dementia care: The National Dementia plan was published in February 2018 and a local strategy is currently being developed in line with this. By end of 2017/2018:

- Dementia Champions are in place on every ward
- John's Campaign was launched in February 2018
- Katie's Wish was launched in March 2018 to combat boredom and loneliness in inpatients with cognitive impairment.
- Read about me was launched in 2017
- 61.82% of the staff had completed Dementia Training by the end of February 2018

Areas for focus in 2018/2019:

- Implementation of Year 2 of the Patient Experience Framework
- Transition from childhood to adult services
- Development of the local Dementia plan
- Consent, Mental Capacity Act and Deprivation of Liberty Safeguards


QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK 2017 - 2020
DELIVERING OUTCOMES THAT MATTER TO PEOPLE
REDUCING WASTE VARIATION AND HARM
AIM 1 - GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY
♦ Quality Safety and Experience (QSE) Committee/Group infrastructure
♦ Safety Culture
♦ QSE performance dashboard
♦ Capacity and capability/LIPS
♦ QSE in commissioning arrangements
♦ Safety WalkRounds™
♦ Health and Care Standards
♦ Regulatory compliance and accreditation
AIM 2 - SAFE CARE
♦ Reduction in same cause serious incidents
♦ Avoidance of Never events
♦ Preventing pressure and tissue damage
♦ Falls prevention
♦ Infection prevention and control
♦ Sepsis
♦ Prompt recognition of the deteriorating patient/ Acute Kidney Injury (AKI)
♦ Nutrition and hydration
♦ Medicines management
♦ Medical devices
♦ Staffing levels
♦ Safeguarding children and adults at risk
♦ Patient Identification
♦ Risk formulation in patients with mental health problems
♦ Reduction in healthcare acquired Venous Thrombo Embolism
♦ Maternity care
♦ Point of Care Testing (POCT)
AIM 3 - EFFECTIVE CARE
♦ Record keeping
♦ Evidence based care (NICE and NCEPOD, National Audit reports)
♦ Patient Safety Solution Compliance
♦ Clinical Audit/National Clinical Audit
♦ Mortality reviews
AIM 4 - DIGNIFIED CARE
♦ Communication with patients and families/information giving
♦ Sensory loss/use of modern technologies
♦ Mouth care
♦ Continence care
♦ Rest and sleep
♦ Care of patients with learning disabilities
♦ End of life care
AIM 5 - TIMELY CARE
♦ Waiting times
♦ Follow up
♦ Cancer targets
♦ 12hour waits in Emergency Unit
♦ Ambulance handovers
♦ Access to Out Of Hours GPs
♦ Safe discharge; delayed transfers of care
AIM 6 - INDIVIDUAL CARE
♦ Listening and learning from patient feedback
♦ Putting Things Right (PTR) arrangements
♦ Promoting independence/care closer to home
♦ Effective transition from childhood services to adult services
♦ Older frail/Dementia/ delirium/
♦ Boredom and loneliness
♦ Mental Capacity Act, Consent and Deprivation of Liberty safeguards
♦ Patient centred care.

TERMS OF REFERENCE – CLINICAL ETHICS COMMITTEE
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 17th April 2018

Executive Lead: Medical Director
Author: Chair Clinical Ethics Committee
Caring for People, Keeping People Well: The Health Board's Strategy includes 'our values
Financial impact: No financial impact
Quality, Safety, Patient Experience impact: The ability to discuss our ethical dilemmas and difficulties provides an opportunity to test our values against an ethical framework and enable the most appropriate care.
Health and Care Standard Number: 4.1 Dignified Care
CRAF Reference Number: No specific risk previously identified
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Review and updating of the Terms of Reference for the Clinical Ethics Committee
- Plan for greater awareness of the work of the Committee

The Quality, Safety and Experience Committee is asked to:

- **NOTE and AGREE** the Updated Terms of Reference including exception reporting to Quality, Safety and Experience Committee, (Appendix One)
- **NOTE** the appointment of the new Chair, Professor Angus Clarke

SITUATION

The purpose of the Clinical Ethics Committee (CEC) is to provide:

1. **Guidance** to professionals in the Board, in respect of specific clinical ethical dilemmas by:

a) Providing analysis of ethically complex issues.
b) Identifying courses of action that are ethically problematic.
c) Offering reassurance where courses of action are ethically robust.
d) Facilitating exploration of possible solutions in discussion with the referring team.

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2. **Support** for the Board's Policies and Guidelines by:

a. Enabling individual members to participate constructively in developing and implementing them by providing continuing professional development in medical/clinical ethics.
b. Critically evaluating them where there are important ethical aspects to consider, during development and consultation phases.
c. Response to consultation documents from outside bodies such as the Welsh Government and General Medical Council that have important ethical dimensions and affect professionals in the Board.

3. **Education and training**

a) In respect of professionals in the Health Board (increase awareness of nature and importance of ethical issues in healthcare, facilitate acquisition of basic competencies)
b) In respect of members of the CEC (specific competencies in ethics in line with UK national guidelines)

BACKGROUND

The Clinical Ethics Committee continues to be available to the UHB and has an agreed operational protocol. The Terms of Reference (appendix one) have been discussed at a special meeting of the Clinical Ethics Committee with the Medical Director in attendance and agreed with the Committee in December 2017. The previous Chair Dr Richard Hain has stood down and a new Chair, Professor Angus Clarke appointed according to the Terms of Reference. The Medical Director fully supports this appointment.

It is also recognized that the number of requests for the Committee have significantly reduced over the last one to two years and there is a need to publicise the Committee and the wider functions it can serve. A significant number of "clinical dilemmas" are now being referred via legal pathways. There is current discussion between the Chair, Medical Director and Assistant Medical Director for Clinical Engagement about further publicizing the work of the Committee.

ASSESSMENT AND ASSURANCE

It is recognised that traditionally the Clinical Ethics Committee has been a body providing independent advice. The Committee Chair reports formally and informally to the Medical Director on the Group's activities. This includes verbal updates on activity, the submission of Group minutes and written reports throughout the year. The Chair of the Clinical Ethics Committee would

also bring to the Medical Director's specific attention any significant matters under consideration by the Group. Further details are given in appendix one.

The Clinical Ethics Committee has not recently formally reported to a Public Sub-Committee/Committee of the Board and the Quality, Safety and Experience Committee is asked to agree that significant ethical issues/dilemmas are reported on an exceptions basis to the Committee as deemed necessary by the Medical Director.

Clinical Ethics Committee

Terms of Reference

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Updated December 2017

1. INTRODUCTION

1. Cardiff and Vale UHB's Standing Orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the LHB 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*".

2. PURPOSE

2.1 The purpose of the Clinical Ethics Committee (CEC) is to provide:

- **Guidance** to professionals in the Board, in respect of specific clinical ethical dilemmas by:
  - Providing analysis of ethically complex issues.
  - Identifying courses of action that are ethically problematic.
  - Offering reassurance where courses of action are ethically robust.
  - Facilitating exploration of possible solutions in discussion with the referring team.

- **Support** for the Board's Policies and Guidelines by:
  - Enabling individual members to participate constructively in *developing* and *implementing* them by providing continuing professional development in medical/clinical ethics.
  - Critically evaluating them where there are important ethical aspects to consider, during development and consultation phases.

- **Response** to consultation documents from outside bodies such as the Welsh Government and General Medical Council, that have important ethical dimensions and affect professionals in the Board.

- **Education and training**
  - In respect of *professionals in the Board* (increase awareness of nature and importance of ethical issues in healthcare, facilitate acquisition of basic competencies)
  - In respect of *members of the CEC* (specific competencies in ethics in line with UK national guidelines (sensitisation to ethical demands in practice and methods of resolution, and other core competencies for clinical ethics committees as set out in Larcher V, Slowther A-M, Watson A. Clinical Medicine 2010;10(1):30-33)
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3. DELEGATED POWERS AND AUTHORITY

1. Through its advice to the Medical Director, the CEC will:

- Advise Board employees (individually or as teams) faced with difficult ethical decisions as to what courses of action are ethically permissible, those that are problematic, and those that should certainly not be pursued.

- Advise Board employees (individually or as teams) where legal advice should be sought[1]

- Advise on the recognition and articulation of careful ethical arguments in Board Guidance and Policies through:
  - advice and support during development process by fielding members with training in ethics to support Board working groups.
  - critical analysis of early drafts by the CEC
  - involvement in Board's existing *post hoc* quality assurance processes (such as Critical Incident Analysis)
  - involvement of individual members in groups tasked with implementing Board Policies and Guidance.

- Advise individual professionals in CVUHB of the need for competence in recognising and addressing ethical quandaries through:
  - Using Board IT infrastructure to:
    - Raise awareness of the Committee and its activities
    - Appropriately disseminate deliberations that illustrate important general principles.
    - signpost and facilitate access to existing educational modules, particularly on-line resources such as Institute of Medical Ethics.
  - Participating in existing Board educational programmes such as Grand Rounds

- Maintain an acceptable standard of competence in clinical ethics among its members:

  - A condition of appointment to the Committee will be that candidates possess, or are willing to acquire, a set of minimum competencies in lines with national publications (Core competencies for clinical ethics committees. Larcher V, Slowther A-M, Watson A. Clinical Medicine 2010;10(1):30-33).
  - To support development of those competencies among members, the Chair shall be responsible for coordinating and arranging a rolling programme of education for CEC corporately during regular meetings, to include occasional invited experts and dissemination of skills and competencies held by CEC members themselves[2].
  - The Chair shall attend to maintaining competencies of the CEC corporately, both through those educational programmes and through discriminating recruitment to and dismissal from the Committee.

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[1] This is the full extent of the CEC's responsibility in respect of legal advice. Although typically several members of the CEC will have legal training, including some who are practising law, this expertise is only the background to their contribution as individual members of the CEC. The CEC corporately should not in any way be seen a source of formal legal advice to the Board or its employees.
[2] Reasonable costs to be approved by the Medical Directorate without the need for tender.

Surveys of competencies held by CEC members individually and corporately ('skills audits') will occasionally be carried out at the discretion of the Chair.
- These arrangements for maintaining competencies will be reviewed annually by the Chair in discussion with the Committee.

2. The CEC will offer support to the Board with regard to its responsibilities for ethically robust planning and practice by being available to review:

- The ***ethical basis*** of, and ***ethical arguments*** set out in, Policy and Guidance documents by those tasked with their development
- The ***ethical implementation*** of these Policies and that Guidance in practice
- Feeding back to the Board:
  - Through the Medical Director
  - By publishing minutes of Ethics Committee meetings, including anonymised summaries of any responses, on its Intranet page.
  - Inviting referrers to provide an update and feedback on cases after a suitable period has elapsed.

3. To achieve this, the CECs programme of work will be designed to provide assurance that:

- Its membership reflects a range of individuals with diverse cultural and ethical lifestyles and world views.
- Its membership includes representatives of those who are users of healthcare as well as those who are providers of it.
- Its membership includes some with formal training in certain key knowledge and/or skills that are essential to the functioning of the Committee:
  - Medical
  - Nursing
  - Legal
  - Moral philosophy and/or theology
  - Management or finance

Sub Groups

6. The CEC may, subject to the approval of the Medical Director, establish sub groups or task and finish groups to carry out on its behalf specific aspects of business.

4. MEMBERSHIP

Members

4.1

- Chair. The Chair will be appointed by CVUHB on advice from the Committee (usually agreed by election). The term will be three years, automatically renewable for a further three. Appointment for any further terms will be at the discretion of the Board on advice from the Committee.

- Vice Chair. The Vice-Chair will be selected by the Chair. The main role of the Vice-Chair is to chair meetings in the absence of the Chair, or when there is a conflict of interest in respect of a specific case requiring the Chair to step down for the duration of that discussion

- Members.

i. Joining.

- The membership of the CEC should not exceed 25 in number. Members will be invited to join the Committee on the basis of a short biography and statement of interest after discussion with existing members. New members will have observer status for their first three meetings, but may participate in discussions at the invitation of the Chair.

- There is no remuneration for members, but the Board expects individual Directorates to make members of the committee available for meetings and to reimburse reasonable travel and study expenses.

ii. Leaving.

- The usual term of membership will be three years. Members who wish to remain for a second term may do so without re-applying by arrangement with the Chair. Members wishing to remain for a third or subsequent term should re-apply as new members.

- Members can stand down from the committee at any time by informing the Chair.

- Members would usually be expected to attend at least 50% of meetings, though individual members might make prior arrangements with the Chair to remain on the Committee during a long absence (for example sickness or sabbatical).

- Three consecutive missed meetings without apologies or prior arrangement will usually constitute resignation from the Committee.

- Three consecutive missed meetings with apologies will prompt an enquiry from the Chair as to whether the individual wishes to continue as a member.

- Five consecutive missed meetings without prior arrangement will usually constitute resignation.

Attendees

4.2 On behalf of the Committee and the Board, the Chair may invite:

- Any employee of the Board seeking advice from the Committee
- Any individual (within or outside the Board) considered by the Committee or the Chair to be able to provide useful expert advice in respect of a specific referral or consultation.
- Any individual (within or outside the Board) able to provide education and training to members of the Committee that enables the Committee more effectively to fulfil its function in the Board.

to attend all or part of a specific meeting to assist it with discussions on any particular matter or to join the committee as a co-opted member

Secretariat

4.3 Effective functioning of the Ethics Committee depends on adequate secretarial support. The Directorate in which the Chair is working will usually provide that support

Member Appointments

4.4 The membership of the Group shall be determined by the Chair of the Group in discussion with current members of the Committee. Appointments to, and dismissals from, the committee will take into account:

- Any specific requirements or directions made by the Welsh Assembly Government, to which those determinations are subject.
- Expressed preferences of individual candidates or members
- The number of current members.
- The balance of skills and expertise necessary to deliver the Committee's remit.
- Possession of, or willingness to acquire, the necessary competencies in ethics.

5. GROUP MEETINGS

Quorum

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

Frequency of Meetings

5.2 Meetings shall be held as frequently as the Chair of the Group deems necessary but no less than three monthly. Where necessary, the Chair will convene meetings to consider urgent cases.

Papers for Meetings

3. Papers for meetings will usually be circulated a week prior to the meeting if time allows.

Interests and withdrawal

4. All interests shall be declared at the beginning of each meeting.

- Where a *conflict* of interests has been determined, the Chair or member concerned should withdraw from the meeting for the duration of the discussion and take no part in the discussion.
-
- Where the Chair herself has declared an interest, s/he should step down as Chair and the Vice Chair or another member should chair that discussion.

6. RELATIONSHIPS & 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 in its purview. The Committee, via the Chair, is directly accountable to the Medical Director for its performance in exercising the functions set out in these Terms of Reference.

6.2 An appropriate formal mechanism for reporting using the SBAR, (clinical care or situational briefing model: Situation, Background, Assessment, Recommendation will be agreed with the Medical Director.

6.3 The Committee will 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, observe standards of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will embed the UHB's corporate standards and requirements, e.g., equality 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 Medical Director on the Group's activities. This includes verbal updates on activity, the submission of Group minutes and written reports throughout the year;

- bring to the Director's specific attention any significant matters under consideration by the Group;

- significant ethical issues/dilemmas reported by the Committee Chair may, on an exceptions basis, be reported to the Quality, Safety and Experience Committee as deemed necessary by the Medical Director.

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

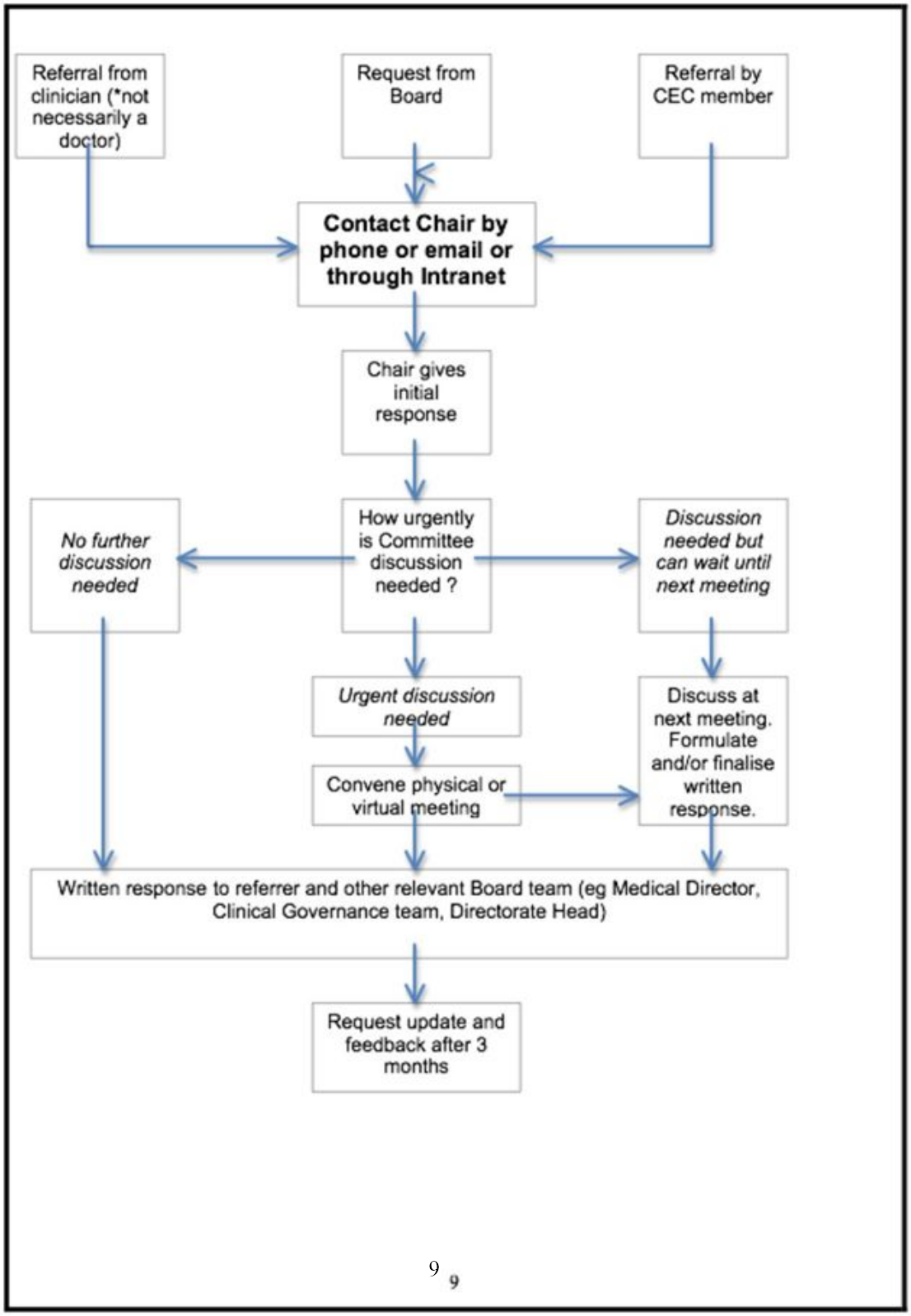
7.3 The Board Secretary, on behalf of the Board, shall oversee a process of evaluation of the Group's performance and operation including that of any sub groups established.

8. REVIEW

1. These terms of reference and operating arrangements shall be reviewed annually by the Committee.

Terms of Reference agreed:
April 2013
Reviewed and Updated: June 2015
Reviewed and Update December 2017

Appendix 1: operation of Clinical Ethics Committee



Appendix 2: CASES approach to Ethics Consultation process

CLARIFY the Consultation Request

- Characterise the type of consultation request
- Obtain preliminary information from the requester
- Establish realistic expectations about the consultation process
- Formulate the ethics question

ASSEMBLE the Relevant Information

- Consider the types of information needed
- Identify the appropriate sources of information
- Gather information systematically from each source
- Summarize the case and the ethics question

SYNTHESISE the Information

- Determine whether a formal meeting is needed
- Engage in ethical analysis
- Identify the ethically appropriate decision maker
- Facilitate moral deliberation about ethically justifiable options

EXPLAIN the Synthesis

- Communicate the synthesis to key participants
- Provide additional resources
- Document the consultation in the health record
- Document the consultation in consultation service records

SUPPORT the Consultation Process

- Follow up with participants
- Evaluate the consultation
- Adjust the consultation process
- Identify underlying systems issues

UPDATE ON THE REVIEW OF OUTSTANDING POLICIES
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 17th April 2018
Executive Lead : Executive Nurse Director
Author : Quality and Safety Improvement Manager Joy.whitlock@wales.nhs.uk - 02920 745099
Caring for People, Keeping People Well : Delivering outcomes that matter to people; avoiding waste variation and harm.
Financial impact : Failure to have updated and approved Policies in place that staff are aware of and working to can create a financial risk to the UHB.
Quality, Safety, Patient Experience impact : Updated and approved Policies, Procedures and Guidelines known by staff and used by staff support the delivery of good quality and safe services to patients.
Health and Care Standard Number : QSE Policies span many of the Standards for Health Services in Wales. However, having approved Policies in place are a key requirement of Standard 1, Governance and Accountability.
CRAF Reference Number : 5.1
Equality and Health Impact Assessment Completed : Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Progress that has been made since the last report to the Committee in September 2017 and the intention to continue to address outstanding policies, procedures and guidance.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report and progress that has been made.
- **APPROVE** the proposal to achieve a position where all clinical policies are in date.

SITUATION

This report outlines progress made over the past twelve months in updating clinical policies and procedures assigned to the Quality, Safety and Experience Committee.

The high scoring risk around expired written control documents is contained within our Corporate Risk Assurance Framework, and a risk analysis report was presented to the UHB's Audit Committee in February with an action plan to address the governance issues that currently exist within this area.

BACKGROUND

The Policy for the Management of Policies, Protocols, Procedures and Other Written Control Documents describes the delegated responsibility for approval

of a number of policies, protocols procedures and other written control documents to the Quality, Safety and Experience Committee.

The Committee has previously received reports in June 2014, February 2015, February 2017 and September 2017. These provided an update on the status of these policies at that time.

In February 2015 there were 57 former Trust policies and 39 UHB policies assigned to the Quality, Safety and Experience Committee that were out of date.

A focussed piece of work commenced to further improve the situation.

ASSESSMENT AND ASSURANCE

Steady progress has been made through tracking progress and prompting authors assigned to revise the controlled documents. Several policies and procedures were also drafted by the Corporate Governance Manager and the Quality and Safety Improvement Manager to facilitate progress.

By September 2017 13 former Trust policies and 18 UHB policies and procedures remained out of date. The following had been achieved:

- 25 policies and procedures had been updated and approved and out of date versions replaced or removed.
- 3 reassigned to Health and Safety and one to PPP Committee. Registers are appropriately updated.
- 12 in process of updating.
- 10 needed assigning to a lead to undertake the review.
- 6 were re-written and out for consultation.
- The remainder number needed further investigation and discussion.

The current status is:

- 38 policies/procedures have been updated and formerly approved.
- 4 policies/procedures have been allocated to another committee structure.
- 6 policies and procedures have been updated and are in the consultation process/waiting approval.
- 9 continue to be updated of which U190 - Antimicrobial Agents Policy is on hold due to resource/ time pressures and U206 Top-Up Medicines Payment Policy and Procedure is an All Wales policy with Velindre as the lead.
- Ref 139 Patient Handover Policy and Ref 306 Clinical Supervision Policy still require leads to be appointed and action to be taken.

Appendix 1 provides a more detailed summary of the progress made with each policy and procedure still in the process of being updated/signed off.

[APPENDIX 1]

SUMMARY OF ACTIONS REGARDING OUTSTANDING POLICIES, PROTOCOLS, GUIDELINES AND PROCEDURES TO 27 MARCH 2018

Policies/procedures/protocols/guidelines that have been updated and formerly approve, allocated to another committee or are no longer required	
Ref	
47	Isolation for Infectious Diseases Procedure
110	Breaking Bad News to Patients, Their Relative and/or Carers
143	Vancomycin Resistant Enterococcus Policy & Procedure – in new Medicines Code
242	Writing prescriptions – in new Medicines Code
244	Telephone prescribing in an emergency (verbal order) - in new Medicines Code
245	Organ Donation from the Emergency unit standard operating procedure - Replaced by the UHB Organ Donation Policy
246	Pre-printed prescription labels - in new Medicines Code
250	Faxing of prescriptions - in new Medicines Code
268	Monitored dose systems - in new Medicines Code
270	Use of bed side medicine cabinets for wards without a POM service medicines management - in new Medicines Code
280	Disposal of medicines - in new Medicines Code
281	Handling linen contaminated with cytotoxic drugs - in new Medicines Code
288	Guidance in the event of unexpected death (Mental Health)
298	Covert administration of medicines - in new Medicines Code
328	Dealing with Visitors who are violent/abusive or vexatious procedure
354	Preceptorship of newly qualified nurses
377	Child Protection Supervision Protocol
UHB003	Child Abduction Supervision Policy

UHB032	Advanced Care & Emergency Pathway
UHB068	Blood and Components Transfusion Policy
UHB068.1	Emergency Unit Procedure for the Nurse Coordinator when the Massive Haemorrhage Protocol is requested by the Senior Clinician
UHB068.2	UHW Procedure for the Nurse Coordinator when the Massive Haemorrhage Protocol is requested by the Senior Clinician
UHB062.3	Obstetric Massive Haemorrhage Protocol Cardiff and Vale UHB Laboratory and Transfusion Response
UHB062.4	UHL Ward Procedure for the Nurse Coordinator when the Massive Haemorrhage Protocol is requested by the Senior Clinician
UHB068.5	Cardiac Theatre/ CITU Procedure for the Nurse Coordinator when the Massive Haemorrhage Protocol is requested by the Senior Clinician
UHB068.6	Theatre/ICU Procedure for the Nurse Coordinator when the Massive Haemorrhage Protocol is requested by the Senior Clinician
UHB068.7	UHW Emergency Unit Portertrac Massive Haemorrhage Activation
UHB068.8	UHW General Wards Portertrac Massive Haemorrhage Activation
UHB069	Safety Notices and Important Documents Management Policy
UHB091	Control of Legionella Policy
UHB104	Choice Protocol - the Discharge Policy and supporting procedure has recently been approved at QSE,I due for review Dec 2020 The Choice protocol is a supporting document to the policy reviewed in July 2016 , so is not an actual policy ,if that makes sense
UHB110	Donation of Organs and Tissues following Death Policy
UHB113	Lasting Power of Attorney and Court Appointed Deputy Procedure
UHB116	Service Evaluation Guidelines
UHB117	Patient Property Policy
UHB125	Prescribing for staff – in new Medicines Code
UHB155	Pressure Ulcer Risk Assessment Prevention and Treatment Policy and Procedure
UHB174	Search of Patients person and belongings
UHB175	Management of patients/visitors in possession of alcohol or un-prescribed/illegal substances policy & procedure
UHB186	Independent Mental Capacity Advocacy

UHB209	Safe Handling and Administration of Intrathecal Chemotherapy Procedure
Written and progressing through the consultation process	
210	Tracheostomy Guidelines for the acute care in Cardiff and Vale UHB
302	Verification of expected death by qualified nursing staff
UHB017	Labelling of Specimen Policy
UHB030	Provision of Intra-Operative Cell Salvage Policy
UHB062	Point of Care Testing
UHB081	Parental Infusion Pumps Policy
Being written – in progress	
217	Trauma Team Protocol **-** The trauma team are reviewing it and writing a number of policies which are required as part of the impending trauma network quality indicators and NatSSIPs framework.
291	Being Open Policy
358	Managing Young People who are Sexually Active Protocol
UHB016	Routine Enquiry Guidelines into Domestic Abuse for the Emergency Unit
UHB101	Patient Identification Policy
UHB119	Mental Health Clinical Risk Assessment & Risk Management Policy
UHB156	Child Visiting Policy in a Mental Health Setting
UHB190	Antimicrobial Agents Policy
UHB206	Top-Up Medicines Payment Policy and Procedure
Outstanding – no defined action at time of writing this paper	
130	Patient Handover Policy
306	Clinical Supervision Policy

CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE REVISED RISK ASSESSMENT FOR CARE OF THE DETERIORATING PATIENT
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 17th April 2018

Executive Lead: Executive Nurse Director
Author: Assistant Director Patient Safety and Quality, 02921 846117
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: There are many financial impacts associated with failure to identify the deteriorating patients and these include longer lengths of stay, intensive care admissions, more complex surgical interventions. Costs can also result from associated litigation claims.
Quality, Safety, Patient Experience impact: Failure to identify the deteriorating patient can can result in increased morbidity and/or mortality. There is also the potential for adverse publicity and reputational damage.
Health and Care Standard Number: 2.1, 2.4 and 3.1
CRAF Reference Number: 5.2 (existing CRAF reference)
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Review of this risk by the Corporate Nursing Directorate as set out in the attached Risk Assessment at Appendix 1
- The control measures that are already being taken and actions identified to further reduce the score of this risk
- Oversight of this risk by the Executive Lead and this Committee.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the current risk rating of 20
- **CONSIDER** the range of measures being taken to mitigate and reduce the risk that staff will fail to recognize the deteriorating patient

SITUATION

The risks contained within the Corporate Risk and Assurance Framework are kept under review and are assigned to a Lead Executive and Board or Committee for oversight.

BACKGROUND

The purpose of this report is to provide an update to the Quality, Safety and Experience Committee, in relation to the current risk rating associated with failure to identify patients whose clinical condition is deteriorating

The review of this risk will feed into the overall UHB risk review that is currently taking place and will inform the entry in the new Corporate Risk Assurance Framework. To that end the report writer is working closely with the Corporate Governance Department to ensure alignment and robust risk assessment.

ASSESSMENT AND ASSURANCE

Delivery of this agenda is aligned with the following UHB Strategic objectives:

- Objective 2 - 2017/18 - For Our Population - Deliver outcomes that matter to people;
- Objective 7 - 2017/18 - Sustainability - Reduce harm, waste and variation sustainably making best use of the resources available to us.

Failure to identify the deteriorating patient is a well recognised clinical risk. In 2014, Welsh government issued a Patient Safety Alert, specifically in relation to the prompt recognition and initiation of treatment for sepsis for all patients. Although patients may deteriorate for a variety of clinical reason, the Alert recognized, that sepsis specifically is a time critical, potentially fatal medical emergency, which if left untreated has a 50% mortality rate. In the UK there are estimated to be about 100,000 episodes of Sepsis causing around 36,800 deaths annually and costs to the NHS of about £2.5 billion. In Wales, this is estimated to be at least 500 cases of sepsis and 1,850 deaths every year.

The Committee has previously received a paper in February 2017, which set out plans to formalise a structure for an outreach service for the critically ill or deteriorating patient. Currently Hospital at Night provides site practitioners to UHW and UHL and Critical Care Outreach services are provided to patients in acute inpatient beds within Specialist Services and Surgical Services (UHW only). The Medicine Clinical Board provides a Medical Rapid Response Team and work continues to align processes.

Data from the CUBE (electronic data capture system for cardiac arrest) and the Resuscitation Service Data is regularly reported on and fed back to the service. This has been shared across the UK and Internationally. The Service and its data is seen as an exemplar of best practice across Wales.

As part of the UHB review of the CRAF currently underway, we are trying to ensure that risks are captured more accurately and clearly set out targeted actions to reduce the risk and achieve our target score. The Corporate Nursing Department has carried out an updated risk assessment to achieve this which is captured below. This assesses the risk currently at a score of 20. The Department will keep the risk under review, with the aim of further reducing the level of risk to the organisation

A detailed review of the risk associated with failure to identify patients whose clinical condition is deteriorating is attached at Appendix 1. Currently the risk is rated at 20.

Strategic Objective:

Objective 2 - 2017/18 - For Our Population - Deliver outcomes that matter to people;

Objective 7 - 2017/18 - Sustainability - Reduce harm, waste and variation sustainably making best use of the resources available to us.

Risk

If we do not address the risk associated with failure to recognise a deteriorating patient, there will continue to be increased morbidity, potentially avoidable deaths, inappropriate admissions to critical care and increased lengths of stay for patients subject to their reason for hospital admission.

