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 12th June 2018
Corporate Meeting Room, UHB HQ
University Hospital of Wales

QUALITY AND EXPERIENCE COMMITTEE
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AGENDA

PART 1: Items for Action		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Committee meeting held on 17th April	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting	Oral *Chair*
Governance, Leadership and Accountability		
7	Patient Story	*CB CD&T*
8	Clinical Diagnostics and Therapeutics Clinical Board Quality, Safety and Experience Assurance Report	*CD&T Clinical Board*
9	Community Health Council Reports: 1. Scrutiny Overview 2. "Our Lives on Hold" 3. Sensory Loss Assessment of NHS Organizations across Cardiff and the Vale of Glamorgan	*S Allen, CHC*
10	Hot Topics including an update on the WAST SIs	Oral *Executive Nurse Director*
11	**Policies for Approval** • NHS Wales Prior Approval Policy • All Wales Point of Care Testing Policy. What when, how? • Intraoperative Cell Salvage Policy and Procedure	*Director of Public Health* *Medical Director* *Medical Director*
12	Patient Experience Framework	*Asst. Director Patient Experience*
13	Revised Corporate Risk and Assurance Framework	Oral *Director of Corporate Governance*
14	Annual Quality Statement	*Asst Director Patient Safety and Quality*
Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)		
Theme 2: Safe Care		
15	Clinical Audit Plan 2018/19	*Medical Director*

16	IPC Exception Report	*Executive Nurse Director*
17	Cleaning Standards	Oral *Director of Planning*
18	Medicines Management - Health and Care Standard 2.6	*Medical Director*
19	Point of Care Testing	*Medical Director*
Theme 3: Effective Care		
20	Cancer Peer Reviews - Gynaecology	*Medical Director*
21	Mortality Data and Mortality Review	*Medical Director*
Theme 4: Dignified Care		
22	HIW Activity Update	*Executive Nurse Director*
Theme 5: Timely Care		
23	Ophthalmology Services Presentation	*Chief Operating Officer & Director of Operations*
24	Out of Hours Interventional Radiology	Oral *Chief Operating Officer*
Theme 6: Individual Care		
25	Sensory Loss	*Chief Operating Officer*
Theme 7: Staff and Resources		
26	Single Rooms, Decant Facilities and Isolation Rooms at UHW	Oral *Director of Planning*
PART 2: Items to be recorded as Received and Noted for Information by the Committee Papers are available on the UHB website		
27	**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 – March and April 2. Mental Health – May 3. Primary, Community and Intermediate Care - March 4. Specialist Services – February and March 5. Medicine – February 6. Surgery – March 7. Children and Women – January, February, March and April 8. Dental – March and May	*Assistant Director, Patient Safety and Quality* *(Chief Operating Officer)*
28	Agenda for the Private QSE	*Executive Nurse Director*

29	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
30	Review of the Meeting	Oral – *Chair*
31	Date of next meeting - 9am on Tuesday 18th September 2018 **Dates for 2018/19** • 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 17 APRIL 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:

Abigail Harris (part)	Director of Planning
Angela Hughes	Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Dr Graham Shortland	Medical Director
Lee Davies	Deputy Chief Operating Officer
Dr Rebecca Broomfield	Clinical Leadership Fellow (Observer)
Robert Chadwick	Director of Finance
Ruth Walker	Executive Nurse Director
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Stuart Egan	Staff Representative

Apologies:

Dawn Ward	Independent Member – Trade Union
Peter Welsh	Director of Corporate Governance
Dr Sharon Hopkins	Director of Public Health
Steve Curry	Interim Chief Operating Officer
Secretariat:	Julia Harper

QSE 18/043 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular, Members of the Clinical Board for Children and Women who were attending the meeting to deliver the patient story and their quality and safety report.

QSE 18/044 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 18/045 DECLARATIONS OF INTEREST

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

QSE 18/046 MINUTES OF THE SPECIAL COMMITTEE HELD ON 13th FEBRUARY 2018

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

QSE 18/047 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 & 18/004 Nutrition and Catering Policy and Never Event NG Tube –** Work to update the Policy continued. This would be brought back to the Committee for approval.
   Action Dr Fiona Jenkins

2. **QSE 17/204 & 18/004 IPC Tier 1 –** The UHB Chair reported that she would take on the role of Board Champion for Cleanliness and Hygiene herself. **Complete.**

3. **QSE 18/012 Committee Workplan –** There had been no changes to the Committee Workplan following the Board Development Day, but Members may, in future, find more detail in reports with overarching reports at Board. **Complete.**

4. **QSE 18/019 Outpatient Follow Ups –** No update on the reasons for DNAs was provided.
   Action – Mr Steve Curry

QSE 18/048 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

The Chair reported that together with two Independent Members, the Medicines Management Policy and Medicines Code had finally been approved and published on receipt of the Equality and Health Impact Assessment.

QSE 18/049 PATIENT STORY – CHILDREN AND WOMEN'S CLINICAL BOARD

The Executive Nurse Director introduced Ms Sarah Spencer, Senior Midwifery and Gynaecology Manager as the Royal College of Midwives Midwife of the Year. Mrs Walker advised that this was the second year running that a midwife from the UHB had won this award. This award relied on patients to nominate midwives who had delivered exceptional service.

Ms Spencer shared the patient story that had led to her nomination for the award and related to the care given to all parties in a surrogate pregnancy. Following a failed pregnancy and subsequent infertility, Surrogacy UK supported two couples from Birmingham and Barry to conceive twins through IVF.

As soon as the families made contact with the UHB Maternity Service, a meeting was arranged with all parties to discuss their needs and wishes throughout the pregnancy and birth. As an elective caesarean delivery was planned, it was possible for the parents to make arrangements to attend the hospital for the birth and all were present in theatre. Care was taken to support the new parents and their extended family with their babies whilst special arrangements were made for the surrogate mother. Staff even made it possible to get the father's name included on the birth certificate.

Such situations were still rare, but staff went through the legislation carefully and made every effort to ensure all parties had a good birth experience.

The Chair thanked Ms Spencer for delivering the inspirational patient story and congratulated her on the RMC award.

QSE 18/050 CHILDREN AND WOMEN'S CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

Mrs Cath Health, Director of Nursing, and Rachel Burton, Director of Operations for the Children and Women's Clinical Board attended the meeting to present their comprehensive report.

Mrs Heath described the governance arrangements for the Clinical Board and reported good representation at quality and safety meetings. In addition, an Internal Audit had provided substantial assurance in the risk management arrangements, although the Clinical Board still carried some substantial risks.

Ms Health also described the developments and successes over the last 18 months including achievement of the Baby Friendly Initiative status and significant improvement in infection rates. She advised that the current focus was on developing a Children's Charter and embedding children's rights and sustaining good referral to treatment times.

The Chair invited comments and questions on the comprehensive report:

- It was requested that details of mortality and morbidity reviews and information governance issues were included in this report and on the agendas of quality and safety meetings.
- The importance of getting children's views on their services was stressed so they were able to contribute to their own care and services were shaped to their needs. In addition, Cardiff Council was committed to working towards becoming a child friendly city. The Clinical Board was also at the start of a 3 year programme to implement the new ALN

Bill (Additional Learning Needs). Mrs Rose Whittle was leading a UHB Group to develop this.

- It was suggested that there may be opportunities to work with the Council and access training programmes on ALN and Cllr Elsmore would provide links to this if required.
- A request was made for the Clinical Board to review their risks around medical devices and to ensure this was discussed at quality and safety meetings.
- Each death in the Clinical Board was thoroughly reviewed including stillbirths. No themes or causes of concern had emerged in the last year.
- In terms of PICU, this was a WHSSC commissioned service. However, WHSSC had requested evidence to support the plan to introduce a 7th bed. It was anticipated that recruitment would not be a problem if this was progressed.
- 16 cots were open including 4 in HDU and 8 in special care and there was flexibility. The UHB was now operating at commissioned capacity.
- There were good links with the CAMHS.
- There was engagement with children in local schools to ensure a diverse range of views were captured.
- Children would be part of the interview process for the new Psychologist.
- There were no repeated patterns of complaint in the Clinical Board and all were graded by the Executive Nurse Director.
- A reduction in the number of women smoking during pregnancy had been seen but the figures for 2017/18 were not yet available.

ASSURANCE was provided by:

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

The Committee:

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

The Chair thanked the Clinical Board for the report and their attendance.

QSE 18/051 COMMUNITY HEALTH COUNCIL (CHC) REPORT

The CHC Chief Officer, Mr Stephen Allen, presented the report that identified areas of good practice as well as areas of concern. He highlighted the areas of sensory loss, capacity in Gwenwyn ward, the recommendations made, and the UHB's positive response to visit reports with 90% of recommendations having been actioned. In future, advocacy would be integrated into visits.

In general, comments from visits were positive on the level of care provided by staff and it was pleasing to hear from staff what they were doing to enhance the patient experience.

Mr Allen advised that the CHC had set up a system for patients to send live text updates to the CHC on the care they were receiving whilst in hospital. In addition, publication of an all-Wales report on the effects of delayed treatment on patients was imminent – "Our Lives On Hold". It was agreed that this report would be received at the Committee.
Action – Mr Stephen Allen

Mrs Walker advised the Committee that the quality of UHB responses to CHC reports had improved and that intelligence gathered by the CHC influenced both HIW's and Welsh Government's perception of the UHB.

The Committee **RECEIVED** and **NOTED** the report of the CHC.

QSE 18/052 HOT TOPICS – SERIOUS INCIDENTS INVOLVING WAST (WALES AMBULANCE SERVICES TRUST)

The Executive Nurse Director, Mrs Ruth Walker gave an oral update on 11 serious incidents connected with WAST and commented that for several of these, the UHB had been completely unaware they had been reported by WAST.

Work was now underway to determine whether the UHB had contributed in any way to the delays in ambulance arrival at scene because they were stacked outside the A&E department. Regular meetings were being held with WAST and it had been agreed that the UHB would be kept informed of any future incidents. It had been a difficult winter, but these incidents demonstrated how important it was for the UHB to release ambulances as quickly as possible and in this regard, the UHB was constantly trying to improve patient flow.

Miss Battle reported that she had spent a day with a front line ambulance crew to get a better of feeling of the service and the challenges they faced. Interestingly, the general view of the crews was that patients were safer in the back of an ambulance than in a corridor in A&E. However, it would be even better for all concerned if there was better care within the community to avoid admission to hospital in the first place. It was clear that not all patients needed to come into hospital but this would require a substantial change in human behaviour.

The grading of ambulance calls was another area that required further work. It was suggested that some Independent Members may wish to spend time with the Ambulance Service and this would be arranged if requested.

It was **AGREED** to receive a progress update in June.
Action – Mrs Ruth Walker

QSE 18/053 QUALITY SAFETY AND IMPROVEMENT FRAMEWORK UPDATE

The Director of Patient Safety and Quality, Mrs Carol Evans presented the report and advised that broad cross cutting themes from the Clinical Boards had been considered in order to develop areas on which to focus in 2018/19. Good progress had been made and better connectivity was seen across the Clinical Boards.

It was noted that Welsh Government had set its areas for focus for the next year and included orthopaedics and ophthalmology. It was suggested that the values based work be included in the framework along with the work on transformation.

Dr Shortland reported that outcome measures for ophthalmology were being developed for roll out.

An issue with end of life care was raised. Community nurses had expressed their concern that they were attending patients who needed IV drugs when death was imminent, yet they had not had any contact with the family previously who had been cared for by Macmillan nurses. This was not providing a good experience for the patient, the family or the staff. It was agreed that this would be investigated further, including whether the Hospital at Home Service was able to administer IV drugs. The CHC also raised the difficulty of getting prescription drugs through the Out of Hours system.
Action – Mrs Ruth Walker

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

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

QSE 18/054 ETHICS COMMITTEE TERMS OF REFERENCE AND NEW CHAIR

The Medical Director, Dr Graham Shortland advised that the Ethics Committee was looking more at UHB wide ethical issues rather than individual cases. Any member of staff who wanted to serve on the Committee could approach the new Chair for further information. Dr Shortland thanked Dr Richard Hain for his Chairmanship of the Committee over many years.

ASSURANCE was 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:

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

QSE 18/055 OUT OF DATE QSE POLICIES

The Executive Nurse Director, Mrs Ruth Walker presented the report that highlighted the number of out of date policies and procedures but also demonstrated the progress that had been made to reduce the number outstanding. Mrs Walker explained to the Committee that there would always be a number out of date due to the nature and timing of the process.

Concerns were expressed that perhaps staff did not completely understand the process for getting controlled documents approved and perhaps the whole process could be simplified. It was agreed to ask Board to reconsider the Policy for the Production of Written Control Documents
Action – Mr Peter Welsh

ASSURANCE was provided by:

- Progress that had 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:

- **NOTED** the report and progress that had been made.
- **APPROVED** the proposal to achieve a position where all clinical policies were in date.

QSE 18/056 CARE OF THE DETERIORATING PATIENT – REVISED RISK ASSESSMENT

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that a number of actions had been ongoing for some time concerning care of the deteriorating patient. This was a high risk to the UHB and the current process had been completely risk assessed through new methodology in order to take stock of where the UHB was, what mitigating actions were being taken and what else was needed.

There was a risk of death if staff failed to identify deteriorating patients, and there were currently inconsistencies in how measurements were taken and the nature of the response. The good news was that the previous trend was

not being seen and indicated that deteriorating patients were being spotted and treated.

The Chair invited comments and questions:

- It was important for the UHB to be honest and open in its organisational self-assessment and to develop an action plan in response.
- Ideally there should be a unified system for Hospital at Night and the Out of Hours service. In this regard, the Medical Director said he may need some resource following the changes to the junior doctor rota in April 2019. In response, the Finance Director said that as no new resource was available and the issue was not identified in the IMTP, money would have to be shifted from other areas.
- The future configuration of services at Llandough needed to be known before a plan for managing deteriorating patients could be developed.
- Hospital at Night was available at both hospitals and was safe but stressful. It had not been possible to sufficiently recruit to run the service. In terms of Out of Hours, this required a full range of clinical staff.
- There was sufficient capacity in the systems when the rotas were full but there were gaps. Junior doctors had started to report times when there were rota gaps. The UHB Chair reported that she would be shadowing a junior doctor through Hospital at Night as the Ambulance Service had reported some concerns when taking 999 patients to Llandough. There was a national cap on locum costs and all decisions were based on patient safety whilst being mindful of financial pressures. Though Hospital at Night was struggling, there was no evidence of an increase in incidents and Management Executive considered staffing issues on a weekly basis.
- It was suggested that families were often better placed to identify condition changes and deterioration and should be encouraged to report this to nursing staff. CHC Members would test this out during their visits.
- Ward based kiosks captured feedback on whether families felt involved in care decisions – this area scored highly.

ASSURANCE was provided by:

- Review of this risk by the Corporate Nursing Directorate as set out in the Risk Assessment at Appendix 1
- The control measures that were 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:

- **NOTED** the current risk rating of 20.
- **CONSIDERED** the range of measures being taken to mitigate and reduce the risk that staff would fail to recognize the deteriorating patient.

- **AGREED** to receive further assurance on Hospital at Night in the Autumn.
  Action – Dr Graham Shortland

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QSE 18/057 INFECTION PREVENTION AND CONTROL – REVISED RISK ASSESSMENT

The Executive Nurse Director, Mrs Ruth Walker presented the revised risk assessment for infection prevention and control and reminded Committee that the lack of single rooms for isolation remained an issue within the UHB. The risk assessment described the controls in place and the further work required. In particular, the IPC team was small, but with the current financial challenges and the improvements that had already been seen, there were no plans to increase its size in the IMTP. However, discussions would be held with Public Health Wales to fill all 6 sessions allocated to leading the IPC team.

Dr Shortland advised the Committee that the UHB was performing well on antimicrobial prescribing, particularly in the PCIC Clinical Board.

ASSURANCE was provided by:

- Review of this risk by the Corporate Nursing Directorate as set out in the Risk Assessment at Appendix 1.
- The control measures that were 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:

- **NOTED** the current risk rating of 20 and
- **CONSIDERED** 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 the UHB would not deliver the annual infection prevention and control programme and achieve the Welsh Government reduction expectations.

QSE 18/058 PATIENT FALLS EXCEPTION REPORT

The Director of Therapies and Health Sciences, Dr Fiona Jenkins told Committee that falls occurred because of a loss of balance or a patient's inability to maintain an upright posture. Many frail patients were compromised physically and medically and were therefore already at an increased risk of falling, particularly in unfamiliar surroundings and wide open spaces. The key to reducing falls was to keep patients in their own homes for as long as possible and much work was ongoing in the community and in nursing homes to support this. There was no undue concern at the number of falls reported. Within hospitals it was important to reduce the level of harm caused when a patient fell.

It was noted that Canterbury had managed to reduce the number of admissions because of a fall and the UHB had set up a Group to consider the falls pathway and monitor UHB figures. This topic would probably be considered later in the year by the Board as part of the UHB's Strategy.

ASSURANCE was provided by:

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

The Committee:

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

QSE 18/059 REPORT ON OUTLIERS

Mr Lee Davies, Deputy Chief Operating Officer presented the report and advised that the aim was to align demand and supply. There was currently a mismatch and work was ongoing to balance the risk of delayed admission, admission to the wrong ward or maintaining patients in the back of an ambulance. The majority of outliers were medicine patients located on surgical wards.

Action had been taken to alleviate pressure but the UHB had seen much higher demand than the rest of Wales during a bad winter and consequently there had been an upturn in outliers. The Board would be receiving a review of the winter period at its meeting in May.

The Committee considered the hospital and community reasons for untimely discharges and noted that the impact of culture should not be underestimated. This would be amalgamated into the work on length of stay.

LIMITED ASSURANCE was 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 in the report.
- The formal approach in place within the UHB for reviewing winter planning.

The Committee:

- **NOTED** the level of outliers during the winter and the steps taken to reduce the risks associated with this including the establishment of a dedicated clinical team.
- **NOTED** the "balance of risk" approach to ensuring patients had 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.
- **ENDORSED** a review of Winter Planning in advance of planning for next winter to ensure adequate processes and "surge" bed capacity was available to mitigate the need for placing outlying patients.

QSE 18/060 CANCER PEER RE REVIEW – CANCER PATHWAYS

The Medical Director, Dr Graham Shortland told Committee that the UHB had been waiting for this work and it was slightly different from the usual specialty peer review that the Committee received regularly.

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the Peer Review assessment and the Peer Review reporting process. Any concerns identified would be addressed via an action plan.

The Quality, Safety and Experience Committee:

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

QSE 18/061 HEALTHCARE INSPECTORATE WALES (HIW) ACTIVITY UPDATE

The Executive Nurse Director, Mrs Ruth Walker presented the update and advised Committee that it had come to light that HIW had undertaken a number of inspections in primary care that had not been shared with the UHB. HIW had promised to ensure this did not happen again and conveyed that no concerns had been identified. Oral feedback had been positive. Detailed reports from the visits would be shared with the Committee at a later date. Mr Allen reported that the CHC had undertaken joint primary care visits with HIW but had not been able to share the reports with the UHB as they were owned by HIW.

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

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

QSE 18/062 ENDOSCOPY – SERIOUS INCIDENTS AND LESSONS LEARNED

The Executive Nurse Director, Mrs Ruth Walker presented the report that described the action that had been taken and the lessons learned from 24 serious incidents received since May 2015. Root cause analyses had been undertaken and demonstrated that the administration system had failed. Serious Incidents (SIs) would continue to be reported to Board, but the number was not disproportionate to the population served.

It was hoped that the imminent start of a new consultant and nurse endoscopists would improve the position and sustainability. In addition, a single entry pathway was being developed. However, the department was not without issues and the team was being supported to work through these.

Questions on the timescale for polyp activity (page 123) were raised and would be referred to Mr Steve Curry outside the meeting.
Action Mr Steve Curry
It was also noted that the Tentacle system had been implemented in gastroenterology and would be rolled out to lung and breast. The pros and cons of the system would be considered at Management Executive.

ASSURANCE was provided by:

- The actions identified to address the outstanding themes and trends.

The Quality Safety and Experience Committee:

- **NOTED** the current position and work ongoing in relation to the management of quality and safety issues in endoscopy services.
- **CONSIDERED** the actions currently being taken.
- **NOTED** the current position.
- **AGREED** a process for ongoing monitoring of the situation.

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

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

QSE 18/063 NUTRITION AND HYDRATION

REASONABLE ASSURANCE was provided by:

- The status report submitted.

The Quality, Safety and Experience Committee:

- **NOTED** 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.
- **WAS ASSURED** that the Nutrition and Catering Steering Group kept a regular review of the action plan to ensure and update on progress.

QSE 18/064 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The following Minutes were received and noted.

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**

It was noted that going forward there would be a focus on securing better medical engagement at quality and safety meetings, looking at the ways Directorates assured Clinical Boards and the content of the Dental agenda and minutes. Dr Jenkins asked Mrs Evans to remind Clinical Boards to assess their risk around medical devices and to report outcomes at the QSE Sub Committees.
Action – Mrs Carol Evans

In addition, the Children and Women's Clinical Board would be asked to submit their minutes in a more timely fashion.
Action - Mrs Carol Evans

QSE 18/065 AGENDA FOR THE PRIVATE QSE MEETING

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

QSE 18/066 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

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

QSE 18/067 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 18/068 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 12th June 2018.

Independent Members were reminded that a tutorial session had been arranged for them on 30th May 9.30am to 12.30pm in Llandough.
Members were asked to notify Mrs Ruth Walker of any topics they would like to see covered.

ACTION LOG FOLLOWING QSE COMMITTEE APRIL 2018 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 18/019	13.2.18	Management of Outpatient Follow Ups and Endoscopy Surveillance		Investigate reasons for DNAs.	S Curry	
QSE 18/055	17.4.18	Out of Date Policies		Consider simplifying process and review overarching Policy.	P Welsh	
QSE 18/062	17.4.18	Endoscopy SIs and Lessons Learned		Questions to be answered on timescales for polyp activity.	S Curry	
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
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 the Committee by 20th July.	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. 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

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
						of initiatives could be seen.
QSE 17/211 QSE 18/060	6.12.17 17.4.18	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**
QSE 18/051	17.4.18	CHC Report		Share the report of the effects of delayed treatment "Our Lives on Hold" with QSE	S Allen	For **QSE on publication**
QSE 18/051	17.4.18	Hot Topic – WAST SIs		Update to QSE in June	R Walker	**QSE June 2018** on June agenda
QSE 18/061	17.4.18	HIW Update		Receive a more detailed report and update on progress in Primary Care.	R Walker	**QSE June 2018**
QSE 18/056	17.4.18	Care of the Deteriorating Patient		Provide assurance to QSE on Hospital at Night.	Dr G Shortland	**QSE Autumn 2018 (September or October Special meeting)**
QSE 18/053	17.4.18	Quality Safety & Improvement Framework		Receive detailed outcome based report.	C Evans	**QSE June 2019**

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
COMPLETED ACTION SINCE LAST MEETING						
QSE 17/204 QSE 18/004 QSE 18/047	6.12.17 13.2.18 17.2.18	IPC Tier 1		Appoint a Board Champion for Cleanliness and Hygiene.	M Battle	This would be actioned following Board Development Day in February. M Battle would take on this role. **Complete**
QSE 18/012 QSE 18/047	13.2.18 17.2.18	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. **Complete**
QSE 18/064	17.4.18	Minutes from CB QSE Sub Committees		Ask Clinical Boards to assess risks around medical devices and report outcomes in minutes. Remind Ch&W CB to submit minutes in a more timely fashion.	C Evans C Evans	Both **completed** on 24.4.18
QSE 17/138.3 QSE 18/004	12.9.17 13.2.18	Nutrition and Catering Policy and Procedure.		Update Policy again to include work on NG tubes.	F Jenkins	Policy and Procedure updated via Governance administration review. Published 15th May 2018. No need to consult given minimal change and recent consultation on this, and the NG Tube procedure. **Complete**
QSE 18/053	17.4.18	Quality Safety & Improvement		Investigate the need to change staff teams when	R Walker	Briefing note provided to the Chair on the new model in place and the

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Framework		death was imminent in the community & access to drugs through OOH.		positive feedback from staff and families. **Complete**

CLINICAL DIAGNOSTICS AND THERAPEUTICS QUALITY, SAFETY AND PATIENT EXPERIENCE REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 12th June 2018

Executive Lead : Nurse Director
Author : Clinical Board Director for Quality, Safety and Patient Experience, CD&T
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Deliver Outcomes that Matter to People" elements of the Health Board's Strategy
Financial impact : (if applicable)
Quality, Safety, Patient Experience impact: The work outlined within this paper reflects the activity taking place to improve patient safety and experience leading to improved quality and care outcomes for patients.
Health and Care Standard Number All
CRAF Reference Number 5.1, 5.1.5, 5.1.6, 5.34, 8.1.4, 8.1.7, 8.2
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE is provided by:

The progress the Clinical Board has made on the range of key quality, safety and patient experience performance metrics and the focus on its integrated governance arrangements. The Clinical Board recognises the key areas of improvement and actions required to further improve the patient experience received.

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **NOTE** the progress made by the Clinical Diagnostics and Therapeutics Clinical Board to date and its planned actions
- **APPROVE** the approach taken by the Clinical Diagnostics and Therapeutics Clinical Board

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SITUATION

The work outlined within this paper reflects the activity taking place to improve quality, safety and patient experience within the Clinical Diagnostics and Therapeutics Clinical Board leading to improved quality and care outcomes for patients.

BACKGROUND

The Clinical Diagnostics and Therapeutics Clinical Board provides a wide range of diagnostic and therapeutic procedures on a local, regional and UK wide basis. Collectively these services underpin, and are core components of, almost every aspect of clinical activity undertaken within the UHB.

The Clinical Board consists of 7 directorates:

- Laboratory Medicine
- All Wales Therapeutics and Toxicology
- Radiology, Medical Physics and Clinical Engineering
- Media resources
- Outpatients/Patient administration
- Therapies
- Pharmacy

The Clinical Board vision is to ensure the quality and prudent use of Diagnostics and Therapeutics across the Health Board by:

- Ensuring that we become better suppliers of services to other Clinical Boards by developing our supplier strategy.
- Ensuring that all users have equal access to our service, and are treated with fairness, dignity and respect.
- Working in partnership with other Clinical Boards, Public Health and external partner organisations to improve health outcomes.
- Ensuring that the 'voice of the customer' is heard and informs the planning, commissioning and delivery of services.
- Behaving in accordance with the values and behaviours of the organisation
- Ensuring that staff working within the Clinical Diagnostic and Therapeutics Clinical Board, are provided with opportunity to achieve their full potential.

The key achievements for the Clinical Board in 2017/18 have been:

1. Improved quality metrics across the Clinical Board
2. Consistent delivery of improved waiting time positions for both radiology and therapies

3. Support to other Clinical services in the delivery of improvements to RTT waiting times
4. Consistent and high quality support through improved recruitment and retention to the unplanned care system.
5. Delivered continuous improvement to the financial position throughout the year
6. The Clinical Board has worked with services to improve our approach to engagement including regular use of staff recognition and the start of a medical engagement project.

During 2017/18, there has been a consolidation of the governance and risk management strategy for the clinical board. Through the implementation of an integrated governance board, decision making has been made in a more balanced way for the Clinical Board.

Underpinning the overall Clinical Board strategy has been improvements to the quality system in 2017/18. Through strengthening the quality team there have been key improvements to the quality within the clinical board demonstrated by the improved performance metrics and the delivery of ISO accreditation through a number of the laboratory services.

The Clinical Board Quality, Safety and Patient Experience (QSPE) governance framework provides an assurance that it is delivering its diverse portfolio of services in a safe and sustainable manner. The Clinical Board's QSPE priorities for 2018/19 are outlined in appendix 1 and include:

- Regulatory compliance and accreditation
- Safe implementation of core Information Systems
- Continued self-assessment against the Health and Care Standards with improvement planning against any indicator requiring action
- Regular review of risk management processes and action plans to provide assurance of mitigating actions and risk reduction strategies
- Serious and Adverse Incident Management and Concerns Management
- Embedding the Patient Experience Framework across the Clinical Board.

ASSESSMENT

Governance, leadership and accountability

Strengthening the Quality, Safety and Patient Experience (QSPE) position has been a key priority for the Clinical Board. The Clinical Board Director leads the QSPE agenda and operational responsibility is devolved to the Clinical Board Director of QSPE. QSPE meetings are held monthly and the Terms of Reference are reviewed annually. The

QSPE meeting agenda has been shaped to align with the Health and Care Standards for Wales and this is replicated at Directorate QSPE meetings.

The Clinical Board has acknowledged the need to strengthen the governance arrangements with regards to regulatory compliance. It has recently established the 'Regulatory Compliance Group' with the specific aim of ensuring that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality and safe healthcare and to assist the Clinical Board, and the Executive Board, in discharging its functions and meeting its responsibilities with regard to regulated services within the scope of CD&T Clinical Board.

The Clinical Board risk register is a live document which is maintained and updated monthly. High rated risks are recorded on the Clinical Board CRAF register which in turns feeds into the Corporate CRAF register. The Clinical Board continues to work with services to review risks held on the register to ensure continued appropriate action and mitigation against all held risks.

The highest risk issues currently on the risk register are:

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Risk Description	Risk Score	Action to Manage or Mitigate
Hardware issues with Telepath servers leading to loss of service in Blood Transfusion and Cellular Pathology. Hardware is aging (10 years old) therefore beyond the recommended life-cycle for a server (5 years).	25	Close co-operation with NWIS to mitigate the risks. Continue implementation of LIMS
Laboratory Information Management System (LIMS) - Risk of clinical governance and information governance concerns as LIMS goes live into additional laboratory areas due to the level of robustness of the system.	20	Internally developed risk management strategies. Collaboration with NWIS to develop solutions to national system issues. NWIS Project Management Arrangements. Staff training arrangements Disaster recovery plan in place Each laboratory has contingency procedures to ensure urgent or emergency results are communicated by telephone.
No predictable investment in novel and	20	Develop business cases to

emergent technologies required to keep pace with modern healthcare challenges.		WHSSC. Work closely with WG to develop funded healthcare technology strategies for Wales. Close management of clinical risks associated with backlogs or unfunded technology. Concerns and serious incident monitoring for themes associated with the absence of testing available elsewhere in the NHS across the UK.
The fabric of some estate is currently suboptimal to deliver modern, safe and sustainable healthcare. Specific risks include significant health and safety risks (e.g. Rookwood), regulatory compliance (e.g. Radiopharmacy unit Medical Physics, Mortuary) disabled access and security	20	UHB Capital planning programme Major discretionary capital programme. Robust risks assessment with amended practices protocols to manage risks. Maintenance of Estates requests placed. Plans in development for the Radiopharmacy production unit.
Risk of poorly managed adult and paediatric diagnostic and therapeutic ultrasound devices leading to avoidable adverse consequences for patients and staff. This includes operational performance for Non Obstetric Ultrasound and the rates of avoidable muscular skeletal disorders reported by staff (RSI). Staff competence and training programmes are inconsistent leading to misuse of ultrasound devices and the potential for misdiagnosis of medical ultrasound images (junior medical staff, staff unfamiliar with particular devices etc.) Poorly maintained and calibrated ultrasound devices are not compliant with MHRA guidance, pose a health and safety risk to staff, have reduced expected life of equipment and can produce erroneous	20	Ultrasound Governance Group meet regularly and are developing UHB wide standards. Development of robust competence framework. UHB wide Ultrasound image storage strategy to include gynaecology clinicians. Development and roll out of audit programme. Development of a comprehensive and robust in-house quality and assurance maintenance service. Extended suite of UHB protocols for the use of ultrasound to include respiratory medicine and in particular the placement of

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diagnostic and therapeutic outcomes. Lack of standard equipment leads to variation in practice and error. Variation in decontamination practices lead to varying degrees of risk to patients. Staff capacity, availability of accredited training programmes, recruitment and retention issues (sonographers are a tier 1 shortage list). Failure to store images securely increases risk of diagnostic errors.		chest drains.
Financial Delivery of a balanced year end position due to costs pressures associated with poor demand management and lack of engagement by service users.	20	Trading framework model in Radiology and Laboratory Medicine being used to support demand management.

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Health and Care Standards
The Clinical Board QSPE sub-committee agenda is framed around the Health and Care Standards. Below are examples of work being delivered against the standards through this framework.

Staying Healthy (Theme 1)
Health Promotion, Protection and Improvement
The uptake of the Influenza vaccination is a key priority for the Clinical Board. The uptake rate for frontline staff for the season 2017/18 was 76.2%. Considerable work has been undertaken in developing the role of peer vaccinators and an evaluation of the outcome of this work will be undertaken at the end of the vaccination season.

The 'Making Every Contact Count' approach is being adopted in out-patient settings and this will was further developed in 2017/18 to include level 2 motivational interventions.

The Health Literacy project in Physiotherapy has completed the first phase and has collected over 300 questionnaires from patients attending MSK physiotherapy across Cardiff and the Vale. The second phase has been delayed due to the maternity leave of lead physio and is due to recommence in 2018/9.

Structured education programmes are provided by Nutrition and Dietetics for both patients and staff groups and are contributing to population health and wellbeing.

Safe Care (Theme 2)

Regulatory Compliance and Accreditation

The Clinical Board services are well regulated and subject to regular inspection against legislation, regulation and standards.

It has been a challenging year of inspections with regulation bodies increasing their focus on quality management and resource in light of their perceived 'squeeze' on financial resources. This has led to the Clinical Board re-evaluating its governance arrangements with regards to regulation by ensuring appropriate senior management oversight, escalation of issues, and monitoring of performance. The Clinical Board is working towards a state of 'Always Inspection Ready'.

In addition, the Clinical Board is undertaking a Quality workforce review and will recommend workforce models to gain synergistic benefits from cross-board working.

In 2017/8 the following regulations inspections took place:

- 9th/10th August 2017, the Human Tissue Authority undertook an inspection in Cellular Pathology/Mortuary. The purpose of this visit was to assess compliance against the HTA standards and assess the suitability of premises on which HTA licensed activities take place. The inspection identified a number of significant shortcomings. In response to this the Clinical Board and service developed an immediate response plan in order to begin corrective actions within a governed framework. The HTA continues to be satisfied with the actions taken and the quality of our submissions.
- 3rd/4th October 2017, Health Inspectorate Wales conducted an inspection against the IR(ME)Regulations in Cardiology/Radiology which was complimentary about the care provided to patients and the safety of the service.
- 12th December 2017, the MHRA undertook a regulatory visit against compliance with GMP/GDP in Pharmacy St Mary Processing Unit. The inspection raised a concern that SMPU lacks the necessary resource to complete all Quality Management tasks. There was also a concern that there was insufficient senior management visibility of compliance failures, progress with remediation and resource difficulties at SMPU. The Licensing Authority reviewed our submitted response and considers that the commitments/proposed actions are acceptable.
- 12th December 2017, the MHRA inspected the Blood Transfusion Laboratory for compliance against the Blood and Safety Quality Regulations. It is recognised that significant effort has been undertaken by the team in BTL to improve the quality management system within the service. Whilst progress has been made since the last inspection (February 2017) and the team are in the process of embedding those improvements, the pace of this improvement was seen by the regulator as slow. As a result there are still a significant number of quality items which have not been actioned or closed out in a timely manner. These include

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incident investigation, closure of corrective and/or preventative action plans, self-assessment/audit, and change control.
It should be noted however, that there has been significant improvement in the number of incidents reported, and a reduction in the number of SABRE reportable incidents, as preventative actions have been implemented. This will have a long term positive effect.

- 26th January 2018, Natural Resources Wales conducted an inspection at the Nuclear Medicine department in UHL with regards to compliance with the Environmental Permitting Regulations Radioactive Waste (compliance with permits, radioactive waste management and the regulations concerning storage of sealed radioactive sources). The department received an excellent report which was a testament to the good compliance work of the team in UHL
- 13th March 2018, the MHRA undertook a regulatory visit against compliance with GMP/GDP in Pharmacy at Building 873, Aerospace Business Park, St. Athan. This inspection identified no critical or major deficiencies.

Laboratory Medicine underwent a number of surveillance accreditation visits against ISO15189 and successfully maintained accreditation across all laboratories. Accreditation ensures safe delivery of services, technical competence, timely, accurate and reliable results and good quality management.

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New Ionising Radiation regulations (IR(ME)R18 and IRR18 were successfully implemented across Health Board services utilising ionising radiation.

Patient Safety Incidents
In the period 1/4/17 to 31/3/18 there were two Serious Incidents reported in the Clinical Board. These were:

Blood Bank	Patient given blood intended for another patient. This was a clinical area error due to failure to check patient ID before administration (blood issued to correct patient)	1
Mortuary	Release of the wrong body from the Mortuary	1

There were three 'No Surprises' letters issued to WG in the same period, one to alert to staff shortages in the Neurointerventional service, and two related to the HTA inspection outcomes.

Between 1/4/17 and 31/3/18 there were four IR(ME)R reportable incidents (reported to HIW).

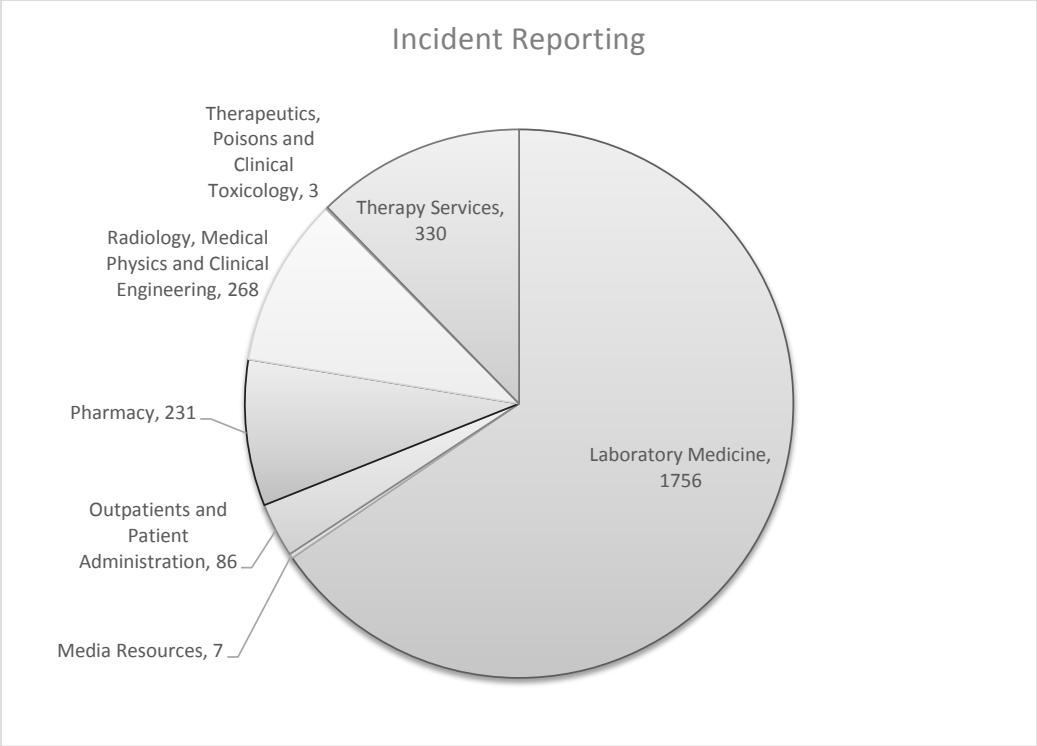
Incorrect addressograph on form (referrer error)	1
Investigation not indicated/justified	1
Incorrect area scanned	1
Incorrect patient (failed ID check operator error)	1

This is significant improvement on the eight IR(ME)R incidents reported the previous year.

Learning from serious and adverse incidents is shared at the Clinical Board QSPE sub-committee and recorded in the risk register where appropriate. There are adequately trained staff to undertake robust investigations including RCA. Significant effort has been made to ensure closure of old incidents and submission of closure forms within WG timescales.

Incident Reporting
For the period 1/4/17 to 31/3/18, 2681 incidents (previous year 2501) were reported by Clinical Board staff using e-Datix.

E-Datix queue are regularly reviewed and managed with emphasis placed on managers and DIF2 users to action and close incidents in a timely manner. There has been significant improvement in the number of incidents held in ‘queues’ and this work will further continue into 2018/19.



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The top 10 reported incidents were (previous year in brackets):

1. Diagnostic processes/procedures – 924 (730)
2. Documentation – 395 (423)
3. Blood/plasma – 315 (227)
4. Patient medication – 249 (183)
5. Patient falls – 140 (175)
6. Staff accidents - 130 (116)
7. Staff exposure to environmental hazards- 112 (67)
8. Service disruption – 63 (59)
9. Behaviour towards staff (including violence and aggression) – 52 (72)
10. Personal Property/Data 46 (72)

Further breakdown of these incidents is described in appendix 2.

Some themed analysis work has been undertaken with regards to incidents; these include patient identification and medication errors. The Clinical Board are supporting the work being undertaken by the Patient Safety Team to reduce addressograph errors and continues to petition for core IT systems which allow electronic referral for diagnosis to

mitigate some of the risk. Further work is currently being undertaken in relation to compliance by clinical areas with blood transfusion protocols.

Health and safety issues
Clinical Board Health and Safety meetings are held monthly. There is a Clinical Board Health and Safety priority work plan in place which is used as a framework to drive improvement. The meeting also receives feedback from workplace inspections.

There have been 4 RIDDOR reportable incidents in the period 1/4/17 to 31/3/18:

- Slip on wet floor (1)
- Fall from small doorstep (1)
- Slip on ice (1)
- Manual handling (lifting box) (1)

No common themes were noted. All cases have been managed with the support of the Health and Safety Unit.

Concerns and compliments
The management of concerns continues to be a key priority for QSPE and significant efforts have been made towards timely response to patient concerns.

The number of concerns is relatively small with 70 being raised in the period 1/4/17 to 31/3/18. The themes were:

Theme	Number
Communication between staff & pts	33
Clinical diagnosis & treatment	27
Deficiency of treatment & facilities	4
Waiting times	3
Case notes issues	2
Staff shortages	1

Tracking of concerns is undertaken and every effort is made to ensure compliance with timescales for formal responses. The average 30 day response rate for the Clinical Board is 80%. Delays in response times were due to complexity of concerns and multi-disciplinary input requirements.

In contrast, 93 compliments were received by the Clinical Board in the same period and it is pleasing to note the positive reports received from patients.

Key patient safety risks

Preventing Pressure and Tissue Damage

E-Datix is used to monitor the number and grade of pressure ulcers reported by Clinical Board staff. In the period 1/4/17 to 31/3/18 there were 8 reported incidents, 1 of these were graded as major harm. This was a significant improvement on the previous year where there were 16 reported incidents, 2 of which were graded as major harm

The Podiatry service within CD&T is responsible for the management of all heel pressure ulcers across all healthcare boundaries including putting treatment plans in place for in-patients and out-reach settings to manage these wounds.

Education of Nursing and HCSW is imperative in risk management of these compromised patients to reduce incidence and pressure damage and Podiatry are involved in the delivery of this education. In particular at:

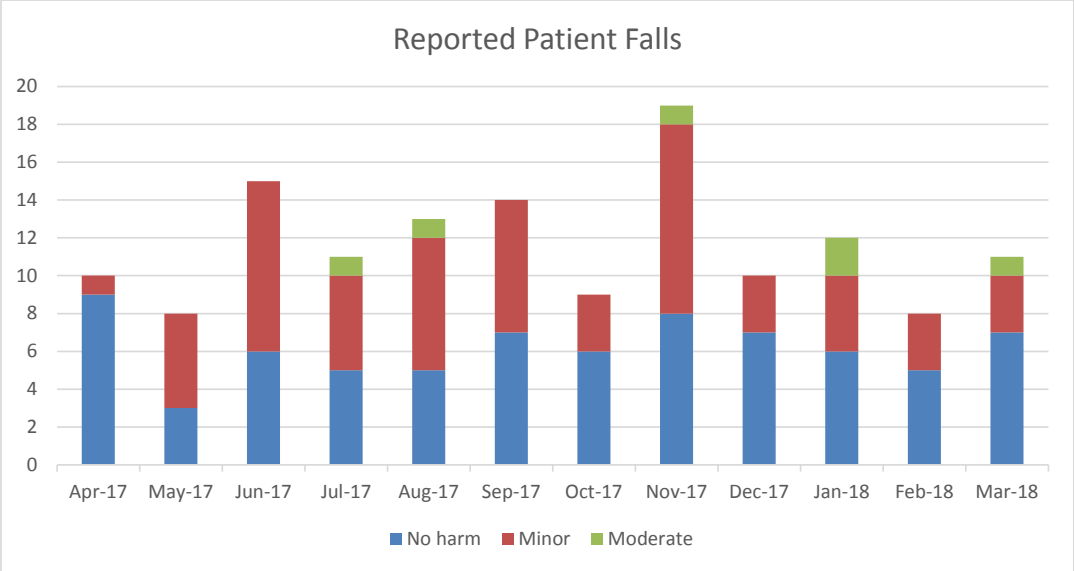
- Pressure ulcer pressure study days
- HCSW induction days (diabetic foot awareness)
- Undergraduate education of nurses and use of diabetes e-tool to identify diabetic foot risks

Appropriate beds, chairs and other equipment are made available to reduce the risks of pressure and tissue damage and all staff are trained in manual handling/moving techniques.

Falls prevention

E-Datix is used to monitor the number and severity of falls within the Clinical Board.

140 patient falls were reported in 2017/18 (reduced from 195 in 2016/17). The majority of falls (96%) resulted in no, or minor, harm. There have been no injurious falls reported in the Clinical Board.



An incident theme review has been undertaken to identify fall hotspots. Risk assessments have been undertaken of environments and of individual patient needs. Patient flow has been assessed to ensure patients can safely traverse clinical areas along with removal of potential trip hazards. Physiotherapists and Occupational Therapists assist with mobility and transfer assessments and the majority of falls (102/140) were associated with this. Appropriate beds, chairs and other equipment are made available to reduce the risks of falls. A review of safe staffing support for therapy sessions has also been undertaken. In the Mental Health environment, physiotherapy are leading on work to reduce falls associated with dementia. Guidance for falls in out-patient areas has been produced and the Clinical Board is supporting the UHB Falls Group.

Infection Prevention and Control (IP&C)

There are Clinical Board Governance structures in place for IP&C. There are Directorate leads across the Clinical Board who champion IP&C and link workers in each Directorate. There is a bi-monthly IP&C group which links through the chair to the UHB IP&C committee. There is Clinical Board membership on the Decontamination Committee, Ultrasound Governance, IP&C committee, and Water Safety group. IP&C risk assessments have been undertaken in all Directorates. E-learning compliance in IP&C and Environment and Waste is monitored by QSPE sub-committee. Physical environments are maintained and cleaned and there is good compliance with the Decontamination of Reusable Medical Device policy.

Proper arrangements exist for handling and disposal of waste including human tissue.

Nutrition and Hydration
Nutrition and Dietetics sit within the Clinical Board. Their work involves menu work, auditing, training staff, patient satisfaction and events. Nutrition and Dietetics also deliver structured education programmes. Speech and Language Therapy (SLT) also sit within the Clinical Board. People with swallowing difficulties are assessed by a SL Therapist and where necessary training in assisting people to swallow food or drink safely is given.

Water dispensers are available in out-patient areas and there is access to hot and cold food and drinks from nearby outlets.

Medicines Management
Pharmacy sits within the Clinical Board. The Clinical Board also has a number of diverse specialties where medications are administered and stored in departments i.e. OPD, radiology, podiatry. Nutrition nurses and dieticians treat inpatients and administer nutritional supplements on the wards. Medication audits have been undertaken in Outpatients and Radiology departments by the Clinical Board Senior Nurse. Improvement in compliance with medication storage has been demonstrated with new cupboards /fridges and digital locked key holding cupboards being installed. Patients are given information to enable them to make informed choice in OPD. Medications used for invasive and non-invasive procedures in radiology are explained to patients and are also incorporated in patient pre-assessments. Nutritional supplements are also explained by nurses and dieticians.

The Medicines Information and Yellow Card service are within the Clinical Board. Pharmacy are involved in the development of medicines-related treatment pathways and medicines-related education and training sessions are provided regularly

Medication errors are reported as per UHB policy and monitored through e-Datix. Themed work on dispensing errors and extravasation of contrast has been undertaken.

Safeguarding Children and Safeguarding Adults at Risk
There are two Designated Lead Managers (DLM) for Safeguarding within the Clinical board. There is Clinical Board representation at Health Board meetings and Safeguarding is a standing item on the Clinical Board and Directorates QSPE meeting agendas. Due to the diversity of directorates/ departments in the Clinical Board staff require different levels of competence depending on their roles and their degree of contact with children, young people and their families and adults. The Clinical Board intend to develop a Safeguarding training strategy to provide a process by which the Clinical Board can audit the type, level and frequency of safeguarding training required.

There have been 3 safeguarding referrals between 1/4/17 and 31/3/18. Due to the relatively low numbers of referrals, the Clinical Board has a 'buddy' arrangement with other Clinical Boards to ensure the DLMs maintain their competence.

Blood Management
The Blood Transfusion service sits within the Clinical Board. The Transfusion Laboratory is fully compliant with the BSQR cold chain regulations and systems are in place to achieve 100% traceability of blood components. Regular audits of transfusion practice are undertaken including participation in relevant National Comparative audits and implementation of any findings.

There is comprehensive documentation available for patients with massive haemorrhage or persisting haemorrhage to ensure they are treated within defined pathways and receive timely haematological advice. Adherence to pathways is audited and significant delays in intervention investigated. The Transfusion Laboratory regularly participate in the Welsh Blood Service blood management scheme and there is evidence of acting on findings to optimise stock and reduce wastage.

All staff involved in the transfusion process receive regular training and have been competency assessed. There are systems in place to ensure ongoing compliance. Staff are able to recognise and report transfusion reactions and incidents. These are promptly investigated and corrective and preventative actions are implemented. Incidents with actual or potential risk of harm and/or recurring incidents are escalated within the organisation, discussed at the appropriate governance meeting and lessons shared through the organisation.

There are systems in place to ensure effective communication of transfusion information to medical and nursing staff.

Medical Devices, Equipment and Diagnostic Systems
Clinical Engineering sits within CD&T. Clinical Engineering manages medical devices within the UHB, ensuring compliance with laid down regulations and policies. The Clinical Engineering Equipment Management Policy outlines the core areas of activity from pre purchase to disposal.

Part of the equipment base is directly managed through the equipment libraries ensuring decontamination after every use. A fully planned maintenance programme is in place for all equipment for which Clinical Engineering is responsible, ensuring compliance, with reference to manufacturer instructions.

Training and competency within Clinical Engineering is covered in various ways. Infusion devices are covered by two specialised trainers ensuring user training and ongoing competency assessment.

Technical training takes place with instructions from manufacturers and where appropriate, through an internal training programme with documented training assessment forms.

Incident investigations are carried out on various pieces of equipment, when reported, linking in with Datix and patient safety team. Field safety notices are managed and actioned for equipment managed by Clinical Engineering and reporting to MHRA takes place in appropriate circumstances.

Disposal of medical devices is managed through Clinical Engineering, ensuring it is clearly documented, with the asset register being updated, with some valve items auctioned through approved auction companies.

ISO registration to 9001:2008, a quality management system, ensures we have the necessary protocols and procedures in place to cover all activities within Clinical Engineering. Audited regularly, the MEG (Medical Equipment Group) is in place to ensure compliance and governance for medical devices within Cardiff & Vale.

Effective Care (Theme 3)

The Clinical Board is committed to delivering effective clinical audit in all the clinical services it provides. The Clinical Board sees clinical audit as an important component of its arrangements for developing and maintaining high quality patient centred services. In addition to national, mandatory audits, enormous benefit is gained from small-scale clinical audit projects designed by local teams, and focused on local care.

The Clinical Board also seeks to influence its clinical audit programme by alignment with the Health and Care Standards and the Clinical Board's Risk Register. The Clinical Board have developed an audit framework with the aim of using clinical audit as a process to embed clinical quality at all levels in the Clinical Board, creating a culture that is committed to learning and continuous quality improvement and organisational development, supported by evidence based practice. The Clinical Board promotes and encourages a culture of multidisciplinary and multi professional audit working in partnership with other services, Clinical Boards and organisations. The Clinical Board has a Clinical Audit Lead and there are Clinical Audit Leads in each of the Clinical Board Directorates.

Best Practice guidance received from WG/NICE/Royal Colleges is reviewed at the QSE sub-committee. Implementation involves evaluation of likely impact on other services. New evidence has resulted in adoption of new techniques/approaches which demonstrate measurable improvement.

The Clinical Board has an active Research and Development committee and it is keen to further develop this area of practice. Service Improvement initiatives are supported and encouraged and there are regular participants from the Clinical Board on the LIPS programme.

The Clinical Board is actively engaged in cross-cutting work including stroke, dementia, diabetes and cancer and fully supports pathway redesign and the reduction of waste, variation and harm.

Dignified Care (Theme 4)
Staff are supported by the Clinical Board senior nurse, professional leads and directorate management teams to implement measures to ensure dignified care and support continuous service improvement.

The CHC environment audits are regularly conducted and improvement plans are robustly monitored to ensure completion of actions.

Equality and Diversity are embedded within the Clinical Board Values. There is a developing Equality Champion network and partnership working is an integral component of the Clinical Board governance process.

The Clinical Board has developed a dementia action plan including the role of the Dementia Champions and the Dementia Friends initiative. Clinical staff have undertaken Mental Capacity Act (MCA) training and a baseline audit of MCA compliance has been undertaken within the Clinical Board. Further development of this work will take place in the coming year.

The Clinical Board is involved in the development of use of the Welsh language in the workplace and recognises the importance of providing care through the medium of Welsh.

Timely Care (Theme 5)
Meeting the Diagnostic and Therapeutics Waiting Times access targets is a key priority for the Clinical Board. A number of IMTP schemes have been developed for meeting Planned Care needs. These schemes aim to ensure diagnosis and treatment that is

compliant with national target delivery times and best practice guidance, and also efficient, affordable and sustainable.

Performance against these targets is monitored on a weekly basis and improvement actions implemented as required. Proactive capacity planning is undertaken to ensure capacity meets demand. Where patients are not able to be seen within the access target their risk is assessed through a process of clinical prioritisation.

The Clinical Board is actively involved in pathway redesign and is keen to ensure effective and efficient use of resources.

Individual Care (Theme 6)

Patient feedback is received in a number of ways for example informal, two minutes of your time, national surveys, concerns and compliments and Datix reports. Stakeholder surveys in Laboratory medicine have been undertaken and Imaging patient surveys have been conducted in Radiology.

Issues that are observed or raised in patient feedback are received by the Clinical Board and discussed at QSPE. Trend analysis of patients concerns has also been undertaken. Complaints and resulting improvement plans are fed through QSPE structures to allow for shared learning. Targeted ‘customer care’ training has been delivered in response to identified ‘hot spots’.

The Clinical Board has developed a ‘Patient Experience and Engagement Framework’ with the aims:

- To listen to and learn from user experiences to improve services together in partnership.
- To increase the volume of feedback received from patients through a number of methods
- To demonstrate feedback received is acted upon
- To demonstrate improvements in user/patient experience, satisfaction and outcomes
- To develop co-production partnerships with patients/families/users and the wider community

Work has been undertaken by the Clinical Board to increase the number of National User Experience Framework questionnaires completed and returned. In the last 12 months, 1468 patients (increased from 1026 in the previous year) completed questionnaires to tell us about their experiences in Out-patients and Radiology. 89% of patients rated their overall experience as 8/10 or greater (84.5% in previous year).

During June 2017, the Paediatric Radiology Department at the University Hospital of Wales undertook a patient satisfaction survey during an eight day period; completed by seventy patients. They assessed;

1. booking and timing of appointment
2. waiting area
3. the investigation
4. overall experience.

Overall results were generally positive including;

- new department and waiting area well received
- 83% examinations performed on time/early
- 100% treated with dignity and respect
- Overall patient experience excellent in 85% (previously 70%)
- Staff excellent 90% (previously 82%)
- 100% of patients rated 8/10 (87% 10/10)

The Patient Experience Framework (appendix 3) will provide an opportunity for the Clinical Board to gain feedback through a wider range of methods.

Staff and Resources (Theme 7)

The Clinical Diagnostics and Therapeutics Clinical Board (CD&T) consists of approximately 2057 wte staff as at March 2018. The breakdown by staff group can be seen in the table below:

Staff Group	Establishment WTE
Add Prof Scientific and Technical	199.74
Additional Clinical Services	407.42
Administrative and Clerical	356.97
Allied Health Professionals	594.25
Estates and Ancillary	11.60
Healthcare Scientists	340.62
Medical and Dental	94.05
Nursing and Midwifery Registered	37.25
Nursing and Midwifery Unregistered	16.17

In March 2018, CD&T had a turnover rate of 9.30% and a cumulative sickness absence rate of 3.96% (against a sickness target of 3.25%). Whilst long term sickness absence has been gradually increasing over the last few months, the Operational HR Team continue to undertake a significant amount of work in ensuring that our staff are appropriately supported and that sickness absence is managed in a timely manner, in line with the All Wales Sickness Absence Policy.

A considerable proportion of the CD&T workforce is made up of registered professionals (including Scientists, Therapists, Radiologists and Radiographers) and as such, regulatory compliance continues to be both of significant importance and risk to the Clinical Board. This is noted within the relevant Directorates' and Clinical Board's Risk Registers.

The Clinical Board is continuing to develop future leaders across all specialties within the Clinical Board. The priority for the Head of Workforce and Organisational Development in 2018/19, is the roll out of the UHB's leadership and management development framework and the development of bespoke training plans to address any identified training gaps. There will also be a focus within 2018/19 on identifying and managing talent within the Clinical Board, as well as ensuring that effective succession planning is in place, as part of the strategic workforce planning process with each of the Directorates.

The recruitment and retention of staff is critical to the delivery of services within the Clinical Board. Within CD&T there are a number of recruitment challenges, including the employment of Radiologists (Diagnostics and Interventional), Sonographers, Clinical Scientists, Medical Physicists and Biomedical Scientists. In light of said difficulties and the Prudent Healthcare agenda, the Clinical Board are working with Directorates to consider new roles and ways of working, which enable the registered workforce to work to the top of their professional license, 'doing only what only they can do,' whilst at the same time utilising the skills and experience of the unregistered workforce in line with the Health Care Support Worker Framework.

The Clinical Board considers staff appraisal to be invaluable and all Directorates are working hard to improve their PADR and pay progression compliance. The current compliance as at March 2018, is detailed in the table below:

Directorate	**Compliance %**
Laboratory Medicine & Toxicology	67%
Media Resources	43%
Outpatients and Health Records	17%
Pharmacy	67%
Radiology, Medical Physics and Clinical Engineering	56%
Therapies	61%
Therapeutics and Poisons	46.5%
Clinical Board Total	**57%**

In relation to the above compliance, it is important to note that within several Directorates (including Outpatients, Health Records and Media Resources) there has been significant challenges, including a high proportion of long term sickness absence, high staff vacancies, as well as significant restructuring; all of these actors have impacted on the respective PADR compliance rates.

Staff engagement within the Clinical Board is considered to be vital in achieving the mutual gains of a happy, healthy and fulfilled workforce, together with increased patient satisfaction, workforce productivity and innovation. The engagement of staff in the development of the Board is inherent to its values, as is working in partnership with Trade Union colleagues. The Clinical Board has an engagement place in place for 2018/19, which was developed in partnership with the Clinical Board's Lead Trade Union Representative. The Board has also undertaken a significant amount of work (on the back of the Medical Workforce Engagement Survey results in 2016) to improve engagement amongst our Medical Workforce. This is work is ongoing and has resulted in the development of a Medical Workforce Engagement Charter.

The Board's quarterly Newsletter continues to be a huge success and provides great opportunities to showcase the fantastic work and achievements of our staff. In addition to this, our bi monthly 'Lunch with the Board' and a 'day in the life of' scheme (whereby members of the Board shadow different professionals within their workplace) have been beneficial in getting to know our workforce much better, as well as the challenges they face on a regular basis.

The Clinical Board continues to ensure that the UHB's values and behaviours are evidenced in everything we do – from recruitment, induction and PADR processes, through to Board meetings and team discussions. Through our Reward and Recognition Scheme, the Board has strategies in place to recognise those who 'live out' the values in their everyday working life, as well as robust mechanisms to manage those who fail to adhere to the required standards.

With staff leading the way, the CD&T Clinical Board continues to maintain and drive the key quality improvements required to ensure optimum patient experience and staff development. The Clinical Board would like to take this opportunity to highlight some of this work below:

Out-patients/Health records
Deputy Sister, Viv Hayes and Staff Nurse Sophie Keeble were awarded first prize in the poster category of Education for their entry entitled 'Making Every Contact Count in Outpatients' at the Nursing and Midwifery Conference on 6th October 2017.

Viv Hayes has also won a 2017 Beacon of Hope Award. The annual Beacon of Hope Awards are a highlight of the Lymphoma Association's Year. The awards recognise carers, supporters and healthcare professionals and Viv has been identified as having made a remarkable contribution to raising awareness of lymphoma and supporting people who have been affected.

Sion O'Keefe, Directorate Manager, was presented with a Clinical Board Award, and was Runner-up at the Staff Recognition Awards, for leading on a number of work streams supporting the needs of individuals with sensory loss and recognising the equality and diversity of patients.

Therapies

The Younger Onset Dementia Team won the HSJ Award for Innovations in Mental Health. The Younger Onset Dementia Service are a MDT team and the individuals from CD&T include Gail Pickford, Occupational therapy, Julie Rees, Physiotherapy, Jay Coakley, OT/PT technical instructor, Claire Hardcastle, Speech and Language Therapy and Phil Addicott, Dietician. The Younger Onset Dementia Service is a specialist and dedicated service for patients who receive a diagnosis of dementia under the age of 65. It works closely with the patient and their families to connect them with support. Younger people diagnosed with dementia have different needs to older people, for example still being in work at the time of diagnosis, or having dependent children still living at home or caring for ageing parents.

A joint submission by the Nutrition and Dietetics Team and EU has been awarded Runners Up in the Guardian Public Sector Awards 2017. In January 2017 the Nutrition and Dietetic service received short term funding from the Intermediate Care Fund to introduce a nutrition and dietetic service to the multidisciplinary team in the A&E Unit. The service was operational for 10 hour shifts over seven days a week and was designed to provide a collaborative, patient centred capability at the 'front door' of the hospital, responding immediately to patients' nutrition and hydration needs. This service operated with the aims of preserving safety, dignity and respect and preventing de-conditioning in hospital. This is an innovative service with no published examples of similar initiatives globally. This project is part of a wider service innovation programme to place nutrition and hydration at the forefront of clinical practice. This service has also been shortlisted in the 'Best Patient Safety Initiative in A&E' category in the Patient Safety Awards 2018.

This work has been further developed with the provision of a 'front door therapy team' in the Emergency Unit during the winter period 2017/18. The AHP team made a significant impact on the flow of patients through the EU and they have been made to feel very welcome by the MDT team**.** Having therapists in EU at the weekend enabled patients to go home whom would otherwise been admitted, especially the frail and elderly. The expertise from the staff particularly helped this very vulnerable group.

A service change project which focussed on the development of an integrated therapy team providing a seven day service model to acute stroke patients at the UHW won the Health Sector Award at the All Wales Continuous Improvement Community Awards. Therapy departments worked together to support the ward's nursing and medical teams in improving the experience of patients admitted to the unit. The 20 week project aimed to deliver a weekend acute stroke therapy service, enabling patients to begin their treatments promptly and receive continued rehabilitation over weekends. It also increased the number of weekend discharges and improved patient flow through the ward.

The 'Model Ward for Nutrition and Hydration' developed by Dietetics and Nutrition has been shortlisted in the 'Quality Improvement Initiative of the Year' category at the Patient Safety Award 2018. Nursing, Therapy, Facilities and Patient Experience teams examined how best to deliver standardised nutritional care to maximise patient outcomes and flow through the organisation. Utilising inter-professional integrated working and challenging the traditional boundaries, the aim of delivering comprehensive and co-ordinated nutritional care was achieved, whilst simultaneously improving patient outcomes and experience. 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 project demonstrated the opportunity to re-model the food care pathway from food ordering, to food service at ward level and how with the input from the extended healthcare support workers and the multidisciplinary team, supporting the patient with dietary intake can enhance nutrition and hydration in patients and unlock the associated benefits to overall patient experience, patient safety and organisational flow.

Alison Clark, Andrea Miller and Sonya Osborne in Dietetics received a Five Star Award from the Wales Council for Deaf People and Wales Council of the Blind for the support they provided to a patient with sensory loss undergoing the DAFNE Diabetes Structured Education Programme.

Cardiff and Vale UHB dietitians, physiotherapists and occupational therapists have been working collaboratively with other therapists across Wales on an innovative service for people with cancer. The service has been piloted across health boards in Wales to help them prepare for cancer treatment and ensure they are as physically, mentally and nutritionally strong as they can be; all this with a view to improving their cancer outcomes and overall survival. The Prehabilitation and Optimisation Programme (POP) focussed on patients with lung cancer and was funded by a Wales Cancer Network innovation grant. The programme involved a range of newly funded health professionals including dietitians, physiotherapists and occupational therapists. Patients were signposted to the innovative prehabilitation service by their doctor or specialist cancer nurse where their health, wellbeing and fitness was assessed and any corrections and treatments required were offered as soon as possible. The team taught, and then supported patients with

techniques that could then be self-delivered at home to ensure patients got as fit as possible before treatment started. The pilot aimed to use the pre-treatment period to demonstrate the ability to improve or maintain exercise performance, optimise nutritional reserves, prevent functional decline and maintain QOL. This programme of work has won "The Macmillan award for leadership and innovation in cancer rehabilitation" at the 2018 National Advancing Healthcare Awards.

Inspired by the documentary "The Old Peoples' Home for 4 year olds", and reflecting on the evidence that intergenerational work improves the sense of wellbeing of older people, the multidisciplinary team in the Rehabilitation Day Hospital in UHL started a pilot project, in conjunction with Llandough Primary school. Over a period of 8 weeks the intergenerational group met weekly for a 2 hour therapy led session focusing on functional rehabilitation with an emphasis on fun. There were cognitive games, outdoor mobility, exercise sessions, cooking and a technology week. Both generations reported positive outcomes following the program. The project demonstrated a new innovative way of working helping to achieve the aims of the wellbeing for Future Generations Act 2015. The next stage of the plan is to commence a larger scale project.

NICE guidelines (updated 2016) recommend provision of a supervised group exercise-based rehabilitation programme designed for patients with heart failure that includes a psychological and educational component in the programme. A new rehab circuit was developed and evaluation shows patients improved confidence with exercising independently, and improved objective walking results.

The physiotherapy service have developed a partnership with Wales Community Rehabilitation Company (CRC) on a project to refurbish walking aids. Wales CRC's Community Payback Service provides a tough, effective and visible punishment and deterrent, requiring people to undertake challenging work while giving some tangible value back to communities that suffer as a result of crime. The Community Payback team will be assisting the Health Board in refurbishing walking aids, meaning that more walking aids can be recycled for reuse. This not only means that patients receive their walking aids in a timely way, but also that money can be diverted back into the NHS to improve patient care. This also helps us, as a community, create a sustainable future through improving the organisation's environmental footprint.

Anthony Cusack, who is originally from England, has been extremely proactive in learning Welsh. He is self-taught via the 'Say Something in Welsh' website. He has actively promoted the use of Welsh Language on the orthopaedic ward and is assisting staff in pursuing learning Welsh. He promotes bi-lingual healthcare, using the Welsh Language with patients who prefer to communicate in Welsh. He has volunteered to run a stall at the National Eisteddfod in Cardiff next year to promote learning Welsh online.

Anthony won a Clinical Board Award, and also won the Welsh Language category at the Staff recognition Awards.

As part of a multi-disciplinary team (MDT), Speech and Language Therapists (SLTs) have a key role to play in ensuring the best possible outcomes for Trans and gender diverse people. SLTs, can support voice modification, facilitating gender expression through vocal and communication style changes. Voice and Communication Therapy enables Trans and gender diverse people to align their vocal and communicative expression with their identity in ways that feel congruent and authentic with their sense of self. This can help to reduce distress related to gender dysphoria, which can cause a lack of confidence and participation in communication. It can also help tackle transphobia and mis-gendering and transphobia (for example, people being vocally mis-gendered on the telephone, or ridiculed in social or workplace contexts because of their voice). In the past, referrals for transgender patients in Cardiff and Vale for Speech and Language Therapy were via their GPs but since Sarah Clements became lead for the out-patient service and was seeing these patients for therapy, it became obvious to her that they were having difficulty accessing our services. Therefore, SLT have now changed the referral process to align with other patients such as dysfluents (stammerers) to offer a self-referral process.

Podiatry services are a key member of the first All Wales 'Foot in Diabetes Network' brings together multi-disciplinary leads from all Local Health Boards involved in management of foot disease. The opportunity to work collaboratively with the Wound Innovation Centre will build on their shared goals of providing a world class equitable service across Wales, through education, prevention and innovative management to improve outcomes for its citizens.

The C&V Podiatry Team were selected as finalists at the AbbVie Sustainable Healthcare Patients as Partners Awards. Their submission of the 'STANCE Project: Diabetes Foot Health Engagement and Empowerment to Self Care' was awarded Runners Up in the category of Welsh Prudent Health Award and the judges were very impressed by the high standard of the submission.

Pharmacy

Medicines reconciliation is a comparison of medicines taken by a patient prior to admission with those prescribed when admitted to hospital, which NICE recommends should be carried out within 24 hours[1]. Medicines reconciliation performed by junior doctors in the Medical Assessment Unit (MAU) is often inaccurate and/or incomplete. If the patient's medicines are not reconciled and prescribed correctly then there is a risk of them receiving incorrect doses or medicines, or missing their regular medicines.

Audit data collected between October and November 2016 on MAU at UHW showed that for 424 patients reviewed by a pharmacist, 37% had a medicine reconciliation dose discrepancy or omission. A total of 500 discrepancies or omissions were identified which needed resolving.

Two pharmacists working in MAU completed the independent prescribing course in September 2016 and started prescribing on the unit in March 2017. A prescribing scope of practice was written and approved by the Acute Physicians. This allows pharmacist independent prescribers to; prescribe any unintentionally omitted regular medications or correct discrepancies in doses, adjust doses taking into account renal/hepatic function and weight, adjust doses of new medications based on guidelines and relevant test results and write a discharge prescription where necessary to facilitate a timely discharge.

Natalie Proctor and Alana Adams are the C&V Bevan Pharmacy innovator leads (part of an All Wales network) and have been very active raising awareness of innovation to 50+ members of staff, liaising with the CAV innovation hub.

Laboratory Medicine
It was pleasing to note that UKAS accreditation against ISO15189 was delivered and maintained across all Laboratory services. It is a real testament to the technical expertise and quality of service provided to patients.

The Phlebotomy team established the Early Discharge Scheme which enables blood results to be available for morning ward round for earlier decision making. This leads to timely patient discharge allowing patients to return home earlier and released bed capacity to better respond to demand and improve flow.

Media Resources
Annually the professional body for Medial Illustrators, the Institute of Medical Illustrators (IMI), presents a number of prestigious awards in recognition of excellence. Pip Stiff, Trainee Clinical Photographer and Meg Pearson, Senior Clinical Photographer were awarded the Peter Kilshaw Student Award for their joint entry: Mycosis Fungoides. The department was also successful in gaining a number of Bronze Awards, from Nicola Kelley, Hannah Wilce, Khris Swann, Lorna Mattocks, Jess Leonard and Pip Stiff.

Radiology, Medical Physics and Clinical Engineering
The Radiology Department celebrated success at the Wales Deanery: The BEST Trainee Awards. The event honours Welsh trainee doctors and dentists who go the extra mile. The awards support and reinforce the Wales Deanery's Strategy to provide an exceptional Welsh Offer to recruit and retain doctors in training in Wales. The successful

nominees were rewarded with accolades in recognition of their exceptional contribution to clinical services through original and innovative work undertaken during their training. Eight trainees were named as winners on the night, and two of the winners were within the Cardiff and Vale UHB Radiology training scheme. The winners were:

Dr Syed Junaid Winner of Outstanding Contribution to Leadership
Dr Keiran Foley Research Project

Cedar healthcare scientist Rob Palmer has been awarded a 'Rising Star' at the Advancing Healthcare Awards Programme. This award is presented to a member of staff who has shown a level of initiative, skill and commitment that is truly exceptional. Winners are staff who have been working as a qualified AHP or healthcare scientist for less than five years, and recognise a 'star in the making'.

The model MRI scanner (called the kitten scanner) is used by Radiology staff and Play Therapists to reduce anxiety in children attending an MRI scan appointment through play interaction and storytelling. The kitten scanner package consists of a miniaturised version of the scanner, a TV screen and several toy animal characters - including a crocodile, an elephant and a robot - that serve as 'patients'. The team recognised that some of our children use Welsh as a first language and so working with the developers in Philips the system was modified so that Doris the Chicken now tells her story through the medium of Welsh.

Finally, the Board would like to congratulate Professor Phil Routledge on his award of a CBE for Services to Medicine and to Dr Rachel Butler on her award of a MBE for services to the development of Genomics in Wales. Congratulations are extended to Sue Rees, Deputy Head of Physiotherapy who was awarded a Fellowship of the Chartered Society of Physiotherapy for services to Physiotherapy in Wales and UK.

Professor Stuart Moat, Consultant Biochemist and Director of the Wales New-born Screening Laboratory has recently been elected as an Honorary Member of the Faculty of Public Health. This level of membership is only offered to those who are recognised as having distinguished themselves through their significant contribution to public health practice, policy or research, or to the specialty of public health.

The Clinical Board would also like to acknowledge the contribution made by Steve Gauci, Lead Staff Representative for his work as a Mental Health Champion, working with MIND Cymru.

Appendix 1
The QSE clinical Board priorities for 2018/19 are outlined below:

ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
AIM 1 - GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
Accountabilities, Roles and Responsibilities **1.1. Strengthen the QSE Assurance Functions** 1.1.1. A review of the governance structures is underway which will include a review of the ToR and membership of the QSE Sub-Committee and its constituent sub groups. 1.1.2. Audit of Directorate QSE structures as part of review. 1.1.3. Identify Senior leaders to complete the Quality Governance programme. 1.1.4. Implement Human Factors training across the Clinical Board. 1.1.5. Improve capacity and capability of staff to undertake RCAs. **1.2. Continue to Support Continuing Service Improvement** 1.2.1. LIPS programme as means of driving quality Improvement. • LIPS project on patient dignity at outpatient consultations and communication preferences. 1.2.2. Continue to develop projects for 'Turning the Curve' using the 60 day improvement cycle. 1.2.3. Identify opportunities to link with 1000 Lives. **1.3. Continue to Support Executive Safety Walkarounds and**	Ensure compliance with statutory regulatory responsibilities as well as strengthening of assurance process from Directorates to Clinical Board	Corporate review completed and recommended structures are implemented

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
implement Clinical Board 'Day in the Life' Visibility Programme **1.4. Regulatory Compliance and Reporting Mechanism** 1.4.1. Support the self-assessment process and internal/external. 1.4.2. Procedure and policy review. 1.4.3. Complete Traffic Light Readiness for ISAS (Imaging Services Accreditation) in RMPCE. 1.4.4. Roll-out of Q-pulse (Quality Document Management System). 1.4.5. Complete and maintain ISO 15189 accreditation for Medical Laboratories. 1.4.6. Compliance with Health Care Standard; Blood Management and MHRA Standards. 1.4.7. Implementation of the recommendations and action plan from the HTA Inspection (August 2017).	• Assurance of compliance • Robust governance arrangements • Delivery of safe systems of work • Accreditation demonstrates the technical competence of services and ensures the delivery of timely, accurate and reliable results. • Support preparation towards accreditation • Robust system for document control, and allocation of Corrective and Preventative Actions (CAPA) from incident investigations	• Inspections provide sufficient assurance of compliance • % of action completed within agreed timescales • % of out-of-date documents • Receipt of accreditation • % readiness assessment • Number of services with Q-pulse implemented • Number of documents in review • Number of open CAPA

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
1.5. Ensuring safe working conditions and practice relating to storage and retrieval of documentation and equipment particularly in relation to Health Record storage in all settings.	Safe and effective working environment for all staff.	
AIM 2 – SAFE CARE		
Avoidable Harm **2.1. To Use Incidents and Concerns to Drive Improvement to Develop Safe and Effective Care** 2.1.1. Implement Audit programme to reflect trends in SIs, adverse incidents and regulatory compliance incidents. **2.2. Continue to Embed NatSSiPS**	Monitoring and management of SI's and adverse incidents through - Tracking of incidents - Incidents, reports, action plans, closure forms brought through QSE Sub-Committee - Regular review with Patient Safety Team Patients concerns are responded to in a timely manner with a response which addresses fully the concern raised.	% of incidents and investigations closed within agreed timescales Audit of RCA quality Trend analysis % completed actions % of investigations closed within agreed timescales % of concerns converted to informal

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
2.2.1. Finalise the gap analysis for all appropriate departments in the Clinical Board. 2.2.2. Implement LoCSSiPS for local procedures and undertake audit to ensure compliance with NatSSiPS. **2.3. Role of Podiatry in Pressure Ulcer Group H&CS 2.2** 2.3.1. Implementation of the diabetic foot bundle	Ensure that safe practices are embedded to prevent a never event in high risk clinical areas such as Radiology.	% compliance with NatSSIPS standards • % of patients admitted to hospital with diabetes who had a foot examination within 6 hours of admission. • Number of healthcare support workers who have undertaken diabetes foot awareness training as part of induction (i.e. touch the toe test).

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
2.4. Falls Delivery Plan H&CS 2.3 Implemented		
2.4.1. Implementation of 'Keep Me Moving' campaign as part of the unscheduled care programme – Inpatient Work Group.	Risk assessments are undertaken of environments and of individual patient needs. An incident theme review undertaken to identify fall hotspots. Patient flow assessment to ensure patients can safely traverse clinical areas along with removal of potential trip hazards. RCA investigations are undertaken and reports and action plans are reviewed at Clinical Board QSE Sub-Committee. Poster, leaflet and training programme for all Therapies staff.	Reduction in e-Datix reported patient, staff and visitor falls % of staff trained in falls prevention
2.5. Ensuring that Patients, Staff and Visitors are Protected from Preventable Healthcare Associated Infections by Implementing the HCAI Action Plan.		

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
2.5.1 Continue roll out of ANTT training and audit progress. 2.5.2 Winter Season outbreak plan – Flu Champion campaign 2.5.3 Continue to deliver BBE/HH and IP&C training. 2.5.4 Sepsis bundle; Dietetics, POCT, Radiology. 2.5.5 Ensure compliance with Legionella prevention plan including flushing regimes and audit. 2.5.6 Ensure IP&C is included in any design and build project led by CD&T.	IP&C risk assessments completed, reviewed and managed. Reduction in bacteraemia associated with line insertion. Compliance with uniform policy and standards of dress. Implementation of Aseptic No-Touch Technique. Adherence to decontamination policy. Hand Hygiene measures. Cleanliness data. Water safety assured.	Reduction in IP&C related incidents. % implementation of ANTT training and competency assessment. % Compliance with Flushing audits.
2.6 Ensure that the Nutrition and Hydration Needs of all Patients are Met Dietetic support for audits of H&CS 2.5		

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
2.7 Medications 2.7.1 Reduce number of serious medication errors through robust use of e-Datix and follow through on RCA actions. 2.7.2 Open and develop pharmacy service at satellite in Childrens Hospital. 2.7.3 Explore potential for pharmacy-led discharge (pilot in acute adult medicine and paediatrics). 2.7.4 Use MTeD and Choose Pharmacy IT platforms to focus referral to community pharmacy DMR service. 2.7.5 Continue Pharmacy systems review in technical service, medicines management and dispensaries. 2.7.6 Use data from Medicines (patient) helpline to feedback. 2.7.7 AWTTC to establish an Institute of Medicines Safety and Improvement (IMSI) in Cardiff and Vale UHB. 2.7.8 Improved reporting of adverse drug reactions in Wales including C&V UHB. 2.7.9 AWTTC, working with AWMSG, develops National Prescribing Indicators of effective prescribing practice for Wales including C&V UHB. **2.8 Medical Replacement Plan H&CS** **2.8.1** Ensure there is a schedule of maintenance, cleaning, calibration	People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury	% patients whose nutrition and hydration needs are met.

ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
and decontamination for all areas that utilise medical equipment		
2.9 WOD Framework Priorities and Staffing Levels		
2.10 Domestic Abuse and Safeguarding Training		
2.10.1 Continue to support photography of pressure ulcers/wounds to inpatients at UHW, UHL and outlying sites.	Photography is undertaken to produce a comparable visual record, to enable the monitoring of progression or regression to treatment. The UHB Pressure Ulcer Risk Assessment, Prevention and Treatment Policy and Procedure states that "All category III or IV pressure ulcers will be photographed…"	
2.10.2 Safeguarding work is undertaken according to UHB Policy e.g. Childrens and Older Persons Safeguarding		
2.11 Patient Identification Priorities		
2.11.1 Achieve compliance with PSN026: Positive Patient		

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
Identification. 2.11.2 Cellular Pathology and Mortuary; compliance with HTA recommendations and action plan. 2.11.3 POCT 2.11.4 Radiology 2.11.5 Laboratory Medicine – Right First Time LIPS Project **2.12 Ionising and Non Ionising Radiation Safety** *2.12.1* Development of Ionising Radiation Optimisation Team *2.12.2* Develop Business Case for Non-ionising Radiation Safety including QA and electrical safety for ultrasound, lasers and MR (MR Safety Expert role) *2.12.3* Redesign of Medical Physics services to bring the Radiation Protection Advisor role 'in-house' (currently procured through external SLA) *2.12.4* Ensure compliance with the revised regulations; IRMER (2018) and IRR (2018)	Compliance with legislation and regulatory requirements and UHB policy. Reduced risk of harm to patient receiving unintended diagnostics or treatment. Ensure traceability of all samples which relate to pathology or post mortem activity. Ensure radiation doses are optimised against image quality and that there is consistency across the UHB	Reduction in number of incidents linked to patient identification CT scanning doses are consistent across UHB and optimised for best image quality (subjective measure) % of ultrasound machines and lasers undergoing quality assurance and electrical safety checks. No incidents involving non-ionising radiation

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
2.13 POCT 2.13.1 Implementation of WPOCT. *2.13.2* To work with all CBs to implement new training and competency programme for all nursing staff using POCT equipment.		No incidents involving ionising radiation
AIM 3 – EFFECTIVE CARE		
Right Care Based on Best Practice **3.1. Compliance with Standard 3.5 -Good record keeping and Professional regulatory requirements** 3.1.1. POCT to produce CB dashboard reports monitoring clinical effectiveness 3.1.2. Undertake programme of record keeping audits 3.1.3. Storage of the Clinical Record; Restricted access to central storage libraries; POD will be developed 3.1.4. Information Governance H&CS 3.4 • Training • Timely investigation of any IG incident	Improved quality of documentation which meets the expected standard Meet the Principles of Good Administration and Good Records Management	• % of records complying with professional standards • % of stored records meeting the standard for Good record keeping • % of staff completing the IG e-learning module, reduce and eliminate IG

ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
• Undertake IG audits • Develop Information Asset Registers		incidents • Audit compliance
3.1.5. Seek funding through ETTF bid for Secure Clinical Image Transfer.	This allows clinicians to use their mobile devices to take photographs of patients, with a small amount of patient data this is then transferred securely to Fotoweb. There will be less IG breeches with clinicians having patient images on their phones.	• Less or no entries on DATIX due IG breeches involving patient images
3.2. Support Work of All Wales NICE Liaison Group	Review of new NICE guidance Full implementation, or follow escalation process for not progressing implementation along with assessment of risk	• % of NICE guidance fully implemented • NICE guidance implementation reviewed at QSE
3.3. Compliance with Patient Safety Solutions/Notices, Full implementation of NATSIPPS – see earlier section		% compliance with

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
3.4. Compliance with National Clinical Audit and Outcomes Programme		implementation and audit.
AIM 4 – DIGNIFIED CARE		
Always Treated with Compassion, Dignity and Respect **4.1. Implementation of the Clinical Board's Patient experience and engagement framework 'Hear my Voice'** 4.1.1. Language and communication needs of individuals are met – More than just words; Welsh language, people with additional communication needs, seldom heard groups. 4.1.2. Ensure that Equality and Health Impact in relation to the 10 protected characteristics is embedded in the business of the Clinical Board.	Capture patients experience across a wide range of settings and use this information to drive improvement. Implement Patient Pager Project in Outpatients Compliance with the assisted information standards	• % of monthly returns • Number of questionnaires completed • % of patients recording experience at score of 8 or greater • 'You said, we did' actions
AIM 5 – TIMELY CARE		
Timely Access to Services Based on Clinical Need		

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
5.1. H&CS 5.1 **5.2. Digital Communication; Text and Digital Appointment Letters** **5.3. Development of FAB to include pathway and overbook mechanisms to support cohort booking** **5.4. Delivery of the transformation programme 'Turning the Curve'** 5.4.1. Deliver priorities of Planned Care 5.4.2. Delivery of Cancer Plan 5.4.3. Deliver priorities in Unscheduled Care 5.4.4. Deliver priorities of Locality Plan		
AIM 6 – INDIVIDUAL CARE		
People are Respected as Unique Individuals **6.1. Implementation of the Clinical Board's Patient Experience and Engagement Framework 'Hear my Voice'** **6.2. Promoting Independence and Closer to Home** 6.2.1. Continue to embed Pyschosocial model of care to support patient activation and self management.	Capture patients' experience across a wide range of settings and use this information to drive improvement.	

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ACTIONS TO DELIVER QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
6.2.2. Implementation of 'Keep Me Moving' campaign as part of the Unscheduled Care Programme – Inpatient Work Group. **6.3. Dementia Plan – see cross cutting themes and dignity** **6.4. Compliance with Consent Policy and procedures including legislative requirements of HTA for Cellular Pathology and Mortuary.**		

Appendix 2

Top ten reported incidents

Diagnostic Processes/Procedures	
Specimen labelling error	389
Investigation not performed	137
Investigation delayed	95
Interpretation of investigation insufficient/incorrect/incomplete	53
Interpretation delayed	52
Investigation incorrect	34
Interpretation of investigation not performed	29
Investigation insufficient/incomplete	28
Investigation performed on incorrect patient	28
Preparation of patient for investigation insufficient/incorrect/incomplete	15
Specimen insufficient/incorrect/incomplete	13
Documentation	
Ambiguous/incorrect/incomplete	234
Incorrect patient	99
Confidentiality breach	17
No access to	16
Temporarily unavailable/delay in accessing	16
Blood/Plasma Products	
Loss of traceability label	187
Insufficient/incorrect storage/refrigeration	18
Pre-transfusion procedural error	16
Product mislabelled (product type/traceability details)	13
Medication/Biologics/Fluids	
Incorrect dose	35
Extravasation	31
Incorrect medication/fluid	29
Incorrect strength	29
Incorrect quantity	10
Product label incorrect	10
Patient Accidents/Falls	
Standing up/sitting down	22
Walking unassisted	13
Walking with assistance	13
Movement to/from Chair	12
Contact resulting in skin tear	11
Staff accidents/Falls	
Walking	23
Lifting/manual handling objects	13
Dirty needlestick	10
Falling object	10

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Staff exposure to Environmental Hazards	
Biological agent	19
Blood or body fluids	13
Chemical agent	8
Heat	8
Staffing levels	8
Service Disruptions (environment, infrastructure, human resources)	
Other service disruptions/infrastructure incident (e.g. lifts)	22
Insufficient numbers of healthcare professionals	12
Water leak/pressure failure (include water heating units)	10
Behaviour (Including Violence and Aggression)	
Verbal Abuse	21
Personal Property/Data/Information	
Unintentional breach	40

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Appendix 3 Patient Experience Framework actions for 2018/19

ACTIONS TO DELIVER PATIENT EXPERIENCE FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
AIM 1 – REAL TIME		
• Continue with the patient booths in Outpatient clinics. Explore using in other outpatient settings such as therapies, pharmacy and Radiology- • Patient Communication Portal for Outpatients appointments • Implement patient pagers • Continue to roll out 2 mins of time process		
AIM 2 – RETROSPECTIVE		
Patient reported satisfaction from attendance at dietetic chronic condition groups Continue to increase usage of the National patient questionnaires Develop plan to introduce national PROMS as part of the	• All patients attending groups are asked to complete a satisfaction question including information on changes made through programme.	• % patients making positive dietary changes. • % patients reporting improved confidence • Patient satisfaction

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ACTIONS TO DELIVER PATIENT EXPERIENCE FRAMEWORK – 2018/19		
ACTION	OUTCOME	MEASURE
Transformation programme; CMATS pilot and roll out.		measures
AIM 3 – PROACTIVE/REACTIVE		
Introduction of feedback cards Explore alternative methods using social media/internet	Introduce in Pharmacy dispensary and Therapies	At least 2 SoMe projects implemented in CD&T
AIM 4 – BALANCING		
AWTTC involves patients in all the work of AWMSG through its Patient and Public Interest Group (PAPIG).	Involvement in patients in medicines appraisals and guidance is essential for the uptake of AWMSG's advice and in order to do this AWTTC hosts regular PAPIG meetings	
Focus group with another of our client groups from 10 protected characteristics	Continuation of the approach taken by CD&T in listening to users from seldom heard groups in the design principles of new builds or developments	User satisfaction of involvement in the design and build process
Increase capacity for taking patient stories Concerns and compliment theme analysis		

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CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

CAERDYDD A BRO MORGANNWG
CARDIFF AND VALE OF GLAMORGAN

9

Scrutiny Overview

Visiting Activity for the period:

06/01/18 – 09/03/18

May 2018

Index

Summary of Scrutiny Activity

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

This report is a considered overview of the scrutiny visiting activity from all visits undertaken between the 6th January 2018 and 9th March 2018. In total 5 visits were planned to be undertaken and all were completed. However, one visit was not reported on, as it was an educational activity.