	Financial Including claims	**Safety**	Adverse Publicity/ Reputation	Quality/Complaints/Audit
Main Risk Impact	4	5	3	4

	Impact	**Likelihood**	**Score**	**Date**
Initial Risk Score	5	4	20	Current CRAF
Current Risk Score	5	4	20	April 2018
Target Risk Score	5	3	15	March 2019

Current Controls

- ALERT, and RRAILs training
- BEACH – training specifically for Healthcare Support Workers
- Sepsis pathway in place
- Clinical Fellow for Sepsis appointed
- Implementation of a national early warning Score (NEWS) as standard in all adult acute ward areas and roll out to community hospitals
- Sepsis 'star' developed for the clinical workstation
- Intermediate Life Support (ILS) Training. Advanced Life Support training
- Learning from mortality review meetings/crude mortality rates
- National Audit data – e.g National Emergency Laparotomy Audit; National Audit Fracture Neck of Femur
- All Resus/Cardiac Arrests are electronically recorded and audited
- Record of all high NEWS scores
- Weekly review of Serious Incidents, complaints and claims at meeting between Executive Nurse Director, Medical Director and Chief Operating Officer
- Member of All wales Rapid Response to Acute Illness Collaborative
- Well established Resuscitation Committee
- Resuscitation team (current establishment 2.8 WTe)

Further Actions	Status	Progress	Lead	Completion
Undertake Organisational self assessment against Rapid Response to Acute illness (RRAILS) 1000 lives tool			Co-ordinated by QSI manager	End April 2018
Roll out and embed Sepsis Pathway across the UHB with teaching resource.			UHB Sepsis leads	Review September 2018
Introduction of 'Making Sepsis personal' model when new software is available			UHB Sepsis leads	Review September 2018
Introduction Deteriorating Patient Protocol (which includes a JUMP procedure to enable escalation to more senior staff)			Resus service	Review March 2019
Consider introduction of a 'Deteriorating Patient' group			Senior Nurse Resus Service	Review Sept 2018
Implementation and regular monitoring of a suite of related KPIs to measure for improvement			Senior Nurse Resus Service	Review Sept 2018
Review of the current capacity of the Resuscitation team			AMD Patient Safety and Quality	March 2019

Suggested Key Performance Indicators			
These will be identified following the completion of the self-assessment against the RRAILS self-assessment tool		Current (Feb 2018)	Target (end March 2019)

14

REVISED RISK ASSESSMENT FOR INFECTION PREVENTION AND CONTROL
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 17th April 2018

Executive Lead: Executive Nurse Director
Author: Assistant Director Patient Safety and Quality, 02921 846117
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: There are many financial impacts associated with failure to control infection transmission ranging from lost bed days due to infection control outbreaks to medical intervention to treat bacteraemia and sepsis. Costs can also result from associated litigation claims.
Quality, Safety, Patient Experience impact: Poor Infection Prevention and Control (INFECTION, PREVENTION AND CONTROL) will adversely affect the quality of the patients' experience of their care and can result in increased morbidity and/or mortality. There is also the potential for adverse publicity and reputational damage.
Health and Care Standard Number: 2.1, 2.4 and 3.1
CRAF Reference Number: 5.2 (existing CRAF reference)
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Review of this risk by the Corporate Nursing Directorate as set out in the attached Risk Assessment at Appendix 1
- The control measures that are already being taken and actions identified to further reduce the score of this risk
- Oversight of this risk by the Executive Lead and this Committee.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the current risk rating of 20 and
- **CONSIDER** the range of measures being taken to mitigate and reduce the risk associated with reduced capacity of the Infection, Prevention and Control team i.e. the potential that we will not deliver the annual infection prevention and control programme and achieve the Welsh Government reduction expectations.

SITUATION

The risks contained within the Corporate Risk and Assurance Framework are kept under review and are assigned to a Lead Executive and Board or Committee for oversight.

BACKGROUND

The purpose of this report is to provide an update to the Quality, Safety and Experience Committee, in relation to the current risk rating associated with reduced capacity and the potential that we will not deliver the annual infection, prevention and control programme and achieve Welsh Government (WG) reduction expectations.

The review of this risk will feed into the overall UHB risk review that is currently taking place and will inform the entry in the new Corporate Risk Assurance Framework. To that end the report writer is working closely with the Corporate Governance Department to ensure alignment and robust risk assessment.

ASSESSMENT AND ASSURANCE

Delivery of an effective Infection Prevention Control service is key to all healthcare related activity in order to protect patients, staff and visitors from harm due to infection.

Delivery of this agenda is aligned with the following UHB Strategic objectives:

- Objective 2 - 2017/18 - For Our Population - Deliver outcomes that matter to people;
- Objective 7 - 2017/18 - Sustainability - Reduce harm, waste and variation sustainably making best use of the resources available to us.

Poor Infection Prevention Control will adversely affect the quality of the patients' experience of their care and can result in increased morbidity and/or mortality. A financial impact can also result from associated litigation claims and lost bed days which in turn affects our overall service delivery. There is also the potential for adverse publicity and reputational damage.

Between January to December 2017 there were 100 outbreaks (of flu, norovirus, diarrhoea and vomiting and respiratory illness) with an associated loss of 1280 bed days impacting on emergency and elective work, especially surgery. In total, 658 patients were affected.

Since the beginning of 2018 there have been 48 reported outbreaks, affecting 307 patients with a loss of 198 bed days to date.

A total of 111 staff were also affected in this total period from January 2017 to the time of writing this report.

In addition there were also 10 other outbreaks during 2017 involving other specific organisms e.g *C Difficle*.

At the time of writing the UHB is expected to achieve the current compliance with WG set targets for *C Difficle*, but not for Staph Aurues or E-Coli infections.

The Infection Prevention Control Team is responsible for the provision of Specialist Infection Prevention Control services to all Clinical Boards and stakeholders in all areas of the UHB. The team needs to be resilient and proactively prevent HCAI as well as respond reactively to incidents and outbreaks and/or new and emerging threats of infection.

Core responsibilities include daily alert organism surveillance and management alongside an annual prevention programme. This includes Health Board wide training & education, audit, surveillance, reactive and proactive evidence based advice, participation in strategic groups e.g. water safety, decontamination, quality and safety, environmental management, clinical practice, as well as participation in national projects and working groups.

These activities are essential in achieving compliance with the HCAI Code of Practice (2014) and contribute to the Welsh Government reduction expectations for C. difficile, E.coli, MSSA and MRSA bacteraemia. This gives assurance to the Board that patient safety and harm reduction is being prioritised.

In addition to core workloads the team have to respond to new and emerging Infection Prevention and Controlthreats as well as the management of incidents and outbreaks on an ad-hoc basis.

The UHB still benchmarks the lowest in Wales against Infection, Prevention and Control nurse to acute beds; there has been no investment to support the community agenda.

As part of the UHB review of the CRAF currently underway, we are trying to ensure that risks are captured more accurately and clearly set out targeted actions to reduce the risk and achieve our target score. The Corporate Nursing Department has carried out an updated risk assessment to achieve this which is captured below. This assesses the risk currently at a score of 20.. The Department will keep the risk under review, with the aim of further reducing the level of risk to the organisation.

A detailed review of the risk associated with reduced capacity is included at Appendix 1. Currently the risk is rated at 20.

Appendix 1

Strategic Objective:

Objective 2 - 2017/18 - For Our Population - Deliver outcomes that matter to people;

Objective 7 - 2017/18 - Sustainability - Reduce harm, waste and variation sustainably making best use of the resources available to us.

Risk

If we do not invest in the infection, prevention and control (IPC) team there is a continued risk that we will not deliver the annual Infection prevention and control programme and achieve the Welsh Government reduction expectations. This could result in harm to patients and non-compliance with accepted standards.

	Service Interruption	Financial	**Safety**	Adverse Publicity/ Reputation	Quality/Complaints/ Audit
Main Risk Impact	4 Negligible	3 Moderate	**5** Major	5 Moderate	4 Moderate

	Impact	**Likelihood**	**Score**	**Date**
Initial Risk Score	4	4	20	Current CRAF
Current Risk Score	5	4	40	March 2018
Target Risk Score	4	3	12	March 2019

Current Controls
IPC Policies and procedures IPC Corporate Group to oversee implementation of policy and achievement of targets IPC team Regular audit Welsh Government Cleaning Standards Mandatory training Corporate KPIs and Professional Performance and Executive Performance reviews Monthly performance reports Daily prioritisation of work according to the greatest risk – reactive response to daily organism surveillance Roll out of Aseptic Non Touch Technique

Further Actions	**Status**	**Progress**	**Lead**	**Completion**
Consider further investment to increase the resource in the IPC team as part of the IMTP process 2019/2020			Deputy END	March 2019
Review of the LTA with Public Health Wales with regards to the provision of the Medical Expert Leadership.			END	March 2019

Appendix 1

Suggested Key Performance Indicators			
Performance against WG targets for:	**Baseline**	**Current (Feb 2018)**	**Target (end March 2019)**
C-Difficle			
MRSA		10	< 11
MSSA		0	< 9
E-Coli		13	
Klebsiella		26	<25
Pseudomonas		N/A	Reduce 10%
		N/A	Reduce 10%
Number of IP+C outbreaks leading to ward closure (monthly)		8	<5

FALLS ASSURANCE REPORT
Name of Meeting: Quality Safety and Experience Committee **Date of Meeting:** 17th April 2018

Executive Lead : Director Therapies and Health Science
Author : Assistant Director of Therapies and Health Science alun.morgan@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" "Values" and elements of the Health Board's Strategy. Further information can be found here
Financial impact : included as part of Clinical Board IMTP plans
Quality, Safety, Patient Experience impact : Improve patient safety and care
Health and Care Standard Number 2.3, 6.1
CRAF reference number: 5.1.6, 5.1.9
Equality and Health Impact Assessment Completed: An HEIA was completed for the policy

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The UHB is currently demonstrating a stable trend in incidents relating to slips trips and falls. Significant work is underway particularly in the community in relation to falls prevention
- There continues to be limited assurance relating to inpatient falls causing serious injury. The trend has not shown any increase. Ongoing analysis is being done as no specific hotspots have been identified which require targeted intervention

The Committee is asked to:

- **NOTE** that the UHB is continuing to hold the reduced trend seen in 2016
- **SUPPORT** the key actions for 2018 with an emphasis on development of the community falls prevention pathway and service.

SITUATION

The UHB is required to comply with a number of directives, standards and guidelines, all of which overlap and require action, monitoring and reporting through Quality and Safety Committee.
These include;

- Welsh Health Circular (2016) 022 Principles, framework and national indicators: Adult inpatient falls
- Health and Care Standards 2.3 Falls and 6.1 Promoting independence
- National Audits; Falls and Fragility Fracture Audit Programme, National Audit of Inpatient Falls; Royal College of Physicians imminent

- NICE/NPSA Guidelines
- 1000 lives #STEADYONSTAYSAFE Campaign to reduce falls in the community

The Falls Delivery Group has been established just over 12 months and with the appointment of the Falls Strategic Lead in February 2018 is now in a position to take forward a number of the initiatives agreed by the group during 2017.

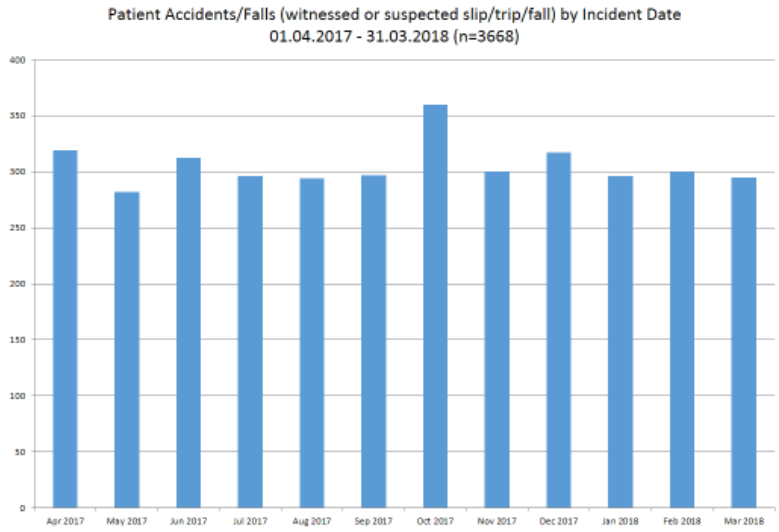
BACKGROUND

How are we doing?

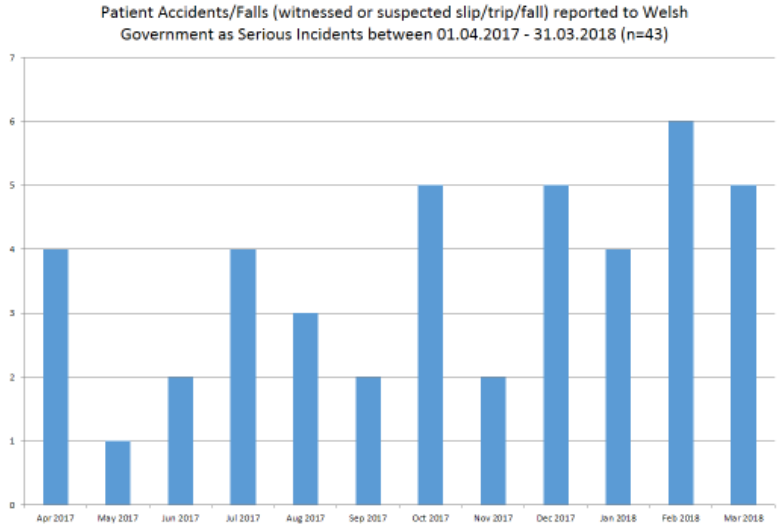
The Patient Safety team is now able to provide additional information relating to falls. They have also worked with IT to set up an interface with BIS which should make it easier to provide information in the future.

3668 falls incidents were reported via Datix, where the slip/trip or fall was either witnessed or suspected. It should be noted that slips and trips are more likely to occur if patients are in unfamiliar ward environments – delays in discharge and above average lengths of stay will increase incidence. Additionally efforts to promote independence and encouraging mobility for inpatients does increase the risk of falls – but is less risky that creating dependence and "PJ Paralysis".

The UHB continues to report a fairly consistent trend in slips trips and falls comparable to 2016. The following table gives a breakdown of witnessed and unwitnessed incidents.



A large proportion of accidents/falls do not result in injury or lead to minor injury to the patient. However, patient falls represents the highest volume of Serious Incidents reported to Welsh Government whereby patients have sustained significant injuries such as fractured limbs or head injuries.



Quarter 4 of 2017 (Oct-Dec) there were 12 Sis (compared to Q4 2016 11) and Jan-Feb 2018 we have had 10 (compared to same period 2018 13 Sis). Analysis of the Sis by ward area demonstrates that the Sis are a poor indicator of good or poor practice. There is no correlation between total number of falls and number of Sis. Significant proportion occur in wards where there is very good falls awareness and practice. This demonstrates that using Sis as an indicator for falls reduction is a crude and unreliable measure. Nonetheless the number has not shown any sign of reducing and further work is required to address this.

ASSESSMENT

The first self assessment of Health and Care standard 2.1 identified a number of recommendations that required a different approach to falls prevention. The Falls Delivery Group was established with 2 key aims;

- Community prevention programme with close links with Public Health Wales and the National Task Force for Falls Prevention with a view to reducing hospital admissions from serious injurious falls.
- Prevention and reduction of inpatient falls.

The Falls Delivery Group has met bimonthly since January 2016.

- All Clinical Boards are represented including Public Health.
- Focus is on the whole system rather than any specific component.
- Wider stakeholder representation includes WAST, Fire and Rescue, Local Authorities, Housing and Carer and Repair Cardiff.
- Support from Patient safety.

The following objectives have been achieved:

- Baseline assessment against the framework and standards in order to provide assurance to the Board. A first draft has been produced by the

Falls Lead and awaits final approval by the delivery group before submission to QSE

- Engagement of all work streams and stakeholders to avoid duplication and ensure all public assets are used effectively. This mapping exercise has been completed and forms part of the falls report.
- Development of Datix reporting to monitor falls and share practice and lessons.
- Ensure key lessons learnt from investigation reports following Serious Incidents involving patient accidents/falls. All SIs and falls data are reviewed and shared at falls delivery group and disseminated to Clinical Boards for discussion at their QSE meetings
- The UHB has once again undertaken a campaign ahead of Christmas 2017 to highlight the importance of appropriate footwear.
- Tim Banner, Consultant Pharmacist has delivered a Community Falls prevention programme to pharmacies throughout Wales.
- A number of the members of the Falls Delivery Group are established members of the National Taskforce for Falls and the Chair of the delivery group sits on the NTF Steering Group.

Key actions for 2018/19

- The falls lead is now in post Oliver Williams and is currently compiling a full report on the state of play with Falls and innovations across the UHB. In addition he is developing an overall strategy.
- Prior to his appointment he developed a number of innovative resources for falls prevention including a poster campaign, falls fuel tank and Falls awareness training in Nursing Homes. He has also developed an Individual Strength and Balance Programme which was shortlisted for NHS Wales award in 2017 and has been shortlisted for the UK Patient Safety Awards 2018. The plan is to consolidate on this work as part of the delivery plan
- A mapping exercise was undertaken in 2017 which identified that there was lack of a single falls pathway across Primary, Community and secondary care. In addition Public Health have also mapped where Cardiff and Vale benchmark against the Canterbury model for falls prevention. It's pleasing to note that a significant number of the key elements are similar to Canterbury but the key factor is lack of a single point of referral for agencies to refer at risk patients to.

  Further to the visit to Canterbury, falls prevention has a higher profile within the UHB. The locality Transformation Board in partnership with the falls delivery group are developing a proposal to improve community falls prevention. This will be submitted to the transformation Board for endorsement in June 2018.

- The Promoting Independence group is about to launch our campaign 'Get up, Get dressed Get moving'. This is the culmination of a year's work engaging with staff to develop resources to support staff and patients while in our hospitals.

The aim is to raise awareness of the risks of deconditioning and to promote the importance of supporting patients to be as independent as they are able whilst in hospital. The work completed so far includes;

- C&V staff took part in a poster competition where the winner (Oliver Williams) was presented with an iPad. This will be used to promote the campaign across the UHB.
- We have developed a multi-disciplinary approach to launch the campaign
- A series of study days were held and attended by over 260 staff
- As a result of the education from the study days ward staff have taken their own ideas forward and introduced lunch clubs and exercise clubs

The Campaign will be formally launched in conjunction with the 70day#PJ Paralysis campaign in April as part of the UK initiative.

- A review of training resources and tools is underway and will be revised for roll out across the UHB during early part of 2018
- A project, led by Medicine Clinical Board has commenced with the aim to explore a new approach to specialing re-named “enhanced supervision” for patients across medical wards in Cardiff and Vale University Health Board.

MEDICAL OUTLIERS
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 17 April 2018

Executive Lead : Chief Operating Officer
Author : Assistant Chief Operating Officer Tel: 029 20746218
Caring for People, Keeping People Well : The UHB's strategy describes a balanced unscheduled care system
Financial impact Not applicable
Quality, Safety, Patient Experience impact: Caring for patients in the most appropriate setting is an important aspect of patient experience and quality of care
Health and Care Standard Number 2.1
CRAF Reference Number 5.1.2
Equality and Health Impact Assessment Completed: Yes / No / Not Applicable No

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- The initiatives implemented for Winter 2017/18 to meet higher levels of demand, including a dedicated team for medical outliers.
- The daily management of patient flow to include the balance of risk approach described below.
- The formal approach in place within the Health Board for reviewing winter planning.

RECOMMENDATION

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the level of outliers during this winter and the steps taken to reduce the risks associated with this – including establishing a dedicated clinical team
- **NOTE** the 'balance of risk' approach to ensuring patients have timely access to a hospital bed to avoid greater potential risks related to extended EU trolley waits and the inability to release ambulances into the community
- **ENDORSE** a review of Winter Planning in advance of planning for next winter to ensure adequate processes and 'surge' bed capacity is available to mitigate the need for placing outlying patients

SITUATION

During this winter, the NHS across the UK has experienced high levels of demand on its services and, along with other Health Boards, Cardiff and Vale UHB has experienced significant unscheduled care pressures. At times this has impacted upon the quality and safety of patient care. One aspect of this is the appropriate placing of patients on the most clinically appropriate wards as there is some evidence that being treated on the correct specialty ward is beneficial and 'outlying' on different wards can lead to an extended length of stay[1]. The QSE Committee requested an overview on patients being placed in beds outside their referred speciality template over recent months.

BACKGROUND

Patients placed on wards other than their referred specialty are commonly referred to as 'outliers'. This occurs when there are no beds available on the correct specialty ward and is a phenomenon seen across the UK[2] and the World[3].

There is some evidence that patients on the correct specialty wards can benefit from the expert nursing and medical care available - certainly it is intuitive that greater familiarity with the symptoms and treatments for patients is likely to contribute to better outcomes. Consequently the number of patients outlying can be an important metric for the quality of care provided.

This objective is set against the need to provide patients with timely care and the reality of matching highly variable demand to a largely fixed bed-base. Most commonly it is medical patients placed onto non-medical wards and a previous audit across the UK estimated that 7.5% of all surgical beds were filled with medical patients (however this audit was conducted in May so is likely to underestimate the impact in the peak winter periods).

There are a number of challenges in meeting high levels of demand, especially during winter months where many of the patients who require care, treatment and support have increasingly complex needs and acuity. The most significant issue is not always the numbers of people presenting at emergency departments but the complexity and severity of conditions of those admitted, the ability to transfer patients safely from hospital to their place of residence and to prevent readmission.

Each year the Health Board develops a winter plan to mitigate these risks. This year the schemes included increasing GP OOH capacity, increasing 'front door' decision maker capacity, opening additional bed capacity in secondary care, and discharge-to-assess beds in the community.

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[1] Alameda C, Suarez C. *Clinical outcomes in medical outliers admitted to hospital with heat failure*. Eur J Intern Med 2009

[2] National Audit Office. *Inpatient Admissions and Bed Management in NHS Acute Hospitals*. London: The Stationery Office, 2000

[3] Creamer GL, Dahl A, Perumal D, et al. *Anatomy of the ward round: the time spent in different activities*. ANZ J Surg 2010;80:930-2

Flow through the hospital was supported by enhanced senior management cover, employing additional support for the transfer team and commissioning a specific medical outlier team (recognising that outliers were likely to increase).

ASSESSMENT AND ASSURANCE

Outliers

The level of outliers for the past three years is presented in Appendix 1. A few observations can be made about the data:

1. There is no obvious trend – September 2017 was the lowest month for outliers for over five years and yet January 2018 was the highest in three years
2. There is however a clear seasonal pattern – July to August average 16 medical outliers per day whereas January to March average 37 daily outliers
3. There is significant variation, particularly during the winter months – January for example has ranged from 22 to 61

It is evident the most recent period has seen a comparatively high number of outliers. The analysis below explores some of the factors behind this.

Demand

Demand this winter has been higher across the system. Some of the statistics describing this for last month (February) are shown in Appendix 2. Key points include:

- the overall volume of calls to GP Out of Hours was up 3.9% on last year
- total EU attendances also saw an increase in February 2018, with 7% more attendances
- Minors and paediatrics both saw an increase in attendances but the greatest increase has been seen in majors, with a 10.7% increase, indicating an increase in the acuity of patients presenting to the EU
- the number of patients over 65 and 85 admitted to the EU resus in February 2018 was up 13.6% and 14.9% respectively
- Total medicine admissions have been higher than previous years (up 10.9% on 2017)
- Notably, the number of surgical admissions has not increased but this may in part be due to the new Emergency General Surgery model introduced ahead of winter

Hospital bed capacity

As part of the winter plan 24 additional winter medical beds were scheduled to open in a phased manner in response to the predicted demand from December to April. These predictions were based on historical medicine bed occupancy data (see below). This year, Cardiff and Vale UHB opened fewer additional beds and enhanced other aspects of patient flow to compensate. A formal debrief of the Winter Plan for 2017/18 will be undertaken to ascertain the approach to capacity

planning for Winter 2018/19, to further mitigate risks associated with outlying patients.

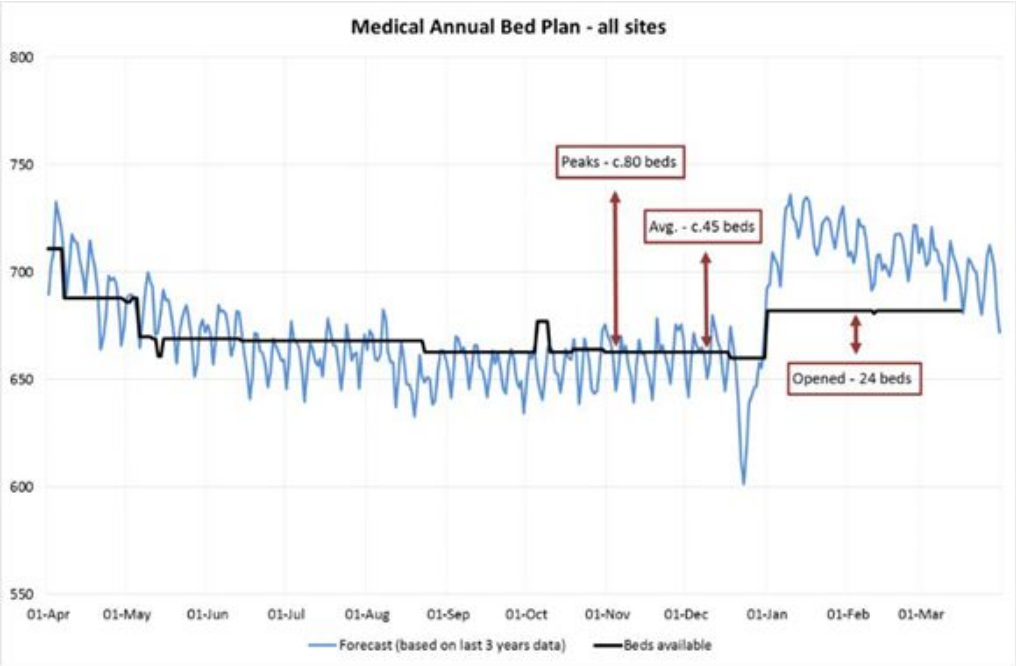


Figure 2 – Medicine bed plan and forecast bed requirement

The actual medical bed occupancy has closely followed the forecast for the majority of the year, albeit February has been unusually busy.

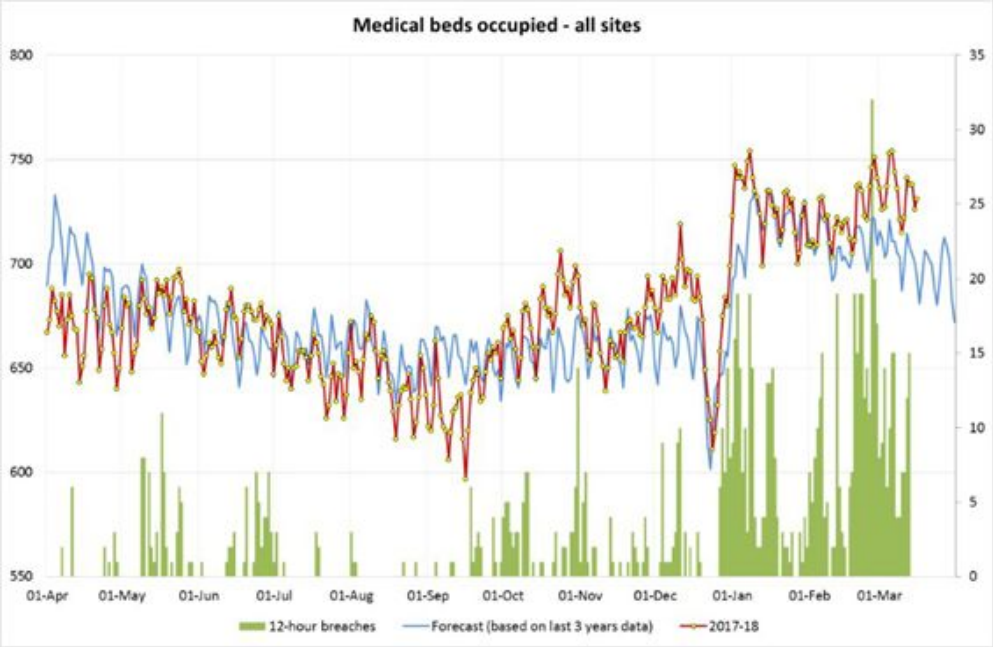


Figure 2 – Total beds occupied by Medical Patients April 2017 to March 2018

The data highlights a higher number of beds occupied by medical patients in early January and throughout February 2018 than any other point over the last 3 years. During this period the Health Board also saw a spike in 12 hour breaches and WAST lost hours (not shown). The observed association between bed occupancy and 12 hour waits demonstrates the balance of risk approach which led to an increased number of outliers. Had this not happened, the 12 hour wait risk volume would have increased and other risks associated with ambulance delays would have been compounded.

Mitigating Actions

A range of mitigating actions were put in place to reduce the need for outlying patients – both in the planning phase and as a reaction to events as they occurred. These included an increase in bed capacity in January, the establishment of a dedicated 'medical outlier clinical team'. This team of doctors and nurses solely concentrated on 'off template' patients to ensure they received timely review and treatment.

In addition, the Executive Nurse Director led a piece of work to expedite in-day discharge activity, to further mitigate the need to outlying patients. Whilst this had some benefit, further work is needed to embed early discharge planning and to secure an increased volume of early morning discharges each day.

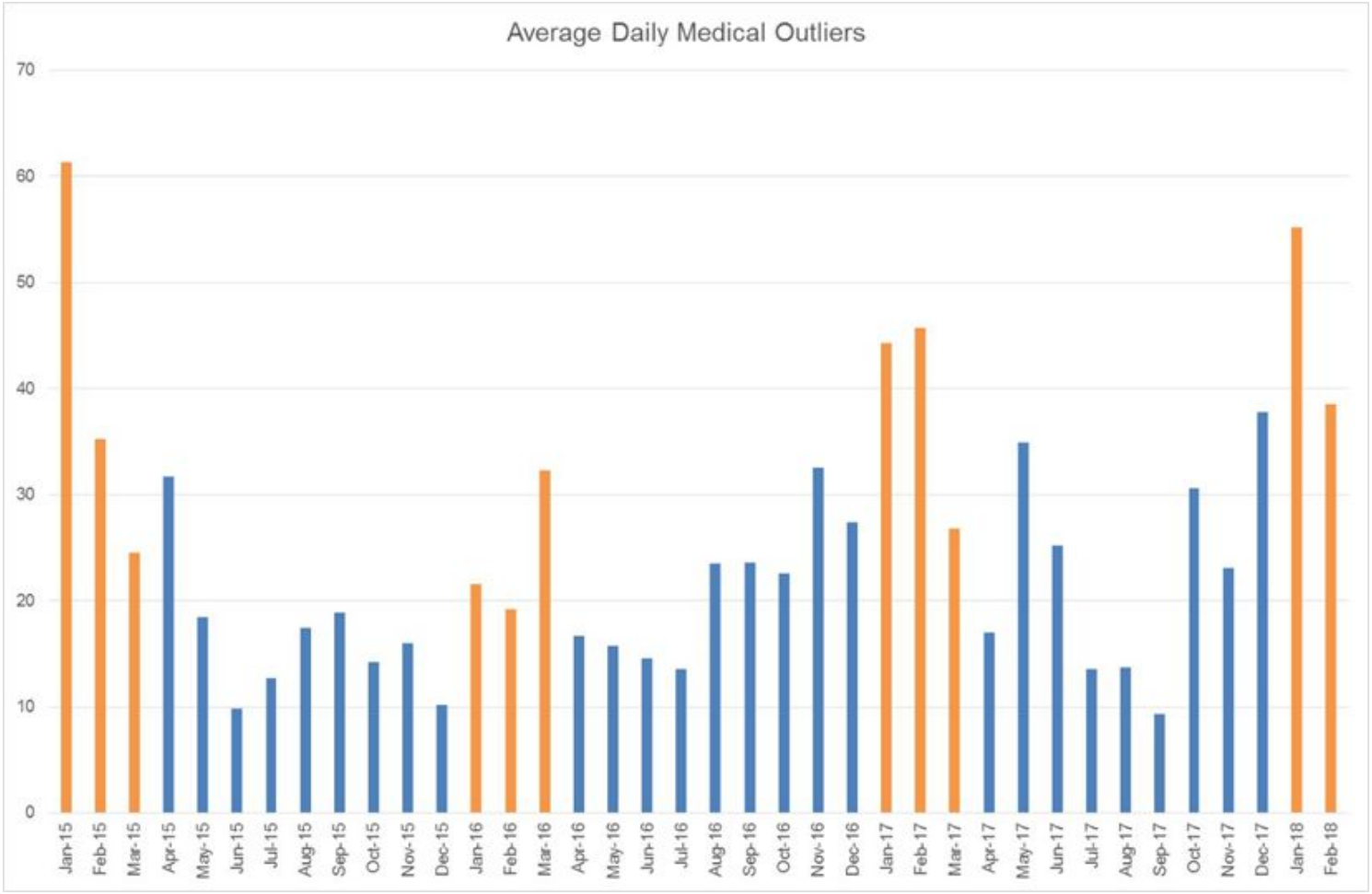
Summary

Overall, winter 2017/18 has been very challenging to date with higher demand in most areas and increased acuity.

Analysis indicates that despite additional senior decision-makers at the front-door, the establishment of a dedicated medical outliers team and increased bed capacity in secondary care and in the community; this additional demand has led to higher medical bed occupancy and a resulting increase in the number of medical outliers.

As part of the normal Winter Planning cycle, a review of Winter Planning will be undertaken throughout April and taken to the Health Board's Board meeting in May. This will provide an opportunity to review winter planning in order to inform process and capacity planning for next Winter. In the meantime, further work will be undertaken on improving flow and discharge throughout the Summer of 2018.

Appendix 1: Medical outliers (winter months highlighted)



Appendix 2: February Pressures

Emergency Pressures 2018 **Health Board** Cardiff and Vale UHB

	Feb-17	Feb-18	+/-%
Total ED Attendances	10664	11412	7.0%
Resuscitation Cases	487	552	13.3%
Majors	5518	6107	10.7%
Minors	2850	2878	1.0%
Paediatric	2296	2427	5.7%
Resus/Majors cases Age 65+	1693	1923	13.6%
Resus/Majors cases Age 85+	478	549	14.9%
Emergency Medical Admissions	1464	1634	11.6%
Emergency Surgical Admissions	608	593	-2.5%
Trauma Cases	n/a	n/a	
ITU Bed days utilised	827	873	5.6%
ITU Bed Days utilised by Flu cases	n/a	n/a	
Total Elective Procedures	5958	5907	-0.9%
Delayed Transfers of Care	46	46	0.0%
Calls to OOH	8641	8978	3.90%

CANCER PEER REVIEW – CANCER PATHWAYS
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 17th April 2018

Executive Lead : Medical Director
Author : Medical Director
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact : A case for cancer services development has been recently approved at the Business Case Approval Group to include funding for delivery of the Single Cancer Pathway. Operational issues/structures relating to this business case are just being agreed. They will be presented to the Management Executive in April 2018.
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 will be addressed via an action plan.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report
- **AGREE** that a formal action plan will be presented to the Committee in June 2018 following the agreement and discussion of cancer structures by the Management Executive.

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 Cancer Network. Normally this is a review or re-review of each of individual cancer tumour sites within the Health Board. This report outlines a different approach taken by the Cancer Network. Health Boards submitted evidence regarding their overall structures and pathways for

scrutiny. Each UHB acted with another UHB to scrutinize each-others plans. The findings are summarized in Appendix one and a letter to the Chief Executive from the Director of the Wales Cancer Network letter in Appendix two. A meeting was also held in December 2017 but the report was not received until mid-March.

BACKGROUND

Peer review of cancer services in Wales is a quality assurance programme that reflects the quality of the service being delivered. The peer reviews are regularly reviewed at the Quality and Safety and Patient Experience Committee.

ASSESSMENT AND ASSURANCE:

The report provides evidence of good practice and some areas of concern. There is currently a case being developed for the Management Executive which will cover areas of concern and in particular start to provide a structure for delivery of the Single cancer pathway (SCP).
Therefore it is intended to bring back assurance to the Committee in June 2018 which will incorporate the Management Executive discussions.

GIG CYMRU NHS WALES | Rhwydwaith Canser Cymru Wales Cancer Network

Mr Len Richards
Chief Executive
Cardiff and Vale University Health Board

Ein cyf / Our ref: DH
Eich cyf / Your ref:
☎: 01745 443 182
Gofynnwch am / Ask for: Damian Heron

E-bost / Email: **damian.heron@wales.nhs.uk**
Dyddiad / Date: March 7th 2018.

Dear Mr Richards

Peer Review Report – Cancer Pathways

Further to the Peer Review event of December 19th 2017 we are now able to share with you the Peer Review report for your organization.

The attached report has been compiled from a number of sources including;

- The self-assessment submitted
- A review of the self-assessment by the Wales Cancer Network and an identified peer Health Board or Trust
- The transcript of the event

Finally we are aware that it is possible that the Peer Review event did not meet your organisations expectations in terms of assessing your approach to the management of cancer pathways and as such we would be happy to arrange a more individualized Peer Review on request.

Yours sincerely

Damian Heron
Director
Wales Cancer Network
Cc
Dr Graham Shortland, Health Board Cancer Executive Lead, Cardiff & Vale UHB
Dr Meriel Jenney, Health Board Lead Cancer Clinician, Cardiff & Vale UHB
Alyn Coles, Informatics and Performance Manager, Cardiff & Vale UHB
Dana Knoyle, Lead, Single Cancer Pathway, WCN
Dr Cath Bale, Clinical Lead, Peer Review, WCN
Dr Tom Crosby, Medical Director, WCN
Gareth Popham, Peer Review Programme Lead, WCN

18

Cancer Peer Review

Cancer Type	Cancer Pathway
Health Board/Region	Cardiff and Vale UHB
Hospital/s/Health Boards	University Hospital of Wales, Llandough Hospital

REVIEWERS REPORT

Overview
Cardiff and Vale University HB provides secondary care services for a population of approximately 445,000 from two acute sites. The main site is the University Hospital of Wales with some limited cancer activity also taking place at its Llandough site. The University of Wales Hospital also provides a range tertiary services for South Wales that include treatment relevant to cancer, these include surgery for lung, UGI, neurological and hepatobiliary cancers. The HB also provide a BMT services as well as hosting the Children's Hospital for Wales. Oncology is provided by Velindre NHS Trust which is situated in close proximity to the University Hospital site approximately 3 miles away. The population of Cardiff is the most ethnically diverse of the Health Boards in Wales with 17.2% of the population being from a non-white background* *Stats Wales Jan 2017

Assessment
National Cancer waiting times and SCP waiting times
The Health Board has like the rest of Wales failed to meet the required level of performance regarding the USC target but it has at times been one of the better performing Health Boards. The HB has recognised the need to report the SCP and has done so consistently since April 2017. Performance has varied between 61 and 84.1%.
Cancer Management and Executive teams
The Executive team is well described and fully populated and all of the identified management team are engaged at a national level. It is noted that the Cancer Clinical lead reports limited time to perform her role and the current cancer manager is part time in the role and is due to retire in the near future. There is also good engagement with the information team who support the requirement for data.

Cancer Services

Cancer services are clearly defined and function in a supportive role with no ambiguity as regards delivery and performance management. This function extends to the provision of data and performance information.

MDT support is via dedicated MDT coordinators with no separate/additional tracking staff within cancer services. Tracking of patients does take place but the inference is that this is done in a generic manner via a pooled resource or at directorate level. As with the HB as a whole there is less clarity regarding the support role for tertiary MDTs.

	AB	ABMU	BCU	C&V	CT	HD	Velindre
Coordinators WTE	**7**	**15.4**	**20.7**	**11.5**	**8.8**	**12.6**	**2.4**
MDTs per person	**2**	**1**	**1 -2**	**1-2**	**1-2**	**1-2**	**3**
Banding 3						**x**	
4	**x**	**x**	**x**	**x**	**x**		**x**
5			**x**		**x**	**x**	
Trackers WTE	**4.8**	**12.7**	**0**	**0**	**2.4**	**0**	**0**
MDTs per person	**2**	**1-4**			**5**		
Banding 3	**x**	**x**			**x**		

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Cancer Infrastructure
The structure in support of cancer in the Health Board is relatively uncomplicated with limited tiers of accountability – this maybe too simple for the size of the organisation in that the complexity of the agenda may be compromised by the limited number of people with the time and authority available to respond and resolve issues. Again perhaps reflecting the above the focus on performance is not as overt as other organisations and it is unclear if this issue is held by cancer services or by another department. It is noted that issues regarding operational delivery issues are delegated to the directorates and it is possible that they feed into the performance agenda via a generic route.
Referral systems
Most referrals from primary care are stated to be electronic though the HB concede that referrals continue to enter the HB via multiple routes. As with all other HBs there is no electronic referral process between teams and referring organisations.
Tracking systems
The HB have their own system for tracking patients – Tentacle. There is positive support for Tentacle in terms of familiarity and usability from within the HB. The HB also state that they are investing in the system further and it continues to be compatible with Canisc and the PAS system. At present not all cancer sites are linked to Tentacle, for sites not on tentacle pathway info is added (by cancer services via directorate update) manually to the SaFF box in Canisc to create/update pathway history. The tracking of patients appears to be well structured and well organised. Levels of escalation are clear though as previously stated there is a question whether the levels of escalation are too limited overburdening key senior staff. The approach to breaches is positive with a proportionate response in terms of corrective action.
Business Intelligence
There is no evidence of any use of business intelligence
Diagnostic Pathway

Whilst there have been some specific areas of progress regarding particular disease sites there is limited evidence of work in relation to diagnostics more widely other than endoscopy.

There are concerns regarding radiology capacity and integration with radiology stating that they have limited information on patients in terms of their place on a cancer pathway. There is a sense that radiology provides a real rate limiting factor for the HB as they share concerns regarding current capacity and their integration with the management of cancer pathways.

There is limited evidence of straight to test and standardisation of pathways outside those disease groups successfully targeted.

Treatment Pathway

There is evidence of improvement processes with focused and successful work in urology and dermatology and this has been led by the Exec Cancer Lead. Further work is due to follow on endoscopy and lower GI.

Noting that the HB are responsible for a number of tertiary services it is noted that patients are recorded with the referring organisation being hidden thus assuring that patients are managed on the basis of clinical priority not the referring organisation. This is important as previously there had been concerns regarding patient waiting list management.

It is noted that Canisc is widely used but MDM module is in low use across the MDT

There is no obvious reporting of component waits and this may be important in terms of the impact on diagnostics and improvement work

There are a high number of suspensions and it is not clear why this might and how important it is as the SCP data does not suggest that the HB is an outlier when no suspensions are included.

Capacity and Demand

The HB perform annual capacity and demand work in order to inform its IMTP and this has led to investment in radiology and endoscopy in recent years.

Concerns remain however with a number of issues including pathology and acute oncology. Importantly the HB make a point of their capacity/demand concerns relating to the SCP assessment 2016/17. There are explicit statements regarding current practice not being configured for introduction of the SCP

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Clinical Engagement
The HB state that clinical engagement is very good although the limited time available to the clinical lead and cancer manager question how easily this is translated into action. It is noted that there are dedicated clinical forum for all health care professionals including AHPs. Despite the above there may be quite limited input into pathway management within those specialties not identified by senior management and it is unclear if all MDTs hold annual business meetings without a prompt from senior management. It is unclear how much direction is given to all clinical teams from the management team. The absence of clear guidelines regarding the governance of tertiary MDTs might suggest this.

Good Practice	**Detail**
Senior management	The HB have demonstrated a turnaround in senior management in recent years with the senior team not only showing clear leadership on cancer issues but also active engagement at a national level. This is evidenced particularly through the peer review process.
Infrastructure	The function of cancer services and information is clear and unambiguous with the associated structure also being relatively straight forward.
Improvement	Whilst not having dedicated cancer improvement resources the HB have utilised HB wide improvement resources to improve the pathways in specific areas particularly urology and dermatology. The HB also have new areas to target in endoscopy and lower GI.
Tentacle	Although the HB has adopted a system unique within in Wales it is able to understand the place of the system and is investing in it further. It understands how to use the system in a manner that replicates the national requirements and as such is a HB who both informs and responds to national requirements regarding data requirements.

Areas of Concern	
Management sustainability	Although a positive feature of the HB it is noted that all of the senior team have cancer in addition to other key roles and the concern must remain that progress might be diminished due to the time constraint that will evolve from over commitment. In addition, it is noted the current cancer manager is due to retire and that the post had been delivered virtually on a part time basis for several years. This post must be replaced and on a full time basis
Diagnostics	With the exception of endoscopy diagnostics are under significant duress and it is noted that radiology in particular does not seem linked significantly to the cancer pathway particularly in terms of identifying cancer cases and where they are on the cancer pathway.
Straight to Test	Linked to the above there seems little evidence of straight to test both operationally or as a principle that might be pursued by the HB on a strategic basis.
Tertiary services	Whilst being a provider of tertiary services there remains limited understanding of the quality of these services and the governance risks associated with participating in tertiary MDTs.
BI	There is no evidence of business intelligence nor its use in planning services
SCP	The HB are actively concerned about the impact of the SCP on their service and have stated the need for resources to assist with its implementation. This may deter the HB from full engagement when they currently offer excellent advice on the detail of the process. Also if correct then adoption of the SCP might prove difficult.

HEALTHCARE INSPECTORATE WALES ACTIVITY
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 17th April 2017

Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and Quality 029 2074 6117
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 : A specific Equality Impact Assessment is not required. Delivery of care which is dignified, respectful and compassionate will ensure equality for all patients receiving care from the UHB.

ASSURANCE AND RECOMMENDATION

ASSURANCE is 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 Health Board QSE Committee.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the level of HIW activity across a broad range of services.
- **AGREE** that the appropriate processes are in place to address the recommendations and to receive future assurance reports as the findings of the Thematic reviews are published.
- **AGREE** that a more detailed report and progress update on HIW activity in Primary Care services is received at the June 2018 Committee.

SITUATION

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the inspections carried out by Healthcare

Inspectorate Wales (HIW) since the last over-arching report to the Committee on 6th December 2017.

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

BACKGROUND

HIW is the independent inspectorate and regulator for health care in Wales. The core role of HIW is to review and inspect the NHS and Independent Healthcare organisations in Wales so that assurance can be given to patients, public, Welsh Government (WG) and healthcare providers that services are safe and of good quality.

Hospital Inspections 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 view of Francis (2013) who emphasised the importance of undertaking direct observations of care. The unannounced inspections undertaken by HIW focus on the following themes:

- Quality of the patient experience
- Delivery of safe and effective care
- Quality of management and leadership
- Delivery of a safe and effective service

ASSESSMENT and ASSURANCE

Thematic Reviews

The following thematic reviews have been underway during the year:

- **Thematic Review of Patient Discharge from Secondary care to Primary care NHS Healthcare**

  This commenced in February 2017 and concluded in the UHB in September 2017. This has involved the submission of a self-assessment questionnaire, relevant evidence and the interview of staff. The final report is still awaited.

- **Thematic Review of Community Mental Health Services**

  This commenced in June 2017 and has now concluded. This too has involved the submission of a self-assessment questionnaire, relevant evidence and the interviewing of staff and service users at The Links Community Mental Healthcare Team on 2nd and 3rd August 2017. The

draft report has been received and an improvement plan has been submitted for consideration. This was a positive visit and there were no immediate assurance issues.

A full report will be submitted to the Committee once the final report and improvement plan has been published.

- **Thematic review of Services for young people in Wales – Transition**

  This commenced in September 2017. The UHB has submitted a self-assessment questionnaire and continues to await guidance on the next phase of the review.

Unannounced inspections

Daffodil Ward – an unannounced visit took place on 9th - 11th January 2018. Oral feedback at the end of the visit was positive. In the draft report that has been issued, the reviewers concluded that: 'Care was delivered to a high standard by a passionate team and in a respectful manner. Processes were in place to ensure safe and clinically effective care. However, improvements are required in the management of medicines and clinical room audits'.

There were no immediate assurance issues.

The UHB has responded and an improvement plan has been submitted. A full report will be submitted to the Committee once the final report and improvement plan has been published.

Beech Ward – an unannounced Mental Health Act monitoring visit took place on 16th January 2018. Overall the reviewers concluded that the requirements of the Mental Health Act 1983 and Code of Practice were being met. The UHB has responded to the draft report and submitted an improvement plan to address the recommendations.

There were no immediate assurance issues.

A full report will be submitted to the Committee once the final report and improvement plan has been published.

Pine Ward – an unannounced visit took place on 14th March 2018. This was a routine visit and whilst we anticipate a report in the usual timeframe of 2-3 weeks, their visit will be incorporated into a pan Wales piece of work in relation to Substance Misuse services in Wales which is due to be published in July 2018.

Again, oral feedback was very positive visit and reviewers praised the work of the team with all the patients expressing a high level of satisfaction with their care and treatment.

There were no immediate assurance issues.

A full report will be submitted to the Committee once the final report and improvement plan has been published.

Primary Care announced inspections

HIW have published four reports in relation to Primary care contractors since the last detailed report to the committee in December 2017. These relate to:

- Butetown Medical Practice
- West Quay Medical Centre
- Fairwater Dental Practice
- Penylan Surgery

These reports were identified as part of the preparation of this report for the Committee; it appears they had not been issued in line with agreed process, which is via the Chief Executive's Office. This matter will be discussed with Mr Alun Jones, Deputy Chief Executive, HIW, as it is an on-going issue that has been raised previously.

There were no immediate assurance issues raised in relation to any of the inspections. All practices have submitted improvement plans. A more detailed report will now be provided at the June 2018 Committee.

Reviews involving other organisations

In March 2018, HIW commissioned an Independent Review of how Abertawe Bro Morgannwg University Health Board (ABMUHB) handled abuse allegations made against (KW). KW was an employee of the ABMUHB at the time, working at Rowan House in Cardiff.

The Terms of Reference for the Review are currently on HIW's website at the link: http://hiw.org.uk/reports/special/specialreviews/termsofref/?lang=en.

The Review relates solely to the actions of and processes within ABMUHB. However, one of the patients who made an allegation against KW was a patient of Cardiff and Vale UHB and, as the UHB remains a commissioner of learning disability services from ABMUHB, it is recognised as a stakeholder in this process and will be actively participating as required.

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OVERVIEW OF SERIOUS INCIDENTS RELATED TO ENDOSCOPY SERVICES AND LESSONS LEARNED
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** April 17th 2018

Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and Quality with support of Assistant Director of Operations
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
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 actions identified to address the outstanding themes and trends

The Quality Safety and Experience Committee is asked to:

- **NOTE** the current position and work ongoing in relation to the management of quality and safety issues in endoscopy services
- **CONSIDER** the actions currently being taken
- **NOTE** the current position
- **AGREE** a process for on-going monitoring of the situation

SITUATION

The purpose of this paper is to provide the Quality, Safety and Experience Committee with an overview of

- endoscopy related Serious Incidents (SIs) reported to Welsh Government
- what the themes and trends of investigations, were found to be

- what action has been taken to reduce the likelihood of similar incidents occurring.
- the current position

BACKGROUND

In the summer of 2015, the UHB recognized an emerging trend in relation to endoscopy related SIs. The Quality, Safety and Patient Experience Committee and Board has received a number of reports in relation to endoscopy services since this time.

In response, the Medicine Clinical Board has developed a comprehensive improvement plan to address all the thematic issues as well as key issues identified through RCA processes. This aims to reduce waiting times and improve patient experience and access to endoscopy services for all categories of patients including urgent, routine and surveillance This has recently been updated and is included as **Appendix 1**. It is monitored on a regular basis within the Clinical Board and while many actions have been implemented and progress in several areas has been achieved, the UHB continues to report SIs, the most recent being reported to WG on 19-02-2018.

It is highly likely that as the Directorate team begin to address the backlog of surveillance patients, there will be other patients identified who have come to harm as a result of a delay in being seen.

ASSESSMENT AND ASSURANCE

In total, since May 2015, 24 SIs related to endoscopy services have been reported to Welsh Government. Of these, 6 are currently under investigation and therefore the root causes are not as yet fully established.

The breakdown of these incidents is as follows:

Nature of referral	Number
Surveillance (inc. 2 re-call in to surveillance)	11
Urgent suspected cancer	3
Urgent	6
Routine	3
Bowel Screening Wales	1
Total	24

Each SI has been investigated by the same senior Gastroenterologist and Governance Lead; this has provided consistency of investigation and oversight of the key issues and themes. It would be fair to say, that while each

incident has it's own unique set of circumstances, there are a number of key themes. Of the 17 Serious Incidents that have been fully investigated, the following themes and trends have been identified and are reflected in the over-arching improvement plan.

Waiting times to see patients exceed RTT/JAG targets due to lack of endoscopy capacity

The main cause of the SIs are that patients are waiting too long for an endoscopy - across all categories of patients. Whilst the Health Board had developed a comprehensive plan to address the demand and capacity gap, there was a significant loss of endoscopy activity in August to October - with the service adversely impacted by the 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.

What action is being taken?

The loss of capacity in the 4th suite was escalated to Executive Level and a number of recovery actions were implemented, including use of nurse bank staff and recruitment to nursing vacancies 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.

Competing capacity to see surveillance patients –

There is competing capacity requirements across all categories of endoscopy patients and historically capacity has been used to meet the demands on the symptomatic service (Urgent suspected cancers (USC) and RTT) as opposed

to surveillance. However these are an equally vulnerable group of patients who should be considered high risk.

The two key issues that need to be addressed are:

- Lack of dedicated oversight of the surveillance waiting list and
- capacity within the Directorate team to manage this.

Due to significant administrative constraints within the Directorate, validation of the lists has been inconsistent and there has not been a reliable system in place to clearly identify which patients need to come back in prescribed timeframes.

What action is being taken?

A process of continual clerical and clinical validation of surveillance patients was put in place in November 2015. Review of the waiting list position for all endoscopy procedures also now takes place at alternate monthly business directorate meetings. There has been a number of workforce problems across Consultant staff, nursing staff and administrative staff over this period. Medical staffing issues are now largely resolved but there are still some nursing vacancies and due to sickness and absence in the administrative function the department is currently significantly understaffed.

A new Consultant Endoscopist is due to take up post in May 2018. In addition, two nurse endoscopists have been trained to undertake colonoscopies which is the highest demand procedure and general nurse vacancies should be fully recruited to by May 2018.

The Directorate has identified a dedicated band 5 member of staff to oversee the surveillance waiting list and have committed to protect this individual's time so that they are not drawn in to work on RTT particular at the end of financial quarters. This is essential to sustain and maintain consistency of approach.

The referral to treatment (RTT) pathway requires that patients undergo investigation and treatment within time periods defined by Welsh Government. The Minister for Health and Social Services for Wales has mandated that Health Boards work towards JAG (Joint Advisory Group on GI Endoscopy) accreditation during 2017, which requires that patients should wait for no longer than 8 weeks past their planned surveillance procedure date. There has previously been no requirement to meet waiting list targets of surveillance patients within Wales. The UHB is currently not JAG compliant, mainly due to waiting times for procedures.

The Directorate now plans to consider as matter of urgency, whether it continues to use 3 categories to prioritise patients waiting for treatment. These are currently 'urgent suspected cancer', 'urgent' and 'routine'. Essentially urgent patients are treated within the same timescales as routine patients. Clinicians feel that the UHB should remove the urgent category and

expedite work to become JAG compliant. This would mean that USC patients are seen within 2 weeks (in line with strict NICE guideline definitions), urgent non-cancers within 2 weeks and all routines within 8 weeks.

The tentacle system - new cancer tracker – is being implemented and will highlight any USC that has not been seen within prescribes timeframes

Lack of robust process for the oversight of specialist procedures

What action is being taken?

The Directorate recognizes the fact that there needs to be greater involvement in case validation and capacity planning. A designated individual has now been identified to oversee Bowel Screening wales and specialist procedure/GA waiting lists.

Lack of consultant expertise for specialist procedures

What action is being taken?

A visiting consultant gastroenterologist now provides 2 days/week cover of complex work. The newly appointed Consultant commences in post in May 2018.

Workforce issues (which have included endoscopists, nursing staff and administrative staff)

What action is being taken?

This has been described in some detail above. At the present time, administrative support remains the most challenging. There have been longstanding administrative issues including widespread short term and long term sickness, lack of robust annual leave and sickness management and consequent administrative backlogs. In addition, it has become clear that there was a significant lack of understanding of some processes by administration staff.

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While there has been over-recruitment in to 8 WTE substantive roles, due to high sickness levels there are currently only 3 WTE staff in work. This is causing significant stress and disruption to long term sustainability and consistency of well-established processes and systems that are understood by the whole team. In addition, to this a senior band 6 service manager is also currently on sick leave

A new Directorate Manager has started in post this week and there is clear commitment to addressing these issues while recognizing that this will take time and the risk continues while the changes are made. A new rota template has been put in place. There will be a restructure and skill mix review in the

department based on demand and capacity. Work has been undertaken with the administrative team, to ensure that there is clarity with regards to the roles and responsibilities of each member in respect of the various systems and processes in place within the department and there is now a commitment to much greater performance management of the administration team. Standard operating procedures for various tasks within the department have been developed and will be shared with staff at the meeting.

Lack of escalation of identified persistent patient waiting time breaches

What action is being taken?

There are now weekly Directorate meetings held to monitor Urgent Suspected Cancer (USC) and RTT. In addition, daily scrutiny of lists takes place to manage long waiters.

Lack of activity review in relation to specialist polyp activity

Historically there has been one endoscopist employed to treat this particular patient group. This individual works in isolation of established Directorate processes and this places a vulnerability in the system as there is not Directorate oversight of his case load which is managed predominantly through paper systems, although patients are, now being placed on the PMS and the Diagnostics and Treatment system.

The speciality GA list is managed by clerical staff. Some of these patients will be in the USC category. Some will be flagged as USC but may have already received treatment and are now in the follow –up category but not flagged as such.

The Directorate does not currently have confidence that it has sight of all the current issues in this particular patient group

What are the actions being taken?

Although there is an improving picture, the Clinical Board recognises that this remains an area of concern and plan to introduce a MDT approach to this particular group when the newly recruited specialist consultant endoscopist commences in May 2018. This will require collaboration of the three Consultants if it is to be successful. The Clinical Board Director will discuss the issue with the AMD for Cancer Services in order to support and facilitate this.

Process mapping of all pathways will be facilitated by the UHB Quality Improvement Manager as a matter of urgency

The Clinical Board will establish a system whereby there is systematic 'drill down' in to any outliers identified in the BIS endoscopy dashboard.

It is evident that there is a lack of awareness of the criteria for the referral and investigation of patients with gastrointestinal symptoms according to national (NICE) guidelines

The National Institute for Health and Care Excellence (NICE) published guidelines titled 'Suspected cancer: recognition and referral – NG12' in June 2015. These advise that patients with unexplained rectal bleeding should be referred and investigated as an urgent suspected cancer (2 week wait) priority.

In recent incidents it is evident that GPs are referring patients in as urgent cases 'to exclude cancer' when they clearly meet the criteria for urgent suspected cancers. There is an educational requirement to improve the accuracy of referrals in to the service from primary care, in line with NICE guidance

What action is being taken?