Next Reporting Period – 10/03/18 to 04/05/18

The May Scrutiny Overview Report will incorporate all visit reports from the visits undertaken between the 10th March 2018 and 4th May 2018. In total 6 visits have been completed and are currently within the reporting process.

Looking Forward

Due to resource constraints within the CHC Office, non-essential activities have been put on hold. Therefore, the visiting plan will need to be reviewed and activity prioritised for the remainder of the financial year.

We anticipate that routine scrutiny activities will resume in October 2018, with more focussed activity undertaken in the interim period.

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 element of local health services, please contact us using the details below:

Telephone: 02920 750112

Free Text: Text the word CAVOGCHC to 62277

Email: cavog.chiefofficer@waleschc.org.uk

Address: Pro Copy Business Centre (Rear)
Parc Ty Glas
Llanishen
Cardiff
CF14 5DU

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Visiting Overview

Cardiff and Vale UHB

Concerns

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

- **Staffing** – In the visit reports for Ward East 4 and Rainbow Ward, members identified issues that appeared to be caused by a lack of staff in these areas, with variable reasons for this. In regards to Rainbow Ward, it was considered that the shortfalls in the nursing establishment and subsequent reduction in inpatient and day therapy beds, led to a higher number of extremely ill children being transferred to other wards. On Ward East 4, a number of issues were identified where staff members were unable to take responsibility and communication had been breaking down, to the detriment of patient care.
- **Information on Display** – Separate issues were identified in regards to the information on display in 2 areas visited. The first related to the waits in the Ante-Natal Clinic, which in line with experiences in Primary Care, patients accepted the waits to be seen but would appreciate a visual indication of their likely wait. The second issue was the lack of information on ward performance, on Island Ward.
- **Parking –** In 2 of the visit reports, issues with parking were noted by patients accessing the UHW site. The reports are to the Ante-Natal Clinic and Rainbow Ward, where patients/parents find it difficult to judge the length of time spent in each area and subsequently cannot judge the cost of their parking in advance. It is also noted that these cohorts of patients may frequent the site on a regular basis over short periods of time and be faced with the difficulties of finding a space on each occasion. Although the CHC are aware that parking is due to become free in the summer of 2018, this will likely cause further pressures and will therefore be subject to some form of management arrangement moving forward. There are concerns that failings experienced at the hospitals Llandough, Barry and St Davids may be more prevalent in UHW.

Good Practice

- **Patient Experience/Staff** – In what has been an on-going trend, 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 4 of the visit reports.
- **Supplementary Facilities** – Members specifically commented on the supplementary facilities in all of the included reports. These facilities included parent rooms in the Children's Hospital, Day Room on East 4 and facilities for Partners in the Ante-Natal Clinics. It is pleasing to see that the people supporting patients are being catered for in areas where the more vulnerable members of society are likely to access services.
- **Environment** – The visiting teams provided positive comments in relation to the cleanliness of the areas visited in 3 of the 4 visit reports and, it's worth noting, that no negative comments were included in the other report.

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 20th April 2018. In total 4 follow-up visits were planned to be undertaken and all 4 were completed.

UHB: Ward B6, UHW (5th March 2018)

Date of Previous Visit: **21st April 2016**
Date of UHB Action Plan: **23rd June 2016**

In total 11 recommendations were made during the original visit, with each provided an attributable action by the UHB and subsequently agreed by Council. Of these 11 recommendations, it was considered that 10 were achieved in their entirety, with 0 being partly met. The action(s) considered not to have been met are provided below:

- A bilingual sanitiser information poster needs to be placed alongside the hand gel dispenser at the entrance doors into the ward

UHB: Ward A1 Short Stay Unit, UHW (26th March 2018)

Date of Previous Visit: **2nd December 2016**
Date of UHB Action Plan: **1st March 2017**

In total 4 recommendations were made during the original visit, with each provided an attributable action by the UHB and subsequently agreed by Council. Of these 4 recommendations, it was considered that all 2 were achieved in their entirety, with 0 being partly met. The action(s) considered not to have been met are provided overleaf:

- Upgrade the bathrooms as soon as possible

Note: The fourth recommendation was marked as Not Applicable, as no new and innovative methods had been made instituted since the previous visit. As a result, this particular recommendation has not been included the summary below.

UHB: Teengae Cancer Unit, UHW (26th March 2018)

Date of Previous Visit: **13th July 2016**
Date of UHB Action Plan: **26th September 2016**

In total 2 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 2 recommendations, it was considered that both were achieved in their entirety.

UHB: Paediatric Dentistry, Dental Hospital (29th March 2018)

Date of Previous Visit: **20th March 2017**
Date of UHB Action Plan: **26th April 2017**

In total 3 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 3 recommendations, it was considered that all were achieved in their entirety.

Summary of CHC Recommendation/Action Performance

Org.	Made	Achieved	Partly Achieved	Not Achieved	% Actioned
UHB	19	17	0	2	90%

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

Report Recommendations

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

Cardiff & Vale University Health Board (UHB) Visits

1. **UHB** – Provide confirmation that no children are being transferred to general medical/surgical beds from Rainbow Ward and also provide immediate assurance that the patients' health and wellbeing is not impacted as a result of ANY transfer whilst receiving such specialist treatment on Rainbow Ward.
2. **UHB** – Provide assurances that the staffing issues experienced on Ward East 4 are being resolved as a matter of urgency and also share evidence that the Ward Manager and his team have been supported to correct the issues identified.
3. **UHB** – Identify a way in which to provide visual, timely information on anticipated waiting times, in areas with a high input of patients who share a common appointment time. I.e. all patients attend clinic for 10am.
4. **UHB** – ensure that any parking arrangement put in place at the UHW site, address any and all shortcomings identified at other UHB sites and that patient/visitor communication is prepared and distributed in advance of the changeover in the summer of 2018.

Follow-up visits:

The **UHB** is asked to provide an action plan, within 4 weeks of the CHC Council meeting on **14th May 2018**, in regard to addressing their respective agreed actions that have yet to be completed following previous CHC visit reports.

Confirmed Outcomes

As a result of the CHC's visiting activity, confirmed by way of the Follow-Up Process highlighted on page 4, the following provide examples of the outcomes achieved for patients in Cardiff & the Vale of Glamorgan:

1. During our visit to the Teenage Cancer Unit, it was identified that the Unit regularly encountered a lack of pillows for patients. It has now been reported that each bed within this Unit has 2 pillows and the storage cupboard is kept well stocked.

2. When we visited the Paediatric Dentistry Department, patients (children & young people) would access the general radiology unit on the ground floor, even if this is in the middle of a treatment session, sometimes having to wear a 'rubber dam' face mask. Even the staff confirmed that this compromised the dignity of patients and added to the fear of other patients located en-route to and from radiology. Since, members have been informed by the Unit that new x-ray equipment has been ordered and will be installed within the Unit in Summer 2018.

3. In the Day Room on Ward B6, it was found that display racks contained out-of-date information and needed updating to better serve patients and their relatives. During our follow-up visit, we found that the racks had been removed and more relevant and up-to-date information provided by other means. Also on the visit to B6, members found that no hand washing signs were provided in the toilets. As a result, new signs were devised by staff to stand out to dementia patients and were placed at all hand washing areas.

Visit Details

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

Type	Date	Service	Site	CHC Team	App.
Announced	08/02/18	Antenatal & Consultant Led Unit (Maternity Ward)	University Hospital of Wales (UHW)	Bablin Molik (Lead), Jane Jenkins	1
Announced	14/02/18	Island Ward	Childrens Hospital for Wales (CHfW)	Julie Williams (Lead), Pat Matthews	2
Educational	19/02/18	Dental Hospital	University Hospital of Wales (UHW)	Pat Matthews Brenda Chamberlain Alison Walker Eleri Jones Jane Jenkins	N/A
Announced	21/02/18	Ward East 4	Llandough Hospital (UHL)	Jane Jenkins (Lead), Judy Simove	3
Announced	28/02/18	Rainbow Ward	Childrens Hospital for Wales (CHfW)	Shirley Willis (Lead), Eleri Jones	4
Type	**Date**	**Service**	**Site**	**CHC Team**	**App.**
Follow-up	05/03/18	Ward B6	University Hospital of Wales (UHW)	Steven Place, Malcolm Latham	5
Follow-up	26/03/18	Ward A1 – Short Stay	University Hospital of Wales (UHW)	Val Evans, Eleri Jones	6
Follow-up	26/03/18	Teenage Cancer Unit	University Hospital of Wales (UHW)	Val Evans, Eleri Jones	7
Follow-up	29/03/18	Paediatric Dentistry,	University Dental Hospital (UDH)	Alison Walker, Shirley Willis	8

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Next Reporting Period – 10/03/18 to 04/05/18

Type	Date	Service	Site	CHC Team	Stage
Announced	13/03/18	Ward C4	University Hospital of Wales (UHW)	Steven Place (Lead), Malcolm Latham	Review
Announced	14/03/18	Ward East 2	Llandough Hospital (UHL)	Rob Henley (Lead), Alison Walker	Complete
Announced	15/03/18	Oral/Maxillo-Facial Surgery	Dental Hospital @ UHW	Julie Williams (Lead), Val Evans	Complete
Announced	21/03/18	Physiotherapy Department	University Hospital of Wales (UHW)	Eifion Pritchard (Lead), Pat Matthews	Awaiting Response
Announced	26/03/18	Children's Kidney Centre	Childrens Hospital for Wales (CHfW)	Val Evans (Lead), Eleri Jones	Awaiting Response
Announced	29/03/18	Restorative Dentistry	Dental Hospital @ UHW	Alison Walker (Lead), Shirley Willis	Awaiting Response

Forward Planning

Date	Service	Site	Date	Service	

We anticipate that routine scrutiny activities will resume in October 2018, with more focussed activity undertaken in the interim period. However, this section will be populated in the next edition of the Scrutiny Overview Report.

* Please note, unannounced visits are not publicised in advance

Our lives on hold…

Impact of NHS waiting time on patients' quality of life

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

BWRDD CYMRU | WALES BOARD

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About Community Health Councils

This report has been produced by the Board of Community Health Councils on behalf of the 7 Community Health Councils (CHCs) in Wales.

CHCs are the independent watch-dog of NHS services within Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

CHCs seek to work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, those who inspect and regulate it, and those who use it.

CHCs maintain a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through enquiries, our Complaints Advocacy Service, visiting activities and through public and Patient surveys. Each of the 7 CHCs in Wales represents the "Patient voice" within their respective geographical areas.

This report brings together a range of patient stories and reflections about the impact that delayed treatment has had on themselves and their families. They represent a small percentage of those waiting for NHS treatment in Wales. We recognise that everyone's individual experience will be different.

Introduction

Health boards and trusts regularly judge their performance in terms of Referral to Treatment Times (RTT) against a set of targets described in weeks. It is regularly reported in the media that targets are missed or that waiting times in Wales are worse than in other parts of the UK.

Reviewing performance simply against figures can provide a useful indication. It does not provide a picture of what it is like to wait for treatment, perhaps in pain or with reduced mobility. Neither does it capture the wider and sometimes life changing impact on individuals, families and communities.

The 26 and 36 week targets were last met in Wales in August 2010. We have seen a welcome improvement in waiting times in Wales over the past year (at the end of February 2018, 87.3% of patients in Wales had been waiting for less than 26 weeks).

Nevertheless, the failure to meet targets has become an accepted norm. The real life implications of this can be devastating. It is important that decision makers look beyond the numbers when judging performance and deciding what to do about it.

This report aims to capture the impact that long waits have had on a range of people across Wales. We believe their stories demand action and challenge Welsh Government to take action to end long waits.

What we asked

We simply asked people to tell us in their own words how waiting for treatment was affecting their life. These people came to us through a variety of sources;

- Advocacy Service clients
- Engagement events
- Social Media
- Print media articles about this project

What we heard

Coping with pain

> "At that point I was in agony, and could only walk a few yards as the pain was excruciating. My Consultant could see how much pain I was in and apologised for the delays, but said the waiting lists were never ending".

Most people we heard from told us they were in pain, and for some patients pain affected their quality of life very substantially.

For some people long term use of strong pain killers was a cause of concern. People worried about side effects, over reliance and reduced effectiveness. Long waiting times for many procedures coincided with long waiting times for Pain Management Clinics (up to 2 years in some cases).

Without the help of Pain Management Clinics, patients with drug intolerances found it extremely difficult to get any form of pain relief. Access to non-drug methods of coping with pain, such as hydrotherapy and physiotherapy were seen as similarly limited.

We heard about what might be described as a catch 22; being told you do not meet the criteria for chronic pain management as there is a known and available surgical intervention that would address your problem completely.

Mobility

> "I cannot walk any distance without the aid of two walking sticks and if I have to wait until the summer of 2018 then I

> can see me becoming housebound, which I know will have an impact on my mental health".

The inability to carry out day to day activities that most people take for granted was a major issue for many people. Some people we heard from were carers and were no longer able to provide the care needed by their spouse or child.

Falls were a major issue;

> "I managed to trip and fall in the house three times due to my poor vision, l must admit l began to feel really down as l had lost my independence and felt isolated and cut off from my normal daily activities. I became totally dependent on my husband which in turn impacted on his independence".

Loneliness & good mental health

> "The present situation is causing me a good deal of stress. I am getting periodically depressed, my marriage is suffering and I am no longer aware of what action I can take to resolve the situation".

Many people told us that the combination of decreased mobility, pain and ill-health removed them from their usual activities and support networks and left them feeling isolated and lonely.

There is also a strong effect on mental health. Some people told us they feel powerless and distressed by waits of 100 weeks^{+}. We heard that for some, this was made worse when their estimated treatment times kept getting extended.

Those who had retired and were looking forward to spending more time with partners and family and developing hobbies and leisure activities told us the pain and stress of waiting for an operation had considerably reduced their quality of life;

> "I do not suffer from depressive personality, I always look on the bright side of life but I must admit the last six months of waiting became very trying.
>
> I could not go out in the garden if there was bright sunshine, indoors, the curtains and blinds needed to be drawn in whatever room I was in order to exclude bright light or sunshine.
>
> Simple things like watching the television became very uncomfortable. I had great difficulty in reading books or newspapers, I could not use my computer without great difficulty".

Private Treatment

> "I had my hip replacement on 1st November 2017 at a private hospital, close to where my daughter lives in England, at a cost of £10,500. If I had known I would have been waiting for this since I was first referred in October 2015, I would have had it done privately long since".

Intolerable levels of pain and mobility problems had led to some people paying for private treatment even though they could ill-afford it. Usually this was for an initial appointment with their NHS Consultant but some had gone on to pay for total joint replacements when waits became unacceptably long.

Loss of dignity

> "I have now been suffering the indignity of having to wear a catheter for almost 12 months. During this period I have suffered five urinary tract infections. Initially the district nurses changed my catheter at the local surgery but they

> began to have problems and now the catheter has to be changed at the hospital".

Some patients commented on the indignity of having to rely on others to carry out intimate personal care because they could no longer do it for themselves.

Being unable to maintain personal appearance was also a concern for many.

Relationships

People reported a severe effect on family life. Many older people had commitments providing care for grandchildren. Inability to carry this out had major financial implications for the entire family. People also told us about the emotional impact of missing out on what should have been a source of happiness and satisfaction and feelings of guilt that they are not contributing to family life;

> "While I was waiting the pain in my breast got worse and worse… It meant I couldn't play with my grandchildren as I normally would because it was just too painful to lift them up or have them jump on me".

Several people highlighted that constant pain and fear had led to being short tempered and "grumpy" with close family members.

Work & finances

Not all those waiting for procedures such as joint replacement, cataract and prostate surgery were retired. Many people told us about significant effects on their work and careers. Patient R is just 25 and facing an 85 week wait for shoulder surgery;

> "Whilst most 25 year olds are career building, I cannot seriously consider any career development opportunities at

> work as, instead, I am struggling to hold on to my job because of my health problems. I fear that in the longer term, even if my shoulder problem is resolved, my working record represents me as an individual with a 'sickness' problem rather than a capable individual willing to work hard and this has the potential to have life-long implications.

Others have had to take retirement while waiting because of on-going problems;

> "I'm retired now but I had been working for a supermarket. My employer was very supportive while I was trying to continue working but I was quite restricted in my ability to undertake any duties that involved lifting. It was clear from meetings with my managers that they were running out of patience so I decided to retire".

Sickness benefits do not take account of long NHS referral to treatment times and we heard how this can result in great financial hardship.

> "I now have a date, for mid-January 2018. The length of time the process takes does cause financial issues. Sickness benefit is only given for one year, so I have been without financial support since July 2017".

Co-ordination of NHS care

Many people told us that they have to act as their own case management co-ordinators. This is particularly true in areas such as cancer care where tests need to be done in a particular order and perhaps at a variety of locations. People told us that they spend a significant amount of time contacting different departments and liaising with consultant's secretaries to ensure things go smoothly.

Information

Lack of information on many aspects of their care was an important issue for most people.

There is a need for greater communication between the NHS and those waiting for operations, without regular communication people told us they felt abandoned;

> "….she has just been left to suffer in this way for months on end. As I say, it feels as though she has just been dumped".

"Harm" caused by waiting

Many people waiting for treatment worried that waiting in itself would cause irreparable damage and make the eventual treatment less successful.

> "…the extra pressure and pain I am putting my body through because of my left knee is causing further problems and issues with my mobility".

Holidays

People told us they had been asked to cancel holiday plans when they had been listed for an operation– even though they felt there hadn't been any realistic prospect of having the operation any time soon. This causes unnecessary financial loss and hardship;

> "Normally we would have been away over the winter and the sun and warmth offer some respite from the pain. Having been told not to go away and missing this much anticipated break, we are both upset to realise that we have waited around for nothing".

Our Stories

The following stories are an example of what we heard from people affected by long waits for treatment, as they described it.

Patient A

I am writing to you regarding a complaint I have regarding hospital waiting times. I have currently been waiting 51 weeks for hand surgery for removal of a very large ganglion. I rang this morning to be told there is at least another 30 week wait.

I have also been waiting 41 weeks for urgent wisdom teeth extraction as I daily have severe toothache and jaw ache which is preventing me from eating correctly. I understand that, if neglected, wisdom teeth can fuse to my jaw bone which will cause lots more problems. I've been told it will be at least another 40 weeks to see a consultant then it will be another long wait until surgery.

The health board have been in contact with me advising that they cannot do anything about the ridiculous waiting times. Apparently they can't afford to fund my treatment elsewhere even though it clearly states on all NHS material I have a right to be seen and retrieve treatment within 36 weeks of referral. This is not acceptable and I want the NHS held accountable for my suffering.

Patient B

In November 2016 I was admitted to Hospital for bladder retention and was fitted with a catheter. It was later discovered that I would need a prostatectomy and this should have been done in February 2017.

I heard nothing and contacted the Urology Department in March. They said my operation had been delayed and would probably take

place in August or September. Following this I receive a letter asking me if I still required the operation. I wrote to the Concerns Team of the hospital expressing my dismay and they informed me that the operation should be done in October.

I received a letter telling me the operation would take place on 23rd October. I attended a pre-op appointment a week before and on the day attended the arrivals lounge and went through the usual procedures and waited to be called. At around 3.35pm I was called into a cubicle and told the operation had been cancelled.

I have now been suffering the indignity of having to wear a catheter for almost 12 months. During this period I have suffered five urinary tract infections. Initially the district nurses changed my catheter at the local surgery but they began to have problems and now the catheter has to be changed at the hospital.

I feel there is little concern given by the hospital to my health and well-being. I fully appreciate that more serious cases than my own must take priority but to have a twelve month break in treatment is stretching things a bit far.

The present situation is causing me a good deal of stress. I am getting periodically depressed, my marriage is suffering and I am no longer aware of what action I can take to resolve the situation. I am retired and my wife and I travel a good deal, these trips are spoilt by frequency in having to use a toilet. I also have a worry as to the effect 12 months of catheter use will have on my bladder.

NOTE – the patient is still awaiting his prostatectomy – recently told it might be "sometime in 2018"

Patient C

Initially I saw my Consultant privately in early 2015, following a referral from my GP, and paying myself to avoid waiting the 6 month

wait to see him on the NHS as I had quite severe pains in my groin, which I knew were related to a failing left hip. The Consultant said he would arrange an MRI Scan, but there might be a wait for that.

Three months later, I had an MRI Scan, which confirmed the diagnosis that I needed a replacement left hip. I received a letter from the Hospital on return from holiday two months after that requesting me to make an appointment for Physiotherapy, I wasn't sure what this was for or who had requested it, and when I asked the Physiotherapist, he said my Orthopaedic Consultant had requested it to see if the acute pain was coming from the hip or the tendon. He said he was going to inject whichever site it was, to give me some relief whilst awaiting a hip replacement.

After a few physiotherapy sessions, the physiotherapist confirmed that the pain was indeed coming from my left hip and said there was no point in continuing now that we knew where the pain was coming from - I could have told him where it was coming from!

I heard nothing more, despite the Consultant's Secretary on several occasions, until I had a letter to go for a pre-op on 12th January 2017. I asked what the pre-op was for, and was told it was for an injection into my left hip to alleviate the pain whilst awaiting a replacement.

On 11th February 2017, I was admitted to hospital and informed by my Consultant that he would give me an injection into my hip, and also an injection into the tendon of the left hip under general anaesthetic, in the hope that these would reduce the pain whilst awaiting a hip replacement.

I returned home and had slight relief for a couple of days, then the severe pain returned, and was now all down my left leg and into my foot, making it very difficult to walk. I thought this was strange, as injections do usually offer some respite, having had them in the past prior to surgery.

I saw my Consultant on return from holiday on 16th March 2017 and told him I was in severe pain, which he could already see as I walked in. He then informed me that on 11th February he had only injected the tendon, and not the actual hip joint, which I found quite annoying as it meant yet another procedure with a general anaesthetic.

On 21st March, I was again admitted to hospital and had an injection into my hip joint under a general anaesthetic, which I assumed would give me some relief from the now excruciating pain I was suffering. The effects of the injection lasted only 3 days, and I rang my Consultant's secretary to ask her to let him know.

On the 18th May 2017, I saw my Consultant at the hospital. At that point I was in agony, and could only walk a few yards as the pain was excruciating. My Consultant could see how much pain I was in, and apologised for the delays, but said the waiting lists were never ending. He told me that I was on the URGENT list and it would probably be "*towards the end of the year*". This was very disappointing to hear, but at least there was a light at the end of the tunnel, or so I was led to believe.

In the following months, I rang my Consultant's secretary regularly to say that I was available at short notice, should there be any cancellations. This was on my GP's advice, as I was now on very strong painkillers every 4 hours as prescribed by my GP. I was told there are very few cancellations, but she would make a note on my file. At that point, she did say it may well be November/December for my operation.

On return from yet another holiday in a wheelchair in October 2017, I rang my Consultant's secretary yet again, just to confirm it was going to be November/December, only to be informed, no, it was more likely to be May/June 2018. As you can imagine, this was very disappointing news, and although I cannot afford it, I decided I had

to have the operation as soon as possible, as my life was becoming impossible and very dependent on others.

I had my hip replacement on 1st November 2017 at a private hospital, close to where my daughter lives in England, at a cost of £10,500. If I had known I would have been waiting for this since I was first referred in October 2015, I would have had it done privately long since.

My GP was very, very annoyed that I have had to pay, and said I should write to the Health Board and the local MP, as it is a national disgrace that anyone should have to suffer so much pain in this day and age. However, not wishing to delay it any longer I did not do that.

I have written to my Consultant, and said how sorry I am for the system, and do not blame him, but the Health Board who need to do something drastic to get the lists down. He is a brilliant Surgeon, and I have been under him for many years, as he did my right knee replacement in 2011.

When we moved to Wales in 2001, the waiting lists for any surgery were minimal, but just what has happened in the last 15 years is a mystery to all, as they are the longest in the UK now. I did request that I could go to another hospital anywhere in the UK several times, but was told that the Welsh NHS would not foot the bill for that. In England as at today's date, the waiting time for a hip replacement from referral to treatment is 11-18 weeks maximum.

Patient D

In July 2016 I was seen by an orthopaedic consultant and was advised that I required a replacement left knee, I was told that I would have to wait approximately 50 weeks for this operation and I agreed to go on the waiting list.

I have other mobility issues including a replacement right hip, which was done in 1998, a left hip replacement which was carried out in 2011. Due to numerous complications, I underwent a complete revision of this hip in November 2013 and I also had a spinal decompression operation in in 2010.

When I saw the Consultant in June 2017 I was told that due to the 'clean ward' being closed for three months due to winter medical admissions, no joint replacement operations had been carried out during that period, resulting in the waiting time increasing to 90 weeks.

I saw the Consultant again in September 2017 and was advised that the waiting list had increased further to approximately 100 weeks, which means that it will be the summer of 2018 before I have my knee replacement – if I am lucky and the waiting list does not further increase!

This is extremely frustrating, not only for myself and my family but also for the Orthopaedic Consultants. It concerns me greatly that I am having to wait another two years for an operation and in that time my situation is only going to deteriorate further, meaning taking increased pain relief medication, which in turn impacts on my quality of life.

Presently I cannot walk any distance without the aid of two walking sticks and if I have to wait until the summer of 2018 then I can see me becoming housebound, which I know will have an impact on my mental health. I am 65 years old and although I do have arthritis, the extra pressure and pain I am putting my body through because of my left knee is causing further problems and issues with my mobility.

I would like to know what the NHS is planning to do in the future to help reduce the waiting list for replacement joint operations as this situation cannot be allowed to continue. I am concerned that the "clean ward" will again be closed to joint replacement surgery this

year, resulting in an even longer waiting list. The extra cost in medication for all these patients waiting up to two years for their operations must surely be eating into budgets.

Patient E

I had a right knee replacement in February 2015 with the understanding that the left knee would get done within a 2 year period once the right knee was successful and I was fully weight bearing.

The appointment for next knee never arrived and on pursuing this matter, I was added to the urgent list in April 2017. I was then told that there was no chance of surgery before Christmas as there was an 80 week wait despite being assessed as clinically urgent.

I am diabetic and can no longer exercise due to pain. My right knee has now failed and needs a full knee replacement. My muscles are wasting due to lack of movement. I have steroid injections but these are reduced in both efficacy and in time they last. I can't take pain killers due to stomach and bowel problems.

My life is on hold.

Patient F

Many thanks for talking to me about the time I have been waiting, I wasn't expecting a response in all honesty so thank you for taking the time to respond.

As mentioned previously I am quite frustrated by the time I have been waiting. I fully acknowledge that the NHS is very busy and it's challenging trying to manage expectations. My mum is a Nurse so I understand how busy it can be for the NHS.

I've had blood tests done by my GP all of which have returned negative. However I live a life of discomfort most days and I really could do with knowing what's causing it, I just find the waiting time to be very long. I'm still reasonably young at 38 and as I pointed out in my last message there are people with far worse conditions than I have so I can't imagine how they must be feeling having to wait but you can only do what you can I guess.

Patient G

At the beginning of 2017, my optician referred me for a CT scan after I experienced sight problems which were thought to be the result of a minor stroke.

I had a scan on 27th February 2017, and this showed a brain aneurysm that needed further investigation to decide what treatment would be best. I had another scan in March 2017 and it was decided to seek the opinion of a Consultant neuro-radiologist regarding treatment options.

I did not get to see the neuro-radiologist because two of the three neuro-radiologists had left and the other is on extended sick leave. I was told that a locum has been recruited in South Wales but will not be providing a service at my local hospital.

I have now been referred to a hospital in Liverpool but I am still waiting for a date for treatment. Since receiving the diagnosis, I have been extremely anxious in case the aneurysm should rupture. I have had on-going vision problems caused by the aneurysm and this had caused me to have several falls.

Patient H

My problems started just before Christmas 2016 when I got flu and then developed sinusitis and a chest infection, a clear, watery fluid

started to discharge from my nose. The discharge was constant and was accompanied by headaches and light headedness.

When the problem did not resolve, my GP telephoned the ENT Department and arranged an out-patients appointment. I didn't want to wait any longer so my GP gave me a letter to take to the hospital. Once there, I saw a doctor who examined my nose with a camera.

I was given a nasal spray to use and a follow up appointment. At the next appointment, I saw a consultant who arranged a CT scan. The results of the scan showed a crack in my skull from which the fluid was leaking.

I was told that I would have to undergo surgery but would need to have an MRI scan first. This took place on 7th April 2017. The surgery took place in June 2017, six months after I had the first symptoms. I am making progress but I'm still not fully recovered yet.

Although I cannot fault the care that I received from the doctors involved, I am frustrated about the time it had taken to get a diagnosis and the waiting time for treatment to remedy the problem.

During that time, I suffered from debilitating headaches and light-headedness and a constant stream of fluid from my nose which went down my throat during sleep and made me cough. I was off work since the symptoms started because I was feeling so unwell and I work with food so could not go back for hygiene reasons. I have lost a considerable amount in wages due to this delay.

Patient I

Hi, I have waited 70 weeks already and will be 88 weeks by the time they say I may be called for pre op for hip replacement surgery. My hip has deteriorated a lot whilst waiting and the last x-ray they look at now is 4 years old.

I was invited to go to Crewe for my operation (*107 miles away*) and when I rang them they said it would be another 3 months wait, so as it is such a long way for my family to travel I decided to wait the extra 6 weeks to have it done locally.

I now use a wheelchair to go out or two sticks. I'm fed up now. When I went to see the surgeon they were taking people from another hospital where the waiting list was even longer. I queried this and suggested that this meant we would then have to wait longer. This is not fair on any of us.

Patient J

My wife had to wait 16 months for a hip replacement operation. At first we were told that it she would have the surgery around Christmas time or perhaps the following February but, in fact, she had to wait more than a year before she actually had the surgery. While she was waiting for an appointment, no one kept us informed about the reason for the delays or about how much longer she might have to wait. Having finally had the operation, she now needs another procedure to drain away some fluid, which is gathering around the operation site. She has been waiting for this follow-up procedure for more than 9 months now and there is still no sign of an appointment.

She feels as though she has just been dumped. Her quality of life is not good and she often says that she wishes she hadn't had the hip replacement at all. She can't go anywhere where there might be large crowds of people because she can't risk being pushed or knocked. She is very unsteady on her feet and can't risk falling over. My wife is much less mobile than she was before and she can't do the things she used to.

She gets terrible pain and is very swollen and bruised where she had the surgery because of soft tissue damage. And she has just been left to suffer in this way for months on end. As I say, it feels as though she has just been dumped.

Patient K

I had had breast implants following a mastectomy as a result of breast cancer. I started suffering with terrible pain and some hardening in my breast. Initially I was told that the implant had ruptured and so I would need it replaced. However, I was later told that this was not the problem after all. Either way, I needed surgery to correct the problem. I had to wait 54 weeks for the surgery.

Throughout that whole time I only ever spoke to someone in the department and got updated if I chased them up myself. Nobody contacted me to let me know what was happening or how long it would be. I knew from the outset that there might be a "bit of a delay" but I had no idea just how long I would actually have to wait.

To begin with I was able to be quite patient about the wait. But then as time went on and no one contacted me I started to get concerned. I couldn't plan my life. I wanted to book a holiday but I couldn't because I was worried that I might miss my surgery slot. This was very stressful for my husband and my daughter.

While I was waiting the pain in my breast got worse and worse. I was worried about the possible reasons for the pain and why it might be getting worse. It meant I couldn't play with my grandchildren as I normally would because it was just too painful to lift them up or have them jump on me.

It made me angry. I felt it wasn't fair. I did get a call with an appointment within 12 months of my referral but then the slot was cancelled. To be honest, this just felt like lip-service. Like they had given me an appointment just to cancel it so that it looked like they were doing something. Maybe that wasn't the case but that's how it felt to me. I had the pre-op appointment but then the pre-op was out

of date before I was even given a date for surgery. When I asked about this I was just told "*Oh, it'll do*". I felt like I was being fobbed off all the time. Why would they bring me in for a pre-op if there was no chance of the surgery happening before the information was out of date?

By the time I saw the consultant I was really angry about it all and this affected the doctor/patient relationship. It's so unfair that there is a difference between the waiting times in England and Wales.

Patient L

I had to wait 2 years just to be assessed by a surgeon when I needed surgery on my rotator cuff. I had some calcification of my collar bone, which was restricting my movement so my GP referred me to see a physiotherapist. After 6 months the physiotherapist decided that I needed to have surgery so referred me on. When I finally did see the surgeon for a consultation he told me that I would be prioritised. However, I had to be taken off the waiting list while I went to see a cardiologist about a heart problem.

Once that was sorted, I was put back at the bottom of the waiting list and was told that I would have to wait another 12-18 months for the surgery. I wasn't kept informed about what was happening and I actually only found out that I was back at the bottom of the list because I contacted the department and asked. I waited for this surgery for 3 ½ years.

I'm retired now but I had been working for a supermarket. My employer was very supportive while I was trying to continue working but I was quite restricted in my ability to undertake any duties that involved lifting. It was clear from meetings with my managers that they were running out of patience so I decided to retire. My condition didn't force me into retirement but it was definitely a contributing factor in my decision to retire earlier than I had planned. My employer did try to support me but at the end of the day they're a

business not a charity and they couldn't carry me while I was unable to perform my duties fully.

I struggled with some of the basic necessities of life such as shopping. I can't carry any weight on my right-hand side. I used to enjoy playing golf but I can't do this anymore. I wasn't able to do small things that I would normally take for granted such as lifting up my grandchildren. I suffered with terrible pain and I had to take Ibuprofen at the highest dose possible. I'm not even totally sure that it is ok to take this alongside my heart medication but I had to have something to ease the pain while I was waiting for surgery.

Patient M

Hello, I believe you're looking for opinions about time spent on waiting lists.

I was referred by my GP to the hospital Rheumatology Department for checks a good two months or so ago, possibly longer. I was given a waiting time of 20 weeks which was unacceptable to me. I'm in constant pain every day, chronic pain. There are people out there in worse condition than myself but the waiting times are so poor for this service around here.

I am still waiting to be seen and have also been put on the cancellation list and no one has called me at all. The excuse I've been given is that no one wants to come and work for this Health Board. Hope this feedback goes some way towards helping.

Patient N

I never imagined the wait for a cataract removal could become so stressful. I waited nearly eighteen months in total before I was called for my cataract procedure. The last nine months became a real nightmare. l live in a fairly rural isolated location. l am also disabled with asthma and COPD consequently this means that I am unable to

walk very far without becoming very breathless, therefore this inhibits the use of public transport due the distance I would need to walk. l had to give up driving for the last six months due to my poor vision.

l went back to the optician as l knew both cataracts were getting worse especially the left eye, the optometrist confirmed that I had virtually become almost blind in the left eye due to the density of the cataract and confirmed that it would be unsafe for me to drive until the cataract removal and subsequently made a urgent referral but l still had to wait many months before I received the procedure.

l do not suffer from depressive personality, l always look on the bright side of life but l must admit the last six months of waiting became very trying. l could not go out in the garden if there was bright sunshine, indoors, the curtains and blinds needed to be drawn in whatever room I was in order to exclude bright light or sunshine. Simple things like watching the television became very uncomfortable. l had great difficulty in reading books or newspapers etc., I could not use my computer without great difficulty.

I managed to trip and fall in the house three times due to my poor vision, l must admit l began to feel really down as l had lost my independence and felt isolated and cut off from my normal daily activities. I became totally dependent on my husband which in turn impacted on his independence.

I cannot even begin to explain the difference when the cataract was eventually done. l was able to live my life again and regained my independence. l am a retired NHS nurse, l retired at the age of 65 so l have understanding of how things work but surely a cataract operation is a lot cheaper than a possible full hip replacement as a result of a fall which thankfully l did not suffer, but many do. Also if a cataract is left too long other complications such as blindness could occur.

And the sad thing - I am still waiting for the other one to be done!

Patient O

I started feeling pain in my left shoulder in early 2016. It was a pain I was familiar with as two years ago I had the same pain leading to an operation on my right shoulder. I visited my GP who prescribed Ibuprofen. This didn't help so I went back to my GP and he referred me to "walk in physio". This was extremely awkward as my work took me all over the country meaning I had to take time off work to undertake a six week course of physio. The physio didn't have any benefit so it was recommended I receive a cortisone injection.

Due to the pain I was in I decided to finish working away and look for work closer to home, in the hope this would make attending appointments a little easier. Unfortunately the pain was so bad the GP signed me off sick in July 2016.

I received a referral to the clinic in September 2016 where I was seen by a consultant and received a cortisone injection. This had no effect so I returned to my GP towards the end of September. In mid-October I was referred back to the clinic where I saw a consultant who referred me to hospital for a scan and maybe another injection. I received the scan in November 2016 which showed an arthritic shoulder which required an operation. I was put on a waiting list.

I feel if I had been given a scan first as last all the treatment in between which did nothing to relieve the pain, would not have been given. Saving the NHS money and me time. In March this year I saw a consultant who confirmed the diagnosis. I was contacted early December to see whether I was able to attend a pre-op appointment as the clinic had a cancellation. I attended this appointment where I was told I would be contacted very soon with a view to an operation in early January 2018.

I now have a date, for mid-January 2018. The length of time the process takes does cause financial issues. Sickness benefit is only given for one year, so I have been without financial support since July 2017.

Patient P

On 1st March 2017, I was placed on a waiting list to have a total knee replacement on my right leg. My next appointment was made for 5th October 2017. I was expecting the Consultant to tell me when I would have my operation. He told me not to go away on holiday during January and February 2018 as there might be an additional operating list at this time.

I normally spend these months abroad but cancelled my arrangements. I subsequently heard nothing and after many phone calls and letters was told that I was number 153 on the waiting list and they had no idea when my surgery would take place. I was told that I could expect to wait a further 92 weeks despite having been listed for 52 weeks already.

I have written to the Chief Executive and Chair of the Health Board with no response to date but was contacted by an administrator who has asked me to fill in a Freedom of information form before I can have information about the waiting list, how the recent funding announced by Welsh Government has affected the list and where I actually sits on the list.

I run my own business dealing in antique furniture and the pain I am suffering is making it hard for me to continue. I have had to alter my stance and gait to compensate for the pain and this is making my hip worse and affecting the other knee. I have to sleep with pillows under my knee to get any relief and I tend not to go out due to pain. My wife is also suffering as I am grumpy and have short patience due to this unremitting pain. Normally we would have been away over the winter and the sun and warmth offer some respite from the pain.

Having been told not to go away and missing this much anticipated break, we are both upset to realise that we have waited around for nothing. I am very disappointed with the NHS.

Patient Q

I had partial knee surgery in February 2015, this failed after 2 years and I was told it needed total replacement. I was advised that I would need to wait 80 weeks just for an appointment with the Consultant so I made arrangements to see him privately to move things forward and saw him in April 2017. He told me I needed an urgent operation but that thus was unlikely to be done before Christmas of 2017. In the meantime, I was waiting for an appointment with the pain clinic but this never came through.

I spoke to the Consultant on the phone in November 2017 and he informed me that he was due to have hand surgery and would not be able to carry out operations until at least after Christmas. He said I should be treated at the end of February or perhaps the beginning of March. In January 2018 I signed a form agreeing to be referred to another consultant. My predicted wait is now another 52 weeks minimum.

I used to be a very fit and useful member of society; refereeing rugby all over North Wales, organising and participating in politics and social schemes such as litter picks with Friends of Anglesey Coastal Path. I am an insulin dependent diabetic and it is essential that I stay fit and healthy which, with the knee pains and developing related ailments, such as sciatica, is proving very difficult.

The physiotherapy offered by the Health Board is ineffective as it is merely classes for general post-knee surgery with no individual time from the staff to deal “hands on” with an individual’s case. I have now lost a significant amount of muscle tone in my thighs and lower legs which will affect my capacity to recover from further surgery.

I am unable to take normal pain medication such as NSAIDs because of the side effects. As mentioned earlier, I have never been given an appointment with a pain clinic.

My relationship with my family is severely affected as I am so grumpy all the time; dealing with the constant pain, having to get up at regular intervals and move around to avoid the legs getting stiff, the sciatica and increased back pain. I am unable to sit for long periods so that precludes going to the theatre or cinema, travelling far etc.

Patient R

I first told my parents that I had been struggling for some time with my gender identity when I was 15. My parents were very understanding and wanted to help but didn't really know how. They came with me to see my GP. My GP was very honest that they had never treated anyone in my position before and asked for a couple of days to discuss what to do with colleagues. I was then referred to Child and Adolescent Mental Health Services (CAMHS).

I had to wait a couple of months and then had an appointment. The person I spoke to also told me that they hadn't had any previous experience but had found out what to do next. I was referred to specialist services based in London, my first appointment was several months later.

I had a number of appointments over the next two years to discuss how I was feeling. This was helpful but did not lead to any action.

At my last appointment with them when I was approaching 18 I was told I would be transferred to the adult service and that this would mean a further wait.

Throughout all this time whilst I feel I have been listened to, it hasn't helped to get me the treatment I need. I have become increasingly frustrated and it has led to me losing confidence. I have found it impossible to concentrate on my education and it has affected my relationships.

I have found support from others in similar circumstances by joining online network sites. I know I'm not alone and in some ways this helps but it also confirms that there is little chance of any action any time soon.

Many people have resorted to ordering hormone treatment online and whilst I'm told this is not a safe option I can understand why people do it. There is a big difference in your body between 15 and 18 and with every month that passes without treatment I feel my body is going further away from who I am.

I am now suffering with anxiety and depression. My GP told me to see someone privately about this because the NHS doesn't understand.

I have been told by adult services that I will have to wait over a year for my first appointment.

Learning from what people told us

The stories shared with us illustrate what life is like for some people in Wales waiting for treatment. This includes the additional issues that can be caused when communication is poor and people feel it is up to them to coordinate the various elements of their care

These stories should be a powerful reminder to those responsible for planning and delivering NHS services of the harm that can be caused by inactivity.

In our current system the requirement to monitor, report and act on harm does not include this.

The number of stories in this report equate to only a fraction of the missed targets reported each month by the NHS in Wales.

For those who spoke to us this measure is unlikely to hold much meaning. Instead, most people measured their wait in terms of the impact on their day to day life, their finances, their relationships, their careers, education and their independence.

It is difficult to see how clear and long established targets on waiting times are, on their own, meaningful to anyone. As they stand, they are not providing assurance to the public nor driving sustained improvement.

Responses to the recent White Paper "Services fit for the future" indicate wide-spread support for the introduction in Wales of Duties of Quality and of Candour. This provides a meaningful opportunity to set out a more effective basis on which performance is judged.

Our recommendations

The Welsh Government should, in developing a framework for the introduction of duties of quality and candour:

- set out clearly and simply what quality means from a service users perspective
- recognise the harm done by inactivity as well as the benefits of timely care
- issue revised quality indicators
- require NHS bodies to monitor and report on quality in a more meaningful way including the harm caused by inactivity.

The Welsh Government should work together with NHS bodies in Wales to make sure their plans clearly set out how waiting times will be improved, and take appropriate action if improvements are not made.

NHS bodies should ensure:

- They communicate regularly and effectively with people who are waiting for treatment
- People waiting for treatment know who to contact if they have concerns or need support managing their condition.

Acknowledgements

We thank the people who took the time to tell us about their experiences. We hope they influence decision makers to make improvements so that other people's lives are not affected in the same way.

CHCs will continue to monitor referral to treatment times across Wales and provide constructive challenge where improvements are not being made.

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CAERDYDD A BRO MORGANNWG
CARDIFF AND VALE OF GLAMORGAN

9

Sensory Loss Assessment of NHS Organisations across Cardiff & Vale of Glamorgan

May 2018

Accessible formats

If you would like this publication in an alternative format and/or language, please contact us.

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About your Community Health Council

CHCs are the independent watch-dog of NHS services within Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

CHCs seek to work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, those who inspect and regulate it, and those who use it.

CHCs maintain a continuous dialogue with the public through: a wide range of community networks, direct contact with patients, families and carers through enquires, our Complains Advocacy Service, visiting activities and through public and patient surveys, with the CHC acting as the "Patient Voice" within Cardiff and Vale of Glamorgan.

Introduction

This report brings together the results of an assessment against some key criteria and to ascertain if the NHS organisations covered under this activity have made progress in ensuring patients with a sensory loss can receive an equitable service. Following a baseline assessment in 2016.

The Cardiff & Vale of Glamorgan Community Health Council (CAVOG CHC) revisited six hospitals within the Cardiff & Vale UHB. In addition CHC members also undertook a follow up visit to the Velindre Cancer Centre where 10 wards/departments were monitored.

The aim was to carry out a follow up assessment of the various departments and wards to compare results of current sensory loss facilities and accessibility to sensory loss resources with those reported in 2016.

CHC members presented details of the areas visited at each hospital, together with comments on their findings.

This overarching report seeks to give an overall indication of how much assistance is being given to people with a sensory loss and to continue to raise awareness of any shortfalls in service delivery throughout the Cardiff & Vale of Glamorgan area.

The hospitals, together with the number of wards/departments visited at each, are given below:

Hospital	Numbers of Wards / Departments visited
Barry Hospital	7
Cardiff Royal Infirmary	3
Rookwood Hospital	4
St. David's Hospital	7
University Hospital Llandough	49
University Hospital of Wales (UHW)	59
Velindre University NHS Trust	10

What we asked?

In our previous assessment undertaken in 2016, CHC Members spoke to a member of **staff on duty** and asked them 5 questions. Each question required a "Yes/No" answer relating to Sight Loss and Hearing Loss. Additional observations made at each hospital / department are given at the end for use by the individual NHS Organisation to respond. The questions were devised using co-production with key stakeholders such as: **RNIB, Action on Hearing Loss and the NHS Equalities Officers.**

Question 1	Are you aware if any patient that you care for has sight / hearing loss?
Question 2	Is a patient's sight / hearing loss shared with the ward / department team, including catering staff?
Question 3	Is the patient's sight / hearing loss recorded in their records?
Question 4	Do you have any access to any equipment / accessible information to assist with communication with a patient who has sight / hearing loss? (eg: large print, braille, audio, hearing loop, personal listeners, and amplifier).
Question 5	Are you aware of any training on how to communicate effectively with someone who has sight/ hearing loss?

Items to note:

The results attributed to Cardiff Royal Infirmary only appears in the 2018 graphs, as it was not visited during the initial assessment in 2016.

What we found out?

Cardiff & Vale University Health Board

Question 1:

Are you aware if any patient that you care for?

From the results received in 2018, it is evident that progress has been slow in increasing staff awareness of patients who may have sight loss. It is disappointing that both the University Hospital Llandough has seen a slight decrease in awareness with the largest decrease being recorded against Barry hospital. It is pleasing to note that increased staff awareness at the University Hospital for Wales was recorded and that Rookwood Hospital which reported 0% score in 2016 is now reporting 100%.

Sight Loss

Hospital	2016 Assessment	2018 Assessment	Ward/ Department	Answered Yes	Answered No
UHW	77%	80%	59	47	12
UHL	95%	92%	49	45	4
Barry	88%	71%	7	5	2
CRI	N/A	67%	3	2	1
St David's	86%	86%	7	6	1
Rookwood	0%	100%	4	4	0

When considering the same question regarding hearing loss there are some minor changes across all Health Board hospitals. It is disappointing that overall there was an increase in the areas which responded with a 'No' when related to hearing loss. It is clear that further awareness activity needs to be considered especially as hearing impairments are known to be a hidden disability.

Hearing Loss

Hospital	2016 Assessment	2018 Assessment	Ward / Department	Answered Yes	Answered No
UHW	71%	78%	59	46	13
UHL	93%	92%	49	45	4
Barry	88%	71%	7	5	2
CRI	N/A	67%	3	2	1
St David's	86%	86%	7	6	1
Rookwood	0%	100%	4	4	0

Even though there has been a slight improvement in UHW, further work is required to improve their performance. Both Barry and CRI hospitals are also falling short of the 2018 average which is disappointing.

Question 2:

Is a patient's sight / hearing loss shared with the ward / department team, including catering staff etc.

It is essential that if staff are aware of a patients requirements these should be shared with key staff who will, during the length of stay on the ward or department, ensure that the patients' are being supported. This could be by gaining access to a consulting room or being able to access their food and drink.

Whist it is pleasing to note that the two major hospitals have increased on the previous levels of sharing information with the team, it is worrying to see significant decline in responses within the **community hospital settings**. The CHC is very concerned that community hospitals have a large proportion of elderly and vulnerable patients who also require enhanced support. It was evident staff questioned had limited knowledge of the provision regarding sight / hearing loss which is unacceptable.

Sight Loss

Hospital	2016 Assessment	2018 Assessment	Ward / Department	Answered Yes	Answered No
UHW	89%	90%	59	53	6
UHL	83%	90%	49	44	5
Barry	88%	57%	7	4	3
CRI	N/A	67%	3	2	1
St David's	100%	71%	7	5	2
Rookwood	100%	25%	4	1	3

It is concerning to note that when asked about hearing impairment there was little change in results recorded apart from an increased awareness at St. David's hospital when compared with sight loss and a decline at Llandough, albeit slight. Both Barry and Rookwood have produced very disappointing decreased results and require attention.

Hearing Loss

Hospital	2016 Assessment	2018 Assessment	Ward / Department	Answered Yes	Answered No
UHW	86%	90%	59	53	6
UHL	93%	90%	49	44	5
Barry	88%	57%	7	4	3
CRI	N/A	67%	3	2	1
St David's	100%	86%	7	6	1
Rookwood	100%	25%	4	1	3

It is imperative the Health Board ensures that the patient is at the centre of the care they receive and should enhance the mechanisms to share information about patients to key staff, who are responsible for providing care and support to patients. We are aware that clinical staff undertake a handover process between shifts and should this be extended to catering and other key staff to ensure patients' support needs are met?

Question 3

Is a patient's sight / hearing loss recorded in their records?

Whilst the CHC remit does not allow access to patient records it was considered important to ask this question from a lay persons' point of view.

All key staff have access to patient records and therefore, it could be reasonable to think that if a patient had identified as having sight / hearing loss that this was recorded. Staff have confirmed that a patient would be forgiven to think the support provided would take account of their sight and hearing needs, as staff should be aware of the support required to assist these patients'.

Sight Loss

Hospital	2016 Assessment	2018 Assessment	Ward/ Department	Answered Yes	Answered No
UHW	89%	85%	59	50	9
UHL	95%	94%	49	46	3
Barry	88%	71%	7	5	2
CRI	N/A	100%	3	3	0
St David's	100%	100%	7	7	0
Rookwood	100%	100%	4	4	0

It was clear from the responses that all staff questioned did indicate both sight and hearing loss were recorded in the patient record. It was concerning to note that both UHW and Barry show a decline when compared with the results in 2016.

Our overarching concern is that staff reported that this information was being recorded in the patient record however; when you look at the previous questions, it is apparent that this is not being reviewed consistently by staff. It is difficult for us to identify where this communication breakdown is occurring. The Health Board may want to consider their own examination of the situation across its sites when compared to the previous answers posed.

Hearing Loss

Hospital	2016 Assessment	2018 Assessment	Ward/ Department	Answered Yes	Answered No
UHW	88%	83%	59	49	10
UHL	93%	94%	49	46	3
Barry	88%	71%	7	5	2
CRI	N/A	100%	3	3	0
St David's	100%	100%	7	7	0
Rookwood	100%	100%	4	4	0

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The CHC remit does not allow access to patient records. Therefore, we will raise this issue with Healthcare Inspectorate Wales for consideration as there is definitely a disparity and lack of consistency between what is recorded in the patient records and what the staff knowledge is surrounding the patients they are providing care for, in relation to sight and Hearing loss.

Question 4

Do you have access to any equipment / accessible information to assist with communication with a patient who has sight / hearing loss? (eg: large print, braille, audio, hearing loop, personal listeners, amplifier)

The Health Board should be congratulated on an improvement in this area for sight loss, with all sites recording an increase of staff awareness for accessing support materials for this patient group, excluding UHL which recorded a slight decrease. It is unclear if these materials are freely available or only by request, and if the latter, what mechanism is in place for patients to know in advance so the information is available to them whilst accessing services?

Sight Loss

Hospital	2016 Assessment	2018 Assessment	Ward/ Department	Answered Yes	Answered No
UHW	36%	42%	59	25	34
UHL	43%	35%	49	17	32
Barry	38%	43%	7	3	4
CRI	N/A	67%	3	2	1
St David's	29%	43%	7	3	4
Rookwood	100%	100%	4	4	0

It is acknowledged further progress is required when comparing overall results across the Health Board sites.

It is pleasing to note that all areas of the Health Board reported an increase of awareness regarding accessing support materials for those with hearing loss. This may be as a result of the previous assessment, due to the purchase of hearing loops across the Health Board.

Hearing Loss

Hospital	2016 Assessment	2018 Assessment	Ward/ Department	Answered Yes	Answered No
UHW	36%	54%	59	32	27
UHL	35%	47%	49	23	26
Barry	38%	57%	7	4	3
CRI	N/A	0%	3	0	3
St David's	29%	57%	7	4	3
Rookwood	100%	100%	4	4	0

When comparing results between sight and hearing loss it is clear that there appears to be little correlation between the two. This may be due to the differing needs of the patient group. It may be useful if the CHC, as part of its routine monitoring, ask patients for their views as to the availability of materials for sight and hearing loss. In addition, a briefing from the Health Board needs to be published indicating the times that alternative formats have been requested over this time period.

Question 5

Are you aware of any training on how to communicate effectively with someone who has sight / hearing loss?

It was disappointing to see that some two years after our initial assessment, staff awareness of where to access training for sight and hearing loss patients across all of the Health Board has declined, except Rookwood Hospital. It is evident that a review by the Health Board is required to reverse this trend and if this correlates with Public Health Board reports reporting on the levels of performance reviews being undertaken for front line staff.

Sight Loss

Hospital	2016 Assessment	2018 Assessment	Ward/ Department	Answered Yes	Answered No
UHW	18%	25%	59	15	44
UHL	52%	31%	49	15	34
Barry	50%	43%	7	3	4
CRI	N/A	33%	3	1	2
St David's	57%	43%	7	3	4
Rookwood	100%	50%	4	2	2

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Whilst the above indicates some improvements, these are slight the majority of the responses received indicated a decline in awareness of training available to staff for supporting patients with sight and hearing loss.

Hearing Loss

Hospital	2016 Assessment	2018 Assessment	Ward/ Department	Answered Yes	Answered No
UHW	23%	27%	59	16	43
UHL	55%	31%	49	15	34
Barry	50%	43%	7	3	4
CRI	N/A	33%	3	1	2
St David's	57%	43%	7	3	4
Rookwood	50%	50%	4	2	2

The results recorded in relation to hearing loss are similar to those detailed for sight loss. If staff are not aware that training is available, then these patients needs are not being met and this is something the Health Board needs to address.

The CHC has identified that the Health Board is requested to provide assurance that staff awareness training will be reviewed as a matter of urgency. The CHC believes this lack of understanding and knowledge will have a direct impact on patient care and experience.

What we found out?

Velindre University NHS Trust

The visit to Velindre was undertaken in the same way due to only visiting one site 'the Cancer Centre', we are unable to cross reference performance of Velindre against that of Cardiff & Vale University Health Board, Where we undertook visits to several sites as part of this assessment.

The questions asked were exactly the same as indicated on page 3 of this report.

Question 1: Are you aware if any patient that you care for has a sight/hearing loss?

Question 2: Is a patient's sight/hearing loss shared with the ward/department team, including catering staff?

Question 3: Is a patient's sight/hearing loss recorded in their records?

Question 4: Do you have any access to any equipment/accessible information to assist with communication with a patient who has sight/hearing loss? (e.g.: large print, braille, audio, hearing loop, personal listeners, amplifier)

Question 5: Are you aware of any training on how to communicate effectively with someone who has sight/hearing loss?

In summary, Velindre has improved significantly across all the questions asked excluding question 3 which relates to if the patients' sight / hearing loss is recorded in the patient records which has seen a 10% reduction. This needs to be addressed by the Trust and is something that Healthcare Inspectorate Wales may wish to consider reviewing as part of their programme of inspection.

Velindre Cancer Centre	2016 Assessment	2018 Assessment	Wards/ Departments	Answered Yes	Answered No
Question 1	70%	90%	10	9	1
Question 2	90%	100%	10	10	0
Question 3	90%	80%	10	8	2
Question 4	60%	80%	10	8	2
Question 5	50%	80%	10	8	2

Staff awareness training along with access to equipment has improved over the past two years and it would be helpful to ascertain how these improvements have been implemented and enhanced. It would be useful if the satellite services provided by Velindre were included in future and also the Welsh Blood Service to include a donor perspective. This is something for the CHC to consider.

In relation to hearing loss Velindre has maintained or increased the level of awareness. However, issues relating to staff training (Q5) and access to equipment / accessible information (Q4) has not increased above 80% over the last two year period, again we would draw attention to the status of record keeping (Q3) which has also shown a decline since the assessment in 2016.

Conclusion & Recommendations

The CHC is aware that actions have been taken following the initial assessment in 2016 and the report was welcomed by the local NHS. We are aware the NHS has worked with key stakeholders in assisting them to action the findings of the assessment.

We are pleased that Sensory Loss has become a key driver for both Cardiff & Vale University Health Board and Velindre University NHS Trust. We are pleased that improvements in the availability of resources for sight and hearing loss have improved however, have concerns that other areas such as recording the status of a patient with sight and hearing loss is quite high but this has not translated into staff awareness when questioned. We believe more needs to be done in a consistent way across both organisations and there may be an opportunity to share good practice which we would encourage.

We have made some recommendations for the NHS to consider and report back on how they will provide assurances to the CHC and the wider community, that progress is being made to establish sight and hearing loss as a key patient safety initiative.

Recommendations to Cardiff & Vale University Health Board

Recommendation 1: (Question 1)

The Health Board is required to advise the CHC and the residents of Cardiff & Vale of Glamorgan how they will attain higher level staff awareness across **all** their sites

Recommendation 2: (Question 2)

The Health Board consider establishing a mechanism for all key staff to be aware of patients' who have sight / hearing loss similar to the hand over process currently undertaken by clinical staff and make this available to the CHC.

Recommendation 3: (Question 5)

The Health Board is requested to provide assurance that staff awareness training will be reviewed as a matter of urgency.

Recommendation to Velindre University NHS Trust

Recommendation 1: (Question 3)

The Trust provides assurances that recording of patient status in relation to sight / hearing loss will be addressed.

Recommendation to both organisations

Cardiff & Vale UHB and Velindre UNHS Trust identify if there are opportunities to share good practice / training resource to further enhance services and awareness for sight / hearing loss patients across the area.

Acknowledgements & Next Steps

Cardiff and Vale of Glamorgan CHC would wish to place on record it's thanks to the CHC Volunteer members who undertook the assessment and provided detailed responses which helped collate this report.

We would also wish to thank all NHS Staff who provided open, honest feedback to the CHC members as part of this assessment.

Both NHS organisations will receive detailed reports for each site visited, in order to assist them in responding to the recommendations set out in this report.

The CHC will publish the NHS responses to this report and will continually monitor progress through our routine visiting process, and will undertake another assessment in due course.

Stephen Allen
Chief Officer
On Behalf of the
Cardiff & Vale of Glamorgan Community Health Council

May 2018

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CAERDYDD A BRO MORGANNWG
CARDIFF AND VALE OF GLAMORGAN

Barry Hospital Sensory Loss Assessment

May 2018

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The Cardiff & Vale of Glamorgan Community Health Council (CAVOG CHC) visited Barry Hospital on Wednesday, 24 January 2018 in order to carry out a Sensory Loss Assessment.

The following areas of the Centre were assessed:

- Phlebotomy Department
- Minor Injuries Unit
- Physiotherapy
- Podiatry
- Sam Davies Ward
- St Barrucs Ward
- X-Ray

On the day that the CHC Members visited the Hospital to carry out this Assessment, the following 4 wards/ departments were closed and therefore information cannot be provided within the results below:

- Neale & Kent Ward
- Dental Department
- Morfa Day Unit
- Morgannwg Ward

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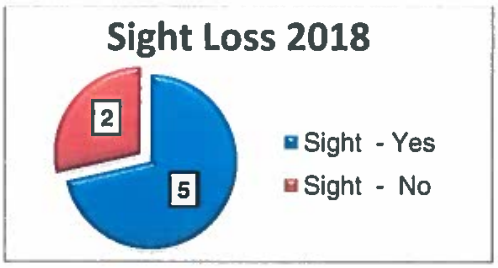
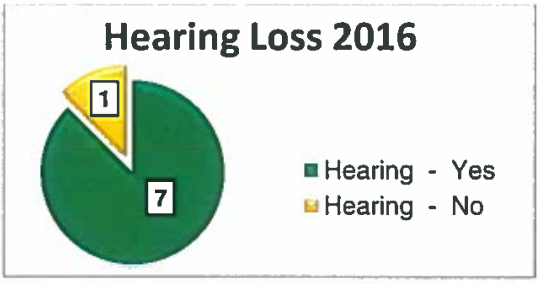
Of the 7 wards/departments visited at the hospital, Members of the CHC spoke to a member of staff and asked the following 5 questions. Each question required an answer relating to Sight Loss and Hearing Loss.

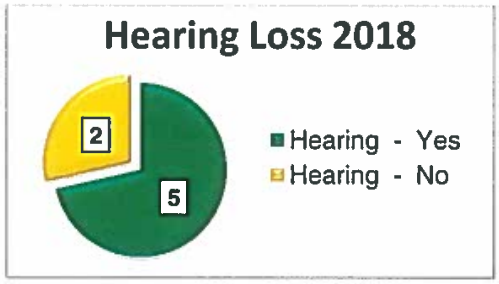
The following data was gathered and the results shown in the charts below:

Question 1

Are you aware if any patient that you care for has a sight / hearing loss?

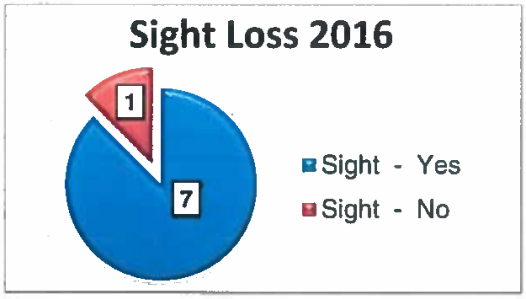


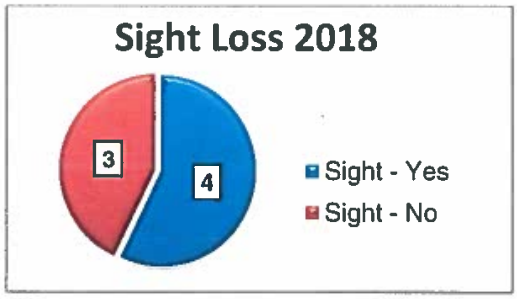


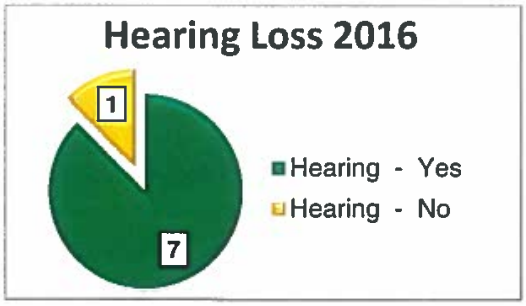


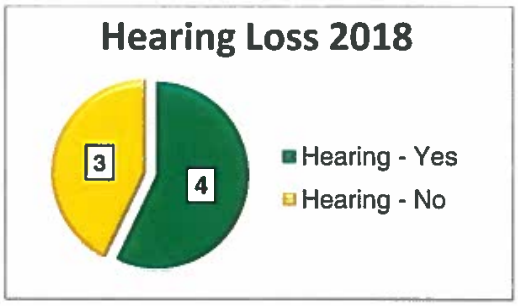
Question 2

Is a patient's sight/hearing loss shared with the ward/department team, including catering staff?









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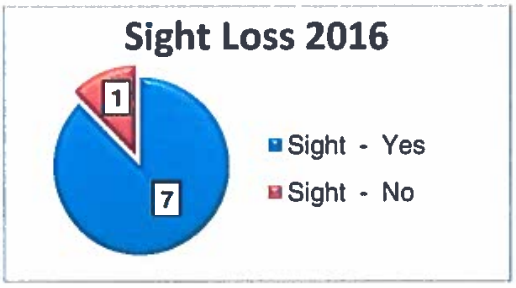
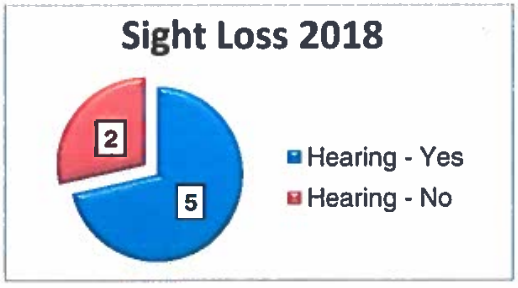
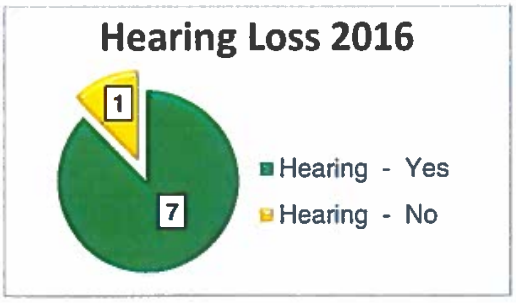
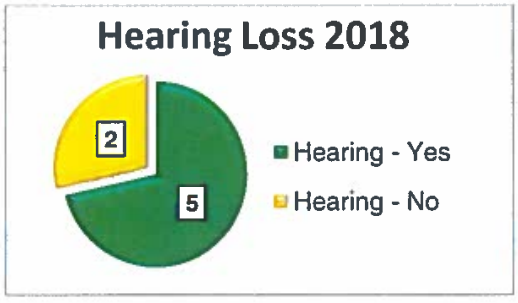
Question 3

Is a patient's sight/hearing loss recorded in their records?



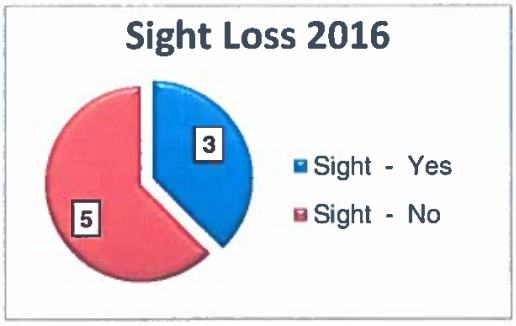


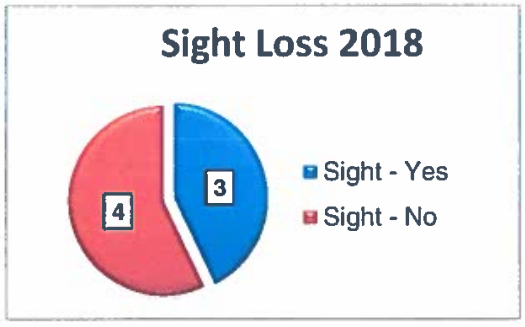


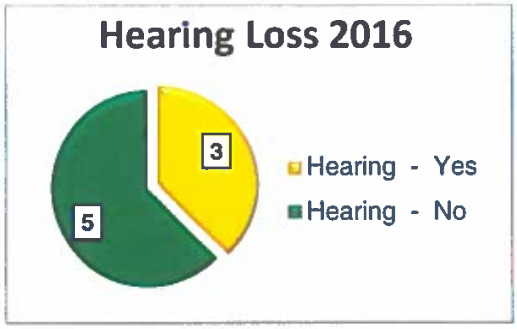


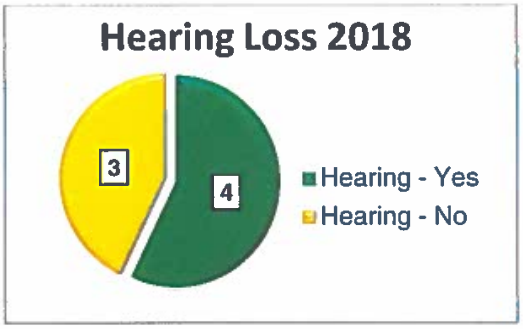
Question 4

Do you have any access to any equipment/accessible information to assist with communication with a patient who has sight/hearing loss? (eg: large print, braille, audio, hearing loop, personal listeners, and amplifier).









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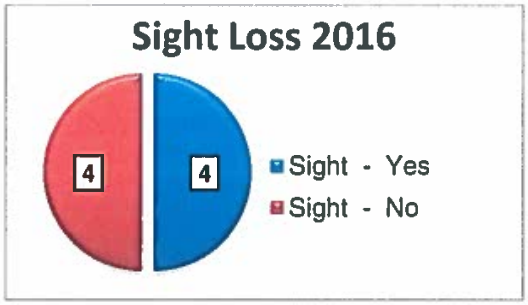
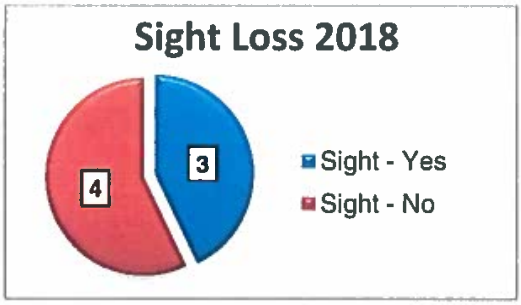
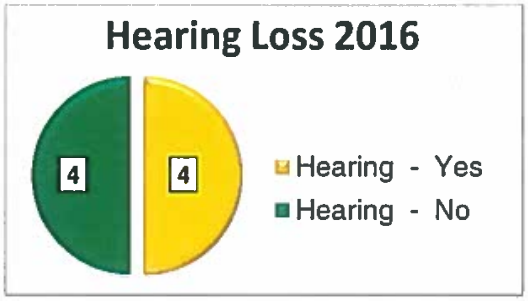
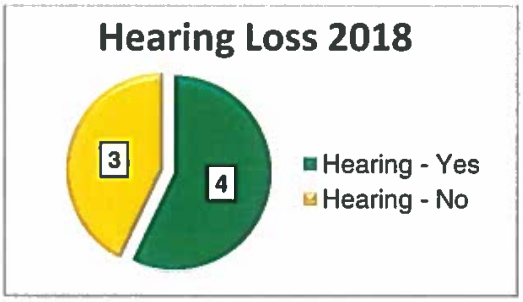
Question 5

Are you aware of any training on how to communicate effectively with someone who has sight/hearing loss?









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Comments:

CHC Members provided the following comments:

	2016
1	There are no hearing loops in 2 wards/departments.
2	The hearing loop is broken on 1 ward.
3	Staff on one ward indicated that although they have a hearing loop installed, no training has been given for its use. However, patients have access to large print books.
4	No supply of batteries available for hearing books or cd players with disposable headphones on 2 wards.
5	One ward confirmed that whilst they had a loop, they were also waiting for a permanent one to be installed. They also confirmed that they have braille newspapers and audio books available for patients.
6	A sign language course had been offered in one specific department.
7	Members visited the main reception of the Hospital, but no one was in attendance. They were informed that the paid receptionist was on sick leave and volunteers only cover reception in the morning.

	2018
1	Three wards confirmed that they had hearing loops on their ward and one other ward stated that a loop was available if required.
2	Staff indicated that there was training provided on general communication and "E-learning" is also accessible but not mandatory. It was felt that training for all staff needs to improve.
3	Two wards confirmed as well as having a hearing loop, they have "show me" cards and literature in large print to help with activities.
4	Both X-Ray and Phlebotomy units stated that questions 2 and 3 were not applicable to their departments as no patient records are available while patient is there.

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Cardiff Royal Infirmary Sensory Loss Assessment

May 2018

The Cardiff & Vale of Glamorgan Community Health Council (CAVOG CHC) visited Cardiff Royal Infirmary on Wednesday, 24 January in order to carry out a Sensory Loss Base Line Assessment. The following areas of the Centre were assessed:

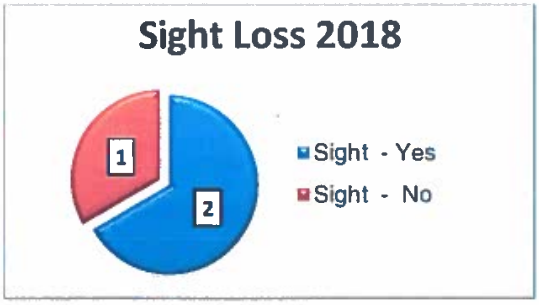
- Department of Sexual Health
- Outpatients
- X-Ray

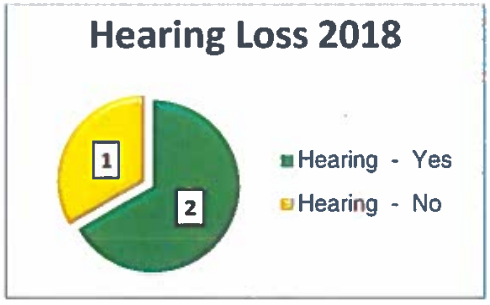
Of the 3 departments visited in our Assessment, Members of the CHC spoke to a member of staff and asked the following 5 questions. Each question required an answer relating to Sight Loss and Hearing Loss.

The following data was gathered and the results shown in the charts below.

Question 1

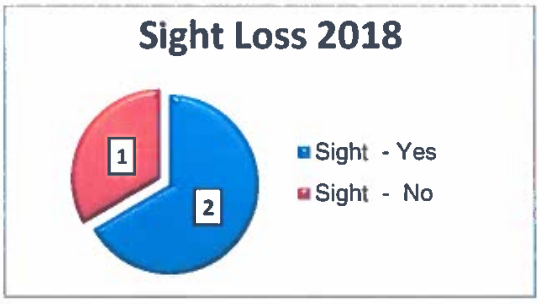
Are you aware if any patient that you care for has a sight / hearing loss?

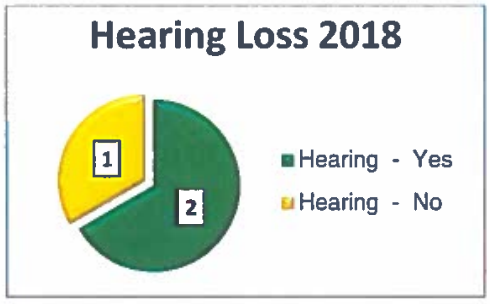




Question 2

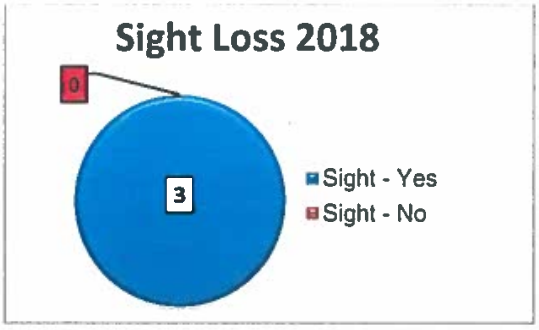
Is a patient's sight/hearing loss shared with the ward/department team, including catering staff?

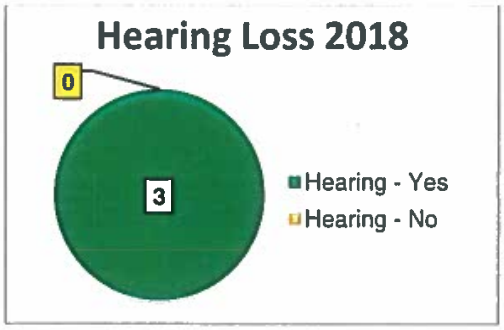




Question 3

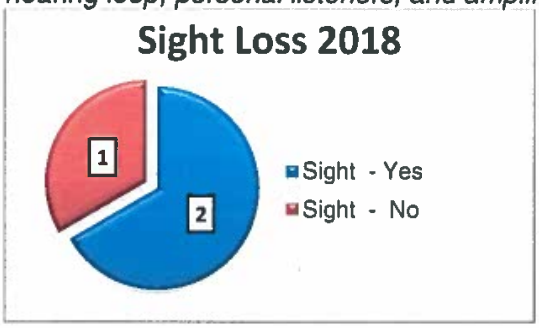
Is a patient's sight/hearing loss recorded in their records?

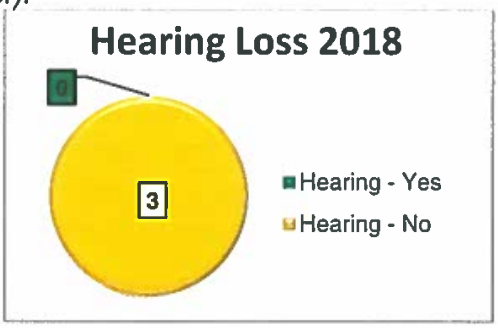




Question 4

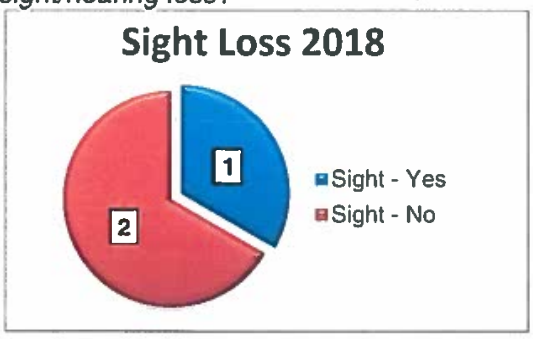
Do you have any access to any equipment/accessible information to assist with communication with a patient who has sight/hearing loss? (eg: large print, braille, audio, hearing loop, personal listeners, and amplifier).

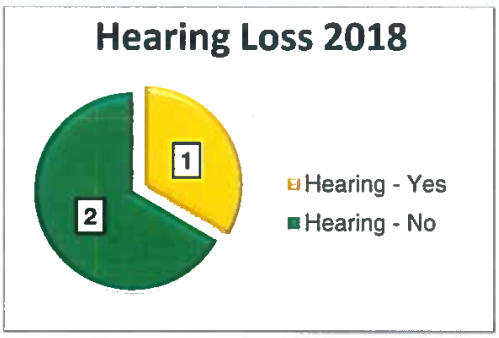




Question 5

Are you aware of any training on how to communicate effectively with someone who has sight/hearing loss?





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Comments:

CHC Members did not visit Cardiff Royal Infirmary during the initial assessment in 2016.

As the Cardiff Royal Infirmary is currently going through an extensive regeneration process, only 3 departments were visited during this assessment and the Members provided the following comments:

	2018
1	Both X-Ray and DOSH confirmed that any patient who has sight/hearing loss has an alert on the record system. Outpatients confirmed that they would only be aware if a patient advises staff of any sight/hearing loss.
2	One staff member confirmed that basic sign language training had been held in November 2017 and that there had also been a Sensory Loss Awareness month.
3	One member was unaware of any training available and another staff member confirmed that access can be arranged for a British Sign Language interpreter to be present if needed.
4	Two out of three staff confirmed that large print literature is available for patients with sight loss, but no equipment is available for patients with hearing loss.

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Rookwood Hospital Sensory Loss Assessment

May 2018

The Cardiff & Vale of Glamorgan Community Health Council (CAVOG CHC) visited Rookwood Hospital on Tuesday, 23 January 2018 in order to carry out a Sensory Loss Assessment.

The following areas of the Centre were assessed:

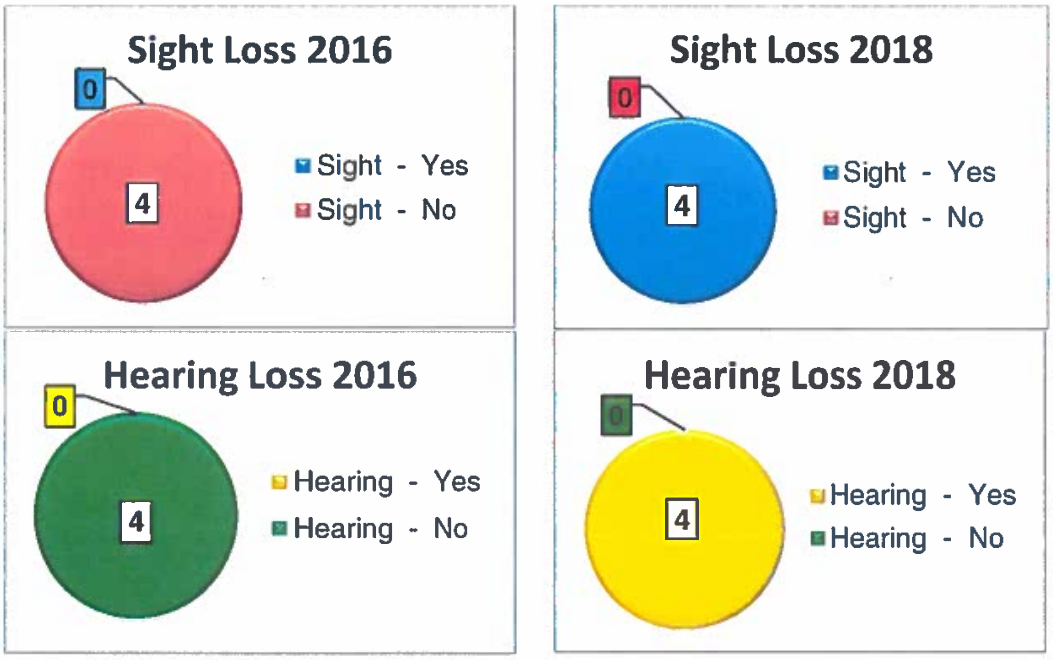
- Ward 4
- Ward 5
- Ward 7
- ALAC

Ward 8 (not visited)

Of the 4 wards / departments visited in our Assessment, Members of the CHC spoke to a member of staff and asked the following 5 questions. Each question required an answer relating to Sight Loss and Hearing Loss. The following data was gathered and the results shown in the charts below:

Question 1

Are you aware if any patient that you care for has a sight / hearing loss?



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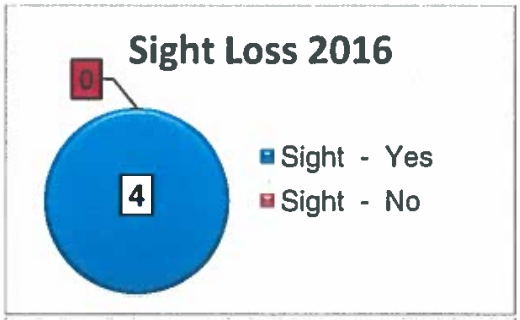
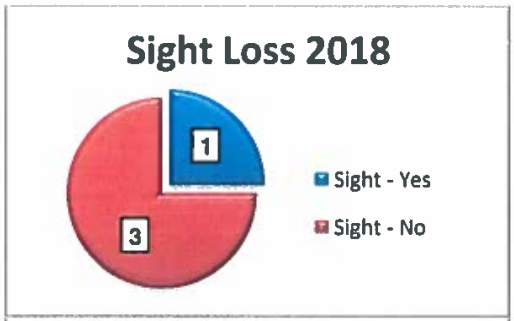
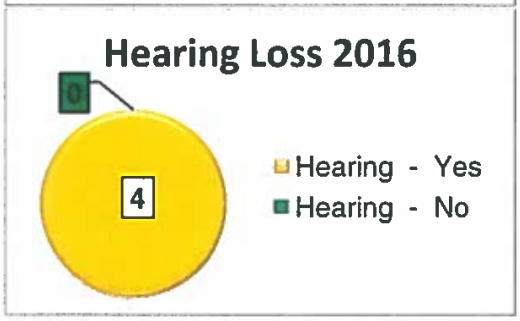
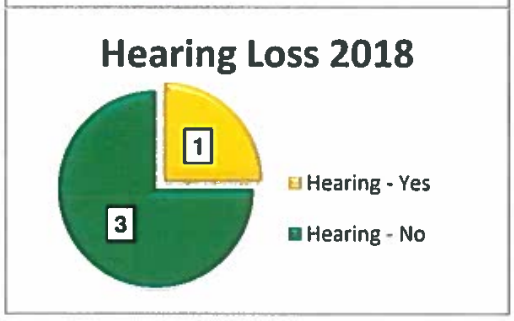
Question 2

Is a patient's sight/hearing loss shared with the ward/department team, including catering staff?



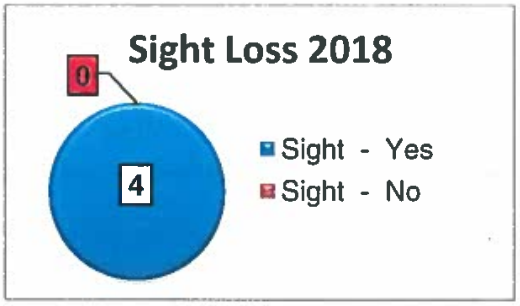


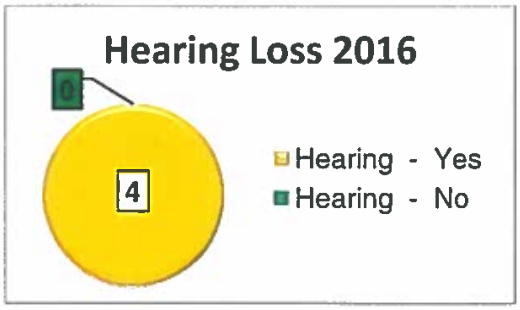


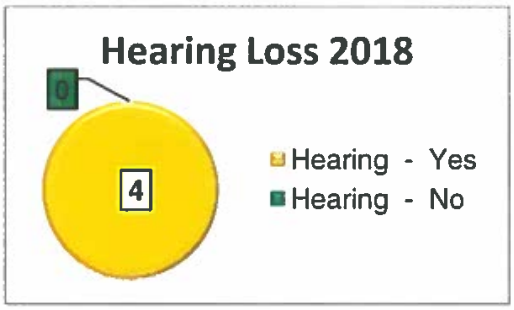


Question 3

Is a patient's sight/hearing loss recorded in their records?