The Clinical Board will engage with PCIC to raise awareness and educate GPs in relation to the requirement of the relevant NICE guidance

Gastroenterology/Endoscopy/Hepatology overarching actio

1	Surveillance patients not pulled through from waiting list – limited capacity due to high number of symptomatic patients	Clerical and clinical validation of patients on all surveillance waiting lists, including specialist/complex/GA procedures. Allocation of dedicated endoscopy list capacity to surveillance patients. Transfer of patients from PMS list 13 once surveillance breach date is reached. Develop mechanisms to reduce surveillance burden longer term such as the repatriation of out of area cases facilitated by validation of recently performed surveillance procedures and directorate sign off of out of area endoscopy requests (highlighted by endoscopy administrative team). Review and refine current surveillance process	(Deputy HOD)
2	Waiting times exceed RTT/JAG targets due to lack of endoscopy capacity	Directorate/UHB to increase number of endoscopy rooms by converting vacant decontamination area at Llandough Hospital to fourth endoscopy room. Endoscopy nurse workforce review & recruitment to support additional room. Weekend lists to be undertaken regularly. Appointment of additional staff, additional lists for existing operators, waiting list initiatives and outsourcing of procedures. Nurse endoscopist workforce planning. Purchase of additional endoscope equipment to support increased capacity.	(Deputy HOD)

3	Lack of review of waiting list for specialist procedures – uncertain capacity requirements.	Directorate team to understand existing waiting list components & structure. Gastroenterology directorate to review waiting list position of specialist procedures (GA, advanced endoscopy, capsule endoscopy cases) to ensure appropriate prioritisation and tracking of existing patients and to inform the demand and capacity of this service. Review at directorate & performance meetings. Clerical and clinical validation of waiting lists by directorate team.	(Deputy HOD)
4	Specialist procedures vetted as a suspected cancer priority not tracked by the gastroenterology directorate or Health Board.	All suspected cancer category patients on specialist endoscopy lists to be added to the directorate and Health Board tracker. Develop a process to prioritise or flag patients as USC category on existing IT systems (PMS)	(Deputy HOD) (DM)
5	Reduction in endoscopy workforce due to long term sickness	Directorate team to undertake a comprehensive review of admin workforce and performance management in line with UHB policies	(Deputy HOD) (DM)

6	Inadequate number of consultants undertaking specialist endoscopy procedures resulting in increased waiting times	Appoint additional consultants or train existing consultants to undertake complex polypectomy	(Deputy HOD)
7	Listing of patients with early planned procedure dates on list 13 of the PMS	Patients with early planned procedure dates are differentiated from surveillance patients on list 13	(Deputy HOD) s (DM)
8	Lack of escalation of identified persistent patient waiting time breaches	Develop a formal escalation policy for the escalation of endoscopy patient waiting list delays within the directorate team and medicine clinical board	(Deputy HOD) (DM)
9	Lack of activity review of specialist polyp activity	Directorate to review and monitor list utilisation, DNA/CNA rates for specialty endoscopy lists to optimise efficiencies and reduce waiting times	(Deputy HOD) (DM)

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(CD's) (DSM) (DM)
(Deputy HOD) (CD's)

(Deputy HOD) (CD's) (DSM) Sarah Edwards (DM)	
(Deputy HOD) (CD's), (CG lead) (DSM) (Directorate Manager)	
(DM)	

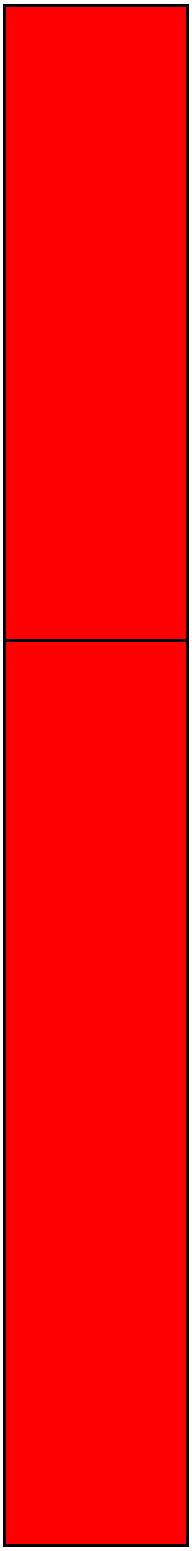
(Deputy HOD) (CD's)
(DM) (DSM)
(DM)
(DM)

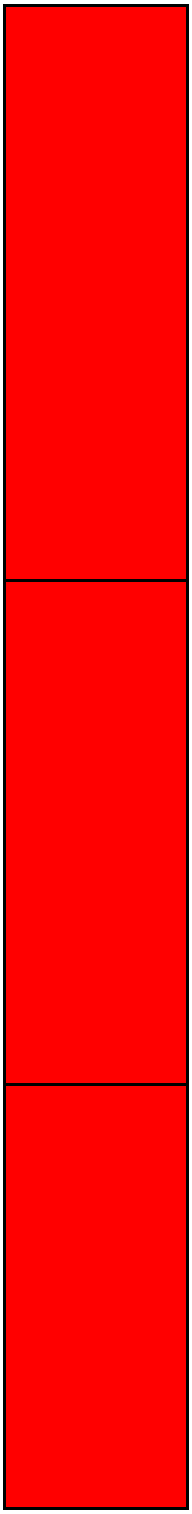
ıs Incidents: In49329, In56422, In62114, In63274 (updated March

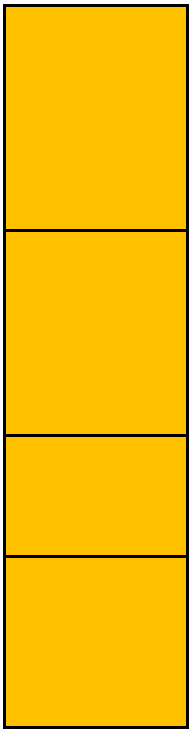
Clerical & clinical validation of surveillance patients (overdue procedures from 2012 onwards) commenced November 2015 and is now a continual process. January 2018 update: Barrier to continual process secondary to current pressures within administrative staffing and RTT pressures. Surveillance patients added to endoscopy capacity from February 2016. January 2018 update: reduced due to admin/nursing workforce shortage leading to reduce capacity Highest risk patients identified using spreadsheet & prioritised. Agreed at directorate Q&S meeting 16.2.16 that appropriate out of area surveillance procedures should be repatriated to relevant UHB's after most recent procedure. Review of the waiting list position for all endoscopy procedures now takes place at alternate monthly business directorate meetings. Update January 2018: Additional Executive support is being provided. March 2018: Dedicate and protect a member of the Directorate team to continously validate surveillance patients to clear the backlog. Provide a detailed trajectory for Q2 to include reduction profile in activity
Building work on new 4th endoscopy room at Llandough completed & now used for endoscopy lists. Has contributed to capacity since. Update January 2018: Nursing vacancies have resulted in this endoscopy room not being consistently utilised. Nursing posts have been advertised and filled with expected start dates Jan-May 2018. Medicine CB director of nursing to oversee a critical review and to address any reasons for acute loss of nursing staff, review the development programme to support nursing staff retention and review of nursing staff banding mix. Slippage monies from WG have allowed the purchase of equipment for the new endoscopy room – commissioned and available from 9th May 2016. An endoscopy fellow commenced in post 5th September 2016 to increase capacity (3 additional lists per week). Post currently re-advertised and filled on an annual basis. A new consultant endoscopist post has been appointed to with a start date of May 2018. Saturday endoscopy lists are undertaken weekly to increase capacity. Additional WLI's and outsourcing is being undertaken weekly in addition. Update January 2018: Insourcing is also being undertaken from January 2018 – March 2018 thereby increasing capacity. Weekly performance meetings are undertaken to optimise endoscopy list utilisation. New band 2, 5 and 6 endoscopy nurses have been appointed to cover the additional room capacity with a planned start date by October 2016. There has been a reduction in nursing establishment due to staff leaving the posts & are due to be re-advertised. Update January 2018: Current nursing vacancies have resulted in one Endoscopy room not being utilised. Nursing posts have been advertised and filled with expected start dates Jan-May 2018. Two newly trained nurse endoscopists have achieved JAG certification & commenced independent lists in OGD & sigmoidoscopy (replaced colorectal list) An existing nurse endoscopist has commenced colonoscopy training (currently trained in sigmoidoscopy), which is the highest demand procedure. Update January 2018: Two nurse Endoscopists have received the appropriate colonoscopy training, with one due to undertake a sign off assessment Jan 2018. Review of existing inpatient demand and capacity. Current underutilisation is leading to reduced capacity for outpatient procedures. March 2018: Establish accurate data reporting templates Implement a trajectory of demand Review the way in which surveillance cases are allocated to insourcing vs outsourcing lists to maximise those allocated to insourcing

Clerical and clinical validation of specialist procedures commenced April 2016. Update January 2018: No senior directorate involvement in case validation and capacity planning New Gastro directorate service manager appointed and designated role of overseeing Bowel Screening and specialist procedure/GA waiting lists. New report generated by IT services on a weekly basis to record and allow monitoring of waiting times. March 2018: Devise performance reporting mechanism that feeds weekly into the directorate Implementation of transparent processes for the review of specialist endoscopy activity and lists by the Directorate and the compilation of a complex general anaesthesia Standard Operating Procedure
Directorate support manager allocated to oversee all patients marked as suspected cancer within the directorate (outpatient clinics & endoscopy). Updated January 2018: No case-by-case review of breaching USC patients. Highlighted in further SI. Directorate team met with PMS/IT teams on 11.5.16. New cancer tracker flag developed & implemented October 2016 to improve traceability of patients. New IT endoscopy report templates developed to track & monitor all USC patients. PMS training update provided to all endoscopy admin staff.
Review completed and action plan implemented Jan 2017. Update January 2018: New appointments to Endoscopy Administrative posts to fill the deficit with training in progress. There is active involvement from the Workforce and Development Team to support a long term plan to support Directorate staff with sickness and absence levels within this area. March 2018: Review and monitor performance reports for all staff Adopt a direct booking process and measure productivity and improvements Thorough monitoring of new sickness and timelines Redesign rota system to improve function and performance Define performance measures and expectations Review roles and responsibilities of directorate support team, inclusive of band 4 team leader Pull skill mix from other directorates

Visiting consultant gastroenterologist providing 2 days / week cover of complex work for up to a 12 month period. Consultant endoscopist post due to start May 2018.
A spread sheet has been developed to specifically record any patient with an earlier planned endoscopy procedure date. Update Jan 2018: Barrier to continual process secondary to current pressures within administrative staffing and RTT pressures.
Weekly directorate meetings held to go through USC and RTT waiting times. Daily scrutiny of lists to validate and manage long waiters in a case management approach. Bi weekly MCB meeting where quarterly plans are monitored and risks shared for advice/action.
ADAM booking system upgrade in Endoscopy will give us more sophisticated reports and these will be fed through the Directorate meetings for analysis and action where performance is suboptimal. These should be available from November. Will be able to monitor DNA and CNA activity more effectively via this system. Update 2018: CWM fully implemented. Reports currently being developed with supplier. March 2018: Reports now completed and available on CWM. Requires regular review as part of Directorate processes







Cardiff and Vale University Health Board
Patient Nutrition, Hydration & Catering Experience Management Action P
Review of progress March 2018

Surveys/Reports included:
Public Accounts Committee Report 'Hospital Catering and Patient Nutriti
Community Health Council (CHC) Survey Report 2015 - 30 wards audited b
Community Health Council (CHC) Visit Report 21/06/17 – A4 UHW
'Two minutes of your time' UHB patient satisfaction surveys -Feb, April, Ju
Annual Health and Care Monitoring Audit 2016 - includes ward self- assessı
All Wales Patient Mealtime Survey 2013 746 patients surveyed including pati
Welsh Audit Office (WAO) survey 2015- 4 wards surveyed which included int
Summary of Meal Service Audits 2016 19 audits undertaken across all sites
Nursing survey of nutrition/hydration issues for Ward Managers /Charge
Summary Nutritional Risk screening audits 2017
Summary Nil by Mouth audit 2017
Model Ward outcomes commenced June 2017
National Audit of Dementia Care in General Hospitals Report ,2016-2017

Recommendation	Planned actions/actions taken
1. Menu Choice	
Need for improvement in patient menu choice especially for those patients who are longer stay, and those patients requiring therapeutic diets, vegetarian, Halal options and healthier choices to ensure all patients nutritional needs are met.	A UHB multidisciplinary Menu Review Group has been set up to address menu related issues with the aim of developing a new two week menu, increasing choices for patients on vegetarian, vegan, Kosher and Halal diets, as well as provision for those patients with very specific therapeutic dietary needs, such as food allegens, and increasing the choice for patients needing healthier menu choices.

2. Provision of menus	
Menus need to be available at ward level to support patient menu choice, and to provide information on what they should expect from catering services	Menus will be printed and included in the new UHB Patient Bedside Information Folder for access by patients and carers.
3. Food service	
a) Better consistency in food quality and service of meals is required across all sites i.e. taste, temperature, appearance and presentation, portions sizes, and to include the offering of second helpings as routine.	Work is ongoing with Shared Services Lead Dietitian and the Catering Commodity Advisory Group to improve quality of food products procured for NHS. Continue to support the All Wales menu Framework in development of good quality recipes to meet the Welsh Government Food & Fluid standards. Review current equipment usage in relation to regeneration practices across all UHB sites and provide the necessary training to improve understanding of patients needs and quality and timing of menu items served.

	An All Wales patient nutrition and catering IT solutions review will be scoped out to replace the variety of existing manual and IT systems, and provide efficient and effective patient catering services. To scope out the use and benefits of introducing dedicated ward hostesses and a hand held tablet ordering IT system.
	Revise WBC training to ensure service incorporates the offering of second helpings where applicable and embed in daily routine

b) Provision of appropriate crockery and cutlery on all wards across the HB should be routinely available	Clinical Board needs to address this issue to ensure all necessary equipment is available across wards.
c) The practice of leaving food within the reach of all patients and ensuring all patients are suitable positioned for eating and drinking needs to be reiterated to all staff	The importance of correct placement of trays etc. needs to be reiterated to all staff.
4. Timing and access to meals, snacks and beverage rounds	
	Choice of drinks offered as a standard will need to be agreed to accommodate patient preferences.
5. Nurse engagement in mealtime process	
a). Improvement is required in engagement of nurses at mealtime and beverage rounds to ensure patients are fully supported.	A review of engagement process of clinical nursing staff within patient mealtimes is required. Produce guidelines to embed in practice.

	Nutrition training for nurses which will include mealtime processes is currently being planned with LED and senior Nurses. Nurse champion's will become part of every ward establishment.
6. Protected Mealtimes	
a) Ensure patient assistance is maximised and pre – mealtime preparation is undertaken	An assistance to eat audit is recommended to provide an accurate picture of the issues. Review of patient need and available staff to assist is required.
	Clear and defined nursing staff roles and responsibilities at mealtimes needs to be relayed to all staff. This will be included within the planned nurse training programme.
b) Hand washing should be encouraged as a priority	Review hand washing procedures and efficient ways of providing the services.
c) Ensure that dining room areas in wards are promoted	Use of dining rooms should be maximised where this is possible and all nursing staff should encourage patients to leave their bedsides when appropriate.
7. Nutritional screening /weighing of patients	

	Introduction of integrated nursing documentation and training planned will assist in meeting this recommendation. Assessment of patient risk screening and weights will form part of the revised
a) Further improve compliance to nutritional risk screening policy and completion of nursing documentation relating to nutrition and hydration needs	tool. UHB wide Nutritional Risk screening audits will provide information to assist in targeting areas that do not meet the standards required. This will be relayed to Directors of Nursing
b) Use of Nutrition & Hydration Bedplan as the means of providing the necessary information on patients' nutrition & hydration needs at admission which includes allergies, therapeutic diets, religious and cultural dietary information and recording	An SBAR has been produced which will be submitted to the Nursing Clinical Standards and Innovation Group
c) Ensure appropriate weighing scales are available in all ward areas accurate and regularly calibrated.	A bid for funding initiated by Dietetic team for new weighing scales for all areas to meet the new weighing scale standards has been partly secured and clinical areas have been prioritised. New scales have been delivered to all wards across the UHB. A maintenance programme has been agreed. Need to secure the remaining funding to ensure 100% compliance to current legislation.
8. Safe storage of supplements and drinks	
9. Patient catering costs	
10. Assessment of oral health and ability to communicate	
11 Availability of healthier choices for staff across staff restaurants, cater	
12. Finance	

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y CHC members and 168 patient surveys

une, August October and December 2016
ment and patient user feedback
ients comments
erviews with UHB staff **,**patient representatives, Ward Managers, Dietetic
within the UHB
nurses -39 responses (MH 5, C & W 1, Surgery 7 Specialist 8 and Medic

Progress	Time Scale
New UHB 2 week Menus is on hold still due to delays in NPS awarding ambient grocery lines contracts. Work needs to be undertaken to evaluate the contract changes and implications for the new menu, likely date for launch of new menu October/November 2017.	Apr-18
A new supplier has been awarded the All Wales Texture modified meal contract, C&V have changed menus and supplier in line with the All Wales Menu Framework.	
A new A La Carte menu has been developed to provide additional meal options to patients with very specific dietary needs (for example allergen free meals, Halal and Kosher suitable meals), this is due for implementation across the UHB in August/Sept 2017.	
A new Maternity menu has been developed in a response to patient feedback, and includes an enhanced range of vegan/ vegetarian and multicultural meals. This was implemented in April 2017.	

Work is currently in progress to address the specific dietary needs of longer stay patients within MHSOP and Mental Health.	
Following internal audit work and patient/staff feedback, and in response to the National Audit of Dementia Care, it has highlighted the need to develop a 'dementia friendly menu' for MHSOP areas that include familiar meals, foods that stimulate an appetite, foods that can be eaten without cutlery (maintaining patient independence with eating and drinking) and the inclusion of buffet meals, and that meet the All Wales Food and Fluid standards. It is hoped that this could be available to implement in October/November 2017 Within adult Mental Health there is a need to develop menus that include a predominance of healthier multicultural meal options, and include the ability for patients to choose their meal times, and be included in the meal preparation process. It is hoped that this could be available to implement in October/November 2017	
This will be synchronised to coincide with new menus launch. Initially there will be bedding in time of 6 months for the new menus and temporary paper copies will be available.	Oct/Nov 2017.
In the longer term menus will be available at ward level that will support patients to make informed meal choices and in the most appropriate format, for example in pictorial menus and in Welsh and English.	Launch date of new menus February '18
Awaiting new ambient grocery line contract information from Shared services /National procurement Services Wales, and the updating of the AWMF web site. Current the Lead Procurement Dietitian post is a vacant within Shared services which has delayed communication and updating of the website. Contractual agreements between C&V and Shared Services exist to support the work needed till the post is filled.	November 2017- currently being awarded

There are outstanding food contracts yet to be evaluated and awarded. These include fresh and frozen meat, fish, fruit, vegetable, bread and diary. These are due to be awarded in 2017 Portion size training for production and ward based catering staff has been developed and is currently being delivered across the UHB Agored Cymru accredited training has been developed for ward based catering staff and a programme of delivery is being developed across the UHB. This training includes aspects of customer care such as presentation of meals, offering of seconds etc. Currently there is a 'model ward' project ongoing across 2 wards in the UHB where there has been a change in nutrition and hydration practices designed to increase opportunities for patients to eat and drink, with improved food choices, meal presentation and accurate meal ordering utilising a visual menu IT system. This has delivered an improved patient experience and significant positive clinical outcomes. The project has been extended whilst outcomes are fully evaluated and reported.	
Cardiff and Vale is represented and heavily involved in driving the All Wales Nutrition and Catering IT Solution business case. The introduction of the Menumark system to manage food production and the use of computer tablets to take patient meal orders has been piloted on the Model wards of Llandough Hospital and UHW alongside a new Ward hostess style, with improved customer care focus, and improved patient meal service. The Model Ward Project outcomes have been extremely positive and will shared.	May-17
Agored Cymru accredited training has been developed for ward based catering staff and a programme of delivery is being developed across the UHB. This training includes aspects of customer care such as presentation of meals, offering of seconds etc.	9/1/2017

A review of crockery and cutlery used across the HB has been undertaken, with an initial acquisition of charitable funds to support the purchase of better quality cutlery and crockery, to improve the patient experience oral intake and independence, and meet patient safety needs. Availability of adaptive cutlery varies across wards This will form part of the funding	Apr-18
Phase 1 UHL, Barry, MHSOP(UHL) and A4 and B6 ward UHW - 20k Charitable funding sourced and purchase made, and new crockery issued to wards. **Phase 2** Children's hospital submitted Noah's Arc bid for 5k (includes cutlery) purchase made, and new crockery issued for use. **Phase 3** UHW, Rookwood, Iowerth Jones- Funding agreed and order made **Phase 4** Hafan Y Coed Requirements differ, specifics to be explored Crockery going missing and being topped up regularly	Sep-17 Apr-18
This is part of Model Ward mealtime procedures and is incorporated within protected meal times processes. The principles of protected meal times are reinforced as part of the Nutrition and hydration champion training. The 'principles poster' has also been refreshed and distributed so that the message is delivered to the widest audience. Compliance with the principles of protected meal times are observed as part of the Health Board's internal inspection programme	June – Sept 17
This was reviewed as part of the Catering review' Model ward' project. Role out to be completed Oct 2017. *Update Aug 2017*	Oct-17
A Nutrition Champion training programme has been developed and are ongoing. 21 wards attended across UHB. 52 nursing and 1 catering supervisor have completed the level 2 'Improving Food and Nutrition care' accredited training.	May-18

Health and Care standard 2.5 Nutrition and Hydration and All Wales Food and Fluid standards are included in the Nurse Foundation Training programme run x4 per year with approx. 30-40 nurses attending each time.	
As above, whilst not all staff are able to attend face to face training, the poster will act as a reminder of the principles of protected meal times	May-18
Compliance is monitored as part of the Health Board's programme if internal inspections which show that practice varies from being excellent to needing improvement.	
The provision of hand wipes was discussed at the last Nutrition and Catering Steering group and a progress report has been requested for the next meeting on handwashing with soap and water. Hand wipes are available to order via Oracle but audits are showing hand hygiene remains and issue. Explore approaches within areas hand wipes or soap and water?	Refresh during model ward evaluation
Where possible, dining room is used. This is constrained by either case mix/ staffing and / or available environments.	7/1/2017
Dining rooms are used for lunch clubs across some areas of Medicine Clinical Board. Dining rooms are used across Mental Health in patient's services. Patient satisfaction feedback is very good. The CHC have published a document on loneliness in hospital, available on CHC website detailing areas of good practice across the NHS and where mealtimes which include social dining patient satisfaction is high.	Part of model ward elements

The audit of compliance with undertaking nutrition risk screening assessments and appropriate action is an all Wales requirement for in-patient areas and the results are reported to Welsh Government on a monthly basis. Audit results are discussed at clinical Board performance reviews as well as at Director of nursing Performance reviews undertaking by the Executive Director of Nursing. Audit compliance for the UHB for December 2016 was reported as 93.74%	
Comprehensive auditing across UHB due in the month of April with report back to the Nutrition and Catering steering group shortly after.	
Eating and drinking forms part of the proportionate nursing assessment completed on patient admission to hospital	
The SBAR was presented to the CSIG in July 2016 and will now go forward to the Nursing and Midwifery Board for approval in September 2016. This needs implementation Compliance with nutrition screening is reported by each in patient area on a monthly basis and the results are discussed at the Clinical Board Director of Nursing Professional Performance Review with the Executive Nurse Director	01/5/17 meeting Oct 2017
New weighing scales have now been issued to all wards where appropriate, yet still weighing patients is an issue. The nutrition risk screening audit in April will provide further information on the situation.	4/1/2017
ring outlets	

c and Catering managers and Executive Directors together with review of documentation

cine 18)

Lead
Judyth Jenkins (with Lee Wyatt)

21

Lee Wyatt

Peter Cockburn (CFPU) &

Lee Wyatt (WBC service)

Lee Wyatt

Lee Wyatt/Dietetics

Directors of Nursing/ Dietetic Catering Lead/Lee Wyatt
Directors of Nursing
Lee Wyatt (with Directors of Nursing)

Directors of nursing

Directors of Nursing/

Directors of Nursing

Directors of Nursing
Directors of Nursing

NUTRITION AND HYDRATION REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 17th April 2018

21

Executive Lead : Executive Director of Therapies and Health Sciences
Author : Head of Nutrition and Dietetics
Caring for People, Keeping People Well This report underpins the Health Board's 'Sustainability' and 'Values' elements within its strategy in relation to care, respect and dignity
Financial impact : This needs to be assessed following completion of the review
Quality, Safety, Patient Experience impact : Implementation of the management action plan will provide the necessary assurance
Health and Care Standard Number: 2.5,3.5,4.1
CRAF Reference Number :5.1,5.18,5.7
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- The status report attached

The Quality, Safety and Experience Committee is asked to:

- **NOTE** progress on actions listed within the Patient Nutrition, Hydration and Catering experience management action plan particularly in relation to the model ward pathfinder project and the pilot of the nutrition and dietetic service within the Emergency Unit.
- **BE ASSURED** that the Nutrition and Catering Steering Group keeps a regular review of the action plan to ensure and update on progress.

SITUATION

The Health Board is continuing to address the 10 key recommendations set out in the Public Accounts Committee report on Hospital Catering and Patient Nutrition ensuring that all elements of Nutrition and Hydration Standard 2.5 are being met. Good progress has been made in many areas notably staff catering and public health with reference to the delivery of the corporate health standard framework. The implementation of a pathfinder model ward if approved by the Health Board will enable more standardized nutrition and hydration practices across the inpatient setting delivering value based healthcare. A refreshed two week menu cycle has been launched across the UHB as well as specific menus to meet the needs of maternity and specialist

clinical areas. New highly coloured crockery arrives for all areas of the Health Board in April 2018 to improve the mealtime experience of our patients further.

A review of the actions outlined in the Patient Nutrition, Hydration and Catering Experience, Management action plan document are monitored, reviewed and reported to the Nutrition and Catering Steering Group.

BACKGROUND

The Patient Nutrition, Hydration and Catering Experience Management Action Plan has been developed to address issues highlighted within the Welsh Government key publications and pathways.

The Public Accounts Committee on Hospital Catering and Patient Nutrition published in March 2017 made 10 further key recommendations. An extensive action plan developed by the Nutrition and Catering Steering committee pulls together all standards resulting in twelve core themes. It encompasses ongoing Health Board wide audits on assistance to eat, meal service (adults and paediatrics) and nutrition screening. Nutrition related training logs are also being collated.

ASSESSMENT AND ASSURANCE

Timescales for implementation of the actions listed in the plan are continually reviewed. The actions to be taken are detailed in the management action plan below which is currently undergoing a refresh with input from all members of the Nutrition and Catering Steering Group.

The UHB's Nutrition and Catering Steering Group are reviewing the pathfinder projects of 'Model ward for Nutrition and Hydration' and 'Dietitans and speech and Language therapists at the front door' as part of the therapy team which were set up to examine how best to deliver comprehensive and co-ordinated nutritional care practices to maximise patient outcomes and improve flow through the organisation. Food, fluid and nutritional care are crucial for the physical and mental health well-being of patients and are also fundamentals of care elements that can enhance the patient experience. The CNO for Wales Jean White was quoted in the Public Accounts Committee Report March 2017 stating 'Nutrition and hydration are one of those things that, to be frank, is almost as important as the medication that people receive'. This powerful statement needs to be adopted by healthcare organisations across Wales.

The addition of the nutrition and dietetic service and Speech and Language in the Emergency dept within UHW has been repeated over the winter period and the outcomes are currently being collated

An inter-disciplinary group of Therapy, Nursing and Facilities colleagues collaborated to deliver the pathfinder project and identify and quantify what

impact it could make on the patient's journey and UHB resource utilisation. The project has involved cross clinical board integrated working, and fits within the UHB's programme of transforming care and turning the curve. The project is closely linked to and underpins the UHBs promoting independence and 'Get Me Home' campaign as assistance to improving patient flow.

The wards nominated to undertake the Model Ward pilot project were 2 acute medical wards, A4 in UHW and East 2 in UHL. The key aims of the project were:

Improve patient satisfaction and experience

Provide clarity in roles and responsibilities of nurses, facilities and therapies staff.

Remodel the workforce to meet the needs of the patients

- Increase snacks and beverage rounds, change timing of meals to reflect patient feedback from previous satisfaction surveys,
- Increase MDT engagement at mealtimes
- Re-invigorate Protected mealtimes which includes preparation of the environment and the patient, with social dining where possible
- Improved compliance and accuracy with nutritional screening and monitoring, and documentation of patients oral intake to facilitate informed nutritional assessments
- Ensure full use of the nutrition and hydration bedplan to maximise patient safety, and use of the safety briefings to identify patients needing cultural, therapeutic and religious diets and specific support and assistance.
- Ensure accurate menu ordering management systems
- Reduction in prescribed product costs e.g. Nutritional supplements, laxatives and IV fluids
- Launch new improved crockery to improve patients mealtime experience and aid independence

A scorecard was developed which captured data and outcomes from therapies, nursing, facilities and the Patient Experience Team.

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

MINUTES OF THE MEETING HELD ON 10TH JANUARY 2018

Present:

Alun Morgan (Acting Chair)	Professional Lead for Quality, Safety and Experience/ Assistant Director of Therapies and Health Sciences
Paul Harrison	Podiatry (in attendance for Sue Dayananda)
Rachael Daniel	Health and Safety Adviser
Suzie Cheesman	Patient Safety Facilitator
Robert Bracchi	Consultant, Toxicology and Therapeutics Directorate
Bolette Jones	Head of Media Resources
Maria Jones	Senior Nurse, Outpatients
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Alexandra Scott	Clinical Audit Manager
Paul Williams	Quality and Safety Lead, Medical Physics
Laura Jones	Graduate Trainee

Apologies:

Matthew Temby	Clinical Board Director of Operations
Sue Bailey	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
David Lewis	Head of Finance
Ceri-Ann Hughes	Head of Workforce and OD
Sarah Jones	Quality and Safety Lead, Pharmacy
Sue Dayananda	Head of Service, Podiatry
Lisa Griffiths	Quality Manager, Laboratory Medicine
Kathleen Morris	Clinical Audit Coordinator

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 18/001 Welcome and Introductions

Alun Morgan welcomed everyone to the meeting and introductions were made.

CDTQSE 18/002 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 18/003 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 17th October 2017 were **APPROVED.**

CDTQSE 18/004 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

The original action was for Mike Bourne to follow this up but has moved on since initial discussion. It was agreed that the Clinical Board will request for Fiona Jenkins, Executive Board Lead for the Clinical Board, to discuss with the Nurse Director.

CDTQSE 17/261 Lung Nodule Follow Up

Mike Bourne was to present the recommendations of the Lung Nodule Follow up to the LMC. Mike Bourne to provide an update.

Action: Mike Bourne

CDTQSE 17/357 Cleaning Standards

Alun Morgan reported that work is ongoing around scoping out the re-usage of rooms that are now being used for clinical practice. This is to ensure that cleaning standards reflect the new usage of rooms to ensure that IPC requirements are being met.

CDTQSE 17/359 Record Archive Storage Facility at Treforest

Therapies have completed a risk assessment and are working with the Manual Handling team and Outpatients in trialling different types of equipment.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 18/005 Patient Story

Alun Morgan welcomed Gemma Ellis, Consultant Nurse to the meeting who presented an update on the work being held in the UHB around sepsis. The UHB has implemented Sepsis Six which is the recognised standard for treating sepsis and has also launched a new sepsis pathway toolkit. This will assist in the collation of data and help develop an audit trail.

A Sepsis Medical and Nursing Lead has been appointed and Sepsis Six trolleys have been procured. Sepsis simulation days are being held and a collaboration with PCIC and WAST paramedics has been put in place, providing first line antibiotics and taking blood cultures.

World Sepsis Day was held in September and the UHB set up a stand in the concourse area to raise public awareness.

Aims for the next 12 months are being developed and there is a lot of engagement across Clinical Boards with this.

Angela Jones, Specialist Podiatrist was welcomed to the meeting to present the STANCE project. The project was adopted by the Bevan Commission and was awarded finalist at the Abbvie Sustainable Healthcare Patients as Partners Awards.

The scope of the project was to provide foot health advice and promote a healthier lifestyle for all patients with diabetes that are referred to the UHB. Focus is placed on patient education and increasing patients' confidence to empower them to self-care. They are provided with the right knowledge to control their diabetes and support them with their foot health and foot pathology prevention.

Process mapping work was undertaken on the current pathway for patients of moderate risk and a new pathway was implemented. Patients attend a structured group education programme and receive a 1:1 consultation. They are provided with a directory of services to facilitate referrals to other services and have easy open access to the department should they require support. They also receive an annual assessment.

An evaluation of the project has been undertaken and patient reported outcomes indicate that the majority of patients now have the confidence to manage their foot health.

Going forward, the plan is to review the 3700 patients already in the system with moderate risk and roll out the STANCE project to patients in Primary Care with diabetes.

CDTQSE 18/006 Feedback from UHB QSE Committee October 2017

The UHB QSE Committee held in October was an Extraordinary meeting. It was noted that the Committee has a new Chair, Independent Member Susan Elsmore. Key issues discussed were around trends and themes of serious incidents and never events. It was noted that there has been a rise in the number of incidents relating to falls and pressure damage.

Presentations were delivered on a paediatric naso gastric tube never event, the use of the World Health Organisation Checklist and the National Safety Standards for Invasive Procedures and a gap analysis for areas undertaking invasive procedures outside of theatres.

CDTQSE 18/007 Health and Care Standards

Alexandra Scott reported that the Health and Care Standards that fall within this Clinical Board include Medicines, Promoting Independence, Blood and Nutrition. Folders for self-assessments will be made available in February.

CDTQSE 18/008 Risk Register

Last month's Clinical Board QSE Meeting was utilised for a review of the high scoring risks within directorates. The risks were discussed in detail and highlighted the need for directorates to review the scoring of some of its high scoring risks to a more appropriate level. It was noted that a separate session is being held with Laboratory Medicine. A new risk register format is being developed and the Clinical Board will await its roll out prior to updating the Clinical Board risk register.

CDTQSE 18/009 Exception Reports

There were no issues to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 18/010 Initiatives to promote Health and Wellbeing

Flu Champions are receiving concerns from staff who received the flu vaccination earlier in the season that they received the trivalent vaccine whereas staff who received it later in the season received the quadrivalent vaccine. Alun Morgan will feed this back to Tom Porter.

Action: Alun Morgan

It was noted that it is not too late for staff to receive the flu vaccination if they have not done so already. The Clinical Board has still not reached the 60% target.

CDTQSE 18/011 Falls Prevention

The new UHB Strategic Falls Lead, Oli Williams will be commencing next week.

SAFE CARE

CDTQSE 18/012 Concerns and Compliments Report

In December 2017, the Clinical Board received 5 formal concerns. There were 0 breaches in response times and since 1st April 2017 there have been 12 breaches reported.

0 AM concerns were received in December, with 8 AM concerns received since 1st April.

The Clinical Board received 11 compliments in December.

Since 1st April 2017, the Clinical Board has received 49 formal concerns and 72 compliments.

It was noted that the key theme of formal concerns has shifted from concerns about medical treatment to communication between staff and patients.

CDTQSE 18/013 Ombudsman Reports

Nothing to report.

CDTQSE 18/014 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 18/015 Patient Safety Incidents

Nothing to report.

CDTQSE 18/016 New SI's

There are no new SI's to report.

A new IRMER incident has been reported involving a patient identification error.

CDTQSE 18/017 RCA/Improvement Plans

Nothing to report.

CDTQSE 18/018 WG Closure Forms – Sign Off

In45102

This incident was shared by Surgery Clinical Board for learning purposes to prevent reoccurrence. A patient attended the Main Theatre department for insertion of a right internal jugular vein central venous catheter. A chest x-ray was taken but not viewed. Four days later the patient complained of pain and swelling at the central line site. The x-ray was checked and it emerged that the central line was misplaced.

CDTQSE 18/019 Regulation 28 Reports

Nothing to report.

CDTQSE 18/020 Patient Safety Alerts

PSN038 Risk of severe harm and death from infusion Total Parental Nutrition too rapidly in babies

Circulated to the Clinical Board and highlighted for the particular attention of Pharmacy and Dietetics.