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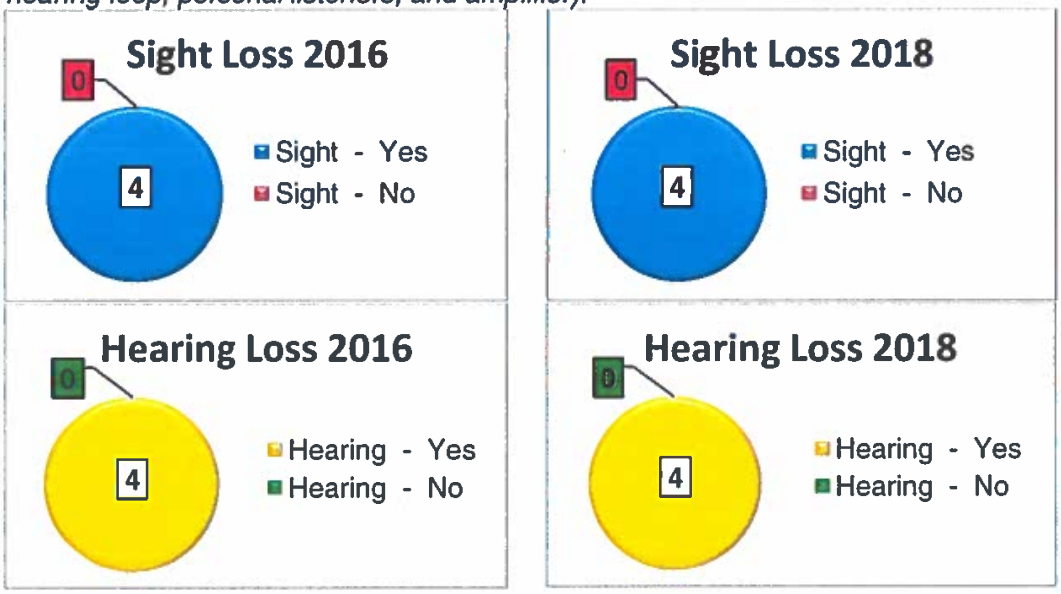
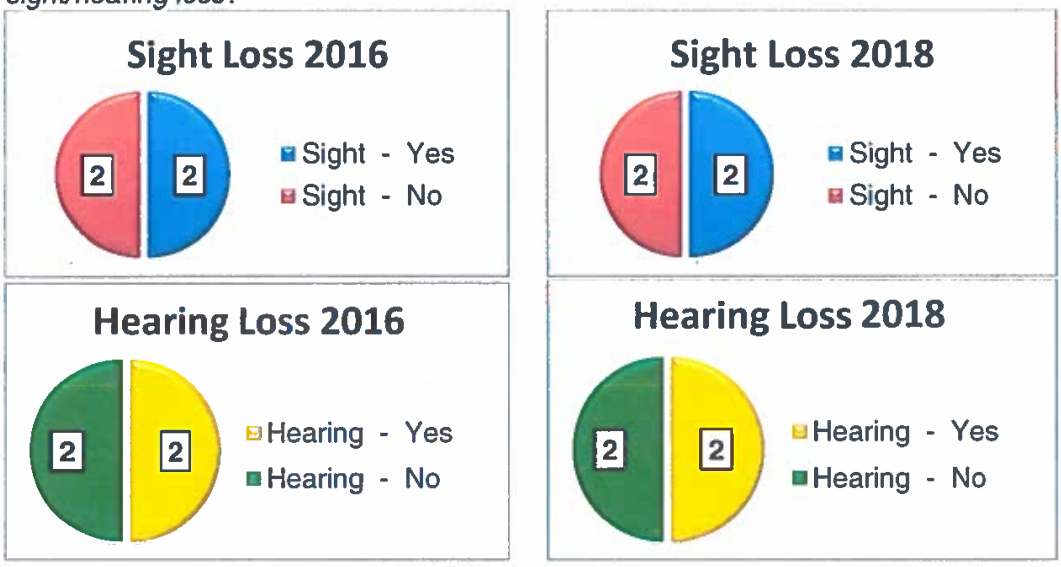
Question 4

Do you have any access to any equipment/accessible information to assist with communication with a patient who has sight/hearing loss? (eg: large print, braille, audio, hearing loop, personal listeners, and amplifier).



Question 5

Are you aware of any training on how to communicate effectively with someone who has sight/hearing loss?



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Comments:

CHC Members provided the following comments:

	2016
1	CHC Members concluded that staff at Rookwood Hospital are able to access a range of aids to communicate via OT and also from Cardiff Institute for the Blind.
2	On one ward, a member of staff had written a policy for staff on how to deal with patients who have assistance dogs and who bring them to the day units.

	2018
1	One ward relies on patients to inform staff of sight/hearing loss on admission.
2	3 out of the 4 wards stated that Catering staff are not informed of a patient's sight / hearing loss.
3	Some staff were unsure of how to access equipment, while other staff confirmed that Occupational Therapy provides equipment when necessary.
4	The Healthcare support workers spoken to confirmed that no specific training is provided to them on how to communicate effectively with someone who has sight / hearing loss.

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St. David's Hospital Sensory Loss Assessment

May 2018

The Cardiff & Vale of Glamorgan Community Health Council (CAVOG CHC) visited St David's Hospital on Tuesday, 13 February 2018 in order to carry out a Sensory Loss Base Line Assessment.

The following areas of the Hospital were assessed:

- Children's Centre
- Dental Department
- Hamadryad/Elizabeth
- Lansdowne Ward
- Physiotherapy
- Rhydlafar Ward
- Turnbull Day Hospital

Of the 9 areas within the hospital to be assessed, CHC Members were able to access 7 wards/departments. At the time of the visit, there were no staff available for a discussion on the 2 wards.

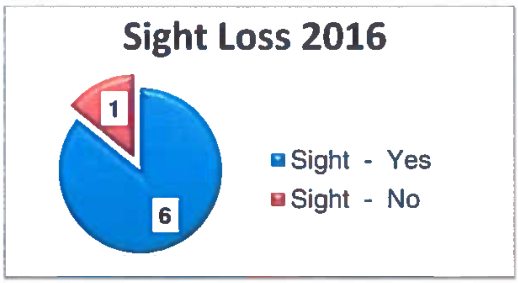
Members of the CHC spoke to a member of staff and asked the following 5 questions. Each question required an answer relating to Sight Loss and Hearing Loss.

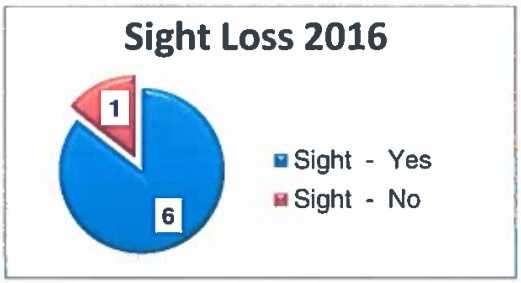
CHC Members were unable to undertake an assessment within the Outpatients Department and Podiatry as there were no members of staff available at the time.

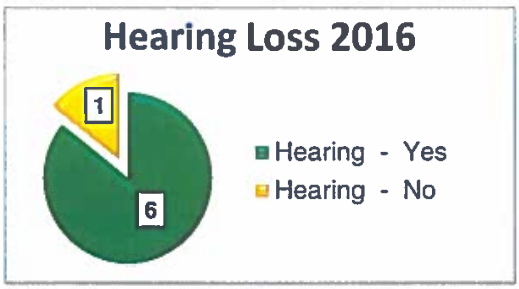
The following data was gathered and the results shown in the charts below:

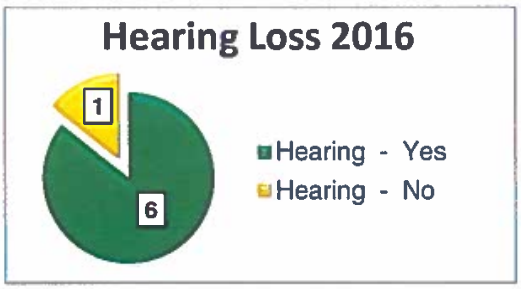
Question 1

Are you aware if any patient that you care for has a sight / hearing loss?



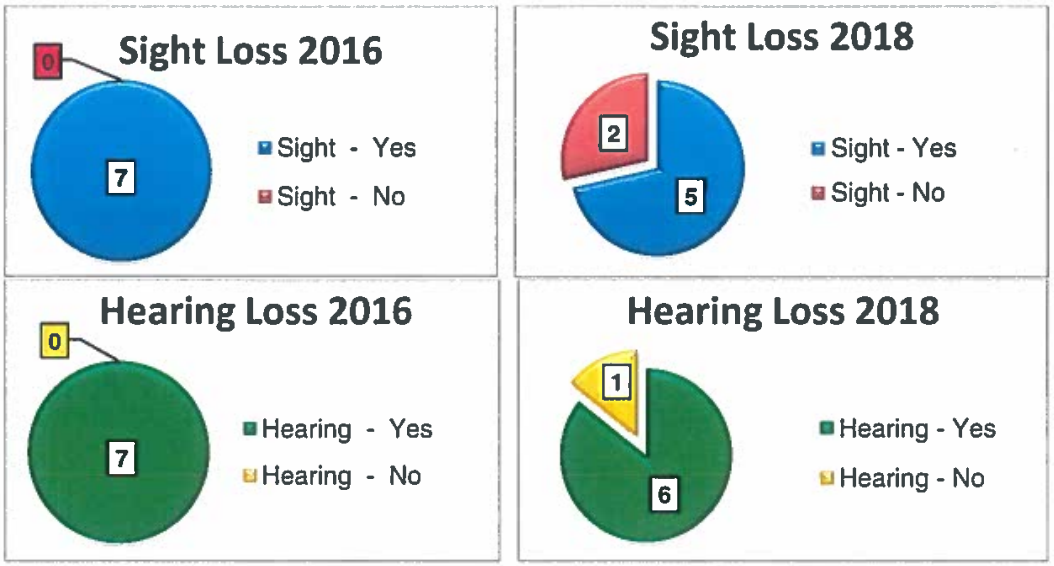






Question 2

Is a patient's sight/hearing loss shared with the ward/department team, including catering staff?



Question 3

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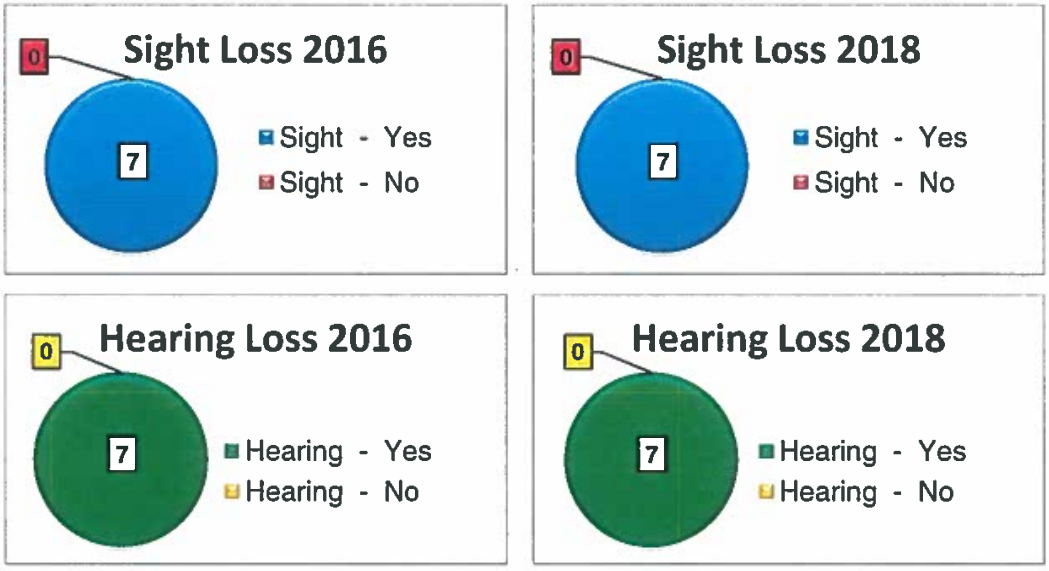

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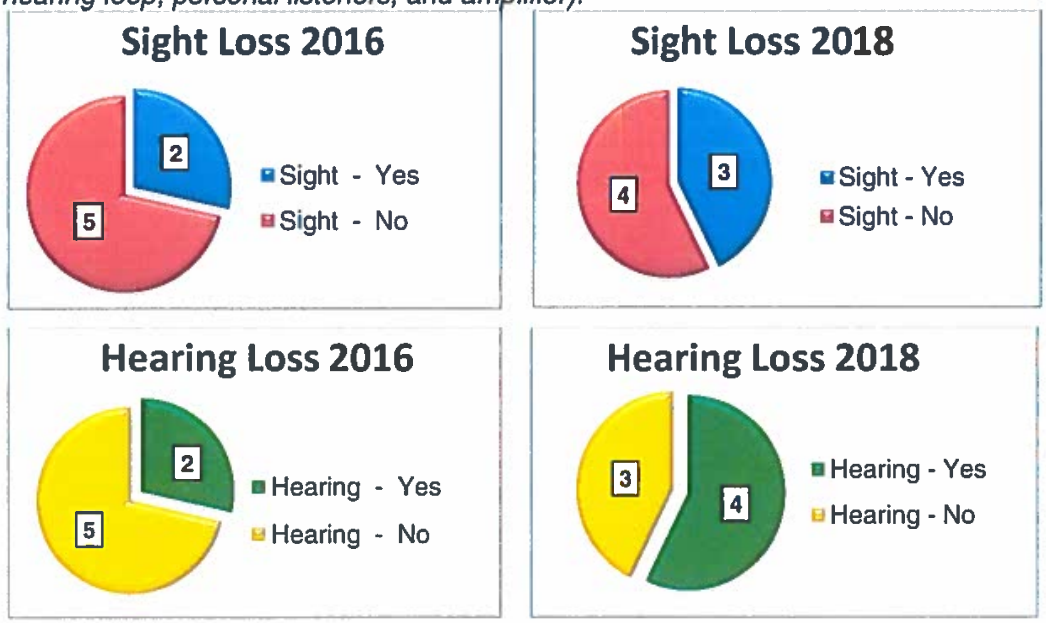
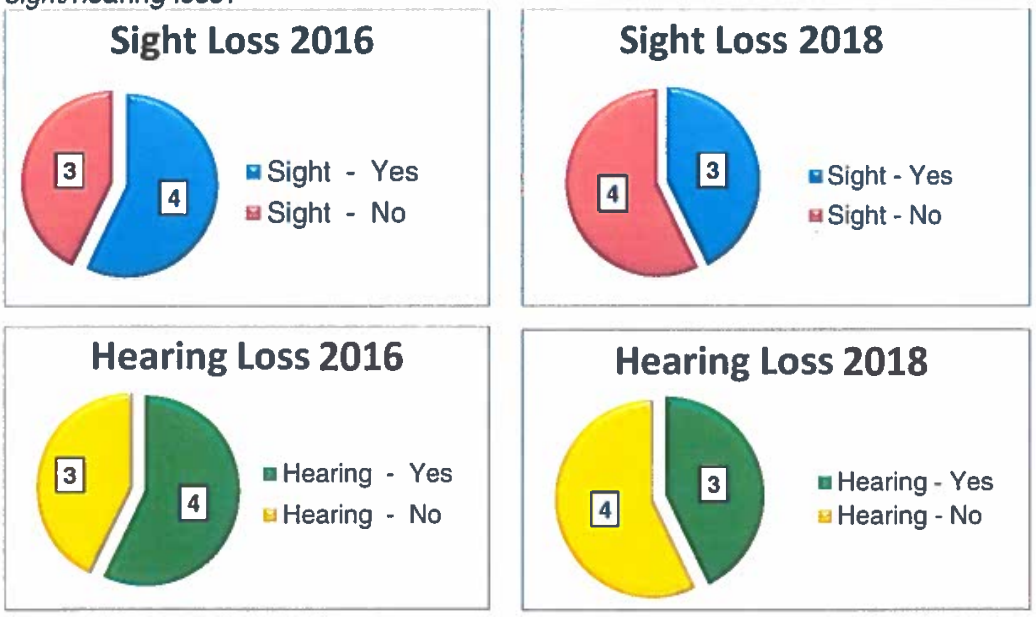
Question 4

Do you have any access to any equipment/accessible information to assist with communication with a patient who has sight/hearing loss? (eg: large print, braille, audio, hearing loop, personal listeners, and amplifier).



Question 5

Are you aware of any training on how to communicate effectively with someone who has sight/hearing loss?



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Comments:

CHC Members provided the following comments:

	2016
1	The majority of staff at St. David's Hospital are aware if a patient has a sensory loss and that it is recorded in their records.
2	Staff also ensure that this information is shared with every member of the team involved with the patient's care.
3	Members were informed that although there are some signs available, they have to ask OT for help with any equipment that may be required.
4	A few departments are aware that there is a sign language interpreter available, if needed.
5	Staff indicated that some training had been received on how to communicate with patients, but not specifically tailored for sensory loss

	2018
1	The team concluded that the situation in St. David's hospital is as it was at the time of the initial assessment in January 2016, namely that the majority, if not all, the staff are aware if a patient has a sensory loss on admission and that this information is recorded in the case notes. All team members are made aware of this information.
2	If a patient requires specific help, there is a limited amount of supporting equipment available, i.e. hearing loops are available on wards only, personal listeners and amplifiers which are available via Occupational Therapy. There seemed little available in terms of braille and large print for sight impaired patients, but from the staff that the CHC members spoke with, this had not been an issue. Elizabeth Ward was trialling a visual assistance tool which was proving to be helpful.
3	There appears to be limited sporadic relevant training available on the sensory loss, although on some of the ward staff were working through the e-sensory loss module.

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University Hospital Llandough Sensory Loss Assessment

May 2018

The Cardiff & Vale of Glamorgan Community Health Council (CAVOG CHC) visited the Llandough Hospital on Wednesday, 24 January & Friday, 26 January 2018 in order to carry out a Sensory Loss Base Line Audit.

The following areas of the Hospital were assessed:

- East 1
- Pulmonary Rehabilitation Unit
- East 3
- Gerontology Rehabilitation Unit
- East 7
- Mental Health Assessment & Recovery Unit
- Main Outpatients
- Cardiology
- X-Ray Radiology
- Haematology
- Therapies
- East 2
- East 4
- East 6
- East 8
- East 10
- East 12
- East 14
- East 16
- Diabetes Centre
- Cystic Fibrosis Outpatients
- Pharmacy
- Breast Centre
- CAVOC
- Day Surgery
- West 1
- West 3
- West 5
- West 2
- West 4
- West 6
- Anwen Ward
- Charles Radcliff Ward
- Gwenwyn Ward
- Cystic Fibrosis Unit/Ward

Hafan Y Coed:

- Alder Ward
- Ash Ward
- Beech Ward
- Cedar Ward
- Elm Ward
- Hazel Ward
- Maple Ward
- Oak Ward
- Pine Ward
- Pharmacy
- ECT Treatment & Recovery Room

Therapies:

- Physiotherapy
- Occupational Therapy
- Speech & Language

On the dates that CHC Members visited the Hospital, the following wards / department were not visited for a number of reasons and therefore we are unable to provide any information concerning these wards:

9

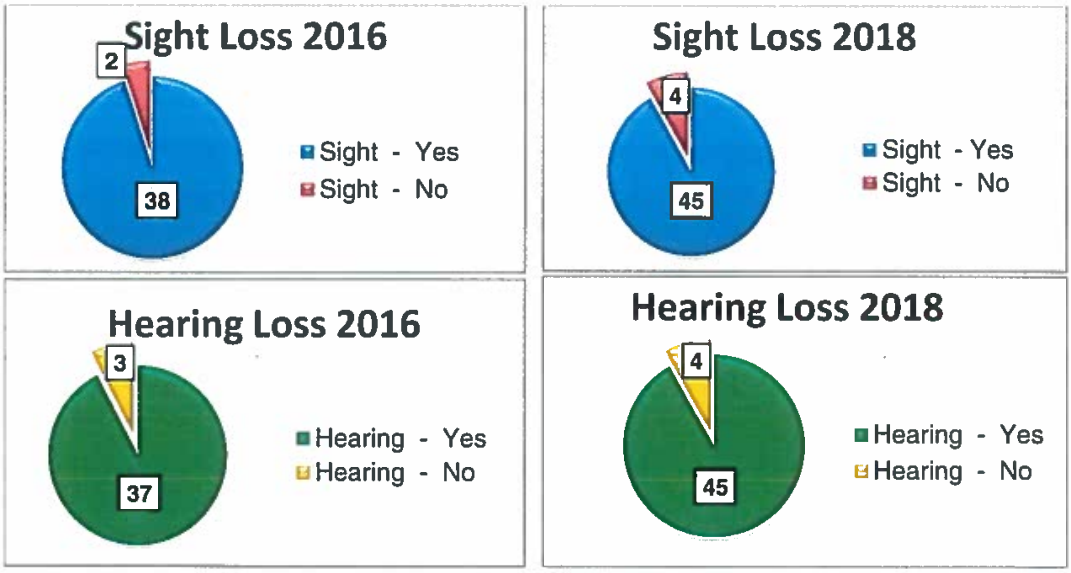
- Daffodil (Llanfair)
- Meadow (Llanfair)
- Delyth Ward
- East 18
- Endoscopy Unit
- Women's Services
- Children's Centre

Of the 49 wards/departments visited in our Assessment, Members of the CHC spoke to a member of staff and asked the following 5 questions. Each question required an answer relating to Sight Loss and Hearing Loss.

The following data was gathered and the results shown in the charts below.

Question 1

Are you aware if any patient that you care for has a sight / hearing loss?



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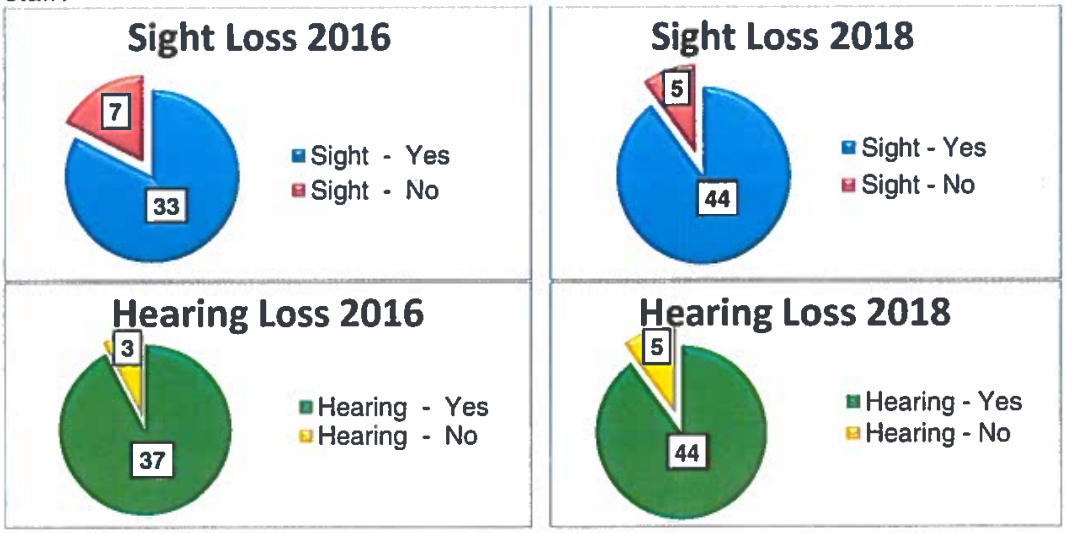
Question 2

Is a patient's sight/hearing loss shared with the ward/department team, including catering staff?



Question 3

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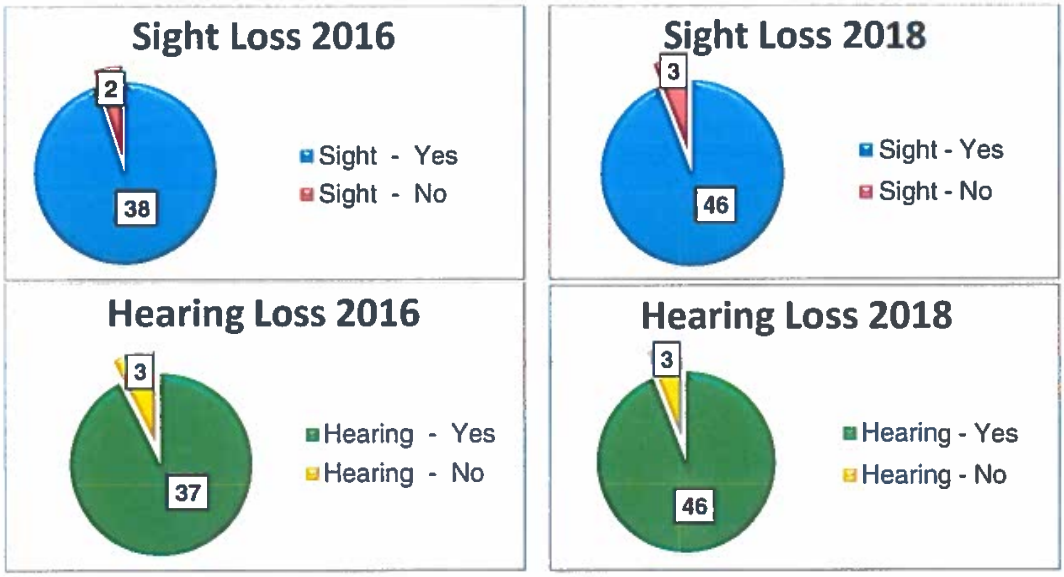

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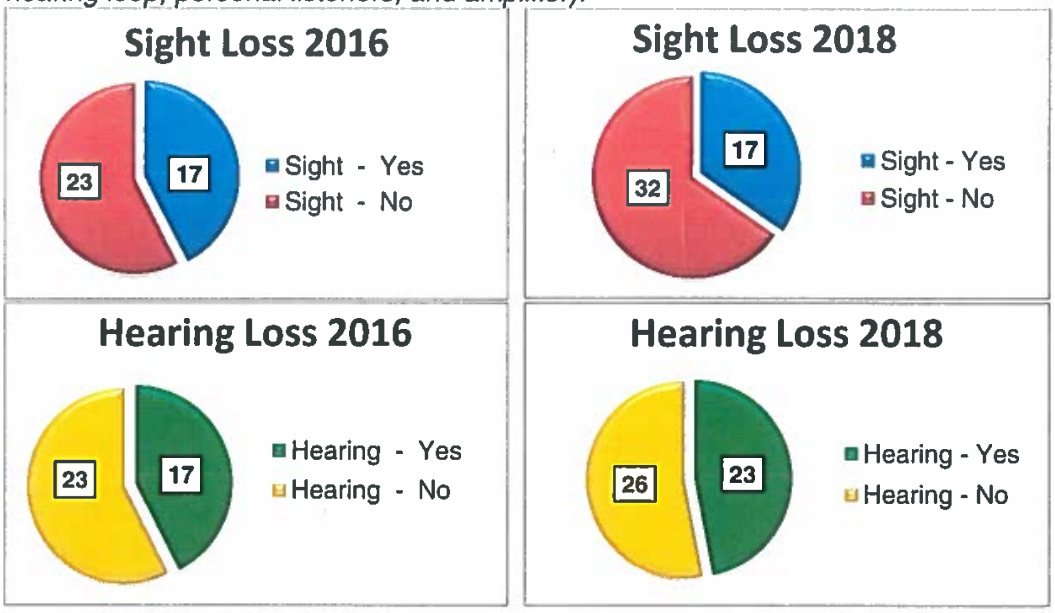
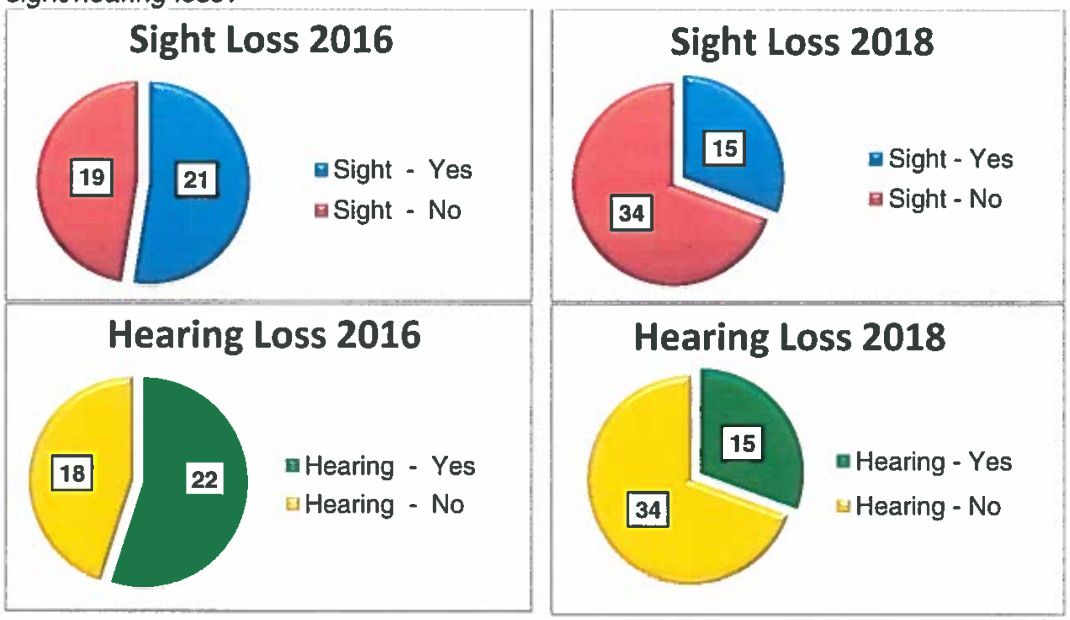
Question 4

Do you have any access to any equipment/accessible information to assist with communication with a patient who has sight/hearing loss? (eg: large print, braille, audio, hearing loop, personal listeners, and amplifier).



Question 5

Are you aware of any training on how to communicate effectively with someone who has sight/hearing loss?



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Comments:

CHC Members provided the following comments:

	2016
1	Certain staff are aware that large print documents can be printed off the system and given to patients, when required.
2	A couple of staff commented that they would be interested in specific training patients with sight/hearing loss, in order to make their journey more comfortable. Other members stated that they had attended a communication training day, but it was not specifically designed to dealing with people who have sight/hearing loss

	2018
1	Some staff did know of online/e-learning training available, while other staff stated they are not aware of any training available.
2	Some staff believe access to equipment /information is available, but were not able to identify exactly who to contact.
3	Some staff are aware that large print documents can be printed off and limited wards have hearing loops in situ or that portable devices are available.
4	Some staff mentioned there is a communications training day, but that it is a general course and not specific to sight / hearing loss.

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University Hospital for Wales Sensory Loss Assessment

May 2018

The Cardiff & Vale of Glamorgan Community Health Council (CAVOG CHC) visited the University Hospital of Wales on Thursday, 25th January 2018 in order to carry out a Sensory Loss Assessment.

The following areas of the Hospital were assessed:

- Accident & Emergency
- Paediatric Accident &
- Ambulatory Care / Short Stay
- Endoscopy Unit
- Oncology Outpatients
- Outpatient Clinics 1 -21 (only available to speak to at time visit)
- Pharmacy
- Physiotherapy
- Psychology Outpatients
- Trauma Department
- Women's Unit
- X-Ray/Radiology

- Wards A1 – A7 (including link
- Wards B1 – B7
- Wards C1 – C7

Children's Hospital for

- Dolphin Outpatients
- Octopus Outpatients (x-
- Penguin Outpatients (eye
- Rocket Outpatients
- Seahorse Unit (Children's Admissions Unit - CAU)
- Starfish Outpatients
- Children's Investigation
- Children's Kidney Centre
- Island Ward
- Jungle Ward
- Owl Ward
- Pelican Ward
- Rainbow Ward

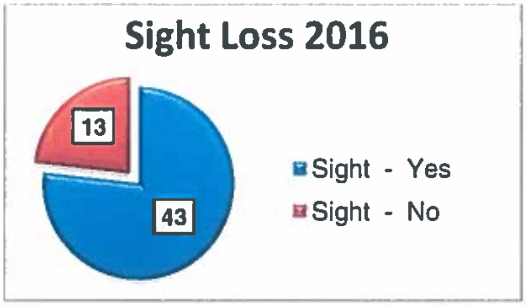
- Neonatal Intensive Care
- Teenage Cancer Trust Unit

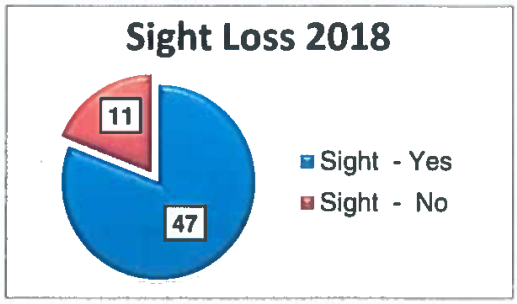
Of the 59 wards/departments visited, Members of the CHC spoke to a member of staff and asked the following 5 questions. Each question required an answer relating to Sight Loss and Hearing Loss.

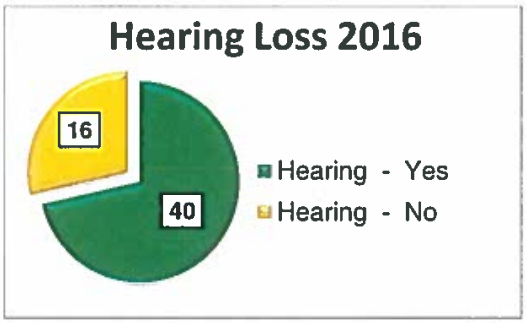
The data was gathered and the results shown in the following charts:

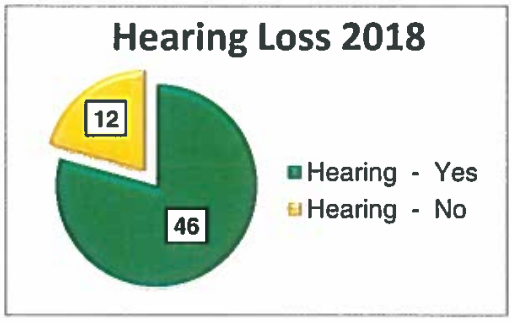
Question 1

Are you aware if any patient that you care for has a sight / hearing loss?



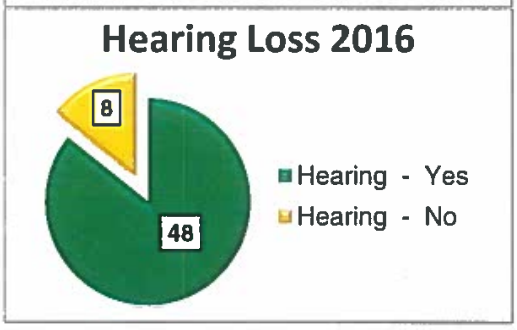


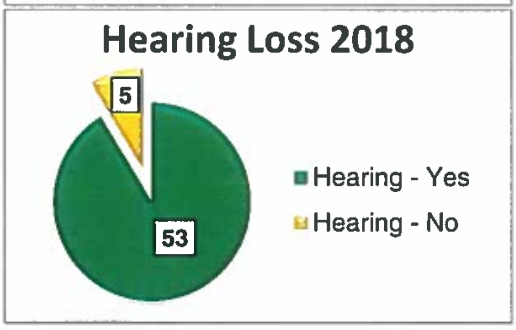




Question 2

Is a patient's sight/hearing loss shared with the ward/department team, including catering staff?





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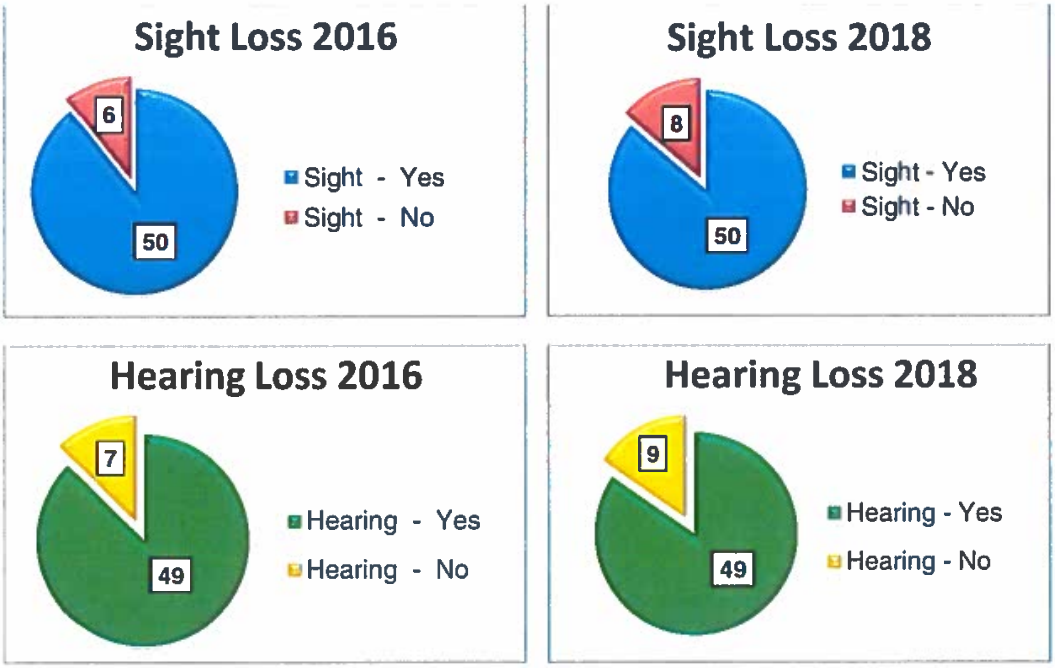
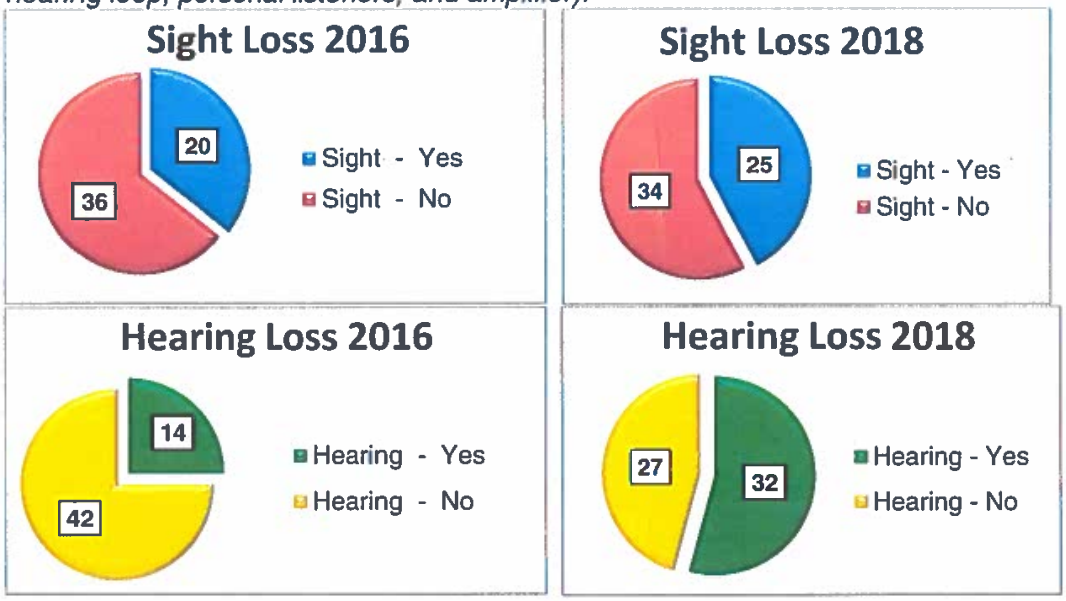
Question 3

Is a patient's sight/hearing loss recorded in their records?



Question 4

Do you have any access to any equipment/accessible information to assist with communication with a patient who has sight/hearing loss? (eg: large print, braille, audio, hearing loop, personal listeners, and amplifier).



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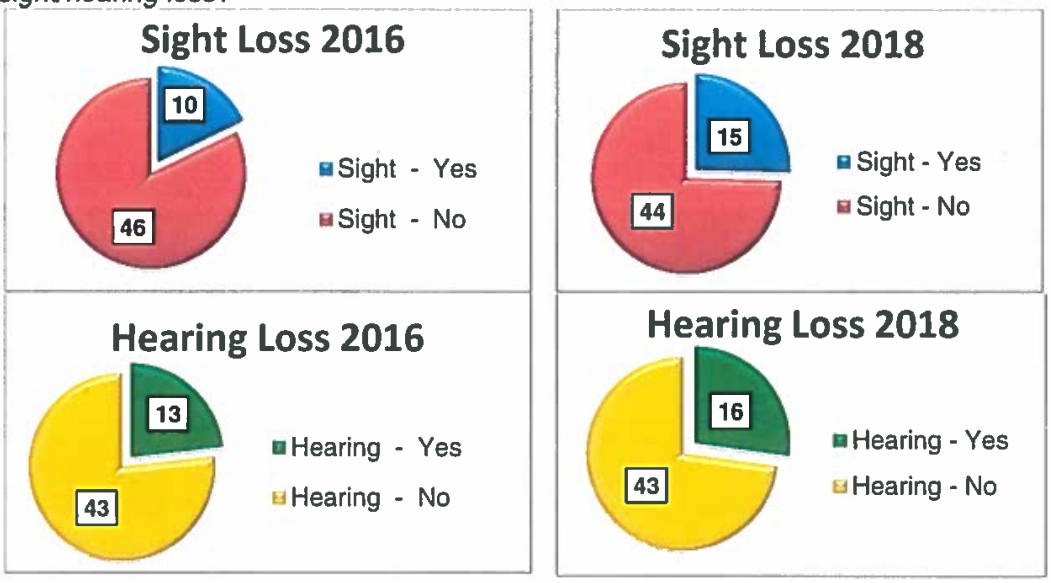
Question 5

Are you aware of any training on how to communicate effectively with someone who has sight/hearing loss?



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Comments:

CHC Members provided the following comments:

	2016
	Children's Hospital for Wales
1	Catering staff were not made aware of any patients that may be on the ward who have sight/hearing loss.
2	Staff are aware of large print boards, but few know where these are located.
3	Penguin Ward confirmed that stickers are used on patients notes that indicate a sensory loss. They also stated that Deaf Awareness training is mandatory every 3 years.
	Outpatients Clinics (only 15 available/open on day of Assessment)
4	A patient's sensory loss may be noted in their records.
5	There may be a piece of paper confirming hearing loss.
6	Some have stickers on the records.
7	Some rely on the patient to inform them of any sensory loss.
8	If a patient has a sensory loss, they are usually accompanied to the clinic.
9	A number of clinics had hearing loop signs, but when asked, staff could not find the loop itself or indicated that it was broken.
	A&E, Paediatric A&E, Pharmacy, Physiotherapy, X-Ray & Trauma
10	Information is generally obtained at reception or pre-assessment.
11	Pharmacy indicated that there were no audio/visual aids available to give to patients, apart from a hearing loop.
12	A hearing loop has recently been installed at X-Ray and they are currently running a trial of personal listeners.
13	A manager at the Trauma department has had sign language training.
	Hospital Wards A1-A7, B1-B7 & C1-C7
14	Staff members recalled receiving a general study day in communication, but none of the wards were aware of any specific training to deal with people who have sight/ hearing loss.

15	It was indicated to Members that a number of wards have hearing loops. One ward is in the process of having a loop installed and other wards stated they can access a loop through Audiology.

2018	
	Children's Hospital for Wales
1	All of the wards, except NICU and Jungle Ward, indicated that a patient's sight or hearing loss is shared with the ward team including catering staff.
2	Members found that hearing loops are held on a number of wards and Makaton signs and picture cards are available upon request. There are interactive or picture boards located in some wards.
3	Members were informed that there is a play therapist available on two wards.
4	Staff indicated that either they were not aware of any training on how to communicate effectively with someone who has sight/hearing loss or that they were unsure.
	Accident & Emergency (A&E), Paediatric A&E, Pharmacy, Physiotherapy, X-Ray & Trauma
5	There was a hearing loop available within the A&E department and it was confirmed that staff are aware of how to access information and equipment to assist with communication.
6	In the Pharmacy department, no audio/visual aids were available to give to patients. A sign was on display to indicate a hearing loop was available, but no loop was located by the member of staff at the time of the visit.
7	The reception area has been designed by RNIB and it has been decorated with dementia friendly colours. Training has not been offered recently to staff on how to effectively communicate with people who have sight/hearing loss.
	Hospital Wards A1 – A7
8	A few staff indicated they had received mandatory training on communication during their induction, but others were unsure if any further training was available on how to communicate effectively with someone who has sight/hearing loss.
9	Staff on 3 wards indicated that a hearing loop was available, and another 2 wards confirmed that they had access to literature in large print.

10	It was indicated that patient information is shared during "handover" by 4 staff members.
	Hospital Wards B1 - B7
11	All of the staff members spoken to on B block wards indicated that they were unaware of any training available on how to communicate effectively with someone who has sight/hearing loss or that they do not have access to any information and equipment to assist with communication with patients who have sight / hearing loss.
12	Two of the wards confirmed that there was a hearing loop on site but one staff member was unsure how to use it. One ward indicated that there is a hearing loop on order.
	Hospital Wards C1 - C7
13	The staff responses from these wards indicated that they were not aware of any training available to deal with people who have sight/ hearing loss.
14	The majority of wards indicated that a hearing loop was held on the ward, but not all of this equipment was visible on the day of the visit. Gerontology confirmed they had 2 sonic digital listeners and earphones on the ward, but do need to make more available.
15	A couple of wards have a dedicated sign language staff member and also some staff identified they have large print cards/literature available.

APPROVAL OF NHS WALES PRIOR APPROVAL POLICY	
Name of Meeting: QSE Committee	Date of Meeting: 12th June 2018

Executive Lead: Director of Public Health
Author: Commissioning Officer, 02921 832101
Caring for People, Keeping People Well: This policy supports the sustainability of the Health Board in avoiding harm, waste and variation.
Financial impact:
Quality, Safety, Patient Experience impact: Clarification of the process for requesting individual funding for routine treatment.
Health and Care Standard Number: 3.1, 3.3, 3.5, 5.1, 7.
CRAF Reference Number: 2.1, 2.5, 3.1, 3.1.2, 4.3, 5.1, 5.1.5, 5.1.6, 5.3
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The implementation of the All Wales Prior Approval policy for requesting individual funding for routine treatment.

The Committee is asked to:

- **APPROVE** the UHBs adoption of the All-Wales Prior Approval Policy
- **SUPPORT** the full publication of the All-Wales Prior Approval Policy in accordance with the UHB Publication Scheme

11.1

SITUATION

In September 2016, the Cabinet Secretary for Health, Well-being and Sport agreed the time was right for a new, independent review of the Individual Patient Funding Request (IPFR) process.

The “Independent Review of the Individual Patient Funding Requests Process in Wales” report was published in January 2017 and made a number of recommendations to support the IPFR process. This included the development of a clear and consistent national process for dealing with requests to access routine services outside of Local Health Board’s existing arrangements (including those of the Welsh Health Specialised Services Committee).

This paper provides members with a summary of the key elements to the All Wales Prior Approval Policy. Members are asked to approve and support implementation of the policy.

This is an All Wales Policy and will be implemented to support decisions made by Cardiff and Vale IPFR Panel.

BACKGROUND

Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

Health Board's in Wales have a statutory responsibility to provide healthcare that meets the needs of their local populations in accordance with the NHS (Wales) Act 2006, the Well-being of Future Generations (Wales) Act 2015, Social Services and Wellbeing (Wales) Act 2014 and Cross Border Healthcare Services (April 2013). They achieve this by either directly providing healthcare or by commissioning healthcare from other service providers.

Patients registered with a GP in Wales who are resident in Wales do not have a statutory right to choose which hospital they are referred to. The Welsh Governments view is that in general, Health Boards can best organise services to meet the needs of their patients when such services are provided in Wales. This ensures equity in terms of access, convenience, and affords each Health Board the opportunity to strengthen and improve the quality of their local services thus providing a net gain for the whole community.

Each Health Board aimed to ensure the establishment of simple uniform arrangements based around high quality, sustainable local services for their patients. Where these cannot be provided by the Health Board's own services for reasons such as resource, expertise or capacity, the Health Board will look to plan and secure necessary services with other appropriate NHS providers through its agreed care pathways. Where the service cannot be provided by the Health Board or contracted provider, the Health Board will plan to secure services from other appropriate providers.

Consequently, patients should not be able to access healthcare services elsewhere unless all treatment options available within locally provided services or those commissioned by Health Boards have been exhausted and it is clinically appropriate to do so.

ASSESSMENT

The Independent Review Group made a total of 27 recommendations which are outlined in the report titled 'Independent Review of the Individual Patient Funding Request Process in Wales, January 2017'. In addition to IPFR recommendations, they also included changes to broader commissioning arrangements.

A prior approval is normally defined as a request for a patient to receive routine treatment outside of local services or established contractual arrangements. Such a request will normally fall within one of the following categories;

- Second opinion
- Lack of local/commissioned service provision/expertise
- Clinical continuity of care (considered on a case by case basis)
- Transfer back to the NHS following self-funding in the private sector
- Re-referral following a previous tertiary referral
- Students
- Veterans

The IPFR team will ensure requests are dealt within in line with the NHS Wales Prior Approval policy for routine individual patient treatments, ensuring that IPFR Panel decisions are made based on the outlined criteria within the policy.

Additional policy processes outlining specific commissioning, contractual and additional prior approval requirements may be in place and will vary across each Health Board. For instances where funding is required for NHS healthcare for individual patients who fall outside the range of services and treatment that a Health Board has arranged to routinely provide, the Individual Patient Funding Request (IPFR) Policy route should be followed. This Health Board's Interventions Not Normally Undertaken' (INNU) policy, that sets out a list of healthcare treatments that are not normally available on the NHS in Wales, should be read together with this policy.

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

NHS WALES PRIOR APPROVAL POLICY

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL Jan 2018
Linked Documents	Individual Patient Funding Request (IPFR) Policy Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Local Health Boards and Primary Care Providers across Wales
Welsh Health Specialised Services Committee (WHSSC)
Public domain via Internet sites

Author: Ann-Marie Matthews, Lead for Clinical Commissioning / IPFR, Aneurin Bevan University Health Board

Development Group: All Wales IPFR Policy Implementation Group

Consultation: Commissioning / Planning Managers
IPFR Panel Members
NHS Wales Medical Directors

Date of Publication: January 2018

Lead Health Board Contact: Contact details as per individual Health Board

1.0 INTRODUCTION

1.1 Background

1.1.1 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being and Sport agreed the time was right for a new, independent review of the Individual Patient Funding Request (IPFR) process. The review panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

1.1.2 The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017 and made a number of recommendations to support the IPFR process. This includes the development of a clear and consistent national process for dealing with requests to access routine services outside of Local Health Board's existing arrangements (including those of the Welsh Health Specialised Services Committee).

1.2. Purpose of this policy

1.2.1 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.2 Health Board's in Wales have a statutory responsibility to provide healthcare that meets the needs of their local populations in accordance with the NHS (Wales) Act 2006, the Well-being of Future Generations (Wales) Act 2015, Social Services and Wellbeing (Wales) Act 2014 and Cross Border Healthcare Services (April 2013). They achieve this by either directly providing healthcare or by commissioning healthcare from other service providers. In addition, the Welsh Health Specialised Services Committee (WHSSC), working on behalf of all Health Board's in Wales, commissions a number of more specialised services at a national level. The use of the term 'Health Board' throughout this policy includes WHSSC unless specified otherwise.

1.2.3 Consequently, patients should not be able to access healthcare services elsewhere unless **all** treatment options available within locally provided services or those commissioned by Health Boards have been exhausted and it is **clinically appropriate** to do so.

1.2.4 Each Health Board in Wales has a separate policy setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because;

- There is insufficient evidence of clinical and/or cost effectiveness
- The intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE) or the All Wales Medicines Strategy Group (AWMSG)'

- The intervention is considered to be of relatively low priority for NHS resources

The relevant policy for the patients' Health Board titled 'Interventions Not Normally Undertaken' (INNU) should be read together with this policy.

1.2.5 For the purpose of this policy, a prior approval is normally defined as a request for a patient to receive routine treatment outside of local services or established contractual arrangements. Such a request will normally fall within one of the following categories;

- Second opinion
- Lack of local/commissioned service provision/expertise
- Clinical continuity of care (considered on a case by case basis)
- Transfer back to the NHS following self-funding in the private sector
- Re-referral following a previous tertiary referral
- Students
- Veterans

Further detail is provided in Section 5.

1.2.6 This policy sets out to deliver the national context and provide clarity for referring clinicians and patients. Additional policy processes outlining specific commissioning, contractual and additional prior approval requirements may be in place and will vary across each Health Board.

1.2.7 For instances where funding is required for NHS healthcare for individual patients who fall outside the range of services and treatment that a Health Board has arranged to routinely provide, the Individual Patient Funding Request (IPFR) Policy route should be followed. Such a request would normally fall within one of the following categories;

- A patient requires a treatment which is new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatment,
- A patient requires a treatment which is outside of existing clinical policy criteria,
- A treatment is required for a patient with a rare or specialist condition and is not eligible for treatment in accordance with the clinical policy criteria.

2.0 AIMS AND PRINCIPLES

2.1 Health Board's in Wales have a responsibility to secure services for their patients. Patients registered with a GP in Wales who are resident in Wales do not have a statutory right to choose which hospital they are referred to. The Welsh Governments view is that in general, Health Boards can best organise services to meet the needs of their patients when such services are provided in Wales. This ensures equity in terms of access, convenience, and affords each Health Board the opportunity to strengthen and improve the quality of their local services thus providing a net gain for the whole community.

2.2 However, patients who are registered with a Welsh GP but are resident in England, or patients who are resident in Wales but registered with an English GP (Cross Border Patients) have a specific right to choose their secondary

care provider. The cross border arrangements are specific to those Health Boards that share a border with England i.e. Betsi Cadwaladr University Health Board, Powys Teaching Local Health Board and Aneurin Bevan University Health Board.

2.3 Each Health Board aims to ensure the establishment of simple uniform arrangements based around high quality, sustainable local services for their patients. Where these cannot be provided by the Health Board's own services for reasons such as resource, expertise or capacity, the Health Board will look to plan and secure necessary services with other appropriate NHS providers through its agreed care pathways. Where the service cannot be provided by the Health Board or contracted provider, the Health Board will plan to secure services from other appropriate providers.

The principles underpinning this policy include;

2.4 **NHS Core Values** – set out by the Welsh Government as;

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

2.5 **Prudent Healthcare Principles**

- Achieve health and wellbeing with the public, patient and professionals as equal partners through co-production;
- Care for those with the greatest needs first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do no harm;
- Reduce inappropriate variation using evidence based practices consistently and transparently.

2.6 **Cross Border Healthcare Arrangements**

- Enable Cross Border patients to exercise their right of choice to a secondary care provider either in England or within the Health Board.

3.0 SCOPE OF THE PRIOR APPROVAL POLICY

3.1 This policy applies to;

- The registered population within the geographical catchment area of the Health Board to whom it has a statutory responsibility for arranging services as outlined in the Local Health Boards (Directed Functions) (Wales) Regulations 2009. (*The Who Pays? Determining Responsibility for payments to providers in August 2013 states that although the Health*

Board has commissioning responsibility for English resident Welsh registered patients they are the legal responsibility of the relevant CCG)

- Secondary Care referrals only made by General Practitioners, Consultants and other clinically qualified health professionals with referral rights within the Health Board area.
- Tertiary referrals only made by Consultants and clinical gatekeepers.

Please note - it is the clinician's responsibility to complete the application form. This ensures that adequate clinical information is provided to aid the decision making process.

4.0 EXCLUSIONS

4.1 This policy does not apply to the following services;

- Emergency Treatment
- Urgent suspected cancer referrals. All referrals for urgent suspected cancer must be **referred by e-referral** into the appropriate Health Board's respective tumour sites which have been set up in accordance with NICE guidelines. If a Cross Border patient has requested to be referred to a local hospital in England then the referral will be made by fax until such time as electronic referrals can be made. A list of the relevant fax numbers by speciality are regularly updated and issues to all GP practices in the Health Board area.
- Community based services such as district nursing.
- Looked After Children
- Requests for treatment in countries of the European Economic Area.
- The specialised services pathways established as part of the arrangements under the Welsh Health Specialised Services Committee (Wales) Regulations 2009.
- Requests which are judged to fall under IPFR or INNU.
- Reimbursement for private treatment

4.2 This policy does not apply to the following cohorts of patients;

- Patients diagnosed with HIV/AIDS as outlined in the Welsh Governments document "Providing for the needs of people with HIV/AIDS in Wales: National Care Pathways and Service Specification for Testing, Diagnosis, Treatment and Supportive Care".

11.1

4.3 This policy does not apply to the following factors;

- Non-clinical factors (such as employment status) will not be considered when making decisions on prior approval requests.
- Waiting time factors will not be taken into account when considering prior approvals as this will theoretically prioritise some patients over others who are in the same clinical position.
- Patient choice. The NHS in Wales does not operate a system of patient choice. However, cross border patients are able to choose their secondary care provider.

5.0 GUIDING PRINCIPLES AND CRITERIA

5.1 **Second Opinion**

If a second opinion is required for routine treatment out of area, the requesting clinician must demonstrate that the patient has exhausted all local options where possible. The patient should first receive a second opinion from a consultant colleague within the same Health Board and then from a Health Board or English NHS Trust with whom a contractual agreement is held.

Please note; if a second opinion is approved, this does not automatically mean that funding will be provided for additional appointments and/or treatment.

5.2 **Lack of local service provision/expertise**

The NHS secondary care consultant or other care provider, for example a GP or dentist, with the support of an NHS secondary care consultant where available, needs to demonstrate that all local and locally commissioned service provision has been exhausted in order for an external referral to be considered for an 'expert' opinion. In addition, for reasons due to lack of local expertise, the clinician must demonstrate that the referral being made is to an 'expert' within that specific clinical speciality.

5.3 **Clinical continuity of care**

Whilst the Health Board understands the importance of continuity, we must endeavour to deliver the patient's care locally. Where comparable services are available locally, the patient will be referred to those services in the first instance. Clinical advice will be sought to ensure local services meet the needs of the patient's clinical condition.

Consideration for a patient to remain with an existing provider will only be given if their specific clinical condition warrants continuity of care and that there are circumstances, which if unaddressed, are likely to have a serious impact on the patient's continuing health and wellbeing.

Before funding on this basis can be considered, a comprehensive report/letter from the existing clinician highlighting the specific clinical reasons why the patient should remain under their care would be required.

If a patient moves into a Health Board's area, they will be expected to access local services. However, in some instances, patients may request to remain with an existing care provider based on 'continuity of care'. As outlined above, clinical information will be required to support the reasons for this.

5.4 **Transfer back to the NHS following self-funding in the private sector**

If a patient has self-funded their own referral/treatment in the private sector, the Health Board cannot be expected to fund ongoing treatment in the private sector. To ensure equity, all such referrals will be declined and the clinician advised to refer the patient to local or commissioned NHS services.

If however there is no local or locally commissioned service provision for the proposed treatment, the request for a referral to an external NHS consultant will be considered, based on the clinical information provided. The patient will be expected to receive all treatment with an NHS provider and should be added to the appropriate waiting list accordingly.

5.5 **Re-referral following a previous tertiary referral**

If a service is not available locally or within existing commissioned services, the Consultant/Clinical Gatekeeper may wish to refer a patient to a specialist

centre for clinical advice and/or potential treatment. Following the assessment/treatment, and when clinically appropriate, the patient should be discharged back to local services.

Patients frequently request to return to the same specialist centre for a 'new episode of care' based on 'clinical continuity'. When comparable services are available locally, patients will be expected to access the local services.

5.6 **Students**
Students who register with a GP in Wales where they are receiving further or higher education become the responsibility of the Local Health Board in that area and should be treated in accordance with the principles outlined with the Responsible Body Guidance for the NHS in Wales.

5.7 **Veterans**
The treatment of veterans should be undertaken in accordance with the principles outlined within WHC (2017) 041 Armed Forces Covenant – Healthcare Priority for Veterans

6.0 PROCESS UNDERTAKEN WHEN CONSIDERING A PRIOR APPROVAL REQUEST

6.1 Prior approval requests are managed by IPFR Team. All prior approval requests are considered on their own merits using the guiding principles and criteria outlined in this document. Decisions are based on the clinical circumstances of the individual patient. It is therefore important to ensure that adequate clinical information is provided to aid the decision making process.

6.2 Where the patient does not meet the guiding principles outlined above, the prior approval request will be declined.

6.3 Should an application be received which has not been completed sufficiently enough to determine whether or not the request meets the guiding principles and criteria, or the incorrect form has been completed, the form will be returned to the requesting clinician within five working days of receipt.

6.4 Prior approval requests made directly by a patient or a patient representative will not be accepted. If a direct request is received, the patient will be advised to contact their GP or Hospital Consultant. Requests for referrals will not be accepted to private providers. The NHS cannot pay for or subsidise private hospital treatment.

6.5 A formal process will be held on a regular basis to ensure that correctly submitted and completed applications are considered in a timely manner. The volume and urgency of applications may require a decision more frequently as and when required.

6.6 A standard decision letter notifying the requesting clinician of the decision will be sent.

7.0 HOW TO REQUEST A REVIEW OF THE PROCESS

If a prior approval request is declined, a patient and/or their NHS clinician have the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, they can ask for that decision to be reviewed.

8.0 WHAT IS THE SCOPE OF A REVIEW

There will be a period of 25 working days from the date of the decision letter during which a review may be requested.

The request for a review form should be completed clearly outlining the grounds for the review and sent to the IPFR Team. The review panel will endeavour to meet within one month of the request being logged by the Health Board. Following the review, a decision letter will be issued to notify the patient and their clinician of the review panel's decision.

If new or additional information becomes available the application will be reconsidered.

9.0 REVIEW PANEL MEMBERSHIP

The review panel should comprise;

- Chair
- Senior Clinical Representative
- Senior Management Representative

10.0 CONFIDENTIALITY AND INFORMATION GOVERNANCE

In operating the prior approval policy, the Health Board will have due regard to the need to ensure that patient confidentiality is maintained at all times.

Each Health Board must comply with the requirements of the Data Protection Act and Caldicott Principles of Good Practice.

11.0 REVIEW OF THIS POLICY

This policy will be reviewed every 2 years or as required to reflect changes in legislation and guidance.

12.0 MAKING A COMPLAINT

Making a request for a prior approval does not conflict with a patient's ability to make a complaint to the Public Services Ombudsman for Wales. Further information is available on the Ombudsman's website www.ombudsman-wales.org.uk.

Annex 1

PRIOR APPROVAL REQUEST FORM

Please only use this form when **all** treatment optional available within locally provided services have been exhausted and it is **clinically appropriate** to consider accessing healthcare services elsewhere.

Details of clinician making the referral:	**Details of clinician patient is being referred to:**
Name:	Name:
Designation:	Specialty:
Address:	Address:
Postcode:	Postcode:
Telephone number:	Telephone number:
Fax number:	Fax number:
Email:	Email:

Patient Details	
Forename:	Surname:
Address:	Date of birth:
	Telephone number:
	NHS number:
Postcode:	Hospital number:

Urgency			
How urgent is the request? (tick as applicable)	**Urgent:** 24-48 hours	**Soon:** Within 3 weeks	**Non-urgent:** 4-6 weeks

Please note: If a decision is required urgently, clinical reasons must be provided. Administrative reasons will not be considered.

11.1

Reason for request
☐ Second opinion ☐ Lack of local/commissioned service provision/expertise ☐ Clinical continuity of care ☐ Transfer back to the NHS following self-funding in the private sector ☐ Re-referral following a previous tertiary referral ☐ Student ☐ Veteran ☐ Other- please specify

Clinical details
Details of treatment requested:
Medical history and current clinical status: (Please provide a copy of the latest clinical report)
What plans are in place to ensure the patient is returned to local services following the treatment/intervention requested?
Has advice been sought from other colleagues or neighbouring Health Boards with whom we hold a contract (please provide details)
Additional information to support the referral: (clinical letters/reports should be attached)

Cost of treatment:

I confirm that as the patients Consultant/GP, I have discussed this application and consent has been provided to obtain further clinical information pertinent to this funding request if required.

Clinicians signature:

Date:

Please return this form with a copy of the referral letter to:

IPFR Team

Cardiff & Vale Public Health Team,

Global Link,

Dunleavy Drive,

Cardiff,

CF11 0SN

CAV.IRT@wales.nhs.uk

Annex 2

Equality & Health Impact Assessment for

NHS WALES PRIOR APPROVAL POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Public Health Melanie Wilkey 02921 832100 Elinor Hammond 02921 832101
3.	Objectives of strategy/ policy/ plan/ procedure/ service	As stated in the individual policies
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages	• The procedure operates within the principles of the: • Cardiff and Vale University Health Board's 2015- 2025 ten year strategy, • 'Shaping Our Future Wellbeing', • 2010 Equality Act, • Human Rights Act 1998, • Welsh Language Act 1993 and Welsh Language (Wales) Measure 2011. • All Wales Policy - Making decisions on Individual Patient Funding Requests (IPFR) 2016. • IPFR Independent Review • Related policies such as Interventions Not Normally Undertaken, Top-Up Policy and European Economic Area funding. • Related UHB policies such as flexible working and Dignity at Work policies. • R v North West Lancashire Health Authority Ex Parte A(2000)1WLR 977CA

	Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	NHS (Wales) Act 2006 • Colin Ross v West Sussex Primary Care Trust 2008 EWHC 2252 (admin) Health Commission Wales: A Review (2008), Professor Sir Mansel Aylward • Priority Setting: Managing Individual Funding Requests (2008), NHS Confederation Routledge Report 2009 • Improving the Availability of Medicines for Patients in Wales: Report of the Routledge Report Implementation Group 2011 R (on the Application of AC) v Berkshire West Primary Care Trust [2011] EWCA Civ 247. • Oxfordshire PCT Equality Impact Assessment on Individual Funding Request Policy (March 2011) During the Independent review of Individual Patient Funding Requests and development of the policy, views were sought from patients, carers, relatives, patient representatives, health charities, lobbying groups, clinicians, healthcare professionals, IPFR panel members in local health boards (LHBs) and the Welsh Health Specialised Services Committee (WHSSC), Assembly Members (drawing from their constituency correspondence), political parties and pharmaceutical industry representatives. The review group held a total of ten face-to-face engagement sessions in Wrexham, Aberystwyth and Cardiff during November 2016. In each location, there was a session specifically for patients, patient organisations, and healthcare professionals, as well as one in Cardiff for the pharmaceutical industry. The review group considered the published documents outlining the approach taken to IPFRs and wider commissioning in England, Scotland and Northern Ireland. And looked at statistics on IPFRs and commissioning processes in Wales and, where available, the equivalent processes elsewhere.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Clinicians submitting prior approval request and their patients for whom the request is for, who are residents of the UHB will be affected by the Policy.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The Prior Approval Request (PAR) application form requires patients to disclose their date of birth. This is collected to help:- • Establish the legal status of the patient and the need for an appropriate adult (parent or guardian) to act as an advocate on behalf of the patient. • To help locate the patient's hospital or general practice records as appropriate when required. The panel provides clinical based decision making and therefore social factors such as age, gender, etc. are redacted prior to review at the IPFR panel. Protected characteristics	N/A	N/A

11.1

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	are not provided to the IPFR Panel for review and consideration therefore, this information is not taken into account during the decision making process. The Office of National Statistics, 2011 Census, Population and Household Estimates for Wales, states the median age of the population in Wales was 40 years for men and 42 years for women.		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	The Policy would be made accessible to staff in alternative formats on request or via usual good management practice. The Prior Approval Request form does not routinely require patients to disclose this information. It is at the referrers discretion to disclose this information if it is clinically relevant to the treatment being sought in the request. Therefore this data is not routinely collected and cannot be measured.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	Clinicians of any gender and patients of any gender are considered in the same way. All protected patient characteristics, including gender, are redacted in the information provided to the IPFR Panel for consideration, therefore this information is not taken into account during the decision making process. However, where there is evidence that capacity to benefit from a treatment is related to gender, this may affect the decision of the IPFR Panel. The Prior Approval Request form requires the disclosure of the patients' gender. The Office of National Statistics, 2011 Census, Population and Household Estimates for Wales states there were 1.50 million men and 1.56 million women in Wales. The Prior Approval Request form does not routinely require the disclosure of information relating to gender reassignment. It is at	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	the referrers discretion to disclose this information if it is clinically relevant to the treatment being sought in the prior approval request. It has been noted that NHS England were legally challenged in the case of AC v Berkshire West PCT [2010] EWHC. The challenge itself related to the evidence for 'exceptional significance' for the IPFR commissioning decision rather than the collection or discrimination of the protected characteristic. Cardiff and Vale IPFR team do not consider requests for gender reassignments as these are considered by the Welsh Health Specialised Services Committee.		
6.4 People who are married or who have a civil partner.	The prior approval request form does not require patients to disclose their marriage or civil partnership status. Therefore this data is not collected and cannot be measured.	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or	The prior approval request form does not routinely require patients to disclose this information. It is at	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	the referrers discretion to disclose this information if it is clinically relevant to the eligibility or treatment being sought in the request. Therefore this data is not routinely collected and cannot be measured.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears not to be any impact on patients regarding race, nationality, colour, culture or ethnic origin. The prior approval request form does not require patients to disclose this information. Therefore this data is not collected and cannot be measured.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	The prior approval request form does not require patients to disclose this information. It is at the referrers discretion to disclose this information if it is clinically relevant to the eligibility or treatment being sought in the request. Therefore this data is not collected and cannot be measured.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The prior approval request form does not require patients to disclose this information. Therefore this data is not collected and cannot be measured.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	The All Wales policy, claim forms, website information and patient leaflets will all be made available in Welsh. Patients have the discretion to apply through the medium of the Welsh language in line with the UHB's Welsh language policy. Receipt of applications in the Welsh language will be measured accordingly.		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	The prior approval request form does not require patients to disclose this information. Therefore this data is not collected and cannot be measured.	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health	The prior approval request form requests the patient's address on the application form to ensure that the patient is a Cardiff and Vale	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
indicators, people unable to access services and facilities	resident and to allow for communication regarding requests. All protected patient characteristics, including address are redacted in the information provided to the IPFR Panel consideration, therefore this information is not taken into account during the decision making process.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups or risk factors to take into account with regard to this Policy. All patient identifiable information is redacted from the request prior to being presented at the IPFR panel and is therefore not taken into account.		

6. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	The All Wales Prior Approval Request policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier	The All Wales Prior Approval Request policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	The All Wales Prior Approval Request policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces	The All Wales Prior Approval Request policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	The All Wales Prior Approval Request policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.		
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	As part of the decision making process, the IPFR panel consider ethics of funding requests e.g. whether the patient is accessing services equitably.		

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this All Wales Prior Approval Policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	All non-clinical information will be redacted from the information provided to the IPFR panel during the decision making process.	IPFR Commissioning Officer	Ongoing	
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very limited impact identified, it is unnecessary to undertake a more detailed assessment and formal consultation is not required.	N/A	N/A	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	The Policy is due to consideration by the QSE Committee. When the Prior Approval policy is developed or reviewed, this EHIA will form part of that consultation exercise and publication. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).			

APPROVAL OF THE ALL WALES POLICY ON THE MANAGEMENT OF POINT OF CARE TESTING (POCT). WHAT, WHEN AND HOW?
Name of Meeting Quality, Safety and Experience Committee **Date of Meeting** 12th June 2018

Executive Lead : Medical Director
Author : Consultant Clinical Biochemist and PoCT Lead for Cardiff and Vale UHB
Caring for People, Keeping People Well : The report underpins the UHBs strategy to provide sustainable services, including the reduction in waste, harm and variation.
Financial impact : None
Quality, Safety, Patient Experience impact : The provision of safe and effective methods of point of care testing is essential for the provision of safe and effective care for patients and the effective use of resources.
Health and Care Standard Number 2.1,2.9, 3.1, 3.4, 3.5, 5.1
CRAF Reference Number 5.1 Deliver safe, efficient and effective care.
Equality and Health Impact Assessment Completed: Yes / No / Not Applicable No all Wales EHIA but the UHB has EHIA to support its own Policy and Procedure

ASSURANCE AND RECOMMENDATION

ASSURANCE has been provided by

- The UHB Clinical Lead who is the author of the document.
- The All Wales Policy is mapped to Health and Care Standards 2015 and the current UHB Point of Care Testing Policy is aligned to both the updated All Wales Policy on the Management of Point of Care Testing and the relevant clauses of the Health and Care Standards 2015.

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** and **ADOPT** the all Wales Policy on the Management of Point of Care Testing (POCT). What, When and How?
- **APPROVE** the full publication of the Policy in accordance with the UHB Publication Scheme
- **AGREE** that the EHIA approved by the Committee in September 2017 for the UHB POCT Policy can also be applied to the All Wales Policy on the Management of Point of Care Testing.

SITUATION

The All Wales Point of Care Testing Policy was updated, on behalf of the Welsh Scientific Advisory Committee (WSAC 2008), to the current WSAC 2017 All Wales Point of Care Testing Policy document. An Equality and Health Impact Assessment (EHIA) was not undertaken when the All Wales

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Policy was updated. However, a local document was produced when the UHB Point of Care Testing Policy and Procedure was approved by the Quality Safety and Experience Committee in September 2017.

The updated update All Wales Policy was submitted to all Clinical Boards for their notification and the LMC. However, due to an oversight, the all Wales Policy has never been formally accepted and adopted through a Committee in the UHB.

BACKGROUND

The Welsh Scientific Advisory Committee (WSAC) periodically reviews and updates existing guidance to ensure it reflects current best practice and scientific developments. Thus, a review of Point of Care Testing Governance Policy (WSAC 2008) was undertaken. The updated Policy provides guidance for Health Care Professionals on how to implement and manage a safe Point of Care Testing Service, incorporating information from the Medicines and Healthcare Products Regulatory Agency (2013), Health and Care Standards (2015) and reflects technological advances and policy priorities.

The current UHB Point of Care Testing Policy is mapped to both the updated All Wales Policy on the Management of Point of Care Testing and the relevant clauses of the Health and Care Standards 2015.Thus, the EHIA undertaken on behalf of the UHB is also relevant and applicable for the All Wales Policy on the Management of Point of Care Testing.

ASSESSMENT

The main changes are as follows:-

1. The scope has widened to include use in the home setting, clinic, General Practice, Care Homes, High Street Pharmacies, screening venues and in-transit.
2. Guidance is mapped to the NHS Wales Health and Care Standards 2015, in the context of providing a Point of Care Testing Service.
3. The guidance is informative rather than prescriptive
4. Laboratory Services are replaced by Point of Care Testing Departments, with the appropriate removal of Service Level Agreement
5. Incorporates principles of Prudent Healthcare.
6. Includes additional sections on audit, risk and information management.
7. Is viewable for information and guidance for all Health Boards to support the roll-out of Point of Care Testing services throughout Primary Care on All Wales POCT Matters Website.

WHC (2017) 034

WELSH HEALTH CIRCULAR

Issue Date: 12 July 2017

Llywodraeth Cymru
Welsh Government

STATUS: COMPLIANCE

CATEGORY: HEALTH PROFESSIONAL LETTER

Title: Policy on the Management of Point of Care Testing (POCT). What, When and How?

Date of Expiry / Review N/A

For Action by:
LHB/Trust CEO'S,
LHB/Trust Directors of Therpies and Health Science,
LHB/Trust Medical Directors
Health Care Professionals

Action required by: Immediately

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Sender: Rob Orford, Chief Scientific Adviser (Health)

DHSS Welsh Government Contact(s) :
Rob Orford, Primary Care Division, Directorate of Health Policy, Welsh Government, Cardiff, CF10 3NQ
Telephone Contact:03000258315

For enquires email: healthcarescienceandtherapies@wales.gsi.gov.uk
gwyddorgofaliechydatherapïau@cymru.gsi.gov.uk

Enclosure(s): None

Prif Ymgynghorydd Gwyddonol (Iechyd)
Y Grŵp Iechyd a Gwasanaethau Cymdeithasol

Rob Orford
Chief Scientific Adviser (Health)
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Date: 12 July 2017

Dear Colleague

WHC/2017/034 Policy on the Management of Point of Care Testing (POCT). What, When and How?

1. The Welsh Scientific Advisory Committee periodically reviews and updates existing guidance to ensure it reflects current best practice and scientific developments.

2. The above policy on Point of Care Testing, updates earlier guidance for Health Care professionals on how to implement and manage a safe Point of Care Testing Service (WSAC 2008) incorporating updated information from the Medicines and Healthcare Products Regulatory Agency (2013), Health and Care Standards (2015) and reflects technology advances and policy priorities.

3. A copy of the updated guidance entitled 'Policy on the Management of Point of Care Testing (POCT), What, When and How?' can be found here: http://gov.wales/topics/health/nhswales/circulars/health-professional/?lang=en

4. The main changes are :

- scope increased to include use: in the home, a clinic, in general practice, care homes, high street pharmacy and screening venue or during transit
- guidance is mapped to NHS Wales Health Care Standards in the context of providing a Point of Care Testing service
- the guidance is informative rather than prescriptive
- laboratory services replaced by Point of Care Departments. Service Level Agreement section removed
- incorporates principles of Prudent Healthcare

- additional sections on audit, risk management and information management
- website for information and guidance for health boards to support the role out of Point of Care Testing services in Primary Care. http://nww.poctmatters.wales.nhs.uk

5. I would be grateful if you could raised awareness of this guidance and ensure your organisation is compliant with the requirements therein.

Yours sincerely

Rob Orford

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Policy on the Management of Point of Care Testing (POCT). What, When and How?

Welsh Scientific Advisory Committee

May 2017

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 WG31745 Digital ISBN 978-1-4734-9536-4

Contents

1. Introduction

1.1. What is Point of Care Testing (POCT)?

This document updates earlier guidance for Health Care professionals on how to implement and manage a safe Point of Care Testing (POCT) service (WSAC 2008) incorporating updated information from the Medicines and Healthcare Products Regulatory Agency (2013) and Health and Care Standards (2015).

For the purpose of this document, POCT is defined as any diagnostic test undertaken by staff other than a laboratory healthcare scientist, which can include health care support workers, nurses, paramedics, pharmacists, podiatrists, dieticians, dentists and medical staff. This is usually carried out near the patient, and can be in the home, a clinic, in general practice, care homes, high street pharmacy, screening venue, at the hospital, or during transit.

Examples of POCT devices include:
Blood glucose and ketone devices, Urinalysis test strips and devices , Pregnancy test kits and devices, Coagulation devices, CRP devices, Creatinine devices, Lactate devices, $HbA_{1C,}$ analysers, Haematology analysers, Rapid test kits for infectious disease markers, Bilirubin analysers, blood gas analysers, electrolyte analysers, lipid analysers and cardiac marker test kits and analysers.

1.2. When can Point of Care Testing be used?

Healthcare organisations have an obligation to ensure that care is delivered by healthcare professionals that is **Safe and Clinically Effective and that Prudent Healthcare practices underpin their care.** *Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs. (Health and Care Standards for Wales, 2015 Standard 3.1),*

Clinical Effectiveness Patients should receive the most appropriate care in the right setting at the right time. Do only what is needed, no more, no less and do no harm.
Patient care should be evidence based. Reduce inappropriate variation using evidence based practices consistently and transparently.
Patients should receive the right care that is cost effective Care for those with the greatest health need first, making the most effective use of all skills and resources.
Supporting shared decision making Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production.

2. Evidence based patient care

In deciding whether to implement POCT it is essential for potential users to establish a clinical need. The clinical need should be evidence based clearly identifying the risks and benefits of introducing a POCT service. The following should be undertaken:

2.1 Undertake a needs assessment

Map the patient's pathway, analyse and challenge what is done. Can things be improved?
What evidence is there that POCT may be clinically effective in this pathway?
How will this pathway redesign affect cost?
Will POCT be able to meet demand and capacity?

There is good evidence that optimisation of pathways using well designed use of POCT can be both clinically effective and cost efficient. However, POCT can offer little or no benefit in a poorly designed pathway and can be more costly than traditional laboratory tests. (Appendix 1)

2.2 Undertake risk and benefits mapping

POCT that is favourably assessed can improve patient outcome by providing a faster result and a shorter time-frame to therapeutic interventions, improve patient compliance with treatment, improve treatment optimisation, decrease the need for hospital visits, increase patient satisfaction, convenience and acceptability, reduce length of stay, reduce complications and reduce the overall cost to NHS Wales. *All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff (Standard 5.1).*

Examples of the benefit of POCT in different applications are provided below. Risks associated with POCT can be mitigated by ensuring that the best practice guidance in the section on "how to implement POCT" is followed.

Setting	Application	Benefit	Risk
Home	Management of long term conditions - diabetes/ Heart Failure. Early detection of complications e.g. infection in patients on chemotherapy Home ventilation unit for measurement of patients on Oxygen therapy.	• Better awareness / self motivation to manage condition – less complications • Avoid need to attend hospital • Avoid cost of transport • Avoid time off work/ patient • Patient convenience / acceptability	No evidence that POCT improves outcome Over testing / inappropriate testing. Lack of knowledge and skills of user of device. Device not sensitive or
General Practice	Management of long term conditions. Antibiotic stewardship.	• Patient convenience / acceptability • Improved access to	

	Enhanced Service for Anticoagulation monitoring. Out-Of-Hours Service.	relevant population • Reduction in acute admissions. • Avoid cost of transport. • Avoid time off work/ patient convenience. • Improve relationship with • GP – supporting shared decision making.	specific for clinical pathway. No Quality assurance. No audit trail. Loss / incomplete patient information. Variation in service Inequitable service Benefits not realised Not cost effective. Potential for Patient harm
Community / Pharmacy	Management of long term conditions Anticoagulation monitoring Health Checks	• Patient convenience / acceptability • Improved access to relevant population • Reduce need to visit GP	
Ambulance	Pre-hospital testing Monitor patients during inter hospital transport. Treatment of sick neonates in transit	• Faster triage through Emergency Department • Earlier intervention • Reduce risk of complications during transport	
Urgent care centres	Urgent care for non-life threatening conditions Rule out testing	• Avoid need to attend Emergency Department	
Emergency Department	Rapid triage testing and treatment	• Reduced length of stay in Emergency Department • Treatment of patients with time-dependent conditions	
Theatre	Monitoring operative procedures	• Reduce post OP care requirement • Convert to day case – reduce need for hospital bed	
Intensive Treatment Unit / Critical Care Unit	Monitoring vital parameters	• Improved mortality and morbidity • Reduce length of stay	

3. How to implement the right test that is cost effective?

3.1 Seek Advice - contact your local POCT Department

Health services must ensure the safe and effective procurement, use and disposal of devices and diagnostic systems. (Standard 2.9).

Each Health Board will have a dedicated team of POCT professionals who will be able to provide advice on how to implement and manage your POCT service.* They can advise you on the right device; a device that "fits " your clinical need, and a device that provides results that are compatible with your local laboratory (if indicated). The latter is essential to minimise variation in the event that the service is shared with your local Pathology laboratory to ensure that the right sensitivity, specificity, calibration and units are used and the correct interpretation is made.

There are existing "All Wales" procurement frameworks and preferred supplier lists in place for a number of devices underpinned by agreed quality specifications.

Support from your local POCT Department can also include the training, competence assessment, maintenance of devices and monitoring the quality of the service. For organisations that do not have a POCT Department, support may also be available from one of the other Health Boards. A resource should be identified for this support and incorporated into a Service Level Agreement (SLA). The SLA should define the scope of the service provided and the responsibilities of both parties.

- Information on who to contact for advice in your Region is available on http://nww.poctmatters.wales.nhs.uk

4 Minimise avoidable harm

4.1 Ensure appropriate training and competence

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need (Standard 7.1). Only Staff that have been adequately trained should carry out POCT procedures. Competency must be assessed and training and competency records maintained**.** *An ongoing programme of training and competency covers all staff and users. (Standard 2.9).*

Training must include the following:

- Intended purpose of the device
- Consequences of improper use
- Limitations of use
- Patient preparation, sample collection and application
- Health and Safety awareness
- Reporting & recording of results
- A Practical demonstration
- How to deal with abnormal or unexpected results?
- What routine maintenance and (calibration) of the equipment is required?
- When and how to do IQC?
- What to do if the IQC fails?
- When and how to do EQA?
- What to do if the EQA fails?
- Competence assessment procedure
- How and When to undertake Refresher training or e-learning?

Your local POCT Department will be able to provide assistance in developing these procedures. A number of "All Wales" training guides have already been developed for Blood gases, international normalized ratio (INR), blood glucose, ketones, HbA1c, Lipids, pregnancy testing and urinalysis. These are available to download from http://nww.poctmatters.wales.nhs.uk.

The POCT supplier may also have educators who will provide assistance in training. However, third party training may not cover all aspects to comply with this Policy. Check with your local POCT Department whether their training is approved by the All Wales POCT Co-ordinators Committee.

Users should be aware that liability under the Consumer Protection Act (1987) will only remain with the manufacturer or supplier of a device if the user can demonstrate that POCT equipment has been used in strict accordance with the manufacturer's instructions.

4.2 Competence assessment

It is important that users can demonstrate their competence to perform POCT irrespective of grade of staff. Managers should ensure that all POCT users have up to date records of practical demonstration of competency. They should work within their competence; record their learning in a portfolio and ensure that evidence of continued competence is available. The "All Wales" POCT

co-ordinators have designed a series of POCT core competencies and specific device competencies which are available as Agored Cymru Units and available at: **http://www.agored.org.uk**

These competencies are mapped to NHS Knowledge Skills Framework (KSF) and based on the National Occupational Standards (NOS) *CHS 217 Perform point of care testing.* The following describes the minimum standard to which an individual is expected to work to undertake POCT. **https://tools.skillsforhealth.org.uk/competence/show/html/id/2842/**

4.3 Understand Quality Assurance principles

Users of POCT should have a sound understanding of the principles of quality assurance (QA). This is a systematic process of verifying that a product, or service being developed, is meeting specific requirements and includes:

- Internal quality control (IQC)
- External quality assessment (EQA)
- Clinical audit
- Risk Management

For POCT this includes the measures taken to ensure investigations are reliable and safe and includes the following:

- Having the right governance structure in place
- Correct identification of the patient
- Choosing the right test
- Obtaining the right sample (at the right time)
- Undertaking the right test procedure
- Undertaking IQC and EQA checks
- Recording results promptly and correctly
- Interpreting results accurately
- Taking appropriate action
- Documenting all procedures and actions
- Identifying and preventing errors
- Implementing quality improvements

A training module which covers the core essential requirements for POCT is available from Agored Cymru, Unit Code PB62CY002 - POCT Principles and Practice.

As a minimum Quality Assurance should include undertaking Internal Quality Control and External Quality Assessment.

4.4 Internal Quality Control

This is a means of checking that the results are safe before they are issued. The user knows what value to expect and knows what range of values is acceptable for that control material.

If the value is within this range it provides reassurance that the system is working correctly. If the values are outside the range this alerts the user that there is a potential problem with the test process. It is essential that the results of QC are recorded appropriately. Often the manufacturer IQC limits are very wide and the user should establish their own limits to fit the clinical purpose.

What you need to consider?

- What material is available?
- What is the storage and stability?
- What frequency should I be testing IQC?
- What acceptance limit should I use?
- What procedure do I need to follow if the results are outside acceptable limits?
- I have an electronic QC; do I still need to perform IQC?
- Is there an easier way to make sure that the devices are safe to use?

Your local POCT Department will be able to advise you on suitable IQC material and how to manage performance.

4.5 External quality assessment

This is when samples with unknown values are tested and reviewed by an external agency. They may compare your results against those obtained from a number of different practices using the same method to determine the degree of variation and whether your results are within this acceptable variation. Alternatively, your results may be compared against a reference laboratory method, the "true" result. These agencies provide useful information on the degree of variation in diagnostic accuracy and reliability of POCT devices across Wales. In the absence of an EQA programme being available, you can also undertake paired analysis of samples with your local laboratory. The local POCT Department will help organise this or recommend the most appropriate accredited EQA provider for you to register with.

4.6 What to do if you get a poor result?

Performance surveillance can either be undertaken directly by the EQA provider or through your local POCT coordinator. Non compliance (e.g. if you didn't return) and poor performance reports (e.g. if the results were outside the acceptable limits) are often generated by the EQA scheme providers immediately after each distribution. Some EQA providers also follow with a repeat sample.

When the individual or POCT site performance is outside the performance criteria on two out of three consecutive occasions, the individual will be offered help by the EQA providers. Failure to respond to this contact or to improve performance will lead to a further contact by the providers. In the UK Persistent poor performance (i.e. no improvement after two contacts) will result in referral to the National Quality Assessment Advisory Panels (NQAAP). If no further improvement is made within a reasonable time period after NQAAP intervention, Health Inspectorate Wales is informed.

4.7 Measuring Outcomes – Audit

Quality metrics, clinical effectiveness, and cost efficiency should be monitored where possible. Prudent healthcare places a greater value on patient outcomes; rather than the volume of activity or procedures delivered, it aims to rebalance the NHS and create a patient-centered system. The following are examples of outcome measurements.

Outcome	Metric
Has this intervention resulted in improved patient experience?	• e.g. patient satisfaction surveys to identify whether more convenient, greater awareness or greater self motivation to manage condition.
Has this intervention resulted in improved disease outcome?	• e.g. rate of secondary complications. improvement in symptoms, re-admission, urgent acute admissions, survival rate percentage of patients with improved diagnostic test .
Has this intervention resulted in improved treatment optimisation?	• e.g. side effects, quality of life
Has this intervention resulted in a cost reduction?	• e.g. reduction in staff resource, avoidance of transport cost, reduction of admission to secondary care, reduce length of stay.

4.8 Risk Management

POCT is usually carried out in a busy environment with little or no 'thinking-time' before a change in patient management is instigated. The major risks arise from poor operator competency, lack of supervision, governance, failure to implement quality assurance processes, inappropriate testing by inexperienced personnel, lack of understanding on the limitations of use and uncertainty on how to act on the results. Adequate checks and balances must therefore be in place to prevent medical errors and reduce risks. *Risks are identified, monitored and where possible, reduced or prevented. (Standard 2.1).*

The following is an example of Failure Mode Effect Analysis (FMEA) risk model for undertaking POCT glucose. An FMEA uses three criteria to assess a risk which includes: 1) the impact of the effect, 2) the likelihood of occurrence and 3) detection and preventative process. Understanding the risks and implementing good quality assurance procedures will mitigate the risk.

The process	**What could go wrong ? (failure type)**	**Impact**	**Likelihood**	**What procedures have I implemented to mitigate risk ?(detection)**
identifying the patient	• wrong patient			positive patient identifiers. name, date of birth electronic ID via CRN/ NHS no.
taking the correct	• sample contaminated: by food / drink			user understands pre-analytical effects

sample	• by alcohol wipe • by interstitial fluid • patient dehydrated or in peripheral shutdown			competence assessed
undertaking the testing	• incorrect sample volume • incorrect filling reagents / strips contaminated or stored at incorrect temperature or humidity. • Device faulty			user trained and assessed as competent electronic operator lock out IQC check of reagent strips and device – QC lock out if outside limits Temperature indicators on reagent boxes Electronic recording of strip information / errors
Recording the result	• transcription error – poor light/ busy			electronic transfer of data to clinical portal/ patient notes audit trail of date / time / operator
Interpretation of the result	• drug interferences galactose/ maltose / haematocrit effects dehydrated/ shut down			user trained in limitations of procedure user aware of pre-analytical effects
Acting on the result	• Not acting on a hypo and hyperglycaemic result			user trained on critical ranges and alerts appropriate personnel.

5 Information management

Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework. (Standard 3.4)

5.1 Ensure good record keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance. (Standard 3.5).

It is important to keep documented records of all procedures so that a full audit trail can be undertaken in the event of a poor EQA result or wrong patient result. Information that should be recorded includes:

- The internal QC for each device, along with the name of the operator, date and time
- Corrective action taken for out-of-control results
- Any review of QC results
- The consumables and reagent lot numbers
- Maintenance and service procedures undertaken including who and when

The patient's result should be permanently recorded in the patient's medical record along with the date, the time and the identity of the person performing the test. This is best achieved using POCT devices with automated full bi-directional connectivity to an external data system.

5.2 Supporting shared decision making

Where possible, POCT devices that allow seamless connectivity to external data systems such as the All Wales POCT Information System, Laboratory Information System, Wales Clinical Portal or the electronic patient record, must be used. This minimises subjectivity, transcription errors and loss of information. Your local POCT Department will be able to advise on the right equipment and devices that can be interfaced. Connectable POCT devices ensure that:

- Patients are clearly identified
- Information is collected to support outcome measurement
- Provides safer and quicker information transfer
- Eliminate duplication
- Facilitates sharing of information

6 Maintenance

It is essential that the routine maintenance and calibration of equipment is carried out according to the manufacturer's instructions. Your local POCT Department can advise on setting up maintenance schedules and establish operating procedures; however, resources for equipment maintenance are borne by the user. *Processes ensure that equipment, and devices are maintained, cleaned and calibrated in accordance with manufacturer's guidelines, ensuring they are appropriate for their intended use and for the environment in which they are used.*
Suitable and sustainable systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment. (Standard 2.9)

7 Safety

Staff shall be trained in safety procedures as detailed in the individual device training documents. . POCT co-ordinator can provide an advisory role on health and safety matters. The requirements of *Health and Safety at Work Act 1974, the COSHH regulations 1988 and the Safe Working and Prevention of Infection in Clinical Laboratories Code 1991,* will apply to POCT sites as detailed in the training documents.

8 References

1. Point of care testing governance Pathology: Why, When and How? - A User Guide. Welsh Scientific Advisory Committee, January 2008.
2. Medicines and Healthcare Products Regulatory Agency (MHRA) guidance: Management and Use of IVD Point of Care Test Devices 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/371800/In_vitro_diagnostic_point-of-care_test_devices.pdf
3. Department of Health. Clinical Governance: in the new NHS. London: Department of Health, 1999. (Health Service Circular: HSC (99) 065).
4. Health and Care Standards for Wales, Welsh Assembly Government, Apr 2015. http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf
5. BS EN ISO 22870:2006 Point of Care Testing (POCT) – Requirement for quality and competence Available from BSI: http://www.bsigroup.co.uk
6. Evidence Based Practice for Point of Care Testing. National Academy of Clinical Biochemistry.
7. Point of Care Testing: Needs opportunity and Innovation, 3rd Ed, Edited by C. P. Price, A. St. John and L.L Kricka.
8. Internal Quality Control in Point of Care Testing: Where's the Evidence?; J. Holt, D. Freedman ; Annals of Clinical Biochem 2015, Vol. 52(5)

Appendix (1) CHECK LIST

Question	Yes/No	Action/Date
Have you identified a clinical need which is evidence based?		
Have you contacted your local POCT Department for advice and consultation?		
Have you undertaken a cost assessment? Examples of what to consider are in App 2		
Have you undertaken a Risk assessment?		
Is the device approved by your local POCT Department?		
Do you have written operating and training procedures in place?		
Have you arranged for all users to receive appropriate training and competency assessment?		
Have you addressed all Health and Safety requirements?		
Are you able to interface with existing IT?		
Have you arranged to monitor performance – IQC/ EQA/ Audit?		
Is there a Service Level Agreement between you and the POCT Department if appropriate)?		

Appendix (2) Example Cost Considerations

Capital Costs		Revenue costs		Professional costs	
Purchase/lease of POCT equipment		Consumables: reagents / calibrators etc		Staff training	
Ancillary equipment: centrifuges, incubators, pipettes etc.		routine maintenance (including service contract)		Management of the POCT programme	
Working environment		Internal Quality Control material		Staff operator time	
Depreciation		EQA Subscription		Conforming to legal requirements	
Interfacing with information management systems		data-handling licences		POCT Department support / IM&T support.	
		Waste disposal		Laboratory support	
Total running costs					
Cost per patient					

Appendix (3) SERVICE LEVEL AGREEMENT SPECIFICATION (If appropriate)

This SLA requires a Quality Management system for the planned systematic approach to POCT. Details to be agreed between the user and the POCT Department.

1. Specify each application, e.g. glucose testing in GP surgery: well person screening in Occupational Health Department, Diabetic clinic etc
2. Specify the site, e.g. wards, accident and Emergency, Outpatient clinics
3. Specify personnel involved
4. Specify the type of procedure
5. Specify the lead contact person for:
    a. POCT Department and the User.
6. Clearly specify the responsibilities of the POCT Department.
7. Clearly specify the responsibilities of the users
8. Define the training procedure and competence assessment as indicated in the approved training documents.
9. Recording patient results
    a. There must be an agreed protocol to record all patient results, include date, time and operator so that a clear audit trail is established back to the patient.
10. Specify performance monitoring requirement
11. Specify cost for provision of POCT department support

The agreement must be signed by both parties to form a binding contract.

Appendix (4) Stakeholder input

Representation on this Committee included:

- Standing Specialist Advisory groups (SSAG).
- General Practice
- Pharmacy
- Representation from each Health Board
- All Wales POCT Co-ordinators Group.

APPROVAL OF PROVISION OF INTRAOPERATIVE CELL SALVAGE POLICY AND PROCEDURE
Name of Meeting Quality, Safety and Experience Committee **Date of Meeting** 12th June 2018

Executive Lead : Clinical Director and Lead Nurse for Perioperative Care
Author: Perioperative Care Directorate Governance Group. Barbara.jones5@wales.nhs.uk 02920 745537
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 : not applicable
Quality, Safety, Patient Experience impact : To ensure that cell salvage is used safely and appropriately in order to avoid the risks of unnecessary autologous transfusion in our patients
Health and Care Standard Number 2.1, 3.1 The UHB is committed to ensuring patient safety and recognises that the peri-operative period poses a high risk to the patient. It is the intention of this policy to identify good clinical practice within the peri-operative environment and to ensure the health and safety of patients throughout their journey within this environment.
CRAF Reference Number 5.1
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Compliance with the Management of Policies, Procedures and Other Written Control Documents Policy]
- Continual training and assessment for users of Intraoperative Cell Salvage
- Review of the Policy and Procedure through the directorate governance forum

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the **review of the** provision of Intraoperative Cell Salvage Policy and Procedure

and

- **APPROVE** the full publication of the provision of Intraoperative Cell Salvage Policy and Procedure in accordance with the UHB Publication Scheme.

11.3

SITUATION
Whilst allogeneic (donated) blood is an essential adjunct to health care, it is a limited resource (subject to the threat of future shortages), increasingly expensive and can present a source of risk for patients, in particular the risk of "wrong blood" incidents as reported by the Serious Hazards of Transfusion (SHOT) Steering Group.

BACKGROUND
To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that cell salvage is used safely and appropriately in order to avoid the risks of unnecessary autologous transfusion in our patients. Utilising appropriate alternatives to blood transfusion is cost-effective and complies with clinical governance requirements. The collection and re-infusion of autologous red blood cells provides an important contribution to reducing the demand for allogeneic blood. However, it is only one aspect of a strategic approach to safe and appropriate transfusion practice.

ASSESSMENT

Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholder and the Health Board. This is a review of a current Policy and Procedure. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between1st May and 29th May2018
- The document was shared within Surgery Clinical Board
- This is a review of a current Policy and Procedure
- Comments were invited via individual e-mails from Perioperative Care Directorate Governance forum

Where appropriate, comments were taken on board and incorporated within the draft document.

- Arrangements for review of the document will take place via the Perioperative Care Directorate Governance Forum and Quality and Safety Group.

The primary source for dissemination of provision of the Intraoperative Cell Salvage Policy and Procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: *UHB 030* **Version Number:** 2	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *UHB 030*

PROVISION OF INTRAOPERATIVE CELL SALVAGE POLICY

Policy Statement

Whilst allogeneic (donated) blood is an essential adjunct to health care, it is a limited resource (subject to the threat of future shortages), increasingly expensive and can present a source of risk for patients, in particular the risk of "wrong blood" incidents as reported by the Serious Hazards of Transfusion (SHOT) Steering Group.

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that cell salvage is used safely and appropriately in order to avoid the risks of unnecessary autologous transfusion in our patients. Utilising appropriate alternatives to blood transfusion is cost-effective and complies with clinical governance requirements. The collection and re-infusion of autologous red blood cells provides an important contribution to reducing the demand for allogeneic blood. However, it is only one aspect of a strategic approach to safe and Appropriate transfusion practice. This policy is based on the original generic policy as written by the UK Cell Salvage Action Group.

Policy Commitment

By adhering to the accompanying Intraoperative Cell Salvage (ICS) Policy and Procedure we will ensure the UHB

- Promotes safer transfusion as part of clinical governance responsibilities
- Utilises ICS in a safe and effective manner
- Safely identifies suitable patients undergoing surgical procedures where ICS could be used
- Delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, by the lawful, safe and appropriate administration of blood/components according to current law, national guidelines and regulatory requirements, and to the maintenance of patient information in accordance with the Data Protection Act 1998.

Supporting Procedures and Written Control Documents

This Intraoperative Cell Salvage Policy and supporting Procedure describe the following with regard to Intraoperative Cell Salvage:

- Responsibilities
- Training
- Indications and contraindications for selection
- Conditions for using ICS

- Resources
- Implementation
- Governance

Other supporting documents are:

List all documents the reader needs to be aware of alongside / in support of this document

- UHB 068 - Blood Component Policy
- UHB 348 - Blood Component Procedure
- UHB – 282 Decontamination of Reusable Medical Devices Policy and Procedure
- UHB 100 - Consent to Examination or Treatment Policy
- UHB 186 - Independent Mental Capacity Advocacy Procedure (Mental Capacity Act 2005),
- UHB 113 - Lasting Power of Attorney and Court Appointed Deputy Procedure (Mental Capacity Act 2005),
- Reference Guide for Consent to Examination or Treatment, WHC (2008) 10
- Good Practice in Consent Implementation Guidance: consent to examination or treatment, WHC (2008) 36
- Mental Capacity Act 2005 Code of Practice
- ANTT all- Wales policy http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/ANTT%20IPC%20Policy%20FINAL%20May%202017%20V1pdf.pdf
- UHB 138 – Incident, Hazard and near miss reporting policy and procedure

Scope

This policy has been written to support the implementation and use of intraoperative cell salvage in the intraoperative/surgical setting within the Cardiff and Vale University Health Board (UHB). It may also be applicable when intraoperative cell salvage devices are used in the pre and/or postoperative environment (e.g. Accident and Emergency, recovery, ward etc) and for devices specifically designed for Intra and Postoperative Cell Salvage.

This policy **does not** relate to the use of unwashed postoperative autologous wound drains.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive impact. No additional key actions have been identified.

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Perioperative Care Directorate Governance forum, quality & safety forum. Surgery Clinical Board Quality & Safety Forum

Accountable Executive or Clinical Board Director	Medical Director

Disclaimer

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

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	22/02/11	*2nd March 2011*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*
2			V1 of the policy also included the procedure. These are now two separate documents. The content of the procedure remains unchanged.

Reference Number: *UHB 030* **Version Number:** 2	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *UHB 030*

Intraoperative Cell Salvage Procedure

Introduction and Aim

This procedure is supporting the Intraoperative Cell Salvage Policy.

The Welsh Health Circular (WHC), "Better Blood Transfusion: Appropriate Use of blood", recommends that in order to make transfusion safer, to provide better information for patients relating to transfusion and to avoid the unnecessary use of blood in clinical practice, blood transfusion must be an integral part of care and clinical governance responsibilities. The WHC further recommended that effective alternatives to allogeneic blood transfusion be explored, including the appropriate use of autologous blood transfusion techniques such as Intraoperative Cell Salvage (ICS).

The aim of this procedure is to support a safe, effective, efficient, lawful, timely, equitable, patient centred and prudent approach to using ICS.

Objectives

- To promote safer transfusion as part of clinical governance responsibilities
- To ensure that ICS is used by adequately trained staff, is simple, safe and cost effective method of reducing allogeneic transfusion.
- To assist clinical staff in the identification of patients and procedures considered suitable for ICS and outlining the indications and contraindications.
- To assist clinical staff to provide appropriate advice on options for treatment, particularly where patients are anxious about risks associated with, or prefer not to receive, allogeneic blood.
- To provide clear written information about the risks and benefits of autologous transfusions from blood salvaged intraoperatively.
- To assist clinical staff to minimise avoidable / potential risks of autologous transfusions from blood salvaged intraoperatively.
- To ensure that any treatment is given lawfully

Scope

This procedure has been written to support the implementation and use of intraoperative cell salvage in the intraoperative / surgical setting within the Cardiff and Vale University Health Board (UHB). It may also be applicable when intraoperative cell salvage devices are used in the pre and /or postoperative environment (e.g. Emergency Unit, recovery, ward etc.) and for devices specifically designed for Intra and Post-operative Cell Salvage.

Document Title: Intraoperative Cell Salvage Procedure	2 of 51	Approval Date: dd mmm yyyy
Reference Number:	UHB030	Next Review Date: dd mmm yyyy
Version Number:	2	Date of Publication: dd mmm yyyy
Approved By:		

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been complete and this found there to be a positive impact. Key actions have been identified and these can be found within this procedure.
Documents to read alongside this Procedure	UHB 030 - Cell Salvage Policy UHB 068 - Blood Component Policy UHB 348 - Blood Component Procedure UHB 282 - Decontamination of Reusable Medical Devices Policy and Procedure UHB 100 - Consent to Examination or Treatment Policy UHB 186 - Independent Mental Capacity Advocacy Procedure (Mental Capacity Act 2005), UHB 113 - Lasting Power of Attorney and Court Appointed Deputy Procedure (Mental Capacity Act 2005), Welsh Government Guide to Consent for Examination or Treatment (July 2017) Mental Capacity Act 2005 Code of Practice ANTT all- Wales policy http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/ANTT%20IPC%20Policy%20FINAL%20May%202017%20V1pdf.pdf UHB 138 – Incident, Hazard and near miss reporting policy and procedure
Approved by	Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	*Medical Director*
Author(s)	*Dr Simon Logan (Consultant Anaesthetist) and Babs Jones (Education Lead, Perioperative Care Directorate).*

Disclaimer

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

11.3

Document Title: Intraoperative Cell Salvage Procedure	3 of 51	Approval Date: dd mmm yyyy
Reference Number:	UHB030	Next Review Date: dd mmm yyyy
Version Number:	2	Date of Publication: dd mmm yyyy
Approved By:		

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
2	*Date of Committee or Group Approval*	*TBA*	*Previous policy is now split into a policy and procedure. Welsh Government Guide to Consent for Examination or Treatment (July 2017) and Mental Capacity Act Code of Practice 2005 referred to.*

Document Title: Intraoperative Cell Salvage Procedure	4 of 51	Approval Date: dd mmm yyyy
Reference Number:	UHB030	Next Review Date: dd mmm yyyy
Version Number:	2	Date of Publication: dd mmm yyyy
Approved By:		

Contents

ROLES AND RESPONSIBILITIES

The UHB

The UHB is responsible for

- Ensuring that there is a Clinical Lead for Cell Salvage. The organisation’s Clinical Lead for ICS is currently a Consultant Anaesthetist.
- Providing a member of the theatre management team to be the Operational Manager, responsible for ensuring overall management and facilitation of the ICS service. The Senior Nurse for Theatres is currently in this role. The Operational Manager will be supported by a number of Cell Salvage Coordinators.
- Ensuring that all cell salvage operators have been trained and achieved their cell salvage competencies.
- Ensuring that competent personnel in sufficient numbers are available to provide the ICS service, including for out of hours cases if applicable.

The Clinical Lead

The Clinical Lead is responsible for

- Identifying members of staff who will take on the role of coordinating the cell salvage service.
- Being involved in the purchase of equipment and service contracts.
- Liaising with the Lead ICS clinician to produce and implement local protocols and guidelines.

The Cell Salvage Co-ordinators

The Cell Salvage Co-ordinators are responsible for

- Delivering and recording of training and competency assessment.
- Arranging for cell salvage to be available at the clinician’s request.

If the service is not available this should be reported to the lead ICS Manager and Clinician

- Ensuring audit is complete
- Regular Quality Control of machines

These roles are carried out as extended roles by named theatre staff.

Prescribing Responsibilities

Salvaged blood for reinfusion will be appropriately prescribed by the responsible clinician on the designated documentation. The responsible clinician must also ensure that valid consent for transfusion is obtained, or where there is reason to doubt a patient's mental capacity to provide consent, the Mental Capacity Act 2005 is followed.

Labelling Responsibilities

The reinfusion bag must be labelled as soon as is reasonably practical (i.e. When the patient is in theatre or as soon as the processing set is loaded if a "collect only" system has been used initially). The patient details should be handwritten and include the following:

- Full name
- Date of birth
- Hospital number
- Collection start date and time
- Expiry date and time

Addressograph labels **should not** be used because of the known associated risks.

Individual Responsibilities

The cell salvage Operators will ensure that they are adequately trained and competent in the safe use of the ICS system in each of the specialities they work in. All individuals involved in the care of patients undergoing cell salvage will ensure that they are adequately trained in the safe use, including the indications and contraindications, of cell salvage i.e. operator, anaesthetic, surgical, scrub, recovery and ward staff.

Documentation responsibilities

Staff must ensure that documentation (including all appropriate labelling) accurately reflect the ICS process, the documentation record should include:

- The ICS audit form (Appendix 1). Audit of use enables future service planning and quality assurance.
- The autologous transfusion label which must be fully completed and attached to the reinfusion bag.
- At the time of reinfusion of the salvaged blood, the peel out section on the autologous transfusion label must be completed and attached in the appropriate place in the patients' clinical records or equivalent as specified in the Blood Component Transfusion Procedure
- There must be appropriate labelling of anticoagulant used e.g. Heparin Saline with confirmation of appropriate dose by lead Anaesthetist at the start of the procedure. (See appendix 10). Guidance on prescribing will be attached to each of the machines.

- Bedside pre-transfusion checks and patient observations should be performed and recorded during the autologous blood reinfusion in the same way as for the transfusion of allogeneic blood. Refer to the UHB 068 Blood Component transfusion policy and UHB 348 Blood component transfusion procedure. The minimum observations required are pre-transfusion, 15 minutes into the transfusion and on completion of the transfusion. Additional observations are at the discretion of the clinical staff based on an individual patient assessment.
- Adverse incidents should be documented in the patients' clinical records

TRAINING

Training is provided in accordance with the Joint United Kingdom Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC). A UK Cell Salvage Action Group was established in 2006 to help support wider implementation of cell salvage as an alternative to donor blood https://www.transfusionguidelines.org/transfusion-practice/uk-cell-salvage-action-group

Individual staff must receive training in the indications, contraindications and technical differences specific to their speciality /specialties. If a member of staff moves from one speciality to another, it is essential that training needs are identified and addressed prior to the staff member using ICS in their new clinical environment.

Theoretical and practical training must be undertaken and staff must be competency assessed before they set up or operate ICS equipment without supervision. This must include Aseptic Non Touch Technique (ANTT) training and assessment

Staff carrying out ICS for patients with particular religious or other requirements must have received training and have been competency assessed in preparing the equipment and blood for reinfusion in accordance with the patients' requirements prior to carrying out the procedure.

An ICS Competency Assessment Workbook is available via the Better Blood Transfusion Toolkit https://www.transfusionguidelines.org/transfusion-practice/uk-cell-salvage-action-group/cell-salvage-competency-workbooks . All members of staff carrying out ICS will hold this workbook and once assessed as competent will keep an ongoing log (as in the ICS Competency Assessment Workbook) of all the ICS procedures they carry out.

Update training is recommended under the following circumstances:

- Any reasonable length of time without practical use of the ICS device
- A learning need is identified by an individual member of staff or supervisor
- Changes in the product from the manufacturer or a change in the product due to the organisation trialling/purchasing new products
- Changes to national and/or local guidelines relating to any aspect of autologous transfusion (which could include changes to the Blood Component Transfusion policy

To ensure that trained personnel are available to operate the cell saver, for elective cases the Consultant Surgeon must give at least two weeks' notice to the Clinical Lead in anaesthesia.

INDICATIONS AND PATIENT SELECTION

ICS systems may be used in elective and/or emergency surgical procedures where the surgical field is not contaminated by faecal or infective matter and where no other contraindications exist (see next section).

Patient selection for ICS is considered via the clinical decision making processes of the surgeon and anaesthetist responsible for the patient. Providing that none of the contraindication listed in the next section exist, patients to be considered for ICS include

- Adult and paediatric patients undergoing elective or emergency surgical procedures where the anticipated blood loss in greater than 20% of the patient's estimated blood volume
- Cases fitting the criteria that are undertaken locally regularly include:
  - Cardiac surgery
  - Scoliosis surgery
  - Revision hip replacements
  - Major gynaecological surgery
  - Abdominal Aortic Aneurysm
  - Cystectomy
  - Nephrectomy
  - Liver resection
  - Pancreatic transplantations
  - Caesarian sections at high risk of bleeding greater than 20% total blood volume
  - Postpartum haemorrhage
  - Meningioma

- Major trauma where blood loss likely to be greater than 20% total blood volume
- Any procedure where blood loss is higher than expected and likely to exceed 20% total blood volume
- Adult and paediatric patients undergoing elective or emergency surgical procedures who have risk factors for bleeding or low preoperative Haemoglobin levels
- Patients who have rare blood groups or multiple antibodies for whom it may be difficult to obtain allogeneic blood

CONTRAINDICATION AND WARNINGS

The risk benefit ratio of ICS should be assessed for each individual patient by the surgeon and anaesthetist responsible for the patient's care.

Contraindications

ICS should not be used in the following situations:

- Bowel contents in the surgical field
- Heparin induced thrombocytopenia or Antithrombin III Deficiency when heparin is the anticoagulant of choice (a citrate containing anticoagulant solution may be used instead) See appendix 10)

Warnings

ICS should be temporarily discontinued when substances not licensed for Intravenous (IV) use are used within the surgical field and could potentially be aspirated into the collection reservoir. The standard theatre suction must be used to aspirate the surgical field and the wound should be irrigated with copious 0.9% IV Sodium Chloride before resuming ICS.

Examples of non-IV materials that should not be aspirated into the ICS system include:

- Antibiotics not licensed for IV use
- Iodine
- Topical Clotting Agents
- Orthopaedic cement of debris
- The use of ICS in the presence of **infection** may result in bacterial contamination of the salvaged blood. The aspiration of blood from an infected site should be avoided and antibiotics should be given as appropriate.
- **Gastric/pancreatic** secretions should not be aspirated into the system as they may cause enzymatic haemolysis and are not reliably removed by the washing procedure.

- **Pleural effusions** should not be aspirated and should be drained prior to cell salvage. However, blood which subsequently accumulates in the pleural space may be aspirated.
- There are concerns relating to the use of ICS in patients with **sickle cell disease**. The use of ICS in patients with abnormal red cell disorders should be made on a clinical, individual patient basis.
- **Amniotic fluid** shouldn't be aspirated into the system due to theoretical concerns related to Amniotic Fluid Embolism. See Appendix III for obstetric ICS usage.
- The use of ICS in patients undergoing surgery for **malignant disease** is not recommended by the manufacturers of ICS devices. This is due to concern about the possibility of malignant cells being reinfused and giving rise to metastases. It is vital that the clinicians remain up to date with the latest evidence relating to this. However, there are now a number of reports in the literature of the use of ICS in cancer surgery without obviously leading to early metastasis and some hospitals now use ICS routinely during surgery for malignant disease. Aspiration of blood from around the tumour site should be avoided to minimise decontamination of salvaged blood with malignant cells and the salvaged blood should be reinfused through a leucocyte reduction filter to minimise the reinfusion of any malignant cells which may have been aspirated into the collection reservoir. The decision to use ICS in the presence of malignant disease should be made by the surgeon and anaesthetist in consultation with the patient and duly documented in the medical records
- As there is no evidence to support the use of cell salvage in **paediatric malignancy** surgery the local paediatric oncologists have advised against its use. In cases where it is felt that benefit may outweigh the risk. Obtain the agreement of the paediatric oncologist prior to proceeding

Cautions

- The use of Hartmann's Solution will inhibit the action of citrate based anticoagulants (e.g. ACD) if used as an irrigant or wash solutions.
- Air will be present in the primary reinfusion bag when it is still connected to the cell saver or when it has been disconnected but air has not been evacuated. Where possible, all air should be evacuated from the primary reinfusion bag prior to reinfusion. Manufacturers advise not to use a pressure cuff as there is a risk of air embolus and some devices may also detect a back pressure if the reinfusion line is open.
- Manual node – it is recommended the ICS devices are not run in manual mode as this may lead to reduced quality, insufficient washing

of the final red blood cell product and the possible reinfusion of potentially harmful contaminants e.g. heparin. Machines should be run in automatic mode and manual mode should only be used when the benefits of doing so outweigh the risks e.g. emergency situations where the need to reinfuse the red cells quickly outweighs the risks associated with running the machine in manual mode.

PATIENT INFORMATION AND CONSENT ISSUES

Patients considered likely to have ICS during planned surgery must receive information about ICS before their operation. The process must be discussed with the patient pre-operatively whenever possible. Written information should be given to the patient wherever possible – for example the Patient Information Leaflet "Cell Salvage" (Appendix 5.1).

The patient must be given comprehensive information, in a format that they are likely to be able to understand, about ICS. They must also be advised of any specific risks peculiar to them that this procedure might involve. They must also be told of any alternatives to ICS (i.e allogeneic blood). The patient's consent must be obtained and documented.

Where the patient is aged under 16 years, a person with parental responsibility must give consent if the patient is not *Gillick* competent.

If there is reason to doubt the patient's mental capacity to consent to ICS and the patient is aged 16 years and over, then the Mental Capacity Act 2005 must be followed.

In an emergency, in the absence of a valid Advance Decision to Refuse Treatment or an attorney of a personal welfare Lasting Power of Attorney, the clinician should decide how to proceed using the information they have available and their clinical experience.

For further information about consent and capacity issues, please see the UHB's Consent to Examination or Treatment Policy

CONDITIONS FOR USING ICS

Use of ICS Equipment

- The ICS system should be used in accordance with the manufacturer's guidelines (Appendix 5).

- All procedures should be carried out in accordance with this and other relevant policy /procedural documents including infection control, management of sharps, decontamination and blood components transfusion.
- The ICS system should be routinely run in automatic mode (see Cautions in the precious section).
- Contraindications should be considered as identified in the previous section
- All staff who set up or operate ICS systems should receive theoretical and practical training and should have completed the ICS Competency Assessment Workbook (Appendix 2).
- Aseptic non-touch technique (ANTT) should be used as appropriate, to reduce the risk of infection.

Anticoagulant

- The type of anticoagulant and dose used should be documented on the cell salvage record and anaesthetic chart for each case (Appendix 1 and Appendix 10).
- Anticoagulant prepared by the operator (e.g. heparin saline) **must** be labelled clearly to avoid error

Wash Solution

- 0.9% IV Grade Saline should be used as the wash solution.
- The minimum wash volume, as outlined in the manufacturer's guidelines (Appendix 5) for the size of the centrifuge bowl in use and the type of surgical procedure should be used in all but the most urgent situations.

Labelling

- All salvaged blood **must** be labelled.
- Labels should be hand written. Pre-printed "addressograph" labels **should not** be used.
- Labelling information should include
  - full name
  - date of birth
  - hospital number
  - collection start date and time
  - expiry date and time
  - the statement "Untested Blood – For Autologous Use Only"
- To avoid errors in patient identification an autologous transfusion label such as that in appendix 6 should be completed at the patient's side, when the patient has arrived in theatre i.e. the reinfusion bag should not be pre-labelled prior to the patent's arrival in theatre or labelled after the patient has left theatre. The patient details should be taken

from their identification band and not from any clinical records or charts that may be present in the operating theatre. All fields on the label should be completed in full.

- If the system has been set up as a "collect only" system (collection reservoir and aspiration and anticoagulant line only), the collection reservoir should be labelled in accordance with the above instruction for labelling a reinfusion bag. If a processing set is subsequently loaded into the machine, the autologous label on the collection reservoir should be transferred onto the reinfusion bag immediately or a new label completed (as above).

Re-infusion

Prescribing responsibilities: Salvaged blood reinfusion should be prescribed by the responsible clinician on the blood transfusion documentation record.

- ICS may be set up as a "closed-circuit" system. Blood is aspirated from the surgical field, processed and transferred to a reinfusion bag. The reinfusion bag is simultaneously connected to the patient's IV cannula via an appropriate filter (see below). The person administering the reinfusion adjusts the rate at which the red cells are reinfused using a clamp on the administration set and by adjusting the height of the reinfusion bag. A pressure cuff **should not** be applied to increase the flow rate because of the risk of air embolism. The same reinfusion bag may fill and empty many times during an operation.
- Alternatively, ICS mat be set up without simultaneous connection of the reinfusion bag to the patient (as above). In this case, the reinfusion bag is disconnected from the ICS device when it is full or at the end of the surgical procedure and is subsequently connected and reinfused to the patient as in the "closed-circuit" system.
- A filter, appropriate to the type of surgery, should be used for reinfusion. In most cases this will be a 200 micron filter found in a standard blood administration set. In certain circumstances (e.g. obstetrics and malignancy) a leukocyte depletion filter may be indicated. A 40 micron microaggregate filter or a 40 micron lipid depleting filter is suggested for orthopaedic surgery where there is a risk of contamination of fat embolism respectively.
- The reinfusion bag should be kept beside the patient at all times.
- The reinfusion bag **should not** be placed into a refrigerator.
- Reinfusion of the salvaged blood should follow standard blood transfusion practice as described in the Blood Components Transfusion Policy.
- The responsible clinician should prescribe salvaged blood for reinfusion in the same manner as for allogeneic blood.

- The patient details on the reinfusion bag must be carefully checked against the details on the identification band attached to the patient before connecting the reinfusion bag to the patient.
- The reinfusion of salvaged blood should be documented appropriately on the blood transfusion documentation record. The autologous transfusion label, as in Appendix 6, contains a peel out section which should be completed at the time of reinfusion and can be used for this purpose.

Expiry

- The collection, processing and reinfusion of salvaged blood should be completed within the timeframes as recommended by the manufacturer. This should be in accordance with guidance from the American Association of Blood Banks (AABB) and the Blood Components Transfusion Policy and Procedure.

The AABB Guidelines state the reinfusion times for cell salvaged blood as follows:

- Intraoperative Cell Salvage: 4 hours from the completion of processing.
- Postoperative Cell Salvage: 6 hours from the start of collection (applicable when Intra-operative Cell Salvage devices are used to salvage blood postoperatively).

Any blood that has not been transfused within the timeframe specified in the guidelines must be disposed of in accordance with local policy for dealing with liquid bio hazardous waste (see Disposal below).

Documentation

- The collection and reinfusion of salvaged blood should be accurately documented on an appropriate form such as the in Appendix 1.
- The use of a generic autologous transfusion label is recommended (Appendix 6) – the peel out section of the label is completed and attached to the patient's clinical record upon reinfusion of the salvaged blood.
- Adverse incidents, near misses and hazards should be documented and reported according to the Adverse Event section of this procedure and in accordance with the Incident, hazard and near miss reporting policy and procedure
- Bedside pre-transfusion checks and patients' observations should be performed and recorded during autologous blood reinfusion in the same way as transfusion of allogeneic blood – in accordance with the Blood Components Procedure. Additional observations are at the

discretion of the clinical staff based on an individual patient assessment.
- The organisation should ensure that adequate records are retained in all cases where ICS is used.

Disposal of used ICS equipment

- Following use, all ICS disposable equipment should be disposed of in accordance with local requirements. The UHB Waste Management Department requires cell salvage associated waste to be disposed of in containers appropriate for incineration.

Cleaning and Disinfection of ICS Machines

- Following use, the cell salvage machine should be cleaned in accordance with the manufacturer's guidance and the Decontamination of reusable medical devises policy and procedure including procedures for cleaning equipment following high risk cases.
- Following contamination of the equipment internally, the equipment should be removed from use, identified as a potential biohazard and referred to the manufacturer.

Maintenance of Equipment

- All ICS equipment should be serviced regularly in accordance with the manufacturers' recommendations. A maintenance record and fault log (Appendix 7) should be kept for each machine.

MANAGEMENT OF MASSIVE REINFUSION

As with the transfusion of large volumes of allogeneic red cells, the return of large volumes of salvaged red blood cells will coincide with the depletion of platelets and clotting factors associated with massive blood loss.

In the event of a massive reinfusion of salvaged red blood cells, it is vital to consider the need for additional appropriate transfusion support e.g. platelets, fresh frozen plasma and cryoprecipitate.

Staff should be alert to a large blood loss into the collection reservoir and report the to the surgeon and/or anaesthetist.

Quality Assurance

It is necessary to maintain a comprehensive quality assurance system to ensure the provision of a safe, high quality ICS service.

Personnel

The UHB has identified a single individual responsible for ensuring that a safe and effective ICS service is provided. The organisation's Clinical Lead for ICS is currently a Consultant Anaesthetist. The Lead is responsible for ensuring that quality assurance systems are fully implemented.

The organisation will ensure that competent personnel in sufficient numbers are available to provide the ICS serviced, including for out of hours cases if applicable. Personnel involved in ICS will have undergone appropriated training (see section 6) and competency assessment (Appendix 2). Training Records will be maintained for all staff involved in the ICS process and it is highly recommended that individuals maintain a case log of all procedures in their own portfolios.

Equipment

All ICS equipment must be appropriately maintained. Maintenance should include both an operator maintenance programme and regular manufacturer maintenance visits. Operator maintenance programmes should include the implementation of a documented cleaning and minor checking system and the use of a machine specific fault log (Appendix 7). Manufacturer maintenance visits must be carried out by an authorised service engineer who will perform a series of documented maintenance controls and fine tune the device for maximum performance.

Product Quality

A Quality Control procedure will be performed on each machine every 2 months at both UHL and UHW sites. The QC log is to be checked by the operator prior to each case, and samples taken if the last QC was performed more than two months ago. This involves taking 2 samples from salvaged blood prior to return to the patients.

A full blood count is requested on 1 sample to assess Haematocrit. An acceptable level to be obtained is above 45%.

An anti-factor Xa assay is requested on the 2nd sample to assess heparin contamination. A result of (less than) <0.05U/ml is reported as the lower limit of detection of the anti-factor Xa assay.

The QC results will be returned to the clinical lead who will record this data in the QC logbook for each machine.

If results are outside the acceptable range further management will be discussed with haematology, and the manufacturers.

ADVERSE EVENT REPORTING

- Technical problems with ICS should be reported to the manufacture. It is advisable to discuss any action suggested by the manufacturer with Clinical Engineering.
- Serious Adverse Events must be reported to the Clinical Lead for ICS and the Transfusion Practitioner. Any adverse events relating to the ICS device must be reported in accordance with the UHB Incident, hazard and near miss reporting policy and procedure. Additionally, where appropriate reporting to the relevant external bodies should be undertaken e.g. Serious Hazards of Transfusion (SHOT), Medicine and Healthcare products Regulatory Agency (MHRA), especially if the incident has led to or, were it to occur again, could lead to death, life-threatening illness or injury.
- Other minor safety or quality incidents should also be reported as these can help demonstrate trends or highlight inadequate manufacturing or supply systems, or inadequate instructions and / or training.
- Adverse incidents, near misses and hazards should be documented and reported in accordance with the Incident, hazard and near miss reporting policy and procedure.

Examples of Adverse Events include:

- Severe reaction on reinfusion of salvaged blood
- Non-labelling / incorrect labelling of salvaged blood
- Equipment malfunction
- Communication failure leading to inappropriate reinfusion of the salvaged blood where contamination occurred within the surgical field and this was not communicated to the operator/anaesthetist.

AUDIT

Appropriate audit activity will be co-ordinated via the Cell Salvage Working Group Refer also to Appendix 1.

RESOURCES

The UHB will ensure adequate resources for the formal, documented training of all staff who set up of operate the equipment and for the regular maintenance and prompt repair of all ICS equipment.

Welsh Blood Service provides a substantial amount of funding for Intra-operative and Postoperative Cell Salvage, however, funding is capped and the UHB makes up the shortfall. In order to recue costs, the reservoir for

collection only is set up in the first instance. Processing is only to occur if adequate volumes are obtained and a decision is made to process and reinfuse collected blood to the patient.

Evidence of cell salvage activity and consumable use must be provided to the WBS to enable reimbursement to the organisation.

EQUALITY

The UHB is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its staff reflects their individual needs and does not discriminate against individuals or groups. An Equality and Health Impact Assessment has been undertaken for this policy and procedure. The assessment found that ICS has a positive impact.

IMPLEMENTATION

This procedure document will be circulated to all relevant personnel and implemented in all areas which may be involved in ICS. This will include:

- Consultant Lead for Transfusion
- Clinical Lead for ICS
- Manager for Theatres
- Transfusion Practitioner
- Jehovah's Witness Hospital Liaison Committee
- Senior Nurse / Theatre Managers
- Relevant surgical specialities
- Obstetrics and Gynaecology

It will also be available via the UHB Intranet. Members of the public will be able to access it via the website of the UHB with hard copies being provided on request.

Guidance on and queries relating to the procedure should be addressed to the organisation's Clinical Lead for ICS.

REVIEW

The procedure will be reviewed at timely intervals when new information becomes available that needs to be incorporated or every 3 years.

APPENDIX 1 – Intra-operative Cell Salvage Competency Assessment Workbook

The intraoperative Cell Salvage Competency Assessment Workbook is available through the Better Blood Transfusion Toolkit website at:

https://www.transfusionguidelines.org/transfusion-practice/uk-cell-salvage-action-group/cell-salvage-competency-workbooks

APPENDIX 2 – Intraoperative Cell Salvage in Obstetrics

ICS is being increasingly used in the UK in obstetrics for women at risk from post-Partum haemorrhage during caesarean section as evidence grows in support of it.
The use of ICS in obstetrics has been endorsed by:

- The Confidential Enquiry into Maternal and Child Health
- Joint Association of Anaesthetists of Great Britain and Ireland/Obstetric Anaesthetists Association Guidelines
- National Institute Health and Care Excellence

Any healthcare professional involved with obstetric ICS should be familiar with these guidelines.

Patient Selection and Preparation
Wherever possible, the advantages and risks of ICS and allogeneic blood transfusion should be discussed with the patient prior to undergoing an obstetric surgical procedure. In a pre-planned case this can be during the pregnancy. It is recommended that patients receive the NHS Blood and Transplant information leaflet entitled “Will I need a blood transfusion?” (Appendix VIII) which contains an “Alternatives to blood transfusion” section in the Intraoperative Cell Salvage Patient Information Leaflet (Appendix IV).

The NICE guidance "Intraoperative blood cell salvage in obstetrics recommends that whenever possible, the woman understands what is involved and the theoretical risks, and agrees (consents) to have the procedure. When obtaining formal consent for a caesarean section, the obstetrician or anaesthetist should discuss the advantages and risks of ICS with the patient and document clearly the agreement of the patient to undertake the procedure. Such detailed consent may not be practicable in an emergency, as for allogeneic transfusion.

Indications for ICS
Patient selection for ICS is at the discretion of the obstetrician and anaesthetist caring for the patient who should be involved in the decision. The type of obstetric cases that should be considered for selection include:

- Emergency situations
  - Ruptured ectopic pregnancy
  - Post –partum haemorrhage

- Elective situations
  - Patient with an anticipated blood loss of (more than) >1000 mls e.g. placenta accrete, large uterine fibroids, and other predictable causes of MOH.

- Other situations
  - Patients who for religious or other reasons refuse allogeneic blood and have consented to the use of ICS in elective or emergency bleeding situations of in significant anaemia.

Additional measures necessary in obstetrics ICS:

Amniotic fluid and use of Leukocyte Depletion Filter
Amniotic fluid should ideally not be aspirated into the ICS collection reservoir, but should be removed by separate suction prior to starting cell salvage. This recommendation will reduce the initial contamination, but it should be noted that the *in vitro* evidence is that the ICS process can effectively remove plasma phase elements of amniotic fluid whatever the initial load, therefore, in life-threatening haemorrhage, a clinical decision to use ICS from the start of the procedure could be carefully considered.

After processing, a Pall RS filter (LeucoGuard® RS Leukocyte Reduction Filter, Pall Biomedical Products Co., East Hills, NY) should be used to reinfuse ICS blood. This is the only filter proved to effectively eliminate residual particulate elements of amniotic fluid. It should be remembered that prior to 2000 this filter was not available, over 250 obstetric cases worldwide safely received ICS blood without a problem prior to the availability of the

filter. Therefore, in life-threatening haemorrhage a clinical decision to reinfuse ICS blood without this filter could be carefully considered.

8 Rh immunisation and Kleihauer testing

In any pregnancy involving an Rh negative mother and Rh positive foetus there's a danger of Rh immunisation of the maternal circulation is exposed to foetal red cells.

Kleihauer testing is required to establish the amount of foetal red cell exposure and ensures that the mother receives and appropriate dose of Anti-D immunoglobulin (usually 125 iu/ml of foetal blood). Depending on the results of the Kleihauer, a minimum of 500 is Anti-D will be offered in the post-partum period to Rh negative mothers with Rh positive babies.

The same protocol should be followed for Rh negative mothers who have undergone reinfusion of ICS blood. The presence of foetal red cells in the ICS blood is likely because the ICS device cannot distinguish foetal from maternal red cells. Depending on the test results it may b that higher doses of Anti-D will need to be administered.

The sample for Kleihauer testing should be taken after the reinfusion of ICS blood and administration of Anti-D should occur within 48-72 hours of delivery.

Patient factsheets – Information about Cell Salvage when you have your baby is available here https://www.transfusionguidelines.org/transfusion-practice/uk-cell-salvage-action-group/patient-factsheet

APPENDIX 3 – Cell Salvage Patient Information Leaflet

The Cell Salvage patient information leaflet can be downloaded from http://www.npsa.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=28445

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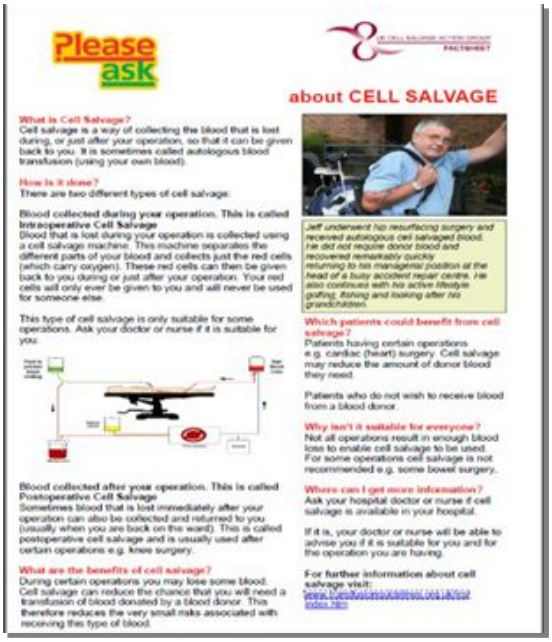

Please ask

about CELL SALVAGE

What is Cell Salvage?
Cell salvage is a way of collecting the blood that is lost during, or just after your operation, so that it can be given back to you. It is sometimes called autologous blood transfusion (using your own blood).

How is it done?
There are two different types of cell salvage:

Blood collected during your operation. This is called Intraoperative Cell Salvage
Blood that is lost during your operation is collected using a cell salvage machine. This machine separates the different parts of your blood and collects just the red cells (which carry oxygen). These red cells can then be given back to you during or just after your operation. Your red cells will only ever be given to you and will never be used for someone else.

This type of cell salvage is only suitable for some operations. Ask your doctor or nurse if it is suitable for you.

Blood collected after your operation. This is called Postoperative Cell Salvage
Sometimes blood that is lost immediately after your operation can also be collected and returned to you (usually when you are back on the ward). This is called postoperative cell salvage and is usually used after certain operations e.g. knee surgery.

What are the benefits of cell salvage?
During certain operations you may lose some blood. Cell salvage can reduce the chance that you will need a transfusion of blood donated by a blood donor. This therefore reduces the very small risks associated with receiving this type of blood.

Jeff underwent hip resurfacing surgery and received autologous cell salvaged blood. He did not require donor blood and recovered remarkably quickly returning to his managerial position at the head of a busy accident repair centre. He also continues with his active lifestyle golfing, fishing and looking after his grandchildren.

Which patients could benefit from cell salvage?
Patients having certain operations e.g. cardiac (heart) surgery. Cell salvage may reduce the amount of donor blood they need.

Patients who do not wish to receive blood from a blood donor.

Why isn't it suitable for everyone?
Not all operations result in enough blood loss to enable cell salvage to be used. For some operations cell salvage is not recommended e.g. some bowel surgery.

Where can I get more information?
Ask your hospital doctor or nurse if cell salvage is available in your hospital.

If it is, your doctor or nurse will be able to advise you if it is suitable for you and for the operation you are having.

For further information about cell salvage visit:

APPENDIX 4 – Manufacturers' Guidelines

These are held centrally by the Clinical Lead for ICS

APPENDIX 5 – Autologous Transfusion Label

These are held centrally by the Clinical Lead for ICS

APPENDIX 6 – NHS Blood and transplant information leaflet entitle "Will I need a blood transfusion"

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An order form for the NHS Blood and Transplant information leaflet “Will I need a blood transfusion” can be downloaded at:

https://hospital.nhsbtleaflets.co.uk/Home.html

Alternatively the leaflet can be downloaded at:
http://hospital.blood.co.uk/media/28307/160511-27360-will-i-need-a-blood-transfusion-final.pdf

The leaflet is available in a number of other languages (Welsh, Albanian, Arabic, Bengali, Chinese, Croatian, Farsi, French, Greek, Gujarati, Pashto, Polish, Punjabi, Serbian, Somali, Sorani, Turkish, Urdu, and Vietnamese) at:

http://hospital.blood.co.uk/library/patient_information_leaflets/leaflets/index.asP

APPENDIX 7 – Blood loss calculation

At the end of the procedure, when all of the blood from the collection reservoir has been processed, an estimate of the volume of blood the patient has lost during procedure can be made using a simple calculation.

The information required is:

Fluid in volume (Machine read out) – Total volume of fluid processed by machine, includes: blood aspirated from surgical field, anticoagulant and irrigation frim surgical field.

Irrigation fluid – Volume of sterile irrigation fluid used within surgical field and aspirated into the ICS collection reservoir.

Anticoagulant used – An estimate of volume used

Swab wash – Volume of IV normal saline (0.9% NaCl) or equivalent used to wash swabs

Theatre suction

Wet-dry weight of swabs – compensates for blood and saline swab wash retained on swabs and allows them to be weighed outside of the sterile field after washing.

Blood Loss Calculation:

Blood loss = fluid in volume plus theatre suction plus (wet-dry weight of swabs) minus irrigation fluid minus anticoagulant used minus swab wash

APPENDIX 8 - Heparin Concentration

Heparin Saline

In usual circumstances, 30,000 iu of Heparin is added to 1,000ml of intravenous (IV) normal saline (0.9% NaCl) and labelled clearly with an appropriate “drugs added label”.

Some manufacturers recommend that 60,000 iu of Heparin should be added to 1,000ml of IV normal saline for **neurosurgical** procedures. This should be confirmed with the manufacturer.

The Heparin Saline anticoagulant concentration should be checked by the Lead Anaesthetist at the start of the procedure and documented on the Welsh Blood Service audit form. **Under no circumstances** should the heparin used for preparation of anticoagulant for cell salvage purposes be prescribed on an inpatient drug chart. This is to reduce the risk of inappropriate administration of heparin saline outside of the theatre environment.

A pre prepared citrate based anticoagulant should be used for patients with antithrombin III deficiency.

Equality & Health Impact Assessment for

Intraoperative Cell Salvage Policy and Procedure

Please note:

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

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Intraoperative Cell Salvage Procedure
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact	Surgery Clinical Board

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

11.3

	details	
3.	Objectives of strategy/ policy/ plan/ procedure/ service	• To promote safer transfusion as part of clinical governance responsibilities • To ensure that ICS is used by adequately trained staff, is simple, safe and cost effective method of reducing allogeneic transfusion. • To assist clinical staff in the identification of patients and procedures considered suitable for ICS and outlining the indications and contraindications. • To assist clinical staff to provide appropriate advice on options for treatment, particularly where patients are anxious about risks associated with, or prefer not to receive, allogeneic blood. • To provide clear written information about the risks and benefits of autologous transfusions from blood salvaged intraoperatively. • To assist clinical staff to minimise avoidable / potential risks of autologous transfusions from blood salvaged intraoperatively. • To ensure that patients are treated lawfully
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research	**REFERENCES** 1. Serious Hazards of Transfusion (SHOT) Report 2005. http://www.shotuk.org/SHOT%20report%202005.pdf 2. Better Blood Transfusion: The Appropriate Use of Blood (2002) HSC 2002/009 3. Murphy GJ, Rogers CS, Lansdowne WB, Channon I, Alwair H, Cohen A, Caputo M and Angelini GD (2005) Safety, efficacy, and cost of intraoperative cell salvage and autotransfusion after off-pump coronary artery bypass surgery: a randomized trial. *J Thorac Cardiovasc*

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	• good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	*Surg*; 130(1); 20-8 4. James V (2004) A National Blood Conservation Strategy for the NBTC and NBS http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService =GET_FILE&dID=26734&Rendition=Web 5. Policy for the provision of Intraoperative Cell Salvage. http://www.transfusionguidelines.org.uk/docs/misc/bbt-03_icsag-policy-v11.doc 6. British Committee for Standards in Haematology Blood Transfusion Task Force (1999). The administration of blood and blood components and the management of transfused patients. *Transfusion Medicine*; 9; 227-238. British Committee for Standards in Haematology Blood Transfusion Task Force (1997) Guidelines for Autologous Transfusion II. Perioperative Haemodilution and Cell Salvage. *British Journal for Anaesthesia*; 78; 768-771. 8. Gray CL, Amling CL, Polston GR, Powell CR and Kane CJ (2001) Intraoperative cell salvage in radical retropubic prostatectomy. *Urology*; 58(5); 740-5. 9. Nieder AM, Carmack AJ, Sved PD, Kimm SS, Manoharan M and Soloway MS (2005) Intraoperative cell salvage during radical prostatectomy is not associated with greater biochemical recurrence rate. *Urology*; 65(4); 730-4. 10. Nieder AM, Manoharan M, Yang Y and Soloway MS (2007) Intraoperative Cell Salvage during radical cystectomy does not affect long term survival. *Urology*; 69(5); 881-4. 11. American Association of Blood Banks (AABB) (2005)

[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

11.3

		Standards for Perioperative Autologous Blood Collection and Administration (2nd Edition) 12. Cardiff and Vale NHS Trust Incident Reporting and Investigation Procedure, May 2007 13. http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/POLICY_PAGEGROUP/LIBRARY/RISK%20MANAGEMENT%20POLICY.PDFMedicines and Healthcare products Regulatory Authority (MHRA) (2007) Device Bulletin: Reporting adverse incidents and disseminating medical device alerts. http://www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dDocName=CON2025834&RevisionSelectionMethod=LatestReleased Roberts, M.M. (2006) Procedure for Post-operative Autologous Blood Transfusion Drainage Systems in Adult and Paediatric Patients. *Cardiff and Vale NHS Trust*. 15. Kelleher, A.A. (2004) Policy for the Provision of Perioperative Red Cell Salvage. *Royal Bromptonand Harefield NHS Trust*. 16. Obstetric Intra-operative Cell Salvage Guidelines (Draft 1). *St Mary's NHS Trust* 2006.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Patients who for clinical and/or personal reasons would benefit from the appropriate use of autologous blood transfusion techniques such as Intraoperative Cell Salvage (ICS). Staff who must be adequately trained to undertake the procedure.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Where the patient is aged under 16 years, a person with parental responsibility must give consent if the patient is not *Gillick* competent. If there is reason to doubt the patient's mental capacity to consent to ICS and the patient is aged 16 years and over, then the Mental Capacity Act 2005 must be followed.	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010	The policy and procedure lists supporting documents to ensure appropriate consent	Staff must be familiar with the list of documents associated with informed	Mandatory training compliance. Evidence of clinical audit.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	to treatment and to affirm the rights of patients and their autonomy without discrimination. The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good management practice. **Note -** the Arial font size 14 recommendation is aimed at communication and information needs for patients. We are aware that	consent.	

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	we may need to amend/provide the format of our communication in line with the appropriate All Wales Sensory Loss Standards and legislation.		

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Where the patient is aged under 16 years, a person with parental responsibility must give consent if the patient is not *Gillick* competent. If there is reason to doubt the patient's mental capacity to consent to ICS and the patient is aged 16 years and over, then the Mental Capacity Act 2005 must be followed.	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical	The policy and procedure lists supporting documents to ensure appropriate consent	Staff must be familiar with the list of documents associated with informed	Mandatory training compliance. Evidence of clinical audit.

11.3

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	to treatment and to affirm the rights of patients and their autonomy without discrimination. The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good management practice. **Note -** the Arial font size 14 recommendation is aimed at communication and information needs for patients. We are aware that	consent.	

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	we may need to amend/provide the format of our communication in line with the appropriate All Wales Sensory Loss Standards and legislation.		

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Where the patient is aged under 16 years, a person with parental responsibility must give consent if the patient is not *Gillick* competent. If there is reason to doubt the patient's mental capacity to consent to ICS and the patient is aged 16 years and over, then the Mental Capacity Act 2005 must be followed.	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010	The policy and procedure lists supporting documents to ensure appropriate consent	Staff must be familiar with the list of documents associated with informed	Mandatory training compliance. Evidence of clinical audit.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	to treatment and to affirm the rights of patients and their autonomy without discrimination. The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good management practice. **Note -** the Arial font size 14 recommendation is aimed at communication and information needs for patients. We are aware that	consent.	

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	we may need to amend/provide the format of our communication in line with the appropriate All Wales Sensory Loss Standards and legislation.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or**	There is no current evidence of positive or negative impact on staff or patients associated with gender though we are aware that it is widely known that there are differences between men and women in the incidence and prevalence of most health conditions. .	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	There is no current evidence of positive or negative impact on staff or patients associated with this protected characteristic	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby	There is a specific section for obstetric patients who may be considered for Intraoperative Cell Salvage	Staff must be familiar with specific section.	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
whether or not they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Patient information leaflets are available in multiple languages from the NHS Blood and Transplant site. Elective surgery patients being considered for Intraoperative Cell Salvage will have access to an interpreter where appropriate	Staff to be familiar with interpreter booking system	Support interpreter service.
6.7 People with a religion or belief or with no religion	This is a positive impact for patients for who, for moral,	Staff to be familiar with aspects of the policy and	Provide training where appropriate.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
or belief. The term 'religion' includes a religious or philosophical belief	religious or other reasons, are unwilling to receive allogeneic blood and have given their consent to receiving autologous blood collected using ICS (all such decisions should be documented).	procedure and receive regular updates and training	
6.8 People who are attracted to other people of: • **the opposite sex (heterosexual);** • **the same sex (lesbian or gay);** • **both sexes (bisexual**	There appears not to be any impact on staff or patients in terms of sexual orientation.	N/A	N/A
6.9 People who communicate using the	Bilingual information leaflets are available for patients.	Staff to be familiar on how to access welsh speaking	Provide welsh language training

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
Welsh language in terms of correspondence, information leaflets, or service plans and design **Well-being Goal – A Wales of vibrant culture and thriving Welsh language**	This is in line with our current Welsh Language Scheme and the future Welsh Language Standards.	colleagues to support the patient. Information should be available in Welsh. Service to encourage Welsh language 'active offer' to those receiving the procedure.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	Minimal Impact is anticipated The procedure aims to deliver an achievable equitable service regardless of an individual's income. Any decisions are clinically made.	N/A	N/A

11.3

6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Minimal Impact is anticipated The procedure aims to deliver an achievable equitable service regardless of an individual's income. Any decisions are clinically made.	N/A	N/A
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are anticipated positive impacts for adult and paediatric patients undergoing elective or emergency surgical procedures who have risk factors for bleeding or low preoperative Haemoglobin levels; patients who have rare blood groups or multiple antibodies for whom it may be difficult to obtain allogeneic blood and adult and paediatric patients undergoing elective or emergency surgical procedures where the anticipated blood loss in greater than 20% of the	Staff to be familiar with aspects of the policy and procedure and receive regular updates and training	Provide training where appropriate.

	patient's estimated blood volume. The procedure lists contraindications		

9. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities	People will be consulted regarding ICS dependent on the surgical procedure being undertaken and their own preferences. Geographical location will have no impact on the decision.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal - A more equal Wales			
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	Indirectly associated with this procedure – patients listed for elective surgery will have the opportunity to improve their wellbeing with healthcare professional support pre-operatively.	N/A	N/A
7.3 People in terms of their	Positive impact by ensuring	Ensure all staff involved with	Enable the trained ANTT

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	staff are appropriately trained for their roles associated with cell salvage in order to maintain safe practice and thus job security. Aseptic Non Touch Technique processes (ANTT) has been introduced as an all-Wales approach to reducing healthcare associated infection. The PADR process supports further development appropriate to role and future employment ambitions.	aseptic techniques associated with ICS are trained and assessed in ANTT	facilitators to continue rolling out ANTT in accordance with the all-Wales approach
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality,	N/A	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	If a patient has a carer or parent/guardian we will ensure they receive the appropriate information.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	Intraoperative Cell Salvage has the potential for a positive impact in terms of supporting the prudent use of donated blood in accordance with the Welsh Health Circular (WHC), “Better Blood Transfusion: Appropriate Use of blood”.	N/A	N/A

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Intraoperative cell salvage has a positive impact by providing an alternative to allogeneic blood transfusion in accordance with the Welsh Health Circular (WHC), "Better Blood Transfusion: Appropriate Use of blood". The policy and procedure promotes safe and effective practice that is consistent with people's beliefs and values.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	All staff should be trained and assessed in line with the all-Wales use of ANTT. This should be embedded in ongoing training for ICS. http://howis.wales.nhs.uk/sitesplus/888/page/64404 There are no additional new actions identified as a result of updating the policy and procedure.	Lead Nurse and Education Lead for the directorate.	Immediate and ongoing	Enable relevant staff to access the e-learning and have a practical assessment by a trained ANTT facilitator within the UHB

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As part of its implementation this procedure document will be circulated to all relevant personnel and implemented in all areas which may be involved in ICS. This will include: • Consultant Lead for Transfusion • Clinical Lead for ICS • Manager for Theatres • Transfusion Practitioner • Jehovah's Witness Hospital Liaison Committee • Senior Nurse / Theatre Managers • Relevant surgical specialities • Obstetrics and Gynaecology It will also be available via the UHB Intranet. Members of the public will be able to access it via the website of the UHB with hard copies being provided on request. Guidance on and queries relating to the procedu should be addressed to the organisation's Clinica Lead for ICS.	N/A	N/A	N/A

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact	Continue unchanged as there are no significant negative impacts. EHIA will be placed on the intranet once approve Adherence to the policy will be monitored throug the Perioperative Care Directorate governance forums When this policy is reviewed, this EHIA will form part of that consultation exercise and publication This EHIA will be reviewed three years after approval unless changes to terms and conditions legislation or best practice determine that an ear review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).	Lead Nurse and Education Lead for the directorate.	Ongoing	

PATIENT EXPERIENCE FRAMEWORK 2017 – 2020 - PROGRESS UPDATE

Name of Meeting: Quality, Safety and Experience Committee
Date of Meeting: 12 June 2018

Executive Lead: Executive Nurse Director

Author: Assistant Director of Patient Experience
Angela.hughes5@wales.nhs.uk

Caring for People, Keeping People Well: The Framework has been refreshed to support and deliver the following elements of the UHB Strategy – Delivering outcomes that matter to people; this approach will support the opportunity to work together to dramatically improve patient experience and drive equity of healthcare value for our patients and service users.

Financial impact: Delivery of the Framework has the potential to reduce costs by listening and acting upon positive and negative feedback

Quality, Safety, Patient Experience impact: The Framework has been written to deliver improvements in key areas of the patient experience framework and to align to each area of the quadrant.

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 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 framework.
- **NOTE** the main high level achievements for 2017/2018
- **AGREE** to monitor the implementation of the framework and to receive regular updates

SITUATION

The purpose of this report is to present the Committee with a high level update on year one implementation of the refreshed patient experience framework 2017 -2020.

BACKGROUND

The Framework was approved by the Committee in April 2017. Since that time, the Patient Experience Team has been working with Clinical Boards and specialist leads within the organization, to support implementation.

The Framework supports, and is integral to the 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. The key measurement is to provide an insight into what does it feel like to be a patient/ carer using our services

The framework will operate in conjunction with the Health Board strategy and the Quality and Safety Framework.

ASSESSMENT AND ASSURANCE

Our priorities are aligned with some of the key domains within the Health and Care Standards framework 2015,

The framework ensures that we hear and actively listen to the voices of our service users. The implementation of the framework ensures that we can demonstrate our response to their feedback.

It is applicable across all health care settings in primary and secondary care. We work with the third sector organisations and we value their support with many of our patient experience activities.

The framework is part of our quality assurance system

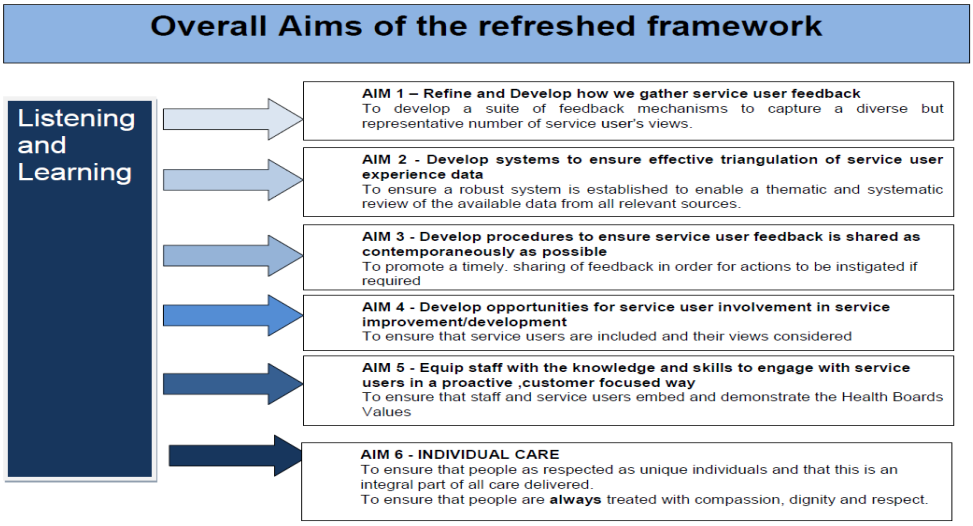
The clinical board submissions for each annual Health and Care standards report demonstrates the embedded maturity of the framework.

Our Annual Quality Statement will account of how we are progressing with the implementation of the framework over the next three years.

The Framework is also aligned with the UHB Quality, Safety and Improvement Framework 2017 - 2020.

In order to capture service user feedback it is recognised that there is no single method that can provide the assurance that Health Boards require and that a number of methods are required for triangulation to verify findings and make improvements. To support this approach the All Wales Framework for Assuring Service User Experience describes four quadrants which group together a wide range of feedback.

Real Time **Short Surveys** Used to obtain views on key patient experience indicators whilst patients, carers and service users are in our care (such as in hospital) or very shortly afterwards (such as on discharge or immediately after an out-patient appointment)	**Retrospective** **Surveys** post discharge or any clinical encounter in any setting to gain in-depth feedback of service user experience. They can also incorporate quality of life measures and Patient Reported Outcome/Experience measures (PROM/PREM)
Proactive/Reactive Provide opportunities for all service users/families/carers to provide feedback. Includes feedback cards, permanent and temporary online surveys and emerging methods such as text, QR codes and social media.	**Balancing** Concerns and complaints Compliments Patient stories Focus groups Third party surveys such as Community Health Council and voluntary organisations

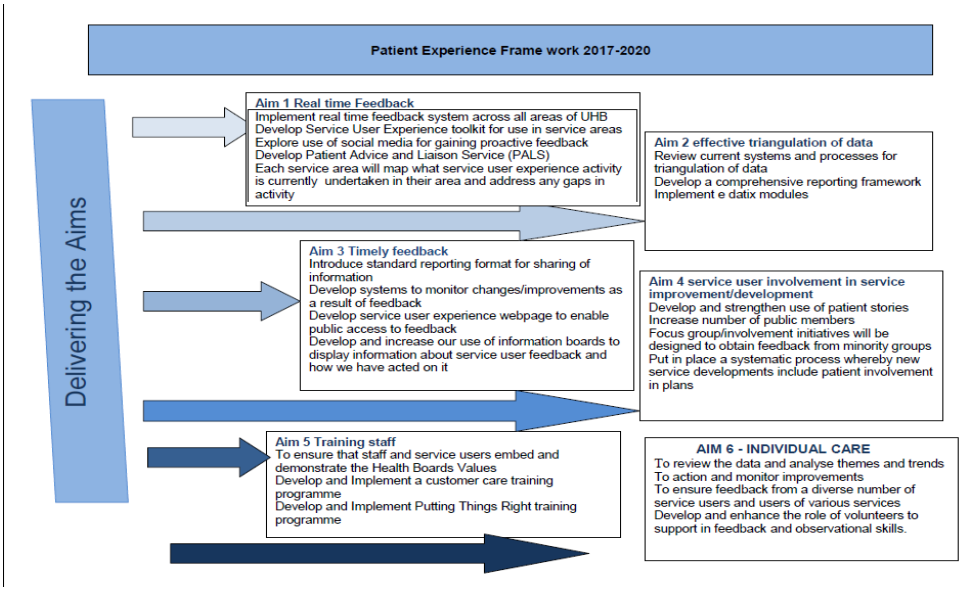


Key Achievements in each domain –more detailed reports on individual elements will be provided to the QSE committee via annual reports

One of the fundamental aims for 2017/18 was to evidence activity in each of the quadrants.

As evidenced in the integrated report to the Board we are able to share activity in each quadrant.

In the framework we have a 3 year plan to deliver the aims



Main achievements in relation to the Driver Diagram 2017/18

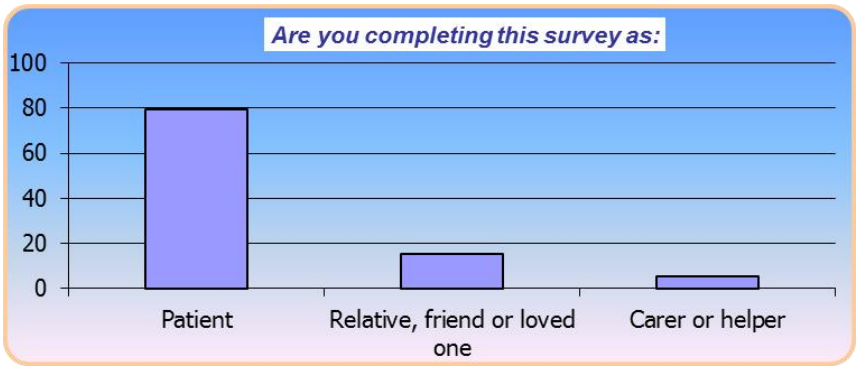
Aim 1 Real time feedback –there has been a lot f focus in 2017/18 in developing this activity

Over 1,000 surveys are completed each month.
Timely reports to clinical boards with themes and trends which are discussed at their QSE meetings

Six Happy or Not machines in use have received over 160,000 responses with 83% of the respondents advising that staff are kind and caring. 82% would recommend this hospital to family and friends.

Based in Outpatients - this Kiosk has received in total 1368 responses mainly from patients and continues to be completed consistently each month by over 100 patients providing real time information.

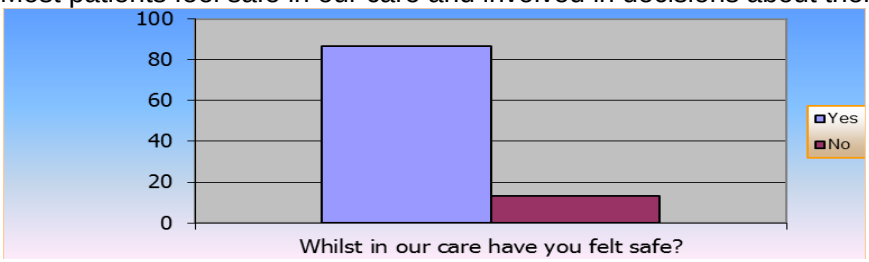
12



Reports have led to service improvement – increased use of way finding volunteers, reminders to staff to inform patients and apologise for any clinic delays.

The ward feedback kiosks were introduced to the wards in June 2017 and were a means of gathering real time feedback from patients, relatives, friends, carers and staff. The survey tools loaded on the kiosks, were available in both English and Welsh. During each survey period, the kiosk remained on its designated ward for 1 week. A detailed report was then sent to the area the following week. To date 3054 surveys have been completed.

Most patients feel safe in our care and involved in decisions about their care.



Concerns –development of the PALS (Patient Advisory Liaison Team)

62% of concerns are now managed informally and less than 2% are converted to formal concerns. The PALS teams are based in UHW and UHL information centres.

Aim 2 Effective Triangulation of Data

We have implemented E datix modules for Concerns-Complaints and Ombudsman cases which enables more effective analysis of the data.

We need to further develop the Claims modules and the Redress pages in 18/19

The Patient Experience team work more collaboratively and we share intelligence to focus resources

E.g. if an area has a poor satisfaction score we review the information and work with the Clinical Board to see if we need to focus some of our volunteers activity or develop a bespoke survey. We have found that using the kiosk with a bespoke survey has enabled us to quickly analyse issues in an area.

Aim 3 Timely Feedback

We have developed the on line surveys and introduced a feedback in 5 survey. However a focus in 2018/19 will be to develop the APPS and QR codes.

Aim 4 Service User involvement in Service Improvement/development

We have started to engage with groups who do not necessarily raise concerns or provide feedback via surveys.

In February 2018 we met with people who are deaf or Hard of hearing and a focussed piece of work supported by our Executive lead Ruth Walker and the Chair is to improve accessibility to our services for these service users. This will improve their experience of using our services. As part of the framework we will continue to try to engage with people who use our services and listen to their experiences

Aim 5 Training Staff

As a team we are proactive in promoting the Health Board Values and living our values

We provide regular training on Putting Things Right and the 30 working day response time has increased to 72% at the end of March 2018

Further work needs to be undertaken to promote living our values the impact of the lasting First Impression. This work is linked with the Hello my name is campaign as patients quite rightly expect all staff to introduce themselves.

Aim 6 Individual Care

The diverse methods of gathering feedback are constantly being reviewed to question do they tell us what it feels like to be a patient/ Carer using our services

One of our areas of focus in 2019/20 will be the analysis of patient stories

Patient Stories involves collecting stories from patients' personal experiences to understand how they perceived the health care they have received. Patients talk about what they felt, saw, heard, the emotions that were evoked and how this may have affected their decisions and actions during their journey. These insights are an important component in understanding how we

can improve different aspects of service delivery and care in our hospitals and in our community-based health care programs.

Other Key achievements

- The UHB has maintained very good patient satisfaction scores throughout out 2017-2018.

- 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 the 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

Areas for focus in 2018/2019:

- Recognition of carers
- Thematic analysis of patient stories
- Recruitment of young volunteers and specifically Activity Volunteers
- Sustained improvement in response times to concerns
- Focus upon improving access to services for those who are deaf or have hearing loss - a further paper on this point will be shared at a future QSE meeting

ANNUAL QUALITY STATEMENT 2017-2018
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting : 12th June 2018**

Executive Lead : Executive Nurse Director
Author : Patient Safety and Quality Assurance Manager (Alexandra.scott2@wales.nhs.uk – 029 2074 4018)
Caring for People, Keeping People Well : The Annual Quality Statement is developed around the Health and Care Standards which underpin all elements of the Health Board's Strategy.
Financial impact : This report carries a financial implication in the region of £2K for production of hard copy versions to be made available to patients, the public and staff and for Welsh translation.
Quality, Safety, Patient Experience impact : The Annual Quality Statement provides the opportunity to inform the public of what action is being taken to deliver safe, effective, patient centred care. Sections are aligned with the seven domains of the Health and Care Standards.
Health and Care Standard Number : Applies to all standards.
CRAF Reference Number : 5.1
Equality and Health Impact Assessment Completed : No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The provision of the draft Annual Quality Statement 2017/18

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the draft Annual Quality Statement for 2017 / 2018; in readiness for endorsement at the public Board session in July 2018.

SITUATION

The purpose of this report is to present the Annual Quality Statement (AQS) 2017-2018 for approval.

14

BACKGROUND

NHS bodies are required to publish Annual Report and Accounts, an important element of this will be the publication of the Annual Quality Statement. Welsh Government issued guidance on production of the AQS in March 2018.

The AQS is intended to provide an opportunity for the health board to inform the public about the quality and safety of the services that it provides, including how it is making better use of resources to deliver safe, effective and patient centered services and how it provides care that is dignified and compassionate. Development of the AQS is subject to Internal Audit assessment.

The AQS for 2017/2018 is required to be published no later than 31st July 2018.

ASSESSMENT AND ASSURANCE

The 2017 /2018 Annual Quality Statement Can be viewed (insert link).

Each chapter of the AQS is aligned to a theme within the Health and Care Standards and comprises several elements:

- A patient and staff story,
- An update of the quality, safety and improvement framework where applicable.
- A focus on the successes and challenges across the health board.

The patient and staff stories were developed in conjunction with the Paediatric Diabetes clinical team and their patients and were designed to give context to the themes explored in each chapter.

The update of the Quality, Safety and Improvement Framework describes the progress made against the key domains within the health and care standards and the work that remains underway.

The third element explores the successes and challenges across the health board .

Development of the AQS has been developed with colleagues across the health board and in partnership with the Community Health Council and also through engagement with the Stakeholder Reference Group.

Contents

Welcome from Our Chair and Chief Executive

Cardiff and Vale of Glamorgan Community Health Council

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

The Cardiff & Vale of Glamorgan Community Health Council your local NHS Watch-dog has responsibility for overseeing the services provided by the Cardiff and Vale University Health Board from a public, patient / service user perspective.

During the last year the CHC undertook

- 43 new visits completed (8 of which were unannounced)
- 6 hospital site visits to undertake the Sensory Loss Assessment (129 areas covered)
- 27 Follow-up visits on previous recommendations

We made 121 recommendations in our reports to the Health Board and can report that 90 have been achieved in their entirety or partly totalling an average 74% compliance rate. For example:

The impact this has had resulted in

1. 3 Healthcare Support Workers trained in foot care – St Barruc Ward, Barry Hospital
2. A Play Therapist was employed on the Unit, additional toys had been purchased including interactive toys on the corridor walls and colourful notice boards placed in the waiting room – Children's Assessment Unit, UHW
3. Rubber runners on the bottom of shower doors to prevent consistent flooding – Ward East 1, Llandough
4. A therapeutic beauty room fitted with hair dryers on stands, mirrors and shelving is planned, funded by the charitable fund – Ward East 12, Llandough
5. Additional clinics to reduce the waiting list for hip and knee replacements – CAVOC, Llandough
6. Radios purchased and patients actively encouraged to bring their own devices – Ward T4, UHW
7. The development of a dual purpose room that could allow patients to access a quiet room – Ward B4, UHW

The Complaints Advocacy Service provided by the CHC has supported a number of clients with our current case load for Cardiff and Vale of Glamorgan being in excess of 100 cases. We also receive data on cases relating to the health board from other CHCs across Wales. Again the impact on complainants has been for example

Brief details of complaint

Client's husband is frail and elderly and has dementia. He was unable to tolerate an excessively long waiting time in the outpatient clinic so had to miss an appointment.

Another appointment was cancelled without the patient being informed resulting in a long journey to the hospital being made unnecessarily.

Outcome

As the result of a letter of complaint to the HB, an apology was given and an offer to reimburse the couple's travel and parking costs was made.

In addition, the HB agreed to give the patient the first appointment of the outpatient clinic in future so that he would be seen without having to wait too long.

The CHC have reviewed the content of this Annual Quality Statement and believe it to be a true reflection on the challenges, progress made by the Health Board.

J. M. Shelton

Jill Shelton
Chair

Stephen Allen
Chief Officer

About The Annual Quality Statement

Welcome to our Annual Quality Statement (AQS) where we describe the successes and challenges that we have experienced in 2017 / 2018. The Annual Quality Statement is an opportunity for Cardiff and Vale University Health Board to demonstrate in an open and honest way how it is performing and the progress that is being made to ensure that all of the services that we provide meet the high standards required.

The AQS has been set out under seven themes, each theme underpining the quality and safety of the care that we deliver, each has three components

- Our Patient and Staff Story
- Quality Safety and Imrovement (QSI) Framework Update
- Succeses and Challenges Across the Health Board

Our Patient and Staff Story - To help us to explain the context of each theme we have worked closely with the staff and patients from the Paediatric Diabetes Services. Although Paediatric Diabetes services care for a very small proportion of our population the approach that they take to deliver excellent care is typical of services across the entire health board.

Quality Safety and Imrovement (QSI) Framework - Update Last year we told you about the Quality Safety and Improvement Framework and how this was important in helping us to identify areas that remain a

priority for us and to monitor the improvement being made within these areas. This year we have included an update in each of the relevant chapters to explain the progress that we have made so far

Succeses and Challenges Across the Health Board - Finally we have given you an update about some of the work that has been underway across the rest of the health board.

We are very grateful to the support that all of our staff have given us in developing this report in particular the Paediatric Diabetes team, but we would like to give an extra big thank you to Alys and Tom, their parents and Ysgol y Wern who have helped to make the Annual Quality Statement so meaningful.

The AQS Themes

Treating People as Individuals	The way that we provide care to people must respect their individual choices in the way that they care for themselves and must ensure that all people are treated equally. We learn from what people tell us about their experiences in our care.
Timely Care	People should have access to services that are provided in a timely manner to ensure that they are treated and cared for in the right way, at the right time, in the right place and by the right staff.
Staying Healthy	We help people to make the right decisions about their own health, behaviour and wellbeing and to access the right information to help them to have a healthy, active and long life.
Effective Care	We work hard to ensure that people receive care and treatment that reflects best practice, which means that there is evidence that to support the care that we deliver.
Safe Care	We are continually looking for ways to be more reliable and to improve the quality and safety of the services that we deliver. There are occasions when we don't do things as well as we could, when this happens we always try to understand what went wrong and make sure that we learn from this and improve the care that we deliver as a result.
Dignified Care	Our patients should expect to be treated with dignity and respect, this means that the care that we provide must take into account every person's needs, abilities and wishes
Our Staff and Volunteers	All of our staff and volunteers help us to ensure that we provide a high quality and safe service

Quality, Safety and Improvement Framework 2017-2020

YEAR 1 – How did it go?

Last year we told you about the work we had undertaken to develop a Quality Safety and Improvement (QSI) Framework for 2017 -2020. We had spent time talking with a lot of people including members of the public, staff and with other organisations that we work with. At the end of the process we identified a number of key quality, safety and improvement priorities that we wanted to focus on across the organisation. We used the Health and Care Standards for Wales to develop our framework, focusing on the following main themes:

- Governance, Leadership and accountability
- Safe care
- Effective care
- Dignified Care
- Timely care
- Individual care

The Health and Care Standards are a set of standards designed around seven main themes and they apply to all health care services and settings. They provide a basis for us to improve quality and to help us identify our strengths and weaknesses. You can read more about the health and Care Standards *here*. They can be summarised in the diagram.

This QSI framework will provide us with a way to check and monitor the quality of our services and to measure whether there has been improvement across all our services in primary, community, hospital and mental health services. It will support and be important to the delivery of our Integrated Medium Term Plan (IMTP) 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.

Click on this *link* to read the QSI Framework. Our progress in delivering the Framework is described throughout the chapters of this Annual Quality Statement.

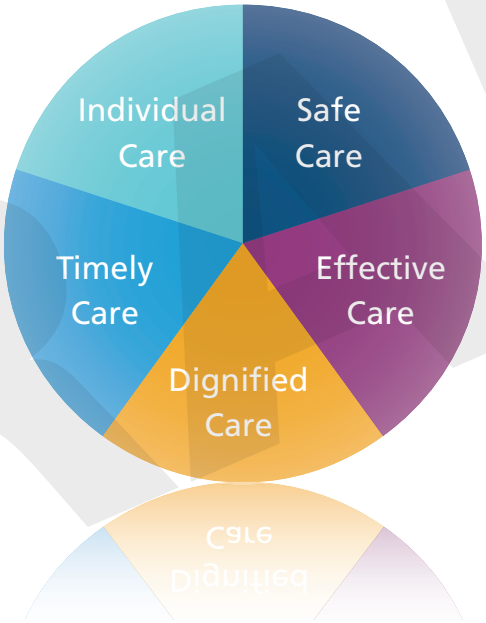
1 YEAR HOW DID IT GO?

QSI Framework update 2017-2020:

Governance, leadership and accountability

Areas where we have improved in 2017-2018:

- Our internal audit department have told us we are doing really well with our Quality Safety and Experience (QSE) groups in our Clinical Boards.
- We are writing more focused **QSE reports** to Board to ensure that there is always discussion around our QSE priorities.
- **Leading Improvement in Patient Safety (LIPS)** - over 750 people have now attended LIPS and the number of quality improvement projects is around 150.
- We have trained staff with skills in human factors to help us work with other staff to help prevent mistakes
- We have agreed a way to monitor quality and safety in services we buy from organisations outside of the UHB (we call these commissioned services)



Things we are going to focus on 2018-2019:

- A safety culture survey of UHB staff
- Embedding of a human factors training programme
- Embedding of a multi-disciplinary QSE across the UHB
- Further work on QSE in our commissioning arrangements with external organisations
- Looking at the way we report and monitor regulatory compliance to the QSE Committee e.g how we meet the requirements of the Human Tissue Act

Treating People as Individuals

The way that we provide care to people must respect their individual choices in the way that they care for themselves and must ensure that all people are treated equally. We learn from what people tell us about their experiences in our care

Moving into Adult Services

Moving from the care of a paediatric team to an adult health team can be an anxious time. To make this transition smoother, the paediatric and adult diabetic teams have developed a programme of joint clinics that are delivered over 2 years designed to ensure that the young people have an opportunity to meet all of the staff involved in their care and to ensure that important topics are discussed.

What Tom told Us

Transitioning to adult services from the paediatric team is daunting. I have spent years developing my relationships with the paediatric staff and trust their judgement completely. They have become part of my family support network. Transition has been made easier through having the adult service consultants and nurses present in our clinic visits.

What Our Youth Worker Told Us

In October 2017, a youth worker, Rebecca Soundy, joined the diabetes team to work with young people aged 11-25. The focus of my role is to work with young people through the transition from child to adult health teams and working with the young people to improve engagement with their diabetes and to support them with the other aspects of their life such as school, work or family. My role is not clinical but by working closely with both diabetes teams to provide a holistic approach then the hope is that their diabetes management will have the benefits.