ISN 2017/003 Patient received a blood transfusion intended for another patient/ PSN 039 Bedside Transfusion Checklist

Both safety notices have been circulated across the Clinical Board. It was reported that there is a UHB wide issue that there is no central record kept of competency

assessments of staff. The Patient Safety team are currently working on an action plan.

CDTQSE 18/021 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 18/022 IP&C Issues

There are an increasing number of IP&C audits being undertaken where it is identified that staff within this Clinical Board are not complying with bare below the elbow procedures. Alun Morgan asked directorates to send out a reminder to their staff on the importance of complying.

Action: Directorates

CDTQSE 18/023 Key Patient Safety Risks

Safeguarding/ Mental Capacity Issues

Maria Jones provided an updated from the last Safeguarding Group. Feedback was received from a Senior Physiotherapist on the Older Persons Day.

Sheila Harrison delivered a presentation on professional standards.

Awareness was raised around county lines, where children are exploited and trafficked to sell drugs in rural towns and cities using dedicated mobile phones or 'lines'.

Sheila Harrison emphasised the importance of staff's responsibilities in regards to information governance.

It was noted that there is an ongoing safeguarding case within this Clinical Board and Alun Morgan will present this as a patient story to a future meeting.

Action: Alun Morgan

CDTQSE 18/024 Health and Safety Issues

Medical Devices Alerts will no longer be issued by the Health and Safety department and will now be issued from Procurement.

CDTQSE 18/025 Regulatory Compliance and Accreditation

It was noted that Physiotherapy and Radiology staff are due to re-register this year.

The Clinical Board has recently been subject to a number of regulatory inspections, including visits from the HTA in Cellular Pathology and MHRA in Blood Transfusion and Pharmacy.

The Clinical Board is looking to set up a separate Regulatory Compliance Group to monitor actions that fall out of inspections. The new Group will report to this Sub-Committee.

CDTQSE 18/026 Policies, Procedures and Guidance

Alun Morgan will ask Lesley Harris for an update on the status of the Non-Medical Referral Policy for Diagnostic Imaging.

Action: Alun Morgan

EFFECTIVE CARE

CDTQSE 18/027 Clinical Audit

Alexandra Scott reported that the number of audits being registered in the Health Board are significantly fewer than the activity being undertaken. An IT solution is being put in place to help monitor and track audits.

In March 2018, the Clinical Board will be asked to produce an audit programme.

Research and Development

A key aspect of work being taken forward by the Clinical Board R&D Group is a review of the Clinical Board R&D Strategy. Grace Carolan-Rees, R&D Lead is writing the first draft.

CDTQSE 18/029 Service Improvement Initiatives

Nothing to report.

CDTQSE 18/030 NICE Guidance

There are 2 NICE guidance notifications relation to child maltreatment and child abuse and neglect that have been circulated to the Clinical Board Director that require a response to indicate that the guidance has been implemented. Alun Morgan will follow this up.

Action: Alun Morgan

CDTQSE 18/031 Information Governance

Nothing to report.

CDTQSE 18/032 Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 18/033 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Alun Morgan reported that he is undertaking a walkround of Radiology to look at room usage and check that cleaning schedules and cleaning standards reflect the usage of the room.

Following inspections of the Hydrotherapy Pools, walkrounds are also being undertaken of the hydrotherapy pools at UHW, Rookwood and the Children's Hospital.

Comments were made from the CHC during an inspection of the UHW Radiology department around the signage of the new toilet. It was recommended that it needed more clarity on who can use the toilet. A notice has been placed on the door and Rebecca Vaughan-Roberts is seeking funding for a new sign to be ordered.

CDTQSE 18/034 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Baseline audits for sensory loss have been completed by directorates.

TIMELY CARE

CDTQSE 18/035 Initiatives to Improve Access to Services

Alun Morgan reported that positive equality and diversity work has been undertaken in Speech and Language Therapy relating to transgender patients. They now operate a self-referral service for Trans people who find it difficult to access speech and language therapy services through the usual referral routes.

CDTQSE 18/036 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Nothing to report.

INDIVIDUAL CARE

CDTQSE 18/037 National User Experience Framework

Positive comments from patients were noted in the December report for the Radiology and Outpatients departments.

STAFF AND RESOURCES

CDTQSE 18/038 Staff Awards and Recognition

It was noted that nominations for the UHB Staff Recognition Awards are now closed.

Robert Bracchi reported that Professor Routledge was awarded a CBE in the New Year's Honour's list. The Clinical Board congratulates Professor Routledge on his honour and his outstanding work on behalf of the Cardiff and Vale UHB.

CDTQSE 18/039 Monitoring of Mandatory Training and PADRs

Nothing to report.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

Outpatient/Patient Administration and Media Resources directorates' QSE Minutes 14.9.17 were **RECEIVED.**

ANY OTHER BUSINESS

It was requested that the closure form for the Mortuary incident to be presented at the next meeting.

Action: Sue Bailey

DATE AND TIME OF NEXT MEETING

14th February 2018 at 2pm in the Council Room, UGF, UHW

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING
15th March 2018
Seminar Room, Hafan y Coed, Llandough Hospital

Present:
Jayne Bell, Lead Nurse Adult Mental Health (Chair)
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Owen Baglow, Clinical Lead for Quality, Safety & Governance
Elizabeth Bowring-Lossack, Mental Health Lecturer, Cardiff University
Jodie Broad, Student Nurse Oak Ward
Lisa Crump, ANP Adult In-patient
Louise Flynn, Senior Nurse Manager, MHSOP In-Patient
Steve Ford, Lead CPN Pentwyn CMHT
Heather Hancock, Interim Directorate Manager Adult MH
Natalie Hulbert, Professional Practice Development Nurse
Robert Kidd, Consultant Psychologist
Lisa Lane, Senior Nurse Manager, MHSOP Community
Christopher Lewis, OT Links CMHT
Mike Lewis, SIMA Trainer
Tracey Lewis, Lead CPN, West Vale CMHT
Deepali Mahajan, Consultant, Gabalfa CMHT
Nick McAndrew, Deputy Ward Manager, Oak Ward
Mary Morgan, Senior Nurse Manager Adult MH
Bala Oruganti, Consultant Psychiatrist Crisis Team
Kelly Panniers, ANP Adult In-patient
Tara Robinson, Senior Nurse Manager Rehab & Recovery
Jayne Strong, ANP Rehab & Recovery
Ian Thomas, Ward Manager, Meadow Ward
Mark Warren, Senior Nurse Manager Criminal Justice Service
Aron White, Professional Practice Development Nurse
Rachel Wicks, CPN, West Vale CMHT
Justin Williams, Team Leader South Crisis Team
Harriet Woods, CPN Links CMHT

Apologies:
Jayne Tottle, Director of Nursing Mental Health
Philip Ball, Interim Senior Nurse Manager, CMHTs
Des Collins, Ward Manager, Pine Ward
Adeline Cutinha, Consultant Psychiatrist, Gabalfa CMHT
Mark Doherty, Lead Nurse MHSOP/Neuro
Alison Edmunds, Concerns Co-ordinator
Catherine Evans, Patient Safety Facilitator
Ruth Evans, Lead CPN Links CMHT
Mike Ivenso, Interim Clinical Director MHSOP
Annie Procter, Director Mental Health
Andrea Sullivan, Concerns Co-ordinator
Ian Wile, Director of Operations MH
Jo Wilson, Directorate Manager MHSOP

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting and introductions were made.
Chair explained that object of this meeting is to learn from the reviews of serious incidents, to identify areas of good practice and exchange ideas. The meeting will look to see if things have gone wrong but with a no blame culture. Managers will hopefully take these findings to their teams if relevant.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

No Actions.

PART 3 : CLOSURES

3.1 RW

RW had a long standing history of depression and had previously taken overdoses.

RW held a professional role and therefore contact was often difficult due to a busy work life and not being available during the day. RW wanted to be seen at the Community Mental Health Team premises as opposed to the home address. RW was having a difficult time in work as the work load had increased. RW relied upon alcohol to manage emotional wellbeing and life stresses.

RW had limited support networks - RW's father had died and RW's mother was living abroad. RW's children were living with their father.

RW's mood was low. RW was tearful and distressed by situations. RW was very upset as she had resigned from her job and was worried about financial difficulties. RW stated that she would not take an overdose but had researched suffocation as a method to end her own life. Medication was increased in response to RW having suicidal thoughts. A referral to the Crisis Team due to increased potential of risk was considered but RW was alarmed at the suggestion. The increased risk was acknowledged and felt that it was more reactive to day to day stresses rather than driven by a significant depressive situation, and varied with alcohol consumption and was therefore difficult to manage. RW refused a referral to the Entry to Drug and Alcohol Services (EDAS). RW was made aware of the Duty system.

It was very sadly reported that the Police had been called to RW's home by neighbours as they had heard the dog barking for a long time. When the police entered the property they found RW deceased. Cause of death was asphyxiation due to a plastic bag secured over the head.

Issues identified:

- RW could not engage with a CPN as working 5 days per week.

It was suggested that an alternative support service may have been able to engage with RW outside of normal work hours - the weekend CPN or Crisis Team could possibly visit.

- Throughout CPN involvement there was no record of domiciliary visits to assess the home situation, as RW had wanted to be seen at the Community Mental Health Team premises.

The Group considered that if the home was visited more knowledge may have been gained.

- RW's profession and training may have helped RW to present as very controlled and boundaried in her interactions.

There was discussion regarding the issue of dealing with a professional person and if this could cause difficulty to assert or force contact with other services. Should staff have been more assertive in referring to other services?

- The Psychologist had been off work through sickness for a prolonged period and there had been no additional cover.

It was noted that a Psychologist was starting in the Community Mental Health Team next week.

- Denies suicidal thoughts

It was acknowledged that some clients deny suicidal thoughts but they do have them. Some clients prefer to be guarded.

Conclusion

It was the opinion of the reviewers that although there are some learning opportunities within this case these are not likely to have impacted upon the outcome of this very sad event.

Philip Ball, Acting Senior Nurse Manager Adult Community MH is looking at a standard tool for supervision and how to monitor case loads. The community services review will also help with addressing some of the capacity issues in the team that were discussed today.

TO CLOSE.

3.2 JH

JH has a diagnosis of Paranoid Schizophrenia; his symptoms are exacerbated by illicit drug use. He has a history of poor compliance with prescribed medication. When unwell, JH's violence will escalate from lower level violence to quite extreme assaults. All his attacks on others are very unpredictable and unprovoked.

The Police transferred JH to Hafan y Coed, Llandough Hospital following violence to his mother and trying to jump from her moving car. He had been non compliant with his medication, taking illicit substances.

After several months at Hafan y Coed, JH attacked a female patient who was 19 weeks pregnant in the garden of Oak Ward, Hafan y Coed and then immediately on re-entering the ward area carried out a sustained violent assault on a male member of staff.

Three months prior to the incident, JH was being considered for rehabilitation services and appeared to be compliant with his prescribed Clozapine. During this time, JH was having periods of leave at home with is mother, sometimes for as long as 5 days. When he returned to Hafan Y Coed he slept out on other wards frequently due to bed pressures, which JH was amenable to.

JH had three Consultants during his admission. Due to compliance issues one of the Consultants changed JH's medication to Clopixol depot. JH's Clozapine was reduced and Clopixol slowly increased over coming weeks.

Issues Identified:

JH often went on leave and slept out on other wards on return to Hafan y Coed making it difficult for any team (parent ward or other) to truly assess his mental state and risks.

No PICU (Psychiatric Intensive Care Unit) referral was made.

The root cause of this incident was identified as a change in medication, reducing Clozapine and starting a depot. Clozapine appears to be the medication that has the most beneficial impact on JH's mental health.

Recommendations identified following completion of review:

PICU referral process to be rolled out to treatment wards,

Suggestion that the CPN attends ward round as a link between community and in-patient. Jayne Bell said she is hoping the new Community Services Pilot /Model will do this.

Good Practice

Incident management.

Appropriate allocation of resources and transfer to low secure ward.

Maintained all staff and JH's safety

Conclusion

Post incident, JH was transferred to Maple ward and placed on observations with extra male staff from other wards. He is now on Elm ward and is currently being managed by the low secure team. JH is now fully re-commenced on Clozapine.

JH is waiting for supported accommodation

Lessons Learned:

Action Plan required to see what can be put in place to prevent assaults whilst looking after the patient. Mary Morgan and Robert Kidd will complete the Action Plan.

TO CLOSE.

3.3 CW

CW has a history of illicit drug use and alcohol use, which includes a 16 year history of crack cocaine use and a 9 year history of heroin use. CW was supported by Community Mental Health Teams and referred to Entry to Drug and Alcohol Services (EDAS).

During CW's in-patient admission between September 2016 and January 2017, three incidents occurred which were reported to Welsh Government as Serious Incidents:

Incident 1
CW was discharged from Section 2 Mental Health Act with a strict management plan. CW had agreed to stay informally whilst accommodation was being arranged. CW requested unescorted leave and agreed to be back in hospital by lunch time. A phone call was received from the police at 16.15 hours; CW had jumped / fallen from a 6 metre high roof after consuming alcohol. There was no loss of consciousness and she walked into A&E, University Hospital Wales. Injuries sustained included a stable T4 fracture, a L4 fracture, a fractured sternum, and lacerations to her scalp which required staples. CW returned to Hafan Y Coed the next day.

Incident 2
CW self lacerated with a razor blade which she stated was passed to her through the fence from Oak Ward garden. CW required transfer to Morriston Hospital for treatment.

Issues Identified/Lessons Learned

Since this incident all wards have been issued with metal detector wands to search patients for potential harmful objects on entry to each ward. Wands should routinely be used to check patients on return to the ward from leave.

The fence between the gardens has gaps around the gate areas therefore items are able to be passed through. Maintenance department have obtained quotations to remedy the fencing.

Incident 3
CW absconded from a nurse escort whilst on escorted leave. Later that day police informed hospital staff that CW had jumped off a car park. CW sustained fractures to her ankles, as well as thoracic and lumbar spinal fractures and required admission to a trauma ward.

Issues Identified/Lessons Learned

The nurse escort took CW on escorted leave without a mobile phone – staff are not allowed to take their own personal mobile phones. It was noted that ward managers were allocated mobile phones but they have gone missing. Adult Directorate have ordered replacements mobile phones for escorting staff to use when out on leave with patients

There is a Missing Persons Policy but there is no formal guidance on escorting patients.

Recommendations:

A Guidance on escorting patients should to be completed which will incorporate the assessment of patients prior to leave, as often leave is written as "at the discretion of nursing staff" and also guidance on how staff should call for assistance if required if not within the range for pinpoint emergency call system to work. The Guidance should form part of the nurse induction.

Action: A flowchart will be produced (by Jayne Strong, Aron White and Nick McAndrew) to include assessing the patient prior to leave being agreed; the reasons for leave and reasons for escort; and the procedure if the patient absconds.

TO CLOSE.

3.4 GS

GS has a long standing diagnosis of schizophrenia and has some history of suicide attempts.

GS had been prescribed Fluphenazine for a number of years. In early 2017 it was noted that he had Tardive Dyskinesia and a discussion was held with him where he agreed to consider converting from a depot antipsychotic to oral medication. Subsequently his medication was amended a number of times during 2017 before the depot was finally stopped in October 2017. In its place Aripiprazole had been initially prescribed but this was replaced by Risperidone as GS felt Aripiprazole was not suiting him.

In December he experienced some difficulties at times but these again appeared to resolve spontaneously when assessed by the crisis team. He took an overdose of his medication in December. He required hospital admission to the Poisons Unit and was then transferred for haemodialysis for acute kidney damage. He also contracted influenza B whilst in hospital for which he was treated.

Having made a good recovery he was discharged from the medical ward and admitted to Hafan y Coed where he was stabilised once more. GS was discharged home in January and is currently maintained on Risperidone depot.

Issues Identified:

Stress factors – financial difficulties. GS was helped to complete a payment plan for rent arrears.

GS needed a daily structure. GS was helped with his diet and appointments.

Good Practice:

The overdose was an impulsive act that would have been difficult to predict or prevent due to his changeable presentation. Not predictable.

Crisis team would not have done anything different at any stage.

Crisis team assess then refer to other services if appropriate; they also sit in on any second assessment.

4.0 DATE OF NEXT MEETING

10th May 2018 at 9.30am in the Seminar Room, Hafan y Coed.

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

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE held at 1.30 pm, 9th January, 2018 in PCIC Meeting Room 1, CRI

Present

Gareth Hayes (GH) (**Chair**)	Clinical Director Clinical Governance
Kay Jeynes (KJ) (Vice Chair)	Director of Nursing PCIC
Anna Kuczynska	Acting Clinical Board Director
Anna Mogie (AM)	Lead Nurse, North and West Cardiff
Ceinwen Frost (CF)	Lead Nurse Vale Locality
Helen Earland (HE)	Senior Nurse PC
Helen O'Sullivan (HO'S)	Quality and Safety Manager
Karen May (KM)	Head of Medicines Management
Matthew McCarthy (MM)	Patient Safety Facilitator
Nicky Hughes (NH)	Lead Nurse S&E Locality
Nicola Evans (NE)	Head of Workforce and OD
Paula Cornelius (PC)	Integrated Manager, Vale Community Resource Service
Sarah Griffiths (SG)	Head Of Primary Care
Sue Morgan (SM)	Director of Operations
Rachel Armitage (Minutes)	Acting PCIC Quality and Safety Officer

By Invitation

Ruth Cann	Nurse Team Lead, South and East Locality Team (for Patient Story)

Preliminaries		**Action**
01/18/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Chair.	
01/18/002	**APOLOGIES FOR ABSENCE** Maria Dyban, Rhian Bond & Denise Shanahan	
01/18/003	**DECLARATIONS OF INTEREST** GH asked for any declarations of interest – none noted.	
01/18/004	**MINUTES OF THE PREVIOUS MEETING HELD 14 NOVEMBER 2017** The minutes of the previous meeting were recorded as accurate **SUBJECT TO** minor grammatical amendments to be made by KJ. **Matters Arising** Page 9: GMS Branch Surgery Visits – to be added to the agenda for the	**KJ** **RB**

	March 2018 meeting Page 10: Consent Annual Audit – to be added to the agenda for the March 2018 meeting	**NH**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
The agenda was re-ordered.		
01/18/ 005 Agenda item 6	**PATIENT STORY – NORTH AND WEST LOCALITY** Ruth Cann presented a story regarding demonstrating admission avoidance. The patient, Mr D, was a 75 year old gentleman with encephalopathy on a background of complex medical conditions and under the care of 5 secondary care Consultants. He was living at home with his wife as his main carer, assisted by a very supportive family. He was referred to the Community Resource Team (CRT) by his GP and District Nurses for urgent help after becoming unresponsive. Mr D's condition was variable with very unpredictable episodes of up to 24 hours of unresponsiveness and double incontinence between periods of independence. When well, Mr D would refuse the provision of equipment and professional support so that during relapses the family called 999 for emergency admission. Despite being eligible for Continuing NHS Healthcare, no agency could be identified which could manage Mr D's complex needs. The CRT developed a plan to ensure Mr D's safety at home and prevent a reactive response as admission was inappropriate. All specialisms providing care for Mr D were co-ordinated and agreed an Advanced Care Plan with an escalation point set at 24 hours of unresponsiveness. CRT Nurses, District Nurses and Age Connects Carers supported Mr D and his family. The co-ordinated partnership approach prevented at least 6 admissions over a 6 month period. The story demonstrated the importance of considering what really matters to the patient and family, tailoring support to individual needs, and supporting the carers and family as well as the patient. The Chair welcomed the flexible provision demonstrated by the patient story, noting the difficulties experienced when the family's needs differ from the patient's, especially during end of life care. AK welcomed that the CRT did not give up until a solution had been devised that was suitable for both the patient and his wife. (Ruth Cann left the meeting.)	
01/18/ 006 Agenda item 11.2	**INFORMATION GOVERNANCE (IG) AUDIT RESULTS** **Vale Community Resource Service** PC summarised the actions taken following one team member losing a diary containing many personally identifiable and confidential details including patient key safe codes.	

22.3

	An IG Standing Operating Procedure for the Vale Locality had been devised with the guidance of the UHB Information Governance Manager, which had been shared with other CRT Managers. This was supported by an audit of staff diaries which found lack of adherence to some parts of the procedure. Consequently an action plan has been developed and a follow-up audit will be carried out in March 2018. **Cardiff Community Resource Teams** PC shared the results of an IG audit in the two Cardiff teams. Induction processes have been updated to include new procedures and a diary review will be included in each supervision session. The teams will be re-audited in March 2018. KJ confirmed that there had been a number of IG breaches in the last few months; the planned repeat audits were welcomed by KJ and GH. NE agreed to re-circulate the IG briefing and remind staff of the requirement to complete IG training.	**NE**
01/18/ 007 Agenda item 5	**PCIC CLINICAL BOARD QUALITY AND SAFETY GROUP ACTION LOG** The Clinical Board (CB) Quality and Safety group action log was reviewed. Members noted the content. The following points were discussed: **Cold Chain SI** KJ confirmed that the Guidance on Vaccine Ordering, Handling and Storage; Fridge Temperature Breach Information Request and Protocol for Cold Chain Monitoring had been authorised and circulated; Primary Care teams were asked to remind Practices to send notifications through when breaches occur. The learning and Protocol have been shared across the Health Board, linking with national and UHB work streams. GH highlighted that other drugs also require refrigeration which should be included in the Protocol. KM confirmed that learning has been shared with Pharmacists, Dentists and Opticians. **Quality Dashboard** The dashboard would be discussed as agenda item 13. **South and East Locality Pressure Ulcers** This action has been completed. **MSSA bacteraemia template** KJ will present the completed template to the March 2018 PCIC QSE meeting.	**KJ**

	Point of Care Testing KJ and SG will review POCT in Primary Care services. GH highlighted that the UHB has recently made recommendations as to which monitors to use and the need to make this clear to Practices. **ACTION**: meeting to be arranged with the POCT team, SG, KJ and Emyr Stephens (Prescribing Advisor) by early February.	**KJ**
	Western Vale Boundary Issues This item is complete.	
	CHAP Service Model and Staffing This subject will be added to the March agenda of the PCIC QSE meeting.	**KJ**
	Procurement Log/Complex Care Packages This item has been completed.	
	CRT Audit This item has been completed.	
	C. diff Trends This item will be included in discussions on the PCIC Quality Dashboard, agenda item 13.	
	AMR Plan Work continues on the plan; further guidance is awaited from Welsh Government (WG) on the urinary tract infection pathway. A further update will be provided at the March PCIC QSE meeting.	
	11/17/006, 11/17/011 HCS Action See agenda item 15.	
	11/17/06 HIW/Branch surgery recommendations The action plan has been developed and will be brought to the March meeting of the PCIC QSE for formal authorisation.	
	11/17/06 OOH IT issues To be discussed under item 7, Risk Register.	
	11/17/08 Risk Register See agenda item 7	
	11/17/008 District Nursing Risk KJ confirmed that a paper had been submitted to the UHB Executive Director of Nursing in w/c 1 January 2018.	
	11/17/009 SI Log See agend item 8.	
	11/17/009 Datix management This item can be removed from the action log.	

22.3

	11/17/013 HIW Reports – General Practice and Dental Action Plan See agenda item 23. **11/17/013 Older Person's Commissioner** This item has been completed. **11/17/016 Consent Annual Audit** Feedback will be provided to the March meeting.	
01/18/ 008 Agenda item 7	**RISK REGISTER (RR)** GH recommended that new items added should be made easily identifiable. KJ agreed to produce a summary snapshot in line with those produced for Executive Performance Reviews. **QS&E 000214 OOH** Risk escalated from 4 to 5 over Christmas relating to volumes of patients rather than staffing levels. KJ confirmed that the GP OOH team reviews activity, demand and performance against targets daily; demand has increased more rapidly than had been predicted. KJ remains confident that the GP OOH team reviews activity and learning and communicates this appropriately with GPs and patients, highlighting positive communications work which had taken place over the Christmas period. AM recommended data analysis to determine the impact of the 4-hour redirection or referrals from the service. KJ noted the regional pressures including WAST experiencing 24 hour delays for conveyance of patients. GH recognised that the GP OOH team had worked very well to manage the challenges and SM highlighted that the service had remained open through the period despite huge challenges. KJ highlighted that the Chief Operating Officer had recognised the good work across the Health Board which has been communicated out to teams. GH and KJ confirmed that work on anticipatory care drugs is under way with in - hours GPs as this was flagged as an issue following the data analysis. **QS&E 000113 Independent Sector** Risk tolerated. **QS&E 020714 CHAP** To remain on RR until next PCIC QSE meeting; revised staffing model is required. **QS&E 160714 Patient Flow** Trial currently under way of the "Perfect Week"; report will be produced on completion. Item to remain on RR. **QS&E 160714 Equipment/JES** Significant improvement has been made and the risk level reduced, this risk is to be removed and transferred to the JES Board. **PCIC 110914 Complex Packages of Care** Risk to be reduced to 16.	**KJ** **KJ**

	PCIC 160614 Primary Care Estates Development Risk remains at 20. Improvement grants need to be matched with population growth, the Integrated Medium Term Plan (IMTP) and workforce plans. **PCIC 0814 Local Development Plan** This has been submitted for inclusion in the IMTP. Awaiting authorisation to progress to Business Case stage. **PCIC 051114 District Nursing Risk** Escalation levels remain consistent RAG rating 3-4 across the Localities. KJ has submitted a paper on District Nursing investment principle to the Executive Nurse Director January 2018. **PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainabilty** The Community Health Council (CHC) has been unsupportive of the CB plans. SM confirmed that she will convene an extraordinary meeting of the CHC, UHB Chief Executive and UHB Director of Strategic Planning to share with the CHC the new context of Primary Care services. There will also be a number of workshops in February 2018 to examine short and longer term sustainability. **PCIC 10.03.16 Pressure Ulcer (PU) Prevalence** KJ confirmed that this item remains on the RR owing to the increased scrutiny of pressure damage grade 3 and 4 which is now mandated to be reported as a serious incident (SI). It is necessary to flag on Datix that a grade 3 and 4 PU could be a possible SI; subsequent investigation will determine whether it will be classified and treated as a SI. AM highlighted the lack of capacity to carry out proper investigations. Risk tolerated. **PCIC18.05.16 Domiciliary Care Provision** Position has improved slightly but demand over Christmas caused deterioration in provision. Risk tolerated. **S&E 05.12.16 HMP Cardiff – Prescribing, Staff Stress, Enviroment** Authorisation for a post to be re-advertised is awaited. **S&E 06.01.17 HMP Mental Health Provision** Position remain the same and requires discussion with Mental Health at Clinical Board level. SM agreed to follow this up with Ian Wile. **N&E 10.01.17 Cardiff CRT Medication Administration Procedure** There remains a lack of clarity around the role of the CRT carers. A meeting with Social Service colleagues is being arranged. **N&W 15.03.17 DN Workload Allocation** This item can be removed from the RR. **VL 29.07.17 Change of phone lines** This position may change once three teams move; CF agreed to check what will happen with telephone numbers when the move takes place.	**SM** **SM** **CF**

	CHC 11.08.17 CHC Commissioning group Progress is being made; consideration to be given to amalgamating this risk with the Independent sector Risk. **PC 14.09.17 and PC 11.11.17 Cathedral View** These items can be removed from the RR. **PC141117 GP OOH IT issues** Improvement work is ongoing; item to remain on RR.	
01/18/ 009 Agenda item 8	**SERIOUS INCIDENT LOG** **8.1 Current SI's** HO'S confirmed that 2 SIs remain open; one is a new PU and one relates to GP OOH. Both remain within the correct timescale for management. **8.2 Medication Errors** KJ confirmed that these are included within Datix reporting and that she reviews every case. There is an insignificant number of errors with no significant themes. It was confirmed that all necessary action is being taken. **8.3 Datix report** KJ confirmed that this report can be run within Locality Datix accounts and highlighted that there are improvements in some areas while noting the challenges of closing incidents down when information is awaited from other Clinical Boards. KJ will meet MM to discuss this. MM agreed to circulate to Lead Nurses instructions on how to produce reports by incident manager. Formal thanks were extended to HO'S and John Webber for their excellent work in managing incident closures. HO'S agreed to produce a report for the PCIC QSE, Medical Director and LMC. **8.4 Closure summary, incident number In39618, 830024 January17** This was shared with colleagues for noting and to share the learning about the adverse effect of antibiotics on Clozapine. KJ confirmed that this information had been submitted to CPET for feedback to GP's as per recommendations.	**KJ** **MM** **HO'S**
01/18/ 010 Agenda item 9	**RISK ESCALATION REPORTS** **Cold Chain Breach** KJ confirmed that the Cold Chain procedure had been authorised and was presented for noting. **GP OOH Closure** See discussion above, 01/18/008, agenda item 7. **EMIS** This further risk was escalated to the meeting by KJ on behalf of N&W Locality; advice to the Locality was to share the risk escalation document with Allan Wardhaugh AMD for IT.	**AM**

01/18/ 011 Agenda item 10	**SAFETY NOTICES AND IMPORTANT DOCUMENTS PROCEDURE** These items were presented for noting.	
01/18/ 012	**BUSINESS UNITS QS&E MINUTES** KJ confirmed that these were presented for accepting and noting. Colleagues were requested to place team minutes in the central folder to enable KJ to check and sign off the minutes outside the PCIC QSE meeting. PC Minutes were outstanding	**RB**
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
01/18/ 013	**QUALITY DASHBOARD** GH confirmed that the dashboard was being developed to enable a reduction of the number of papers to consider at PCIC QSE. The dashboard is a dynamic document and remains under development and review.	
SAFE CARE		**Action**
01/18/ 014	**HCAI REPORT AND ANTIMICROBIAL DELIVERY PLAN** KJ confirmed that the plan will be brought to the March PCIC QSE meeting. KJ summarised the HCAI report and confirmed that it has been reviewed both within the clinical board and at Executive performance review. She highlighted that WG expects the plan against target areas, while the challenge for Primary Care is that infection remains a population issue. It was confirmed that further work is required on E. coli and MSSA bacteraemia; a template for MSSA will be developed similar to that for C. diff. KJ highlighted the challenge of managing urinary tract infection and Ecoli target; a great deal of scoping work had been undertaken through the clinical boards Reducing Ecoli Task and Finish group. The group is still awaiting the revised UTI pathway from Welsh Government which will then require authorisation from the UHB MMG before it can be implemented.	**KJ**
01/18/ 015	**HEALTH AND CARE STANDARDS** KJ confirmed that significant progress has been made against the standards from last year. RA will circulate the plan to Lead Nurses and Primary Care for updates prior to submission of the document to the Patient Safety Team and subsequent review at every PCIC QSE meeting. Formal thanks were recorded for all the good work that had been undertaken. HCS submissions are required from each Clinical Board in February 2018	**RA**
01/18/ 016	**LOCALITY PRESSURE ULCER REPORTS** AM summarised the North and West Locality PU report and confirmed that it is now possible to identify residential homes against PUs, which enables proactive work relating to nutrition and mobility.	