QSI Framework update 2017-2020:
Individual care

Areas where we have improved in 2017-2018:

- **Patient Experience Framework** - the UHB can demonstrate achievements and activity in all four quadrants
- The UHB has maintained very good patient satisfaction scores throughout out 2017-2018 achieiving an overall score of 89%
- There has been an increased % of Concerns managed informally and a sustained improvement in the formal response times. With 72% being responded to within 30 working days.
- District Nursing Patient Satisfaction Surveys were undertaken in September and October 2017
- **Dementia care**: The National Dementia plan was published in February 2018 and a local strategy is currently being developed
- 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

Things we are going to focus on 2018-2019:

- Implementation of Year 2 of the Patient Experience Framework including:
  - ✔ Improving access for people with sensory loss
  - ✔ Identifying more young carers in schools
  - ✔ Increase the number of GP surgeries achieving Carers accreditation
- Transition from childhood to adult services
- Development of the local Dementia plan
- Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Successes and Challenges Across the Health Board

1080
formal complaints have been received

1648
Informal Complaints have been received

4,294
Surveys have been undertaken on our Touch Screen Patient Experience kiosks

We have responded to
72%
of formal concerns within 30 working days an increase of 19%

672
compliments have been received

On Average
165,040
people respond on the happy or not Kiosks

You Said
That a number of appointments for Botox clinics to treat muscular disorders had been cancelled increasing the amount of time you were waiting for treatment

We Did
We organised an additional evening clinic to teat 200 patients

85%
gave a positive response

The highest number of concerns we receive is about clinical diagnosis and treatment, waiting times and cancellation of appointments .

The Clinical Boards investigate all of these concerns to ensure that they can be properly addressed and to ensure that as a health board we learn from them and improve care as a result.

You Said
that you have difficulty in parking and this frequently makes you late for your appointments

We Did
We introduced a Park and Ride service this year to relieve some of the pressure around parking on the UHW site. The service has been used 32000 times by people who may otherwise have brought their vehicles onto the UHW sites.

The touch screen Patient Experience kiosk situated in the outpatients department was well used and gave us valuable information.

You Said
You were bored and lonely when staying in hospital

We Did
We have worked hard with our staff and our volunteers to develop activities to combat isolation.

- we have started and arts and crafts group,
- Knit and Natter group,
- provided wards with activity boxes,
- recruited befriending volunteers and
- Worked with other organisations to provide musical activities

You Said
Sometimes we don't communicate well enough about your appointments and admissions

We Did
We contacted the clinical areas on your behalf to find out as much information as possible including where possible the dates of appointments and admissions.

You Said
We needed to provide more support for Carers

We Did
We have started a project to support carers. The project is starting on seven wards across four hospital sites with a plan to extend this further.

We want to ensure that we are always identifying the carers of the patients who are staying on our wards and to ensure that we support them to continue to be actively involved in the care of their relatives if they wish to be.

We care for those who care
Rydym ni'n gofalu am y rheini sy'n gofalu

You Said
We needed to recognise our young carers

We Did
A project with our Local Authorities to work with schools to identify and support young carers

Timely Care

People should have access to services that are provided in a timely way to ensure that they are treated and cared for in the right way, at the right time, in the right place and by the right staff.

The on Call Phone Service

The diabetes out-of-hours on-call phone service is run by the Paediatric Diabetes Specialist Nurses together with the diabetes/endocrine consultants. Its purpose is to provide reassurance to patients and their families that, in the event of an out-of-hours emergency, they will be able to obtain specialist diabetes management advice. This service is of significant benefit to families as they are be able to speak to someone from their diabetes team who knows them at a time when they are anxious and worried. Families typically call if their child develops an everyday childhood illness that has affected their usual blood glucose management. Speaking to a member of the diabetes team often prevents an unnecessary admission to hospital as we offer specialist advice that keeps the child safe and at home.

What Tom told Us

The on call phone provides a clinical back up to treatment and this service has been vital in providing fast and timely advice in times of emergency. We have used the service many times to get advice when I have high ketones and blood sugars that are uncontrollable. This has prevented me from having to go to the hospital on many occasions. I have even contacted the team whilst on holiday, when the insulin pump broke down and I needed emergency advice on accurate insulin dosage through injections. Without this help I would have got very ill, very quickly

What Alys' Mum Told Us

The oncall phone service that we have access to is invaluable. I have called a few times on a weekend and spoken directly to one of the diabetes specialist nurses/doctors. Their advice and guidance has helped during a stressful time which has allowed us to care for Alys at home and saved us from taking Alys directly in to the UHW assessment unit. For example when Alys recently had a stomach bug, Dr Warner advised me over the phone how to keep Alys' blood sugar levels up and her ketones down and meant we could nurse her back to health.

QSI Framework update 2017-2020:
Timely care

Areas where we have improved in 2017-2018:

- 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 49% reduction 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 picture 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

Things we are going to focus on 2018-2019:

- Implementation of the Single Cancer Pathway
- Ambulance handover times
- Reduction in the number of 12 hour waits in the Emergency Unit
- 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

Successes and Challenges across the Health Board

785,731
Outpatient appointment attendance

105,464
People failed to attend their outpatient appointment

There were
136,469
attendance at the Emergency Unit

There were
8786
attendance in Barry Minor Injury Unit

5639
Babies Born

87,385
Inpatient Admissions

At the end of April 2018 **783** people had waited over 36 weeks from their referral to the time of their treatment. This is **32%** fewer patients than the previous year

Our aim is to reduce the number of people waiting over 36 weeks even further next year

86.5%
of our patients were referred and treated within 26 weeks in 2017 /2018.

We halved the number of patients waiting more than 8 weeks for a diagnostic test in 2017 /2018

By the end of next year we aim to have no patient waiting longer than 8 weeks for a diagnostic test

1359

Mental Health Inpatient Admissions

270

Mental Health Day Cases

Emergency Unit Pressures

This year we have seen 4444 more patients in our Emergency Unit and in Barry Minor Injuries Unit. The Emergency Unit has experienced a very challenging winter with some patients experiencing long waits and others remaining in ambulances outside the department for extended periods. Delays in transferring patients from ambulances into the department has meant delays to Welsh Ambulance Service NHS Trust (WAST) responding to emergency calls. There were occasions when it was impossible to bring patients into the emergency unit for treatment or find them a space from the waiting room due to overcrowding. The pressures have been as a result of a number of factors but include increasing numbers of attendances to the Emergency Unit, high number of flu cases and patients who have increasingly complex needs including frailty and are more unwell and a lack of capacity within the hospital to admit them.

To support the patients being cared for in the right place and by the right people two projects run jointly with WAST have been undertaken this winter.

The **Hospital Avoidance Project** has seen Physiotherapists, Emergency Nurse Practitioners (ENP) and Occupational Therapists working with paramedics to deliver care in the patient's home and where possible to avoid conveying the patients into hospital. This care has included accessing equipment for patients who had fallen, referring and discussing with the patients GP and Suturing wounds.

The **HALO project** has meant that a senior paramedic has been based in the Emergency Unit reviewing and assessing patients arriving in ambulances in conjunction with the Emergency Unit staff to ensure that they are brought into EU in order of need.

1066

people waited in the emergency unit for more than 12 hours

83.68%

of patient waited for less than 4 hours in the emergency Unit

Musculoskeletal Services

A successful project to run knee, shoulder and spine musculoskeletal services from the community is now being rolled out to the whole of Cardiff and the Vale. Patients are being assessed and treated in the community setting by a GP and physiotherapists. 70% of the referrals into this service would otherwise go into our hospital based trauma and orthopaedic clinics. Now patients have the benefit of being seen closer to home, having a shorter waiting time and our specialist Trauma and Orthopaedic appointments are available for those that need them.

Hepatitis Screening on the Salvation Army Bus

The Blood Borne Virus Team along with volunteers spent their evenings aboard the Salvation Army bus in Cardiff City Centre, where they carried out liver screenings and hepatitis tests for some of the most vulnerable people in our society. The team occupied the upper deck of the Salvation Army bus for one week to not only carry out testing, but to raise awareness of the virus amongst this vulnerable population, including how to prevent infection, and to make arrangements to deliver treatment when required. Reducing the burden of Hepatitis C is not only good for these individuals who receive treatment, but also all for

other members of society as treatment decreases demand on valuable resources, such as liver transplant, and also decreases the risk of onward transmission.

Cancer Target

We met the non urgent suspected cancer (USC) 31 day target 9 months out of 12 and were very close the remaining 3 months.

Whilst the UHB only achieved the USC 62 day target for one month in 2017/18, our performance improved in comparison to the previous year. Our performance was 88% in 2017-18, a 3% improvement on the previous year. We treated 55 more people and 84 more within target compared to the previous year

Single Point of Access for Children's Services

At present children requiring unscheduled or emergency care in hospital can come into our services through either the Paediatric Emergency Unit or through the Children's Assessment Unit. We want to ensure that all children who require urgent or emergency care receive this at the right time, in the right place and delivered by the right people. In order to achieve this, we are reviewing the way in which unscheduled care for children is currently delivered. Our aim is to improve quality of care, efficiency and patient experience by reducing the variation that exists in the current system and agreeing a standardised approach to service delivery in the future.

Endoscopy

An endoscopy is an investigation where a long thin flexible camera is used to look at the digestive tract. There are a number of reasons why a patient might have an endoscopy but it can be one of the investigations undertaken if a patient has suspected cancer. Last year we told you that out waiting times were increasing and we have seen the same thing happen this year as a result of higher number of referrals into the service. To address this problem we have outsourced some of these endoscopies to private providers as well as training some of our nursing staff to undertake these investigations.

UHL Dental Service

A new dental surgery has opened in Llandough Hospital. Patients at the Adult Mental Health Unit at Hafan Y Coed are now able to receive dental care onsite. Patients have access to a Specialist Consultant who is able to provide appropriate dental treatment to meet patient needs.

Teledermatology

A project to allow GPs to get advice from a dermatologist on the best way of treating skin conditions without having to refer the patient to an outpatient department was so successful that the system was adopted for all dermatology referrals. In the first year up to August 2017 17,000 referrals were reviewed and 5000 patients were given diagnostic management without the need to attend the clinic.

Staying Healthy

We help people to make the right decisions about their own health, behaviour and wellbeing and to access the right information to help them to have a health and active long life.

Ensuring that patients are given the right information to allow them to manage their conditions and to make healthy choices is vital. When a child or young person is diagnosed with type 1 diabetes the information that they are given and the way that they are taught about their condition is balanced and takes into consideration their age. Parents are supported to manage the health of younger children and as the child gets older they are provided with the information that they require to help them manage their own condition more independently.

What Tom told Us

The teenage clinics offer a safe and welcoming environment where I can discuss matters that are affecting me as a young person. I have been provided with access to advice on teenage issues and diabetes, such as sex and alcohol. I have also had opportunity to take part in cooking with diabetes courses, to help prepare me for living alone at university.

What Alys' Mum Told Us

Alys has been living with type 1 diabetes for over 4 years so we as parents have become experts in her diabetes management. However, UHW continue to provide training to supplement the knowledge that we have and keep us up to date on developments. For example, they rolled out an advanced carbohydrate counting class which taught us about the effect of fat and protein on insulin absorption. Keeping us up to date with new tips and tools is very useful.

SEREN is a structured education programme that breaks the subject of type 1 diabetes down into different topics. It supports the individual to build up their knowledge of diabetes as they work through the SEREN programme with the diabetes team over 6 to 8 weeks. SEREN helps by breaking down information into smaller easier chunks and helps individuals to feel able to manage type 1 diabetes in order to achieve health and happiness.

The Successes and Challenges Across the Health Board

64%

of our staff were vaccinated against flu over 10% higher than last year and exceeding this year's target

170

staff became flu vaccine champions

22

Strength and Balance Classes are running across Cardiff and the Vale

62%

of the patients on our wards who are smokers have been provided with information in relation to smoking cessation

£80

the fine issued by the Smoking Enforcement Officer for littering on health board sites

Expansion of the food and Fun programme to include children from 15 different schools in Cardiff and Vale.

Smoking and Mental Health

Smoking rates for patients with mental health conditions are typically over 80% and tailored smoking cessation programmes are required to support those people wishing to quit smoking, as nicotine dependence is often higher with greater volumes of tobacco. In January 2018 the Health Board, as part of a trial period, removed the exemption which permits mental health patients to smoke in enclosed, outside areas of the hospital. This followed a comprehensive planning and engagement process which aims to ensure fairness and equity for all smokers accessing hospital sites. This pilot programme will be monitored continually with an evaluation report produced. If successful, Cardiff and Vale UHB will be the first health board in Wales to comprehensively include mental health patients within a No Smoking Policy.

Healthy Travel

We are working in conjunction with partner organisations in Cardiff and Vale Public Services Boards to increase the number of staff across the public sector who walk or cycle to work; with transport and planning colleagues to support improvements to cycling and walking infrastructure; and with communications colleagues to support people in our area to spend less time sat in traffic jams and more time enjoying themselves and staying fit in the great outdoors.

Read the Annual Report of the Director of Public Health for Cardiff and Vale in 2017, '*Moving Forwards*'

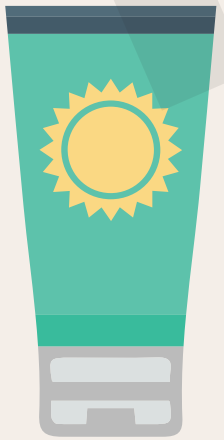
Staff Flu

All staff with patient contact are encouraged to have the flu vaccine each year, to protect themselves and their patients from serious illness. Our staff uptake has increased every year for the last five years and the 17/18 season was no exception. We further expanded our popular Flu Champion peer vaccinator programme, with over 170 staff trained to vaccinated colleagues in their clinical area; and highlighted Flu Stars across the organisation - staff who have gone over and above the call of duty to help vaccinate their peers. With uptake at 53% in 16/17, we improved this by over 10% to 64% in 17/18, exceeding a new 60% target introduced by Welsh Government. We are already planning our campaign for 18/19 and hope to improve uptake even further.

Skin Cancer

This year our dermatology team have become ambassadors with SKCIN http://www.skcin.org/ a skin Cancer charity. They are working hard to raise awareness of skin cancers such as malignant melanoma as well as supporting other health professional and people working in the beauty industry to recognise skin cancers and sign post individuals to the right place to get help. This work has included supporting the healthy schools scheme helping to promote and reinforce sun safety in school and at home.

Did you Know



1 episode of Sunburn every **2 years** will

triple

your chances of getting **skin cancer**.

Effective Care

As an organisation we work hard to ensure that people receive care and treatment that reflects best practice, which means that there is evidence that to support the care that we deliver.

What the Evidence Told Us

The National Institute for Health and Clinical Excellence (NICE) produce clinical guidance that is developed using the best available evidence. The health board have a process to review all published guidance and to consider how we can ensure that our patients are receiving excellent, evidence based care. NICE have recommended that some children and young people with type 1 diabetes who have frequent episodes of hypoglycaemia (low blood glucose) can benefit from continuous glucose monitoring rather than relying on finger prick blood tests.

What the Diabetes Team told us

Last year the Diabetes Specialist Nurses launched the virtual clinic. This allows patients to upload their insulin pump data on to a shared platform (Diasend) which the Diabetes team can also access. This has been helpful as it provides an opportunity to discuss treatment change on a regular basis (weekly if needs be) in between clinic appointments.

What Alys' Mum Told Us

Alys has been lucky to receive access to new technologies since her diagnosis. This made the process of living with type 1 diabetes much easier - it gave the flexibility for her to receive insulin more regularly throughout the day - which in turn provided Alys with more freedom. Recently Alys has trialled the Freestyle Libre and Dexcom via the UHW - these are a continuous glucose monitors which allow us as parents to test her blood glucose less often via finger prick tests which can be painful and irritating for her. Since using these technologies, Alys' health has improved year on year.

What Tom Told Us

Since being diagnosed with diabetes, the technology to help me maintain a good blood glucose levels has made huge advances. Having an insulin pump means I can take control of my diabetes. The continuous blood glucose sensor has been the main and most valuable addition, allowing me to ensure that my blood glucose levels remain with an acceptable range. I believe that this is main way I have achieved a low HBA1c.

QSI Framework update 2017-2020:
Effective care

Areas where we have improved in 2017-2018:

- **Patient Safety Solutions** – we have increased our compliance from 81% in January 2017 to 91% in March 2018. We are investing in an electronic wristband system which will achieve compliance with an historical alert that the UHB has been non-compliant with for over 10 years.
- **Mortality reviews** – we have undertaken a lot of development on our electronic system EMAT that we use to record this data. Reported incidents can now be seen at individual patient and consultant level.
- 80% of in-patient deaths have been subject to Universal Mortality Review (UMR). We still need to do better than this.

Things we are going to focus on 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 a mortality review
- Further development of EMAT to ensure that if a patient with learning disabilities dies in hospital there is automatically a more in depth review of their care.

The Successes and Challenges Across the Health Board

116

Pieces of NICE guidance were circulated within the health board for clinical areas to consider implementing

Participation in

31

national clinical audits

164

local clinical audits were registered

LEADING IMPROVEMENT LIPS IN PATIENT SAFETY

184

People completed the Leading Improvement Through Patient Safety (LIPS) course undertaking 31 quality improvement projects

95%

of our patients are seen by a Clinical Nurse Specialist – National Bowel Cancer Audit

National Clinical Audits

The health board participates in the National Clinical Audit and Outcome Review Plan. This is a programme of audits designed to measure the quality of clinical practice and to evaluate this practice against published guidelines. The findings of these audits are fully considered and improvements are put in place where necessary.

2163

of deaths that have occurred in our hospital have been reviewed to establish if a further and more detailed review is required

Breast Cancer for Older People

In 2017 the National Audit of Breast Cancer in Older People demonstrated that nationally older patients were less likely to receive surgical treatment for breast cancer and were less likely to have treatments that conserved their breast. The audit highlighted the fact that as a health board we had not developed a formal process to assess the frailty or cognition of older patients diagnosed with breast cancer, important factors when deciding on appropriate treatment.

To address these findings the breast surgery team are working with colleagues from Clinical Gerontology to develop a formal assessment to ensure that every patient receives the most appropriate and effective treatment.

Critical Care Physiotherapy

Physiotherapy is one of the main therapy services delivered in critical care units, but the role that physiotherapist plays has changed in recent years with a greater focus on early rehabilitation of patients and with physiotherapist being required to deliver care 24 hours a day. To ensure that all Physiotherapists working within the department have the appropriate skills a project was undertaken jointly with Cardiff University and Sheffield Teaching Hospital to develop a minimum standards skills framework. The project will be important in reducing variation in clinical practice by ensuring that all of our staff working in these areas have the right skills and experience.

You Can Read our Delivery Plans Here

Stroke Delivery Plan

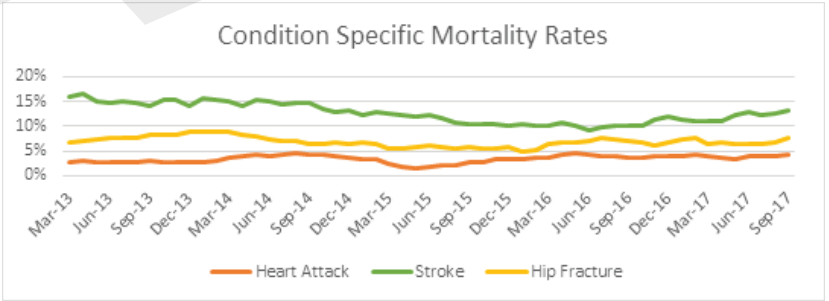
Eye Delivery Plan

Stroke Delivery Plan

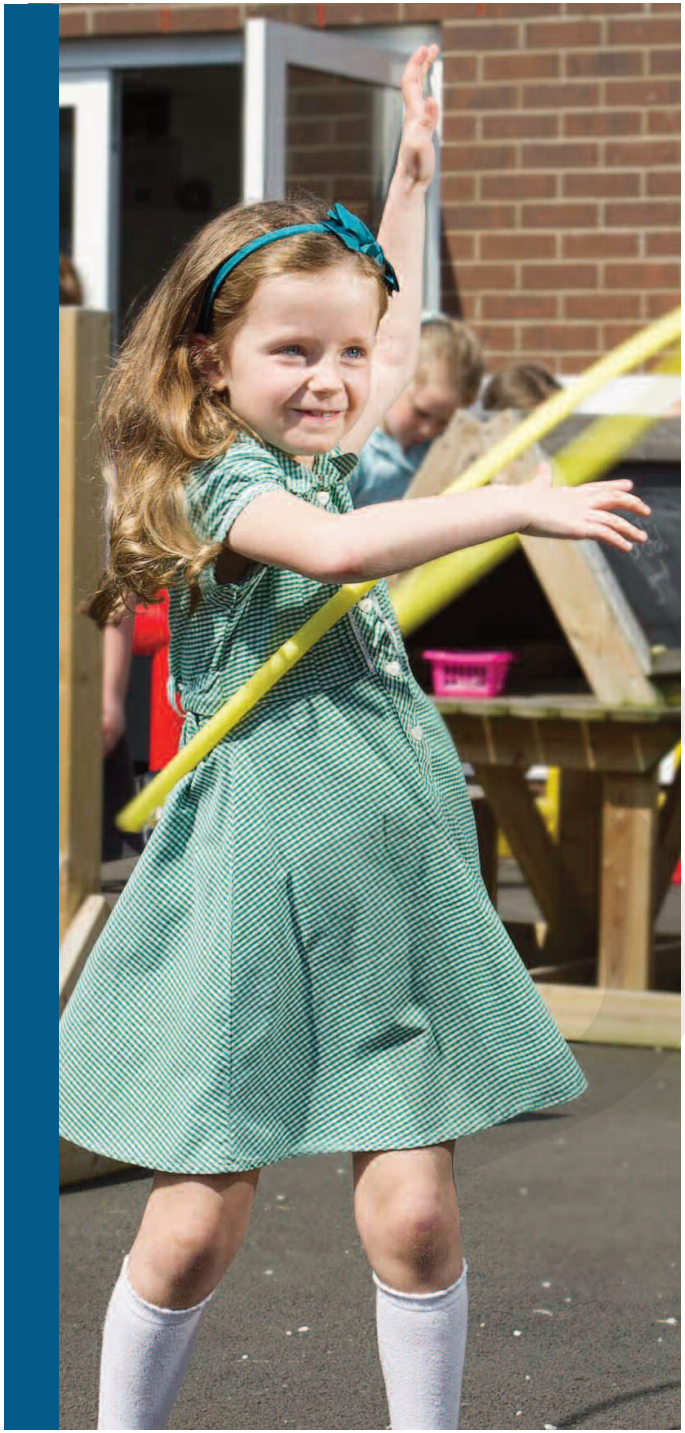
Local Oral Health Delivery Plan

Neutropenic Sepsis

A project to reduce delays in antibiotic treatment for young patients who have developed sepsis as a result of chemotherapy has won the Improving Patient Safety NHS Wales Award. Chemotherapy can mean that patients are more susceptible to infections and are more likely to develop sepsis. Sepsis is the second most common reason of hospital admissions among children and young people with cancer. Patients who come into hospital should have antibiotics within 1 hour of arriving in hospital but an audit demonstrated that this target was only met 27.3% of the time. A project undertaken in the Teenage and Young Adult Cancer Service supports specially trained nurses to give the antibiotics to patients age 14 and over who have had anticancer treatment in the last 4 weeks who develop Sepsis . The project has been a great success and 87% of the patients seen by the nurses received their antibiotics within 1 hour.



We are pleased to see a general improvement in Stroke mortality rates. Our mortality for hip fracture has fallen from its peak of 8.9%. We have not seen the same improvement in heart attack, which we need to further examine. This remains unchanged.



Safe Care

We are continually looking for ways to be more reliable and to improve the quality and safety of the services that we deliver. There are occasions when we don't do things as well as we could, when this happens we always try to understand what went wrong and make sure that we learn from this and improve the care that we deliver as a result.

What Alys' Mum Told Us

Alys was admitted to the UHW assessment unit a year ago with very low blood glucose levels and high ketones as a result of a stomach bug. Because Alys blood glucose was low and she could not stomach any food or drink to raise her levels, we were advised to stop her insulin pump. Whilst this resulted in her blood glucose levels rising, it also meant that her ketone levels rose dangerously high and resulted in Alys becoming poorly very quickly. In hindsight, the insulin shouldn't have been stopped but this was quickly addressed with the arrival of the Diabetes consultant.

What our Diabetic Team told us

We quickly established that some staff lacked confidence in the use of insulin pump therapy. Shortly after we became aware of this we took the opportunity, to support junior paediatric medical staff to present the case to their colleagues at an educational meeting and run a practical diabetes workshop specifically addressing insulin pump therapy, carbohydrate counting and hypoglycaemia management.

What our Clinicians Told us

The insulin pump training session was very useful, as this is a piece of medical equipment that I have very limited experience in using and operating. The session explained to me how the pumps work and how to troubleshoot problems I may encounter with them. It also highlighted to me that patients and parents are very familiar with how their pumps operate and can be a valuable source of information when they are admitted to hospital. I feel more able to care for a patient with an insulin pump following the training session.

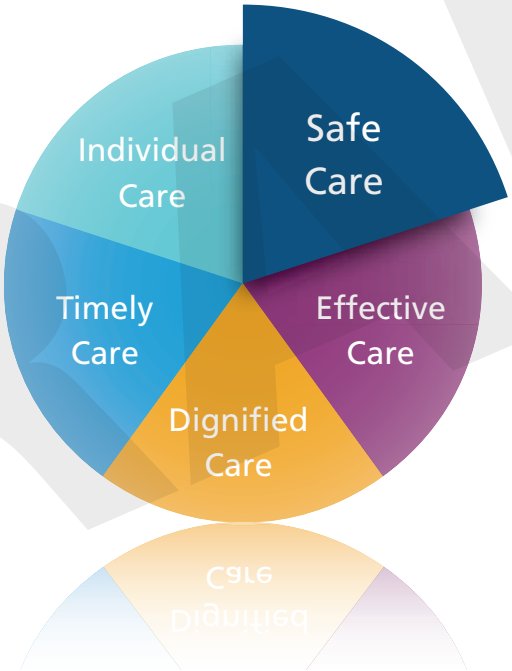
QSI Framework update 2017-2020:
Safe Care

Areas where we have improved in 2017-2018:

Same cause serious incidents - there has been a reduction in the number of reported serious incidents from 238 to 232 in the previous year. Also the number of incidents of:

- self-harming behaviour (suicide, serious self-harm, drug and alcohol related deaths) has reduced from 35 in to 23
- serious falls has fallen from 74 to 48
- serious medication errors has reduced from 7 to 3
- unnecessary exposure to radiation has reduced from 10 in to 4
- never events has reduced from 7 to 4 and overall there has been a reduction in the number of same cause never events, particularly in relation to retained swabs. The number of never events related to dental extraction remains the same.

Pressure damage: we have improved reporting and have a very good Pressure Ulcer group.



Things we are going to focus on 2018-2019:

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

The Successes and Challenges Across the Health Board

15,429

patient safety incidents were reported by staff. We actively encourage staff to report issues. It is important that we encourage an open and safe reporting culture

14,118

of these incidents caused no harm or minor harm to the patients

232

were thought to be significant enough that we should report them to Welsh Government

32

of incidents reported to Welsh Government were as a result of injuries suffered after falling in hospital.

74

of incidents reported to Welsh Government were Pressure Damage related

23 of incidents reported to Welsh Government were incidents of self-harming behaviour. These are mainly patients known to Mental Health Services who come to harm in the community.

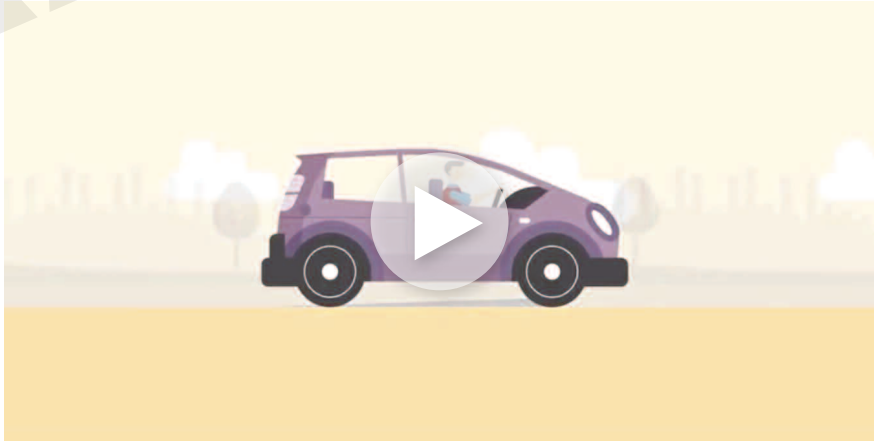
Patient Falls

This year our Falls Lead has started in post, he will be working with colleagues across the health board to reduce avoidable patient falls.

We are actively engaged in ageing well in Wales and the Steady On… Stay Safe awareness campaign to help people be more aware of how they can best take care of themselves, their friends and family, and reduce the number of falls suffered by older people. We have also developed and published a video explaining the simple steps all of us can take to "keep our tank topped up" and reduce our risk of falling.

Never Event

A never event is a serious and largely preventable patient safety incident. Last year we told you that we had reported a wrong tooth extraction as a never event. This year we have seen further similar incidents. To help us to understand where we can improve our care we will be reviewing work undertaken in England around standardising the process.



What We are Doing to Reduce Infections

- Our IP&C teams undertake regular audits and focus on areas where there has been increased incidence of infection
- We undertake monthly hand hygiene audits which are reported at the Executive Performance Reviews
- 100% of clinical areas had Aprons, gloves and masks available when audited

Health Board position in Wales	
MRSA / MSSA 59 cases over target	3rd
Clostridium difficle target met	2nd
E coli 56 cases over target	1st

Pressure Damage

All grade 3 and 4 pressure ulcers are investigated by Clinical Boards using an All Wales investigation tool and the lessons learnt are shared in the Quality safety and Experience sub committees.

92.4% of patients who needed assistance to look after their skin had evidence of an up to date plan of care which was being implemented and evaluated and which had been reviewed within the appropriate timescale.

We have revised the health board Pressure Ulcer Risk Assessment, prevention and Treatment Procedure

Welsh Health Specialised Services Committee (WHSSC)

Specialised services support people with a range of rare and complex conditions. They are not available in every local hospital because they have to be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience. Unlike most healthcare, which is planned and arranged locally, specialised services are planned nationally by Welsh Health Specialised Services (WHSSC) on behalf of the seven Health Boards in Wales. WHSSC works closely with the Health Boards to ensure that any specialised service commissioned is of a high standard and that there are no concerns identified from a quality perspective. They do this on our behalf through a quality assurance frame work which is monitored by their Quality and Patient Safety Committee and reported into the Health Board.

Inspections

In 2017 /18 Healthcare Inspectorate Wales (HIW) undertook a number of Inspections within the health board to give assurance about the standards of care that we are providing.

These included:

- 4 General Practice Inspections
- 18 Dental Inspections
- 4 Hospital Inspections
- 3 Thematic Reviews

The Unannounced hospital inspections were largely positive, finding services safe and effective. Recommendations made by HIW included

- ✔ Information for patients and visitors to be clearly displayed
- ✔ The appropriate information was displayed and is checked monthly
- ✔ There was poor compliance with the no smoking policy outside Hafan y Coed
- ✔ A No Smoking and Waste Enforcement Officer was present on UHL site from 21st May 2018
- ✔ The health board had to ensure that children who needed emergency surgery received care in a timely manner
- ✔ An emergency surgical list operates twice a week in children's theatre and options are being considered to extend this further

Dignified Care

Our patients should expect to be treated with dignity and respect. This means that the care that we provide must take into account every person's needs, abilities and wishes

Providing dignified care for children diagnosed with type 1 diabetes means that we have to ensure that they are able to fully participate in and benefit from all of the activities that children of their age enjoy.

What the School Educator told us

Living with a medical condition like type 1 diabetes can have a great impact on a child's health as well as their educational achievement if they do not have access to the right help and support at school. Children spend much of their time at school, so it is very important that their health needs are met during school time. I assist school staff to feel empowered to promote an environment that allows pupils to develop, grow and flourish in their school life despite the daily challenges of living with diabetes, which is complex to manage and requires considerable dedication to treatment if health complications are to be avoided.

The education sessions I provide are designed to meet the individual needs of the pupil and the school. Some sessions are delivered to large groups of staff to help staff recognise a diabetes emergency and understand what action to take. Other sessions involve small groups of staff who have volunteered to help a pupil with their daily blood glucose monitoring and administering insulin.

Many schools offer residential trips and if a pupil with diabetes wants to participate I will meet with the staff attending the trip and provide the necessary education regarding how to:

- help with carbohydrate counting and insulin administration at meal times
- how to safely support increased activity levels
- how to recognise a life-threatening diabetes emergency (severe low blood glucose levels or high blood ketone levels).

What Alys' School Told Us

Alys developed diabetes before she came to the school. We contacted the diabetes nurse and had our first training in 2015. Since then we try to train new staff every year. The School Educator leads the

training and she is very patient as she delivers it clearly and slowly. All the teachers and Learning Support Assistants have different anxieties about administrating the insulin but the school educator and mum go through all the questions and worries with each member of staff until they feel more secure. We arrange these meetings every year and the School Educator is always easy to get hold of and very accommodating. If ever we need more training or anything else we know she is only a phone call away.

What Alys' mum told us

The training provided by the school educator means that Alys can be included in all school activities, such as gym classes and school trips, with the knowledge that the staff have been trained to manage her daily needs as well as any acute complications such as low blood glucose levels.

This service has given us, as parents more confidence in our daughter's diabetes management and it has also led to an improvement In her health

Members of the paediatric diabetes team were instrumental in assisting Diabetes UK Cymru to lead a group of health and children's organisations to ensure the new Additional Learning Needs and Educational Tribunal (Wales) Act (known as the ALN Act) specifically mentions children with medical conditions such as Type 1 diabetes. Dai Williams, National Director, Diabetes UK Cymru, said, "The ALN Act is vital new legislation which will make a difference to thousands of families across Wales. It will give children and young people with medical conditions like Type 1 diabetes support they have never had before. It is very encouraging to see some schools already adopting the new framework, and we hope many more do so in the near future. Diabetes UK Cymru would like to thank the paediatric diabetes team at Cardiff & Vale University Health Board for its help in making this change happen. Your support will make a real difference to children with medical conditions like Type 1 diabetes, now and for future generations, ensuring they are no longer left behind."

Diabetes UK Cymru

QSI Framework update 2017-2020:

Dignified care

Areas where we have improved in 2017-2018:

- **Mouth care** –there has been a trial of the current assessment documentation and an action plan has been put in place.
- **Patients with learning disabilities** - The 1000+ lives guidance for improving general hospital care for people with Learning Disabilities has been rolled out.
- **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.
- **Continence care** – we responded fully to the Older People's Commissioner in relation to continence care and we have agreed a pathway for the use of appropriate continence aids.
- **Quality of sleep** – we have approved and are monitoring an action plan to promote better sleep.

Things we are going to focus on 2018-2019:

- **Our Sensory Loss Plan**
  We will progress the All Wales Standards for Accessible Communication and Information for People with Hearing Loss Action Plan
- **Exploring the experience s of our service users with Learning Disabilities**
  we will be undertaking patient experience surveys with patients with Learning Disabilities being cared for by us.
- **End of Life Care**
  we are recruiting 2 Macmillan Advance Care Plan Facilitators to support patients

The Successes and Challenges Across the Health Board

We have undertaken

4768

face to face continence assessments

87.02%

of patients told us that they felt that they always had their hygiene needs met.

We have completed

122

unannounced internal inspections of our wards and clinical areas.

78.27%

of our patient told us that if they needed help to use the toilet we responded quickly and discreetly

92.42% of our patients agreed that nursing staff were involved in the mealtime services. But...

67.8% of our patients have told us that they have their water jug changed three times a day. We need to do this for all our patients.

Feedback from our patients confirms that they gave an overall satisfaction rate of

86.5%

when asked about whether we provide dignified care.

Model Ward

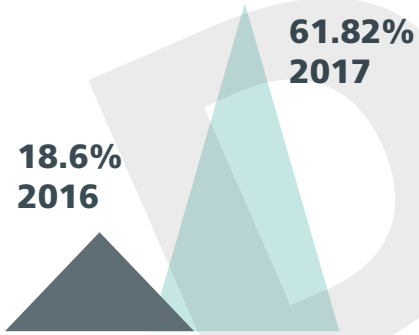
Between May and July 2017 two wards ran a project to improve the nutrition and hydration of the patients. In 2011 it was recognised that 45% of patients being admitted to hospital in Cardiff and Vale were malnourished compared with 25% nationally. Malnourishment can lead to poor outcomes for patients including increasing the risk of pressure ulcers, developing kidney problems and an increased risk of falls. To ensure that patients on the participating wards received the best possible nutrition the menu choices were increased and patients were able to see images of what they were choosing on an ipad. Wherever possible, patients ate together in the dayroom with plenty of staff available to help where necessary. The numbers of snacks and drinks between meals was increased. Patients were overwhelmingly positive about the project and it was noted that they required less nutritional supplements, less laxatives and enemas and a decreased use of Intravenous fluids. Funding has been agreed to extend this project to four more wards to allow us to study the benefits in greater detail.

Volunteers on A7

Volunteers used on A7 in the dementia room roll out, the ward receptionist who has an interest in dementia has secured funding to set up a dementia room with activities special lighting etc to benefit dementia patients, it has been such a success that additional funding has been secured to set up dementia boxes to loan to other wards across UHB.

Success for Younger Onset dementia Service

The Younger onset Dementia Services has been awarded the Innovation in Mental Health Award at the Health Service Journal Awards. The service works closely with patients who receive a diagnosis of dementia before they are 65 years old. Young people with dementia often have different needs , they might still be in work when they are diagnosed or have younger children living at home with them. The service work closely with both the patients and their families to connect them with the support that they need.



We want all of our staff including porters, doctors, receptionists and nurses to be confident in providing excellent care to patients who have dementia. In November 2017 over **60%** of our staff had received training in dementia a huge increase from the previous year

Caring for Patients with a Learning Disability

We have introduced a risk assessment, pain assessment tool and National Early Warning score chart to be used when we care for patient who have a learning disability. The tools ensure that this group of patients have access to the same investigations and assessments as the rest of the population but recognises that the assessments might need to be delivered differently in order to get the same outcomes.

Read about me' person-centred toolkit

The 'Read about Me' person-centred toolkit for people with a cognitive impairment or dementia was launched in October 2017. The toolkit includes information including the patient's likes and dislikes, personal interests and family details. This allows staff to be able to have a better understanding of the patient and the things that are important to them. Patients can take the 'Read About Me' with them wherever their journey takes them: e.g. theatre, x-ray and any other departments they might visit during their inpatient stay or also within the community so that anyone who cares for them can ensure that they can provide patient centred care

Exercise clubs

Physiotherapists and ward staff at Llandough Hospital have been working with elderly inpatients to prevent de-conditioning by holding regular exercise classes followed by lunch clubs. Deconditioning is the physiological change to the body, such as wasting of the muscles, developed through prolonged bed rest.

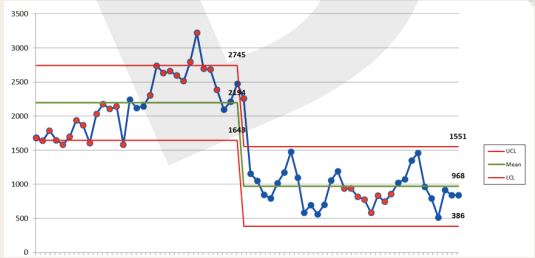
In a group led by physiotherapists, up to 8 patients participate with simple exercises and ball games to increase their activity levels whilst in hospital. The classes run 2-3 times a week on several of the medical wards at Llandough Hospital. The staff experience of the exercise clubs has been positive, and patients have reported feeling the benefits of attending the class. The exercise classes increase patient appetite, so it helps that the classes are followed by lunch clubs. The sequence of the classes ensure patients are already up and mobile to eat lunch in a group together in the day room, rather than in their beds in isolation. They not only promote movement, but also socialising with other patients which further provides peer support for

eating meals. For cognitively impaired patients, the social aspect and verbal encouragement from peers can be even more important.

Enhanced Supervision

Some patients on our wards require additional supervision due to behavioural disturbances that could cause them to fall. Providing additional supervision on a 1 to 1 basis can be restrictive for patients and is also requires additional staff to be available. An enhanced supervision framework has been developed to ensure that patients receive the appropriate level of supervision and are supported towards a more active recovery with more therapeutic activities and stimulation being provided. Since the development of the framework the use of bank and agency staff within the Medicine Clinical Board has reduced by over 50% and has led to improvements in the quality of care experienced by patients.

Temporary Staffing Hours per Week



September 2106 – January 2018

Sensory Loss

Loop systems and Sonidos have been installed in all clinical areas throughout the Dental Hospital and the Community dental clinics to benefit patients who have hearing loss when they are attending these services.

Pagers giving visual and vibration alerts are being used to inform patients with sensory loss when they are being called for their outpatient appointments.

Get up Get Dressed Get Moving

Once admitted to hospital, many patients resign themselves to simply staying in bed, in their pyjamas, for the duration of their stay. However, research shows that bed rest is not a good way to recover from many illnesses or injuries and mat actually increase recovery times. Staying in bed can and not moving can actually contribute to a number of other problems. That's why we are running a campaign get up Get Dressed Get Moving, to help people keep patient active and independent in hospital. It is conjunction with the nationwide #EndPJparalysis challenge.

The messages are:

- get up - stay out of bed in the daytime, as you would at home.
- get dressed - change from your pyjamas into your clothes in the daytime as you would at home.
- get moving - at least every hour. When sitting, move your arms and legs regularly.
- use it (your muscle strength) or lose it.
- get home well.

Many of our staff are supporting the scheme on social media by sporting their pyjamas

#endPJparalysis

Our Staff and Volunteers

All of our staff and volunteers help us to ensure that we provide a high quality and safe service.

Diagnosing Type 1 Diabetes

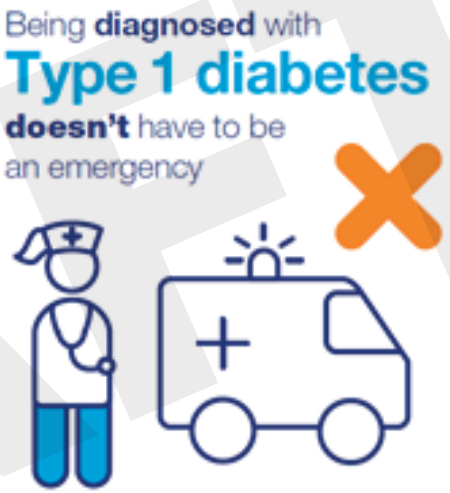
Avoiding an emergency situation at the diagnosis of type 1 diabetes helps make the start of a family's journey with their diabetes far calmer. Diagnosis is invariably a very emotional time for parents and the children as the enormity of the diagnosis starts to sink in. If a child can be 'well' at diagnosis opposed to being 'sick' the diabetes team can swiftly focus on providing the support needed to deal with all the practical elements of managing diabetes (blood glucose monitoring and insulin administration) as well as starting the SEREN structured education programme that covers everything families need to know including 'what is diabetes', 'hypoglycaemia', 'carbohydrate counting', 'illness and diabetes' and 'coping with diabetes'.

Children can't be prevented from developing type 1 diabetes, but with greater awareness of the signs and symptoms of type 1, children can be prevented from becoming critically unwell with DKA at diagnosis. An early diagnosis prevents the emotional trauma of a medical emergency and promotes the smooth delivery of the support and education families need from the diabetes team.

Providing excellent care to our patients always requires us to work together and to collaborate to ensure that we achieve the best possible outcomes. Our paediatric diabetes team have worked closely with colleagues from secondary care or hospital based services and primary care or community health services, the Royal College of General Practitioners and The Children's and Young People's Wales Diabetes Network to develop a pathway that ensures that children presenting with type 1 diabetes for the first time are assessed and treated quickly and effectively.

What our Paediatricians told us

Work between primary Care (General Practice and community services) and hospital services is being undertaken to ensure that Children with type 1 Diabetes are diagnosed swiftly reducing the risk of life threatening complications. A referral pathway ensures that the first health professional to see a young person who has suspected type 1 diabetes knows what signs to look out for and what tests to undertake and immediately refers the child to the Children's Assessment Unit. When a GP Referral has been made, the Diabetes Specialist team write to the GP to commend good practice and also to highlight how things might have been improved.



The Successes and Challenges Across the Health Board

3182
Staff trained in Safeguarding Children

7396
Staff trained in the Mental Capacity Act

345
Staff nominated for staff recognition Awards

2390
Staff trained in infection prevention and Control

9.33%
staff turnover rate

We have a
5.73%
vacancy rate

72.04%
Staff had completed their mandatory training

57.19%
of our staff had an annual Performance and Development Review

We have over
600
volunteers working with us to make improve the experience of our patients.

There are over
30
different roles undertaken by volunteers within the health board

Wales for Africa

Our health board has a multi-disciplinary group which oversees and supports our partnership working. A number of health board staff, and associated colleagues in Cardiff University, are also involved with charities that support work in Africa. Our partnerships include Mothers of Africa, Life for African Mothers, Penarth and District Lesotho Trust and the Welsh Government's International Learning Opportunities Programme.

Through their work initiatives of sharing skills, establishing positive collaborative working relationships with local communities and supporting education and health, these charities in Wales are helping to build strong communities in Africa. This work demonstrates the UHB's commitment to making a positive contribution to global wellbeing.

SRA

STAFF RECOGNITION AWARDS

Staff Recognition Award

345 nominations were received across 16 categories and over 400 staff members were invited to attend the evening.

This year we introduced two new categories, the first was the 'Acting Today for a Better Tomorrow' award which focuses on our work with the Well-being of Future Generations Act 2015. The second was the 'Living Our Values' award which will highlights the work which has taken place around the UHB Values and Behaviours framework.

Recruitment

To improve the recruitment of nursing staff

- The health board has been represented at national recruitment events
- Individuals who have been out of nursing for some time are being supported to undertake return to practice training
- A number of health Care support Workers have been accepted on the Nurse Adaptation Programme
- We are reaching out to wider numbers of nurses through social media

A Poem Written about the staff on Ward 7 in Rookwood hospital by one of their patients

Superheroes

Today I'd like to talk
About Superheroes, not the type
You see in magazines,
Or that wear capes.

The type that work in hospitals.
Give up their time, not just
To save people's lives and nurse
Them back to health.

They also keep patients company
And are a friend to them,
Even just a smile can make
A lonely patient's day.

I've been fortunate enough to
Have the pleasure of having
The company of these superheroes.
They really have changed my life.

I wish I could return the
Good they have kindly gave
To me for four months of my
Short sixteen years of life.

Working with students

We are working with universities and colleges across Cardiff and Vale to recruit student volunteers into befriending and activity roles across the health board

Our Inclusive Workforce

During LGBT History Month, people from the Lesbian Gay Bisexual & Trans (LGBT+) LGBT community have been asked to share their history, their lives and their experiences. One of our colleagues has provided an insightful look at how life has changed over the past few decades.
I grew up in an environment where being gay was taboo, there was still quite a bit of homophobia around. Jokes about gay people were pretty commonplace, and even those who may have seemed quite accepting would pass it off as "just a bit of banter".

By the time I was in my late 20s I'd developed the art of gender neutral conversations. This only changed when I met an NHS senior manager who was both successful and out. This was a combination I didn't think possible. The realisation that I could be out, and just be me, able to mention my partner by name occasionally, or use the pronoun 'she' and not 'they', was life changing.

Flying the Rainbow Flag, and wearing Rainbow lanyards reflect acceptance and support for the LGBT+ community. This is important for our patients as well as our colleagues. Those who are feeling vulnerable need to know that the people important to them are recognised too.

RCM Awards

For the second year in a row a Cardiff and Vale midwife has won the Royal College of Midwife Emma's Diary Mum's Midwife of the Year Award. Sarah was nominated for the prestigious award by Elouise, after seven failed attempts at IVF, Elouise and her husband Paul finally found an amazing friend, Jen, willing to be a surrogate. Thankfully Jen fell pregnant and went on to deliver beautiful twin boys, Jude and Joshua in June 2017.

With Elouise and Paul living in Birmingham and Jen and her family living in Barry, Wales, it meant every scan, every midwife appointment and every visit to fetal medicine was miles away, reinforcing the physical separation and administrative hurdles to overcome. Elouise was also understandably anxious about how surrogacy would impact their treatment and the care afforded to their surrogate. Whether they would feel like "parents", be treated like "parents" and how the hospital would accommodate their family. They needn't have worried, as their midwife, Sarah, put their minds at ease instantly, spending time with them to understand their relationship, their needs, their fears and their expectations. She kept in touch for months via email and met them twice prior to delivery, even giving them a tour of the hospital

Corporate Health Standard

The UHB has been successfully revalidated for both the Gold and Platinum Corporate Health Standard (CHS), the national quality mark for health and wellbeing. The CHS assessors highlighted a number of our key strengths, including:

- **Union involvement** - they described full collaboration and partnership working to an extent they have never seen elsewhere. They felt the unions had full ownership of the agenda and were engaged with the health board in every aspect of health and wellbeing. Midwifery's engagement with the RCN's work on health and wellbeing was highlighted, as was the Unions' lead on developing the work on menopause.

- **Passion, enthusiasm and buy-in** - they recognised that the Health and Wellbeing Advisory Group set the vision and then Clinical Boards and corporate departments take ownership for innovative delivery locally, choosing what they do and how they do it. They heard some fantastic stories of engagement and health and wellbeing initiatives from across several sites. Staff even sought the assessors out to share stories and experiences over the two days.

- **Catering** - singled out due to their recent huge developments. The assessors were extremely impressed with the thought that has gone in to all aspects of catering provision.

- **UHL** - the assessor who attended UHL was incredibly impressed with the extent to which the health and wellbeing of staff had been integrated into the design of Hafan y Coed, the HeARTh Gallery and The Orchard.

The Platinum Standard focuses more on our corporate social responsibility activity including strong partnership working with local and national partners, improved use of volunteers and community engagement including the work on Smoke Free Playgrounds and Smoke Free School Gates.

Areas for future development include becoming better at sharing our achievements within and beyond the UHB, targeting staff groups we may have failed to reach in the past to ensure they are empowered and have access to opportunities, medical engagement, and mental wellbeing.

Living Our Values

The UHB always strives to put patients first. During 2017, a project called Values into Action listened to staff to find out what it's like to work for the UHB and how to improve things, and to hear from patients and families about their experiences in our care. We identified values from these conversations and have developed a set of behaviours to accompany them. We are now using these values and associated behaviours within all of our staffing processes including recruitment, induction and appraisals to ensure that we all demonstrate the commitment to live our values every day.

We want to create an environment where our four values reflect the behaviours we want to see from one another, and inspire us to keep improving our patient and staff experience. We have begun to put boards up around the site to remind us about those behaviours and the leaders across the organisation have been given tools to support them.

Our Chief Exec and Executive Team have committed to our pledge "…to be kind and caring in my dealings with others and look after their wellbeing, to treat everyone with respect, to conduct myself with integrity, trusting others and learning from mistakes, and to take personal responsibility for my actions at all times."

Looking forward

The health board has sought out best practice from other organisations, including Canterbury District Health in New Zealand which has delivered a shift in models of care towards more community based services. The Canterbury journey has taken nearly ten years and is an organisation similar in nature and demographics to the UHB. A visit took place in December 2017 and highlighted several key learning points which have been used to inform the development of Transformation within the UHB.

The four key aims of the Transformation Programme are agreed as follows:-

1. To reduce outpatient appointments on hospital sites;
2. Reduce length of stay ;
3. Reduce harm, waste and variation;
4. To improve the productivity of our theatres.

The Programme will also focus upon the following seven approaches:-

1. Delivering care in a consistent way
2. Ensuring that staff are able to access all of the information they require to deliver excellent care
3. Ensuring that we have the right information technology to provide excellent care
4. Working with other organisations;
5. Supporting culture change and build capability and capacity;
6. Having a sustainable community health system that delivers the right outcomes for the population
7. Embedding our vision , values and behaviours.

Our aspiration is that the aims will support the delivery of our Shaping Our Future Wellbeing Strategy. We will also be working with partners such as Cardiff and the Vale of Glamorgan Councils to ensure that our approach is cohesive and aligned to our population needs. In particular, we are working together to implement the recommendations of the Parliamentary Review on Health and Social Care.

How are we doing? – help us hear your voice

Your feedback is very important to us because as a Health Board we want to give you the best possible care and treatment. We want to ensure you are treated in clean, safe surroundings and that help is always there when you need it. There are different ways in which you can provide feedback;

- By completing paper surveys
- On the website via the QR code or *www.cardiffandvaleuhb.wales.nhs.uk*
- By joining a patient group
- By undertaking a patient /carer story
- By talking to our Concerns, Compliments and Complaints Department 029 20744095
- Completing a 'how are we doing feedback card'

For more Information please contact the Patient Experience Team on; 029 20745692.

The Cardiff and Vale of Glamorgan Community Health Council provides an independent advocacy service to people aged 18 years or over, and will provide you with independent support with your complaint. You can get further detail on their *website* or ring their office on 02920 377407

ANNUAL CLINICAL AUDIT PLAN
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 12th June 2018

Executive Lead : Medical Director
Author : Patient Safety and Quality Assurance Manager (Alexandra.scott2@wales.nhs.uk 029 20744018)
Caring for People, Keeping People Well : The Clinical Audit plan underpins the quality and safety services that deliver the improvements in population health that our citizens are entitled to expect
Financial impact : There are no financial implications associated with the actions currently being taken as identified within this report.
Quality, Safety, Patient Experience impact : Clinical audit seeks to improve patient care and outcomes through systematic review of care against explicit criteria. A prudent clinical audit programme requires a focused and directed approach to address clinical priorities.
Health and Care Standard Number 3.1 Safe and Clinically Effective Care
CRAF Reference Number 5.1 Deliver Safe Effective and Efficient Care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The development of a local Clinical Audit Plan based on Tier1,Tier2 and Tier 3 priorities

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Clinical Audit Plan

SITUATION

The purpose of this paper is to present the UHB 2018 / 2019 Clinical Audit Plan.

BACKGROUND

The National Institute for Health and Clinical Excellence 2002, defines clinical audit as: "A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change."

ASSESSMENT AND ASSURANCE

The NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) is developed annually by Welsh Government and confirms the list of National Audits and Outcome Reviews which all health boards and trusts are expected to participate in. In addition there are a significant number of national clinical audits administered by national professional bodies that are not included within the NCAORP but that provide valuable assurance around the quality of care provision.

The National Clinical Audits are an integral part of the quality improvement process and are embedded within the Welsh Health and Care Standards. The requirement to participate and learn from the audits is a central component of the Delivery Plans developed for NHS Wales.

A formal assurance process is in place for all audits included within the NCAORP. The results of audits should be used as part of the Clinical Board assurance arrangements, however full assurance can only be obtained if the requisite improvements are implemented.

Local clinical audit functions best as part of a planned programme of quality improvement activity. The development of a clinical audit plan should be informed by local quality and safety priorities and should meet the priorities of each Clinical Board. Clinical Boards should have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. When deciding on clinical audit activity consideration should be given to recent:

- Serious Incident / Never Events
- Patient Safety themes
- Patient outcomes
- Release of new or revised best practice guidance.

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In February 2018 the committee agreed an approach to categorise clinical audits into three tiers, to support a prudent and targeted approach (appendix 1).

- **Tier 1** National clinical audit.

- **Tier 2** Local clinical audit undertaken to address the patient safety and quality agenda,

- **Tier 3** Local clinical undertaken for any other reason including revalidation and CPD purposes.

Tier 1 audits should take priority and Clinical Audit Leads, Directorates and Clinical Boards should prioritise the data collection, reporting and development of requisite improvements around these audits before agreeing the allocation of any resource to Tier 2 or Tier 3 audits.

Tier 2 audits should be developed to give assurance around patient safety issues that have been identified as a result of Serious Incidents, Regulation 28 and patient

safety incident themes etc or to give assurance that care delivery is in line with recently published or updated best practice guidance.

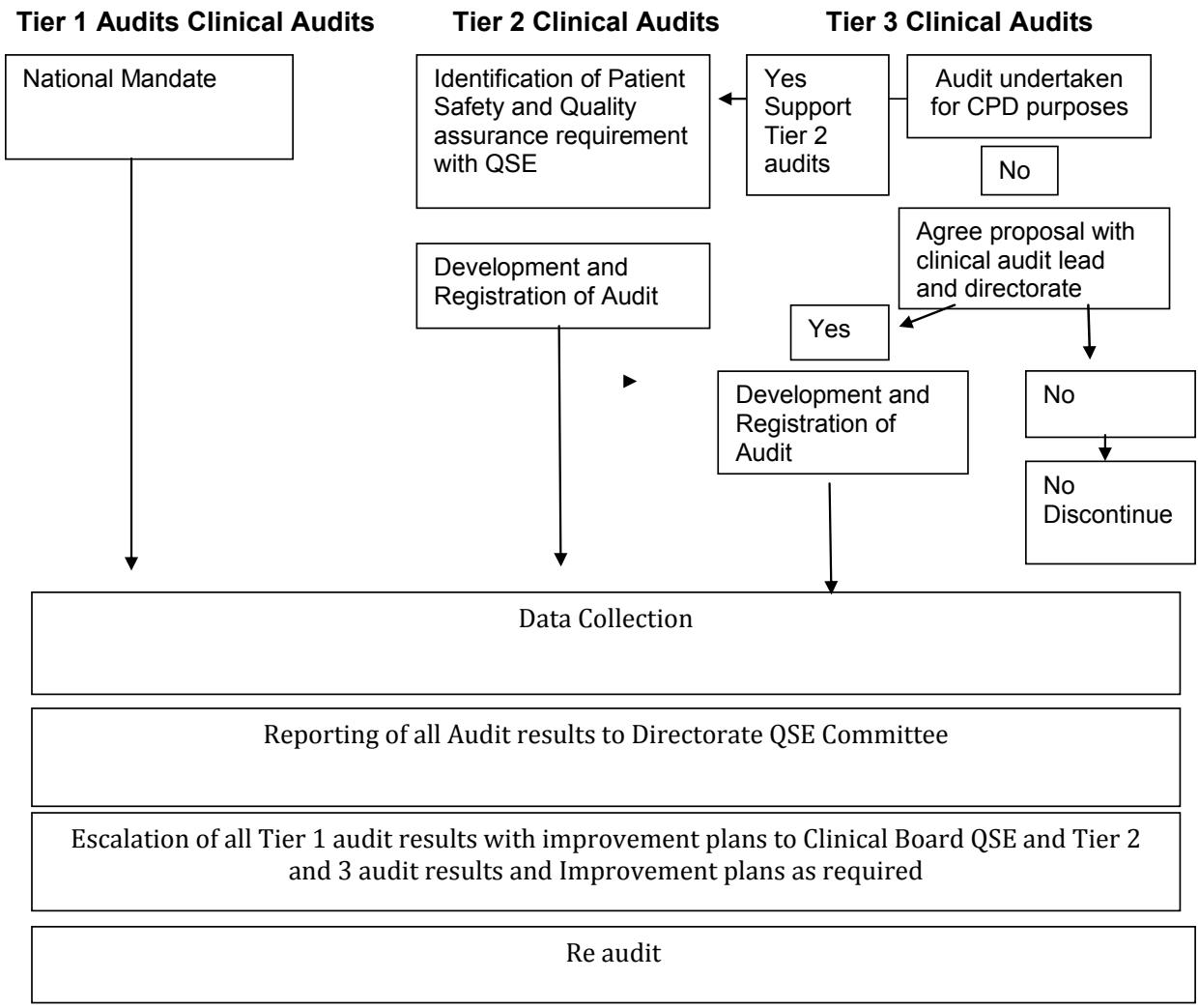
Tier 3 audit proposals should be scrutinised by the Clinical Audit Lead and the Clinical Director to ensure they are prudent and offer a benefit to the Directorate and Clinical Board.

Clinical Audit Leads have developed a 2018 /19 Clinical Audit Plan incorporating all Tier 1 and anticipated Tier 2 audits (Appendix 2). There is not an expectation that Tier 3 audits will be included in the clinical audit plans, however the requirement to register and have approved all audits and to report and escalate the results remains imperative.

Progress against the 2018/19 Clinical Audit Plan will be reported to the committee In June 2019.

(Appendix 1)

Clinical Audit Process



Appendix 2 - Cardiff and Vale University Health Board - Local Clinical Audit Plan 2018-2019

Clinical Board	Directorate	Tier	Audit Title	Audit Lead	Anticipated Completion
Corporate	All Inpatient areas	1	National Audit of Inpatient Falls	Karl Davis	TBC
Corporate	All Inpatient Areas excluding Mental healt	1	National Dementia Audit	Swapna fernandez	Aug-18
Corporate	All Inpatient Areas	2	Audit of Falls Risk Assessments	Oliver Williams	Feb-19
Corporate	UHB wide	2	Audit of risk assessment fro Women of child bearing age prescribed Valproate	Mathew McCarthy	Feb-19
Corporate	All Inpatient Areas	2	DNACPR audit	Resus team	Nov-18
Corporate	All Inpatient areas	2	Audit of Mental Capacity Assessment	Julia Barrell	Feb-18
Children and Women	Acute Child health	1	National Neonatal Audit project (NNAP via Badgernet)	Alok Sharma	annual
Children and Women	Acute Child health	1	MBRRACE-UK perinatal mortality reporting (and contribution to Each baby Counts via maternity)	Alok Sharma	annual

Children and Women	Acute Child health	1	Vermont-Oxford Network- benchmarking	Alok Sharma	annual
Children and Women	Acute Child health	2	All Wales neonatal network: Neonatal Sepsis calculator	Amar Asokkumar	Dec-18
Children and Women	Acute Child health	2	All Wales neonatal network: management of RDS	Mallinath Chakraborty	Dec-18
Children and Women	Acute Child health	1	Paediatric Intensive Care Audit	Allan Wardaugh	Ongoing
Children and Women	Acute Child health	1	National Neonatal Audit Programme	Roshan Adappa	Ongoing
Children and Women	Obstetrics and Acute Child health	1	National Maternity and perinatal Audit	Suzanne Hardacre / Nigel Davies	Ongoing
Children and Women	Acute Child Health	1	National Paediatric Diabetes Audit	Justin Warner	Ongoing
CD&T	Laboratory medicine	1	Calculated Globulin	Dr Soha Zouwail	May-18
CD&T	Laboratory medicine	2	Inpatient Troponin Testing	Dr Soha Zouwail	Aug-18
CD&T	Laboratory medicine	2	Effects of GP transport on patassium - CAV and BCUHB	Dr Soha Zouwail	Ongoing

CD&T	Laboratory medicine	1	Myeloma - All Wales Audit	Dr Soha Zouwail	Ongoing
CD&T	Laboratory medicine	1	HbA1c in presence og Hb variants and other interfering factors	Dr Soha Zouwail	Nov-18
CD&T	Laboratory medicine	1	Fluids	Dr Soha Zouwail	Ongoing
CD&T	Laboratory medicine	1	Troponin	Dr Soha Zouwail	Ongoing
Dental	Dental Hospital	2	An audit of compliance by UDH OMFS department to new MRONJ protocol guidelines (SDCEP) prior to extractions.	Andrew Cronin	Ongoing
Dental	Dental Hospital	2	Re-audit WHO checklist in oral and maxillofacial surgery	kim Lewis	Ongoing
Dental	Dental Hospital	2	An audit on new patient periodontal assessments in UDH	Polyvius Charalambous	Ongoing
Dental	Dental Hospital	2	The use of cone beam CT in impacted maxillory teeth	Baljeet Nandra	Ongoing
Medicine	Gastroenterology	1	IBD standards	Dr Clare Tibbatts + Dr Dharmaraj Durai	Rolling audit
Medicine	Gastroenterology	1	JAG audits (includes GI bleed, Gastric ulcer FU and Missed GI cancers, ERCP audit, Endoscopy withdrawal times, Decontamination audit, oesophageal stents & dilatation perforation rates)	Dr John Green (Endoscopy lead C&V)	Rolling audits

Medicine	Internal Medicine	2	An assessment of allergy and adverse reaction history and documentation in patients on UHL MAEU	Dr Laurence Gray	Apr-18
Medicine / Surgery	EU / T&O	1	TARN	Melissa Rossiter / Suzanne Thomas	Ongoing
Medicine	Internal Medicine	2	Sepsis audit: adult medicine	Dr Laura Potts	Apr-18
Medicine	Internal Medicine	2	Care pathway and observation chart for adults undergoing treatment with acute NIV	Mr Andrew Bishop	Apr-18
Medicine	Internal Medicine	2	Audit of Drug errors on an in-patient medical ward	Dr Laurence Gray	Jul-18
Medicine	Internal Medicine	1	National Diabetes Audit	Aled Roberts/ Julia Platts	Ongoing
Medicine	Gerentology	1	Sentinal Stroke National Audit	Shakeel Ahmed	Ongoing
Medicine	Gastroenterology	1	Inflammatory Bowel Disease registry		Ongoing
Medicine	Internal Medicne	1	National Asthma and COPD	Ramsey Sabit / Katie Pink	Ongoing
Medicine	Rheumatology	1	Rheumatology and Early Arthritis	Anurag Negi	Ongoing

Medicine	Inetrnal medicne	1	Hip Fracture database	Anthony Johansen	Ongoing
Mental Health	Adult Mental health	2	Audit of Psychosocial screening practices used with older adults with Chronic physical health Conditions	Ms F Evans	Ongoing
Mental Health	Adult Mental health	1	National Audit of Psychosis	Bala Oruganti	
PCIC	Primary Care	1	National Core Diabetes Audit	Sarah Davies	Ongoing
PCIC	Department of Sexual health	2	British Association of Sexual Health & HIV UK National Audit into Partner Notification in newly diagnosed people living with HIV	Dr. Darren Cousins	Apr-18
PCIC	Department of Sexual health	2	Syphilis treatment and outcomes	Dr. Nicola Lomax	2018
PCIC	Department of Sexual health	2	Audit of sexual and reproductive healthcare issues in HIV positive women	Dr. Sinead Cook	2018
PCIC	palliative Care	1	National Audit of Care at the End of Life	Melissa Jefferson	Jul-18
Specialist	Critical Care	1	Case Mix Audit	Dr Martyn Reed	Ongoing
Specialist	Cardiology	1	Natonal Heart Failure Audit	Dr Z Yousef and Dr Sim	Ongoing

Specialist	Cardiology	1	Cardiac Rhythm Audit	Dr Peter O Callaghan	Ongoing
Specialist	Cardiology	1	National Audit of Cardiac Surgery	Indu Deglurkar	TBC
Specialist	Cardiology	1	National audit of percutaneous coronary Interventions	Dr Tim Kinnaird	Ongoing
Specialist	Cardiology	1	National Congenital heart Disease Audit	Dirk Wilson	Ongoing
Specialist	Cardiology	1	MINAP	Tim Kinnaird	Ongoing
Specialist	Cardiology	1	National Vascular Registry	Mr Richard	Ongoing
Specialist	Cardiology	1	Cardiac Rehabilitation Audit	Rachel Owen	Ongoing
Specialist		1	Epilepsy 12 Children and Young People National Audit		Ongoing
Specialist	Medical Genetics	2	CEQAS Clinical Genetics Quality Assurance Scheme- Cardiovascular Genetics	Angus Clarke and Francis Sansbury	TBC
Specialist	Medical Genetics	2	CEQAS Clinical genetics Quality Assurance Scheme- Cancer Genetics	Angus Clarke and Alex Murray	TBC

Specialist	Medical Genetics	2	CEQAS Clinical genetics \quality Assurance Scheme-Dysmorphology	Angus Clarke and Arveen Kamath	TBC
Specialist	Medical Genetics	2	CEQAS Clinical genetics Quality Assurance Scheme-Mendelian Disorders	Angus Clarke and Andrew Fry	TBC
Specialist	Medical Genetics	2	Use of 6 item or 24 item GCOC (genetic Counselling Outcome Scale) across the all Wales Medical Genetics Service)	Angus Clarke and Fadmin Team	TBC
Surgery	Surgery	2	National Lung Cancer Audit	Dr Diane Parry	Ongoing
Surgery	Surgery	1	National oesophago Gastric Cancer Audit	Prof. Wynn Lewis	Ongoing
Surgery	T&O	1	Fracture Liason Service Database		Ongoing
Surgery	Surgery	1	National Audit of Breast Cancer in Older People	Ms Eleri Davies	Ongoing
Surgery	ENT	1	All Wales Audiology Audit		Ongoing
Surgery	Urology	1	National Prostate Cancer Audit	Mr Owen Hughes	Ongoing
Surgery	Urology	1	Stress urinary Incontinence I Women	Mr O Tatarov	Ongoing

Surgery	Urology	1	Urethroplasty	Mr O tatarov	Ongoing
Surgery	Urology	1	Cystectomy	Mr j Fethaerstone	Ongoing
Surgery	Urology	1	Nephrectomy	Mr R Coultard	Ongoing
Surgery	Urology	2	Release Audit	H Serag	Apr-18
Surgery	Urology	2	Time to TURBT	H Serag	Apr-18
Surgery	Urology	2	Waiting times for Nephroureterectomy for upper tract urothelial tumours	H Abdelmoteleb	Sep-18
Surgery	Urology	2	Long term functional outcomes post robotic assissted Laparoscopic radical prostatectomy	H abdelmoteleb	Apr-18
Surgery	Urology	2	Scrotal Pain Pathway Audit	H Wells	Jul-18
Surgery	Urology	2	Consent for day of surgery admission patients	R Fraser	Jul-18
Surgery	Opthalmology	1	National Opthalmology Audit	Roger McPherson	Ongoing

Surgery	Anaesthetics	1	NELA	Dr Margaret Coakley	Ongoing
Surgery	Anaesthetics	1	National Anaesthetic Audit Project NAP 6	Dr Simon Logan	May-19
Surgery	Anaesthetics	2	OBS CYRU	Dr Sarah Bell	Ongoing
Sugery	T&O	1	National Joint registry	Alun John	Ongoing
Sugery	T&O	1	Surgical Site Infection	Mark Foster	Ongoing
Sugery	T&O	1	National Hip Fracture Database	Anthony Johansen	Ongoing
Sugery	T&O	1	National Knee Ostetomy	Chris Wilson	Ongoing
Sugery	T&O	2	Return To theatre	Angus Robertson	Ongoing

INFECTION PREVENTION & CONTROL REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 12th June 2018

Executive Lead : Executive Director of Nursing
Author : Senior Nurse IP+C 02920746618
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy, particularly focused on 'Avoiding Harm, Waste and Variation'
Financial impact : There are no financial implications currently quantified with the within this report.
Quality, Safety, Patient Experience impact : The work outlined below will provide assurance to the committee that we will achieve the expectations set by Welsh Government whilst providing quality and safe care to our patients.
Health and Care Standard Number 2.4 4 Infection Prevention and Control and Decontamination
CRAF Reference Number …5.2
Equality and Health Impact Assessment Completed: No

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- Compliance with Welsh Government target for CDifficile during 2017-2018
- Well established and proactive Infection Prevention and Control group
- Processes in place for the active monitoring and reporting of performance against targets
- Further focused work is required to meet the WG expectations for 2018-2019

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the contents of the report and agree a suitable timeframe for an update report to the committee given the revised WG targets for 2018-2019

SITUATION

This report serves to update the Quality and Safety Committee of the current position with regard to our experience of healthcare associated infections across Cardiff and Vale University Health Board and our position in terms of infrastructure to minimise the risks of healthcare associated infections for our patients and staff.

BACKGROUND

The key Welsh Government documents relevant to this area are:
Commitment to Purpose: Eliminating Preventable Healthcare Associated Infections (HCAIs). December 2011
http://wales.gov.uk/docs/dhss/publications/111216commithcaien.pdf
Code of Practice for the Prevention and Control of Healthcare Associated Infections. June 2014
http://wales.gov.uk/topics/health/cmo/publications/cmo/2014/cmo-june14/?lang=en
The antimicrobial delivery plan for Wales was introduced in 2016 in response to the UK antimicrobial resistance strategy to attempt to reverse the increasing trend in antimicrobial resistance:
http://www.wales.nhs.uk/sitesplus/documents/888/Antimicrobial%20Resistance%20Delivery%20Plan.pdf
2017 Point prevalence survey of healthcare associated infections and antimicrobial usage:
http://www.cardiffandvaleuhb.wales.nhs.uk/news/47633

ASSESSMENT AND ASSURANCE

Welsh Government Reduction Expectations for Healthcare Acquired Infections (HCAI) and Antimicrobial Resistance (AMR) to be achieved between April 2017 and March 2018 were set in WHC/2017/011. Specifically each LHB needed to:

- Reduce *C. difficile* disease to no more than 26 per 100,000 population BY March 2018
- Reduce *Staph. aureus* bacteraemias to no more than 20 per 100,000 population and
- Reduce E.coli bacteraemias to no more than 60 per 100,00

At end March 2018 the Cardiff and Vale UHB position is as shown below:

C. difficile:

***At the end of the target period C&V UHB had 1 case below the required number to meet the reduction expectation therefore the reduction expectation has been achieved*.**

The rate for the 12 month period was **25.72 per 100,000 population.**

126 cases of *C. difficile* were diagnosed during 2017/18 against 161 in 2016/17 a 21% reduction.

***Staph. aureus* Bacteraemia**

At the end of the target period C&V UHB had 59 cases in excess of the required number to meet the reduction expectation. The rate for the expectation period was **31.64 cases per 100,000 population.**

Within the *Staph. aureus* bacteraemia cases, the incidents of MRSA bacteraemia decreased. For the financial year 2017/18 when compared with 2016/17 a there were 13 cases of MRSA bacteraemia vs 17 cases, a 24% reduction.

For MSSA bacteraemia there was no improvement between 2017/18 and 2016/17 with an increase in the number of cases (142 vs 129)

***E.coli* Bacteraemia**

There was a new challenge for C&V UHB in the Welsh Health Circular (WHC/2017//011) issued on 31st March 2017. In addition to further reductions expected in *C. difficile* and *Staph.aureus* bacteraemia rates, a new reduction expectation to reduce *E.coli* bacteraemia was introduced.

At the end of the target period C&V UHB had 346 cases, 56 cases in excess of the required number to meet the expectation.

However, the E.coli bacteraemia rate was the lowest of the major acute health boards and lower than the rate for 2016/17 FY.
Welsh Government Reduction Expectations for AMR and HCAI to be achieved between April 2018 and March 2019 were set in WHC/2018/020.

There is a new approach outlined in this WHC with the introduction of Antimicrobial Prescribing Improvement Goals for the first time. There is a requirement for Health Boards to link these two areas of work to achieve the required improvements in HCAI and AMR that the WHC sets out.

Specifically each LHB needs to deliver on the following improvement goals:

The Improvement Goals for Antimicrobial Prescribing 2018-19:

Compared to the baseline year of April 2015 to March 2016, the improvement goals for antimicrobial prescribing for the 2018-19 financial year are as follows:

Primary Care and Secondary Care 5% reduction:

- Primary care reduction in total volume measured as Items / 1000 STAR-PU.
- Secondary care reduction in total volume measured as items DDD/1000adm

Secondary Care:

- Increase the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption (as DDD/1000adm) OR increase by 3% from baseline 2016 calendar year.

The Improvement Goals for Healthcare Associated Infections 2018-19:

C.difficile:
It is expected that in 2018/19 to work towards an additional 10% reduction in rate by the end of March 2019.

To note:
From April 2018 changes are planned to the diagnostic tests used in Public Health Wales Microbiology laboratories for the routine diagnosis of *C. difficile* disease. Implementation will be sequential across the PHW Microbiology network of laboratories. The change in diagnostic test will improve the sensitivity of the test, allowing identification of more cases so that appropriate treatment and control interventions can be instituted. The change in the diagnostic test will however mean that direct comparison of data between 2018/19 and preceding years in those laboratories implementing this change will not be possible. The PHW Microbiology laboratory in Cardiff is due to move to the new diagnostic test from July 2018.

***Staph. aureus* bacteraemia**:
To reduce to 20 cases per 100,000 population by end March 2019.

***E.coli* bacteraemia**:
To reduce to 60 cases per 100,000 population by end March 2019.

***Klebsiella* sp. and *Pseudomonas aeruginosa* bacteraemia** have been added to the reporting dashboards, and a reduction of 10% in numbers of cases in 2018-19 compared to 2017/ 2018 cases is expected.

Results April 2018:

C. difficile	3
Staph. aureus(total)	12
MRSA	1
E.coli	24
Klebsiella sp	6
Psuedomonas. aeruginosa	2

Monthly target for improvement have not been set as yet by Public health wales but the committee should be advised that in April 2018 CAV UHB had 3 cases of *C. difficile*, this was the lowest number of cases in the Health Board since prior to August 2006. The Staph Aurues and MRSA is above what is likely to be the monthly target and the UHB continues to monitor EColi, Klebsiella and pseudomonas until the monthly targets are set.

Infections other than those targeted under the WG reduction expectations have also challenged the organisation over the last financial year:

Impact of Diarrhoea & Vomiting and flu 2017/18

- Wards affected 89 (includes part of ward and full ward closures – some wards affected more than once)
- Number of bed days lost 428 (the number of BDL is low and does not reflect the pressure in the unscheduled care units where patients, with influenza in particular, were cohorted and stayed for longer)
- Number of Patients affected 603
- Number of Staff affected 122

Outbreaks/periods of increased incidence of multi-drug resistant organisms and *Clostridium difficile*:

Acinetobacter baumannii
Outbreak on the Critical Care Unit in April 2017 with 3 patients affected.

Linked cases caused the closure of ward B6 trauma in April to June 2017. This resulted in the ward being closed for refurbishment with a total of 244 bed days lost.

Vancomycin Resistant Enterococcus:
Outbreak in Cardiac Intensive Care in March 2018 resulted in 4 clinical cases and 10 patients colonized with the outbreak strain of VRE

Clostridium difficile:
Period of increased incidence (PII) on several wards throughout the year, including:

Rainbow	3 patients	Feb 2017
Heulwen	2 patient	June 2017
A7	5 patients	July/Aug 2017
SRC	2 patients	Aug 2017
B4 Neuro	2 patients	Sept 2017

Other incidents of infection:

Pertussis	Sea horse	May 2017	1 patient
Hep B	Cardiac	Nov 2017	1 patient
SAUR Bacteraemia	A1 Link	Nov/Dec 2017	2 patients

The UHB has a robust Outbreak Policy in place and the Infection, Prevention and Control team work closely with the Clinical Boards in these situations to put in place a range of suitable measures to repent further transmission and to monitor the situation until the outbreak can be declared closed.

European Centre for Disease Control Point Prevalence Survey

The 2016 European Centre for Disease Control (ECDC) point prevalence survey (PPS) was undertaken across Europe between 2016 and 2017 and

was conducted in Wales during June and July 2017. The survey captured data in Healthcare Associated Infections (HAI), device use and antimicrobial use.

In Cardiff and Vale UHB 1294 patients were surveyed, of those **6.9% had one or more HAI**. Of the HAI's, Urinary Tract Infections (UTI) and Pneumonia were the most prevalent, 21.7% and 19.3% respectively.

All patients were assessed for **an indwelling device**. Of the 1158 patients **in acute areas 476 (41.1%) had an indwelling device** at the time of the survey.

Urinary catheter	190 (16.4%)
PVC	343 (29.6%)
CVC	83 (7.2%)
Intubation	32 (2.8 %)

At the time of the survey **29.2% (*n*=378) of patients in hospital were on one or more antimicrobials.**

The results of the PPS demonstrates the ongoing burden of HCAI broadly across the HB and also the usage of Antimicrobials and this underlines the need to tackle both.

The data presented in this report show that there continues to be improvement in the burden of *C. difficile* disease across the Health Board, which is excellent and a credit to the hard work of clinical teams across the organisation. The position against the required improvements in other healthcare associated infections is less positive and improvements seen have been minimal and with new challenges of resistant organisms emerging there remains much work to do.

Excellent work has commenced on improving Urinary Tract Infections (UTI) management across the whole healthcare system with pilot work in PCIC regarding the use of urine dipsticks; a planned trial of improved diagnosis of UTI and the roll out of the recently published revised guidance on UTI antimicrobial prescribing. In secondary care there is a planned project to support nurse led Urinary catheter removal and improved use of the urinary catheter passport.

Initiatives that have been implemented and need to be sustained with continuous improvement:

- Introduction of blood culture packs
- Care bundles for central venous catheter insertions
- Continues roll out of Aseptic Non-Touch Technique (ANTT) to all invasive interventions.
- *C. difficile* ward rounds
- Continued use of fidaxomicin as option for *C. difficile* treatment

- Medical Director led Antimicrobial Stewardship Patient Safety Walkrounds.

New Challenges:

Learning from recent outbreaks has identified the following common themes continue to be a challenge:

- challenging staffing levels,
- poor environment / infrastructure
- poor practices in relation to medical equipment management / replacement / decontamination.

These have been highlighted to clinical boards in feedback of audit and outbreak summaries.

The introduction of new *Klebsiella* sp. and *Pseudomonas aeruginosa* bacteraemia reduction expectations to reduce blood stream infections by 10% is a particularly challenging target.
The Health Board needs to continue its focus on improving UTI management across the whole health care system as a first measure towards addressing the necessary reductions and also continuing the drive to improve antimicrobial stewardship to reduce the risk of resistance.

Assurance:

The Infection Prevention and Control Group is in place to oversee the work of the Health Board to reduce the burden of HCAI and AMR. Clinical Boards have been asked to present their programme of work to reduce HCAI and address the WG reduction expectations and AMR delivery plan. Clinical Boards' HCAI data is monitored through the Executive and Professional performance review process.

Public Health Wales have developed useful infographics which summarise the Cardiff and Vale UHB and All Wales position for 2017-2018 and these are attached at **Appendix 1** and **2**

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Cardiff and Vale UHB

C. difficile surveillance

2017/18 FY financial year (FY) update

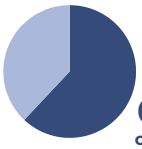
Count

Apr 17
May 17
Jun 17
Jul 17
Aug 17
Sep 17
Oct 17
Nov
Dec 17
Jan 18
Feb 18
Mar 18

126 cases

-35 compared to 2016/17 FY

-401 compared to 2010/11 FY



62% over 65 years old

Rate

per 100,000 population

25.72 per 100,000 population

-22% compared to 2016/17 FY

-77% compared to 2010/11 FY

per 1,000 hospital admissions

1.93 per 1,000 hospital admissions

-21% compared to 2016/17 FY

-74% compared to 2010/11 FY

Location of diagnosis

Acute hospital **82%**

Community hospital **1%**

GP practice **15%**

Other location **2%**

Not specified **0%**

69% Inpatient

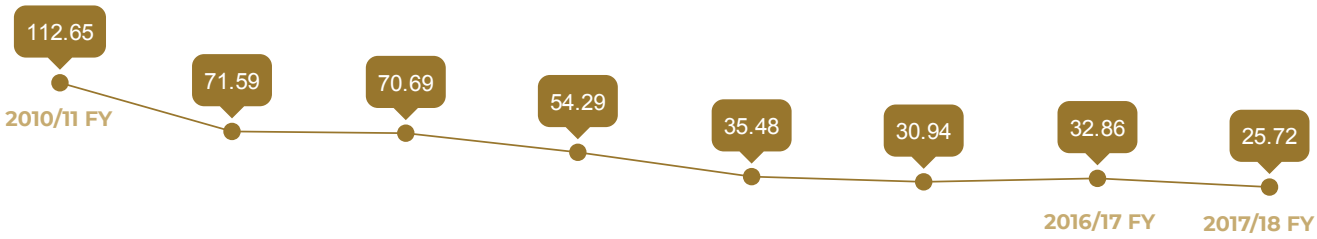
Inpatient rate/ 1,000 hospital admissions **1.33**

Proportion of inpatient cases by FY

91% 2010/11 FY

69% 2017/18 FY

Rate per 100,000 population by FY



University Hospital Llandough

22 cases

-7 compared to 2016/17 FY

-133 compared to 2010/11 FY

Rate **1.29** per 1,000 hospital admissions

73% Inpatient

Inpatient rate/ 1,000 hospital admissions **0.93**

University Hospital of Wales

81 cases

-22 compared to 2016/17 FY

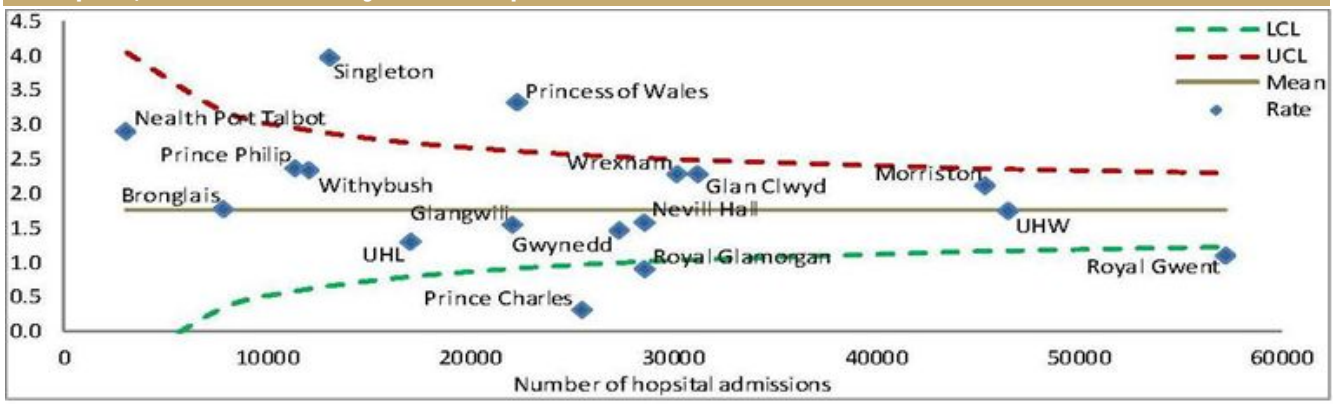
-74 compared to 2010/11 FY

Rate **1.74** per 1,000 hospital admissions

86% Inpatient

Inpatient rate/ 1,000 hospital admissions **1.50**

Rate per 1,000 admissions by acute hospital



GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Cardiff and Vale UHB

E. coli bacteraemia surveillance

2017/18 FY financial year (FY) update

Count

Apr 17
May 17
Jun 17
Jul 17
Aug 17
Sep 17
Oct 17
Nov 17
Dec 17
Jan 18
Feb 18
Mar 18

356 cases
-2 compared to 2016/17 FY
+33 compared to 2010/11 FY

71% over 65 years old

51% male

Rate

per 100,000 population

72.66 per 100,000 population
-1% compared to 2016/17 FY
+5% compared to 2010/11 FY

per 1,000 hospital admissions

5.44 per 1,000 hospital admissions
=0% compared to 2016/17 FY
+20% compared to 2010/11 FY

Location of diagnosis

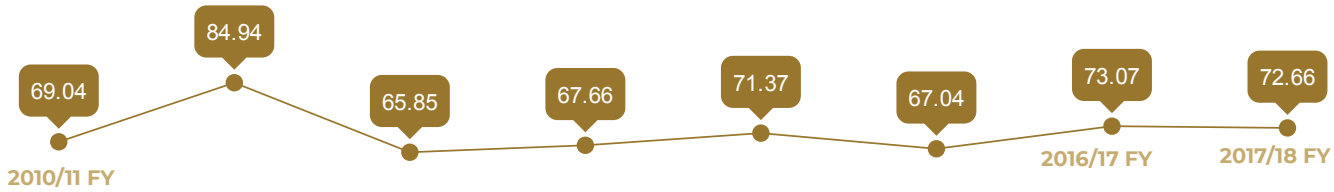
Acute hospital 98%
Community hospital 1%
GP practice 0%
Other location <1%
Not specified <1%

37% Inpatient
Inpatient rate/ 1,000 hospital admissions 2.03

Proportion of inpatient cases by FY

65% 2010/11 FY
37% 2017/18 FY

Rate per 100,000 population by FY



University Hospital Llandough

85 cases
+12 compared to 2016/17 FY
+16 compared to 2010/11 FY

Rate 4.97 per 1,000 hospital admissions

31% Inpatient

Inpatient rate/ 1,000 hospital admissions 1.52

University Hospital of Wales

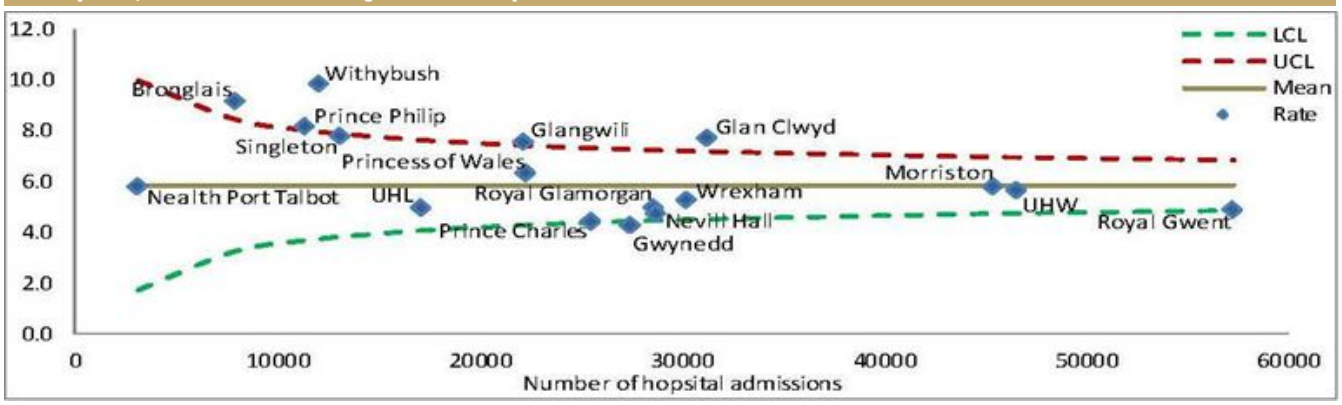
264 cases
+1 compared to 2016/17 FY
+195 compared to 2010/11 FY

Rate 5.67 per 1,000 hospital admissions

39% Inpatient

Inpatient rate/ 1,000 hospital admissions 2.19

Rate per 1,000 admissions by acute hospital



GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Cardiff and Vale UHB

MRSA bacteraemia surveillance

2017/18 FY financial year (FY) update

Count

Apr 17
May 17
Jun 17
Jul 17
Aug 17
Sep 17
Nov 17
Dec 17
Jan 18

13 cases

-4 compared to 2016/17 FY

-37 compared to 2010/11 FY

Rate per 100,000 population

2.65 per 100,000 population

-24% compared to 2016/17 FY

-75% compared to 2010/11 FY

Rate per 1,000 hospital admissions

0.20 per 1,000 hospital admissions

-23% compared to 2016/17 FY

-72% compared to 2010/11 FY

Location of diagnosis

Acute hospital 92%

Community hospital 8%

GP practice 0%

Other location 0%

Not specified 0%

62% Inpatient

Inpatient rate/ 1,000 hospital admissions **0.12**

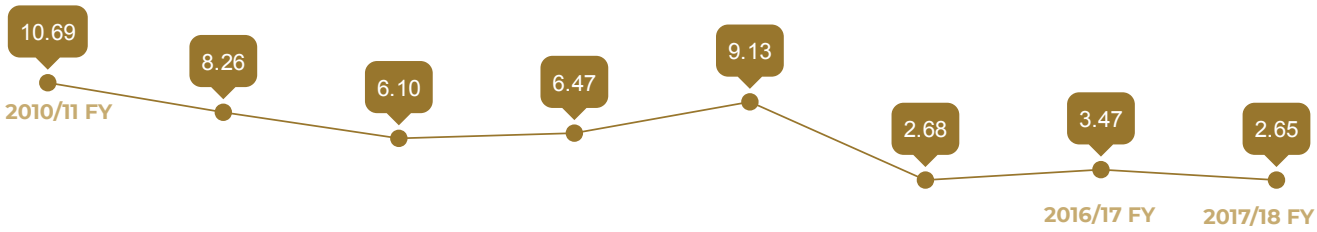
Proportion of inpatient cases by FY

62% (2010/11 FY) → 62% (2017/18 FY)

62% over 65 years old

62% male

Rate per 100,000 population by FY



University Hospital Llandough

1 case

-2 compared to 2016/17 FY

-8 compared to 2010/11 FY

Rate **0.06** per 1,000 hospital admissions

0% Inpatient

Inpatient rate/ 1,000 hospital admissions **0.00**

University Hospital of Wales

11 cases

-3 compared to 2016/17 FY

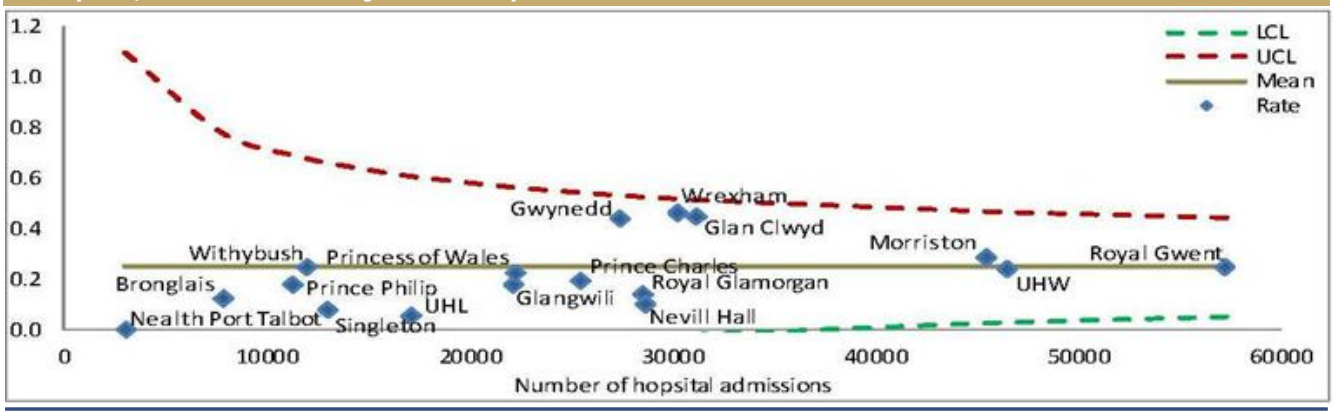
+2 compared to 2010/11 FY

Rate **0.24** per 1,000 hospital admissions

64% Inpatient

Inpatient rate/ 1,000 hospital admissions **0.15**

Rate per 1,000 admissions by acute hospital

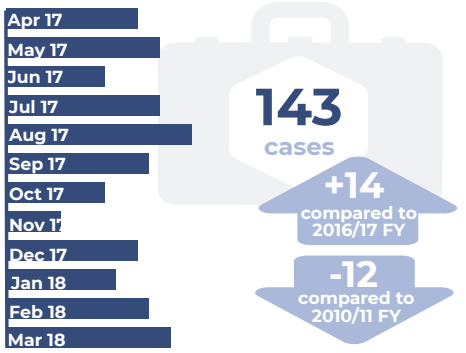


Cardiff and Vale UHB

MSSA bacteraemia surveillance

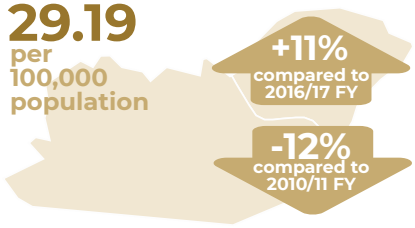
2017/18 FY financial year (FY) update

Count

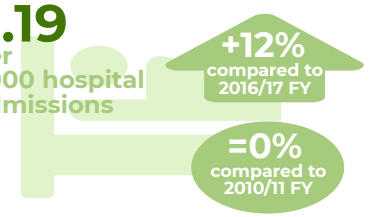


Rate

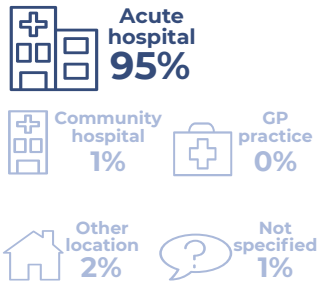
per 100,000 population

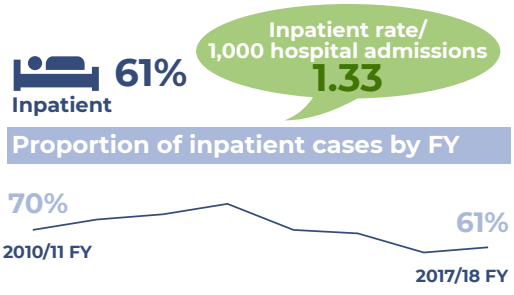


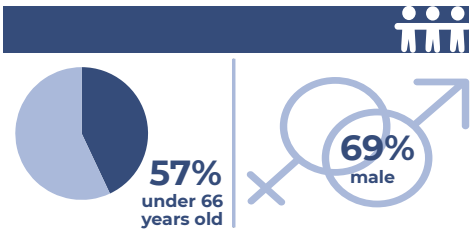
per 1,000 hospital admissions



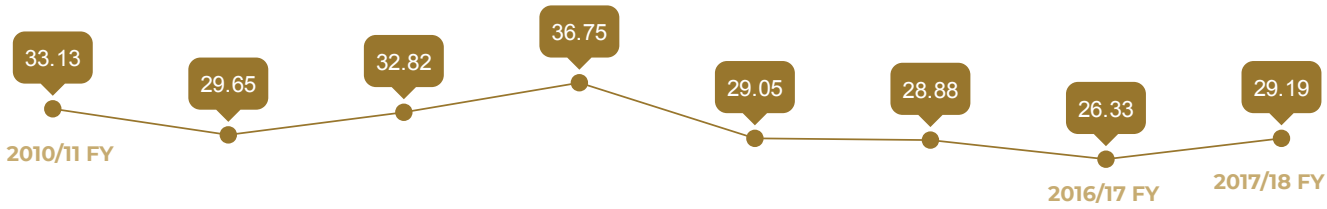
Location of diagnosis



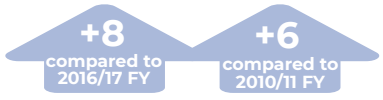




Rate per 100,000 population by FY



University Hospital Llandough



Rate 1.58 per 1,000 hospital admissions

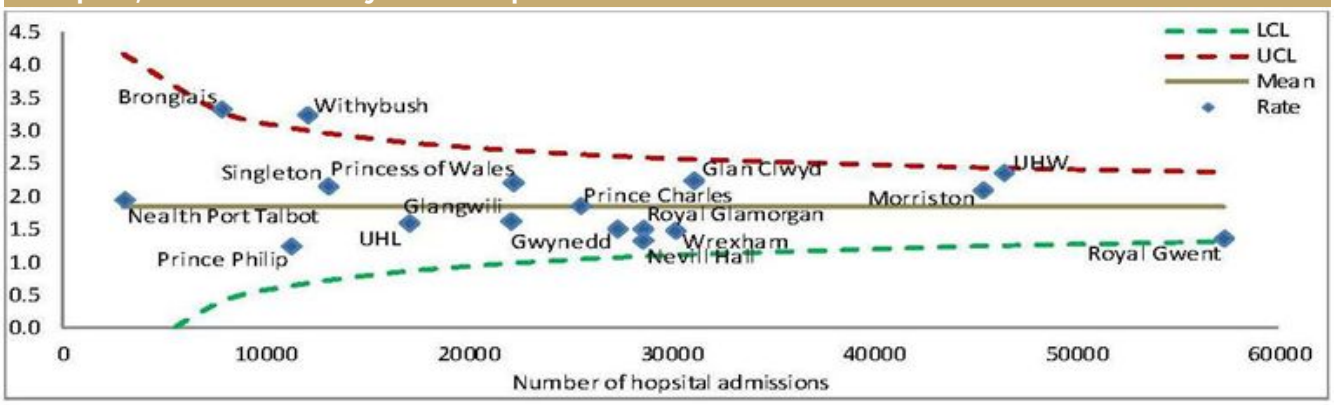
Inpatient rate/ 1,000 hospital admissions 0.70

University Hospital of Wales

Rate 2.34 per 1,000 hospital admissions

Inpatient rate/ 1,000 hospital admissions 1.53

Rate per 1,000 admissions by acute hospital



GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

All Wales
C. difficile surveillance
2017/18 FY
Financial year (FY) update

Count

Apr 17	95
May 17	119
Jun 17	93
Jul 17	111
Aug 17	102
Sep 17	105
Oct 17	107
Nov 17	86
Dec 17	67
Jan 18	100
Feb 18	74
Mar 18	87

1146 cases

+99 compared to 2016/17 FY

-1649 compared to 2010/11 FY

Rate

per 100,000 population

36.81 per 100,000 population

+9% compared to 2016/17 FY

-60% compared to 2010/11 FY

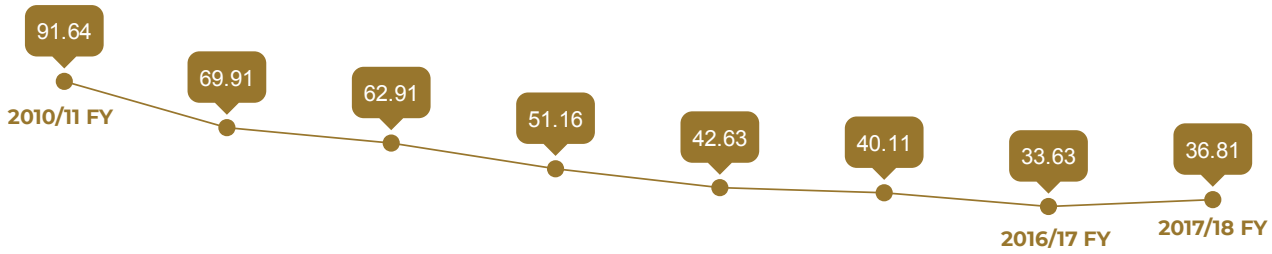
per 1,000 hospital admissions

2.47 per 1,000 hospital admissions

+8% compared to 2016/17 FY

-60% compared to 2010/11 FY

Rate per 100,000 population by FY



Location of diagnosis

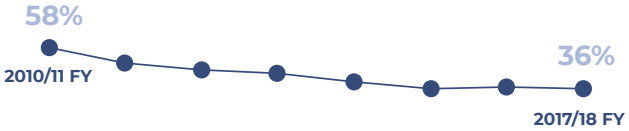
Acute hospital **68%**

Community hospital 7% | GP practice 23% | Other location 1% | Not specified 1%

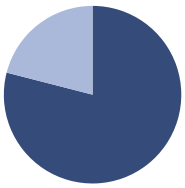
61% Inpatient location

Inpatient rate/ 1,000 hospital admissions **1.51**

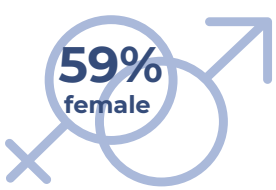
Proportion of inpatient cases by FY



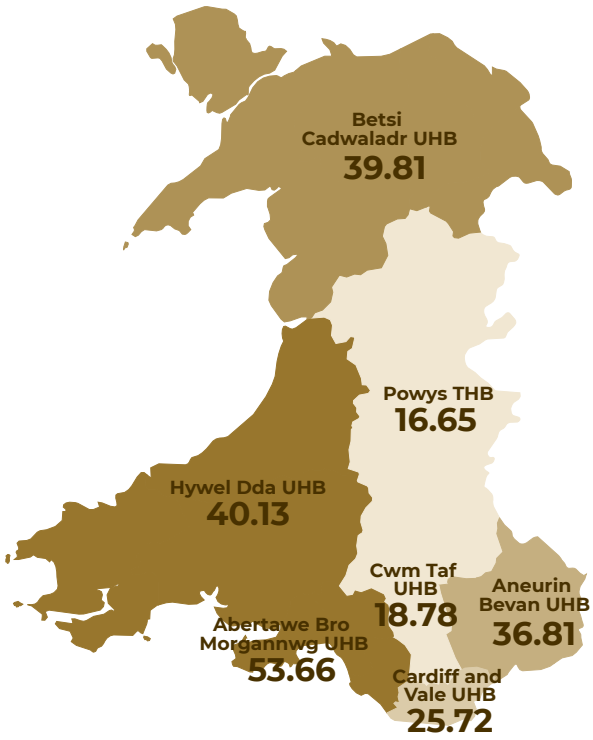
Demographics



79% over 65 years old



Rate per 100,000 population by health board



Created by: Public Health Wales
Data extracted: 10/05/2018

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

All Wales
E. coli bacteraemia surveillance
2017/18 FY
Financial year (FY) update

Count

Apr 17	251
May 17	229
Jun 17	227
Jul 17	227
Aug 17	231
Sep 17	242
Oct 17	234
Nov 17	199
Dec 17	208
Jan 18	204
Feb 18	152
Mar 18	200

2604 cases

+56 compared to 2016/17 FY

+707 compared to 2010/11 FY

Rate

per 100,000 population

83.65 per 100,000 population

+2% compared to 2016/17 FY

+34% compared to 2010/11 FY

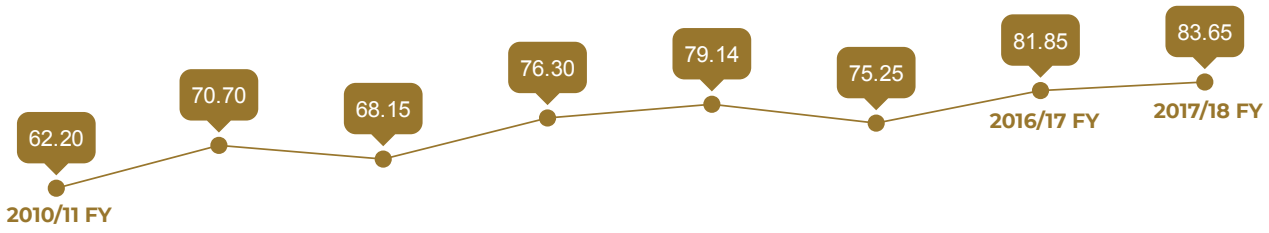
per 1,000 hospital admissions

5.62 per 1,000 hospital admissions

+1% compared to 2016/17 FY

+33% compared to 2010/11 FY

Rate per 100,000 population by FY



Location of diagnosis

Acute hospital **97%**

Community hospital 3%

GP practice 0%

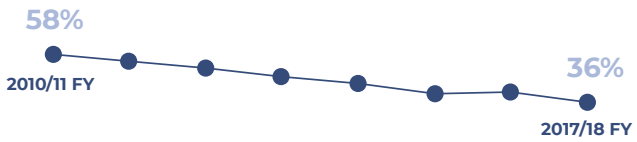
Other location <1%

Not specified <1%

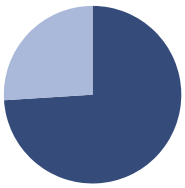
36% Inpatient location

Inpatient rate/ 1,000 hospital admissions **2.04**

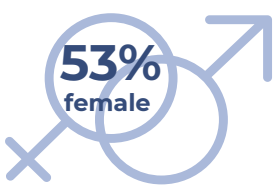
Proportion of inpatient cases by FY



Demographics

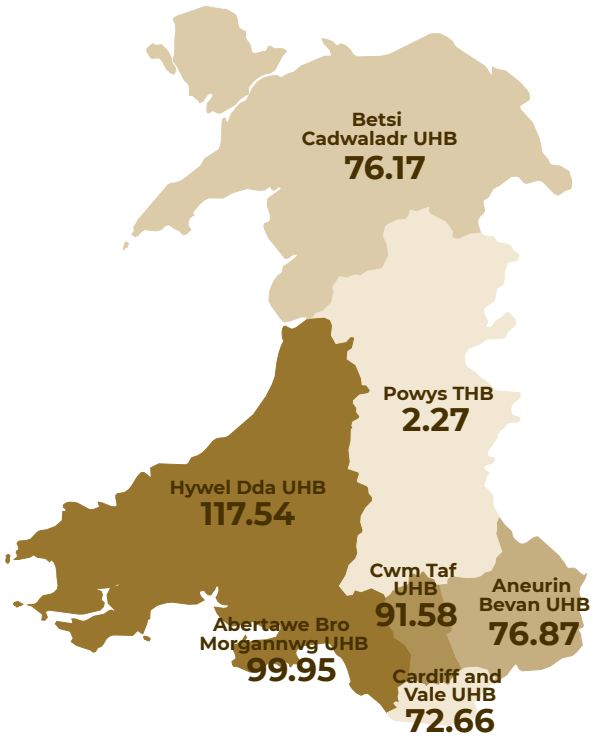


74% over 65 years old



53% female

Rate per 100,000 population by health board



Created by: Public Health Wales
Data extracted: 10/05/2018

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GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

All Wales
MRSA bacteraemia surveillance
2017/18 FY
Financial year (FY) update

Count

Apr 17	16
May 17	13
Jun 17	14
Jul 17	6
Aug 17	10
Sep 17	9
Oct 17	5
Nov 17	7
Dec 17	9
Jan 18	7
Feb 18	9
Mar 18	7

112 cases

+12 compared to 2016/17 FY

-106 compared to 2010/11 FY

Rate

per 100,000 population

3.60 per 100,000 population

+12% compared to 2016/17 FY

-50% compared to 2010/11 FY

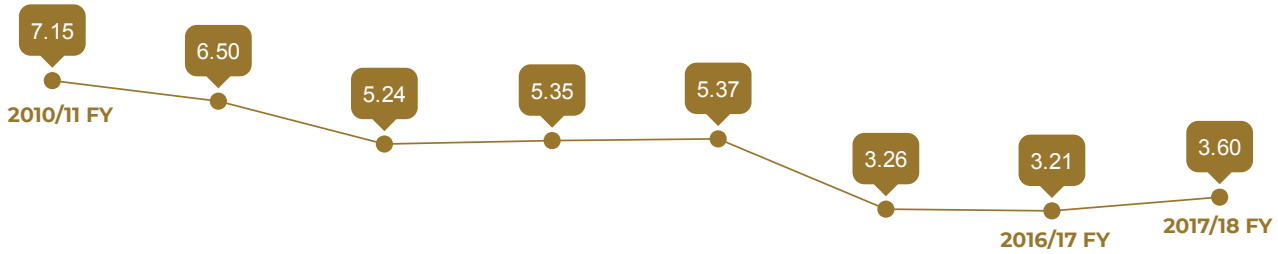
per 1,000 hospital admissions

0.24 per 1,000 hospital admissions

+10% compared to 2016/17 FY

-50% compared to 2010/11 FY

Rate per 100,000 population by FY



Location of diagnosis

Acute hospital **96%**

Community hospital 4%

GP practice 0%

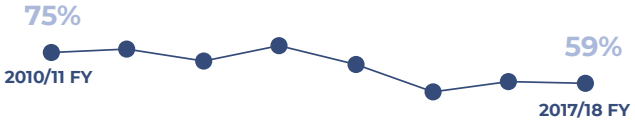
Other location 0%

Not specified 0%

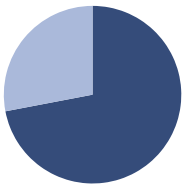
59% Inpatient location

Inpatient rate/ 1,000 hospital admissions **0.14**

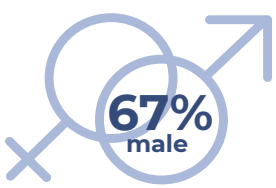
Proportion of inpatient cases by FY



Demographics

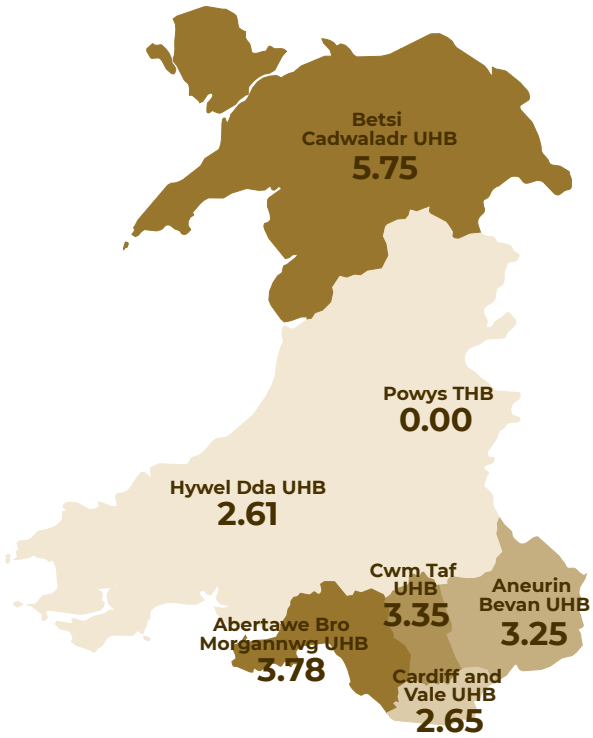


72% over 65 years old



67% male

Rate per 100,000 population by health board



Created by: Public Health Wales
Data extracted: 10/05/2018

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

All Wales
MSSA bacteraemia surveillance
2017/18 FY
Financial year (FY) update

Count

Apr 17	68
May 17	74
Jun 17	68
Jul 17	72
Aug 17	71
Sep 17	68
Oct 17	65
Nov 17	53
Dec 17	70
Jan 18	74
Feb 18	71
Mar 18	68

822 cases

+78 compared to 2016/17 FY

+163 compared to 2010/11 FY

Rate

per 100,000 population

26.40 per 100,000 population

+10% compared to 2016/17 FY

+22% compared to 2010/11 FY

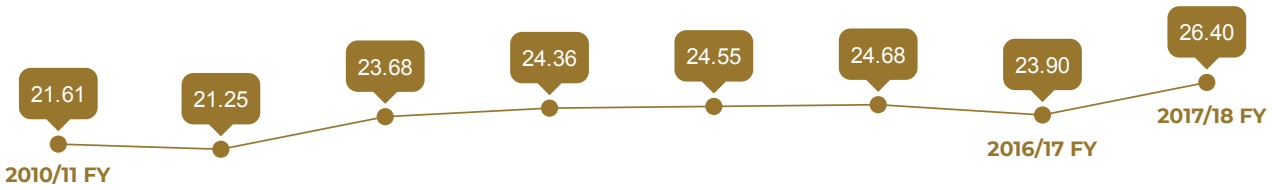
per 1,000 hospital admissions

1.77 per 1,000 hospital admissions

+9% compared to 2016/17 FY

+21% compared to 2010/11 FY

Rate per 100,000 population by FY



Location of diagnosis

Acute hospital **96%**

Community hospital 2%

GP practice 0%

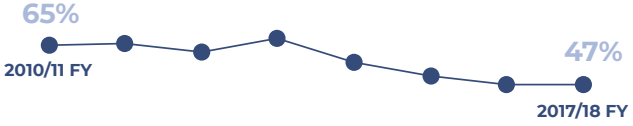
Other location 1%

Not specified 1%

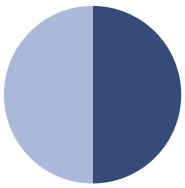
47% Inpatient location

Inpatient rate/ 1,000 hospital admissions **0.84**

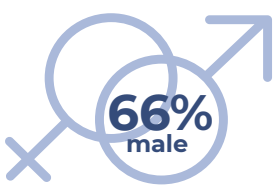
Proportion of inpatient cases by FY



Demographics

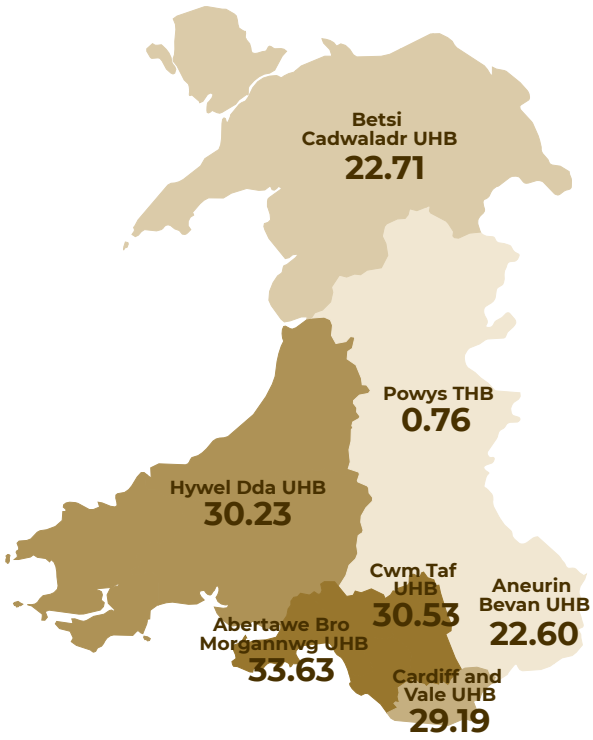


50% over 65 years old



66% male

Rate per 100,000 population by health board



Created by: Public Health Wales
Data extracted: 10/05/2018

MEDICINES MANAGEMENT - HEALTH AND CARE STANDARD 2.6
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 12th June 2018

Executive Lead : Medical Director
Author : Director of Pharmacy and Medicines Management 029 2074 4331
Caring for People, Keeping People Well : Medicines management focus is on reducing waste harm and inappropriate variation.
Financial impact : not applicable
Quality, Safety, Patient Experience impact : The annual self-assessment supports strategic planning to reduce medicines related harm and improve quality and cost-effective use of medicines
Health and Care Standard Number 2.6 (Medicines Management)
CRAF Reference Number N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE/LIMITED ASSURANCE/NO ASSURANCE is provided by:

- The annual self-assessment process against the Health and Care standards is led by the multi-disciplinary corporate Medicines Management Group which meets on a monthly basis
- Clinical Board Quality, Safety and Experience Committees have had the opportunity to contribute and share best practice in terms of medicines quality and safety work

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the self assessment rating of *"Getting there"* against the Health and Care Standard 2.6 Medicines Management.

SITUATION

Standard 2.6 Medicines management (Corporate)
Self-assessment completed May 2018 **Overall rating: Getting there**
The assessment has been completed through the UHB corporate Medicines Management Group

BACKGROUND

The overall conclusion is that the Health Board is **Getting there**
The rationale for this response is that, whilst there are some areas of robust and innovative practice in relation to safe and effective medicines

management and very good governance processes, this is not yet consistently evidenced either within Clinical Boards or across the Health Board.

Notable improvements over the past year include the widespread implementation of Medicines Transcribing and electronic Discharge (MTeD) on all wards, except Mental Health and some specialised day units (where a "discharge on demand" functionality has recently been launched. The links to the community pharmacy Choose Pharmacy platform facilitates discharge communication to primary care and safe transfer of patient care. Also supports post discharge medicines review with patients.
All initial target outpatient clinics implemented electronic prescribing (COPPS).

Dissemination and actions related to Patient Safety Notices and internal communication of medication safety issues is led by the Medicines Safety Executive (reporting to corporate Medicines Management Group). Effective sharing of lessons from medication-related incidents is supported through this process, including a widely circulated monthly medicines safety briefing.

Systems to manage the UHB joint formulary and manage the entry of new medicines are well embedded. The New Treatment Fund has supported timely and robust patient access to new medicines.
Medicines-related procedures have been updated to align with the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS) published November 2015 (update progressing) and a single UHB Medicines Code was launched in November 2017. A Health Board wide audit of all inpatient areas relating to storage and security has been undertaken supported by Clinical Board nurses and the Nurse Advisor.

Continued development of Antimicrobial stewardship across primary and secondary care remains a challenge due to lack of resource and clinical engagement. Positive outcomes have been realised in relation to healthcare acquired infections (HCAI) – the concern is that these may not be sustainable. A case for resource support on a sustainable footing in 2018-19 IMTP failed to cross the UHB prioritisation threshold.

A patient helpline to support provision of information and advice on medicines (after hospital discharge or outpatient consultation) is available and messages are fed on to Pharmacy Medicines Management Practice Group to inform improvement strategy.

ASSESSMENT AND ASSURANCE

Medication chart (prescribing and administration, including omitted and delayed doses) audits need to be fully implemented and reported with supporting remedial action plans across all sectors (including district nursing and domiciliary care). A plan to complete this audit for 2017/18 is in place.

Recent NICE guidance on management of controlled drugs in hospitals (May 2016) has been used to support review of all related processes across primary and secondary care, via the Local Intelligence Network.

Training and revalidation of staff (including healthcare support workers) involved in medicines administration (including intravenous therapy) is a key development area and supports the continued implementation of the MARRS policy noted above. Supporting e-learning is now available.

A review of the Non Medical Prescribers register held within pharmacy was completed to ensure all information and scope of practice was up to date for each individual non medical prescriber. A UHB forum for Non-Medical Prescribing has been re-established.

National Prescribing Indicator performance has improved across all indicators and the UHB performs best for number of practices meeting the National Prescribing Indicator thresholds. Pain and antimicrobial prescribing shows greatest variation and is a specific focus for the Medicines Management Incentive Scheme 2018-19 (by both NPI improvement and also audit of prescribing and peer review).

Key performance metrics for medicines management to be agreed and reported through Clinical Board and corporate Medicines management groups.

Improved access to the GP-record of a patient's medication has been implemented, and facilitates safe admission processes including medicines reconciliation. MTeD supports safe transfer of care at discharge.

Yellow card (adverse event) reporting has increased across primary care and by pharmacists in secondary care.

With the aim of achieving "Meeting the Standard", progress with each of the actions noted above will be monitored through the corporate Medicines Management Group.

Specific areas for focus in 2018-19 are:

- Strengthen medicines-related audits in non-ward areas
- Medicines storage, security and destruction compliant with UHB Medicines Code (and updated MARRS policy when available)
- Specific support to patients/carers in presence of sensory loss
- Agree UHB non-medical prescriber strategy
- Work to understand and reduce medicines-related admissions

This assessment will be signed off by the Executive Medical Director and Independent Member (Susan Elsmore) and through the corporate Medicines Management Group.

POINT OF CARE TESTING: GOVERNANCE UPDATE
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 12th June 2018

Executive Lead : Medical Director
Author : Consultant Clinical Biochemist and PoCT Lead for Cardiff and Vale UHB
Caring for People, Keeping People Well: The report underpins the UHBs strategy to provide sustainable services, including the reduction in waste, harm and variation.
Financial impact : The PoCT Department is under pressure to provide a robust service for its users. It was recognized that investment was required to help sustain and expand the service to meet the demands from an expanding user population across all sectors of the UHB. A funding solution was submitted as part of the CD & T IMTP. The agreed financial plan is to cross-charge Clinical Boards based on activity.
Quality, Safety, Patient Experience impact : The provision of safe and effective methods of point of care testing is essential for the provision of safe and effective care for patients and the effective use of resources.
Health and Care Standard Number. Standard 2.9 – Medical devices, equipment and diagnostic services. (Also Stds.- 2.1, 3.1, 3.4, 3.5, 5.1.)
CRAF Reference Number. 5.1 Deliver safe, efficient and effective care.
Equality and Health Impact Assessment Completed: Not Applicable – Note EQUIA is included in accompanying Policy Document provided as a separate paper.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current governance and reporting structures in place.
- Further initiatives to strengthen the PoCT functionality.
- Training and educational programme.

The Board (or name of Committee) is asked to:

- **AGREE** the continuation of the current Governance Structure for Point of Care Testing and **NOTE** the initiatives for service improvement that are being put in place to further strengthen governance.

SITUATION

Within the UHB, the Point of Care Testing (PoCT) Department is responsible for agreeing a specification for proposed acquisition of PoCT devices and their integration into patient care pathways, as part of clinical effectiveness. Its remit is extensive and covers procurement advice, equipment evaluation, training and competency assessment, device connectivity, quality assurance, performance surveillance, audit, governance surveillance and incident reporting within the UHB.
It is important to ensure that the right equipment is used in the right clinical setting, it is managed appropriately and the effectiveness of PoCT in the clinical pathway is reviewed.

BACKGROUND

The governance and management of PoCT within the UHB is described in the PoCT Policy and PoCT Procedure which was approved by the Quality Safety and Patient Experience Committee in September 2017. The governance review undertaken in September 2017 highlighted resource challenges going forward which required solutions and ongoing work.

ASSESSMENT

This paper provides further update to the Committee on the governance of PoCT and progress made as set out below in a number of important areas.

1. **Organisational structure.**

The PoCT Department is operationally managed within the Clinical Diagnostics and Therapeutics Clinical Board.
Update:
The agreed IMTP for 2018/2019 will provide a solution for both Clinical Lead succession and an additional PoCT co-ordinator within the Clinical Diagnostics and Therapeutics Clinical Board.

2. **Governance of PoCT**

This is addressed by the PoCT Group. This group meets 4 times a year and is responsible for approving PoCT services, defining the scope of PoCT, taking into consideration the clinical need for PoCT, its financial implications, technical feasibility, and ensuring that appropriate measures are in place to monitor the accuracy and quality of PoCT. All PoCT devices must only be purchased after a case for clinical need has been approved by the PoCT Group.
This group is chaired by the Assistant Medical Director and reports to the Quality and Safety Committee through the Medical Director by exception reporting.

Update:
Group's membership has been expanded to provide greater clinical engagement.

3. Service Improvement Initiatives

- IM&T initiatives**:**
  Interface the PoCT Data management middleware to the ADT feed (*Admission, Discharge, Transfer*), thus facilitating positive patient verification on the device.
  Update:
  This work has now been completed and all devices that are capable of being interfaced, have been connected to the All Wales Connectivity Solution (WPOCT). Where supported, positive patient identification has been implemented. Cardiff and Vale UHB was the pilot site for this project and have been "live" since March 2018. WPOCT is interfaced to the Welsh Clinical Portal providing access to patients' results irrespective of where they are measured.

- Interface the PoCT data management middleware to the UHB Business Intelligence tool to facilitate PoCT -dashboard reports for Clinical Boards to provide activity, test usage and operator test performance criteria.
  Update:
  WPoCT has been successfully interfaced to the UHB Business Intelligence System (BIS) to facilitate patient alerts. The BIS system has successfully being used by the Diabetic Inpatient Teams, with improved patient outcomes. The PoCT Department has also met with Senior Nursing Leads to scope dashboard reports to include: workload activity, operator competence and clinical effectiveness reports. These are planned for Quarter 2 2018.

- Roll out automated fully connectable devices to replace manual testing procedures to facilitate data capture, audit and quality monitoring of uncontrolled manual procedures.
  Update:
  The PoCT Department has successfully replaced a number of manual procedures with interfaced devices as part of the WPOCT implementation. This programme will continue through 2018.

4. Training and competency initiatives:

- Improve awareness of PoCT IT governance issues during HCSW initial training.
  Update:
  This is now included in the Committed to Care and Nurse Foundation training programmes.

- PoCT Department and LED to monitor ongoing competency and re-validation of qualified staff. A new process has been developed for ward based on-going assessment of registered nurses and HCSW.
  Update:
  This process has now been actively adopted for PoCT Glucose/ Ketone testing across the UHB. Ongoing discussions with LED to adopt a similar model of assessment for all PoCT activity is planned for 2018.

- PoCT Department to undertake spot audits to determine accuracy of the recording process for blood glucose monitoring of diabetic patients. The audit will analyse the data recorded on paper based nursing notes and the information held electronically in WPOCT. A period of amnesty for 3 months for lost (borrowed) ID badges will be implemented in the first instance to facilitate the process. Old style ID badges will be replaced with the current format.
  Update:
  The PoCT Dept. have effectively' cleaned-up ' PoCT database with regards to eradication of old -style badges and deactivation of inactive operators on the system. Spot audits to commence within next 3 months.

- PoCT Department to undertake weekly audit of the emergency bar code and any misuse will be reported to the Clinical Board nurse.
  Update: Reports will be circulated to Clinical Boards within the next month.

- PoCT training for glucose monitoring for registered nurses working in a clinical environment will be mandatory. Any lapsed training will be reported to the respective Clinical Board nurse. A notice period of 21 days will be sent to the individual operator.
  Update: On going work - reports will be made available to Clinical Boards within Quarter3 2018.

- PoCT and LED to develop and implement e-Learning packages.
  Update:
  This development is planned for 2018/19.

5. UHB - Organization wide (outside scope of PoCT Dept):
On-going vigilance and re-enforcement of record keeping and awareness of IT Data Protection Policy. Prevention measures for PoCT ID badge sharing by all stakeholders and notification of termination of employment linked to PoCT ID badges.

- Improved governance of blood gas operators.
  The existing middleware used by Medical Biochemistry (Radiance) has limited functionality for the management of operators. To ensure that an equitable service is rolled out across the UHB for all PoCT, the blood gas middleware will be upgraded to Acqure to allow full connectivity with WPOCT.

Update:
The upgraded system Acqure has now been installed and is in test phase. The PoCT Dept. has been actively 'cleaning-up' the out-dated Blood Gas operator database and has scheduled an operator re-training exercise across the UHB for 2018. Similarly, the mobile blood gas devices (Abbott i-Stats) will require additional middleware (DE software) to enable full connectivity. This software is currently being installed and will be tested within the next month. All Clinical areas using these devices will require re-training. An SLA is to be drafted between Medical Biochemistry and the PoCT Dept., detailing operational and governance arrangements.

6. Financial Analysis/Governance

- The proposed financial plan is to implement a cross-charging mechanism, employing a similar charging mechanisms already in operation within the CD & T Clinical Board.

  Update:
  In October 2017, the PoCT Dept. submitted an IMTP proposal, which has been approved. Thus, potentially supporting implementation of a Trading Framework for PoCT across all Clinical Boards. In addition, it was anticipated that planned savings from establishment of a Managed Service Contract for PoCT would facilitate payment of the on-going NWIS licence fee for hosting WPOCT on behalf of the UHB. Unfortunately, the MSC has not yet been established due to delays in the Procurement process.

CANCER PEER REVIEW – GYNAECOLOGY
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 12th June 2018

20

Executive Lead : Medical Director
Author : Macmillan UHB Lead Cancer Nurse
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact : Nil applicable
Quality, Safety, Patient Experience impact: The work outlined within this paper reflects the significant activity taking place to improve patient experience for people 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 efficient care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Quality, Safety and Experience Committee is asked to:

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

SITUATION

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

BACKGROUND

Peer review is a collaborative, quality improvement process which allows for the evaluation of scientific, academic or professional work by others working in the same field and constitutes a form of self-regulation by qualified members of a profession. It is designed to allow peers to share information, learn where their strengths and weaknesses lie and agree plans for improvements to patient care.

Peer review methods are employed to maintain standards of quality, improve performance and provide credibility. In 2011 Welsh Government recommended that the peer review process for cancer services

be led by Health Inspectorate Wales (HIW), working in partnership with the Cancer Networks. Peer review was then launched in Wales in 2012.

In 2017, through Welsh Health Circular WHC/2017037 the NHS Wales Peer Review Framework was published and tasked the NHS Wales Health Collaborative to oversee an all-Wales programme for peer review.

A three yearly re-review process has been developed by the cancer network. Following the peer review meeting, a report is sent to the UHB. An action plan is then developed and implemented to address the concerns raised at each peer review and re-review.

ASSESSMENT AND ASSURANCE: Summary of Peer Re-review Report for Gynaecology

Good Practice/Significant Achievements:

- Good progress made against peer review of 2015.
- Communicating results via telephone in a virtual clinic.
- Formalising the inclusion and clinical input of a colorectal surgeon at the regional MDT.
- Nurse led preadmission clinics.
- Good morbidity data collection.

There were no immediate risks or serious concerns highlighted.

Concerns noted were:

Service Level Agreement (SLA)	Further work is required to finalise the service level agreement (SLA) around the regional service provision for Cwm Taf and Aneurin Bevan University Health Board.
Oncology provision	Extra capacity to cover the oncology provision, including brachytherapy, where absent.
Outpatient service / survivorship	HNAs are not completed as standard practice and continue to be completed in hardcopy. There are still gaps and areas of vulnerability within the AHP services which will impact on the rehabilitation of patients.

Where appropriate, overarching actions have been identified and an action plan formulated and implemented to address the concerns outlined above. It will be noted that some of the issues identified have now been addressed. Further detail is provided in the full action plan appendix 1.

Cardiff and Vale University Health Board
Gynaecology Cancer Peer Review Action Plan 2018

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
	CONCERNS					
1	Service Level Agreement (SLA)	Further work is required to finalise the service level agreement (SLA) regarding the regional service provision for Cwm Taf and Aneurin Bevan University Health	Medium	Head of Operations & Delivery, Directorate of Obstetrics and Gynaecology Head of Operations & Delivery, Children & Women Clinical Board.	6 months	The SLA for ABHB is almost complete. This is now being developed for Cwm Taf.
2	Oncology provision	Extra capacity to cover the oncology provision, including brachytherapy, where absent.	Medium	C&V UHB AMD for Cancer will correspond with Clinical Lead, Velindre Cancer Centre.	3 months	Dependent on progress within VCC
3	Outpatient service / survivorship	A. HNAs are not completed as standard practice and continue to be completed in hardcopy. B. There are still gaps and areas of vulnerability within the AHP services which will impact on the rehabilitation of patients.	Medium	Gynae-Oncology Lead CNS and Macmillan UHB Lead Cancer Nurse Macmillan AHP Lead	6 months 6 months	Gynae-Oncology Lead CNS participating in 2nd eHNA pilot commencing Spring 2018 Therapies action plan developed with specific actions for dietetics, physiotherapy and occupational therapy. Therapies action plan to be signed off April 2018

MORTALITY DATA AND MORTALITY REVIEW
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting 12th** June 2018

21

Executive Lead : Medical Director
Author : Quality and Safety Improvement Manager. Email joy.whitlock@wales.nhs.uk Phone 029207 45099
Caring for People, Keeping People Well : This report underpins the Health Board's "Delivering Outcomes that Matter to People" and "Being a great place to work and learn" elements of the Health Board's Strategy.
Financial impact : None
Quality, Safety, Patient Experience impact: This provides an opportunity for organisational learning and improvement.
Health and Care Standard Number 3.1 – safe and clinically effective care
CRAF Reference Number 5.1 Safe, effective and efficient care.
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Monitoring of Mortality measures and reviews
- Internal Audit report

The Quality, Safety and Experience Committee is asked to:

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

SITUATION

BACKGROUND

Mortality reviews are a way of providing assurance to bereaved families and to the Cardiff and Vale University Health Board (UHB) about the quality and safety of care provided. A collaborative approach to developing processes in NHS Wales has been ongoing for some years.

NHS England has published National Guidance on Learning from Deaths. A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

It promotes the use of an evidence based structure and promotes the Structured Judgment Review tool published by the Royal College of

Physicians to be used following training. The Guidance helpfully identifies priorities for case note reviews. This is useful as we move forward. NHS Wales is developing its own level 2 mortality review tool based on the one used for the extensive research into harm in NHS Wales.

The Medical Examiner (ME) Role was proposed by the Department of Health (DoH) to: strengthen safeguards for the public; make the process simpler and more open for the bereaved; and improve the quality of certification and data about causes of death. The ME role will replace the level 1 mortality reviews currently being undertaken by the doctor completing the death certificate in the UHB. In essence it will provide further clarity on which deaths should be reviewed. The DoH started their consultation in March 2016 and Welsh Government followed in December 2016. Progress has been hampered by a variety of issues including the impact of Brexit plans and a general election.

There is further delay due to funding and implementation challenges throughout England and Wales. The original plan was to fund the ME through cremation fees. However, there is much geographical variation in burial v cremation which would result in inequitable ability to provide MEs.

A phased implementation has now been proposed starting with hospital deaths. The suggested implementation date of April 2018 has been extended but there is no apparent timeline moving forward.

Originally Mortality Reviews (MRs) focused on deaths of people who had been in NHS inpatient general hospital care. Thus they excluded NHS mental health and learning disability inpatient and community services. This is now being addressed.

The all-Wales Mortality Review Steering Group is developing an information sheet on Mortality Reviews for Bereavement Services to share with families ahead of the ME role.

Learning disabilities and mental health - Across England and Wales there is a major focus on the inequalities faced by people with learning disabilities. These people die on average 15-20 years sooner than the general population. The Learning Disabilities Mortality Review Programme Annual Report (https://www.hqip.org.uk/wp-content/uploads/2018/05/LeDeR-annual-report-2016-2017-Final-6.pdf) was published recently and identifies some key themes. Work to progress this is described in more detail below.

The Electronic Mortality Audit Tool (EMAT) is a UHB solution for gathering information and generating reporting data. Since its launch in September 2014 it has been developed further to provide useful information at individual patient level which can be aggregated to directorates, clinical boards and the UHB. A ‘once for Wales’ approach is being explored to procure a platform to record and monitor mortality reviews.

ASSESSMENT AND ASSURANCE

Mortality Reviews

A final Internal Audit report on mortality reviews was published on 17th May 2018 – reference C&V-1718-17 which concluded reasonable assurance.

The audit report highlighted that appropriate processes are in place to enable the completion of level 1 mortality reviews but that only around 80% were completed. The percentage of the combined death certification and level one mortality review forms received has decreased. In 2016-17 only 2% forms were not received. This has increased to 5% in 2017-18. A review of the current process will be undertaken to ascertain where the gaps are.

The internal audit report identified two further issues: lack of standardized level two review tool; and no central oversight of level two reviews. There are plans to address these at an all-Wales level.

The Wales mortality review steering group commissioned a comparative analysis of harm-measurement tools and this has been undertaken. Following this a draft level 2 mortality review tool has been developed and is now being piloted in the UHB. The new tool is aligned to the serious incident review processes. Clear instructions about whom/ how the case note review should be conducted need to be developed for all Wales use and a robust training structure for carrying out mortality reviews must also be developed to ensure a consistent approach. This work is being progressed.

Learning Disabilities and Dementia

A National Steering Group (NSG) for Wales is established to develop and implement specific mortality reviews for patients with learning disabilities. The NSG recommended that all Health Boards and Trusts in Wales should build systems and capacity for routinely undertaking Mortality Reviews for all specialist mental health and learning disability services, across all associated NHS services.

In Wales 1000 Lives Improvement, the NHS Delivery Unit and Health Inspectorate Wales jointly lead an improvement programme on *'Sharing the Learning from Untoward Incidents'* in Mental Health, Learning Disability and related NHS services.

The most commonly reported learning and recommendations were made in relation to the need for:

a) Inter-agency collaboration, including communication
b) Awareness of the needs of people with learning disabilities
c) The understanding and application of the Mental Capacity Act (MCA)

The NSG has adapted Mortality Review tools currently used in NHS physical healthcare inpatient services in Wales and developed new tools which are being piloted in all Health Boards that are responsible for Mental Health and Learning Disability services. The pilot aims to identify potential implementation issues, including how easy or difficult it is to integrate within wider UHB Mortality Review processes.

In accordance with the pilot study the IT developers in C&V UHB have introduced two extra fields to EMAT to capture patients with learning disabilities and dementia who were cared for in physical health inpatient wards at the end of life. The data collection form for mortality reviews and death certification has similarly been amended. The fields on EMAT will increase the governance around patients with LD by automatically escalating them to a level two review. We will be able to count the number of patients with dementia at the time of death that may not yet have a code on PMS.

There is a need to review all deaths of patients of the NHS MH and LD secondary care services. However, there are no new resources for undertaking an increased number of reviews. A pragmatic approach has been undertaken to manage this. Patients with dementia will all have a level 1 review but will not automatically be escalated to level 2 reviews unless there is another trigger. A conversation between the certifying doctor and the consultant should ensue as to the quality of care the patient received and whether a second stage review should be carried out.

The PARIS IT system has been developed to record stage one mortality reviews for patients who die in mental health hospital beds and there is a plan to try and progress work so that this information on PARIS can interface with EMAT ensuring that all mortality data is held in a central database.

The Procedural Response to Unexpected Deaths in Childhood (PRUDIC) is focused on safeguarding rather than clinical risks. An additional work stream is progressing at Welsh Government level to establish a consistent and robust way of generating wider learning from the deaths of children and young people.

Information Management

A local investigation is underway in to a data entry issue leading to a mismatch between the number of deaths on PMS and the number of death certification/ mortality reviews being received and entered on the EMAT. This is the difference between light blue area and the green line in Figure 1 below.

There is no current requirement to report Stage 2 reviews, nationally to Welsh Government. There is a tendering process for an all-Wales platform to record mortality reviews. The current forerunner under development is the Datix Cloud. The prototype will be available in the next couple of months with the intention to procure a system in October. The overview of the development presented at the national steering group fell a long way below what is currently available via EMAT. A discussion/decision will be required as to

whether EMAT is further developed to include stage 2 reviews which would be against the general direction of the Wales approach. This Committee can be assured that the UHB representation on the national group is informing the Datix Cloud development.

The UHB updates mortality statistics on the public facing website. The latest updated information on hospital deaths is shown in appendix one. There is much more detailed information, including community mortality statistics available on: http://www.cardiffandvaleuhb.wales.nhs.uk/our-safety-systems

The Health Board is able to monitor the % of patients who have a mortality review (figure 1) recorded.

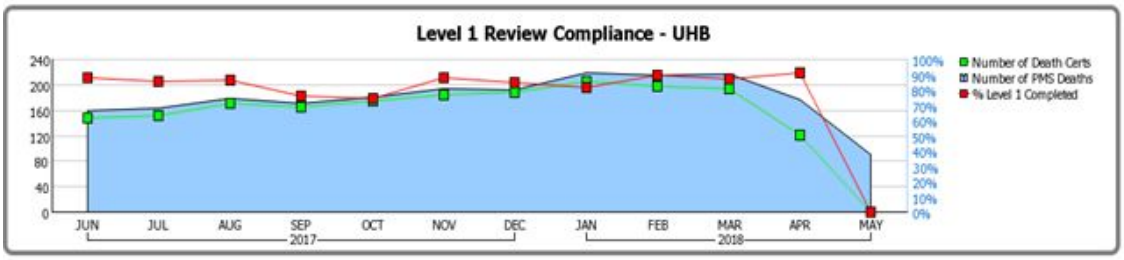


Figure 1 - % patients having a level 1 mortality review – note April and May 2018 data inputting is incomplete.

Of the approximate 200 deaths per month in the UHB hospital inpatient services 120 – 130 occur in Medicine Clinical Board which achieves over 90% of level 1 mortality reviews – see figure 2 below – red line indicates %.

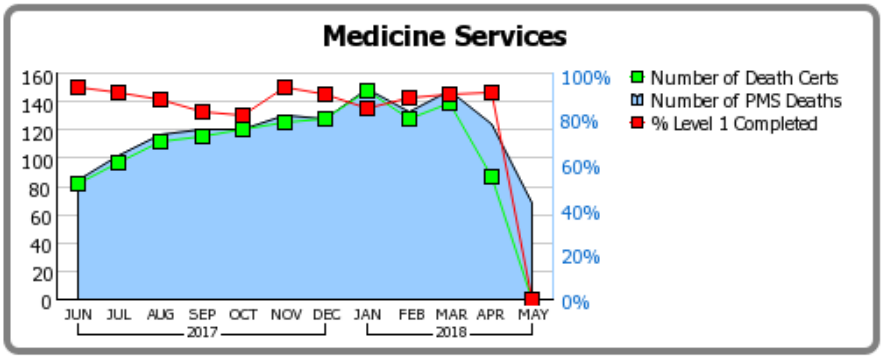


Figure 2 – mortality reviews being achieved in Medicine Clinical Board.

The sensitivity and specificity of the level 1 mortality reviews is poor such that about 40% patients continue to trigger a level two review. Previous investigations suggest that triggers are due to the disease processes at the end of life. Medicine Clinical Board is affected most because of the large numbers of people receiving care at the end of their natural lives. A revised process involving a discussion with the Consultant about the cause of death and quality of care at stage one is being tested in order to over-ride and reduce level two triggers.

This new approach has reduced the % triggering a level 2 review by about half. The red line indicates the level two triggers using the old process and the purple line indicates the % triggering a level 2 review using the new process. We will need to monitor this to ensure sufficient learning and assurance is maintained.

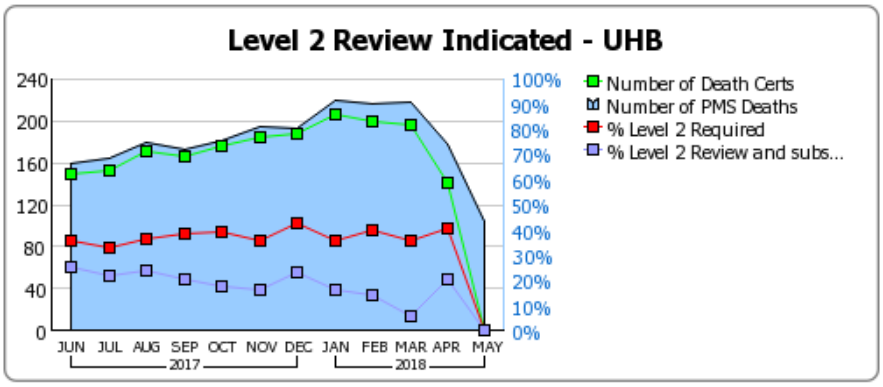
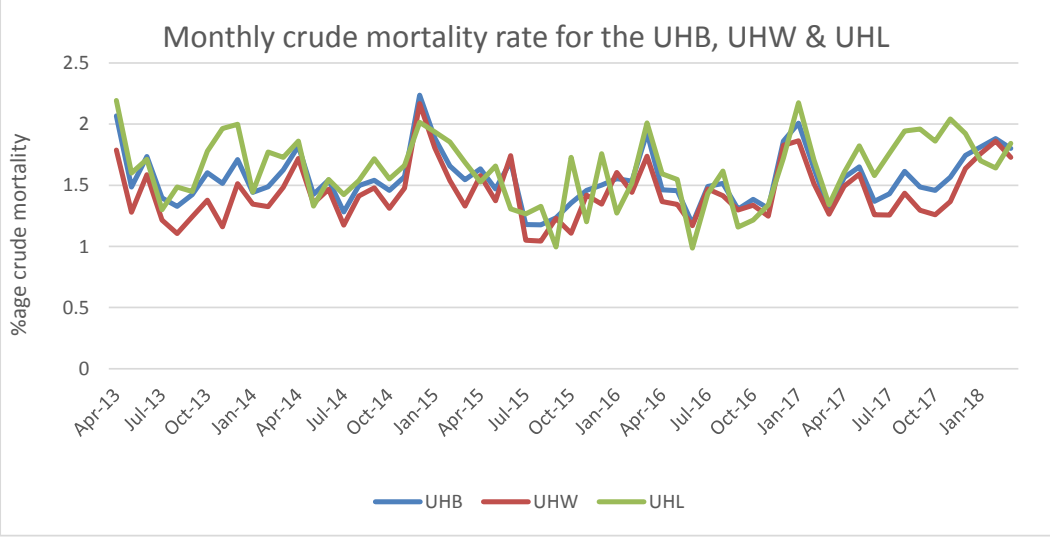


Figure 3 - % patients triggering a level 2 review with the original process (red line) and with the new process (purple line). Note data is incomplete for May 2018 and possibly for April 2018.

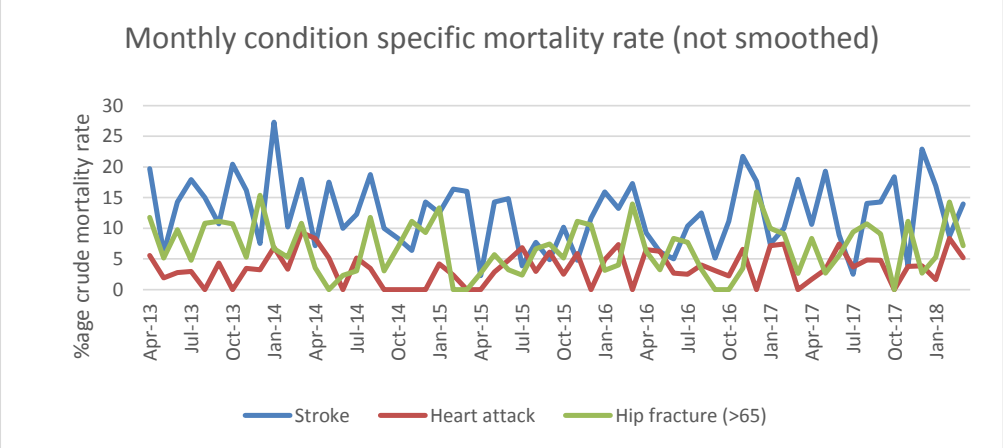
Appendix One shows the percentage of crude mortality, condition specific mortality (stroke, heart attack, hip fracture) and mortality rate per 10,000 mortality rate in the Emergency Unit has improved while the other data show stable situations for the past year.

Appendix One.

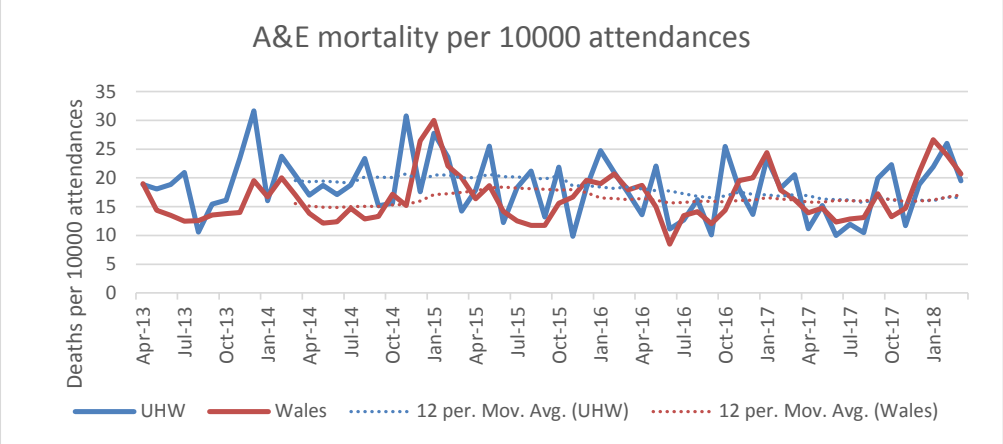
% crude mortality



% condition specific mortality



A&E mortality rate per 10,000 attendances.



PRIMARY CARE GENERAL MEDICAL SERVICES AND DENTAL GOVERNANCE HEALTHCARE INSPECTORATE WALES (HIW) PRACTICE INSPECTION UPDATE REPORT – May 2018
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting: 13th June 2018**

Executive Lead:	Executive Nurse Director
Author:	Helen O'Sullivan, Quality and Safety Manager
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 : N/A	
Quality, Safety, Patient Experience impact : Gives assurance and confidence on quality, safety & patient experience.	
Health and Care Standard Number: 2.1, 2.4, 2.7, 2.9, 3.1, 3.4, 3.5, 4.2 **CRAF Reference Number:** Not Applicable	
Equality and Health Impact Assessment Completed: Not Applicable	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- No immediate assurance issues identified by HIW during visits to primary care contractors (since last report in August 2017)
- Actions taken by practices to address the recommendations
- Processes in place within Primary, Community and Intermediate care (PCIC) to monitor outcomes and progress with improvements

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the ongoing monitoring and performance management systems and outcomes for Primary Care Dentists.

SITUATION

The routine Welsh Government practice and performer inspection programme has been commissioned from Healthcare Inspectorate Wales (HIW) from August 2014. The UHB Primary Care Team needs to provide assurance to the Executive Team that Inspection Reports have been received, reviewed and acted upon.

BACKGROUND

All General Practices and General Dental Services/Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are

announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local CHC. The HIW inspections produce an Action Plan which is assessed and followed up on by HIW. The UHB then ensures ongoing compliance with the outcomes of the inspection.

ASSESSMENT

The process for the inspection is as follows:

1. The practice is inspected by HIW.
   a. Any significant issues are sent to practice and UHB in the form of an Immediate Assurance letter.
2. The initial report is written and checked and sent to the practice with the HIW action plan.
3. The practice replies with details of their response for each element of the Action Plan.
4. HIW acknowledge whether they are content with the feedback.
5. Once feedback from the practice is received and HIW approve the actions undertaken, the report is released to the UHB and goes to be translated.
6. The UHB Clinical Director for Clinical Governance for PCIC (CDCG PCIC) and Primary Care Dental Advisor reviews the Inspection Report and Action Plan and produces a 1-page summary with a RAG-score and any additional actions for the UHB to undertake.

HIW review each report and produce recommendations for the visit. Any responses from the practice which HIW are not happy with are escalated internally and a more detailed response and actions requested from the practice. This communication is copied into the UHB. The outcome of the action plan is assessed by HIW and satisfaction with steps taken or proposed by the practice are included in the final report. The process is overseen by the executive Nurse Director and the Assistant Director Patient Safety and Quality.

The Primary Care Team undertakes a review of each practice report and any potential actions for follow-up required. These steps are in addition to any satisfaction HIW have with the outcome and so are managed with sensitivity. The status of each practice is graded in accordance with the following ratings:

Status	Issues
Green	Minor issue e .g : Price list not displayed Translation services not present Patient Feedback
Yellow	Issue requiring remediation, but not likely to pose patient safety issue. E. g - QA arrangements - Policies updating and signing Complaints Processes
Amber	Serious Issue requiring remediation due to **potential** patient safety concern. e.g: - Safeguarding procedures - IR(Me)R Issues - Record Keeping Issues - Staff Training Records - Access to staff areas HTM 01-05 issue : Minor
Red	Serious Issue requiring immediate remediation due to present patient safety issue:, e. g : - Decontamination processes - Cross Infection control - Emergency Drugs/Equipment HTM 01-05 : Major

HIW review each report and produce recommendations for the visit. Any responses from the practice which HIW are not happy with are escalated internally and a more detailed response and actions requested from the practice. This communication is copied into the UHB. The outcome of the action plan is assessed by HIW and satisfaction with steps taken or proposed by the practice are included in the final report. The process is overseen by the executive Nurse Director and the Assistant Director Patient Safety and Quality.

The Primary Care Team undertakes a review of each practice report and any potential actions for follow-up required. These steps are in addition to any satisfaction HIW have with the outcome and so are managed with sensitivity. This 1-page summary is logged on the practice file and the follow-up actions undertaken. The Review and summary of reports are attached **(GP Appendix 1. Dental Appendix 2).**

Since the last report to the Committee in August 2017, the following inspection reports have been published:

General Medical Services

- Butetown Medical Practice
- The Penylan Surgery
- Woodlands Medical Centre
- Llanrumney Medical Group

There is one Amber Practice (Llanrumney) that the GMS team continue to work with following the merger of two practices. There are no immediate concerns.

General Dental Services:

- Church Road Dental Practice
- West Quay Dental Practice
- Rhoose Dental Practice
- {my}dentist – Fairwater Practice
- Clifton Dental Practice
- Greenfield Dental Care
- Bupa Dental Care (Pentwyn
- Cyncoed Dental Practice
- {my}dentist
- (Countisbury Avenue, Llanrumney)
- Restore Dental Group (215 & 354 Whitchurch Road)
- Dental Surgery (G O'Keeffe & J Jones)
- Hillcrest Dental Practice
- Calgary Dental Practice (Llantwit Major)

There are three yellow Practices and one Amber Practice that the Dental Team are following up. There are no Practices requiring immediate action from the Health Board.

Over the past Year the Health Board are not always given prior notice of inspections occurring and have not always received embargoed reports in a timely way. The situation has been raised formally with HIW and we will continue to monitor over the next Quarter.

HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS – *APPENDIX 1* – TABLE OF INSPECTIONS

HIW Inspection Reviews				
Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions/ Update*
Butetown	March 2018	1. The Practice must have a Notice Board 2. The Practice must ensure that Complaints process and information is up to date. 3. The Practice should continue to update and share Policies on shared IT system 4 the Practice should keep a record of safety checks 5. The practice should ensure that all staff are Trained to appropriate Safeguarding Level 6. The practice should consider introducing more structured staff meetings 7. The practice should review Incident reporting Process 8. The practice should ensure that there is sufficient support to the Practice Manager to assist in Management of the practice		1. Completed. 2. The complaints leaflet has been updated and information is displayed on the notice board. 4. The Practice continues to improve in the recording and compliance of safety checks and is adhering to HB fridge Temperature Policy. 5. All GP's are level 3 trained. The practice scored themselves as level 2 on the Self Assessment Toolkit. The Practice has engaged with the Health Board Sustainability Team for support. The Practice was granted a temporary List Closure of 1 month in February 2018.
The Penylan Surgery	24 October 2017	4.1. The practice to ensure that patients are aware of their right to request a chaperone during intimate examinations regardless of the gender of the GP/nurse conducting the consultation. 3.2. The practice to review process in place to follow-up those patients who fail to attend their appointments. 6.3. The practice need to ensure Complaints process is clear and information is available to patients. 2.1. The practice is complete staff DSE assessments. 2.4. The practice to implement IPC checks in respect of baby changing facilities.		4.1. Primary Care Team to review chaperone training register and Practice literature during Practice Annual Appraisal visit. 3.2. New Policy in place 6.3. Primary Care Team to request copy of Complaints Policy and review at Practice Annual Appraisal visit. 2.1. Workstation risk assessments completed.

HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS – *APPENDIX 1* – TABLE OF INSPECTIONS

		2.7. The practice is to ensure nursing staff complete level 3 safeguarding training.		2.4. Primary Care team to review records at Practice Annual Appraisal visit. 2.7. Primary Care team to review at Practice Annual Appraisal visits due September 2018 .
Woodlands Medical Centre	5th September 2017	The practice is required to inform HIW of the action taken/to be taken to provide patients with a website link to the My Health Online service and to ensure that the Carer's link contained within the practice website is fully functional. 2.1.The practice is required to provide HIW with details of the action taken in response to the identified absence of an Equality and Diversity Policy and Business Contingency Plan 2.7. The practice is required to inform HIW of the action taken to ensure that staff receive refresher training in relation to CPR.		4.2. The Primary Care team verified recommendation has been implemented. 2.1. The Primary Care team to review policies during Practice Annual Appraisal visit. 2.7. The Primary Care team to review during Practice Annual Appraisal visit due November 2018 .
Llanrumney Medical Centre	2nd Nov 2017	1.The Practice is required to review and update referral process 2. The practice is required to ensure Staff are appropriately trained in Equality Act Training 3. Regular Fire Drills are required 4. The practice are required to ensure all Nurses complete Level 3 Safeguarding Training		Since the Inspection (December 2017) the Practice has merged with Llanedeyrn Medical Centre and is now known as Llan Healthcare. The Practice will receive a Practice Appraisal visit from the Primary Care Team in June 2018. The Team will review Policies and Procedures during this visit.

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HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS – *APPENDIX 1* – TABLE OF INSPECTIONS

		5 All Safeguarding Policies are to be up to date 6 Incident reporting process to be followed		4. The Practice have confirmed that Nursing Staff have completed or have dates to complete relevant Safeguarding Training. 5. Llan Healthcare engage in the Health Board Interface Reporting system.
The City Surgery	24th January 2017	1. Strengthen review of patient test results 2. a)Inform HIW of actions taken for flexible registration appointments, b)also treating patients with respect 3. Protocol in place for patients without appointment but in need for medical advice 4. Ensure action taken to obtain patient views and act on them accordingly 5. Ensure Sharps containers are relocated and secure in patient areas 6. Action to provide minimum emergency/resuscitation equipment 7. Content of medical records is comprehensive enough and carry out audit to improve 8. Ensure med notes are summarised, to assist in clear clinical decision making 9. Access to current policies and procedures to meet requirements		1. Patient results are now checked daily by Senior GP and actioned. The practice Manager audited the new system in May 2017 and has concluded that the new system is effective. 2. a) A more flexible registration process now exists with registration appointments available daily. b) Practice manager confirmed Dignity and Respect Policy is in place and was reviewed at team meeting. 3. A new protocol is in place for registered and non-registered patients who attend the practice outside of normal consulting hours with a need for medical advice. An Emergency/Temporary Appointment Request Form has also been developed. 4. The Practice Manager has developed a patient

HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS – *APPENDIX 1* – TABLE OF INSPECTIONS

				Questionnaire. To be reviewed at Practice Development meeting 2017/18 5. Wall brackets for sharps containers are in place in all clinical areas 6. The practice have purchased relevant equipment 7. Information regarding GMC and NMC standards is available to the practice and has been signposted to relevant record keeping courses. GP's to discuss record keeping in their annual appraisal and provide Form 4 to Quality &Safety Director. 8. The practice GP's have refined their summary and care planning process. The practice will share outcome of audit Feb 2018 Practice have scored Level 2 on Clinical Governance Self-assessment tool kit. Primary care to check on policies at Annual practice development meeting
Four Elms Surgery	18th January 2017	1. The practice is required to describe the action taken/ to be taken in order to address the absence of staff (DSE) Health and safety risk assessments. 2. Ensure Sharps containers are relocated and secure in patient areas		1. A training DSE training session occurred in March 2017. Training is diarised in staff calendars. Workstation risk assessments have been completed 2. All sharp containers are securely wall mounted.

HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS – *APPENDIX 1* – TABLE OF INSPECTIONS

Cloughmore Medical Centre	31st January 2017	1. Non clinical staff made aware of what's expected when they are required to act as a chaperone. 2. Obtain patient consent to clinical procedures 3. Manage concerns/complaints with accordance to Putting Things Right 4. Describe action taken to address the absence of staff health and safety risk assessments 5. New staff have access to appropriate induction		1. Chaperone Policy is in place and has been discussed in Team Meeting. The Practice has booked training for October 2017.The Practice have reported themselves as Level 4 on the CGS 2. The practice has new consent forms which are being embedded into practice. 3. A new protocol and patient leaflet has been developed. The Practice scored themselves as level 2 on Clinical Governance tool kit and this will be verified during Practice development visit. 4. The practice have undertaken risk assessment on all workstations and staff received E learning training in April 2017. 5. New chairs have been order. 6. The practice has developed a new Induction checklist and embedded into practice.
Meddygfa Albany Surgery	23rd February 2017	1. Non clinical staff made aware of what's expected if they are required to act as chaperone. 2. Manage concerns/complaints with accordance to Putting Things Right		1. Primary Care Team have checked and a Chaperone Policy is in place. Training is being rolled out to practice staff.

HIW GENERAL PRACTICE INSPECTION PROGRAMME
FOLLOW UP ACTIONS – *APPENDIX 1* – TABLE OF INSPECTIONS

		3. Recording outcome of house call consultations 4. Receive annual appraisals in the near future and on an ongoing basis		2. Putting things right leaflet and poster in practice. Clinical Governance Tool Kit . Primary Care team to review at Annual Practice Development Visit in October 2017 3. The practice remind all GP's that all clinical records must be written contemporaneously. 4. The practice is reviewing their HR policies and process and will provide detail in their Annual Practice Plan

HIW Immediate Assurance Letters (received since last SBAR update)			
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*

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Appendix 2
HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

	Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
41	Church Road Dental Practice	05/02/18 (published 08/05/18)	*Improvements Required* • Review /update website to include information about NHS dental provision • Amend its complaints policy to include relevant and up to date contact information. • Develop process for recording patient concerns • Suitably qualified person to undertake PAT testing • Ensure all clinical staff received appropriate infection control training • Undertake audits in line with WHTM 01-05 • All staff to receive CPR training • Ensure all staff have access /complete relevant safeguarding training. • Record keeping: o Basis Periodontal Examination (BPE) o Medical histories signed by patient and countersigned by the dentist • Appropriate health and safety risk assessments • Records to evidence policies read and understood by all staff *Positive Findings* • Staff interaction with patients was professional, kind and courteous • Dental equipment was well maintained and regularly serviced • Clinical facilities were well equipped and were visibly clean and tidy		• Initial review by Dental Advisor Identified practice as Amber due to the Number of potential improvement areas. Positive comments also acknowledged. • Dental advisor has recommended the Health Board is not required to undertake any immediate actions. • Dental Team have written to the practice for update and a Response requested by: 30/06/18	• HIW satisfied with Action Plan submitted by practice (18/04/18)

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Appendix 2
HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

40	West Quay Dental Practice	11/12/17 (published 12/03/18)	Overall a positive report *Improvements Required* • Ensure staff have access to and completed the relevant safeguarding training. • Record provision of advice on smoking cessation and alcohol cessation in records • Ensure compliance with recommended guidelines regarding the intervals and justification for radiographs. • Amend medical emergency policy/ procedures so staff are aware of roles in a medical emergency. • Ensure staff have access to and complete relevant training: o POVA for 1 Staff • Obtain confirmation that all clinical staff have necessary Hepatitis B documentation *Positive Findings:* • The practice is committed to providing a positive experience for its patients • There was evidence of good management and leadership from the practice manager, area manager and clinical advisor • The practice had dedicated and appropriate facilities for the decontamination of dental instruments		• Dental Team have written to the practice requesting an update on Improvement work. Response requested by: 30/06/18	• HIW satisfied with Action Plan submitted by practice (12/02/18)
39	Rhoose Dental Practice	09/11/17 (published 12/02/18)	Overall a positive report *Improvements Required* • Radiography: • Review location of isolation switch for one surgery • Review frequency of radiographs to be in line with FGDP/ GDC guidance • Ensure all records stored in line with data protection requirements:		• Response requested by: 31/01/18	• HIW satisfied with Action Plan submitted by practice • Response to UHB letter received 30/01/18 **Actions taken in response to Report**: <u>Need to secure outbuilding</u> A 6 foot wooden fence has now been erected at the exposed

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Appendix 2
HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

			• Secure the outbuilding
			• Record keeping issues:
			  • Updating medical histories
			  • Consent to treatment
			  • Condition of oral hygiene
			  • Oral cancer screening
			  • Treatment plans
			Positive Findings
			• Patient feedback was very positive about the service provided.
			• Staff were friendly, welcoming and committed to providing a good standard of care.
			• Clinical facilities were well equipped and clean.
			• There were arrangements in place for the safe use of X-rays.
						side of the Practice and the alley way/footpath to the side of the Practice has also been secured with a lockable gate which is also 6 foot in height. Replacement of the single glazed wooden window in the outbuilding Now a double glazed window with obscured glass. Re-Positioning of Isolation Switch for X-Ray Machine in Surgery 3: the isolation switch has now been moved. Record Keeping: All dentists have now discussed record keeping and are aware of what needs to be recorded to ensure that clinical records are contemporaneous. Record keeping will be audited on a regular basis.

38	{my}dentist – Fairwater Practice	26/10/17 (published 29/01/18)	Overall a positive report *Improvements Required* • Ensure information is provided in appropriate language and format • Review and update its website in line with GDC guidance • Review patient access to its complaints procedure information • One member of staff where further inoculation detail is being sought • Review the location of one X-ray isolation switch • Radiation protection training at an appropriate level for dental nurses		• Response requested by: 31/01/18	• HIW satisfied with Action Plan submitted by practice • Response received 29/01/18 **Actions taken in response to Report:** Leaflets and information to be made available for individual patient needs and those who speak Welsh – poster in Welsh added to Practice notice board Review website in line with GDC guidelines for ethical selling – has been put forward to Head Office (Cont'd.)

Appendix 2
HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

			• Ensure audit processes are undertaken periodically • Findings addressed around record keeping *Positive areas* • Majority of patients were satisfied with the service provided • Staff friendly, welcoming and committed to providing a good standard of care • Clinical facilities were well equipped and clean • Dental instruments were cleaned and sterilised appropriately • Arrangements in place for the safe use of X-rays.			Review complaints procedure and display – complaint procedures are now prominently displayed on notice board in patient waiting area and all staff are aware of protocols Opportunity for patients to provide feedback – the practice now has a suggestion/feedback box Risk assessment for staff where further inoculation is being sought – the practice is now in receipt of the outstanding titre levels for one member of staff Relocation of isolation switch for Xray – photographic evidence provided Radiation protection training to be kept up to date in line with GDC and Ionising Radiation regulations 2000 – evidence of certificate provided Audit processes to be undertaken periodically – completed audits will be uploaded to Mycomply which will prompt Practice Manager when they are due again so deadlines are not missed Dentists must ensure that the specific findings in the report are addressed around record keeping – Practice Manager to

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Appendix 2
HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

						review findings on next audit and should results not have improved then to contact Clinical Support Manager for guidance and action plans.

37	Clifton Dental Practice	23/10/17 (published 24/01/18)	Overall a reasonable report
			Improvements Required
			• Qualified person to undertake PAT testing
			• Use of an ultrasonic bath or washer-disinfector
			• Ensure all drugs are kept securely in locked area/cabinet
			• Training records of policies updates with all staff.
			• Radiography
			  • Consider radiation dosimeters
			  • Maintain log of all radiographs
			• Confirmation that 3 clinical staff have necessary immunity Hepatitis B status
			• Complaints policy
			  • Include reference to ""Putting Things Right""
			  • Display "Putting Things Right" posters and leaflets in waiting areas
			• CPR training out of date for one nurse
			Positive findings:
			• Evidence of strong management and leadership
			• Patients were treated with respect and received a good standard of dental care
			• The practice actively sought patient feedback
			• Staff team competent in carrying out their responsibilities and were committed to providing a high quality service.
					• Review undertaken
					• Letter sent to practice outlining good practice and areas picked up in HIW Action Plan
					• Response requested for ongoing work.
					• Response requested by: 14/02/18
						• Undated response reviewed on 20/02/18. No further action required.
						Actions taken in response to Report:
						Quality of patient experience improvement – posters and leaflets are displayed in the Practice together with a copy of the Complaints Policy which has been amended to show reference to ""Putting Things Right""
						Delivery of safe and effective care – copy submitted of the Certificate of Competence confirming that a member of staff has completed the necessary course to qualify as PAT tester; Practice PAT test was completed on 27th January, 2018 and report submitted to UHB
						Pre-sterilisation cleaning of instruments – negotiations under way with Wright Cotterill Dental Suppliers and further discussions will take place at staff meeting in April 2018.

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Appendix 2
HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

						Locked drugs – implemented during the Practice inspection and photographic evidence supplied that the Practice emergency drugs are stored in a locked steel cabinet in a room protected by a "No Authorised Persons Allowed" sign. Radiation Dosimeters – these have now been placed on the s-ray handset in each surgery. Service Level Agreement awaited. Radiograph Log – copy of the x-ray log recording all the necessary information submitted Policy Log – submitted copy of a log drawn up and signed by every member of staff confirming that they have read and understood d the Practice policies currently in force Hep B immunity – confirmation received that all but three members of staff have the necessary immunity from Hepatitis B. Risk assessment undertaken for remaining 3 staff in context of worldwide shortage of Hep B vaccination supplies.

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Appendix 2
HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

36	Greenfield Dental Care	16/10/17 (published: 17/01/18)	Overall a positive report *Improvements Required* • Medical emergency equipment/drugs - Cannula* use by date had expired *[* this is **not** mandatory equipment in kit]* • Regular checks to be completed on the emergency drugs and equipment • Update adult safeguarding policy - appropriate safeguarding team contact details • Ensure medical history forms are signed by the patient and countersigned by the dentist at each visit • Immunisation levels - review hepatitis B level for 1 member of staff; retain immunisation outcomes for all staff		• HIW issued satisfactory assurance • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work. Response requested by: 31/01/18	• Response received on 12/02/18. **Actions taken in response to Report:** Change made to the way Practice audits emergency drugs, oxygen and defibrillator – there is now a sheet for each individual item, with the expiry date at the top of each sheet. Weekly checks carried out. POVA policy updated to include the latest telephone, email and contacts for the Vale of Glamorgan and Cardiff. Designed a new medical history form, and updated medical history taking policy, so that all patients, and their dentist, sign the medical history completed at every appointment. Hepatitis B surface antibody levels confirmed as satisfactory for all members of staff. In the context of the worldwide shortage of Hep B vaccination it has now been made a condition that anyone attending for interview must bring their Hep B paperwork with them as well as their GDC certificate. Complaints policy updated to acknowledge that response to a

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						complaint must be within 2 days, not 3.
35	Bupa Dental Care (Pentwyn)	07/09/17 (published: 06/12/17)	Overall a positive report *Improvements Required* • More health promotion information in waiting area • Verification of inoculation immunity check status required for three staff • Amend infection control policy to refer to WHTM 01-05 (and not the HTM 01-05) • Review access to stock room area and decontamination room		• HIW satisfied with outcome of Action Plan submitted by practice • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work. Response requested by: 31/01/18	Meeting scheduled with the practice for 05/06/18.
34	Cyncoed Dental Practice	17/08/17 (published: 20/11/17)	Overall a positive report *Improvements Required* • Language Services - information in language/ format meeting needs of patients; formal arrangement in place to access interpreting services • Complaints procedure - compliant with NHS "Putting Things Right"; develop private patients' complaints procedure; review complaints handling processes and record keeping • Five yearly electrical wiring certificate • Patient records improvements required - recording oral cancer screening; recording valid		• Response requested by: 31/01/18	HIW satisfied with Action Plan submitted by practice **Actions taken in response to Report:** Language Services - a policy for helping non English speaking patients to understand treatment needs and for obtaining their informed consent to dental treatment has been made and a protocol for helping patients receive suitable help and advice with interpretation adopted. Contact details for a

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			consent; written treatment plans; justification and clinical findings of radiographs			number of interpreting agencies provided. (Cont'd.) Complaints Procedure – Cyncoed DP 'Complaints Policy' is now displayed in Welsh and English. Separate complaints policies for NHS and Private patients have been designed following guidelines in 'Putting Things Right' and Private Dentistry 2008 Regulations. A log book for filing and recording complaints (and also 'concerns raised') has been made with pro forma for recording action, outcome and closure of every complaint or concern raised. Complaints procedures will be reviewed on a regular basis, six monthly at least, with the complaints officer. Electrical Wiring - a company has been contracted to perform a safety check of the electrical wiring of the premises and to issue a certificate when completed. Patient Records Improvements: Oral Cancer Screening will now be recorded in the patient record cards as OCS with any relevant findings. Screening will continue to be completed for every patient as part of their

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						routine examination. Consent to examination and treatment for every patient will be recorded in the records. A treatment plan, estimate and consent form will be signed in advance of providing any treatment. The patient will be given time to ask questions and consider alternative options to ensure the consent is informed. It will be updated at each visit. Justification, quality and clinical findings of radiographs will be recorded in the patient records.
33	{my}dentist (Countisbury Avenue, Llanrumney)	17/07/17 (published: 18/10/17	A reasonable report overall *Improvements Required* • Review storage of hazardous and non-hazardous waste • WHTM 01-05 Issues (decontamination training) • DBS certification for all dentists Review storage and access of patient records • Administrative (centralised training records)		• HIW satisfied with outcome of Action Plan submitted by practice • Response requested by: 31/01/18	No response received from the practice. Chase email sent May 2018
32	Restore Dental Group (215 & 354 Whitchurch Road)	28/06/17 (published: 29/09/17)	An overall poor report, with a significant number of areas of improvement identified being described below: • System checking medical emergency equipment and drugs • Health promotion information to be available for patients • Private patient's price list displayed • Patient information provided in language/ format meeting needs of patients • Review NHS complaints procedure to :		• HIW satisfied with outcome of Action Plan submitted by practice • Originally categorised as Red. • Letter sent to practice (29/08/17) by UHB to seek	**May 2018** Following chase email a comprehensive response has been received from the practice. Re categorised to yellow. Due to the number of issues and the difficulty obtaining a response a follow up visit is required. Practice visit rescheduled for Spring 2018.