	The reports were noted for information. It was highlighted that that some pressure damage is repeat reported and recommended that the Datix help desk can assist in identifying duplicate reports. Colleagues were advised to provide as much contextual information as possible with each report.	
01/18/ 017	**CONCERNS REPORT** No report received.	
01/18/ 018	**RCA RECOMMENDATIONS: SURGERY CLINICAL BOARD** Report shared for information, noting the significance of detailed and clear handover and communication between teams.	
01/18/ 019	**REVIEW OF THE DISTRICT NURSE (DN) MEDICATION ADMINISTRATION CHART PILOT** CF confirmed that the insulin chart had been brought to the PCIC QSE for consultation and highlighted that the process will be piloted with 5 GP Practices in the Vale of Glamorgan.	
01/18/ 020	**MEDICAL EQUIPMENT ISSUES** None to report.	
	EFFECTIVE CARE	**Action**
01/18/ 021	**21.1 Cariad Research study – Marie Curie – exploring informal carers administering EOL medications to family members** This project has been given approval. **21.2 Community Catheter Survey Update** Data input is continuing. **21.3 Implementation of key NICE Guidance** For noting. **21.4 Guidance on Vaccine Ordering, Handling and Storage** For noting. **21.5 Protocol for Cold Chain Monitoring** For noting. **21.6 Fridge Temperature Breach Information Request** For noting.	
01/18/ 022	**ASEPTIC NON-TOUCH TECHNIQUE (ANTT) UPDATE** KJ highlighted that implementation of ANTT is variable and that a consistent approach is required. Colleagues were requested to identify facilitators in all departments to ensure that all staff are assessed and competent. It was emphasised that DN teams should not be using alcohol gel; wipes	**LNs**

	must be used. KJ thanked Teresa Neate, Jane Britten and Lynne Cronin for their excellent leadership in delivering training to staff both employed by the UHB and staff within General practice.	
DIGNIFIED CARE		**Action**
01/18/ 023	**HIW REPORTS - GENERAL PRACTICE AND DENTAL ACTION PLAN** HO'S confirmed that a new flow chart has been developed which requires agreement. A further update will be provided to the next meeting of PCIC QSE. HO'S confirmed that there have been 2 GMS inspections since the last PCIC QSE meeting, along with one dental inspection for which the action plan is awaited. KJ recommended that the HIW report should be revised and updated for presentation to the next PCIC QSE meeting.	**H O'S**
01/18/ 024	**FRAGILE PRACTICE UPDATE** SG confirmed that, as previously agreed; Practices which score red and amber will receive sustainability support. This work will be commenced soon by the Practice Development Team. A protocol has been developed to examine contractual compliance and allow Practices to feed back their concerns. Reports on the outcomes will be presented to PCIC QSE along with consideration of whether the methodology is fit for purpose. A lot of work has been done to improve sustainability with the objectives of being helpful to the Practices and providing assurance to the UHB. It was noted that it is possible that HIW will also visit any Practices; in that instance the Practice Development support work will be linked with the HIW report so that the Practices only have to provide information on one occasion.	
01/18/ 025	**GMS BRANCH SURGERY VISITS NOVEMBER TO DECEMBER 2016** This report was deferred to the next meeting of PCIC QSE.	
TIMELY CARE		**Action**
01/18/ 026	**SAFEGUARDING** **26.1 Safeguarding Update** KJ reported that the Clinical Board had scored reasonably well against the annual Safeguarding Standards assessment, noting that there had been changes to the advice given to independent contractors about the level of training required. It was noted that domestic violence now comprises part of the mandatory training suite, noting the challenge of ensuring all Practices undergo the training. It was highlighted that there is good interface with the Local Authorities regarding adults, but improvement is required for safeguarding children. Colleagues were reminded that Judy Hunt is the PCIC link in the Corporate Safeguarding Team.	

	26.2 Annual Self Assessment – Health Care Standards: Safeguarding Children and Safeguarding Adults at Risk April 2017 HO'S summarised the recommendations of the domestic homicide review, noting that the CB is reasonably compliant, action plan is in place and being progressed.	
INDIVIDUAL CARE		**Action**
01/18/ 027	**MANDATORY TRAINING UPDATE** It was noted that the mandatory training rate for clinical boards staff are reported within the Dashboard. Mandatory study compliance was over 80% for the UHB and Business units are to be congratulated for their excellent work. KJ confirmed that the December rate will be circulated to the localities and highlighted that the Executive Director of Workforce and Organisational Development is currently reviewing which staff are required to follow which training units. **27.1 Dementia Update** KJ agreed to circulate the dementia plan to all Business Units for updating. It was highlighted that dementia champions are required in all areas. **27.2 Mental Capacity Act Leads Update** KJ agreed to circulate the update provided by the Mental Capacity Act Manager. She highlighted that the UHB Mental Health and Capacity Legislation Committee had recommended that Clinical Boards should review compliance with DNACPR instructions which will be supported by a Grand Round on the topic. The PCIC Clinical Board will therefore need to carry out an audit of the use of the Mental Capacity Act, Independent Mental Capacity Advocates and Best Interest decisions and it will be necessary to record the outcomes of Best Interest decisions and patient mental capacity on PARIS. District Nursing MCA audit is to be presented to the March QS&E committee.	**22.3** **KJ** **KJ** **RA**
STAFF AND RESOURCES		**Action**
01/18/ 028	**PCIC STAFF TURNOVER/RECRUITMENT AND RETENTION ISSUES** NE referred to the data included in the Quality Dashboard, confirming that vacancy rates had been reduced but remained high. Work continues to review vacancies in line with the established 3-month time frame and the Cost Reduction Programme. It was confirmed that a report into nurse productivity will be produced, and there had been positive responses to advertisements for Band 5 vacancies in the DN and Prison teams. Retention and turnover remained challenging, with people leaving for reasons of work life balance, age and promotions. The staff survey will be used to improve engagement and a tool will be developed to support Localities. It was confirmed that, although turnover remains high	

	compared with other CBs, measures are in place, the hot spots are well recognised and the current position is the best it has been for 2 years.	
SUB-GROUP REPORTS		**Action**
01/18/ 029	**29.1 GP OOH Business Unit** Issues discussed above. **29.2 Vale Locality** CF highlighted the result of the mobile phone upgrade and Western Vale Netbook coverage, noting that improved connectivity is expected early in 2018. **29.3 Cardiff South and East Locality** It was confirmed that the Butetown DN team remains fragile. An in-depth establishment review has been completed. In response, one whole time equivalent nurse will be transferred from another team to bolster the Butetown team. Challenges were noted for the Rumney team which continues to have 3 staff on long term sick leave. In addition, 4 residential/nursing homes are being closely monitored in response to concerns. **29.4 Cardiff North and West Locality** A medication error is being managed through the capability process. A meeting with a new provider has been set up to gain assurance on concerns about new arrangements. **29.5 Pharmacy and Medicines Management** KM confirmed that a new cluster pharmacist had commenced service in Cardiff North; support will be provided to allow a balanced working life and reduce isolation. **29.6 Palliative care** Colleagues were asked to note the number of patients for whom support is being provided simultaneously within the community setting. The DN and SPC teams are working to the maximum it can achieve at between 60 and 70 patients actively EOL across Cardiff and the Vale of Glamorgan; this is having an impact on all services.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		**Action**
01/18/ 030	**CMO UPDATES** CEM/CMO/2017/6 – Influenza Season 2017-18: **Use of antivirals** now recommended in line with NICE guidance. CEM/CPhA/2017/10a –Drug Alert Class 4: **Kyowa Kirin, Bleo-Kyowa (Bleomycin),** PI 16508/004 CEM/CPhA/2017/12 – Drug Alert Class 2, Action within 48 hours, Pfizer Ireland Pharmaceuticals, **Lipitor (Atorvastatin) 80 mg** Tablets/Atorvastatin 80 mg Tablets in Almus Livery CEM/CPhA/2017/13 – Drug Alert Class 4: **Shire, Buccolam Oromucosal Solution Pre-Filled Syringes**	

22.3

	2.5 mg, 5 mg, 7.5 mg and 10 mg, Eu/1/11/709/001; Eu/1/111/709/002; Eu/1/11/709/003; Eu/1/11/709/004 CEM/CPhA/2017/13a – **Gadolinium Contrast Agents** and Risk of Tissue Accumulation Removal of Omniscan and Intravenous Magnevist from February; Restriction to use of other Linear Agents CEM/CPhA/2017/14 – Drug Alert Class 4, for information, **Wockhardt UK Ltd, Co-Amoxiclav 1000 mg/200 mg Powder** for Solution for Injection or Infusion CMO Update 90: December 2017 **MEDICAL DEVICE ALERTS** MDA/2017/035 – **Nasogastric (NG) feeding tubes** – recall due to risk of neonatal or paediatric patient choking on ENFIT connector cap **WELSH HEALTH CIRCULARS** WHC (2017) 051 – Raising Awareness of **Carbon Monoxide Poisoning** and Action Required by Health Professionals WHC (2017) 052 – Ordering **flu vaccine** for the 2018-19 season **WELSH GOVERNMENT ADVISORY** Annual influenza vaccination (dental) **NICE GUIDANCE** NG76 – Child abuse and neglect NG79 – Sinusitis (acute): antimicrobial prescribing **INTERNAL SAFETY NOTICE AND GUIDANCE** • Clexane (enoxaparin) 40mg injection • Memorandum of Understanding for the Administration of feed and fluid via a gastrostomy tube • Bactroban (mupirocin) Nasal Ointment – shortage of supply **UPDATES FROM OTHER GROUPS** • Agenda for UHB Nutrition and Catering Steering Group December 2017 • Minutes from UHB Nutrition and Catering Steering Group September 2017 • Minutes from the UHB Safeguarding Steering Group September 2017 • Minutes from the UHB Safeguarding Steering Group November 2017 • UHB Staff flu profile December 2017 • Paediatric Single Point of Entry Newsletter November 2017 • UHB Safeguarding Team Newsletter Autumn 2017	

22.3

	ANY OTHER BUSINESS	
01/18/ 031	Nil Noted	
DATE OF NEXT MEETING		
Tuesday, 13th March, 2018, 1.30 pm – 3.30 pm, PCIC meeting room 1, CRI		

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 11th January 2018
Venue: Critical Care Resource Room

22.4

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
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
Colin Gibson, Clinical Engineer, ALAS
Rachel Barry, Lead Nurse, Neurosciences
Helen Scanlon, Service Manager, Neurosciences
Jennifer Proctor, Lead Nurse, Haematology, Immunology, TCT and Medical Genetics
Vince Saunders, IP&C
Gemma Ellis, Consultant Nurse, Critical Care
Sarah Matthews, Senior Nurse, N&T
Kevin Nicholls, Service Manager, Cardiothoracics and Critical Care
Nick Gidman, Directorate Manager, Cardiothoracics
Lorraine Donovan, Senior Nurse, Neurosciences

Present: Andrea Lowman, Consultant in Neuro Rehabilitation
Julia Barrell, Mental Capacity Act Manager
Jenny Thomas, Clinical Board Director, C&W, and Consultant, Neurosciences

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions	
1.2	Apologies for absence Received from; Ceri Phillips, Mary Harness, Anne-Marie Morgan, Maria Roberts, Lorraine Donovan, Claire Main, Carol Evans, Beverly Oughton, Orla Morgan and Lisa Morgan.	
1.3	To review the Minutes of the previous meeting 15th December 2017 The minutes were agreed as an accurate record. Matters Arising	

	Item 1.3 – SC will ask MRR for the updated minutes from the 3rd November meeting. MRR to send to GW to circulate.	**MRR/SC/ GW**
	Bare Below Elbow – 2nd Letter from NM. CF will speak to NM regarding getting this letter sent out.	**CF/NM**
	GW to arrange a meeting with Eleri Davies, CF, NM and VS.	**GW**
	HTA Disposal of Organs – SM noted that the N&T documents had been updated but that she hasn't as yet had confirmation that they have been signed off. **Action:** SM to follow this up.	**SM**
	Audit Plans – **Action:** Any Directorates who haven't as yet sent their audit plans to CF to send to her after the meeting.	**Dirs**
	VS confirmed that he had visited the Rookwood offices in relation to mould growing on the walls. VS has taken photos. RB confirmed that most of the work has now been carried out and the walls have been re-painted.	
	Item 2.1 – Open SIs – CF asked SC about the closure forms sitting with Patient Safety. SC confirmed that they were working through the forms. CF noted that a firm plan was needed regarding progressing these. CF referred to the pancreas case from 2012 and noted that Tony Turley and Carol Evans need to sign this off. **Action:** SC will follow this up.	**SC**
	Item 2.2 – Field Safety Notice – Vascutek Gelsoft used in Cardiac Surgery – KN confirmed that the graft is being soaked for 5 minutes prior to implantation.	
	Item 2.3 – Hoist Repairs – CF confirmed that we now have a hoist on loan. **Action**: RB to check with Procurement regarding repairs needed to our own hoists. RB to also update CG to feed back to the Medical Equipment Group.	**RB**
	Item 2.4 – HCAI – Hand Hygiene and Bare Below the Elbow (BBE) – CF confirmed that she had spoken to the same Consultant twice this week regarding their persistent lack of BBE. CF has spoken to their Clinical Director and if the issue continues it will be escalated to Graham Shortland, Medical Director.	
	Hep B case in Cardiac Surgery – CF reiterated that staff who carry out exposure prone procedures need to continue to check their status and that it is their responsibility to get regularly updated with vaccines. Most Directorates had discussed this within their areas. **Action:** Any Directorates who have not yet discussed this need to do so and inform the CB to that effect.	**Dirs**
	Item 3.2 – CMP Annual Quality Report – **Action:** CF noted that this needs to be picked up in Critical Care.	**DCM/MR/ OM/HR**
	Item 3.3 – Risk Register – moved to the February meeting as full agenda for this meeting.	**GW**
	Item 6.1 – AOB – Pacing Theatre – Leaking Pipe – KN confirmed that the leak had now been fixed.	
	New beds – ongoing concern. **Action:** CG requested that Directorates send him any relevant information around the issues with these beds in order to escalate to the Medical Equipment Group. SC noted that Matt McCarthy was looking into the issues. CG and Matt McCarthy to link in.	**Dirs CG**

22.4

	Audits – **Action:** GW to email out to the Group regarding the documentation and MCA audits required. CF confirmed that the MCA audit needed to be completed by the end of January and the Documentation Audit carried out in February.	**GW**
1.4	Patient Story – EY Andrea Lowman, introduced herself as Consultant in Neuro Rehabilitation. The patient story related to a young gentleman who had visited his doctor due to sinusitis, was given pain killers. He was subsequently found unresponsive in bed by his wife. Scan showed multiple issues – such as brain swelling, pan sinusitis, falkcine herniation and L frontal abscess. The patient never regained consciousness. He was transferred to for Prolonged Disorder of Consciousness (PDOC) assessment. Discussions were held with the family regarding ceilings of care but the continuation of life prolonging treatment i.e. nutrition and hydration were raised. Obviously the patient lacked capacity so Best Interests meeting was held. Two meetings were held between the clinicians, Clinical Board, UHB legal team, Medical Director and Julia Barrell re process that would need to be gone through. Originally it was thought that a referral to the Court of Protection would be required but that was not the case. Following the decision to withdraw treatment the patient went to the Marie Curie hospice and passed away peacefully. Issues encountered were discussed. A significant amount of work was carried out around this – seeking guidance and advice where necessary. Discussions took place around what the patient would want and around "best interest decisions". Need to follow the MCA. NM commented that he felt the case was dealt with immaculately. **Action:** AL will send the written information on what the service is able to provide to NM along with the guidelines of what is expected. Further discussion regarding Critical Care withholding/withdrawing treatment to be continued at a future meeting.	**AL**
PART 2: SAFE CARE		
2.1	PVS Covered above in Item 1.4.	
2.2	Open Inquests SC noted that the Patient Safety team hasn't as yet managed to meet with Karen Lewis, Claims Manager. JO report still being completed. **Action:** CF requested that this is finalised by the end of the month and that SC provides an update on all inquests by the next meeting. Serious Incidents (SIs) CF informed the group that there had been one new incident where a man had fallen (accidentally) on B1 and fractured his femur. Some issues related to his condition led to delay getting to theatre but did manage to. Gentleman then went back to the ward. SW confirmed that the patient has now been discharged. SI meeting held, 2 iterations of injurous falls RCA completed. Drafting closure form. Closure Forms	**SC**

	X 3 Forms signed off. - Grade 4 pressure damage to outer malleolus under plaster cast in Neuro. Patient had craniotomy and decompression after trauma injury. Could only lie on his side with cast. When the cast was taken off there was significant pressure damage. Blister grade 2. Issue that the patient wasn't on an appropriate mattress and assessments not carried out regularly. Delay referring patient to the Tissue Liability service. Actions put in place. Work around the management of patients with pressure damage and the way in which they are graded. This will be picked up in the pressure damage group. LD is our Clinical Lead on this group and will feed back on specific actions taken. CF reiterated the importance of documentation audits. Directorates to audit at least 5 patients per month with full review of all documentation - Gentleman in Haematology on end of life care with multiple myeloma developed pressure damage. Possibly caused him increased pain by following the policy too far, need to consider this going forward. This will be fed back to Linda Walker, Director of Nursing for the Surgery Clinical Board, who leads on this pressure damage group for the Health Board. - Pressure damage in Critical Care – arterial line/sacrum reported together. Now closed.	**CF**
2.3	<u>Patient Safety Alerts</u> <u>Shortage of Clexane® 40mg strength</u> Directorates confirmed no issues with this. <u>Re: Bactroban (mupirocin) Nasal Ointment</u> Manufacturing shortage of Bactroban. VS highlighted to the group that the alternative medication (Naseptin) is recommended to be used for 5 days by Pharmacy in line with the antiseptic wash even though manufacturers are recommend 10 days. SM also flagged that the alternative medication Naseptin is made from peanut oil. **Action:** Directorates must be made aware of this information. <u>MDA syringe pumps MHRA</u> CG confirmed that all pumps are being replaced. **Action:** Staff to be aware. There will be a full education programme for introduction of new pumps. <u>MDA MDA/2017/036(Wales)</u> CF noted that this alert was in relation to an incident where a patient's blood and wrist band were not checked properly and the patent was given the wrong blood. **Action:** CF requested that Directorates ensure that checks and audits are being carried out around this. **Action:** MR noted that there was a protocol in relation to this that he would send to CF and the Patient Safety team.	**Dirs** **Dirs** **Dirs** **MR**
2.3	<u>RTT Backlog clearance Neurosurgery, Neurology and Neuropsychology</u> PG informed the group that there was a backlog issue specifically within Neurosurgery. Waiting list for surgery has been over 100 weeks with a couple patients still over 100 weeks. Projected 52 weeks by end of March. In relation to patient safety the Board is now reviewing the way these patients are monitored. Need to ensure that we monitor and assess clinical condition of patients on waiting lists. It is understood that there are several incidents of patients not being reviewed. Will review and revise moving forward. NM noted that this work is about how we manage the risk. Each specialty needs to be aware of the possible deterioration from patients not being seen whilst on waiting lists. **Action:** All areas must have a process for reviewing/monitoring patients on long waiting lists. PG confirmed that she had met with John Martin, Clinical Director, Neurosurgery, yesterday and that they now had an agreed process in place.	**Dirs**

2.4	Legionella prevention measures required in Clinical Boards - Water Safety Plan - Appendix E - Letter to Clinical Boards - Little Used Outlet Flushing Evaluation and Record Documents for information and implementation. Very explicit regarding what is an underused outlet and requirements to flush.	**Dirs**
2.5	Healthcare Associated Infections Deferred to next meeting.	
PART 3: GOVERNANCE, LEADERSHIP & ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee Deferred to next meeting.	
3.2	JACIE Action Plan GJ provided an update of the action plan following the 2013 JACIE inspection. - Facilities adult programme – day unit at full capacity, it is always crowded. Funding from WHSSC for expansion. Business case submitted to Welsh Government. Using the Tenovus Mobile Unit for additional capacity. When Heulwen ward is empty it is possible that Haemophilia could move there, releasing space for the Day Unit. Needs to be discussed at SpS Major Projects Board. - Infection control management – lack of space and nowhere to isolate patients. Addressed this to an extent by moving patients to the Tenovus Unit. JP referred to a specific incident where a patient needed to be isolated and wasn't. She will raise an incident form. - Generally satisfied with TYA unit. Didn't raise any specific issues regarding Singleton. Will request their refurbishment plan. - Concern raised regarding policies and procedures. Consent form regarding BMT revised and now completed. - Concern raised regarding continuing professional development. Staff requested to undertake 10 hours of BMT training which they plan to audit. Training manual for individual records completed. - Concern raised regarding lack of SLA with Singleton. **Action:** GJ to link in with HP. - Concern programme supported by only 2 transplant physicians. Now appointed a 3rd so this issue has been addressed. Further update in 3 months.	**PG** **JP** **GJ** **GJ** **AMM**
3.3	Delivery Unit Report and Action Plan for Cardiac Surgery NG provided an update to the group. Exercise initiated by WHSSC following concern raised in relation to Cardiac Surgery waiting times being longer than recorded. Results showed that patients were waiting longer than originally thought. This was down to clerks not understanding the RTT rules. Main problem in Cardiff was in relation to the tertiary referrals which is still an issue as wrong clock start date being used due to lack of information from referring centre about exact pathway start date. This requires persistent prompting from Cardiff to ensure an accurate date is recorded. This is also an issue for some Cardiff patients where Cardiologists are not reporting the correct pathway start date. Trialling electronic system for start dates. **Action:** CF noted that this would be on the agenda every 3 months along with the JACIE Action Plan.	**GW**

3.4	Exception reports and escalation of key QSE issues from Directorate QSE groups Flu VS informed the group that Flu is on the increase. UHL has seen a number of cases, this is an upward trend across the whole population. 3 cases confirmed in Critical Care this month.	
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business None discussed.	
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	Received and noted for information 2 minutes of your time Report /National Report December 2017 Both reports for information. Patients still raising the issue that they are cold – extra blankets and hot drinks must be provided. Call bells not always working was also raised, spare call bells to be held in all ward areas. Any incidents of this need to be reported straight away.	**Senior Nurses**
PART 6: DATE OF NEXT MEETING		
6.1	Friday 2nd February 2018, 8am, in the Critical Care Resource room, UHW.	

22.4

AGENDA
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 18th January 2018 09:00-11:30
Venue: Right hand side Pathology Seminar Room

22.5

Present: Jason Roberts, Kath Prosser, Tara Cardew, Gill Spinola, Alex Scott, Lisa Harwood, Ian Dovaston, Gemma Murray, Derek King, Sharon Parkhouse, Jennie Palmer, Sharon O'Brien, Jane Whittingham, Emma Mitchell, David Pitchforth, Jeff Turner, Suzie Cheesman, Rebecca Aylward, Angela Jones

In attendance: Claire Jones, Caroline McArdle

Apologies:
Dr J Coulson, Dr K Emerson, Mudassir Pasha, Sian Brookes, Debbie Hendrickson, Dr R Evans, Sarah Follows, Denise Shannahan, Loretta Reilly, Barbara Davies, Jane Murphy, Hannah Rix, Lisa Waters, Lisa Graham

Preliminaries			**ACTION**
A1	Welcome & Introductions	JR welcomed all present. Members of the group introduced themselves for the benefit of those in attendance to present extraordinary items	
A2	Apologies for absence	Noted as above	
A4	To receive the Minutes of the previous meeting Matters Arising	Minutes of January 2018 Quality and Safety meeting noted with no amendments Nil noted that is not on agenda for discussion	
GOVERNANCE, LEADERSHIP AND ACCOUTNABILITY			
1.1	Patient Story	ID shared feedback from a recent audit around physiotherapy and discharge planning at St Davids and patient feedback. Action plan ongoing. Claire Jones, Senior Rehabilitation Physiotherapist presented recent multigenerational working that had been inspired by a Channel 4 documentary at the Day Hospital in UHL. As part of the recent Older Persons' Day, a number of children from the Teddy Bear nursery were brought into the Day Hospital at UHL to take part in games related to physiotherapy, such as 'Heads, Shoulders, Knees and Toes' and a standing on one leg challenge. Extremely positive feedback arising from questionnaires completed after the games were received, included patients saying that they did more than they thought they were able to, particularly as they didn't want to show the	

		children they couldn't do what the children were doing. Patients expressed that they exercised without realising, and felt their anxiety levels decrease. It was evident that the children also enjoyed the activities and showed compassion to the patients while learning about aging and health conditions. A further pilot of 8 weeks is planned with the cooperation of a local primary school and four 8 – 9 year old were due to join 4 patients for similar activities with additional focus to include speech and language, extended activities such as outdoor treasure hunts and music and movement activities. The pilot was due to start on the afternoon of this meeting with an ice breaker activity 'Pimp My Zimmer' taking place. It was planned that this programme would also benefit the children who were thought to be shy and had been selected to take part with the hope that this would increase their confidence. Appropriate safeguarding discussions and consent were obtained as part of this pilot. All present agreed that this programme sounded very successful and had great further potential. JR agreed to contact CJ to discuss presenting the story to the Executive Quality and Safety Committee. With regard to discussions surrounding sufficient physiotherapy resources, JR asked if there was an SOP in place. SP confirmed that patients in St David's are required to undertake three sessions a week which is completed. These were often limited to a short walk along a corridor which although it met the SOP was not ideal in a rehabilitation setting. It was noted that OT resources were even more stretched than physiotherapy resources.	JR
1.2	Feedback from UHB QSE Committee	Noted for information.	
1.3	Directorate QSE minutes – exception reporting	JR noted the following - Internal Medicine notes submitted for October and November – there were no exceptions to discuss - Emergency Medicine due to meet in February, last meeting notes not currently available - Clinical Gerontology had met recently and notes would be circulated as soon as they were completed, next meeting scheduled for February - The most recent Gastro Q&S meeting had been extraordinary so there were no notes to circulate	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT			
2.1	Nurse Led Pleural Protocol	Jane Whittingham – Acute Oncology Advanced Nurse Practitioner presented developments being made to improve the management of pleural disease based on the British Thoracic Society (BTS) Guidelines of 2010. Dr Helen Davies, based in UHL, was leading on this work with the support of a team of SpRs. The proposal arising from this development work is to improve the patient pathway and decrease their length of stay by undertaking a pleural effusion assessment following the protocol developed. The procedure is	

		normally undertaken within the Respiratory Procedures Rooms with the arrangement of the Ward Sister. A new document, the Nurse Led Pleural Effusion Assessment Protocol, based on BTS guidelines had been released. JW confirmed that the guidelines were based on current NATSSIPS guidance. KP agreed to forward a copy to Matt McCarthy who is the Patient Safety Lead for NATSSIP's as this would need to be formulated into the local NATSSIP's template. It was noted that patients with cancer who are referred to UHW have flags on their notes that will alert JW's team to their admission and the need for them to be assessed within 24 hours. The patient's destination following their treatment for pleural effusion would be determined by JW so not all patients would continue their stay on B7.	KP
	Tazocin Patient Group Direction for suspected Neutropenic Sepsis	JW presented information on the target for patients with suspected Neutropenic Sepsis to be given antibiotics within 30 minutes of presentation. A significantly high number of patients die 30 days after receiving chemotherapy secondary to sepsis. Performance against this target had been improving since 2009 but in 2016, according to the most recent data available, only 28.75% had been treated within the target timeframe. Following the Haematology Department's success in reducing the target to 15 minutes, JW had recently implemented their PGD. This had been signed off by the Clinical Directors in Emergency and Acute Medicine and was being piloted in UHL with a view to being rolled out to UHW at a later date. This plan had also been presented to Internal Medicine.	
2.2	MINAP assurance	Alex Scott outlined the MINAP audit, 2014/15 and 2015/16 audit results were available and the relevant clinical leads had been asked to take action on the results. It was felt that improvements in the implementation of actions arising from the results had been made following the introduction of a clinical lead within Cardiology in UHW alongside an existing lead in Medicine in UHL, as opposed to both leads sitting in Medicine. AS emphasised the need to be transparent in how we act upon the results of the audit and noted that some areas were classed as outliers. There were also discrepancies between the results found in UHW and UHL and the need to improve UHL to the standards of UHW was noted. The results of the patients with heart failure had been discussed and it was queried whether the patient cohort and any comorbidities had been examined in detail. Reports from the audit were being submitted to Vaughan Gethin and the UHB was to be benchmarked and challenged on the results. The UHB would be given 4 weeks to present WG with an action plan and 2 months to ensure a structure for the action plan was in place. A large part of this action plan had been the introduction of a Cardiology clinical lead. JR asked that RHE share the results of the audit with the MINAP clinical leads. KP also suggested that these audit	

22.5

		results be shared with Quality & Safety Directorate Clinical Leads in-order for the results and recommendations to be widely shared. AS recommended the identification of high level actions and noted she would also speak to Cardiology representatives to ensure a joint approach to the implementation of an action plan.	
2.3	Flu Plan 2017 up date	KP announced that the Medicine Clinical Board were currently at 64.7% up take for the flu vaccination. The Clinical Board are currently third highest within the UHB and had achieved target for the first time ever which is an amazing achievement for the Clinical Board. KP was in the process of providing the Communications Team with her nominations for Flu Stars. It was noted that those clinical areas who had low compliance with uptake of the vaccination had experienced outbreaks of Flu. The vaccines are still available and all Flu Champions have been encouraged to continue offering the vaccine. Some myth busting information around flu and the vaccination was shared with the group to disseminate across their relevant areas.	
SAFE CARE			
3.1	New SIs WG closure forms for discussion and shared learning: Internal Medicine:	KP announced that the number of SIs had risen from 7 to 22 over the last month. The majority of these cases involved injurious injuries and hospital acquired pressure damage. The following cases were presented for discussion and closure: • In57711 In60030 In60038 – hospital acquired pressure damage: All patients had pre-existing grade 2 damage on admission to the UHB that deteriorated to grade 3. Some re-occurring themes identified that Skin Bundles had not been completed in line with UHB best practice. Concerns around the correct mattress selection and timely referrals to speciality services such as medical photography and Tissue Viability. Actions included specific audits around Skin Bundle compliance, education and training around pressure damage reporting and prevention. • In55460 – hospital acquired pressure damage A grade 3 pressure damage was attributed to a clinical area, however the All Wales Pressure Damage RCA could not clearly clarify where the pressure damage occurred as the documentation and review of the area was extremely poor. It is believed that Grade 2 pressure damage was already present on admission and described by Primary Care colleagues prior to admission as a 'scabbed over area'. It is believed that when this 'scab' fell off whilst on the ward it revealed the presence of slough underneath which resulted in the requirement to report as Grade 3 pressure damage. KP emphasised the importance of assessing dressings and wounds as soon as patients were admitted to particularly note the grading and location and treatment in line with UHB best practice.	

		SO'B raised concerns around the potential delay for patients being seen by either Tissue Viability or Podiatry and the potential for deterioration whilst waiting their review, or potential errors in grading on admission secondary to lack of knowledge or understanding. KP advised that there are currently two work streams on-going within the UHB. The UHB Tissue Viability Task and Finish Group and a process mapping group are leading on pressure damage reporting and how the UHB can work together to improve pressure area care, pressure damage reporting and validation. DP noted an increase in the workload generated in processing investigations and the impact this was having on the Safeguarding team which had resulted in some cases being overlooked. EM suggested that recent changes to the guidelines on grading wounds may not have been circulated widely and could account for judgement differences in grade 2 and 3. It was noted that photos posted on Cavweb to illustrate the differences between grades weren't effective. DP advised encouraging staff to draw wounds and write a description in the notes. KP advised that the KPIs on pressure damage were to move from the Fundamentals of Care to Datix so it was even more important that all information was accurate. Secondary to this a small working group has been established within the Clinical Board to drive the education, accurate reporting and learning for pressure area care and pressure damage. • In59642 and In59390 – Injurious Injuries These two incidents occurred within the same clinical area within a short period of time. The investigations found that there was a missed opportunity to co-hort one of the patients who had previously fallen into an area where enhanced supervision was being undertaken. Risk Assessments were also not completed in line with UHB best practice. In terms of learning the Ward Sister has developed a falls education board for all staff. Staff have all been formally reminded of their professional requirement to ensure that all documentation is completed in line with UHB and NMC best practice. Staff concerned have also had to complete a written reflection around these incidents and their learning from it. The ward have been invited to take part in a LIPs project commencing in April and will shortly be commencing some simulation training with the newly appointed UHB Falls Lead as part of this project in March.	