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FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

			- Compliance with NHS 'PTR' - Complaints handling processes (Cont'd.) - Recording and audit trails • System for recording views of patients • Five yearly electrical testing certificate • Fire risk assessment review • Review access to stock room and decontamination room • Decontamination training required for relevant staff. • Review resuscitation policy for both premises • Review stock control processes: - Materials - Anaesthetics • Child protection/POVA training needed for relevant staff • Review location of X-ray isolation switches • Review appropriate IR(ME)R training for dental nurses • Formalise QA arrangements • Patient records: - Patient medical histories - FP17s for banded NHS COTs - Justification and reporting of radiographs - Treatment plans and options • Clinical Issues: - Clinically necessary treatment carried out under private arrangements - Frequency of BW radiographs • DBS required for five dentists • Staff appraisals on an annual basis. • Practice management and leadership in this practice need to be reviewed and strengthened		written assurances on issues outlined in Action Plan with a request to follow up the process with a meeting within six months. • Response received 19/09/17 • Re-categorised as Amber following response from Practice	

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31	Dental Surgery (G O'Keeffe & J Jones)	18/07/17 (published: 19/10/17	A reasonable report overall *Improvements Required* • Review of complaints process to include trail of complaint • Review system for capture of informal comments • Review storage of hazardous and non-hazardous waste • Storage of sterilised instruments in line with WHTM 01-05 • OOD Emergency equipment to be replaced & system for regular checks to ensure they remain in date. • Radiography (critical examination reports missing and system for X-ray QA audits required) • Peer review system recommended • Patient record system needs reviewing • Review storage and access of patient records • Formal induction for Agency staff Administrative (Centralised training records, staff appraisal system, formally document team meetings)		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan once Report has been formally published. • Response requested for ongoing work. Response requested by: 31/01/18	Meeting scheduled for June 2018.
30	Hillcrest Dental Practice	21/06/17 (published: 27/09/17)	A positive report overall *Improvements Required* • Review the NHS complaints policy and procedures • Electrical wiring certificate • Gas maintenance certificate • Review environmental risk assessment • WHTM 01-05 Issues (hand washing sink and dual sink arrangement) • Dentist requires inoculation immunity check • Staff to complete decontamination training. • Review of the cleaning schedule.		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan once Report has been formally published. • Response requested for	• Response received from practice 26/02/18 **Actions taken in response to Report:** <u>Extension of the decontamination room</u> has been scheduled for the end of 2018. <u>Hep B status -</u> performer was seen at Occupational Health on 11/08/17 and told that he does not need a booster.

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			• Residual works to cabinetry, decorative works to surgery		ongoing work. Response requested by: 31/01/18	Redecoration of the ground floor surgery is scheduled to be painted in the next couple of weeks and repairs to the cabinetry will be made by the end of 2018. A record keeping audit was completed in Nov 17. Infection prevention control theory and practical training was provided by the DBG on 14/08/17. Electrical wiring certificate received POVA training certificate Safeguarding certificate
29	Calgary Dental Practice (Llantwit Major)	08/05/17 (published: 09/08/17)	A positive report overall *Improvements Required* • OOH number for private patients • Update complaint process to include ""Putting Things Right"". • Surgery floor needs to be appropriately sealed • Update Adult and Child Safeguarding policies • Explore relocation of isolation switch for X-ray unit & radiograph processing audit • QA Audit • Immunisation Records need to be retained • Updated DBS certificates for HIW registered dentists.		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan once Report has been formally published. • New practice owner. Letter to new owner to check that improvement plan is being followed through on.	**May 2018** No significant concerns highlighted, due to change in Ownership and lack of response to request for update the practice remains Yellow. Chase email sent to new provider

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28	myDentist (Quay Street)	21/03/17 (published 22/06/17)	Report found on HIW website – July 2017. **Not notified.** A positive report overall *Improvements Required* • Environment Review: Dental Unit and equipment need to be in satisfactory condition. • Patient record issues (storage/stationery) • Patient record issues (treatment plans/NHS or private/ NHS PRW Forms) • Ensure all policies are kept up to date and reviewed in correct time frames		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work. Response requested by: 31/01/18	**Actions taken in response to Report:** Review of environment in surgeries – photographic evidence submitted of improvement works carried out Review of bins – all surgeries now have foot operated bins and can be closed Review of patient records – the Practice has become paper free, scanning in all FP17's, lab dockets and medical histories; as of 29/01/2018 all PRW's are scanned to the patient's file Review of patient stationery – the Practice was previously using printed treatment plans from R4 for private patients but has since changed to FP17s for all patients; these are scanned into the patient's file Review of treatment plans –the Practice is now using FP17s for all patients which clearly identifies if the treatment is NHS or private PRW forms are consistently completed and scanned to the patient's file Review of policies and procedures – Practice Manager has confirmed that this work in progress and will be updated on Mycomply

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FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

						Appraisals – All staff appraisals were completed July 2017; evidence can be supplied if required.
27	Gwena Dental Care	02/03/17 (published 05/06/17)	Report found on HIW website – June 2017. **Not notified.** A positive report overall *Improvements Required* • Update complaint policy to reflect correct timescales. • Complaint policy on the website • Methods for regular checks of Emergency Drugs • IR(Me)R Training for all relevant staff • Patient records quality		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work. Response requested by: 31/01/18	Awaiting Response
26	Wilton House Dental Practice	28/02/17 (published 31/05/17)	Report found on HIW website – July 2017. **Not notified.** A number of areas of improvement were identified, with the main issues being described below: • Separate NHS and Private complaints procedures needed • Private Price List • WHTM 01-05 Audits • WHTM 01-05 (dirty to clean workflow signs, instruments to be cleaned and sterilised properly, single use items not reused on same patients) • Checks on Emergency Drugs expiration dates • Radiographic Audit (Cont'd.) • Patient Record Improvements • Implement Resuscitation Policy		• HIW issued satisfactory assurance • Practice written to by UHB to seek assurances on issues outlined in Action Plan. • Practice under new management (01/12/17)	Meeting to be arranged with the new owners for July 2018

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FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

			• POVA Training • Child Protection Training			
25	The Orthodontic Centre	05/01/17 (published 06/04/17)	Report found on HIW website – August 2017. Not notified. An overall positive report. *Improvements Required* • Ensure that surgery floors are kept clean and tidy • Ensure the surgery floor is sealed appropriately • Ensure work surfaces are sealed appropriately • Ensure all instruments and equipment are in suitable condition • Ensure compliance with WHTM 01-05 for storage of sterilised instruments • Patient records Issues (updating and countersigning medical history, oral health of patient, extra oral findings) • Process for audit of equipment and materials BBE		• HIW issued satisfactory assurance • Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	
24	Cathedral Orthodontics Ltd	05/12/16 (published 06/03/17)	Report found on HIW website – August 2017. **Not notified.** A positive report overall *Improvements Required* • WHTM01-05 Issues (performing tests and procedures on autoclave machines/maintaining logbooks of the tests and procedures on autoclave machines) • Ensure patient records completed are maintained in accordance with standards • Radiographs (Ensure X-rays have full justifications and reports) (Cont'd.)		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	

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FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

23	Bupa Dental Care (Canton)	24/11/16 (published 27/02/17)	A relatively positive report overall with some significant areas of concern *Improvements Required* • Website to comply with GDC standards for advertising. • Deep cleaning schedule to be implemented • Remedial work to cupboard/dental chair and stool • Electrical wiring certificate to be updated • Fire Exit access query • Environmental Risk Assessment • Inoculation Records • CPR training evidence for all staff • DBS Checks to be updated • Position of X-ray switch review • IR(ME)R Training for all staff • Records Keeping Improvements (MH updates/ smoking cessation advice)		• Practice written to by UHB to seek assurances on issues outlined in Action Plan (22/08/17) • Originally categorised as Amber	• Response received 17/10/17
22	Wilson Road Dental Surgery	18/11/16 (published 20/02/17)	Notified to UHB – 15th May 2017 A positive report overall *Improvements Required* • Clinical/hazardous waste storage needs to be safely stored • Review of cleaners handling clinical waste • Review clinical facilities to ensure safety and condition. Specific attention: worktops and handles/flooring sealed in the surgeries/ repairing or replacing the light unit, suction pipe, upholstery/rusting or damage to the dental chair. • WHTM 01-05 Compliance (separation of clean/dirty areas, dental impressions and disinfection, autoclave data logger not being used correctly) • Confirmation letter to HSE (Cont'd.)		• HIW issued satisfactory assurance • Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	Meeting scheduled with the practice 12/06/18

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FOLLOW UP ACTIONS (up to May 2018) - TABLE OF INSPECTIONS

			• IR(ME)R training certificates obtained and kept on file • Patient records administration • Radiography: • Review of policies			
21	Cardiff Smile Centre	15/11/16 (published 16/02/17)	Report found on HIW website - 08/17 **Not notified** A positive report overall *Improvements Required* • Review location of clinical waste bin. • Website to comply with GDC standards for advertising. • Patient records: - Comprehensive patient information to be recorded - Specific Attention: - Addresses - Cessation advice - Consent - OCS • Justification and reporting of radiographs needs to be recorded • Review of all policies and procedures needed to ensure the correct organisations and/or appropriate guidance is listed. • Policies and procedures need to be consistent with version and review dates mentioned within documents • Review of staff training needed.		• Review undertaken • Letter to practice outlining good practice and areas picked up in HIW Action Plan • Response requested for ongoing work.	No Updates
20	Ellen Davies Dental Practice	27/10/16 (published 30/01/17)	A positive report overall *Improvements Required* • Informing patients and visitors of the CCTV in operation • Ensure full compliance with WHTM 01-05 (Cont'd.)		• Review undertaken • Letter to practice outlining good practice and	No Updates

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			• Resuscitation equipment needs to be checked • First Aider: certificates obtained held/first aid box needs to be checked regularly • IR(ME)R for dental nurses • Patient records: - Medical histories countersigned - Medical histories are updated - Soft tissue examinations • Justification for x-rays • Review of all staff training needs required and courses • Policies and procedures need to be consistent with version and review dates		areas picked up in HIW Action Plan • Response requested for ongoing work.	
19	Nicola Taaffe @ West Grove	26/09/16 (published 29/12/16)	A weak report overall *Improvements Required* • Practice's complaints procedures need updating • Compliance with WHTM 01-05 in respect of: - Autoclave tests - Procedures on Ultrasonic Bath - Maintaining records • Ensure floors are appropriately sealed between the cabinets and walls • Implement system regular checks on the emergency equipment • Review storage of emergency drugs and equipment in one location for easy access • Review safeguarding procedures: • Ensure staff complete training • Patient records issues: - Medical histories - Use of templates - Treatment planning - Consent - Radiographic reports (Cont'd)		• Originally categorised as Red • HIW satisfied with outcome of Action Plan submitted by practice • Practice written to by UHB to seek assurances on issues outlined in Action Plan. • Assurances received from practice. • Re-categorised as Yellow	Practice Meeting to be arranged

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			• Review of all policies, procedures and demonstrate implementation • Training certificates for all clinical staff • Confirmation of the Hepatitis B immunisation for all staff			
18	Hickman House	04/04/17 (published 05/07/17	WHTM 01-05 Compliance: • Monitoring of water temperatures used • Magnifying devices in process of visually checking instruments. • Storage of materials and equipment		• HIW Assurance Received	• Confirmation of issues rectified
17	Marlborough Dental Practice	16/05/17 (published 17/08/17)	A positive report *Positive Findings* • Systems were in place to capture patient feedback • Patients unanimously stated they were happy with the service provided • Staff we spoke to said they were happy in their roles and felt supported • Relevant audits were being undertaken which provided evidence of a practice continually looking to improve their services • The environment provided clinical facilities that were well-equipped, well maintained and visibly clean and tidy • Record keeping was comprehensive and up to date • Systems were in place to ensure staff were supported and had the necessary training to deliver their roles efficiently		• None	

HIW Immediate Assurance Letters (received since last update)

Members should note that Immediate Assurance letters for Primary Care are *issued* to the Practice for response and *copied* to the UHB for Information and to feed into the broad Performance Management of the practice.

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	Practice Name	*Inspection Date*	*IA Letter Date*	*Summary*	*UHB Actions*
1	No Immediate Assurance Letters since last update				
HIW Concerns Raised (received since last update)					
	Practice Name	*Contact from HIW*	*Follow Up*	*Summary of Concerns*	*Summary of UHB Actions*
1	No Concerns raised by HIW since last update				

SENSORY LOSS PROGRESS REPORT 2017-18
Name of Meeting: Quality, Safety And Experience Committee Committee **Date of Meeting** 12 June 2018

Executive Lead: Chief Operating Officer
Author: Equality Manager Tel: 029 2074 2267
Caring for People, Keeping People Well: This report underpins the Health Board's 'Priorities', 'Sustainability', 'Culture' and "Values" elements of the Health Board's Ten Year Shaping Our Future Wellbeing Strategy
Financial impact: There are no anticipated costs identified with this paper.
Quality, Safety, Patient Experience impact: The information provided in this paper supports the organisation's goal of providing high quality, safe services to its patients
Health and Care Standard Number 3.2, 4.2 & 6.2 **CRAF Reference Number** 8.1.6
Equality Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Continued development of and action taken by the UHB's Sensory Loss Standards Working Group
- The UHB's six monthly report to Welsh Government against the All Wales Standards for Accessible Communication and Information for People with Sensory Loss

The Board is asked to:

- **NOTE** the progress made in relation to sensory loss

SITUATION

As work continues across the UHB Wales to implement the All Wales Standards for Accessible Communication and Information for People with Sensory Loss, it is important to share the progress being made to improve access to healthcare for people with sensory loss and also, to highlight the issues and experiences of people with sensory loss which we need to understand to ensure that the changes being made actually will make a positive difference to the patient experience. This paper reports on the progress made by the UHB in meeting its obligations under its sensory loss agenda.

BACKGROUND

In December 2013, the Welsh Government Minister for Health launched the '*Sensory Loss Standards for Wales*'.3 The standards were broad and set out a challenge to

the Welsh National Health Service (NHS) to improve the way that patients with sensory loss receive care in three service settings, namely primary, secondary and unscheduled care.

The The All Wales Standards for Accessible Communication and Information for People with Sensory Loss (Sensory Loss Standards) reflect the Equality Act 2010 in which needs are to be anticipated and reasonable adjustments made. Subsequently, other legislation, such as the Social Services and Wellbeing (Wales) Act 2014 and Wellbeing of Future Generations (Wales) Act 2015 have now been enacted. All three pieces of legislation are material to the delivery of the sensory loss standards. There are five thematic standards that need to be taken into account, namely identifying patients with sensory loss; communicating with them; training of staff; environmental considerations such as signage and raising concerns or complaints.

An All Wales officers group meets regularly, which includes the UHB's Equality Manager to support sharing of practice and exploring challenges. Six monthly progress returns to Welsh Government are also required to demonstrate the actions taken by the UHB to meet the Sensory Loss Standards (Please see Appendix 1). In November 2017, the third sensory loss awareness month campaign 'It Makes Sense', was promoted throughout the UHB. The campaign aims to support staff to communicate effectively with people with sensory loss.

The It Makes Sense Logo is an easy way to help raise awareness and promote sensory loss awareness month.

It Makes Sense
SENSORY LOSS AWARENESS MONTH

Previous updates have been received by the Board, Quality and Safety Committee and the Equality Diversity Human Rights Sub Committee.

ASSESSMENT AND ASSURANCE

There have been some noteworthy improvements in the work of the UHB Since the last progress report to the Board.

- The Dental Clinical Board has successfully achieved the Louder than Words accreditation. The first Hospital in Wales to do so. Louder than Words is a nationally recognised accreditation for organisations striving to offer excellent levels of service and accessibility for customers and employees who are deaf or have a hearing loss.
- Sensory Loss Awareness 'It Makes Sense' campaign month took place for the third year running in November 2017 and it was pleasing to see the momentum for the campaign beginning to grow. A variety of approaches were used by our Sensory Loss Champions/Leads and the Communication Team to promote these key Campaign messages across the UHB during November,

including use of the intranet, social media and promotional packs. For example, campaigns such as the recent Deaf Awareness Week have been promoted on the intranet.

- Meeting the Standards continues to be a key delivery action for 2018/19 as part of the UHB Strategic Equality Plan Fair Care 2016-20.
- Our Clinical Boards have continued to work in close partnership with third sector organisations, including Action on Hearing Loss and the Royal National Institute for the Blind. For example, In Specialist Services Clinical Board a number of wards within the Clinical Board have recently undergone refurbishments which comply with RNIB recommendations for patients with sensory loss.
- There is a named lead for Sensory Loss in every Clinical Board
- The Sensory Loss Champions, who represent all the Clinical Boards and Corporate departments, such as Capital, Estates & Operational Services, as well as the Patient Experience Team continue to meet on a regular basis to explore the Standards and feedback to the Working Group, with its next meeting taking place on 13th June 2018.
- A patient story video, for use in training, is in the process of being subtitled and is based on the high quality support and good practice received by one of our deaf patients by a Multi-Disciplinary Team.
- In CD&T negotiations to use a Patient Portal (website) for viewing appointment information are in advanced phase and will enable zoom functionality. Patients would receive a link to this Portal via text.
- Patient pagers have been introduced in out-patients. These pagers vibrate, flash and make a sound when activated which signals to patients that they have been called for their appointment.
- A trial for text reminders for patients is currently underway in CD&T. This will remind patients of their appointments via a text message and give them the option to reply by text to confirm, cancel or book by text. This will allow patients to increase the font on their mobile phone or the message can be converted to voice at their home.
- Radiology information system can hold electronic alert and is being used to record patients' needs
- Loop systems are available for use in all Mental Health clinical areas for those with hearing loss
- Hearing loops are available across all Directorates within Medicine Clinical Board and a sensory loss action plan completed.
- The Mental Health Clinical Board hosts a quarterly sensory loss forum and has a clear action plan for improvement
- In PCIC assurance around sensory loss is included in their practice appraisal process
- A pilot project which aimed to develop the awareness of staff in GP practices about how to communicate effectively with Deaf patients who use British Sign Language took place in a Cardiff surgery.
- Specialist Services Clinical Board patients communication needs and limitations are identified in long stay critical care wards. In Haematology a sensory loss audit with associated action plan was undertaken.
- A walk about by the Director of Nursing and Director of Operations to review the bathrooms in the Clinical Board identified areas where improvements

could be made to change the colour of toilet seats and hand rails to better assist patients with sensory loss, these changes have been enacted.
- A sensory loss audit was undertaken within Specialist Services across the wards of the Clinical Board in December 2017 and an action plan is now being prepared to address outcomes and findings.
- Surgery Clinical Board has produced a Sensory loss action plan, which is monitored via the Q&S group. A trial for text reminders for patients is now taking place.
- The schedule detailing the building and engineering services standards and how they impact on Sensory loss and equality has been drafted. Discussions will take place regarding its use and implementation

The Chair of the Health Board led a public meeting for the Deaf and hard of hearing earlier this year. The key themes raised and explored were the standard of our written and other communication and information, the lack of use of our technology and the on-going need for staff awareness and training. An action plan has been developed and implementation work is beginning around issues such as flag alerts for patient records, identification of our patient's sensory loss status and awareness training.

The Community Health Council has recently produced a sensory loss assessment report for the Health Board. They note that sensory loss has become a key driver for the organisation and that the availability of resources has improved. However, they do have concerns that recording the status pf patients with sight or hearing loss has not been translated into staff awareness. They have made three key recommendations which will be considered at the next Sensory Loss Standards Working Group at its next meeting on the 13th June 2018.

Summary
There has been progress in developing the sensory loss agenda since the last up date to the Board last year. There is high visible recognition of the need to continue to embed this work on an ongoing basis. A refreshed approach to standardizing the work of the Sensory loss Champions is beginning to pay dividends and the gaining of the Louder than Words accreditation means that there is great potential to put learning into practice across the UHB. That is not to say that there are not challenges to face, but perhaps we can view some of them with a little more optimism.

Next Steps
Continued work will be undertaken to develop and support the Sensory Loss Champions and to act upon the themes emanating from the views expressed at the public meeting by our service users.

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

MINUTES OF THE MEETING HELD ON 7TH MARCH 2018

Present:

Alun Morgan (Acting Chair)	Assistant Director of Therapies and Health Sciences
Rachael Daniel	Health and Safety Adviser
Suzie Cheesman	Patient Safety Facilitator
Bolette Jones	Head of Media Resources
Maria Jones	Senior Nurse, Outpatients
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration

Apologies:

Matthew Temby	Clinical Board Director of Operations
Sue Bailey	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
David Lewis	Head of Finance
Ceri-Ann Hughes	Head of Workforce and OD

Secretariat:

Helen Jenkins	Clinical Board Secretary

27.1

PRELMINARIES

CDTQSE 18/040 Welcome and Introductions

Alun Morgan welcomed everyone to the meeting. The poor attendance at today's meeting was noted. Going forward from April, this meeting will need to be given priority.

CDTQSE 18/041 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 18/042 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 10th January 2018 were **APPROVED.**

CDTQSE 18/043 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 17/261 Lung Nodule Follow Up

Mike Bourne is currently on leave so unable to obtain an update on whether the recommendations have been presented to the LMC.

CDTQSE 18/10 Flu Vaccination

Alun Morgan has discussed staff concerns with Sharon Hopkins and she has advised that there is no difference in the effectiveness of the trivalent and quadrivalent vaccines.

CDTQSE 18/023 Safeguarding Case

The Safeguarding case relating to a patient's identification is closed as a Health Board but still open with the police and Social Services. Alun Morgan will present this as a patient story at a future meeting.

CDTQSE 18/026 Medical Referrer Policy for Diagnostic Imaging

Alun Morgan has asked Lesley Harris for an update on the All Wales position and is awaiting a response. Following the meeting Lesley Harris advised that the All Wales Imaging Quality Forum is undertaking this work rather than the Wales Radiology Managers Committee. A draft document and application form has been produced and is being amended for submission to the MISC.

CDTQSE 18/030 NICE Guidance Notifications

Alun Morgan to follow up with Mike Bourne to check if the notifications around child neglect and child maltreatment have been circulated and implemented.

Action: Alun Morgan

CDTQSE 18/Any other Business

Sue Bailey to present the closure form for the mortuary incident at the next meeting.

Action: Sue Bailey

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 18/044 Patient Story

No patient story was presented. Rebecca Vaughan-Roberts volunteered to present at the next meeting.

CDTQSE 18/045 Feedback from UHB QSE Committee December 2017

The UHB QSE Committee minutes 7th December 2017 were **RECEIVED**.

CDTQSE 18/046 Health and Care Standards

The self-assessment process is to be completed by end of April. Sue Bailey is leading on this for the Clinical Board.

CDTQSE 18/047 Risk Register

A review of directorates' risk registers was held in December and individual sessions have also been held with Therapies and Laboratory Medicine. Laboratory Medicine is currently refreshing individual areas of their register and a further meeting will be held in April for an update.

Alun Morgan emphasised that directorate risk registers need to be underpinned by individual risk assessments.

CDTQSE 18/048 Exception Reports

Sue Bailey conducted a visit to Outpatients CRI and Maria Jones is awaiting her feedback on the waiting area.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 18/049 Initiatives to promote Health and Wellbeing

The latest flu uptake figures have not yet been released. The UHB is anticipating that the Clinical Board will increase its compliance by 11.4% when the final figures are verified. It was noted that there has been a significant improvement in uptake for the UHB as a whole this year.

It was also reported that staff are being encouraged to take up the Chief Executive's 'Len's Challenge' in June.

CDTQSE 18/050 Falls Prevention

Alun Morgan reported that the Chief Executive is keen that there is focus on falls in the community and a project is being set up. Evidence from Canterbury indicates that this approach can lead to a reduction in neck of femur fractures, reduction in mortality rates and a reduction in the impact on EU.

The Falls Prevention Fuel Tank has been launched. This is a new animated video which highlights the risk of falls and how individuals can prevent them.

QSE 18/051 Concerns and Compliments Report

The Clinical Board received 7 concerns in February. There were no breaches in response times and 0 AM concerns were received during February. The Clinical Board received 9 compliments.

Since1st April 2017 the Clinical Board has received 61 formal concerns and 88 compliments.

The key theme for formal concerns relates to clinical diagnosis and treatment.

CDTQSE 18/052 Ombudsman Reports

Nothing to report.

CDTQSE 18/053 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 18/054 Patient Safety Incidents

No SIs to report.

CDTQSE 18/055 New SI's

There are no new SI's to report.

1 IRMER case was reported in January related to an unintended CT hip due to poor handwriting on referral form.

CDTQSE 18/056 RCA/Improvement Plans

NC962 PETIC School of Medicine RCA Report

The RCA Report was shared for learning purposes. This incident relates to an unintentional exposure received by a patient due to incorrect patient identifier label being attached to a request form by the referrer.

Alun Morgan to speak to Sue Bailey about the Cardiff University RCA investigation report format and whether there should be consistency with the UHB process.

Action: Alun Morgan

CDTQSE 18/057 WG Closure Forms – Sign Off

In51047

The Report was **RECEIVED**. However it was agreed that Sue Bailey will be asked to present this at the next meeting.

Action: Sue Bailey

CDTQSE 18/058 Regulation 28 Reports

Nothing to report.

CDTQSE 18/059 Patient Safety Alerts

PSN040 Confirming Removal or Flushing of Lines and Cannulae after Procedures

The Patient Safety Notice was **RECEIVED.** This has been circulated to directorates. It is linked to work on NATSSIPs.

WHC 2018 001 Guidance on Safe Clinical Use of Magnetic Resonance Imaging (MRI)

The guidance suggests that the UHB should employ a Medical Physics Expert. It was noted that the UHB is utilising the expertise of an individual in Swansea due to lack of expertise and individuals with the required qualifications nationwide.

WHC 2018 007 Ionising Radiation Requirements for NHS Organisations

It was noted that individual applications for licences have been submitted.

CDTQSE 18/060 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 18/061 IP&C Issues

A meeting was held today with housekeeping to review room cleanliness in Outpatients and changes required to the cleaning schedules to reflect the usage of the rooms. A good piece of work has been undertaken looking at how room usage has changed. Work is now being taken forward around mapping out high risk areas where different clinics with different procedures and examinations occur in the same room on the same day.

Rebecca Vaughan-Roberts noted that she has been unable to obtain a definition of a deep clean. In Radiology if a patient has a latex allergy, they are scheduled for the first appointment of the day and the room is given a deep clean prior to their attendance. She has asked what a deep clean entails but has not received a response. Maria Jones agreed to follow this up.

Action: Maria Jones

It was agreed that decontamination issues will be discussed within this item. Helen Jenkins to change the item to read IP&C Issues/Decontamination.

Action: Helen Jenkins

CDTQSE 18/062 Key Patient Safety Risks

Safeguarding

WHC 2018 008 New Law on Intimate Piercing of Children

The WHC states that it is now illegal to intimately pierce children under the age of 18.

CDTQSE 18/063 Health and Safety Issues

Rachael Daniel reported that the UHB was contacted by the HSE following concerns relating to the histopathology laboratory in terms of the lifts being out of order and general environment concerns around clutter in the area. A response has been produced from Scott Gable and Sue Bailey which has been forwarded to the HSE. The UHB is awaiting a response.

Sue Bailey and Alun Morgan have undertaken 2 hydrotherapy walkrounds. They have received assurance that the actions from the HSE have been closed out. One outstanding concern is around inconsistency of estates management during the weekend.

CDTQSE 18/064 Regulatory Compliance and Accreditation

The Clinical Board Regulatory Compliance Group will be set up in the next month.

The Clinical Board has been discussing learning and planning for inspections with its directorates that receive regulatory inspections and being 'Always Inspection Ready (AIR).

CDTQSE 18/065 Policies, Procedures and Guidance

Protocol for Adjustment of Insulin

A protocol has been produced by Dietetics department for use for adults with diabetes under the care of this UHB. Alun Morgan to discuss with Judyth Jenkins. Item to be deferred to next meeting.

Action: Alun Morgan

Sion O'Keefe reported that the UHB Records Management Policy has been approved. Contains updated information and links to the retention schedule produced by the Department of Health. The Policy will be uploaded on to the intranet. Robust local procedures need to be put in place for destruction of records linked to the retention schedule.

EFFECTIVE CARE

CDTQSE 18/066 Clinical Audit

Nothing to report.

CDTQSE 18/067 Research and Development

The Clinical Board R&D Strategy for next 3 years has been produced. Where directorates support studies, the mechanism needs to be reviewed so that Clinical Board has oversight and signs these off.

There is an intent for the R&D Lead to attend Clinical Board meetings on a quarterly basis.

CDTQSE 18/068 Service Improvement Initiatives

Only one Group from the Clinical Board has been put forward for the next LIPS Cohort. This is a project within Outpatients/Patient Administration in conjunction with the Welsh Language Officer and Equality Officer focussing on dignity of patients in the Outpatient Setting.

The Clinical Board Improvement Group continues to meet. 10-12 projects have been identified and are currently in progress. The aim is now to extend the group wider across the Clinical Board and there will be an open invite.

The Clinical Board has also recently introduced the 'Genius Hour' which is a way of generating ideas from staff and allowing time for free thinking. The first session will be held next Tuesday.

CDTQSE 18/069 NICE Guidance

Nothing to report.

CDTQSE 18/070 Information Governance

A request has been received from Paul Rothwell for directorates to submit their Information Asset Registers. Helen Jenkins to send a reminder to the directorates that have not responded.

Action: Helen Jenkins

General Data Protection Regulations training has been delivered through Information Governance Team. It was noted that the charge for access to records is being reduced from £50 to £0. This is likely to increase demand for requests.

CDTQSE 18/071 Data Quality

The last UHB Data Quality Meeting was cancelled. Work is being undertaken with PCIC Clinical Board to understand patient demographics and contact details. It was noted that there is a 12% difference in the information stored by PCIC to the acute setting systems.

DIGNIFIED CARE

CDTQSE 18/072 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 18/073 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Following a public meeting which was attended by the UHB Chair, the Clinical Board is supporting work with patients with hearing loss. Looking at the ability for BSL functionality on PMS and also looking at a process mapping exercise for booking interpreters.

CDTQSE 18/074 Equality and Diversity

It was noted that services for the transgender community is a key area of focus and needs to be considered by services in any planning of developments.

TIMELY CARE

CDTQSE 18/075 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 18/076 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

The Clinical Board is on track to achieve tier 1 target for 0 waiters 14 weeks or over. The target for Radiology is to be at or below the level it achieved last year.

The impact of the adverse weather is still to be quantified. Recovery plans are being put in place.

The Clinical Board acknowledged the hard work and efforts of all the staff who have been working to deliver the targets.

INDIVIDUAL CARE

CDTQSE 18/077 National User Experience Framework

The report for January 2018 was **RECEIVED.** Alun Morgan suggested it would be useful if local user experience surveys were presented.

STAFF AND RESOURCES

CDTQSE 18/078 Staff Awards and Recognition

The UHB staff recognition awards are being held on Friday.

It was noted that 2 Radiology Registrars have won high profile national awards.

The CD&T Staff Recognition Award Scheme continues in 2018 and directorates are asked to encourage their staff to make nominations.

A 'Thank You Event' for staff in the Clinical Board is being held on 25th April at UHW with a further event being planned for staff at UHL.

CDTQSE 18/079 Monitoring of Mandatory Training and PADRs

Nothing to report.

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

The Laboratory Medicine QSE Group Minutes 30.1.18 were **RECEIVED.**

ANY OTHER BUSINESS

Alun Morgan suggested that a Clinical Board debrief on business continuity and lessons learnt from the adverse weather is held. Alun Morgan will discuss with Matt Temby.

Action: Matt Temby

Alun Morgan, on behalf of the Clinical Board, thanked all staff who worked above and beyond during the adverse weather last week.

27.1

DATE AND TIME OF NEXT MEETING

11th April 2018 at 2pm in the Council Room, UGF, UHW

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

MINUTES OF THE MEETING HELD ON 11TH APRIL 2018

Present:

Sue Bailey	Clinical Board Director of Quality, Safety and Patient Experience
Alun Morgan	Assistant Director of Therapies and Health Sciences
Robert Bracchi	Consultant, AWTTC
Bolette Jones	Head of Media Resources
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Kevin Hogan	Safeguarding Team

Apologies:

Matthew Temby	Clinical Board Director of Operations
Mike Bourne	Clinical Board Director
David Lewis	Head of Finance
Ceri-Ann Hughes	Head of Workforce and OD
Rachael Daniel	Health and Safety Adviser
Suzie Cheesman	Patient Safety Facilitator
Maria Jones	Senior Nurse, Outpatients
Rhodri John	Assistant Head of Workforce and OD

Secretariat:

Helen Jenkins	Clinical Board Secretary

27.1

PRELMINARIES

CDTQSE 18/080 Welcome and Introductions

Sue Bailey welcomed Kevin Hogan, Safeguarding Team to the meeting and introductions were made.

CDTQSE 18/081 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 18/082 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 7th March 2018 were **APPROVED.**

CDTQSE 18/083 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 17/261 Lung Nodule Follow Up Recommendations

Mike Bourne to update whether the recommendations of the Lung Nodule Follow paper have been presented to the LMC.

Action: Mike Bourne

CDTQSE 18/023 Safeguarding Case

The safeguarding case is still open and awaiting closure from the police. When closure is confirmed, Alun Morgan will present the case as a patient story.

Action: Alun Morgan

CDTQSE 18/056 Cardiff University RCA Reports

Sue Bailey to discuss with the Patient Safety Team that the Cardiff University RCA format should be consistent with the UHB format.

Action: Sue Bailey

CDTQSE 18/061 Definition of 'Deep Clean'

Maria Jones has asked Operational Services for a definition and protocol and is awaiting a response.

Action: Maria Jones

CDTQSE 18/065 Adjustment of Insulin Protocol

Alun Morgan has met with Helen Nicholls. The protocol has been approved through the relevant governance forums and has been signed off by Medicines Management. Alun Morgan has taken chair's action to approve the procedure on behalf of this Group.

CDTQSE 18/AOB Adverse Weather

It was noted that a meeting is being set up corporately to discuss the lessons learned.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 18/084 Patient Story

Rebecca Vaughan-Roberts presented a patient story based on incident involving a patient admitted to the Surgical Assessment Unit (SAU) in December 2016.

A patient was referred by his GP to the SAU at UHW complaining of abdominal pain and shortness of breath. Blood and urine samples were taken for analysis and a chest x-ray was requested. The patient was diagnosed with suspected gastro-oesophageal reflux disease. He was prescribed medication to treat the symptoms and discharged the same day.

The Concerns Team received a letter from the patient's father in March 2017 with information that the patient had collapsed at home in December 2016. He was taken to Prince Charles Hospital where he was diagnosed with cardiomyopathy. The family were informed that the patient required a heart transplant and the patient was transferred to Birmingham and underwent a heart transplant on 15th January. The heart transplant was unsuccessful and the patient sadly died on 16th January.

On review of the medical records from the patient's admission to SAU, the chest x-ray which was formally reported on 29th December showed marked cardiomegaly.

The factors that contributed to the missed diagnosis:

- The SPR did not document a differential diagnosis of cardi-respiratory as a cause for the symptoms and did not communicate these concerns to his colleagues.
- The SPR did not handover the request for an ECG or Peak Flow to determine an underlying cardio-respiratory condition.
- ECG/Peak Flow was not performed.
- Significance of subtle blood test abnormalities were not considered.
- Significance of breathlessness/orthopnoea were not taken into account during the surgical assessment.
- Enlarged heart on chest x-ray was not noted or acted upon whilst on SAU by any member of the team.
- There were no symptoms to support a diagnosis of gastro-intestinal reflux disease.
- The chest x-ray was not formally reported until thirteen days after the patient's attendance on SAU.
- The reporting radiologist did not flag this finding to any clinician involved in the patient's management.

The following actions are being progressed:

- An 'Emergency Stream' category is established on PACS so that SAU receives the same priority reporting as EU and MEAU and other emergency areas.
- A process is now in place to flag urgent, unexpected or significant findings electronically to the referrer.
- Surgical consultants will agree to review emergency patient radiology results report within 24 hours of receipt.
- A Radiology report box has been established in SAU which is reviewed daily by the on call SPR/Consultant.

- A review of the handover sheet to incorporate extra checks such as outstanding tests and additional information will be undertaken.
- Breach of care has been admitted to the family and redress offered.

Next month the Integrated Therapies Front Door Team will be presenting their evaluation of the EU project.

CDTQSE 18/085 Feedback from UHB QSE Committee 13th February 2018

The UHB QSE Committee minutes 13th February 2018 are not yet available.

CDTQSE 18/086 Health and Care Standards

Sue Bailey reported that all the templates have been completed.

CDTQSE 18/087 Risk Register

The revised risk registers for Therapies and Laboratory Medicine are not yet completed so the meetings to review these were stood down and will be re-arranged.

CDTQSE 18/088 Exception Reports

Pharmacy Executive Patient Safety Walkround Report

The report from the Executive Patient Safety Walkround was **RECEIVED** and **NOTED.** The Pharmacy department is in need of estates work and redesign and a Charitable Funds Bid has been submitted to improve the facility. It was noted that the environment staff are working in is distracting and can lead to errors and ideas have been put forward to improve the working environment.

27.1

A Clinical Board Safety walkround was held in Radiology in response to an IP&C audit and a large number of the actions have been closed off. It was noted that there are environmental and estates issues that are outside of the directorate's control.

Sue Bailey reported that she has undertaken a walkround of Park View Health Centre in Ely. During the adverse weather a pipe burst out of hours causing significant flooding. The assessment for the cost of repairs are too significant as the building was already designated for demolition, however the new build is not planned until 2019. The main presence at Park View is the Podiatry Team which also contains the manufacturing laboratory. Due to the damage, the centre is now unable to provide the manufacturing service and the Clinical Board is working with Estates to identify an alternative venue for this service.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 18/089 Initiatives to promote Health and Wellbeing

Sue Bailey thanked the flu champions for their hard work in supporting the flu campaign. The Clinical Board reported 76.2% uptake by frontline staff.

Third Sector Update

Apologies were received from Linda Pritchard.

CDTQSE 18/090 Falls Prevention

Alun Morgan reported that a lot of work is being undertaken relating to falls under the transformation agenda and focus on falls is high on the corporate agenda. PCIC Clinical Board has submitted 2 bids for the community falls programme to enhance the CRTs.

The End PJ paralysis 70 day campaign is being launched next week which will have a positive impact on frailty and promoting independence. However there is concern that this campaign may result in an increase in falls.

Alun Morgan was pleased to report that Oli Williams, Falls Lead for the UHB, has been nominated for a national patient safety award.

CDT QSE 18/091 Concerns and Compliments Report

In March 2018, the Clinical Board received 9 formal concerns. 2 breaches were reported against response times. 14 breaches were reported in total this year.

0 AM concerns were received this month and 9 AM concerns were received in total this year.

5 compliments were received in March.

From 1st April 2017-31st March 2018 the Clinical Board has received a total of 70 concerns and 93 compliments. This compares to 56 concerns and 110 compliments in 2016/17.

The key theme for formal concerns reported this year is communication between staff and patients. This is the same key theme as in 2016/17.

Sue Bailey presented a concern received relating to a deceased child and how a breakdown of communication between mortuaries at UHW and the Princess of Wales hospital resulted in a delay to the Funeral Directors being able to collect the child and a delay to the funeral being held. An investigation was undertaken and it emerged that the UHW had failed to notify the Princess of Wales that the post mortem had been carried out. The Clinical Board responded to the parents' concern admitting that an error had been made and apologised profusely for the distress caused. The response letter also explained the measures that have been put in place to prevent this happening again. A response was received back from the mother, thanking the Clinical Board for taking the time to undertake a thorough investigation and for the honesty from the department.

This concerns highlights that staff should not be afraid to admit when an error has been made. Whilst it cannot undo the experience for that patient, measures can be put in place to prevent it happening again.

CDTQSE 18/092 Ombudsman Reports

Nothing to report.

CDTQSE 18/093 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 18/094 Patient Safety Incidents

No SIs to report.

CDTQSE 18/095 New SI's

There are no new SI's to report.

There are 2 open IRMER incidents.

CDTQSE 18/096 RCA/Improvement Plans

Nothing to report.

CDTQSE 18/097 WG Closure Forms – Sign Off

27.1

In51047

This incident involved an incorrect patient being released from the mortuary to a funeral director. The error was detected by the funeral director and the patient was returned to the mortuary. An investigation was undertaken which highlighted two main issues:

- There were two patients with the same surname and very similar dates of birth in the mortuary at the same time. The procedure for the identification of patients with the same name was not followed and it was identified that this procedure is not fit for purpose.
- The process for releasing the body was not followed.

It was noted that this incident occurred prior to the HTA investigation which has resulted in a full review of all mortuary procedures and governance structures.

In42308

It was recommended that this incident involving a patient in the SAU was presented to the Clinical Board for learning purposes. This was presented earlier as a patient story.

CDTQSE 18/098 Regulation 28 Reports

Nothing to report.

CDTQSE 18/099 Patient Safety Alerts

The Top 10 Health Technology Hazards for 2018 was **RECEIVED** and **NOTED.**

PSN041 Risk of Death and Severe Harm from Failure to Obtain and Continue flow from Oxygen Cylinders

The notice has been circulated to directorates who are requested to communicate the key messages to staff.

ISN 2018/001 Nursing Staffing Levels (Wales) Act 2016

The Act requires the UHB to report to the Board and Welsh Government on whether not maintaining the nurse staff level has contributed to the following Serious Incidents:

- Hospital acquired pressure damage (grade 3, 4 and unstageable)
- Falls resulting in serious harm or death
- Medication related Never Events.

Concerns were raised that this may lead to increased demand on Radiology and Media Resources services and this should be monitored.

To support the implementation of the Act, the UHB has updated its RCA templates and documents which have been circulated. Clinical Boards are asked to use the revised documents with immediate effect even if clinical area are not within section 25B of the Act.

It was noted that the former Patient Safety Agency's incident decision tree has now been replaced with a Just Culture guide.

Helen Jenkins will circulate the documentation to the Group.

Action: Helen Jenkins

CDTQSE 18/100 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 18/101 IP&C/Decontamination Issues

Alun Morgan reported that as part of a walkround in Radiology, work will be undertaken with Radiologists around ANTT and an awareness session will be provided at their audit session.

The training needs analysis for departments for facilitator training will need to be reviewed.

The bacteraemia incident needs to be closed down. This case will be presented at the next meeting.

Action: Alun Morgan

CDTQSE 18/102 Key Patient Safety Risks

Safeguarding

Kevin Hogan reported that there are 7 wtes within the Safeguarding Team and a further member of staff Sarah Richards has been appointed as IDVA, who offers a specific service for signposting for domestic abuse and offers on call support and referral.

An Out of Hours service for Paediatrics is available with a community paediatrician on call and child protection team. A Multi-agency Safeguarding Hub Team (MASH team) is available for the Cardiff area but not for the Vale.

Safeguarding face to face training is available at levels 2 and 3. A large number of staff are now accessing the on line training so the number of face to face sessions are being reduced.

Level 3 safeguarding adults training is available on 31st May. This will cover a strategic overview of safeguarding and operational issues in key areas. Presentations will be given on trafficking.

County lines is becoming an issue for the Cardiff area and training is being provided on this issue. Dates are available in the UHB training prospectus.

27.1

The Safeguarding team has access to PARIS and Clinical Portal and works closely with other safeguarding teams across Health Boards and with agencies such as the local police. Safeguarding case notes can be accessed from PARIS system. Individuals can contact the PARIS team to obtain permission rights if required.

A recent key development is Female Genital Mutilation (FGM). Mandatory reporting is required of females under 18 that present to departments.

The Safeguarding Newsletter is available online from the Safeguarding intranet page. The next newsletter will focus on FGM and the summer newsletter will focus on county lines. Any contributions to the newsletter to contact Kevin Hogan.

Maria Jones has raised the issue around transgender cases linked to safeguarding. Kevin Hogan advised her to contact Gareth Edgell. Alun Morgan reported that a specific shelter has been set up for the transgender community.

Kevin Hogan reported that he has a role one day a week with Welsh Government related to radicalisation and counter terrorism as an additional safeguarding concern.

It was noted that recently a Regional Domestic Violence Strategy has been implemented.

CDTQSE 18/103 Health and Safety Issues

It was noted that fire training sessions set up as part of Mandatory May are not available for staff who only require fire training as they are being reserved for staff who wish to undertake multiple modules. Staff who only require fire training are being advised to use the monthly drop in sessions.

CDTQSE 18/104 Regulatory Compliance and Accreditation

The Cellular Pathology department has maintained its ISO Accreditation and it was pleasing to note that the assessor raised no findings in the Mortuary.

UKAS will be inspecting Haematology at the end of April.

It was noted that concerns have been raised at the UHB Ultrasound Governance Group that there are quality assurance and electrically safety checking issues for ultrasound machines that are not part of the managed service contract.

CDTQSE 18/105 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 18/106 Clinical Audit

Nothing to report.

CDTQSE 18/107 Research and Development

It was noted that individual Clinical Board R&D Performance meetings have been arranged with the Medical Director in September.

CDTQSE 18/108 Service Improvement Initiatives

Genius Hour Training related to service improvement was held yesterday for the Clinical Board. Sion O'Keefe will ask for feedback on the session. A further session will be held at UHL.

Action: Sion O'Keefe

One team from this Clinical Board is participating in the LIPs programme with a project relating to Equality and Diversity.

CDTQSE 18/109 NICE Guidance

Nothing to report.

CDTQSE 18/110 Information Governance

Sion O'Keefe has raised concerns on the new guidance for General Data Protection Regulations (GDPR) particularly in relation to Health Boards no longer charging for access to medical records and concern that demand on the medical records service is likely to increase. The issue has been raised through the Medical Records Management Group and the Finance Director's Team has been made aware. Sue Bailey suggested that a risk assessment should be undertaken and depending on the score placed on the risk register.

Action: Sion O'Keefe

CDTQSE 18/111 Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 18/112 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 18/113 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

CDTQSE 18/114 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 18/115 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 18/116 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

At year end the Clinical Board reported 0 waits at 14 weeks for all therapies. Radiology was set a target to reduce waiters over 8 weeks to 300 and the department reported 258.

A Clinical Board Thank You Event for staff is being held at UHW and UHL where staff will be thanked for their hard work and efforts.

INDIVIDUAL CARE

CDTQSE 18/117 National User Experience Framework

The Clinical Board reported a 72% response rate overall with a 90% response rate in Radiology. Very positive comments were received.

STAFF AND RESOURCES

CDTQSE 18/118 Staff Awards and Recognition

A number of staff within the Clinical Board were recognised at the UHB Staff Recognition Awards, including Sion O'Keefe who was awarded Runner Up in the Equality, Diversity and Human Rights category. Sion O'Keefe thanked all the staff in his directorate.

CDTQSE 18/119 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting 81% compliance with mandatory training.

PADRs 59% compliance.

It was noted that the pay agreement for 2018 will likely be introducing a mechanism that will prevent staff automatically receiving their increments unless they have had their PADR and are compliant on mandatory training (unlike the current pay progression scheme which automatically moves people up the scale unless anything is sent to payroll to stop it). Further details will be released in due course.

Sickness episodes relating to work related stress have increased in the Clinical Board. It is important that early advice is sought from Occupational Health and stress risk assessments completed.

The Health and Wellbeing Group are attempting to create a network of Health and Wellbeing Champions. The aim is to get people across the whole of the UHB in each Clinical Board, in each department involved in actively encouraging health and wellbeing activity and sharing success stories, encouraging challenges (e.g. Fitbit steps).

Managers are asked to inform Ceri-Ann Hughes of anyone interested in being a Health and Wellbeing Champion. Role profiles are being developed.

It was noted that Rhodri John is commencing his new role in the mortuary team next week.

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

Nothing to report.

ANY OTHER BUSINESS

Details of an informal QSE Network Meeting have been circulated.

Sue Bailey has raised concerns to the Clinical Board Director relating to poor attendance at this meeting.

DATE AND TIME OF NEXT MEETING

23rd May 2018 at 2pm in the Council Room UHW.

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

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING
10th May 2018
Seminar Room, Hafan y Coed, Llandough Hospital

Present:
Mark Doherty, Lead Nurse MHSOP/Neuro (Chair)
Simon Amphlett, Senior Nurse Manager Crisis & Liaison
Owen Baglow, Clinical Lead for Quality, Safety & Governance
Philip Ball, Senior Nurse Manager CMHTs
Matthew Brayford, Integrated Manager Pendine CMHT
Des Collins, Ward Manager, Pine Ward
Natalie Coombs, Deputy Senior Nurse Manager CMHTs
Lisa Crump, ANP Adult In-patient
Alison Edmunds, Concerns Co-ordinator
John Edwards, Deputy Ward Manager, Willow Ward
Ruth Evans, Lead CPN Links CMHT
Steve Ford, Lead CPN Pentwyn CMHT
Sarah Furniss, Pool CPN
Martin Harper, Integrated Manager Links CMHT
Emily Harrington, Consultant Psychiatrist
John Hyde, Mental Health Lecturer, Cardiff University
Noel Martinez-Walsh, Integrated Manager Pentwyn CMHT
Mary Morgan, Senior Nurse Manager Adult MH
Eleanor Pilgrim, Student Nurse Pendine CMHT
Mallikarjuna Reddy, Speciality Doctor
Tara Robinson, Senior Nurse Manager Rehab & Recovery
Jayne Strong, ANP Rehab & Recovery
Rachael Sykes, Health & Safety Adviser

27.2

Apologies:
Jayne Tottle, Director of Nursing Mental Health
Jayne Bell, Lead Nurse Adult Mental Health
Adeline Cutinha, Consultant Psychiatrist, Gabalfa CMHT
Catherine Evans, Patient Safety Facilitator
Carol Evans, Assistant Director Patient Safety & Quality
Katie Fergus, Clinical Director Adult MH
Louise Flynn, Senior Nurse Manager, MHSOP In-Patient
Mike Ivenso, Clinical Director MHSOP
Jayne Jennings, Ward Manager Willow Ward
Mark Jones, Directorate Manger Adult MH
Robert Kidd, Consultant Psychologist
Lisa Lane, Senior Nurse Manager, MHSOP Community
Annie Procter, Director Mental Health
Andrea Sullivan, Concerns Co-ordinator
Andrew Vidgen, Deputy Clinical Director Adult MH
Mark Warren, Senior Nurse Manager Criminal Justice & Forensic
Ian Wile, Director of Operations MH
Jo Wilson, Directorate Manager MHSOP
Lowri Wyn, Ward Manager Cedar Ward

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting and introductions were made.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

No Actions.

PART 3 : CLOSURES

3.1 SK

The Community Mental Health Team (CMHT) received a referral for SK, an18 year old gentleman, who was feeling low in mood and had expressed thoughts about "ending it". In the referral, the GP indicated that SK had reported feeling low in mood for the last 2 years.

Four days after receiving the referral, SK was assessed at the CMHT. There was evidence of lack of social functioning and isolation. SK said he felt lonely a lot of the time. It was felt that further discussion and on-going assessment was required therefore a Consultant and the original assessor at the CMHT conducted a further thorough assessment and the initial impression was that of an unclear diagnosis. The Consultant commented that there was no clear evidence of psychosis or of depression. The agreed plan from the assessment was for SK to be seen in three weeks time to continue the assessment.

Three weeks later, SK was assessed again and reported having dips in mood that had resolved now that he was back in school (following school summer holidays). The importance of having a social network and how this could have a positive effect on SK's health was discussed. The conclusion from this assessment was no evidence of serious mental illness.

27.2

SK was discussed in the Multi Disciplinary Team (MDT) meeting and it was documented that there was no evidence of first episode psychosis (FEP) or at risk mental state (ARMS). It was agreed that the Consultant would contact the Youth Psychosis Service (YPS) for advice or suggestions. This was done, via email, the YPS replied the same day with suggestions for community engagement which included; Occupational Therapist input if SK was to remain under the CMHT; the Fairbridge Programme – a Prince's Trust run project which engages 16-25 year olds who have difficulty developing social skills; Cardiff City FC Young Men and Mental Health and the School Counselling Service.

A further out-patient appointment was scheduled, however, a couple of weeks before the appointment the CMHT were informed by the GP that SK had sadly passed away. SK died in University Hospital of Wales due to multi organ failure caused by sepsis.

Good Practice

The referral was requested as a routine referral. This means that, if accepted by the Community Mental Health Team, the patient should be seen within 28 days from the date of the referral. The referral was discussed in a Multidisciplinary team meeting and SK was assessed within 4 days. This was seen as good practice that the referral was discussed, allocated and patient seen within 4 days.

Length of Time for Assessments

The Mental Health Measure, nor the Code of Practice, indicate how long an assessment period should be or how many sessions the assessment should take before a patient is allocated and deemed a relevant patient.

Within Cardiff and Vale we have worked under the rule that a patient should only be under assessment for a maximum of 12 weeks or 3 assessments, whichever is the fewer. As it stands 12 weeks or 3 assessments is still the working rule, but that this may be reduced to 6 weeks in future.

TO CLOSE.

3.2 MB

MB is a 49yrs old male with a diagnosis of Bipolar disorder

Whilst on Alder ward, Hafan y Coed, MB became agitated. This was in response to having been told he couldn't have his rings back. His rings had previously been removed due to the risk they presented to staff due to his repeated assaults. His response to the refusal was to go to the small lounge on Alder and start to bang and break up the Ward's stereo. Staff asked him to stop but he did not. This resulted in him being placed in safe-holds by two nurses who walked him to the High-Care Room. On arrival at the High-Care Room, he escalated and was restrained to the floor in a supine position. This was carried out by two nurses during which he kicked a Staff Nurse a number of times in the side. Other staff assisted by containing MB's legs and head. MB accepted oral medication and was released from holds.

The incident was reported to the police. MB was deemed to have mental capacity.

The Staff Nurse hurt in the incident resulted in being on sick leave with a shoulder injury. A RIDDOR was submitted as the staff member was off work for over 7 days.

27.2

Support

The staff who had been involved in the assault were referred to Occupational Health and encouraged to engage with Well Being Services.

A De-brief meeting was held.

The SIMA Trainer supported the staff involved.

Issues Identified:

The patient was initially compliant with the intervention but when in a safe environment the situation became more aroused. The situation escalated with the momentum taking staff forward to the floor.

Confusion in relation to who was where during the restraint.

The incident happened quickly and was chaotic.

Patient was really unwell. Triggers had not been identified.

Consultant input – Katie Fergus, Clinical Director, is looking at designated Consultant cover

Recommendations:

Looking at Policies, it was unclear if a patient should be left alone in a High Care Room or whether the room should be staffed. Mary Morgan, Senior Nurse, will look at the Guidelines for the use of the High Care Room.

Conclusion

The patient is very sorry about the things he did. A clear Treatment Plan is in place.

MB was charged and given a 12 month conditional discharge. Recommended that this be recorded in MB's medical record and communicated to all teams providing care.

It was advised that should any further violent or aggressive incidents occur involving MB they should be reported to the Police and the status of being on a conditional discharge be highlighted to the Police.

TO CLOSE.

3.3 KG

KG was a 62 year old lady. She was receiving care from the Community Addictions Unit Cardiff Drug Team. KG was being treated for Opioid dependence for which she was prescribed methadone. KG also had alcohol dependence. KG had three hospital admissions for opiate and alcohol detox. KG had a number of physical health problems which included Cirrhosis of the Liver, Portal hypertension, Grade 1 varices, previous variceal bleed, Osteoarthritis, Hepatitis C Virus genotype 3, Ischaemic heart disease and chronic leg ulcers. She had also been diagnosed with diabetes in 2017.

KG regularly attended her appointments with the Community Addictions Unit Cardiff Drug Team and engaged well with the support and interventions being provided.

Enquiries were made by the Cardiff Drug Team following concerns raised by a pharmacist that KG had not attended to collect her prescription (this was very out of character for KG), she had also missed an appointment. The GP confirmed that KG had been found in bed deceased.

Coroner's office contacted cause of death recorded as: 1.Bilateral pneumonia 2. Cirrhosis of the Liver

Good Practice

- KG received on-going regular reviews which included physical health monitoring. ECG's were completed and medication was being adjusted accordingly as required.
- There was appropriate liaison with the GP and specialist services regarding KG's physical health co morbidities.
- There was evidence of good communication from the Community Addictions Unit Cardiff Drug Team with both the GP and pharmacy.

TO CLOSE.

4.0 DATE OF NEXT MEETING

19th July 2018 at 9.30am in the Seminar Room, Hafan y Coed.

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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, 13th March, 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
Denise Shanahan	Nurse Consultant
Helen Earland (HE)	Senior Nurse PC
Helen O'Sullivan (HO'S)	Quality and Safety Manager
Karen May (KM)	Head of Medicines Management
Maria Dyban	Community Director
Rachel Armitage (Minutes)	Acting PCIC Quality and Safety Officer

Apologies

Matthew McCarthy (MM)	Patient Safety Facilitator
Nicola Evans (NE)	Head of Workforce and OD
Nicky Hughes (NH)	Lead Nurse S&E Locality
Rhian Bond	Head of Primary Care Services
Paula Cornelius (PC)	Integrated Manager, Vale Community Resource Service
Sarah Griffiths (SG)	Head Of Primary Care
Sue Morgan (SM)	Director of Operations

By Invitation

Judy Brown (JB)	Safeguarding Nurse Adviser

Preliminaries		**Action**
03/18/001	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Chair.	
03/18/002	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
03/18/003	**DECLARATIONS OF INTEREST** GH asked for any declarations of interest – none noted.	
03/18/004	**MINUTES OF THE PREVIOUS MEETING HELD 9TH JANUARY, 2018** The minutes of the previous meeting were recorded as an accurate record.	

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	Matters Arising There were no matters arising.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
03/18/ 005	**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: **MSSA Bacteraemia Template:** comments would be sought and updated version brought to the next meeting. **Update on service model and staffing for CHAP**: to be followed up outside the meeting and update to be brought to the next meeting. **AMR Plan:** HCAI Collaborate will meet in April; KJ will bring an update report to the next QSE meeting. **01/18/008 Risk Register snapshot:** this action is completed. **01/08/009 Serious Incident Log**: should be amended to "Interface Incidents". It was noted that Datix work was making progress; the Quality and Safety team meets monthly with the Patient Safety Team. These meetings will be weekly throughout April and further work is required on how to take actions forward. An interim LMC report will be produced and further information will be shared when it becomes available. **01/08/010 Risk Escalation Report – EMIS:** Anna Mogie confirmed that this had been forwarded appropriately and would be followed up by Lynne Topham. **01/18/012 Business Unit QS&E minutes:** Primary Care meetings are not yet being minuted. Action ongoing to ensure this is undertaken. **01/18/027 Mandatory Training Update – Dementia:** Dementia Action Plan requires comments and input from localities.	**KJ/KE/ RT** **KJ** **LLNs**
03/18/ 006	**PATIENT STORY – PRISON – SOUTH AND EAST LOCALITY** Gareth Hayes summarised the patient story on behalf of the South and East Locality, noting the positive outcome and the value of the approach of the Prison health care team.	
03/18/ 007	**RISK REGISTER (RR)** GH recommended that new items added should be dated. **QS&E 000214 OOH** This remains an ongoing IT issue, noting that the risk was escalated to the UHB QSE Committee in late 2017. It was highlighted that the	

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	numbers of attendees at the service were high, with added pressure brought about by the adverse weather. It was reported that non-clinical staff had failed to attend for work which affected patient care; this has been discussed with HR colleagues, with a recommendation that a policy should be put in place regarding a management support structure. It was confirmed that new protocols will be put in place for escalation. It was also confirmed that challenges continue. In particular there is a major issue with transporting patients into hospital; this will be raised with WAST and reported on Datix. **QS&E 000113 Independent Sector** Risk to be amended to "tolerate" following work undertaken across the nurse assessor teams it has been agreed toshare the risk by transferring the responsibility for one care home in N&W to S&E locality. **QS&E 020714 CHAP** To remain on RR until next PCIC QSE meeting; revised staffing model is required. **QS&E 160714 Patient Flow** It was reported that there were no further plans for escalation weeks; risk to be classed as "tolerate". **PCIC 110914 Complex Packages of Care** New agencies are being trialled and the establishment of the framework is being prioritised. It was highlighted that a strategic review is required. **PCIC 160614 Primary Care Estates Development** Update is awaited. **PCIC 0814 Local Development Plan** Update is awaited. **PCIC 28.01.15 GMS Services/Primary Care Capacity and Sustainabilty** The Primary Care Team has commenced Practice visits for those Practices included in the sustainability framework and rated as amber. The work has been positively evaluated. **PCIC 10.03.16 Pressure Ulcer (PU) Prevalence** The All Wales Policy is an agenda item for this meeting. A process has been agreed with the Patient Safety team for the reporting of Serious Incidents, which will be included on Datix. Matthew McCarthy is in the process of developing guidance for the LLN's. **PCIC18.05.16 Domiciliary Care Provision** Challenges remain and there still exist very complex care packages which cannot supported in a timely manner. Risk tolerated. **S&E 05.12.16 HMP Cardiff – Prescribing, Staff Stress, Environment** There have been fewer "spice" incidents; KJ will seek an update from NH.	

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	S&E 06.01.17 HMP Mental Health Provision Consequent on Sue Morgan's transfer to Welsh Government, work is under way to identify a lead for this work. **N&E 10.01.17 Cardiff CRT Medication Administration Procedure** AM will attend a meeting with Social Service colleagues in April . **VL 29.07.17 Change of phone lines** CF highlighted that there may be challenges when the service is changed to a different location. **CHC 11.08.17 CHC Commissioning group** An update will be provided at the next meeting. **PC141117 GP OOH IT issues** The IM&T team is working closely with the OOH team on capacity and demand. 20 new screens will be provided so that IHR can be accessed via the Clinical Portal rather than AdAstra; the AdAstra server awaits sign off and system upgrade. This will be further discussed in the Senior Team Meeting. **Further discussion:** • AM raised the matter of the Park View Clinic flood and consequent relocation of the teams and clinics based there. AM to provide a risk escalation report. • GH highlighted the risks associated with the projected transfer from EMIS to a new system, noting the clinical risk and additional pressures associated with having to learn a new system. RA to ask RB and SG for risk escalation regarding EMIS. • HE highlighted that there is no call recording at the CRI OOH site; to be escalated to identify a solution as soon as possible. • HE highlighted the lack of security overnight at CRI and the challenges of parking – it was recommended that these matters be submitted to the CRI User Group. **Risk Matrix** The Risk Matrix was reviewed and noted.	**AM** **RA** **HE** **HE**
03/18/008	**QUALITY DASHBOARD** KJ summarised the dashboard. The following points were highlighted: **Current SI's:** HO'S confirmed that 2 SIs had been closed while one new SI has been reported. This is being investigated by the Police so no further action is permissible until that work is completed. **Medication Errors:** Numbers are low, no particular trends or issues of concern to note	

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	Vacancy Rates: have demonstrated a significant improvement**.** **Risks:** remain under review and challenge by the Executive team. **MSSA:** has been identified as predominantly linked to cellulitis and wound infections. **GP OOH performance:** has been demonstrated to deteriorate significantly at weekends. **Datix:** was summarised and will be built into the dashboard. **8.4 Closure summary**: noted. **8.5 Improvement in performance required – Independent Contractors:** KJ confirmed that a meeting will be held to agree a position; feedback is awaited.	
03/18/ 009	**RISK ESCALATION REPORTS** These were discussed under item 7.	
03/18/ 010	**SAFETY NOTICES** These items were presented for noting.	
03/18/ 011	**MANAGING FLU** It was noted that the documents had been previously circulated but gave contradictory advice.	
03/18/ 012	**PCIC NURSING UNIFORM AUDIT RESULTS OCTOBER 2017** CF confirmed that audits had been undertaken in October 2017 and covered the District Nursing, ART and DoSH services. The identified themes related to jewellery non-compliance, particularly necklaces and fitbits; bias arising from the fact that some teams were aware of the audit while others were not; and hosiery. It was noted that a repeat audit will be carried out in several months' time.	
03/18/ 013	**INFORMATION GOVERNANCE** The Information Governance Group minutes were noted. Changes to GPDR were highlighted, noting the associated significant training required.	
03/18/ 014	**BUSINESS UNITS QS&E MINUTES** KJ agreed to feedback to individual business units on matters recorded in their minutes.	**KJ**
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**

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SAFE CARE		Action
03/18/015	**HCAI REPORT AND ANTIMICROBIAL DELIVERY PLAN** This had been discussed above as part of the Dashboard review.	
03/18/016	**HEALTH AND CARE STANDARDS** Colleagues were requested to provide feedback directly to KJ.	**LLNs**
03/18/017	**LOCALITY PRESSURE ULCER REPORTS** KJ highlighted the numbers of pressure ulcers reported and requested that a consistent time period is used across all Localities. CF agreed to review the Vale figures.	**CF**
03/18/018	**PRESSURE ULCERS** The Pressure Ulcer Risk Assessment, Prevention and Treatment Policy and Procedure, Pressure Ulcer Reporting and Investigation – All Wales Guide and the Pressure Ulcer Procedural Guide were noted for inclusion in clinical practice.	
03/18/019	**POCT MEETING SUMMARY** KJ confirmed that a meeting had been held to consider POCT issues for Primary Care in particular and linking with the work undertaken on Glucometers by Emyr Stephens, Prescribing Adviser. All Practices will be contcated by the Prescribing Adviser which will enable agreement on a collective position before wider issues are considered.	
03/18/020	**MEDICAL EQUIPMENT ISSUES** AM raised Glucometers for use by bank staff, confirming that a new contract is under negotiation, and highlighting that there must be robust governance for banks staff.	
EFFECTIVE CARE		**Action**
03/18/021	**PCIC R&D STRATEGY** KJ confirmed that the Strategy had been refreshed following a meeting with the Medical Director. **Cardiff Research Forum Newsletter** was noted for information.	
03/18/022	**ASEPTIC NON-TOUCH TECHNIQUE (ANTT) UPDATE** KJ confirmed that this work is progressing well. She highlighted that the WG has developed an All Wales initiative to improve the infection prevention and control practices of healthcare professionals, noting the cost implications for the UHB. HCAI – this had been discussed as part of the Dashboard review.	

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DIGNIFIED CARE		**Action**
03/18/023	**FRAGILE PRACTICE UPDATE** This had been included in the Dashboard review. It was noted that there are 3 list closures under way and that the Butetown Practice is not accepting new patients, which is having an adverse impact on homeless people.	
TIMELY CARE		**Action**
03/18/024	**SAFEGUARDING** **24.1 Safeguarding Update** JB provided an update. It was confirmed that a Standard Operating Procedure will be shared with the CB. It was highlighted that the Safeguarding Team is now fully up to capacity with a broad range of experience covering child and adult services, and working to HCS 2.7. She recognised the challenge for CBs of the breadth of the safeguarding remit and releasing staff to attend safeguarding training. She welcomed the support provided by PCIC in obtaining records at times of domestic homicide reviews which have enabled the identification of good practice and GPs who have tried hard to help some victims and perpetrators. It was noted that there are currently 8 domestic homicide reviews ongoing which take a long time to complete. There are also 7 child practice reviews and an adult practice review under way, and 2 multi-agency forum reviews ongoing. It was confirmed that level 2 safeguarding training for all staff must be undertaken every 2 years, while mandatory e-learning is available on domestic abuse for all staff working at group 2 level. Note was made of the new statutory requirement to report female genital mutilation, modern slavery and human trafficking. It was confirmed that CHAPS have a good record for reporting these activities. JB drew attention to “County Lines”, where criminal gangs from one city go to another city to identify vulnerable people to carry out crimes on their behalf. Training about this is being developed, particularly for DNs. PREVENT training was highlighted as necessary for all staff visiting people in their homes to enable them to recognise individuals who are being groomed for terrorist activity. An update on PARIS developments was provided, noting that automated messages regularly remind staff to cross-check patient information and the associated person’s facility, and the Emergency Unit also now can access the system for safeguarding information. The Safeguarding team members rotate through the Cardiff MASH arrangement; JB offered to explain MASH to the DN team meetings if required. It was highlighted that referrals can be made to Women’s Aid and there is an equivalent project to support male victims of domestic abuse.	

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	There has been appointed an Independent Domestic Violence Adviser (IDVA) – Sarah Richards – based in the safeguarding office in the Children's Hospital. She will see people who identify themselves as victims of domestic abuse while in hospital and will arrange support services when they are discharged. **24.2 Annual Self Assessment – Health Care Standards: Safeguarding Children and Safeguarding Adults at Risk April 2017** It was confirmed that development of the plan is under way; it will be brought to a future meeting. **24.3 Agenda Safeguarding Steering Group January 2018 and** **24.4 Safeguarding Steering Group Minutes 25 January 2018** These documents were noted for information.	
03/18/ 025	**POINT OF CARE TESTING** KJ confirmed that learning from ABMU regarding Glucometry following the Andrews Report should be shared across Locality teams. **25.2 WHC – Policy on the Management of Point of Care Testing (POCT). What, When and How? and** **25.3 UHB Point of Care Testing Procedure** These documents were noted for information and to ensure Business units are aware of the All Wales requirements .	
INDIVIDUAL CARE		**Action**
03/18/ 026	**MANDATORY TRAINING UPDATE** **26.1 Dementia Update** This was discussed as part of the Dashboard review. **26.2 Mental Capacity Assessment to Consent Treatment Audit S&E Locality, MHCLC MCA data and workplan, Mental Capacity Assessment to Consent Treatment Audit N&W Locality** KJ confirmed that, following completion of all Locality audits, an action plan would be devised for submission to the UHB Mental Health and Capacity Legislation Committee.	
03/18/ 027	**DISTRICT NURSE SURVEY RESULTS** KJ highlighted the excellent feedback received from patients and formally thanked the DN teams for their hard work and professionalism.	
03/18/ 028	**COVERT MEDICATION ADMINISTRATION GUIDANCE AND DECISION TOOL** DS confirmed that training sessions had been carried out at the last CPET in January 2018 and positive feedback received. The guidance tool will become an appendix to the Medicines Code and the Policy is available for use by the CB.	

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03/18/029	**THE AUSTRALIANTHERAPY OUTCOME MEASURE FOR OCCUPATIONAL THERAPISTS (AusTOM-OT)** KJ formally noted the excellent work undertaken by CRTs resulting in significant positive patient outcomes, especially in the Vale of Glamorgan.	
STAFF AND RESOURCES		**Action**
03/18/030	**PCIC STAFF TURNOVER/RECRUITMENT AND RETENTION ISSUES** This item was deferred to the next meeting.	
03/18/031	**LAUNCH OF *TOGETHER WE CARE: A FRAMEWORK FOR THE DEVELOPMENT OF THE MEDICAL WORKFORCE IN WALES*** This was noted for information.	
03/18/032	**CHC BRANCH SURGERY RECOMMENDATIONS** This item was deferred to the next meeting.	
03/18/033	**OUT OF HOURS SERVICE DELIVERY** The GP Rosterpro audit was noted for information. KJ highlighted that the action plan remains outstanding.	**HE**
SUB-GROUP REPORTS		**Action**
03/18/034	**34.1 GP OOH Business Unit** Issues discussed above. **34.2 Vale Locality** CF congratulated the Wound and Continence teams for moving their clinics from Park View in just under a week. **34.3 Cardiff South and East Locality** No additional update. **34.4 Cardiff North and West Locality** Park View and associated service relocation were highlighted as the main issues. **34.5 Pharmacy and Medicines Management** No additional update. **34.6 Palliative care** KJ highlighted that there will be a new contract effective from 1st April, 2018 whereby City Hospice will be responsible for palliative care provision for the whole of Cardiff, while Marie Curie will provide services for the Vale.	
PART 2:	**Items to be recorded as Received and Noted for Information by the Committee**	**Action**
03/18/035	**<u>CMO UPDATES</u>** CEM/CPhA/2018/1 Drug Alert Class 2 – Action Within 48 Hours: Winthrop Pharmaceuticals UK Lmited Trading as Zentiva, Molipaxin 100 mg Capsules	

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	CEM/CMO/2018/2a Esmya (Ulipristal Acetate) for Uterine Fibroids: Monitor Liver Function in Current and Recent Users; Do Not Initiate Treatment in New Users or Those Between Treatment Courses CEM/CPhA/2018/3 & 4 Drug Alerts Class 2, Glaxo Wellcome Uk Ltd, Ventolin Accuhaler 200mcg And Seretide Accuhaler 50 Microgram / 250 Microgram CMO Letter: Planning for Increased Seasonal Demand in Respiratory Illness CMO Annual Report 2016/17: Gambling with our Health **MEDICAL DEVICE ALERTS** Discussed above. **WELSH HEALTH CIRCULARS** WHC (2018) 004 UK Policy Framework for Health and Social Care Research WHC (2018) 008 1 February 2018 Coming into Force of the Intimate Piercing Provisions Within the Public Health (Wales) Act 2017 **WELSH GOVERNMENT ADVISORY** Written Statement: Implementation of service regulation under the Regulation and Inspection of Social Care (Wales) Act 2016 and nursing care in care homes, 21 November 2017 New Regulations for the Use of Ionising Radiation **NICE GUIDANCE** **INTERNAL SAFETY NOTICE AND GUIDANCE** • Public Health Public Health notification to clinicians on Scarlet Fever • HIW Annual Report • Antivirals for prophylaxis of seasonal influenza in residential care • home outbreaks • Enteral-pH leaflet • Important message to all staff from the Medical Director/Caldicott • Guardian • NHS England Quick guide: planning for increased seasonal demand in respiratory illn • Public Health Wales: Infections Associated with Heater Cooler • Units Used in Cardiopulmonary Bypass and ECMO – An UPDATE on the • Patient Notification Exercise and Further Actions Required for Health • Boards and Trusts in Wales. **UPDATES FROM OTHER GROUPS**	

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	• NHS Wales Safeguarding Network Minutes 23 November 2017 • Agenda for UHB Nutrition and Catering Steering Group • Minutes from the UHB Nutrition and Catering Steering Group	
	ANY OTHER BUSINESS	
03/18/036	Nil Noted	
DATE OF NEXT MEETING		
Tuesday, 8th May, 2018, 1.30 pm – 3.30 pm, PCIC meeting room 1, CRI		

27.3

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

Specialist Services

Quality, Safety & Experience Committee
22nd February 2018

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions Nia Bromage (NB), Critical Care Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety Lorraine Donovan (LD), Senior Nurse, Neurosciences Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board (Chair) Nick Gidman (NG), Directorate Manager, Cardiothoracic Services Mary Harness (MH), Senior Nurse, Haematology, TCT, Immunology and Medical Genetics Gareth Jenkins (GJ), Service Manager, Haematology, Immunology and Medical Genetics Sarah Lloyd (SL), Directorate Manager, Neurosciences Lisa Morgan (LM), Senior Nurse, Nephrology & Transplant Adam Partlow (AP), Trainee Clinical Scientist, ALAS Ceri Phillips (CP), Lead Nurse, Cardiothoracic Services Sian Pring (SP), PA, Haematology, Immunology & Medical Genetics- minutes Vince Saunders (VS), IP&C Maurice Wentworth (MW), ALAS Hywel Roberts, Consultant Intensivist, Medical QSPE Lead Clinical Board	
1.2	Apologies for absence Anne- Marie Morgan (AMM), Directorate Manager, Haematology, Immunology & Medical Genetics Orla Morgan (OM), Lead Nurse, Critical Care Bev Oughton (BO), Ward Manager, Critical Care Jennifer Proctor (JP), Lead Nurse, Haematology, TCT, Immunology & Medical Genetics Martyn Read (MR), Consultant Intensivist, Critical Care Keith Wilson (KW), Consultant Haematologist & Medical QSE Lead, Haematology	
1.3	To review the Minutes of the previous meeting 11th January 2018 (2nd Feb meeting cancelled) The minutes were agreed to be an accurate record of the previous meeting. Action Log *Matters Arising- Item 1.3* • SC to chase Maria Roberts for minutes from meeting on 03/11/2018 for circulation. • HCAI meeting to be arranged by GW. • Sign off of N&T HTA disposal of documents is awaiting sign off by pathology. This should be complete by the beginning of March. • Audit plans from all directorates have now been received. *Matters Arising- Item 2.3* LD to check if temporary neuro hoists are able to weigh patients. *Matters Arising- Item 2.4* The Hep B case in Cardiac Surgery is now ready for closure. *Matters Arising- Item 3.3* Health Board- wide changes are underway. CF to meet with risk team in March. *Item 2.2* The report on JO has not been finalised as yet, it is currently with Maria Roberts.	**SC** **GW** **RC** **LD** **MR**

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	Item 2.3 The logistics of moving to electronically printed wrist bands are being investigated. Item 3.2 • JACIE action plan- another meeting with estates and the execs is to be held. A robust plan to improve facilities needs to be in place ready for the next inspection. • Infection control management- MH to chase JP regarding incident form on patient who could not be isolated. • The refurbishment for Singleton remains outstanding. GJ to chase. • A date has not yet to be set to discuss the concerns raised by the lack of SLA with Singleton. GJ to link in with HP. • The 3rd BMT consultant is now in post, a Clinical Fellow is to be appointed shortly. <u>Matters Arising</u> None.	**Execs & SpS** **GJ** **GJ/ HP**
1.4	<u>Patient Story – Critical Care</u> NB presented the story of a TCT patient who was admitted to Critical Care with neutropenic sepsis following chemotherapy for AML. During her stay she went into multi organ failure and required resuscitation 4 times. The patient recovered after 7 weeks and was discharged home. The patient is currently in remission and in spite of there being no time to freeze her eggs prior to commencing treatment, she became a mother last year. She has raised £40K for charities including TCT and Bloodwise so far.	
PART 2: SAFE CARE		
2.1	<u>Open Inquests</u> INQ/IN61137- the out- of- date valve was not relevant in this case, but the patient's family are to be made aware prior to the inquest. CoD per the coroner was choking. A statement from the patient's consultant is outstanding, CP/ NG to chase. INQ/IN44394- with patient safety. Statements have been sent. INQ/UHW/3285- SC to chase outcome. <u>Open Serious Incidents</u> There are 10 open Sis. The neuro drill incident is currently sitting with surgery. An investigating officer has been appointed, neuro involvement is also required. <u>Closure Forms</u> Patient on Cardiac ward who fell and fractured femur on Christmas day. RCA showed genuine accident as patient fell whilst using urinal. Appropriately assessed at the time, Hoverjack used to move patient. Some issues with post falls documentation which did not impact on patient but has been addressed	**CP/ NG** **SC** **LD**
2.2	<u>Patient Safety Alerts</u> It has been confirmed that "Aerospacer" mattresses are not suitable for use for patients with unstable spines.	
2.3	<u>RTT Backlog clearance</u> <u>Neurosurgery, Neurology and Neuropsychology</u> Neurology and neurophysiology are on target for 0 36- week breaches at year end. The patient cohort for 36- week breaches in neurosurgery has been reduced. Work remains ongoing.	

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	Colin Gibson investigating the patients waiting over 100 weeks for neurosurgery (pituitary tumours), it was also noted that 2/3 of the patients in this cohort are complex and require a multidisciplinary approach to surgery. The process for monitoring long waiters while they wait is currently under review, 3- 6 month reviews are being considered. Cardiology Following the previous deaths on the cardiac surgery waiting list it was agreed that ongoing monitoring would be done by the cardiologists, the process for reviewing such patients is currently under review as there is concern that they are not being routinely monitored in C&V. This matter has been discussed at DMT on 26/02/2018.	
2.4	Healthcare Associated Infections In February there have been 1 case of *C. Diff* and 5 cases of MSSA. There have been no cases of MRSA since October. Both *C. Diff* and E. Coli cases are in line to meet Health Board targets. VS is currently investigating a probable transmission case of carbapenemase-producing Enterobacter (NDM) involving Critical Care, T4 & B4N. The index case is yet to be identified. A meeting to discuss the case is scheduled for next week, Public Health will be attending.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee None.	
3.2	Business Continuity NG provided an update; PG is leading on this project, with all DMs taking this forward. Commencing on IT services. Each directorate should analyse their areas and identify the priorities for business continuity of essential services and restoring services. A template for IT business continuity has been circulated for completion by 05/03/2018.	**DMs**
3.3	Mental Capacity Act Audit Results Cardiothoracics A second audit was recently conducted in all areas. There has been some improvement since the last audit, but there is still work to do. Mental capacity will be discussed at the Directorate QSPE. Staff compliance with the Mental Capacity mandatory training module has massively improved, drop- in sessions organised by the Practice Educator have been very useful. CP noted that the drop-in sessions were open to everyone, not just cardiothoracic staff. Haematology Very few patients under the care of haematology have capacity issues. An audit was undertaken by the Practice Educator recently, there were no issues. MH to upload this data to the s:drive. ALAS Staff rarely encounter patients who lack capacity, but MCA documentation is very good for patients who do lack capacity. N&T There was only 1 patient in the sample for the audit, but documentation on mental capacity was good. An audit of transplant consent process underway. Julie Barrell is to speak at the directorate QSPE meeting. Neurosciences MCA compliance is good overall. Ward 7 at Rookwood has few patients with mental capacity, assessments are only conducted for these patients when necessary (ie. when important decisions need to be made). It was also noted that audit tool confused staff a little. Critical Care	**MH**

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	Critical Care's MCA Audit was completed last year as the pilot audit and so new results were not presented this time. MCA Audit results were to be sent to HR to collate and discuss further with Julia Barrell.	
3.4	Health and Care Standards The annual Health Care Standards self- assessment must be undertaken by year end. They have been split across the CB so that all Directorates are included and each assessment is completed by an appropriate person. We have a fair bit of time to do this so quality will be high, can you request information from other Directorates for information if required so that the information in each self-assessment is relevant to all areas. The link to upload your assessments (provided in the email) is now live.	
3.5	Exception reports and escalation of key QSE issues from Directorate QSE groups None.	
PART 4: ANY URGENT BUSINESS		
4.1	Any Urgent Business None.	
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	National Report – January Returns A number of patients remarked about being cold. Clinical Board H&S minutes - Sept 2017 and Nov 2017 For information only. WHC (2018) 008 For information only.	
PART 6: DATE OF NEXT MEETING		
6.1	Friday 16th March 2018, 8am, in the Critical Care Resource room, UHW.	

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

Specialist Services Clinical Board

Quality, Safety & Experience Committee
16th March 2018

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions Rafael Chavez (RC), Consultant Surgeon, Nephrology & Transplant Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety Carol Evans (CE), Assistant Director of Nursing, Patient Safety Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board- *chair* Steve Gage (SG), Clinical Board Lead Pharmacist Fiona Kear (FK), Assistant Service Manager, Haematology, Immunology & Medical Genetics Sarah Lloyd (SL), Directorate Manager, Neurosciences Sarah Matthews (SM), Senior Nurse, Nephrology & Transplant Dale-Charlotte Moore (DCM), Directorate Manager, Critical Care Lisa Morgan (LM), Senior Nurse, Nephrology & Transplant Ravindra Nannapaneni (RN), Consultant Surgeon, Neurosurgery Bev Oughton (BO), Senior Nurse, Critical Care Sian Pring (SP), PA, Haematology, Immunology & Medical Genetics- *minutes* Jennifer Proctor (JP), Lead Nurse, Haematology, TCT, Immunology & Medical Genetics Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead, Critical Care Maria Roberts (MRo), Patient Safety Manager, Patient Safety Sian Williams (SW), Senior Nurse, Cardiothoracic Services Keith Wilson (KW), Consultant Haematologist & Medical QSE Lead, Haematology	
1.2	Apologies for absence	
1.3	To review the Minutes of the previous meeting 22nd February 2018 To be circulated for comment and ratification shortly. Matters Arising Deferred.	
1.4	Patient Story None this meeting, timetable to be developed with rolling dates for each Directorate	**GW**
PART 2: SAFE CARE		
2.1	Open Inquests INQ/IN61137- the inquest was held earlier this week and a ruling of accidental death made. An SI meeting to discuss the outcome and process closure of the matter is to be arranged. Upcoming Inquests The coroner has been approached for dates for the outstanding inquests. Open Serious Incidents There are 12 open Sis for the Clinical Board, and also 1 shared care with surgery. There have been 2 new SIs since the last QSPE meeting. Closure Forms The pancreas case from 2012 has now been closed by the Clinical Board.	

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	The fall on B1 has been closed by WAG. There are currently 5 ready for closure including the chest drain incidents which are a UHB wide issue.	
2.2	Patient Safety Alerts Confirming removal or flushing of lines and cannulae after procedures. This safety alert mainly pertains to theatres, but all areas to feedback to their QSPE meetings to raise awareness. All areas confirmed that they have safeguards in place, will reiterate local practice	**Direcs**
2.3	RTT Backlog clearance Neurosurgery, Neurology and Neuropsychology SL confirmed that by the end of the financial year neurosurgery will have 55 patients breaching the 36- week target, with 23 waiting more than 52 weeks. There will be no 100- week breaches. There will be no 36- week breaches in neurology or neurophysiology. The patient who was waiting >100 weeks will be operated on very shortly	
2.4	Healthcare Associated Infections Outbreak of NDM in Critical Care The index case was identified and isolated, but there was transmission to 3 other patients. Only the index case required treatment. Actions required. Outbreak of VRE in Cardiac ITU A meeting to discuss the matter is being held on 16/03/2018. Patient screening has highlighted more patients who have tested positive (6 on C5, 4 on Cardiac ITU). Repatriated and discharged patients who came may have been affected are to be identified. Meetings have demonstrated some issues for CITU and C5, actions to prevent further transmission are in place. Norovirus on TCT The ward has now reopened following the outbreak. The index case remains on ITU in an IPC isolation cubicle	**OM**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Feedback from UHB QSE Committee The pressure ulcer treatment pathway was approved. However All Wales guidance for the document is outstanding. The Medicines Management code has been approved. The Welsh Audit report on discharge planning was discussed, there is a lot of work to be done. Further details required A paper on patient safety solutions was presented, specifically relating to patient wrist bands. Implementation of printed wrist bands (via PMS or Clinical Workstation) is expected soon. Project work on a single point of entry for children is progressing.	**CE**
3.2	Documentation Audit Results Neuro have not completed their audits as yet due to staffing issues. N&T reviewed both medical and nursing notes. Overall documentation was good, the main failings were - lack of consultant being named on the top of the continuation sheets, VTE assessments not being completed (unless the patient was having surgery), poor documentation of discharge planning and some people used blue ink. Cardiac reported that overall the results were quite positive. However, shortfalls in	

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	documentation were found regarding patient follow up and medications on discharge and confirmation that the patient had been informed of changes in their care. There were also some issues with legibility of signatures and times of writings in the notes. Critical Care reported similar themes. There were some issues around documentation of discharge planning and evidence of relatives being informed of changes to care. JP reported that the results of the haematology audits are not yet available, but the themes are very similar to the other areas. <u>Mental Capacity</u> All audit reports should be added to the s:drive for HR to review ASAP. Please send HR the link to your file for ease of access.	**ALL**
3.3	<u>Health and Care Standards</u> All completed standards are to be submitted by the end of April (27th).	
3.4	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> *N&T* SM confirmed that the department had gone 201 days without a case of *C. Diff*. *Cardiac* None to report. *Haematology* KW stated that facilities still remained a major concern for the department and a complaint has now been received about them. The BMT service is at risk of losing its accreditation if a robust plan for improvement is not formulated in time for the next inspection. JP highlighted the lack of facilities for the PICC service. Potential areas for relocation are being reviewed, including space in SSSU and T1. *Critical Care* Over the past 3 weeks, CC have had to double their capacity due to demand. No specific reasoning could be identified to explain the increase. No adverse events as a result of this event have yet been identified, HR is to contact the consultant team to identify any shortfalls that occurred. Discussions between the DMT and CB teams are ongoing to prevent this happening again. HR wished to thank all staff from CC, anaesthetics (who were recruited to support nursing staff due to shortages) and EU for all their hard work during this difficult period.	**HR**
PART 4: ANY URGENT BUSINESS		
4.1	<u>Any Urgent Business</u> SG noted that the cancer thrombosis clinic at Velindre is being discontinued, which will put a number of patients at significant risk. Raza Alikhan reported this as a risk at the recent medicines management meeting at it will put significant pressure on the DVT service at UHW. Graham Shortland has approached Velindre for more information.	
PART 5: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	<u>Received and noted for information:</u> 2 minutes of your time Report/National Report for February have been returned.	
PART 6: DATE OF NEXT MEETING		
6.1	Thursday 5th April 2018, 8am, in the Critical Care Resource room, UHW.	