		• In59911 – Injurious injury A patient in MEAU fell while moving from a trolley to a chair when the trolley rails were down. Risk assessments reflected that the patient was not a potential falls risk. Post falls procedures undertaken in line with best practice. Discussion around whether given the height of the trolleys that the rails should be raised at all times.	
3.2	Paracentesis Care Plan NaTTSIP's	Dr J Turner presented the Therapeutic ascitic paracentesis care plan for ratification following the local NATSSIP's guideline. Also shared and agreed with the UHB Patient Safety Lead for NATSSIP's.	
3.3	Patient Safety Alert Medication Safety Briefing Dec 17 PSN 039 – Blood transfusion checklist	Noted. No further questions. It was agreed that competencies were already in place and being followed, however SO'B noted the guidelines stated that bank and agency staff were not to use pumps and IVs; Ruth Walker had overruled this and recommended that these nurses are asked if they are competent in their use as they are professionally accountable for their actions and competencies.	
3.4	Health Care Associated Infections HCAI rates CDiff/MRSA RCA reports	DK advised of the following: MRSA – 1 case reported, the first since May 2017. The patient had MRSA on their skin so infection had been attributed to when the patient was cannulated. The RCA investigation noted that there could have been improvements in PVC documentation. The patient also had poor skin integrity which resulted in them not being able to receive the required topical treatment for the MRSA to skin. MSSA - 3 cases had been reported in December and 1 to date in January. C.difficile – 1 case reported for the clinical board in December. Unfortunately the clinical board will not achieve the expected reduction target this year and learning continues from the RCA investigations. The organisation as a whole was not on track to meet infection reduction targets. In December flu outbreaks had been reported on 6 wards, affecting 102 patients and 36 staff and a total of 28 bed days were lost. There were still ongoing cases of flu in Internal Medicine and Clinical Gerontology. GPs were reportedly seeing double the number of flu cases as were on the wards. Patients with flu were also being reported in EU but not all were getting as far as the wards. It was believed that the flu season had peaked and was now expected to fall.	

		The Norovirus season was believed to be over. The Executive Board team had challenged the clinical board for the number of E.coli cases reported. RCA investigations are completed for each case which are predominately identifying urinary sepsis and long term catheters as the source. DK advised that Cardiff and Vale was the best performing Health Board in Wales, with a much lower reduction target than any other Health Board. A plan is being developed to address concerns arising from recent environmental audits. A representative of the Medicine Clinical Board was being sought to sit on the environmental committee; all present were asked to send the names of nominees to KP. Rebecca Aylward was also seeking nominations from the Senior Nurses to take responsibility for individual standards to support the clinical board in completing Health & Care Standards. Bare Below the Elbow – names of staff not complying with these requirements were being taken and reported to Sheila Harrison. JR asked that names were also sent to him. To try and promote the flow of patient through the Emergency Department action cards have been developed around screening of patients. Two cubicles are being protected on T2 (winter pressures ward) as a means of trying to improve patient flow. Rapid flu testing is also being trialled at UHW with a plan to roll out to UHL and all clinical areas.	
3.5	Up date on blood transfusion competencies	GM and ID had carried out a scoping exercise on all wards to check the status of competency assessors. Wards without assessors had been given dates for training and asked to nominate staff to take this role. All wards were required to have at least one assessor. All new staff would be trained at induction and assessed on their ward. A booklet with guidance for Ward Sisters on updating competencies was being made available to each ward and GM/ID agreed to circulate for comment in advance of the next meeting. GM also agreed to provide figures on the current status of assessors and improvements made since the scoping exercise. It was agreed that better reporting on uptake of training was required from LED.	GM/ID GM
3.6	Presentation to NHS Wales Safeguarding network ABMU Blood Glucometry review	RA encouraged all staff to read this report from the case involving nurses in ABMU who were imprisoned following a review of blood glucose records. RA particularly drew the attention of all present to the summary of professional practise on page 21.	
EFFECTIVE CARE			
4.1	Director of Nursing Quality & Safety reports	Shared with the group	
4.2	Patient Story - Physiotherapy		
DIGNIFIED CARE			

5.0	HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans – verbal up date on action plan	JR asked that this item be removed from future agenda.	AH/KP
5.1	SBAR County Lines	RA presented for information. SO'B noted that she had attended a presentation in 2017 and one case had been reported since and she had been able to apply her learning.	
5.3	Goodness Model Posters	LW had supported a group of nurses in putting together posters for every area within the emergency/acute department to remind patients of the things they can ask nursing staff. Example posters had been circulated. JR asked that those present give consideration to rolling this idea out to other areas.	
TIMELY CARE			
6.1	Waits within Emergency/Acute Medicine	LR provided information noting assessment unit waits remain a major challenge with increased length of stay in the departments over the last few weeks. Recent infection control outbreaks with Flu and Norovirus have been a challenge. A review of 'stopped clocks' is being undertaken supported by Internal Audit. Overall a difficult period for patients in the department and long ambulance waits compared to last year which has impacted on an increase in 12 hour breaches.	
6.2	Winter Pressures Ward up date	T2 at UHW and West 3 at UHL remain open.	
INDIVIDUAL CARE			
7.1	National User Experience Framework Feedback from 2 minutes of your time survey – relevant improvement plans	Noted for information - Patients were still making complaints about being cold on the wards. Staffing had also been noted in patient concerns. A patient in Rhydlafar had returned the following compliment: 'if it was possible to enjoy a hospital stay then I've enjoyed it!'	
7.2	Complaints and trends Compliments & Good news	Concerns not present – however JR explained that weekly tracker meetings are well embedded and improvements are being made in overall response times. KP shared some recent compliments from West 1, Dermatology and the Emergency Department	
Staff and Resources			
8.1	Staffing levels	Chair/Group As of 2018 each Health Board was required to give assurances to the WG that clinical areas were being staffed in line with the Staffing Act. It was noted that acuity data from January and June informed staffing information. There had been difficulty around the interpretation of this Act and differences across the Clinical Boards. It was estimated that the implementation of this Act would result in funding to a 26.9% uplift the provision of Supervisory Ward Sisters.	

		The Surgery and Specialist Services Clinical Boards had never funded these changes. Ruth Walker had confirmed she was seeking an additional £1.8m to fund nursing. It was noted that the Act dictated that wards were required to escalate to the Clinical Board as an incident any shift on a clinical area that wasn't staffed to Act requirements and to provide assurance of how the risk had been professionally managed. It was suggested that for some areas this would involve a report on each shift. RW was working on a mechanism to report this. As part of this monitoring hospital acquired pressure damage was being monitored against staffing shortfalls.		
PART 2: Items to be recorded as Received and Noted for Information by the Committee				

22.5

Date and time of next meeting: 15th February 2018 09:00 – 11:30 Right Hand Side Pathology Room B Block first floor

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 16th January 2018, 08:00-10:30 hours
Seminar Room B, A Block, UGF, UHW

22.6

CONFIRMED MINUTES

Present:		
Richard Hughes	Chair, Consultant Anaesthetist	RH
Linda Walker	Nurse Director, Surgery Clinical Board	LW
Ceri Chinn	Interim Lead Nurse, Perioperative Services	CC
Mark Bennion	Clinical Governance Facilitator, Perioperative Services	MB
Rafael Baraz	Consultant Anaesthetist	RB
David Scott-Coombes	Clinical Governance Lead, General Surgery	DSC
Adrian Turk	Pharmacy	AdT
Catherine Evans	Patient Safety Team	CE
Matt McCarthy	Patient Safety Team	MMc
Babs Jones	Perioperative Care	BJ
Simon White	CD, Trauma & Orthopaedics	SW
Claire Mahoney	Infection Prevention & Control	CM
Helen Luton	Senior Nurse, Trauma & Orthopaedics	HL
Denis Williams	DM, ENT/Ophthalmology	DW
Sharon Irving	Senior Nurse, ENT, Ophthalmology, Urology	SI
Nicola Jardine	NELA Nurse Practitioner	NJ
In attendance:		
Edwina Shackell	PA, Surgery Clinical Board	ES

Patient Story: General Surgery (In42308)
Nicola Jardine presented the case history of a 36 year old patient who had presented to SAU. Symptoms and observations were described. The patient had been clerked by a medical student. On the day in question the SAU had been busy, staffed by one consultant and one SpR. The SpR had been called out of theatre to review the patient with the medical student. The SpR requested further tests before returning to theatre, and referred the patient to the consultant, but did not hand over his thinking. The patient was reviewed by the consultant on the ward round. There had been no validated report of the chest X-ray. The patient was discharged home.

The patient sadly died following admission to another Health Board, following which a Concerns letter was received by Cardiff & Vale from the patient's parent. The diagnosis had not been picked up at Cardiff & Vale. The result of the X-ray report had not been received until 13 days later, but the patient had not been informed. The patient had died as a result of liver failure due to heart failure.

Recommendations from the Root Cause Analysis:
Expert Cardiac opinion had been that the patient would ideally have followed the cardiac pathway, as described by NJ.
Key Issues:
- The SpR did not document a cardio respiratory problem and communicate to colleagues.
- The SpR did not hand over peak flow and ECG so not performed.
- Blood test anomalies were not considered.

	- Breathlessness was not taken into account - Enlarged heart on chest X-ray not noted while the patient was on SAU Actions: - The case had been presented at the General Surgery Quality & Safety meeting. The consensus had been that surgical consultants would not be confident in diagnosing an enlarged heart. - Work is ongoing on the reporting of X-rays by radiography. The Cardiac expert felt that an enlarged heart in a 36 year old should have been flagged. Discussion: - The SpR had been pulled out of theatre, and did document that peak flow and ECG should be done. There could be no blame attached to the SpR. Why did SAU not follow the SpR's instructions? - Discussion at the General Surgery Quality & Safety meeting had centred around the unusual presentation of the case. Heart failure with abdominal pain was unusual. Assessing an acute abdomen in SAU, procedure is to discharge. - CE noted that other incidents where there had been abnormal findings from radiology had not been handed over. Radiology does not notify the requesting team. It was noted that the new radiology system should address this. - SW noted that clinicians do review X-ray images, but do need the formal report. Personal contact would remain key, whatever system was in place. - LW advised that work was in progress to propose a protocol to radiology. .	
PART 1: PRELIMINARIES *(Chair)*		**Action**
18/01	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
18/02	**Apologies for Absence** Received from Carole Evans, Oleg Tatarov, Angela Jones, Clare Wade, Andy Jones, Susan Mogford, Jayne Thain and Chris Williams.	
18/03	**Declarations of Interest** None declared.	
18/04	**Approval of the minutes of meeting held 21st November 2017** The Minutes were approved as an accurate record.	
18/05	**Matters Arising** To receive Action Log from the above meeting: *Minute 2.1.3, 17/5/2011. NPSA/2011/RR011: Checking pregnancy before surgery*. Ready to be formatted into the UHB standard template, and then will be ready for approval. RH observed that the upper age limit is 55 yrs in Radiology. *17/088 21/11/17: NATSIPPS – Standing item*. Agenda item. **CLOSED.** *17/090 21/11/17: Directorate Assurance Report for Anaesthetics. Line insertion service and need for guidelines for each type of line*. *LW to discuss with Carole Evans.* LW explained the position regarding lines for patients at UHL. Staff on the ward would need training. It had become apparent that CVC, mid line, PIC were all being done differently. The Nutrition team was progressing this work, but the UHL situation remains to be resolved. **Action: Update next meeting.** *17/090 21/11/17: Directorate Assurance Report for Anaesthetics. Drug Error, sub-lingual Nifedipine Dr Baraz and Adrian Turk had jointly presented at Anaesthetic Q&S, Sept 2017*. AdT had sent the bulletin to Dr Baraz. **CLOSED.** *17/091 21/11/17: Exception Report for Anaesthetics – management of insulin dependent diabetic patients.* Clarification to be sought from Aled Roberts on the correct modern fluid	

	management regime. AdT advised that the dissemination of the correct message to all relevant staff remained a challenge. T&O had tried to set up a meeting with a Diabetic Nurse. DSC had spoken to Endocrinologists who were content with the new protocol, which is now embedded in the Emergency stream. AdT confirmed that correct stock is in all areas, but it was reported that awareness of this was being described as the biggest challenge. RH confirmed that in Anaesthetics a presentation had been given on the management of elective patients, but that the Emergency stream patients remained a challenge. **CLOSED** *17/093 21/11/17: Alerts & Safety Notices: Shortage of Litmus paper for NG fluid testing To be added to Clinical Board Risk Register*. Resolved. CE litmus paper procured. **CLOSED** *17/093 21/11/17: IPG 575 – Trabecular stent bypass microsurgery for open-angle glaucoma. 23/3/17 remains outstanding.* **Action: DW to chase. ES to continue to monitor.** *17/093 21/11/17: CG65 – Hypothermia: prevention and management in adults having surgery. UHB non-compliant as indirect measurement thermometers used – response to Clinical Audit remains outstanding ES to resend guidance to Richard Hughes.* *RH to complete and submit to Audit.* **Actioned. CLOSED.** *17/093 21/11/17: ISN: 2017/003- Blood Transfusion Safety. All directorates respond direct, cc ES, embedding copies of assessments or database. Assurance to be provided at next meeting. Responses being submitted; directorates to add to Assurance Reports. Assurance to be provided at next meeting from ENT, Ophth, Gen Surg, Urol, T&O*. **Assurance RECEIVED. CLOSED.** *17/093 21/11/17: 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. Assurance next meeting.* **Assurance RECEIVED from T&O, Gen Surg, Ophth, ENT, Urol, Periop. CLOSED.** *17/093 21/11/17: HIW Surgical Services Inspections*. *All to read the report* BJ has all audit tools and the presentation given to inspectors, saved on the S drive, and circulated to all lead nurses. **Assurance RECEIVED. CLOSED**.	
PART 2: PATIENT SAFETY AND QUALITY		
18/06	**Standing Item: NatSIPPS Progress report** Matt McCarthy explained that a gap analysis had been undertaken across all CBs; all had been returned from Surgery Clinical Board. There was variation across the Health Board, with regard to policies and procedures in place and Directorates outside of theatres. There were many clinical areas where invasive procedures were undertaken eg chest drains. LoCSIPPS – this will state how NatSIPPS is implemented in local areas. A template had been discussed to facilitate progress. This would provide a focus for discussion. There would be an Area LoCSIPP and a Procedure LoCSIPP. Eg, for chest drains undertaken in non-specific areas a Local Procedure would be developed. This is being piloted in Dental and Radiology. Working groups will be convened for groups of procedures, a total of 5 or 6 for the UHB. The documentation is detailed with regards to practical procedures, but training is not specified and is to be addressed. Good practice will be shared widely, eg Gastroenterology LoCSIPP Safety Briefing. The key is standardisation, allowing for tailoring to an individual area. There is standardisation of documentation for eg central lines. Much good work is underway. It has been agreed with Perioperative Care to look at the Area template when documentation is due for renewal. Discussion:	

	- September 2017 WG deadline compliance. WG had agreed that providing a plan was in place, the UHB could report compliance. There will be a continual process, with continual improvement. - NaTSIPPS forum – was there any need for a forum where good practice could be shared? The plan was to organise a NaTSIPPS day to facilitate this. The Royal London NaTSIPPS day was being explored as a model for such a day. There was no confirmed date, but anticipated within the year. - A LoCSIPPS round would enable sharing of good practice.	
18/07	**National Hip Database Annual Report – deferred to March 2018**	**ES**
18/08	**Director of Nursing Q&S Report December 2017** There had been improved closure of Serious Incidents. The high volume was due to reporting Grade 3 and 4 pressure damage. Pressure damage was being attributed to a problem with some types of mattress. LW was chairing a working group to manage the bed contract. Falls – there had been a reduction from the previous month E datix – managers were reminded to close incidents in a timely manner. It was of concern that as of December, there were currently 96 that had not been opened and reviewed. **Action: colleagues to liaise with Clinical Leaders and Ward Managers to review these and close them down.** CE advised that should any area have a particularly long list, Patient Safety is available to visit and work through. Concerns have increased. Weekly meetings to address these continue. IP&C. CM reviewed the current status: January – 2 x C.Diffs reported. On target. Staph aureus – off target. Target would not be met. E. coli – on target LW commended the consultant led Root Cause Analyses; there had been an excellent turnaround.	**LNs**
18/09	**Directorate Assurance Reports:** 1. <u>General Surgery & Wound Healing</u> Timeliness of consent for surgery in Outpatients. It was explained that Montgomery ruling stipulates that patients should have time to reflect. For specialist surgery for example, the option of not operating was discussed, but for other procedures, eg hernias, this option is not discussed. Mr Clark had attended a mock trial which had concerned him such that his clinics were now reorganised so that all of his patients were consented in clinic. The remainder of consultants consent on arrival at the Day Surgery Unit, assuming that verbal consent had taken place. GB explained that the consensus of the spectrum of consultant opinion was that this would have a major impact on consultant time in clinic. One approach was that formal recording of verbal consent documented in clinic, and then signed when the patient presented for surgery. Discussion: - Pooling of lists. RH noted that patients would see on consultant in clinic and another on the day of surgery, resulting in the patient being consented by someone who does not know the patient. - Cancellation by patients on the day of surgery, Operation Not Needed = 5 or 6 per day. - ENT described their use of an electronic system whereby the patient could upload a video of their procedure. Implied consent is that they have 2 weeks to consider, and to notify the department via a website if they wish to go ahead. Funding had been secured via the 1000 Lives project. The geographical spread of patients benefited from virtual clinics. 2. <u>ENT</u>	

	- Decontamination, still using Tristel wipe system. The directorate had visited Morriston hospital to see the UV set up. This enabled a fast turnaround, possibly prolonging scope life. - Medical Equipment. LW advised that the bids had been submitted, outcomes awaited. 3. <u>Perioperative Services</u> - CEPOD service, is utilising Theatre 10. No particulate matter seen. - Cardiac implant that was past its use by date was implanted into a patient. The incident is being managed by Specialist Clinical Board. - New modular orthopaedic theatre at UHL is operational. - MDA/2017/036. UHL has changed these pumps to new Fresnius Agilia syringe pumps with effect from 18th December 2017. The UHL pump library has also changed them all. A programme is in place to change the pumps in UHW in the New Year. Dr Baraz had been assured that training would be rolled out. The old pumps continued in use on Labour ward pending training on new pumps. 4. <u>Anaesthetics</u> - Oct & Nov 2017 Zero tolerance report, presented to Anaesthetic Q&S 14th Nov. Workshops have been set up over 5 days in Jan/Feb to provide 1-1 training for at least 50 consultants = 70%; the remainder will be captured thereafter. - Neuraxial devices – there is an ongoing process to govern the safe transition to the new devices. The changeover from Luer to non-Luer is starting shortly in Newport, then to be rolled out to Cardiff 6 months later. It is anticipated that all of Wales will have transferred by the end of 2018. 5. <u>Trauma & Orthopaedics</u> - Non-Luer is applicable in spinal surgery. RB explained that off licence spinal needles would be provided, a Long Luer Needle. Will be called NRfit, incompatible with wrong connectors. It was explained that the long timescale from 2009 to the present was due to the unavailability of good kit on the market, and publication of international standard in 2016. The full range of kit still not manufactured. - HIW Surgical Services Inspection report inspection discussed and shared. - WHC/(2017)051 Raising awareness of Carbon Monoxide poisoning distributed to medical and nursing staff. - Compliance with blood transfusion (see report) – new staff, targeting hotspots to achieve compliance. 6. <u>Urology & Ophthalmology</u> - Ophthalmology: o Yag laser safety. Replacement of Yag laser, accepted as part of the capital bids process, resolution therefore anticipated. o Optos fouracline-angiograme scanner machine continues to fail and needs urgent replacement – urgent bid submitted. o There are pressures around vacancies. The Consultant Glaucoma post advert is anticipated this week. o AMD administrative support vacancy. o Significant payout of £1.25m from 2013 case of delay in review/treatment. - Urology: o 8 week evaluation of Consultant on-call week indicates very productive and efficient change. o Significant push in getting diagnostics down to 8 week waits.	
18/10	**Exception reports from Directorates/Working Groups** ▪ General Surgery, Vascular , Wound Healing - nil ▪ Head & Neck, Maxillo Facial and Ophthalmology - nil ▪ Urology - nil	

	▪ Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services: - A breast surgery patient had received a burn the previous week. RCA underway - Critical care capacity is having a major impact on surgery. PACU is closed due to staff sickness. Efforts had been made to mitigate the situation but the current solution was not sustainable. It was advised that a patient had remained in Recovery for 2 days instead of PACU. Recovery staff do not have the skill set to manage patients safely. LW noted that the shortage of staff on wards was presenting an operational challenge, there being 50 medical outliers in Surgical beds. This was extremely challenging, particularly for T&O and General Surgery. LW advised that plans to reduce capacity in Surgical beds had been put on hold. ▪ Trauma and Orthopaedics – as above.	
18/11	**Policies and Procedures** 1. **National Hip Database Annual Report**. **Action: medical staff, Nursing, and ODPs to read.** 2. Perfusion Cleaning Protocol. This had been developed and implemented by Perfusion. However, Perioperative Care had identified that this did not align to Theatres Housekeeping and Cleaning procedure. Clare Mahoney asked for comments to be sent to her. **Action: BJ to send the Protocol back to perfusion explaining that it needed to align with the Theatres procedure. The revised Protocol will be received back at this meeting.** 3. Procedure for the Provision of Take Home Medication (TTH's) from Urology A5 AdT proposed adapting the process embedded in adult SSSU. It was agreed that this was a good solution. **Action: AdT to speak to Louise Williams.** 4. SBAR: Second Check of intra versical Medicines Administration in Urology Clinic. –defer in absence of Louise Williams. **Action: invite to next meeting.**	**BJ** **AdT** **ES**
18/12	**Alerts and other Safety Notices** <u>MDA</u> 1. <u>MDA/2017/035 (Wales), issued 20th December 2017: Nasogastric (NG) feeding tubes – recall due to risk of neonatal or paediatric patient choking on the ENFIT connector cap.</u> Correct NG tube now in use. **CLOSED.** 2. <u>MDA/2017/036 (Wales), issued 20th December 2017: Syringe pumps – required user actions in the event of PL3 alarm to prevent risk of interrupted infusion.</u> Discussed at 18/09.4 above. <u>NICE Guidance</u> 3. Surgery CB summary spreadsheet – received for information 4. NG76 – October 2017: Child abuse and neglect – circulated to Directorates. Clinical Bard response being collated. 5. NG77 – October 2017: Cataracts in adults: management – **Action: DW to check.** 6. NG79 – October 2017: Sinusitis (acute): antimicrobial prescribing. **Action: DW will check** 7. CG89 – October 2017: Child maltreatment: when to suspect maltreatment in under 18s.- circulated to directorates. Clinical Board response being collated. 8. MIB124 – October 2017: Mepilex Border dressings for preventing pressure ulcers. AdT – explained that a tab had been added onto the existing Surgery CB NICE spreadsheet for NICE guidance for medication. <u>Patient Safety Notice</u> 9. ISN 24 November 2017, Special Edition – Urgent Action: Clexane (enoxaparin) 40mg injection. This had been resolved. Clexane supplies restored. **CLOSED.** 10. PSN039 January 2018: Safe Transfusion Practice – Use a bedside checklist.	. **DW** **DW**

	Field Safety Notice 11. FSN SP17-001/A, 6 December 2017: for Gelatin Sealed Polyester and Gelatin Sealed ePTFE products (Vascutek). Used by vascular surgeons for specific procedure. A Risk assessment had been carried out; this did not score high enough to be placed on the Risk Register. Richard Whiston will be asked to sign the Risk Assessment to provide assurance. **Action MB** Welsh Government Briefing: 12. 5th October 2017: deployment of neuraxial ISO 80369-6 devices in the Welsh NHS during 2017. Discussed above. Medication Safety Executive 13. Briefing for Clinical Boards: Issue 20, December 2017 RECEIVED and NOTED. Medicines code will be updated every quarter.	**MB**
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
18/13	**Key Messages from Board/ Committees/ Groups** 1. UHB Medicines Management Group Minutes 16th November 2017 o Item 4b – the English approach had been adopted, with Urologists consulted on the management of prostatectomy patients. o All Wales Drug chart –poor compliance with medicines audit. The code on the new drug chart does not appear to work on the ordering system. 2. Medicines Code Flier – information noted. 3. UHB Decontamination Group Minutes of meeting 17th October 2017 Nil of note. 4. Research Governance Group – Minutes of meeting 17th October 2017 Nil of note 5. Clinical Board H&S Group Draft Minutes 13th December 2017 Nil of note. 6. Clinical Board IP&C Group – next meeting 29 January 2018 7. UHB Water Safety Group update It was highlighted that there had been a change in the shower flushing procedure. All showers, including those in regular use, must be flushed 3 x a week, and logged on the as per the template. This was in addition to seldom used taps. 8. Blood Transfusion Committee update. No meeting. 9. Zero Tolerance Report November 2017. Heulwen Ward was the outlier for Surgery Clinical Board. Investigation had shown that the blood labels which had to be taken to CHfW had become lost in the system over the Christmas/New Year period. MB noted that the report did not show what the error is, which made it difficult to address. Blood Transfusion had to be referred to for this information. Number of rejections, 300/month – this should be improving. 10. UHB Vulnerable Adults & Safeguarding Children o County Lines – this was a recommended read. For circulation to teams. 11. Annual Self Assessment: Health Care Standards: 2.7 Safeguarding Children and Safeguarding Adults at Risk April 2017 SBAR. **RECEIVED.** 12. TAAG Group. This Group will be reconvened by the Surgery Clinical Board Lead Nurse.	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
18/14	**IP&C RCA database** The data was showing an improvement.	
18/15	**LIPS Progress Report – update from Urology** Deferred.	

18/16	**NELA** Emergency Laparotomy Collaborative, Wales (ELCW) Mr Scott-Coombes provided a verbal update. Year end this month. The process of getting patients onto the NELA database was good, but closing was poor. Margaret Coakley was confident that all will be closed at year end. ELCW had been launched the previous week. The National database would continue to be used at present.	
18/17	**Clinical Governance/Audit Programme** Review Annual Programme: good progress was being made.	
18/18	**Health Care Standards Process for 2017-18** Work is due to commence imminently.	
PART 5: GOVERNANCE		
18/19	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. <u>Open Sis, No Surprises:</u> 19 open, 4 of which dated from 2016. These were very complex, either involving other Clinical Boards or Health Boards. The RCAs were complete. 15 from 2017. Target closures is 5 per month. Pressure Damage and Falls work progressing well. Themes: Pressure Damage; there was difficulty in identifying if health acquired, and which ward. Work was underway to improve documentation of when Tissue Viability Nurse review was requested. 2. <u>Regulation 28 report & Open Inquests</u> One report: vascular interventional radiology not available out of hours. This should be attributed to Clinical Diagnostics and Therapeutics. It is planned that there would be an interventional radiologist on call from August 2018, linked to the Vascular Service. . The Director of Nursing had written to the Executive team to raise awareness of lack of out of hours interventional radiologist. Score of 25 on the Risk Register. 3. <u>Serious Incidents:</u> Closure forms sent to WG since January 2017: - In54043 – wrong site nerve block Improvement Plan MB summarised the incident and actions completed. - In47972 – Closure Summary – closure returned. Wrong route medication. Most actions complete. 4. Falls Report – 5 open. Oliver Williams had joined the Patient Safety Team, and is the Falls Strategic Implementation Lead. 5. Pressure Damage Report – 11. Only theme is one of Aerospacer mattresses, which the provider had been asked to remove at UHL and replace them with foam. 6. <u>Complaints, Claims and other Concerns</u> (i) All New Clinical Negligence claims opened 15/11/17– 9/1/18. It was noted that Ophthalmology was of concern, with a recent large claim awarded for lack of follow up. The VR service was in the process of being reorganised to enable patients to be brought in with in a 6 week timeframe. (ii) New Personal Injuries Negligence Claims opened 15/11/17 – 9/1/18 - nil	
18/20	**Patient Surveys:**	

	1. National Survey Report for Surgery (December 2017) 2. "2 Minutes of your Time" (December 2017) Colleagues, including medical colleagues, were referred to the Comments for learning.	
18/21	**Research & Development**	
PART 6: DATES OF NEXT MEETING **Tuesday, 27th March 2018, 08.00 – 10.30, Classroom 1, UGF, A Bl, UHW.**		

PART 7: URGENT BUSINESS		
18/22	Nil	
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
18/23	**Alerts and Other Safety Notices** Nil	
18/24	**Recent Reports & Communications** 1. CMO Update 90 – December 2017 2. ABMU – review of Blood Glucometry Investigation RECEIVED for information	
18/25	**Directorate Q&S Minutes** The following papers were received: 1. Anaesthetics ▪ Matters arising from CB Nov 2017 ▪ Matters arising from CB Dec 2017 ▪ Anaesthetic Q&S Minutes Nov 2017 ▪ Minutes, Agenda & Action log from Local Neuraxial T&F Group Oct 2017 ▪ Minutes, Agenda & Action log from Local Neuraxial T&F Group Jan 2018 2. Trauma & Orthopaedics: ▪ Minutes of Clinical Governance meeting 13 December with accompanying papers and M&M 13 December 2017	

22.6

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 28 November 2017
8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		**Action**
	Welcome & Introductions Cath Heath, Director of Nursing (Chair) Jenny Thomas, Clinical Board Director Suzanne Hardacre, Head of Midwifery Belinda Channing, Band 7 Midwife Paula Davies, Lead Nurse, Community Child Health Bev Thomas, Asst Head of Operations & Delivery, Community Child Health Mary Glover, Lead Nurse, Acute Child Health Diane Rogers, Interim Head of Operations & Delivery, Acute Child Health Heather Gater, Interim Head of Therapies, Acute Child Health Catherine Salter, Health &Safety Representative Michelle Abel, Infection Prevention Control Nurse Rachael Sykes, Health & Safety Advisor Anthony Lewis, Clinical Board Pharmacist Cheryl Evans, Directorate Head of Operations & Delivery, Obstetrics & Gynaecology Sarah Spencer, Senior Midwife Laura Bassett, Risk Manager, Obstetrics & Gynaecology Louise Protheroe Jones, Clinical Supervisor for Midwives Sarah Evans, Head of Workforce & OD **In Attendance** Kirsty Hook, Board Secretary	
	Apologies for absence Rachel Burton, Louise Young, Angela Jones, Rim Al-samsam, Alison Jones, Matt McCarthy, Jane Maddison	
PART 1: HEALTH & SAFETY		
1.1	**To note any specific Matters Arising from the last CB H&S Meeting dated 22 August 2017** **Water Safety Group** Representation is required to attend the Water Safety Group. The group were asked to advise of a suitable representative to attend. **Fire Report** All confirmed that the report has been cascaded widely. **Temporary Entrance - Maternity** The delivery suite entrance is now in use, however concerns were raised with regards to the temperature within clinic and vulnerability of the cleaners within the area. CH agreed to	**ALL** **CH**

	escalate further with Estates following the meeting. **Workplace Inspections** The new workplace inspection forms are in use and inspections are being completed throughout maternity between Alison Jones and Wendy Bridges, as RCM H&S reps. Alison is also in contact with the Directorate, to develop a spread sheet for all the action plans originated from the inspections. **Sun Reflection in CHFW Outpatients** It was confirmed that this has now been implemented. Feedback received that this has helped improve the situation for staff. **MARF updated Multi Agency Referral Form – Vale of Glamorgan** This has been agreed for adults, nothing specific for children at present.	
1.2	**Feedback from UHB Health & Safety Operational Group Meeting** • Presentation of the annual report was provided. V&A accounts for 60% of all staff incidents reported which is concerning. • Enforcement Agencies report was presented and further feedback from the HSE is awaited. • Fire Safety report presented and it was noted that a survey of all buildings has been undertaken following the Grenville Tower Incident and there are no issues to note within the health board. Discussion ensued with regards to responding to fire, the need to confirm the fire with switchboard as without this, they will not respond immediately. • Glide Sheets have been bought and any ongoing replacements will be the responsibility of each Clinical Board. • Pedestrian strategy has been added to the work plan following the recent incident outside the Emergency Unit. Interim actions have been implemented whilst further work is completed. Access to tunnels is being reviewed. • Charging for non attendance at tutor led training is being implemented from December 2017 with the aim to try to reduce the DNA rate. • Mental Health are introducing a complete Smoking Ban to patients in the New Year.	
1.3	**To note the latest Health & Safety Report** The report was noted for information. It was pleasing to note that the number of incidents awaiting review have decreased. Formal thanks were expressed to all for the efforts in working to reduce the number of incidents. There were also no HSE incidents reported within the period of the report.	
1.4	**COSSH Report for Noting** The COSSH report was noted for information. There are a few areas where COSSH assessments are out of date and the group were asked to review and update accordingly as the COSSH assessments should be completed every 3 years.	
1.5	**Workplace Inspections Update** Acute workplace inspections are complete and CCH workplace inspections are scheduled. Update for O&G was provided as part of item 1:1 above.	
1.6	**Feedback from H&S Staff Side** Concerns were raised as to the length of time being taken across the UHB with regards to the disciplinary processes. Discussion ensued and it was noted that there is nothing specific that is able to be changed and the only issues that have been raised are with regards to lack of	

	representatives and sickness of staff. The sun reflection in CHFW is improved, however noting that this could be better if the reflection was lower.	
1.7	**Exception Reports and Escalation of key H&S issues from Directorates** **Acute Child Health** • Mandatory Training is being validated and this will also be linked into the Directorate Q&S Meetings in order to monitor progress. Discussion ensued with regards to manual handling and the need to ensure that staff have been moved into the "new" compliance section which has been set up on ESR. CS agreed to feedback to the central ESR group. • Safeguarding – it was noted that if level 2 and 3 are complete, this should cover level 1 anyway, however it was acknowledged that there are difficulties with accessing level 3 training. • Fire Training – Major Incident Mock Exercise undertaken and also the Fire Evacuation documents are being updated. Fire lectures within the CHFW are also being arranged. Task & Finish group to outline what learning is required from the mock exercise is being arranged. **Clinical Board Health & Safety Action Plan** This is being reviewed in order to have an updated overall plan which will be noted at a future meeting. **CCH** Work is being undertaken with regards to security at Global Link and it is hoped that this will be implemented from early in the new year. It was noted that this will ensure staff safety of not needing to "sweep" the building at the end of the day. **O&G** There were no specific Health and Safety issues to note for this meeting.	**CS**
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**To receive the Minutes of the previous meeting dated 17 October 2017 for approval** The minutes of the meeting were agreed to be an accurate record.	
2.2	**QSE bring forward action log / Matters Arising** Actions noted and updated accordingly.	
2.3	**Patient Story - Eliose's Journey** The background to the patient story was provided where it was noted that there were a number of barriers from the start and there was a need to ensure that appropriate policies were followed. It was acknowledged that there is a need to ensure that direct and clear communication throughout. This was a very positive story where it highlighted that the need for clear communication is paramount.	
2.4	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **CCH Report** • School Flu Campaign is progressing well	

22.7

- Information Governance Breach with a child taking home consent forms. It was noted that this will be reported as a school breach not a health board breach
- Ongoing serious investigation with former HV accessing records.
- A further IG breach has been found through staff accessing records through PARIS. A reminder to all staff is being sent out to reiterate the responsibilities of all staff. There are information governance workshops being held in January 2018 which may require Directorate representatives to attend. CH/JT agreed to review and feedback outside of the meeting.
- Bookstart packs containing plastic bags have been removed and Welsh Government are checking any new packs prior to distribution.
- Medication error related to Flu programme in school, parent had not consented and an RCA investigation is being undertaken.
- Joint training for Safeguarding has been delivered to Ysgol Y Deri and staff now clear of responsibilities.
- Orthoptic guidelines now available and training has been rolled out across Health Visiting with regards to concerns associated with squints in children.
- CCNS Memorandum of Understanding has been developed and will be shared with this meeting as soon as feedback is received from Legal Services prior to distribution.
- Longer term plan for workload pressures within the Looked After Children's service is being reviewed and meetings scheduled
- Re-launch of 2 minutes of your time is being undertaken within the Children's Centres
- Appointment to the Senior Nurse for Complex Needs has been completed
- Recruitment is ongoing across a number of areas within the Directorate

ACH Report

- X4 RCA's ongoing and concerns have been raised with regards to MM associated with Radiology comments as this report has already been finalised. CH agreed to discuss with Concerns.
- Hand Hygiene audits have been reviewed and it was noted that the decrease in scores is associated with visiting consultants and medical students. Further work is required.
- Children's Rights Week was launched by the Chair and was very positively received.
- Recruitment continues, all nursing cohorts have now started and work is being undertaken to look at completing a further recruitment day in February 2018.
- LIPS Project on Transition has been completed and it was agreed that this would be presented at a future Clinical Board Q&S Meeting for information sharing etc.

Break Glass Reports

Break Glass Report concerns were raised as to the responsibilities for the Clinical Director to investigate. Discussion ensued and it was noted that there needs to be an acknowledgement of the receipt of the report. JT agreed to discuss with the Medical Director.

O&G Report

- Prudent Maternity Care Paper received and an SBAR has been produced.
- Ongoing challenges with regards to ongoing Neonatal and Obstetrics meetings as to how appropriate information can be shared robustly and also the need for policies and guidelines to be interlinked. Extra ordinary meeting is being arranged in order to review and address any issues.
- Audit of fetal losses is being undertaken to provide assurance
- In Obstetrics -there are currently 6 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.
- Grade 3 / 4 pressure area reported and is being investigated. Teaching package is in place for all staff to follow. It was noted that a snapshot audit is also being carried out.

	Mattresses are being reviewed and links are being made to review the bed contract for replacements. • Ongoing work associated with the FGM Midwifery Service and how this can be linked into the service. Further feedback will be provided as this work progresses. • You Birth We Care launched • Recruitment is ongoing across a number of areas within the Directorate specifically within gaps associated with the medical rotas. **Maternity Performance Meeting with Welsh Government** The meeting was well received and assurance has been requested to be provided when the service is Birthrate plus compliant. There were some issues highlighted regarding medical cover, however it was noted that formal feedback is awaited and actions will be completed accordingly as soon as this is received.	
2.5	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Covered as part of item 2.4 above, no new risks to be added to the Risk Register from this meeting.	
2.6	**Paediatric Surgery Update** No specific issues to note for this meeting. Work progresses in a number of areas including M&M, new rota implementation etc. Further feedback will be provided as this progresses.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	Initiatives to promote health and wellbeing of: • Health & Wellbeing Week was undertaken for Staff in conjunction with the RCN with a number of daily activities • Dignity room for patients being developed • Inpatient kitchens are being reviewed for implementation within Delivery Suite and First Floor in order to improve patient experiences • New Neonatal Unit move has taken place and it was acknowledged that the environment is significantly better • Mindfulness Sessions are being undertaken within the CHFW • Children's Rights Week has also taken place within the CHFW in partnership with ACH and CCH • Visit by RCN • 73% compliance against Flu has been reported and thanks were expressed to all the flu champions for all their hard work in achieving this target.	
SAFE CARE		
4.1	**Update on Serious Incidents** X4 reported and a further 1 has been reported. Work is progressing with no issues to note for this meeting. Work is progressing within all Directorates on current ongoing RCA's and information and lessons learnt will be shared when the investigations are completed.	
4.2	**RCA – AC – 247704** This investigation was undertaken following a junior doctor slipped to her knee during the instrumental delivery possibly due to the pool of liquor or the inco pad. This resulted in the doctor being unable to provide perineal support or perform an episiotomy prior to the baby's head delivering. It is possible that the fourth degree tear was sustained due to the lack of perineal support but consideration must be given that this may have also occurred with adequate perineal support.	

	Lessons learned • Documentation in the notes must be a true reflection of the events. **Recommendations** 1. Health and safety team to investigate the quality of the flooring to review if the co-efficient of friction in appropriate. 2. Guidance to be developed to cover writing retrospective entries in the notes. 3. Reflection of incident by doctor with educational supervisor and use for portfolio. 4. Midwife to discuss case with clinical supervisor for Midwives. 5. Audit of the use of VE stickers 6. Audit of the WHO checklist The lessons learnt and recommendations have been shared and actions highlighted are being progressed.	
4.3	**RCA – AR – 239548** This case involved a patient suffering a placental abruption leading to fetal hypovolaemia and unsuccessful resuscitation. **Lessons learned** • Despite the outcome this case demonstrates the importance of the 3,6,9,12 rule. • A fetal heart rate under 60bpm in labour in a previously normal CTG over 3 minutes has to be presumed to be an obstetric accident (Abruption, Uterine rupture, Cord prolapse) unless proven otherwise. Senior obstetric help should always be summoned. • In this situation the emergency buzzer should be activated to ensure prompt review by the labour ward team. • The mode of anaesthesia has to be carefully considered and a plan made with the anaesthetic team jointly in cases where the fetal bradycardia persists and the suspected reason for it is an abruption. • A neonatal crash call should be issued on decision for a category 1 emergency caesarean section to ensure a fully assembled and prepared team are present for delivery. • NLS algorithms should be followed for all newborn resuscitations, with timely involvement of senior support where required. • The on-call neonatal consultant must be involved in decisions to stop resuscitation or withdraw intensive care. **Recommendations** It was noted that an Improvement plan has been developed to address the following recommendations. 1. Audit of antenatal urinalysis monitoring 2. Display 3, 6, 9, 12 rule in all delivery rooms, and teach staff in its use to call for help. 3. Regular multi-disciplinary team drills to enhance communication within the team for prompt management of obstetric emergencies. 4. All staff within the unit to be reminded of the appropriateness of using the emergency buzzer. 5. Clinical supervisor for midwives to meet with midwives involved 6. Case & CTG to be used for learning. 7. A neonatal crash call should be issued on decision for a category 1 emergency caesarean section to ensure a fully assembled and prepared team are present for delivery. 8. All neonatal medical and nursing staff reminded of the need to involve a neonatal	

	consultant in the decision to stop resuscitation. It was agreed that this would be shared with ACH Q&S Meeting for noting and lessons learnt to be shared.	
4.4	**Infection Prevention Control Update** The report was noted for information. Feedback was provided in relation to; • Hand Hygiene audits are being re-audited and it was noted that some of the figures highlighted are not a true reflection of the procedures and practices in place within the Clinical Board. • Flu Uptake is reported at 73% which is a significant achievement • No C Diff, No MRSA and No MSSA reported through Tier 1 targets • Different decontamination methods are being reviewed across the Health Board and benchmarking undertaken for decontamination of scopes.	
4.5	**Safeguarding** No issues to be noted for this meeting.	
4.6	**Patient Safety Alerts (internal/external)** **PSN038 - Risk of severe harm and death from infusing TPN too rapidly in babies** Action report circulated and a further meeting is required to ensure that all actions are completed. A number of changes have been made included colour changes to the TPN bags. **Welsh Health Circular 2017 051 - Raising Awareness of Carbon Monoxide Poisoning and Action Required by Health** Noted for information and onward dissemination as appropriate.	
POLICIES, PROCEDURES & GUIDANCE FOR APPROVAL		
5.1	**Proposal for the Introduction of a New Clinical Procedure or Technique – Laparoscopic Colposuspension** The proposal for the new procedure was noted for information and a background to the new technique was provided which will mean that the procedure can be competed laparoscopically which will mean a reduction in stay and experience for the patient. Queries were raised as to any support for this procedure and it was noted that this is being reviewed within the Directorate. It was noted that there is a very robust process in place and it was acknowledged that a number of cases may also be able to be transferred to this procedure so there was be no anticipated impact to RTT. It was agreed that an SBAR would be completed so that this can be shared with the Executive Team outlining the benefits, impact and risks.	
EFFECTIVE CARE		
6.1	**7 Days, No Delays** Information will be shared outlining the initiative being taken forward within the organization. There have been very detailed discussions within the directorates as to how all areas can support patient flow etc with plans in place.	
6.2	**CSSI Infection Update** Deferred.	
DIGNIFIED CARE		
7.1	**Latest Cleaning Scores Report – for information** The cleaning scores report was noted for information. The scores reporting 98% compliance	

	across all areas. No specific issues to note for this meeting.	
TIMELY CARE		
8.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** The latest Q&S scorecard was noted for information. It was acknowledged that there have been significant improvements made in a number of areas and thanks were expressed to all for their hard work and commitment.	
INDIVIDUAL CARE		
9.1	**Update on latest 2 minutes of your Time feedback** Discussed as part of item 2.4.	
STAFF AND RESOURCES		
10.1	**Feedback on current position for Sickness & PADR** There was an increase from September to October which was attributed to short term sickness which is anticipated for "winter" illnesses. Deep dive is being undertaken with regards to Long Term Sickness in order to understand the detail to ensure that there is nothing specific associated with work related stress. Discussion ensued in relation to PADR and it was noted that significant work has been undertaken across the Directorates in order to improve the PADR rates. Queries were raised with regards to recording of PADR and it was noted that whilst there was an issue, it was mainly down to uploading of the information and not the completion of the PADR itself. There was a general discussion with regards to accessing the system itself. Two days on 5th and 12th December have been arranged by the Clinical Board for rooms to be available within IT in order for staff to be able to attend and complete stat and mandatory training, with support available if required. It was reiterated that there is a need to improve across the Board and it is a mandatory requirement. It was noted that for Nursing & Midwifery an improvement target of 5% has been requested by the end of the financial year.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
11.1	**Medication Errors Report – October 2017** The report was shared for information. It was noted that a Medications Safety Update has been produced within ACH and this will be rolled out widely across all areas from the new year. This briefing will outline the errors, lessons learnt and any information sharing. It was requested that "potential harm" also be included within the briefing in order to reiterate the importance and responsibilities for all staff. It was noted that there needs to also be a focus of zero tolerance for errors as this is a very serious issue that needs to be addressed. AL agreed that the update would be reviewed and amended, taking on board the comments noted.	
11.2	**Medication Safety Metrics – October 2017** Noted for information.	
11.3	**Closure Form to note - In50123** Noted for information. This closure form has been submitted to Welsh Government and the findings and lessons learnt were discussed as part of item 4.2	
ANY OTHER BUSINESS		
12.1	**Clexane Shortage / Switch to Inhixa**	

	It was noted that clexane is being ring fenced for maternity patients due to the current shortage. A biosimilar product has been found and will be stocked on all wards with Pharmacy completing the endorsements etc. **Kennedy Review** Discussion ensued with regards to the recent review of the response of the Heart of England NHS Foundation Trust to concerns about Mr Ian Paterson's surgical practice. It was noted that the lessons learnt and recommendations are now available. All were encouraged to read.	

DATE AND TIME OF NEXT MEETING

22.7

The next meeting is scheduled for **Tuesday 23rd January 2018, 8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW (Quality & Safety Focus)**

<u>2018 Meeting Dates</u> (4th Tuesday of the Month, between 8.30 – 10.30am unless otherwise stated below)

Tuesday 23rd January, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 27th February, Meeting Room, Clinical Board Offices, Lakeside (H&S Focus)
Tuesday 27th March, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 24th April, Council Room, UHW
Tuesday 22nd May, Council Room, UHW (H&S Focus)
Tuesday 26th June, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 24th July, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 28th August, Venue to be confirmed (H&S Focus)
Tuesday 25th September, Meeting Room, Clinical Board Offices, Lakeside
Tuesday 23rd October, Venue to be confirmed
Tuesday 27th November, Meeting Room, Clinical Board Offices, Lakeside (H&S Focus)
Tuesday 18th December, Meeting Room, Clinical Board Offices, Lakeside

Dental Clinical Board

Minutes of Quality, Safety & Experience Committee Group Meeting
2nd November 2017 at 8:00 AM
Dental Boardroom

Present: Mr Andrew Cronin (Chair)(AC) Eira Yassien (EY) Catherine Evans (CE) **In attendance**: Jonathan Peck (JP)	James Gillespie (JG) Barbara Chadwick (BC) Gurcharn Bhamra (GB) Ivor Chestnutt (IC)	Shannu Bhatia (SB) Julia Charles (JC)
Apologies Received from: Rowena Griffiths N Drage	Dinah Jones Mike Lewis	Sarah Merrett

		ACTION
PRELIMERIES		
1.1	**Welcome & Introductions** AC welcomed everyone to the meeting of the Quality, Safety and Experience Group.	
1.2	**Apologies for absence** Received as above.	
1.3	**To receive the Minutes of the previous meeting** The minutes of the Quality & Safety meeting held on the 7th September 2017 were accepted as an accurate record. **Matters Arising** There were no matters arising.	
MONITORING & REPORTING – DENTAL CLINICAL BOARD SUB GOUPS		
2.1	**Oral Surgery, Medicine and Pathology** **- Mr N Drage** Minutes from the OSMP Audit Group meeting on the 13th October 2017 were received and noted.	
2.2	**Restorative Dentistry** **- Mr G Bhamra** Minutes from the Restorative Dentistry Audit Group meeting on the 20th October 2017 were received and noted. GB noted the presentations given: • Audit proposal: A retrospective audit on the incidence of root canal flare up associated with patients seen in MClinDent.	

	AC queried why the literature being cited in the proposal was from 20 years ago. GB explained that the age of the literature was one of the reasons for undertaking the audit. • Audit proposal: Re-audit of the technical quality of root canal fillings performed by postgraduates. • Audit proposal: Audit of Restorative referrals. GB commented that this audit would be of particular interest as there would be a re-audit after the introduction of the new referral form to provide a comparison. EY commented that referrals would soon be received electronically via the Welsh Admin Portal and the new forms to be used have been submitted. IC noted that the proposed audit could be a retrospective audit on old referral forms and a re-audit could be carried out on the new electronic form. EY requested feedback from the group to determine whether the new electronic referral forms should now be available on the Cardiff & Vale UHB website. IC confirmed yes. • Incident Reporting Presentation from Catherine Evans • DSDU presentation from Claire Legge GB commented that that the issue of non-disposable items being thrown away was still an issue. Students were still unclear as to what items were disposable. GB requested from the group any suggestions to improve student awareness. IC commented that ongoing audits were being made of sharps bins and he was under the impression that the issue had been resolved. BC will discuss the issue with teaching leads. BC queried the frequency of audits and the clinics that sharps bins were being checked. AC will find out. GB informed the group that the smoking cessation question was now on the SALUD system and was being completed.	AC
2.3	**Joint Orthodontic and Paediatric Dentistry** **- Mrs S Bhatia** Minutes from the Joint Orthodontic and Paediatric Dentistry Audit Group meeting on the 13th October 2017 were received and noted. SB noted the presentations given: • DSDU presentation from Claire Legge • Audit on Minimum Dataset for Orthognathic Patients • Orthognathic Patient Satisfaction Audit • Patient Story – SB summarised the patient story to the group that resulted in a complaint being received from the parents of the patient due to multiple extractions after a GA appointment. The group discussed. SB informed the group that sharps injuries caused by wands had been discussed and it had been suggested there should be a change of practice. Students should not be allowed to bend the wand. BC agreed to enforce the teaching of this to students. SB commented that an audit had been proposed on patient satisfaction in Hypodontia and the group had been given a brief overview of the proposal and shown an example questionnaire for feedback. SB informed the group of a recent incident where a video was taken on clinic and shared on social media. The group discussed. IC clarified that it was UHB policy that photos and videos were not to be taken on clinic and posters informing patients of this were already on display. SB noted that audit group meetings were being utilised to their fullest and the opportunity was also being taken to incorporate training, consultant meetings and PAR audits into the time allocated. SB showed the group an example of the new Hypodontia leaflets. SB commented that the quality of the paper and photographs could be improved and noted that the leaflet was still a work in progress. AC noted it was good to be pro-active and the leaflet was in keeping with what the UHB would like to see. AC requested any Patient Stories be forwarded to JP to be kept.	

2.4	**Community Dental Service** **- Mr J Gillespie** JG commented there had not been a recent CDS Quality & Safety meeting. There had been 2 locality meetings where there had been presentations and training. JG noted there were currently 6 audit proposals ready to be submitted.	
2.5	**DSG HSC: Minutes of the Dental Division and School H & S Advisory Group** **- M Wilson** IC briefly summarised the last meeting held in September. The target for flu jab uptake has been increased from 50% to 60% and UDH were now providing free flu jabs to students for the first time. IC clarified that despite a worldwide shortage of Hepatitis B vaccine it has been confirmed that all students will be inoculated. The University will not be impacted and the teaching program will not be affected.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Health and Care Standards Monitoring data	
3.2	Consent	
3.3	Patient Identification Policy	
3.4	Audit Plan	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
4.0	WHC/2015/001 - Improving Oral Health for Older People Living in Care Homes in Wales – Dinah Jones WHC 2008 (008) – Designed To Smile – Dinah Jones	
SAFE CARE		
5.1	Risk Register- Rowena Griffiths review and revision	
5.2	**Incident Report** • Incidents 300817 - 271017 The document was received and noted. AC noted that all incidents were discussed at their respective audit group meetings and requested if there were any that needed to be escalated to this Quality & Safety meeting. CE queried the incidents involving light fittings. EY confirmed that this had now been addressed and resolved. CE queried incident 55602 and commented that all incidents should be given an outcome. AC requested GB follow up. Top 3 learning areas arising from review of incidents and clinical audits **New Serious Incident IRMER Breach** • Never Event 2 & 3 Improvement plan FINAL The document was received and noted. CE noted that a re-audit in compliance of the WHO checklist was now due. AC will clarify progress of the re-audit with Nicholas Drage.	GB AC

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	SB queried whether the checklist was to be shared and implemented across all specialities, St David's Hospital and Mountain Ash Hospital. AC commented that this was a decision that needed to be made and requested feedback from the group. The group discussed. AC suggested that the planned re-audit should first be completed before a final decision is made.	
5.3	Medicines Management Audit Report – Rowena Griffiths	
5.4	New Medical alerts	
5.5	Medical devices/equipment issues	
5.6	Decontamination CDS WHTM01-05	
5.7	HIW Inspections and report	
5.8	Infection, Prevention & Control Clinic inspection reports and improvement plans	
5.9	**NatSSIPs – Julia Charles** JC informed the group that the Gap Analysis for UDH had been submitted. It was likely that there would have to be a separate one for CDS. JC to forward UDH Gap Analysis to JG for information.	JC
EFFECTIVE CARE		
6.1	**Monitoring of CB Clinical Audit plan** • Ongoing Audits as at 30 October 2017 The document was received and noted. AC reminded audit leads that ongoing audits needed to be monitored and closed when appropriate.	
6.2	**Research and development** • RD newsletter 20th Edition 2017 The document was received and noted.	
DIGNIFIED CARE		
7.1	Initiatives to improve services for people with: • Dementia – Dinah Jones • Sensory loss – Eira Yassien • Mental Capacity Act	
TIMELY CARE		
8.1	RTT – Eira Yassein Waiting list issues – Eira Yassein	
8.2	LIPS Bariatric Pathway	
INDIVIDUAL CARE		
9.1	**Concerns** • Concerns Aug17 - Oct17 The document was received and noted.	
9.2	**Compliments** • Compliments Sep17 - Oct17 The document was received and noted.	

9.3	**Safeguarding** • wbscb-child-practice-review-report-wb-b20-2015 The document was received and noted.	
STAFF AND RESOURCES		
10.1	**Employee of the Month** • September - Huw Owen. Oral Surgery • October - 1st Floor Reception Staff	
10.2	Staffing levels – Eira Yassien	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
	None received.	
Any Other Business		
	AC noted an Information Governance email that he had received summarising a 'Break Glass' incident on Clinical Portal. AC will update the group should any further information become available.	

Date and time of next meeting

Thursday 11th January 2018	8.00 AM	

Dental Clinical Board

Minutes of Quality, Safety & Experience Committee Group Meeting
11th January 2018 at 8:00 AM
Dental Boardroom

Present: Mr Andrew Cronin (Chair)(AC) Eira Yassien (EY) Catherine Evans (CE) Rowena Griffiths (RG) Beverly Withers (BW) **In attendance**: Susan Dunkeld (SD)	James Gillespie (JG) Barbara Chadwick (BC) Gurcharn Bhamra (GB) Ivor Chestnutt (IC) N Drage (ND)	Shannu Bhatia (SB) Julia Charles (JC) Sarah Merrett (SM) Dinah Hughes (DH) Prof M A O Lewis (ML)
Apologies Received from: None given		

		ACTION
PRELIMERIES		
1.1	**Welcome & Introductions** AC welcomed everyone to the meeting of the Quality, Safety and Experience Group.	
1.2	**Apologies for absence** Received as above.	
1.3	**To receive the Minutes of the previous meeting** The minutes of the Quality & Safety meeting held on the 2nd November 2017 were accepted as an accurate record. **Matters Arising** There were no matters arising.	
MONITORING & REPORTING – DENTAL CLINICAL BOARD SUB GOUPS		
2.1	**Oral Surgery, Medicine, Pathology & Radiology** **- Mr N Drage** Minutes confirmed from the OSMP Audit Group meeting for November and December 2017 were received and noted. ND advised of two Oral Medicine presentations, both led by Dr P Atkin. One a service review on biopsies undertook in Oral Medicine Clinic and the second an audit of sample adequacy. The results of the second audit were compared to a similar audit undertaken at Prince Charles Hospital. There was also a presentation by Alex Siddle who undertook an audit of patients undergoing sedation entitled 'Are we getting it right'.	

	There had also been a presentation regarding patient satisfaction in Radiology. RG asked that this be used for the Patient experience – ND to send RG the power point. ML had a meeting on the 27/11/17 with Bristol Dental Hospital and met with S West. In February 2017, a National audit re antibiotic prescriptions which is a two minute form to fill in. MW has been round all the audit groups to advice of this.	ND/RG
	Restorative Dentistry **- Mr G Bhamra** **Minutes from the Restorative Dentistry Audit** Group meeting on the **20th December 2017** were received but not confirmed there was a problem with wrong email address for the chair being used. **To be presented at the next Q&S meeting.**	
2.3	**Joint Orthodontic and Paediatric Dentistry** **- Mrs S Bhatia** **Minutes from the Joint Orthodontic and Paediatric Dentistry Audit** Group meeting on the **13th December 2017** were received but not confirmed re on A/L. **To be presented at the next Q&S meeting.** SM - Patient stories where one GA tooth extraction incorrect due to communication breakdown to be discussed at next Ortho/Paeds Audit. Emma Stone to give hand washing update. Post grad exams for pathways Consent and how it's documented and if required for every visit – there have been no answers to date. MSC Orthognathic – Post grad Masuma to present at next OSMP audit. BC raised the question for fissure sealants and Fluoride varnish and both can be used.	
2.4	**Community Dental Service** **- Mr J Gillespie** There were currently 6 audit proposals ready to be submitted. Looking at consent process for paeds GA and there is to be a joint locality meeting coming up. DJ said Design to smile working well – nothing to report. Nurses no longer able to sign off Fluoride varnish causing Will McLaughlin a build up of folders to sign off and its causing an issue.	
2.5	**DSG HSC: Minutes of the Dental Division and School H & S Advisory Group** **- M Wilson** ML explained that MW would not be attending due to part time contractual hours. MW will be covering minutes for Infection Control and if days in meet with Q&S then MW will attend.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Health and Care Standards Monitoring data	
3.2	Consent	
3.3	Patient Identification Policy AC will distribute a report regarding Patient A receiving Patient B blood. Process break down in identification. JC meeting in UHW regarding wrists bands. AC has document for Patient Safety of policy and Processes.	AC AC
3.4	Audit Plan	

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HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
4.0	WHC/2015/001 - Improving Oral Health for Older People Living in Care Homes in Wales – Dinah Jones WHC 2008 (008) – Designed To Smile – Dinah Jones	
SAFE CARE		
5.1	Risk Register- Rowena Griffiths Still in progress, being reviewed and to be user friendly. Updates for all departments and RG to see CDS.	RG
5.2	**Incident Report** Incidents: RG said that Ruth Walker said the incidents were low but RG said we could be under reporting and this raised discussion that Datix taking time to fill in. Not all incidents being raised. AC suggests all Audit Leads to encourage clinical incidents are done in the correct manner. **New Serious Incident IRMER Breach** Never Event – Paeds / Ortho to mention at their next audit in February 2017. RG has HIW document to circulate. RG said there will be an improvement plan next week. CE shared two never events for the EDS. ND reported that new legislation is coming into force namely the IRR17 and IRMER 2018. IRR 17 requires registration (for dental equipment). This will be an electronic process undertaken possibly by the head of the radiation protection group. The radiation protection service has provided check list which ND has distributed to the radiation protection supervisors to complete prior to the registration process. IRMER 18 will require procedures for 'carers and comforters' and for 'giving patients dose and risk information'. ND attended a workshop at the end of last year and it is hoped there will an all-Wales approach to producing the necessary procedures to comply with the regulations.'	
5.3	Medicines Management Audit Report – Rowena Griffiths	
5.4	New Medical alerts	
5.5	Medical devices/equipment issues	
5.6	Decontamination CDS WHTM01-05	
5.7	HIW Inspections and report	
5.8	Infection, Prevention & Control Clinic inspection reports and improvement plans	
5.9	**NatSSIPs – Julia Charles** JC informed the group that the Gap Analysis for UDH had been submitted there is a meeting on the 18th February 2017. It was likely that there would have to be a separate	

	one for CDS. The Dental Hospital to be used as a pilot but JC still waiting to hear. RG/BW went to Bristol/Manchester Dental Schools and RG to share findings. JC has paperwork to distribute to group. This is national so all clinical areas are working the same. ML has guidelines for NatSSIPs and has disseminated to the group at the time of writing these minutes.	JC
EFFECTIVE CARE		
6.1	**Monitoring of CB Clinical Audit plan** AC reminded audit leads that ongoing audits needed to be monitored and closed when appropriate.	
6.2	**Research and development** • RD newsletter 20th Edition 2017 The document was received and noted.	
DIGNIFIED CARE		
7.1	Initiatives to improve services for people with: • Dementia – DJ that Grace Kelly is do a presentation for ALL the audit groups and DJ to see GK for presentation for CDS. DJ mentioned that a stand had been in place in November 2017 at Mountain Ash for Dementia Day. AC has documents for MCA leads 2017 will disseminate to the group • Sensory loss – EY advised group that there was an inspection tour of the UDH for accreditation in February 2018. All areas sensory loss folders will be up to date. • Mental Capacity Act	DJ DJ AC
TIMELY CARE		
8.1	RTT – EY Q3 Oct-Dec there were 5 breaches but there could have been a lot more and EY thanks everyone for their hard work and help. 2 x breaches were the Children's Hospital, 1 x diagnostic – pathway not closed and 2 x put on GA list late in December. Q4 end of March will be better planned. Waiting list issues – none discussed.	
8.2	LIPS Bariatric Pathway	
INDIVIDUAL CARE		
9.1	**Concerns** • Concerns Nov17 - Jan18 None received	
9.2	**Compliments** • Compliments Nov17 - Jan18 The document was received and noted. RG suggested the compliments go to PALS in UHW and there have been two individuals to make sure this is actioned.	
9.3	**Safeguarding** • BC disseminated Annual Self Assessment to the group. BC advised there was a meeting in a couple of weeks. • BC stated that Paeds had pro-forma letters within the department and these were	

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	working well.	
STAFF AND RESOURCES		
10.1	**Employee of the Month** • November - Samantha Long Dental Nurse • December - Andrew Williams Dental Records Library	
10.2	Staffing levels – Eira Yassien – nothing to report	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
	None received.	
Any Other Business		
	AC noted that Mandatory training up to date. EY announced there is a Welsh Translation service in the UDH overseen by Rachel Willington-Thomas and she would be happy to give you any information you require. IC sending out newsletter soon. IC wants trainees to write up their experiences for educational practice but their reflection not to be tracked back to a specific patient. AC spoke to the group regarding 3 break glass incidents accessing patient sensitive information breaching data protection and Governance for own/friends/family NHS records and asked the group to disseminate to all the staff that this is not acceptable and could result in a disciplinary or dismissal. There were 3 incidents where this has taken place and is to be managed in-house. DJ to disseminate to all CDS staff. **IC this is to be put on all agenda's for all audits and newsletter.** SB has done a PowerPoint and will send to the group.	DJ SB

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Date and time of next meeting

Thursday 15th March 2018	8.00 AM to 10.00AM	PGG 222/223 2nd Floor UDH

PRIVATE QUALITY SAFETY AND EXPERIENCE COMMITTEE

17th April 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 13th February 2018	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting	Oral *Chair*
7	Safeguarding Update	*Executive Nurse Director*
8	Royal College of Surgeons Report - Paediatric Surgery and Improvement Plan	*Executive Nurse Director*
9	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
10	Review of the Meeting	Oral – *Chair*
11	Date of next meeting Tuesday 12th June 2018	