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Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 15th February 2018 09:00-11:30
Venue: Right hand side Pathology Seminar Room

Attendees:	Jason Roberts	Katherine Prosser
Jane Murphy	Gillian Spinola	Emma Mitchell
Sian Brookes	Ben Durham	Jennie Palmer
Gemma Murray	Suzie Cheesman	Derek King
Alex Scott	Angela Jones	

Preliminaries		**Actions**
A1	**Welcome & Introductions** KP opened the meeting until JR arrived	
A2	**Apologies for absence** Lisa Graham, Fran Wilcox, Lisa Harwood, Wayne Parsons, David Pitchforth, K Rockey, S Nicholas	
A4	**To receive the Minutes of the previous meeting** **Matters Arising** - NATSSIP – Report shared - GM – update on blood transfusion competencies, being presented today Ian Dovaston to update the presentation with Clinical Gerontology figures	**ID**
GOVERNANCE, LEADERSHIP AND ACCOUTNABILITY		
1.1	**Patient Story Emergency/Acute Medicine** BD presented an SBAR to demonstrate the improvement in collaborative working for staff to improve patient experience within Ambulatory Care units across Acute/Emergency Medicine ACU into MEACU Collaborative workir	
1.2	**Feedback from UHB QSE Committee** Link is attached for information http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee-	
1.3	**Directorate QSE minutes – exception reporting** • Emergency Medicine - minutes received – JR referenced the 16 – 17 year old CAMHS booklet that was noted to be working well • Clinical Gerontology QSE is taking place this afternoon • Internal Medicine not due until 17th April • Acute Medicine was held 14th February	**BD** to forward Acute Medicine Minutes **SOB** to bring CAMs booklet to next meeting
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**Major Trauma Centre up date** Unfortunately Dr M Rossiter was unable to present secondary to clinical duties, to bring forward – date to be agreed	
2.2	**NICE/Clinical Audit** A Scott presented on NICE Guidance and expectations with returns compliance for outstanding submissions Best practice 2018-19 Clinical Audit Plans – it is hoped that with the implementation of electronic AMaT will accurately reflect audits that are being undertaken and will improve monitoring of compliance	
2.3	**Flu Plan 2017 up date**	

	Flu Uptake is currently 65% (The UHB has the highest uptake with 11.7% increase. As a clinical board we have increased our uptake by 19.9%. Figures are yet to be validated yet but the winner achieving 82% is Children's and Women Clinical Board. We have nominated our flu stars as a group of new champions and are still waiting to hear back from the Communications Team on when these will be presented. KP expressed her thanks to all of the Flu Champions that have done such and amazing job this year in supporting the Clinical Board achieve target for the first time.	
SAFE CARE		
3.1	**Serious Incidents** It was noted that there has been a significant increase in the number of Serious Incidents reported to Welsh Government over the last two months. In January 4 Injurious injuries (one of which was reported but following further review no fracture was evident) and 7 healthcare acquired pressure damage were reported to Welsh Government. The Clinical Board recognises the significant increase in the number of health care acquired pressure damage being reported, in conjunction with the UHB Tissue Viability Task and Finish Group ongoing education/work is being implemented across the UHB with the support of the Patient Safety Team. WG closure forms for discussion and shared learning: In59682/In60709 – Grade 3 health care acquired pressure damage. The All Wales Pressure Damage Tools identified that both patients had pre-existing Grade 2 pressure damage on admission to the UHB which evolved into Grade 3. Both patients had significant risk factors and co-morbidities that increased the potential risk of deterioration. Risk assessments, Skin Bundles and the correct mattress selection was used and completed in line with UHB best practice. Learning identified was that whilst both patients had core care plans completed they lacked individual patient information and were not updated to reflect changes to the patients' skin integrity. In61527/In60122 – Grade 3 health care acquired pressure damage. The All Wales Pressure Damage Tools identified that both patients had pre-existing Grade 2 and moisture lesions on admission which evolved into Grade 3 pressure damage. Both patients had significant risk factors and co-morbidities that increased the potential risk of deterioration. Risk Assessments, Skin Bundles and care plans were completed and up-dated in line with UHB best practice. Evidence of timely referrals to Tissue Viability and appropriate mattress selection. Learning identified that there was no evidence to suggest that the patient/relatives/carers were involved in forming the patients' plan of care. In59320 – Grade 3 health care acquired pressure damage. The All Wales Pressure Damage Tool identified the patient had significant risk factors that a pre-existing wound to the left ankle including admission for sepsis, normally bed bound, incontinence and NG feeding which was intermittent secondary to the patient aspirating. All risk assessments and body map were completed and up-dated in line with UHB best practice. There was a failure to note and review the dressing to the ankle on admission which was well known to primary care prior to admission. When this was reviewed a grade 3 pressure ulcer was noted. All staff have been reminded of the importance of timely reviews of patients dressings to inform the correct grading and treatment plan on admission. In60202 – Grade 3 health care acquired pressure damage. The All Wales Pressure Damage Tool identified that the patient had pre-existing Grade 2 pressure damage on admission. In addition the patient had risk factors which increased the risk of further deterioration including poor mobility, peripheral vascular disease, which later required surgical intervention, and malnutrition for which NG feeding was recommended but the patient declined. Risk Assessments and body maps were completed in line with UHB best practice and despite involvement and encouragement from all multi-disciplinary colleagues the patient remained extremely reluctant to comply with advice and care being provided. The investigation noted that there was a delay in referring to speciality services, eg, Podiatry and Tissue Viability, however all staff have been reminded that support/advice can be sort from a Senior Nurse regarding the correct grading and treatment plan in the interim. In59252 – Injurious Injury. Patient sustained a fracture to the left neck of femur following an un-witnessed fall. The investigation found that there was no evidence of an actual fall noting the patient to be found sat on the side of the bed after using the commode. Further advice and support was gained from the ward consultant and Ortho-geriatrician who suspected that the mechanism of the injury was from a twisting motion rather than a fall. All risk assessments were completed and up-dated in line with best practice. The patient was nursed in an	

	observable area of the ward with the bed at its lowest with 30 minute observational checks in place. On-going education continues for falls and post falls procedures provided by Practice Development Nurses. The Clinical Board is also fully engaged with the UHB Falls Group and newly appointed falls lead as a means of sharing good practice and falls prevention. In60754 – Injurious Injury. Patient sustained a fracture to the left neck of femur following an un-witnessed fall whilst attempting to stand from a tilt/recliner chair. The investigation found that the family had requested that the foot rest of the tilt chair be left up as when left in the down position the family felt that the patient was using this as leverage to try and stand. Following a physiotherapy review the foot rest was left down which allowed the patient to leverage themselves out of the chair resulting in the subsequent fall and injury. Suspecting an injurious injury the patient was kept immobilized on the floor until a medical review could be undertaken. The Hover jack was not used to safely manoeuvre the patient from the floor and neurological observations not undertaken in line with UHB and NICE 2015 guidelines. All staff have been reminded at safety briefings for the correct post falls procedures in line with best practice. Staff have been reminded to complete appropriate risk assessments and discussion with Physiotherapy colleagues, patients/carers to ensure a clear care plan is agreed, in place and regularly reviewed in conjunction with the manufacturer's guidance and the foot rest on a tilt chair being kept up. In57718 – Injurious Injury. Patient sustained a fracture to the left neck of femur. The investigation noted that the patient had an un-witnessed fall and complained of pain in the left hip. A review was undertaken by a night practitioner noting that the patient was able to fully mobilize at that time and did not deem an x-ray was indicated. Post falls procedures were completed in line with UHB and NICE 2015 guidance. A further medical review was undertaken by the ward consultant where the patient continued to mobilize independently without any further reports of pain. A week later whilst walking back from the bathroom the patient complained of pain in the left hip. An x-ray was requested which confirmed a fracture to the left neck of femur. No further falls were reported during this time. Following Radiology advice the investigation was unable to clearly establish when the fracture occurred. All risk assessments were completed and up-dated in line with best practice with Intentional Rounding evident. A rolling educational programme continues across the Clinical Board with full engagement in the UHB Falls Delivery Group to ensure best practice is shared. All staff were reminded of the potential requirement to undertake pelvic/hip x-rays for any un-witnessed fall in line with NICE 2015 guidance. This was also shared with the UHB Site Practitioner Team.	
3.2	**Patient Safety Alert** – for wider circulation and distribution PSN 040 – Confirming removal or flushing of lines and cannulae after procedures WHC 2018 (008) – 1st February 2018 Coming into force of the intimate piercing provisions within Public Health (Wales) Act 2017 – Important to note that from February 2018 it is illegal for any person under the age of 18 to have any intimate piercing and this should be reported as per guidelines	ALL
EFFECTIVE CARE		
4.1	**Clinical Board Quality & Safety report** Dashboard shared with the group. JR noted nothing of major significance to report that is not already discussed within this meeting.	
4.2	**Feedback from IP&C group** 47 days since last MRSA Bacteraemia 37days since last MSSA Bacteraemia 21 days since last *C difficile* 7 days since E. Coli bacteraemia Full report attached MCB jan report.docx	
4.3	**Feedback from Decontamination group** Decontamination – Endoscopy improvement plan. There is a new Directorate Manager coming into post, consideration of a joint approach with surgery and radiology. New product evaluation has a projected cost saving of 6% which is currently being tested.	
4.4	**Falls up date**	

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	UHB Falls Delivery Group Feedback – Working in partnership with Public Health, community services such as Care and Repair and Welsh Fire Service exploring all options of supporting adults over 65 years of age with falls and falls prevention and the impact that this can have on secondary care. KP advised that the national falls audit completed this year will not be repeated. The focus will be on post falls and injurious injuries. Two wards within clinical board are involved in a LIPS project around falls, this includes simulation training pre and post falls procedures. KP presented information on falls within the clinical board during October and November 2017 highlighting that whilst on average the board report 160 – 180 falls per month the level of major harm is minimum with evidence of frequent fallers who had been identified as high risk and the appropriate levels of action taken in line with the enhanced supervision framework.	
DIGNIFIED CARE		
5.0	**Blood Borne Virus Clinical Nurse Specialists presentation** Apologies received secondary to workload commitments – agreed to bring forward to next meeting	**KP**
TIMELY CARE		
6.1	**Waits within Emergency/Acute Medicine** Standard agenda item – unfortunately no information provided. BD asked to feedback to ensure that this information is provided	**BD**
6.2	**Winter Pressures Ward up date** The main concern around the winter pressure ward is staffing levels. An SBAR has been submitted this week. The main concern continues to be around substantive nurse staffing with improvements in consistency noted. It was agreed that the environment was much better but remained a challenge but had improved from last year. More patients are being admitted directly from the acute/emergency streams which results in improved patient experience.	
INDIVIDUAL CARE		
7.1	**National User Experience Framework** Feedback from 2 minutes of your time survey – shared with the group and examples included negative comments around nursing levels and positive comments such as staff being extremely friendly and approachable.	
7.2	**Complaints and trends/compliments** Compliments & Good news – compliments were shared from Dermatology, Acute Medicine and Gastroenterology thanking all staff for the care, compassion and effective communication showed. Concerns – continued improvement noted for informal and formal responses. Common themes around communication, diagnosis and treatment.	
Staff and Resources		
8.1	**Staffing levels** JR shared with the meeting information around the safe staffing act for Wales. There are components that we have to be in line with, establishments are being reviewed currently. Medicine have a 26.9% uplift compared to other areas.	
8.2	**Up-date on staff training** Practice Development Nurses	b/f to next month
	PART 2: Items to be recorded as Received and Noted for Information by the Committee	
	Any Other Business – Sian Brookes – Monthly auditing is a little bit too much teams are really struggling there is no time to follow up on the action plans. Agreed that this will need to be streamlined.	

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Date and time of next meeting: 15th March 2018 09:00 – 11:30 Ty Dewi Sant Room 2/22b - cancelled

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 27th March 2018, 08:00-10:30 hours
Classroom 1, A Block, UGF, UHW

CONFIRMED MINUTES

Present:		
Richard Hughes	Chair, Consultant Anaesthetist	RH
Clare Wade	Lead Nurse, Surgery Clinical Board	CW
Ceri Chinn	Interim Lead Nurse, Perioperative Services	CC
Mark Bennion	Clinical Governance Facilitator, Perioperative Services	MB
Rafal Baraz	Consultant Anaesthetist	RB
Sally Finlay	Dietetics	SF
Adrian Turk	Pharmacy	AdT
Catherine Evans	Patient Safety Team	CE
Catherine Twamley	Pain Service	CT
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
Susan Mogford	Senior Nurse, SSSU, PCAC & Pain	SM
Graham Roblin	Clinical Governance Lead, ENT	GR
Antony Johansen (for item 2.2(	Consultant, T&O	AntJ
Gemma Ellis (for item 2.3)	Critical Care	GemE
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Ophthalmology	AJ
Angela Jones	Resuscitation Service	AngJ
Chris Williams	Clinical Governance Lead, Ophthalmology	ChrW
In attendance:		
Edwina Shackell	PA, Surgery Clinical Board	ES

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	Patient Story: Perioperative Services - deferred	
PART 1: PRELIMINARIES *(Chair)*		**ACTIONS**
18/26	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
18/27	**Apologies for Absence** Received from Linda Walker, Gillian Edwards, David Scott-Coombes, and Mike Jones.	
18/28	**Declarations of Interest** None declared.	
18/29	**Approval of the minutes of meeting held 16th January 2018** The Minutes were approved as an accurate record.	
18/30	**Matters Arising**	

	To receive Action Log from the meeting 16th January 2018 2.1.3 17/5/2011. *NPSA/2011/RR011: checking pregnancy before surgery*. It was agreed around the table that this issue needed resolution. CC confirmed that the SCB was implementing the policy, written by Children & Women. C&W ward staff being reluctant to implement the policy, it fell to Perioperative Care to pregnancy test in theatres, which was far from ideal with regard to timing and environment. **Action: update to be provided at the next meeting by Linda Walker**. 17/090 21/11/17. *Line insertion Service*. **Action: update to be provided at the next meeting by Linda Walker** *IPG 575 – Trabecular stent bypass microsurgery for open-angle glaucoma*. Chris W confirmed that neither of the glaucoma surgeons undertake this surgery. **CLOSED** 18/07 & 18/11 16/1/18 National Hip Database Report – Agenda Item. **CLOSED.** 18/11 16/1/18 Perfusion *Cleaning Protocol.* Revised protocol written and sent back to Specialist Services CB for approval. **Update next meeting.** 18/11 16/1/18 *Procedure for provision of TTHs Urology A5. Proposed adapting process to be embedded in adult SSSU*. AdT had spoken with Louise Williams. Andy Jones to pick up with AdT outside the meeting. **CLOSED.** 18/12 16/1/18. *NG 79 October 2017. Sinusitis (acute); antimicrobial prescribing*. Chris W advised not relevant, for Primary Care. **CLOSED.** 18/12 16/1/18 FSN SP17-001/A, 6/12/17. Gelatin Sealed Polyester & Gelatin Sealed ePTFE products (Vascutek). Signed report received **CLOSED.**	**Linda Walker** **Linda Walker** **BJ** **ES to update NICE log**
18/31	**Work Plan 2018 – 2019** Reference was made to the workplan. Any comments direct to Edwina Shackell prior to the next meeting.	**ALL**
18/32	**Terms of Reference – Annual Review** All to review, all comments to Edwina Shackell prior to the next meeting.	**ALL**
PART 2: PATIENT SAFETY AND QUALITY		
18/33	**Standing Item: NatSIPPS Progress report** All gap analysis submitted. Now need to develop an area and procedure LOCSIPs for each area. Templates are in the NatSIPPS folder on the shared drive. Need to be also on audit schedules for each procedure. Pilot areas are currently Radiology and Dental, prior to wider roll out. There are separate groups looking at specific procedures, e.g. central lines, Barbara Bahlmann leading. Timescale – by October 2018 for specific procedures. Area LOCSIPPS as soon as possible. Perioperative Care area LOCSIPP will be completed and made available as an exemplar. Guidance on what is an invasive procedure is located here: \\cav-vstor11\department2\Patient Safety IS\NatSSIPs Action Plan from Task & Finish Group to be circulated. **Action: BJ/ES**	B**J/ES – actioned 27/3/18**
18/34	**National Hip Database Annual Report** Mr Johansen described the patient pathway for a typical frail elderly hip fracture patient. All data for the UHB and Wales is in the public domain on NHFD.co.uk. Focus throughout the year is on improvement in the UHB year on year. The mortality rate in 2013 drew the attention of the then Executive team and plans were made to address this. All patients are now admitted to an acute and rehab bed and admitted to our own wards. A report is	

	submitted to WG annually. Indicators for the whole of Wales could improve perhaps indicating that there are issues to be addressed across the whole of Wales It was explained that the Best Practice Tariff in England, where fines are imposed for breaches, ensures that every patient receives the best quality care. Eg in Wales, physiotherapy availability the day after surgery is lower than in England. Currently less than 2/3 of patients are getting out of bed after surgery. In 2007 there had been an investment in physiotherapy, resulting in a reduced LOS however The current LOS is approximately 14 days longer than England, although the T&O directorate is proactive at getting people home. The Average time to ward from EU is 11.6 hours, Currently less than 8% reach the orthopaedic ward within 4 hours this would improve if we were able to ring fence beds on B6 for major fractures Mean fast time is 12.5 hrs – waiting for theatre. Albeit accepted that e.g. clear fluids 2 hrs prior to theatre is safe, some patients continue to be fasted for a longer period Mr Johansen explained that there is currently no anaesthetic lead for the trauma team. There is no standardised anaesthetic care, i.e. spinal or general In 2017, Time to theatre reached national average for first time. As part of the planning for ERAS, a number of patient notes had been reviewed, which highlighted a concern regarding standard of care. Key issues included: - No clear post-operative anaesthetic plan. This is of concern for the management of the patient. - Handover between could be improved between anaesthetic and Hip fracture team **Action: To be discussed at Anaesthetic Q&S and invite Mr Johansen to present** With regard to patient safety, inpatient hip fractures within the UHB were higher than the national average, Reference was made to the National Audit of Inpatient Falls. However Surgery Clinical board has shown a significant 50% reduction in Inpatient injurious falls from April 2017- March 2018. These are reported via the Clinical Board Nursing Board meetings **Discussion:** - Pockets of improvement had been tried over the years. . The key is to identify what is best practice for each patient and how we do it. It was felt this could improve by widening MDT working **Action: To be discussed at Anaesthetic Q&S and invite Mr Johansen to present** - It was felt not possible to set up a system comparable with England Best Practice Tariff, where weekly reviews are undertaken, - It was agreed that part of the solution was within the gift of the Clinical Board. - Post-operative anaesthetic plans were agreed as a positive idea. It was noted that, although the WHO Sign Out compliance was improving, there was significant scope for improvement. - Reference to the AGBI report was made with regard to anaesthetic guidance for hip fracture patients. - When compared with the standardised care in the England model, the UHB does not at present have one person responsible for the quality of care for the trauma stream. - There was a need for an enthusiastic team for this group of patients. Further discussion would take place outside the meeting with regard to anaesthetic care for this patient group. Mr Johansen would be meeting with the Anaesthetists on 17th April.	**RB** **RB**
18/35	**Sepsis Update (deferred Jan 18)** GE gave an overview of the presentation (saved on the shared drive, SSG Q&S) which had been presented to all Clinical Boards following World Sepsis Day, September 2017. The following were highlighted: - 2,200 deaths in Wales per year at a cost of £150m	

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	- 'Sepsis Six' was described. - UHW data showed a reduced mortality in the previous 3-4 years, through implementation of NEWs, and Outreach. -UHL mortality (33%) had not been impacted, as there was no outreach. This was higher than the national average. - Acute Kidney Injury (AKI) correlation with sepsis: 7.2% of AKI patients had sepsis; the. % of sepsis patients with AKI = 17% - Where we are now: - Sepsis Medical and Nursing Lead in place - UHB wide Sepsis Interest Group convened - Sepsis trolleys in place - Web page up and running - Deanery funded Sepsis Simulation days - Primary Care & WAST collaboration. - New NICE compliant Sepsis 6 pathway from Sept 2017. - Compliance data is reported monthly to WG. - Stickers introduced with new pathway. - Driver diagram for Sepsis. - Significant work is being taken forward over the next 12 – 18 months. - Making Sepsis Personal, developed by Nottingham. The 'flag' system was explained for sepsis patients admitted to Critical Care. - World Sepsis Day – annually in September. Actions from CB: Focus on improving compliance with Sepsis Six. Compliance is variable 40 – 70%. Good work is ongoing with John Dunne, in the education of Drs.	
18/36	**Director of Nursing Q&S Report February 2018** Annual report – received, for taking back to Directorate Q&S.	**ALL**
18/37	**PCA Morphine Stickers and Anti Emetic Prompt** Catherine Twamley explained that the pre-printed Morphine PCA stickers currently in use also incorporate the prescribing of naloxone and cyclizine as an anti-emetic. New stickers need to be ordered. The use of cyclizine is now limited to Recovery as a stock controlled drug although some specialties continue to use it and it remains available in their areas. This has caused a number of problems. To overcome this, the label has been revised, so that rather than stipulating a specific anti-emetic there is merely a prompt which will allow for appropriate prescribing as indicated across all areas and in accordance with changing trends. At least one anti-emetic should still however be prescribed. AdT advised that voluntary guidelines had been sent out. These need to be circulated to anaesthetists, to consider what agent is best for the patient. Discussion followed around the table regarding specific anti-emetic agent. **Action: To be discussed at Anaesthetic Q&S**.	**RB**
18/38	**Directorate Assurance Reports:** 1. General Surgery & Wound Healing. Nil outstanding. Low Rise beds brake faulty mechanism added to Risk Register. There is an immediate investment in changing all those beds. Will own beds as a HB. 2. ENT, see General Surgery combined report above. 3. Perioperative Services. Every operating theatre (40+) will be subject to quad audit. Incident – UHL surgery patient had not been admitted to a ward area, no pre-operative checks completed. Incident – debris on kit, operation cancelled Incident – wrong kit ordered Incident – Surgery on child not admitted to ward area	

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	Incident – wrong site surgery Never Event Compliance with NatSIPPs to be discussed. Action log assurances from previous meeting all completed. 4. Anaesthetics: Safe transfusion practice, escalated to Directorate Q&S. Training sessions blood bank workshops undertaken. 3 Mortality and Morbidities presented. Changeover from current luer to non-luer for spinal epidurals: Work in progress in Wales. Cardiff and Vale is likely to be the last Health Board to make the change in order to ensure that the full range of equipment is available. Anticipated by Spring 2019. Affects chemotherapy, oncology, pharmacy, general medicine, urology, neurosurgery, spinal, radiology and emergency departments. **Action: Agenda item for next meeting: SBAR for training for Staff**. 5. Trauma & Orthopaedics. Additions to Risk Register: Low rise bed brake fault, and delay to treatment due to unavailability of long lines, in particular at Llandough. 6. Urology & Ophthalmology. See combined report for General Surgery above.	**ES**
18/39	**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: One incident, arterial cannula on removal, tip remained in patient. The tip was retrieved from the patient and the item has been sent to STML for testing. ▪ Trauma and Orthopaedics: nil	
18/40	**Policies and Procedures** Approval of Business Continuity Policy & Guidance CW explained that Business Continuity Plans would need to be reviewed and updated for each directorate. CW and Tina Bayliss had been tasked as leads for this for the Clinical Board. The recent snow incident had highlighted some gaps in plans. Directorates would be contacted and asked to nominate a lead and a deputy to take this forward on behalf of each directorate. Plans would be taken to Surgery Board, and Clinical Board Health & Safety Sub Group meetings.	
18/41	**Alerts and other Safety Notices** MDA - Nil received <u>Public Health Wales</u> 1. *Infections Associated with Heater Cooler Units Used in Cardiopulmonary Bypass and ECMO – an UPDATE on the Patient Notification Exercise and Further Actions Required for Health Boards and Trusts in Wales*. Refers specifically to the decontamination of the internal workings of the unit. Mark Bennion advised that this was a national issue. This would be raised at the next Perioperative Q&S. <u>NICE Guidance</u> 2. Surgery CB summary spreadsheet. Outstanding items: – trabecular stent – not done. Sinusitis – not relevant **Action: NG77 – cataract – ES to send to Chris Williams** 3. NG37: Fractures (complex); assessment and management. SW advised that the UHB is not NICE compliant (SW) as there is currently no 24/7 orthoplastic or interventional radiology service. It was important that this was addressed regardless of the Major Trauma Centre potentially being located at Cardiff & Vale. It was highlighted that the lack of interventional radiology had resulted in a significant claim against the UHB. RH advised that it was planned to bring Interventional	**actioned 2/4/18**

	Radiologist from Royal Glamorgan Hospital to provide a service from Summer 2018, but there were as yet no details. 4. IPG595: Total distal radioulnar joint replacement for symptomatic joint instability or arthritis, SW had responded to Clinical Audit. Procedure not done at C&V. . 5. NG81: Glaucoma: diagnosis and management. DW advised that this was with the Glaucoma team. Medicines NICE guidance: **6.** AWMSG Ref 3035: Adalimumab (Humira) in the treatment of paediatric chronic non-infections anterior uveitis. ChrisW had been unable to access this. **Action: ES to forward to Chris W.** 7. AWMSG Ref 2224: Cefuroxime (Aprokam) 50mg powder for intracameral injection. **Action: ES to forward to Chris W.** **8.** AWMSG Ref 3435: Aviptadil phentolamine (Invicorp) in the treatment of erectile dysfunction in adult males –Urology, need sign off. **Action: Howard Kynaston.** **9.** AWMSG Ref 3282: Desmopresssin Acetate (Noqdirna) for the treatment of nocturia due to idiopathic nocturnal polyuria in adults – Urology need signoff. **Action: Howard Kynaston** 10. NG79: Sinusitis (Acute): antimicrobial prescribing. Not relevant to acute setting. 11. TA460: Adalimumab and desamethasone for treating non-infections chronic uveitis. **Action: ES to forward to Chris Williams.** **12.** TA486: Aflibercept for treating choroidal neovascularisation. **Action: ES to send to Chris Williams.** 13. TA467: Holoclar for treating limbal stem cell deficiency after eye burns.- advanced medical therapies. **Action: ES to send to Chris W** 14. NG77: Cataracts in adults: management. Duplicate. 15. TA369 Ciclosporin for treating dry eye disease that has not improved despite treatment with artificial tears. **Action: ES to send to Chris W** <u>Patient Safety Notice</u> 16. PSN040: January 2018. Confirming removal or flushing of lines and cannulae after procedures. Relevant for Anaesthetics, on anaesthetic chart, practice now embedded. **Action: RB will recirculate.** Mark B advised that from the Welsh Government perspective, this should be added to the WHO checklist, but this is not straightforward. CW proposed that it should be stated that this has been risk assessed locally. <u>Field Safety Notice</u> 17. FSN SP17-001/A, 6 December 2017: for Gelatin Sealed Polyester and Gelatin Sealed ePTFE products (Vascutek) – signed off Risk Assessment. **Actioned.** <u>Welsh Government Briefing:</u> 18. WHC (2018) 008: 1/2/18. Coming into Force of the Intimate Piercing Provisions within the Public Health (Wales) Act 2017. **Noted.**	**actioned 2/4/18** **actioned 2/4/18** **HK** **HK** **actioned 2/4/18** **actioned 2/4/18** **actioned 2/4/18** **actioned 2/4/18** **Raf Baraz**
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
18/42	**Key Messages from Board/ Committees/ Groups** 1. <u>UHB Medicines Management Group Minutes 18th January 2018</u>	

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	○ 3e: All Wales Drug Charts. ALL 2012 charts MUST BE REMOVED. AJ confirmed that all ward areas had been checked. To maintain vigilance. ○ 4d: New Treatment Fund. A specific concern has been raised by WG with C&V relating to delay in implementation which was not escalated to WG. Recommendations to strengthen the internal process and ensure escalation to HSMB/CEO where any delay were accepted. ○ Item 9b: Protocol- Insulin dose adjustment by dietitians working in adult services 2. <u>UHB Medicines Management Group Minutes 15th February 2018</u> ○ Item 4 –Icatibant for treating drug-induced angioedema. This has been addressed. Previously this drug had not been kept, but this is now in stock should the need arise. ○ 4 c – electronic Yellow Card survey was supported. Will increase reporting. 3. <u>UHB Medicines Management Group Minutes 15th March 2018</u> ○ 3b – local intelligent network, controlled drugs, meeting April with primary care, chronic pain and mental health to build better relations. ○ Item 4a –Electrostatic pressurised intraperitoneal aerosol chemotherapy (ePIPAC) procedures and governance arrangements. Signed off by AWMMG. ○ Advanced Medical Therapies (Cell and gene therapies). Ophthalmology, orthopaedics - advance tissue engineering. Does HTA apply? GS had written to WG on behalf of the UHB to outline the implementation challenges and request extension to the NTF timeline. Discussion with WG officials has supported the need for these therapies to be implemented safely and robustly with clear commissioning arrangements across NHS Wales and a supporting process will be developed. Chris W advised that in Ophthalmology a bandage impregnated with stem cells, not the patient's own, is used. ○ 4d – Health and Care standard 2.6 (Medicines management)- midyear update. COPS prescribing. Aim to avoid handwritten prescriptions, for legibility. Ophthalmology is the biggest user of handwritten prescriptions. It is requested that the electronic system to be used where possible. It was noted by Chris W that the electronic system was found to be cumbersome, taking up to 10 minutes, which is not practicable in a busy clinic. DW noted that there had been some new staff who possibly were not yet on COPS as yet. DW asked for a list of drugs that were only obtainable from the Health Board, so that patients were not inconvenienced by being sent away with those prescriptions and having to return to Pharmacy. 4. <u>Pharmacy Report to Clinical Board 28 December 2017</u> – noted. 5. <u>Clinical Board IP&C Group – Draft Minutes 23 January 2018</u> ○ Nicky Jardine had presented on Microbiology ward rounds, which took place every Wednesday for any patient recently discharged from Critical Care and had been well received in the directorate by the clinicians. ○ Environmental audits – Hand Hygiene and Bare Below Elbow compliance had improved in recent months, in particular Orthopaedics at Llandough. 6. <u>Clinical Board Health &Safety Sub Group – Update from 7th March 2018</u> ○ Litter officers patrolling the site, employed by Cardiff Council, with the authority to fine staff, visitors and patients for e.g. dropping cigarette butts. ○ Flushing of low use outputs re Legionella. The Director of Nursing is clear that this is not the role of the registered nurse. It is the role of the Charge Nurse/Ward Manager to determine who should do this. 7. <u>UHB Water Safety Group update</u> – nil in addition to flushing, above. 8. <u>Safeguarding Steering Group (SSG) Minutes 25th January 2018</u>. Nil to report.	

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	9. Message from Medical Director/Caldicott Guardian – a reminder regarding unauthorised access to patient records. 10. Cardiff & Vale UHB Insulin adjustment Protocol for Dietitians working in adult service. Provision for dietitians to start to adjust insulin without specialist nurse present. 11. Perioperative Diabetic Study – for awareness. 12. Medical Director's Bulletin March 2018 – for information. 13. UHB Decontamination Group Minutes of meeting 8th December 2017 Meeting next Tuesday. o AER main theatres need replacement cassettes. o Laryngoscope handles, agreed to use disposable, funding needed. o Possibility of using UV decontamination units for nasoendoscopes, Mark Campbell has scoped the space available. 14. Health Care Standard 2.7 SBAR o CRB checks – all to ensure that enhanced level is in place across all areas. o Issue regarding uptake of safeguarding training, particularly with some of the medical staff groups. A bespoke training had recently been successfully completed in Ophthalmology. o Feedback has highlighted that the new e-learning Domestic Violence training is slow. Sara Richards is the Independent Domestic Violence adviser. o Learning Disability safeguarding and training – Champion training and ward resources will shortly be available. 15. Messaging Services – Do's and Don'ts – letter from Medical Director 21/3/18 No patient data or photographs. Ensure that all adhere to the guidance. An instance was highlighted by MB that a surgeon had needed to access the in-house digital photography service, did take a photo of the patient and send to colleague in Swansea, as it was deemed that the patient could have come to more harm than not, so in that case this was acceptable. SW had highlighted to the Medical Director and Mike Bond that patient care is the priority, and as long as data is anonymised and deleted, can data or photographs be sent, given there is currently no alternative in place. Information Governance is not clear MB explained that this does create conflict between theatre staff and clinicians. The issue is out of hours, when medical photography is not available. RH reiterated that phones should not be used in theatres as this puts theatre staff in a difficult position.	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
18/43	**IP&C RCA database** End of year performance: it was anticipated that the Clinical Board would meet its C.Difficile target of no more than 24 in the year. MRSA, MSSA and E.Coli targets would not be met. All incidents are rigorously reviewed via the Clinical Board Infection Prevention & Control Sub Group. Many patients are complex, with long stays and multiple moves between e.g. Critical care and wards. New targets 18/19 not yet available. Two new targets would be introduced, to be advised. RH asked all present to ask their teams to regularly review antibiotic prescribing.	
18/44	**Theatre Audits** 1. Perioperative Care Patient Consent & Laterality Audit Theatres UHL 2/18	

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	2. Perioperative Care Patient Consent & Laterality Audit SSSU Theatres 3/18 3. Perioperative Care Patient Consent & Laterality Audit Theatres UHW 3/18 4. Perioperative Care Patient Consent & Laterality Audit CHFW 3/18 Key findings: ▪ Abbreviations starting to creep back in. ▪ Patient's Consent - not printing names next to signature. Awareness is being raised in Perioperative Care. It was noted by RH that Short Stay Surgery lists are set up by Pre-assessment nurses, and that this was the source of some abbreviations. RH requested that Administration staff are included in the reminder. 5. Perioperative Care Catheter Care Documentation Audit February 2018 16 care plans were audited of which 7 were completed in full. More rigorous checking is needed. Omissions included no date of insertion, no date of removal, size of catheter. 6. Perioperative Care Bare Below the Elbow compliance January 2018 7. Perioperative Care Hand Hygiene compliance January 2018 8. Perioperative Care compliance with procedure for wearing uniform in operating theatre environment January 2018 There had been a marked improvement in compliance. Posters and virtual red lines had supported this improvement. Some issues remained regarding e.g. wearing of wrist watches, which continued to be challenged. All audits are logged with the Clinical Audit team and shared. .	
18/45	**LIPS Progress Report – End of year progress report**. The event on 2nd March 2018 had been cancelled due to adverse weather conditions.	
18/46	**Transfusion Committee** **1.** Blood Transfusion Committee Minutes of meeting 20th October 2017 2. Zero Tolerance Report February 2018 – share with teams. 3. Blood Component Transfusion Procedure – comments back to Sam McWilliams 4. Blood Transfusion Incident Report 1/8/17 – 30/11/17 All reports **RECEIVED** for noting and sharing with teams.	
18/47	**HIW/CHC/ Internal Quality visits** 1. A6N: report received – this had been presented at the Surgery Nursing Board. 2. B6: 7th March 2018 3. A5 4. Dental Hospital Theatres 5. West 4 These were part of a rolling programme of inspections by Ward Managers/Charge Nurses from other wards. The last four would be presented at future Nursing Board meetings.	
PART 5: GOVERNANCE		
18/48	**Concerns (Clinical Incidents, Complaints, and Claims)** 1. Open Sis, No Surprises: 15, reduced since the previous meeting. Outstanding SIs were quite complex. Two of the 2016 incidents had been closed in month. 2. Regulation 28 report & Open Inquests 3. Serious Incidents: Closure forms sent to WG since 1st January 2018 – 11 had been sent in since January. 4. Falls Report – a significant 50% reduction in Inpatient injurious falls within the Clinical Board. These are reported via the Clinical Board Nursing Board. 5. Pressure Damage Report – Reporting of Grade 3 and 4 had reduced. A UHB Pressure Damage Task and Finish Group was working with Medstrom regarding the types of mattresses and bed frames.	

	Action: Agenda item for Next Meeting: Directorate Annual Reviews of Pressure Damage. ES. 6. Complaints, Claims and other Concerns (i) All New Clinical Negligence claims opened 10/1/18 – 22/3/18 (ii) All Clinical Negligence Claims Settled 15/11/17 – 9/1/18. It was highlighted that one claim had been allocated to Perioperative Care instead of Spinal surgery. **Action: CW to review.** The reports were RECEIVED, and were noted as useful for Directorate Q&S discussion.	**ES** **CW**
18/49	**Patient Surveys:** 1. National Survey Report for Surgery (February 2018) 2. "2 Minutes of your Time" (February 2018) **All to note comments, share with teams, and use on information boards**.	**ALL**
18/50	**Research & Development** 1. Workshop on completion of new R&D Paperwork 2. Assessing, Arranging, and Confirming: clarifications on HRA terminology 3. Guidance Document for HRA Statement of Activities for Participating NHS Organisations in England (version 4.2) 4. Research Governance Group Minutes 6th February 2018 5. Cardiff Research Forum Newsletter February 2018 6. Glaucoma Triage Draft Guidelines & Standard Operating Practice (SOP). AdT advised that this project would look at patients who respond to treatment. For those who do not respond to treatment, the project would investigate why there may be difficulty with compliance.	
PART 6: DATES OF NEXT MEETING **Tuesday, 8th May 2018, 08.00 – 10.30. Seminar Room B, UGF, A BI, UHW.**		
PART 7: URGENT BUSINESS		
18/51	1. DOSA site work commencing today, for 12 weeks.	
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
18/52	**Alerts and Other Safety Notices** 1. *IPG597 – Processed nerve allografts to repair peripheral nerve discontinuities* – for information	
18/53	**Recent Reports & Communications** 1. Ombudsman Report 17061 – not upheld 2. Management of VCJD Cases – Risk Assessment 3. Minimising harm to residents (care settings) when flu is circulating & Influenza surveillance briefing January 2018 4. Control of Legionella and flushing audit Jan 2018 5. 2018 All Wales Endoscope Decontamination Survey – letter from Deputy CMO, WG 19/3/18	
18/54	**Directorate Q&S Minutes** 1. Anaesthetic Q&S 15th Feb draft Minutes	

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MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 23rd January 2018
8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		**Lead**
1.1	**Welcome & Introductions** Jenny Thomas, Clinical Board Director (Chair) Bev Thomas, Assistant Head of Operations & Delivery, Community Child Health Alex Scott, Patient Safety and Quality Assurance Manager Jane Maddison, Interim Head of Therapies, Community Child Health Cheryl Evans, Directorate Head of Operations & Delivery, Obstetrics & Gynaecology Michelle Abel, Infection Prevention Control Nurse Lois Mortimer, Senior Midwife, Obstetrics & Gynaecology Mary Glover, Lead Nurse, Acute Child Health Ian Sprigmore, Directorate Head of Operations & Delivery, Acute Child Health **In Attendance** Kirsty Hook, Board Secretary (minute taker)	
1.2	**Apologies for absence** Cath Heath, Rachel Burton, Suzanne Hardacre, Sarah Spencer, Rose Whittle, Paula Davies, Angela Jones, Rim Al-samsam, Louise Young, Anthony Lewis	
1.3	**To receive the Minutes of the previous meeting 28th November 2017** The minutes of the meeting held on Tuesday 28th November 2017 were agreed to be an accurate record.	
1.4	**QSE bring forward action log / Matters Arising** The matters arising from the last meeting were noted and update on actions were provided below. It was agreed that the action log would be circulated for information following the meeting for information. **Water Safety Group** Further to discussions at the last meeting, it was noted that Heather Gater has agreed to be the Water Safety Representative for the Clinical Board. **Temporary Entrance Maternity** The concerns highlighted at the previous meeting have been raised with Estates. **SBAR for Laparoscopic Colposuspension** Further to discussions at the last meeting it was noted that the Directorate are awaiting some final information to include in the SBAR and this will then be sent through to the Clinical Board for information and consideration.	**CE**

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GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Update on Gait Clinic Audit** Annemarie Jefferies, Paediatric Physiotherapist was welcomed to the group and provided an update on the Audit has been undertaken within the Gait Service. The audit was undertaken in order to see if there were any options to streamline the patients to ensure that the appropriate appointments were being offered for appropriate management of these patients and their conditions. By undertaking the audit, the efficiency of the clinic has been improved as designated appointments (half hour slots) rather than a walk in appointment (within a 2hr time slot). 5 out of 6 clinics had a 100% discharge rate for the patients with onward referrals made where appropriate. The outcomes have been very successful and patients that do not need physiotherapy have been discharged more quickly. With regards to the DNA rate, reviews are being undertaken in order to implement text reminders for patients. Discussion ensued as to the possibility of linking with orthotics as this would then streamline further for the patients requiring orthotic review. HG agreed to discuss options to link in with the orthotics team.	**HG**
2.2	**Health and Care Standards Self Assessments Deadline** The deadline for health and care standards was noted as being 01st June 2018. 12 of the standards have been linked into existing committees and therefore there are 10 standards that require self-assessments to be completed. The deadline for submission of information is 27th April 2018. Discussions ensued as to having one set of actions and one score for the Clinical Board instead of x3 separate returns. All were asked to action appropriately.	**ALL**
2.3	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **Acute Child Health** • X6 ongoing RCA's. The RCA for MM has been sent to the family • Mandatory training continues to be improved across the Directorate. Work is ongoing with regards to no study leave being agreed if mandatory training is not up to date. This has been implemented for nursing staff and medical staff. • Paediatric Parenteral Nutrition Guidelines approved by directorate Q&S. It was agreed that the link would be shared with the group for final ratification. • Blue Health Visitor forms remain an issue, the volume is increasing. Work is ongoing with regards to electronic information being shared, however this is not in all areas at present. Concerns were raised as to the information not being shared with health visiting of possible safeguarding concerns. MG agreed to review the SBAR and send back through to the Clinical Board for consideration to reduce the risks. JT agreed to discuss possible options with the Director of Nursing. MG also agreed to review interim measures in order to ensure the risk is managed whilst a solution is sought. • Tracker projection for zero 36 week breaches by the end of March 2018 has been produced and is continually monitored. A locum has been appointed from February in order to help manage these patients. There has been a shortage of surgical registrars which is anticipated to continue until all appointments are filled by the end of March. This has impacted on elective activity; however the directorate is working hard to mitigate this through external locums and agency cover. • Nurse Recruitment Open Day on 10th February 2018 and feedback to date has been very positive. Work also continues with regards to recruitment across all specialties.	**MG** **JT** **MG**

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	Obstetrics & Gynaecology • Prudent Maternity Care Paper has been received and an SBAR has been submitted to the Clinical Board • Safety Culture in Theatre is being taken forward as a LIPS Project and commenced in September 2017. Updates will be provided as this work progresses. • Joint Neonatal and Obstetrics Meeting arranged to review guidelines and address challenges. • Audit of 2017 Stillbirth rate is being undertaken in February 2018. • Procurement Report has been received for the Baby Tagging and this has been submitted to the Clinical Board for sign off. Benchmarking has been undertaken and following sign off this can be progressed through funding from Capital Bids. • External Team Building for Medics is being undertaken • Infection rate is currently at 3.9%, slightly above the All Wales rate of 3.5%. • Snack boxes have been implemented within maternity as part of the two minutes of your time feedback on overnight snack provision. • FGM Midwife has been undertaking some benchmarking to review midwifery led clinics. • Perinatal Mental Health Midwife funding has not been agreed to continue, funding is due to cease from March 2018. Further discussions are needed as to possible options to continue. • Serious Hazard of Transfusion Report has been received, with 80% of errors identified (4 cases). All staff involved have been reassessed by the blood transfusion practitioner and further study day booked to train more assessors. A database is also being collated on blood transfusion competency. **Community Child Health** • Reviews are being undertaken to purchase netbooks for the CCNS service • Transcribing in Special Schools has been highlighted as a risk and this has been added to the Directorate Risk Register. JM agreed to send a further update outside of the meeting. • Education Funded post has commenced for patients with Tracheostomy in Special Schools and this has worked well. • OT Waiting List is currently reporting 52 children breaching at 22 weeks. Work is underway to review options to improve the position to zero breaches at the end of March 2018.	**JM**
2.4	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** There were no new risks to consider for this meeting.	
2.5	**Paediatric Surgery Update** Work continues in order to address the issues within the service. A Quality & Safety Visit by WHSSC is arranged for this week. It is anticipated that one of the paediatric surgeon appointments will commence in March 2018. A locum consultant has been appointed from February 2018 in order to help manage the RTT position. Work is underway with support being received from Patient Safety with regards to Metrics from Alderhey that are being reviewed in order to look at lessons learnt and share learning. It was noted that the ward is working well and there are no specific issues regarding risk or governance at this time.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients & Staff** • X2 successful bids from Charitable Funds Committee for Beds for First Floor Maternity and IPAD's for discharging patients on First Floor Maternity. Information has been shared with the Directorate Teams with regards to the submission of bids for consideration. CE agreed to provide support if required.	

SAFE CARE		
4.1	**Closure Forms** **Incident In45102 – Misplaced CVC Line – Shared Learning** Information received from Surgery Clinical Board with regards to documentation issues highlighted as part of the RCA. It was agreed that the anonymised RCA would be requested and shared with the Directorates for raising awareness within all areas for shared learning. **Incident In57640 and review tool – to note** The closure form was noted for information and all actions have been completed.	**KH**
4.2	**Infection Prevention Control Update** • No issues with regards to Tier 1 targets to note for this meeting. • Antimicrobial audit is being undertaken on Rainbow. Discussion ensued with regards to having an antimicrobial lead for both Obstetrics & Gynaecology and ACH. The group were asked to consider leads for each of the areas.	**ALL**
4.3	**Safeguarding** **SBAR re: Healthcare Standard 2.7** Further to discussions at the last Safeguarding Committee, it was noted that a response is needed with regards to Healthcare Standards 2.7. MG agreed to discuss with O&G and CCH outside of the meeting and the SBAR will be brought to the next meeting for sharing.	**MG**
4.4	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** **Patient Safety Notice 039 - Safe transfusion practice** Noted for information. The group were asked to ensure that this is widely disseminated and reiteration of the responsibilities of all.	**ALL**
EFFECTIVE CARE		
5.2	**Medication Errors Report** The report was noted for information. There have been improvements in a number of areas and work continues.	
DIGNIFIED CARE		
6.1	**Latest Cleaning Scores Report – for information** Noted for information. Currently the Clinical Board are reporting compliance of 95% and above for all areas and there are no specific issues to note for this meeting. Concerns were raised in relation to the cleaning of non-clinical areas, as these are not a priority. Concerns were raised as to where the responsibility sits, especially in cases where they are adjacent to clinical areas or where clinical areas are accessed through non-clinical areas. It was agreed that these concerns would be fed back as to the responsibilities and requirements for cleaning of these areas.	**MA**
TIMELY CARE		
7.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes – for information** The scorecard was noted for information. It was acknowledged that there has been significant work undertaken in all areas and improvements are being made across the board. Discussion ensued as to the immunisation rates and it was agreed that this would be reviewed as to what can be implemented and improved in order to increase the uptake rate. JM agreed to review and feedback.	**JM**

	Thanks were expressed to all for the hard work that has been undertaken in order to further improve the PADR and Mandatory Training rates in the anticipation to reach the 85% target. If there are any issues with ESR and recording, please feedback for review. With regards to sickness, all were asked to check that records are closed down for long term sickness to ensure that the rates have been calculated appropriately.	**ALL**
GUIDELINES/POLICIES		
8.1	**Paediatric PN Policy for ratification** It was agreed that the link for the policy would be shared with the group following the meeting for review and comment. It was agreed that this would be considered for ratification at the next meeting.	**MG**
8.2	**Guidelines for the use by parents of cannabis oil in the children's hospital** Noted for information. This policy has been discussed at both Directorate Q&S and Medicines Management meeting. There is a robust pathway in place and following implementation within the Directorate this will be closely monitored.	
INDIVIDUAL CARE		
9.1	**Update on latest 2 minutes of your Time feedback** Work is ongoing to restart this within Community Child Health areas. The feedback machine has been implemented in some of the Children's Centres. Work continues across Acute Child Health and O&G. Information board have been implemented in all ward areas and issues are reviewed and options to address considered as this arises.	
Staff and Resources		
10.1	**Feedback on current position for PADR and Sickness** Noted as part of item 7.1 above.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
11.1	**Water Safety Group: Legionella prevention within clinical boards** Noted for information and onward dissemination across all areas in order to reiterate the requirements of actions to be undertaken.	**ALL**
ANY OTHER BUSINESS		
12.1	**Ysgol Y Deri Core Values Leaflet** The draft leaflet was shared for information. Discussion ensued and it was noted that engagement has been undertaken with the staff to produce the leaflet. It was agreed that once the final version has been received, this will be shared with the group for information and final ratification.	**JM**
	Toshiba Ultrasound Management Group The name of the company has changed and now called Canon. Further updates will be provided on the plans for the company going forward and any possible changes to maintenance contracts etc. **HSE Report – Hydro Pools** Work is being undertaken on joint working policies for all Hydro Pools. **Educational Governance** Discussion ensued as to the requirements for Educational Governance and how this can feedback through the Clinical Board Quality & Safety agenda. It was agreed that updates will be provided at future Quality & Safety meetings. Consideration of how this can be shared was	

	discussed and it was agreed that a summary would be shared from the Directorates as to what is being undertaken. SME agreed to send out information to the Directorates for consideration.	**SME**

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 27th February 2018, 8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW (HEALTH & SAFETY FOCUS)**

<u>2018 Meeting Dates</u> (4th Tuesday of the Month, between 8.30 – 10.30am unless otherwise stated below)

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

MINUTES
CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 27 February 2018
8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		Action
	Welcome & Introductions Cath Heath, Director of Nursing (Chair) Jenny Thomas, Clinical Board Director Rachel Burton, Director of Operations Jane Maddison, Interim Head of Therapies, Community Child Health Heather Gater, Interim Head of Therapies, Acute Child Health Mary Glover, Lead Nurse Acute Child Health Sarah Spencer, Senior Midwife, Obstetrics & Gynaecology Paula Davies, Lead Nurse Community Child Health Cheryl Evans, Directorate Head of Operations & Delivery, O&G Directorate Suzanne Hardacre, Head of Midwifery, Obstetrics & Gynaecology Rachael Sykes, Health & Safety Advisor Lois Mortimer, Concerns Midwife, Obstetrics & Gynaecology Bev Thomas, Deputy Head of Operations & Delivery, Community Child Health Laura Bassett, Risk Manager, Obstetrics & Gynaecology **In Attendance** Kirsty Hook, Board Secretary (Minute Taker)	
	Apologies for absence Louise Young, Angela Jones, Anthony Lewis, Alison Jones, Sarah Evans, Ian Sprigmore	
PART 1: HEALTH & SAFETY		
1.1	**To note any specific Matters Arising from the last CB H&S Meeting dated 28th November 2017** No specific matters arising to note from the previous H&S meeting.	
1.2	**Feedback from UHB Health & Safety Operational Group Meeting** Feedback was provided following the last UHB Health & Safety Operational group. It was agreed that the feedback notes would also be circulated with the minutes for information. The main areas of discussion at the meeting related to the following:- • Importance of raising manual call points if there is a fire, even if the alarm is going off as Fire Service during office hours would only send a single appliance, unless a fire is confirmed. • Safety of Pedestrians in the Tunnel is part of the overall pedestrian safety strategy. The Director of Estates will be shortly convening a Group to progress this issue. • Feedback provided on the hoists and slings, it was noted that there is still ageing stock and work is ongoing to review a corporate maintenance contract • Lone worker devices report is showing 70% compliance With regards to the Enforcement agencies correspondence report the following was noted: • <u>Road Traffic Accident</u> Remains active as remedial actions not yet implemented	

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	• Legionella • Audit findings submitted to the Water Safety Group continue to show high level of awareness but some areas have yet to implement the recording of flushing. Attendance of Clinical Boards to the Water safety Group did not allow for assurance to be given that remedial actions were implemented to close out the HSE Action Plan • Hydrotherapy Pool • A Working Group of Therapies, Estates and the Health and Safety Department has continued to actively pursue the required actions to close out HSE involvement. • Contractor Fall Reported at the meeting that no indication of any decision however, since the meeting there has correspondence with the HSE and the UHB are putting a case together as to why further actions should not be taken • **NEW Event-** Assault in Mental Health Correspondence from the HSE was received following the report of a RIDDOR whereby a staff member within mental health was assaulted during a restraint episode. Information requested was provided and to date no further correspondence has been received	
1.3	**To note the latest Health & Safety Report** The latest H&S report was noted for information. It was noted that there has been progress on the number of incidents awaiting review, with just a few that need to be reviewed. There were x2 RIDDOR incidents reported. With regards to the first incident, this is being managed through the Directorate and Estates and actions are being undertaken to resolve.	
1.4	**C&W Clinical Board Health & Safety Report Update** HG advised that work has been progressing on the H&S Report for the Clinical Board. This report will be available for all updates to be added in order for a collated Clinical Board response to be produced and updates shared as part of the Health & Safety agenda going forward. **Update from Water Safety Group** • Flushing of taps continues to be a priority and needs to be completed x3 times per week. An audit sheet is being developed which will circulated. It was noted that this is the responsibility of the ward managers. MG noted that feedback has been received from the Nurse Director that it is not the responsibility of the nurses to undertake. It was agreed that this responsibility should be delegated appropriately in order to ensure this is completed. • Hydro review has been undertaken and it was agreed that this report would be shared for information. It was noted that the feedback received has been very positive. A three monthly meeting is also being arranged for the leads responsible for the pools. • All water dispensers should not be bottle filled, they should be mains fed. The group were asked to ensure that there are no water bottle dispensers in any areas. • Legionella training day has been undertaken and the presentation will be shared for information and awareness.	
1.5	**COSSH Report for Noting** Noted for information. The group were asked to review and ensure that any outstanding areas undertake the COSHH assessment. All assessments need to be completed every three years.	**ALL**
1.6	**Workplace Inspections Update** Workplace inspection has been undertaken at Riverside Health Centre and it was noted that formal feedback is awaited, however there were specific issues raised in relation to the building.	
1.7	**Feedback from H&S Staff Side** No issues to note for this meeting.	

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1.8	**Exception Reports and Escalation of key H&S issues from Directorates** It was agreed that this would be picked up as part of the Directorate Reports within item 2.3.	
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**To receive the Minutes of the previous meeting dated 23rd January 2018 for approval** The minutes of the meeting were agreed to be an accurate record.	
2.2	**QSE bring forward action log / Matters Arising** There were no specific matters arising from the last meeting. The action log was updated and it was agreed that this would be circulated with the notes for information.	**KH**
2.3	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **Acute Child Health** • Currently there are x6 RCA's ongoing. • Mandatory Training is being undertaken and no study leave is being approved without mandatory training being completed. • Blue Health Visitor forms continue to be an issue, however the backlog has been managed and work is ongoing in order for the discharge date to be passed to PARIS. • Physiotherapy RTT wait is at 10 weeks • Nursing Open day undertaken on 10 February which was very successful. There continue to be vacancies within Physio, OT and Play Therapy which is being reviewed and managed. Reviews are being undertaken with LATCH to look at options of providing play therapy within oncology also. **Community Child Health** • Welsh Government have confirmed funding for 2017-2019 for the school immunisation programme which will allow recruitment to support the service • Ongoing risk management at Rover Way, Gypsy Traveller Site. Safeguarding concerns were disclosed and a strategy meeting was undertaken with x3 children being removed from the site. Meetings have taken place to review options to return services to the site. At present this will not be reinstated however the off-site clinics will continue to be undertaken. • Security issues within Global Link continue. There is a plan to review security for opening and locking up of the building. There are also reviews to implement a band 2 receptionist and how this cost can be split with Mental Health. All lifts have a TDSI fitted. • Meeting has taken place regarding the Medicines Code and the need to add changes for community and specifically prescribing for children in the community. • Memorandum of Understanding for the CCNS Service has been produced with legal support. It was agreed that this will be shared with the Clinical Board once ratified. • Netbooks for the CCNS service are being implemented and a pilot will be undertaken shortly. • Out of County pressures with regards to Looked after Children and out of area support needs to be reviewed in order to look at options of support and linking with ABMU Health Board. • Contracting for Continuing Healthcare has been reviewed and a Service Level Agreement will need to be produced and ratified. • Children's Charter engagement work continues and there is Child Friendly City training is being undertaken with representatives attending. • CHAT app is being reviewed for implementation within School Nursing which will have a 24hr response instead of a face to face consultation. • CCNS Locality Managers have been appointed and the Flying Start Health Manager post has been appointed. There continue to be a number of vacancies within Health Visiting.	**PD**

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	SBAR Archiving Issues at Lansdowne/Trefforest Notes have been moved from Lansdowne to Trefforest, however there are notes that remain at Lansdowne and due to current work being undertaken, there is an inability to gain access for approximately 10 weeks which is problematic as these may need to be retrieved for legal purposes. There are also a number of health & safety issues with the archiving facility within Trefforest. Concerns were raised in relation to both health & safety and governance issues due to the access available. Options are being reviewed as to having designated staff available at the facility and also a designated hopper van for transporting of notes as accessing of notes is very time consuming. The management of this facility is managed through CD&T Clinical Board. It was agreed that the SBAR would be submitted to the next Medical Records Management Group for consideration, and RB agreed to discuss with CD&T Clinical Board. **O&G** • Healthy Pregnancy Clinic has commenced • Neonatal/Obs & Midwifery Joint Meeting has commenced to review guidelines and it was noted that feedback has been very positive. A few issues have been identified as risks which have been reviewed and added to the Directorate Risk Register. • Weekly incident meetings continue in Obstetrics, however there continue to be issues with regards to Estates & Housekeeping actions as if the incidents have been reported by a directorate member, the incident remains with the Directorate. Concerns were raised that there will be a reduction in reporting if there is nothing that can be actioned or influenced. RS agreed to discuss with the Datix team as to the reallocation of incidents to the appropriate department for action. • Stillbirth Audit has been undertaken and it was agreed that this will be shared at the next Q&S Meeting for information. It was noted that there has been a significant decrease in the numbers and there were no specific themes to note. • 12 ongoing RCA's and one chronology that are being progressed within Obstetrics. In Gynaecology there is one RCA and one case review ongoing. • BFI assessment is planned for next week, no specific issues identified. Outcome will be shared at the next meeting. • Families First Funding for the Perinatal Mental Health Midwife will cease at the end of March 2018 and a POD has now been completed and submitted as part of the 2018/19 IMTP. • Work is ongoing with SANDS to create a specialised room on delivery suite to be used to care for women • Band 6 coffee and catch up was undertaken and a pulse survey has been completed following some concerns with regards to undermining behaviour. • Resilience Day is planned for May 2018 which is being supported by the RCM. • Multi-professional day was undertaken and it was agreed that the feedback would be shared once collated. • Manual Handling update training remains an issue with regards to access. It was noted that the timescales are being reviewed and it was noted that the e-learning is just an awareness module. It was noted that some areas have had training tailored to their needs. Sam Skelton is the Manual Handling advisor for Children & Women and would be able to provide further information as to the requirements based on the needs of the area and services. The two day foundation course is for staff members who have not completed any manual handling.	**BT/RB** **RS**
2.4	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** • MS 33 - Cwm Taf Health board plan to open RGH as a free standing birth enter in August 2018. C&V environmental work and 3rd theatre build not due for completion until Spring 19. It is anticipated that 635 patients will flow to C&V. Current service provision and environmental capacity will not be able to meet the demand and finance will not be in place to follow. • MS 34 - Women with a BMI 30-34.9 are not been offered OGTT routinely in pregnancy. Potential missed GDM cases relating in subsequent neonatal admission for hypoglycaemia. Uncompliant	

	with NICE guidance (2015) which states pregnant women with BMI >30 are to be offered 75g 2-hour OGTT at 24-28 weeks. • MS 35- There is a variation in the blood glucose results between the blood glucose machine on the postnatal ward and blood glucose analyser on NNU. This could potentially delay treatment and / or admission to the NNU. **Risk Register Workshop – 13th March 2018** Following a recent meeting with Sian Rowlands, Head of Corporate Governance with regards to the risk registers and review of the UHB guidance, the Clinical Board feel that it would be beneficial for a detailed review and overhaul of the Clinical Board Risk Register (and Directorate Risk Registers) to ensure that all our risks are recorded and scored appropriately, and those that can be removed taken off. A workshop has been arranged for 13th March which is being facilitated by Sian Rowlands and Rachael Sykes. It was noted that x2 staff forums within Acute Child Health have been designated to Risk. It was agreed that representatives from each of the Directorates would attend in order to review options to roll out across the Clinical Board.	**DMT's**
2.5	**Paediatric Surgery Update** Progress is being made within the service. Concerns were raised with regards to M&M and evidence is required as to ensure that there is a robust process for feedback of cases in order for lessons learnt shared and actions identified and progressed. Fortnightly meetings continue with the Executive Team. Ward Round and Handover Audits have been undertaken and these will continue in the short term.	
2.6	**Neonatal Transport** Meetings are being held in order to look at the capacity within the unit and the requirements for service ensuring that there is equity and transparency across the service. Discussion ensued with regards to concerns highlighted associated with neonatal deaths within the transport service, and it was noted that this information will need to be reviewed however there was acknowledgement that there were no specific issues for Cardiff & Vale UHB.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients / Staff** • Yoga for staff has commenced and is open to all staff groups • Walk for Offa's Dyke is being undertaken by the Chief Executive and it was suggested that a team be organised to attend some of this walk.	
SAFE CARE		
4.1	**Update on Serious Incidents** X3 SI's that have been ongoing within the Clinical Board. It was noted that work is ongoing to resolve, however it was noted that the PRUDIC SI has been raised with Patient Safety as this should not sit within the Clinical Board and further feedback is awaited. **Stillbirth – RCA** The scope of the investigation was to explore the antenatal care provided to KR and review the multitude of antenatal appointments and care provided amongst the multi professional team. This investigation found that KR has a complex pregnancy due to a combination of social needs, fetal medicine input, raised BMI and gestational diabetes. The complexity was complicated by the number of appointments and disjointed documentation and that there was a lack of a clear management plan with an identified lead professional.	

	Lessons learned • Elan midwives reminded to complete full antenatal check as well as identifying and managing social concerns • Practice has altered in MANC and there is a clear management process by the midwife running the clinic • HCSW and MCA's are reminded to sign any documented entries • Medical staff aware of highlighting any concerns to more senior obstetric Doctors • Doctors reminded about clear documented management plans and signing any entries • The purpose of GROW reinforced **Recommendations from the RCA** • Documentation guidance to be update to emphasize the need for clear documentation with a date and signature. • Elan midwives to conduct antenatal checks in addition to social circumstances • A pathway for women who have complex medical needs whereby MDT involvement is required • A refresher of the GROW process • A review of the setup of antenatal clinic.	
4.2	**Infection Prevention Control Update** **RCA Feedback** • X2 C Diff cases on Rainbow which have been reviewed and there were no concerns raised. An antimicrobial ward round is being undertaken by the Medical Director. • MRSA screening compliance is being reviewed • Hand Hygiene continues to be high and is being reported at 95% • No staff members should be in scrubs outside of the building and all were requested to challenge	
4.3	**Safeguarding** Noted as part of item with regards to the Rover Way Incident.	
4.4	**Patient Safety Alerts (internal/external)/WHC** **Welsh Health Circular 2018 008 - 1 February 2018 Coming into Force of the Intimate Piercing Provisions Within the Public Health (Wales) Act 2017** Noted for information and onward dissemination for raising awareness. **Patient Safety Notice 040 - Confirming removal or flushing of lines and cannulae after procedures** Noted for information and onward dissemination for raising awareness. **NHS Alert - CEM CPhA 2018 02a ' Esmya (Ulipristal Acetate) For Uterine Fibroids' (All Wales HB Pharmacy & Prescribing Advisors)** SBAR and action plan has been completed within Obstetrics & Gynaecology and work is ongoing. Prescribing has ceased and there is exclusion criteria being undertaken and reviewed for all patients that have been prescribed.	
POLICIES, PROCEDURES & GUIDANCE FOR APPROVAL		
5.1	**Proposal for the Introduction of a New Clinical Procedure or Technique – Laparoscopic Colposuspension** The SBAR was noted for information and final ratification. This has been agreed by the Clinical Board to progress.	

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DIGNIFIED CARE		
6.1	**Latest Cleaning Scores Report** The latest report has not yet been received. It was agreed that once received this would be shared with the group for information and action as appropriate. Joint audit rounds have been implemented in order to understand any issues and challenges that need to be resolved.	
TIMELY CARE		
7.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** Performance dashboard was noted for information. Informal concerns responses have decreased significantly and request has been made to ensure there is a robust process in order to resolve informally. 30 day response has also decreased slightly however work continues to manage these concerns.	
INDIVIDUAL CARE		
8.1	**Update on latest 2 minutes of your Time feedback** Discussion ensued as to reviewing alternative ways of gaining feedback and it was noted that the feedback machines have received positive data.	
STAFF AND RESOURCES		
9.1	**Feedback on current position for PADR / Sickness** Sickness has increased slightly, but there are no specific concerns with regards to this increase. Thanks were expressed to all for the hard work that has been undertaken in order to further improve the PADR and Mandatory Training rates	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
10.1	**January medication safety metrics** Noted for information. No specific issues to note for this meeting.	
ANY OTHER BUSINESS		
	Business Continuity Plans Work is being undertaken with regards to completing the business continuity plans for the Directorates. It was noted this is a significant piece of work however is progressing well to ensure that the plans in place are robust. **UHB Pressures** There are significant pressures within the UHB and also the current snow reports issues. It was requested that all review options to ensure that options for staff coming into work and appropriate cover arrangements have been undertaken.	**ALL**
DATE AND TIME OF NEXT MEETING		

The next meeting is scheduled for **Tuesday 27th March, Meeting Room, Clinical Board Offices, Lakeside, 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)

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Tuesday 22nd May, Council Room, UHW (H&S Focus)
Tuesday 26th June, Meeting Room, Clinical Board Offices, Lakeside

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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

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MINUTES
CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 27th March 2018, 8.30am, Meeting Room, Clinical Board Offices, Lakeside UHW

Preliminaries		Action
1.1	**Welcome & Introductions** Rachel Burton, Director of Operations Jenny Thomas, Clinical Board Director Pam Powis, Senior Nurse, Community Child Health Directorate Bev Thomas, Asst Head of Operations & Delivery, Community Child Health Matthew McCarthy, Patient Safety Advisor Anthony Lewis, Clinical Board Pharmacist Lois Mortimer, Senior Midwife Cheryl Evans, Directorate Head of Operations & Delivery, O&G Directorate Paula Davies, Lead Nurse, Community Child Health Directorate Avril Gowman, Senior Nurse, Acute Child Health Directorate Sarah Evans, Head of Workforce & OD **In Attendance** Kirsty Hook, Board Secretary	
1.2	**Apologies for absence** Cath Heath, Heather Gater, Suzanne Hardacre, Laura Bassett, Angela Jones, Mary Glover, Ian Sprigmore, Jane Maddison	
1.3	**To receive the Minutes of the previous meeting 27th February 2018** The minutes were agreed to be an accurate record.	
1.4	**QSE bring forward action log / Matters Arising** **Paediatric PN Policy** It was agreed that the link would be shared following the meeting for ratification to be taken outside of the meeting so that this can then be progressed for corporate ratification and approval.	**AG**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **ACH** • Pressure damage – RCA being completed in conjunction with Gwent as the patient attended Cardiff & Vale with the ulcer. It was also noted that there were concerns with regards to the changes made with the plaster casts in orthopaedics which has been changed and is more rigid which has resulted in x4 pressure damage. These concerns have been raised with Surgery and reviews are being undertaken to change to new plasters. • Interface with PARIS system is being rolled out • Facebook page is going really well for communication within Nursing • Champion Stigma in Mental Health training has been undertaken to allow staff the tools in dealing with patients and parents/carers. It was agreed that this would be rolled out across the Clinical Board.	

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	• Work is ongoing however there has been significant progress made with RTT within Paediatric Surgery resulting in all patients waiting >36weeks being seen and no 52 week breaches to report. **CCH** • Safeguarding supervision model pilot was taken through LIPS. The new model covers group supervision and an evaluation has been undertaken by Cardiff University, however this is a small group that has been reviewed. This will be taken to the Safeguarding Steering group for further discussion and will then be shared with the Clinical Board for discussion. Concerns have been raised with regards to the time restraints and less dialogue being undertaken with a safeguarding expert. It was felt that when newly qualified, 1:1 supervision is needed. • Grade 3 Pressure Ulcer is being reported in school. An RCA is being undertaken by Safeguarding and links are required to link in with Primary Care with regards to the health input. • X2 Medication Errors reported – one in Ty Gwyn School with regards to an expired medication and another with a duplicate dose being given in school. This was all actioned appropriately however the process is being reviewed. **O&G** • LIPS Project regarding Safety in Theatre is now completed. A montage is being developed for patient experience. It was agreed that this would be shared with the Clinical Board once completed. • 12 ongoing RCA's and one chronology and work is continuing to progress. The SI process is being streamlined in order to ensure that there is appropriate representation from Patient Safety at the weekly datix meeting. • The new security tagging system has been approved and work is now progressing for implementation. • Non hospital acquired pressure area has been reported in Gynaecology. • The new 4th stage paperwork from Obs Cymru on post-partum haemorrhage has been launched • Induction of Labour script is out for comment via the CAV parent voices page in order to review options to improve communication. It was noted that concerns have been raised with regards to the use of WhatsApp and the sharing of confidential patient information. The group were asked to be mindful of the information that is being shared ensuring that this is in line with confidentiality protocols on patient identifiable information.	
2.2	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Following the workshop held regarding the risk register, it has been agreed that a robust review would be undertaken of all risk registers to ensure appropriate scoring/adequate mitigation is included. This is currently in progress and it was agreed that the new documentation is much clearer in order to recognise and identify risks. Once the review is finalised, it was agreed that the risk register would be noted at a future meeting for final ratification. Further discussion ensued with regards to some issues that need to be reviewed and considered for inclusion within the risk register: • Bladder Service – Reviews are being undertaken with regards to the required mitigations needed to manage this risk. • Health Visiting Service – review being undertaken as to the requirements as to what can and can't be provided. PD agreed to review how this can be linked in with the First 1000 days.	
2.3	**Paediatric Surgery Update** The service is in a period of modernisation with a number of changes being undertaken. Appointments are being made to x2 locum posts initially with a view to working towards x2 substantive posts.	

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	The risks are being assessed regularly and it was noted that with mitigation the risk is currently scored as a risk of 12. Communication and patient experience on the ward is much improved and concerns with regards to waiting times have also improved. The teams are working well together which is making improvements to the pathway.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients & Staff** • Yoga sessions have been set up within Community • Virtual cycling challenge for Offa's Dyke has been set up within Global Link • Ty Gwyn are undertaking a 100 mile cycle ride. Contact AG if anyone would like to be involved. • Link to be shared with the group with regards to the Chief Executive Walk – Offa's Dyke for consideration	
SAFE CARE		
4.1	**Update on Serious Incidents** Work is progressing with regards to the outstanding 5 serious incidents. It was noted that all incidents are on track. There is one M&M review outstanding for incident number IN58701 which was also reported as a PRUDIC and it was agreed that this would be reviewed and progressed as necessary in order to finalise and close the incident.	**AG**
4.2	**SBAR's for Sign Off** **Datix Number 218751 BV** The SBAR was noted with regards to a neonatal fracture that was found at day 12 following birth. Following failure to progress in the second stage of labour the decision was made for a trial of instrumental delivery. BV was born following manual rotation. Baby BV remained on antibiotics on the transitional care ward following 3 failed lumbar punctures for 14 days. On day 12 BV was noted to have bilateral lumps and a lump on the right clavicle- subcutaneous fat necrosis – an X-ray was requested and confirmed a clavicle fracture. A full case review was undertaken and it was confirmed that there were no omissions in care highlighted. **Lessons learnt** • Documentation could be improved and the feedback has been given to the individuals involved. • Feedback to the family would have benefited from being joint neonatal and obstetric. • The family discussed their care with the Concerns & Compliments midwife. The SBAR was approved by the Clinical Board acknowledging that all lessons learnt have been shared and all necessary actions have been completed. **Datix Number 247539 SD** The SBAR outlined the case in relation to an inappropriate discharge with baby due to safeguarding concerns. A case review was undertaken where it was identified that in 2016 the patient's previous children had been removed from care due to safeguarding concerns. It was highlighted that there were discrepancies between the different systems and there was no information disclosed to the midwifery team. The review highlighted a lack of communication between the community midwife and health visitor and there had also there had been a number of social workers involved in the patients care. It was noted that although there had been safeguarding involvement in SD's previous pregnancies there was nothing to suggest any concerns noted on the maternity informatics system – E3. There was no alert on PARIS records only on her children's and no concerns highlighted from the GP. The recommendations noted were: • Midwife and health visitors to meet to discuss caseload antenatally	

	• Health visitor to cross reference antenatal list with PARIS • Safeguarding team to have access to E3 to place alerts on the system • Health visitor, GP & Midwife to have safeguarding team meeting. Discussion ensued with regards to input into Health Visiting as it was noted that health visitors only see vulnerable mothers antenatally and concerns were raised as to whether the notes had been shared between the health visiting team. PD agreed to review the detail of the case in order to understand the risks. It was agreed that further discussions would take place outside of the meeting in order to ensure that there are robust pathways in place for management of these patients. It was agreed that further actions would be agreed and shared at a future meeting in order to understand all actions and lessons learnt.	**PD/EF**
4.2	**Infection Prevention Control Update** The report was noted for information. There were no specific issues to note for this meeting. Significant improvements have been made across a number of areas, specifically in relation to hand hygiene. There has been one case of C Diff reported in month and actions are being undertaken.	
4.3	**Safeguarding** There were no items to note for this meeting.	
4.4	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** There were no patient safety alerts to note at the next meeting. It was noted that an alert has been received in relation to Risks with portable Oxygen Cylinders Alerts. This has not yet been shared but will be shared in due course.	
EFFECTIVE CARE		
5.1	**Medication Safety Metrics** Noted for information. Continued communication and good practice to continue **Medications Report** The medicines management process adopted within Acute Child Health will be rolled out across all Directorates and information will be shared from the pharmacy team. The zero tolerance is still key, however it was acknowledged that communication has improved overall.	
5.2	**New Procedure - Small Mechanical Morcellator Device** Deferred to next meeting.	
DIGNIFIED CARE		
6.1	**Latest Cleaning Scores Report – for information** Noted for information. No specific areas of concern to note for this meeting. The areas have been updated and some removed that were not associated with the Clinical Board.	
TIMELY CARE		
7.1	Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes – for information The latest scorecard was noted for information. • Number of concerns managed by informal resolution was discussed and it was agreed that a number of cases were more complex and could not be managed informally. • Hand Hygiene has improved across all areas • The Flu Awards have been achieved by the Clinical Board. The money will sit within the Clinical Board and a process for applications will be considered in conjunction with the flu champions	

	and union colleagues. Areas of staff development, team building are some of the areas that will be considered. Further communication will be circulated outlining this process in detail when the incentives are received. • 89% of patients are waiting less than 26 weeks • Therapies waiting times have been significantly improved and on track to have zero children waiting more than 14 weeks. • Further work to be undertaken with regards to job planning across all areas in order to improve the position.	
INDIVIDUAL CARE		
9.1	**Update on latest 2 minutes of your Time feedback** No specific issues to raise. With regards to the latest results reported there have been very positive comments received overall. Some issues with regards to vending machines within the CHFW has been raised. Discussions have taken place with the Catering Dept, however it was noted that unfortunately due to cost effectiveness this is not a way forward to consider. RB agreed to have further conversations in relation to other options to be explored.	
Staff and Resources		
10.1	**Feedback on current position for PADR / Sickness** 70% for PADR being reported and work continues to maintain this position. Long term sickness and short term sickness has increased. Short term sickness is starting to reduce. A number of long term sickness cases are due to return to work imminently which should also improve the position. Work is being undertaken with regards to missing drugs are being undertaken and it was agreed that following completion of these investigations, lessons learnt will be shared at this meeting for information.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
11.1	**Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2018 – 2023** Noted for information.	
ANY OTHER BUSINESS		
12.1	**Inappropriate disposal of waste on to roofs** It was agreed that this information would be circulated following the meeting.	
12.2	**Thank you to Jenny Thomas** Formal thanks, support and guidance were expressed to Jenny. Dr Meriel Jenney has been appointed as the new Clinical Board Director for Children and Women's Clinical Board and discussions are taking place as to the start date.	
DATE AND TIME OF NEXT MEETING		

The next meeting is scheduled for **Tuesday 24th April 2018, 8.30am, Council Room UHW**

<u>2018 Meeting Dates</u> (4th Tuesday of the Month, between 8.30 – 10.30am unless otherwise stated below)

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

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 24th April 2018
8.30am, Council Room, UGF, Main Hospital A Block UHW

Preliminaries		**Action**
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing (Chair) Rachel Burton, Director of Operations Suzanne Hardacre, Head of Midwifery/Directorate Lead Nurse Laura Bassett, Risk Manager, Obstetrics & Gynaecology Jane Maddison, Interim Head of Therapies Bev Thomas, Asst Head of Operations & Delivery, Community Child Health Alicia Williams, Service Manager, Obstetrics & Gynaecology Anthony Lewis, Clinical Board Pharmacist Ian Sprigmore, Directorate Head of Operations & Delivery Mary Glover, Lead Nurse, Acute Child Health Matthew McCarthy, Patient Safety Advisor **In Attendance** Kirsty Hook, Board Secretary	
1.2	**Apologies for absence** Meriel Jenney, Sarah Evans, Paula Davies, Rose Whittle, Heather Gater, Angela Jones, Louise Young, Cheryl Evans	
1.3	**To receive the Minutes of the previous meeting 27th March 2018** The minutes of the meeting were agreed to be an accurate record.	
1.4	**QSE bring forward action log / Matters Arising** **Paediatric PN Policy** The policy documentation has been completed and it was agreed that the link would be circulated for comments and sign off of the policy. **Update on Serious Incidents** Part of agenda for April meeting.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **Acute Child Health** • X5 RCA and one has been requested for external review. Update on the TA RCA investigation to be provided. • Safer Patient Medication group meet to discuss learning points from the incidents. X10 under and x10 over prescribing is a theme that has been identified but this is a national error within paediatrics. • New dignity suits have been ordered for paediatrics	

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	• Information Boards proofs have been received and the mock up is now awaited before implementation • No patients waiting over 36 weeks for treatment within Paediatrics. Tracker projection tool has been produced to monitor this going forward. • Recruitment processes are ongoing throughout the Directorate. Locum paediatric surgeon appointment is progressing. • DTOC's are reported for paediatrics **O&G** • 13 RCA's ongoing at present and x1 RCA and case review within Obstetrics • Security tagging system is progressing • Gap and Grow programme has been implemented and it was noted that capacity for scans is an issue of which an SBAR has been produced for consideration • Pressure sore grade 2 has been reported • BFI assessment feedback is still awaited. • Bid for Psychosexual Counselling service was successful for 1 session per month • Filming for the induction in labour tours are scheduled for next week • CHC report and action plan from Maternity Services has been received there were x2 recommendations with regards to heating and the maternity lifts. This has been updated and is being raised with Estates for further update. **CCH** • Flu Campaign recruitment is going forward • Security is now available at Global Link. No receptionist cover at present and a workplace inspections have been completed which could highlight patient access to the building. • Meetings scheduled for Ty Hafan Medicines Management • Supervision for safeguarding models for Health Visiting is being monitored • CHAT Health School Nursing initiative is progressing • OT Review is ongoing and meetings with staff scheduled to take place. • Introduced a monthly performance meeting to monitor the timely access. It was noted that primary mental health is currently reporting 60%, Neurodevelopment being reported at 30 week wait at the end of April. • A further meeting is awaited with the Council in relation to provision of services to Rover Way Gypsy Traveller site. • Development of the Children's Charter is being taken forward. This will include wide representation including Equality & Diversity, C&YP representatives etc and updates will be provided.	
2.2	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Discussed as part of item 2.1	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of Patients & Staff** There were no specific items to note as part of this meeting.	
SAFE CARE		
4.1	**Stillbirth Review Audit** MBRACE 2015 report recommended a multi-disciplinary approach which was the driver in setting up the Stillbirth Review forum and ensure that feedback to staff and patients was robust and joint approach. The detail of the findings were discussed and it was agreed that the presentation would be circulated to the group following the meeting. The numbers of stillbirths have decreased however there have been no specific trends identified to the causes. It was noted that all cases are reported via Datix.	

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	Themes Identified and Actions: Next Steps: Healthy Pregnancy Clinic has commenced Refresh of Safer Pregnancy Campaign There is a joint focus in reducing stillbirths which has been a very positive way forward. It was noted that all information will be included as part of the MBRACE report and discussions and information sharing takes place across Wales. The presentation has also been shared at the Your Baby, We Care Event at the SWALEC Stadium.	
4.2	**Update on Serious Incidents** 6 incidents open at present of which x2 are overdue. X1 is awaiting M&M review and it was noted that a closure form is being progressed. CH agreed to follow up for an update on the community incidents.	**CH**
4.3	**SBAR's for noting / Sign Off** **Datix Number 247539 SD** This incident relates to an inappropriate discharge home as a result of safeguarding concerns, however prior to discharge there was nothing to highlight on the system. On investigation it was found that within the PARIS System and Maternity System there were no specific flags highlighted within the patient notes, only within the previous children's notes but nothing to link all. Communication between the community midwives and health visiting were highlighted to ensure that any concerns and information can be shared. It was agreed that a clear action plan on how the recommendations can be taken forward was required to be progressed. It was agreed that a further meeting would take place outside of the meeting to discuss the way forward. **Datix Number MR 253679** This incident relates to an unexpected term neonatal admission due to an acute episode of fetal hypoxia in labour, with a background of underlying sepsis. Lessons learned: • In complex cases, where induction of labour is required and the situation falls outside the usual IOL protocol, a review at the bedside by an SSPR or Obstetric consultant should be carried out and a clear plan of care should be documented in the notes. • All staff to be made aware of the guideline which states that all women should be reviewed by the Obstetric team within 1.5 hours of the Sepsis pathway being commenced. If there is inadequate medical staffing to facilitate this it should be escalated to the Consultant Obstetrician by the Senior Midwife on duty. • If the acuity of the unit means that Obstetric reviews of high risk patients cannot be made, this should be escalated to the on call Obstetric Consultant and the Midwifery manager on call. The recommendations of the investigation noted: • An audit of the sepsis pathway with a focus on appropriate actions and timings of review. • All staff to be reminded of the escalation guideline to ensure that it is escalated if it is not possible to get a review. • Use CTG review meetings to highlight to staff the increased risk of fetal hypoxia with a background of sepsis, and the need for close surveillance in such cases. • A record should be kept of all CTG training for doctors, midwives and locum staff. The group noted all actions and it was agreed that the SBAR be approved.	**LB**

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4.4	**RCA Report for Noting** **Datix Number In55077** This RCA was shared for information and to share lessons learnt. This incident related to an incident within EU where the patient **Lessons Learnt** • Seeking support and advice with regards to the correct procedure for disposal of fetal remains following miscarriage • Numerous Requests for gynaecology review were highlighted within the report however it was noted that a further review of the notes would be undertaken to understand whether this was a lack of timely review of the patient. CH agreed to feedback once the review has been undertaken.	**CH**
4.5	**Infection Prevention Control Update** As a Clinical Board it was noted that the all targets for hospital acquired infection were met which is a significant achievement. Thanks were expressed to all for their hard work in continuing to achieve the targets, specifically in relation to hand hygiene. It was noted that one case of uro sepsis has been reported, however it was noted that this patient attended with this infection and was not hospital acquired. It was noted that C Diff figures are anticipated to increase as a result of additional testing for paediatric patients under two years. Further feedback is awaited as to the requirement of this additional screening.	
4.6	**Safeguarding** There were no specific issues to note for this meeting.	
4.7	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** **Internal Safety Notice 2018/001 Amendments to patient safety incident templates in line with the Nurse Staffing Levels (Wales) Act 2016** Noted for information and onward dissemination as appropriate. It was noted that this relates to gynaecology only at present. All establishments have been signed off and it was noted that staffing levels need to be displayed both internally and externally as part of compliance with the act. The timeframe for paediatrics is awaited. **Patient Safety Notice 041 – Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders** Noted for information and onward dissemination as appropriate. It was noted that these are used for transport only. This has been shared widely within all areas.	
4.8	**Every Baby Counts** This is part of RCOG and MBRACE reporting. It was highlighted that the neonatal deaths and HIE cases were not being reported. All cases have now been reported however there is a need to ensure that there is a joint and collaborative robust process going forward. Discussion ensued and it was noted that this should be part of the role and obligation under safe care. It was noted that the stillbirth cases are included as part of the stillbirth forum and it was agreed that the neonatal cases could be included as part of the neonatal mortality review.	
EFFECTIVE CARE		
5.1	**Medication Safety Metrics** Medication safety metrics information was shared for information. The documentation of allergy status on neonatal was highlighted and this is being review.	
5.2	**Medication Errors Report**	

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	The medication errors report was shared for information. There were no specific issues to note and the themes identified with x10 over and under prescribing will be reviewed when the final report is available. Queries were raised with regards to the top up of lorazapan and it was noted that following some incidents highlighted, learning is being taken forward within pharmacy with regards to topping up of medications (whilst acknowledging that lorazapan is not a controlled drug). With regards to Ulipristal x4 patients are on active treatment but all other patients have stopped/switched.	
DIGNIFIED CARE		
6.1	**Latest Cleaning Scores Report** Noted for information with all scores remaining persistently high at circa 97%.	
TIMELY CARE		
7.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes – for information** Very positive end of year performance with all targets for timely care being met. Thanks were expressed to all staff. There is a review of performance management being undertaken and once further information is received this will be shared.	
INDIVIDUAL CARE		
9.1	**Update on latest 2 minutes of your Time feedback** Overall positive feedback received, there were no specific concerns highlighted.	
Staff and Resources		
10.1	**Feedback on current position for PADR / Sickness** No issues to note for this meeting. Data is awaited.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
11.1	**All-Wales draft level 2 mortality review tool for information and comment** This has been shared for information and use. It was noted that the tool is very adult focussed and it was agreed that further clarity would be sought.	**CH**
11.2	**Memorandum of Understanding CCNS to note** The memorandum of understanding was shared for information. There will be an agreed care plan between the parent and carers going forward.	
11.3	**For Awareness - Contaminated Sterile Water Bottle Incident** Noted for information of a recent incident which took place within Medicine Clinical Board with regards to a contaminated sterile water bottle. It was acknowledged that a patient safety alert is anticipated.	
ANY OTHER BUSINESS		
	South Wales Alliance Marie Davies was welcomed to the meeting and provided an update on the sustainability of paediatric and obstetrics services across South East Wales. There will be a number of changes within service provision within Cwm Taf Health Board and the impact associated with this. The service model for the paediatric assessment unit at Royal Glamorgan which is being run between 8am – 8pm has been produced and pathways are being	

	developed as to how the patients will be managed. Any overnight patients will be transferred to Prince Charles Hospital. There will be an impact on our services for out of hours patients and this is currently being worked through. The plan is for the changes for paediatric will take place from September this year, with Obstetrics anticipated from February 2019. With regards to Obstetrics, the service model outlines that pre and post natal care will continue to be provided at Royal Glamorgan. The anticipated number of deliveries for UHW is circa 600. Agreement of pathways and management of patients is ongoing to ensure seamless service provision for all patients and clear operational models in place. In relation to Neonatal, discussions have taken place with WHSSC who have confirmed that there will be a full contract variation for all activity to be recovered at full costs. If full funding is received for the additional x4 costs, risks have been highlighted with regards to lack of compliance to BAPM standards and further discussions will be taken forward. It was agreed that regular updates would be provided at this meeting going forward to ensure that all are appraised of the changes as the programme progresses.	

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 22nd May, Council Room, UHW (H&S Focus)**

<u>2018 Meeting Dates</u> (4th Tuesday of the Month, between 8.30 – 10.30am unless otherwise stated below)

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

27.7

Dental Clinical Board

Minutes of Quality, Safety & Experience Committee Group Meeting
15th March 2018 at 8:00 – 10.00 AM
PG222/223 2nd Floor

Present: Mr Andrew Cronin (Chair)(AC) Eira Yassien (EY) Catherine Evans (CE) Gurcharn Bhamra (GB) Ivor Chestnutt (IC) N Drage (ND) **In attendance**: Susan Dunkeld (SD)	Sarah Merrett (SM) Dinah Jones (DJ) Prof M A O Lewis (ML)	
Apologies Received from: Julia Charles Shannu Bhatia Rowena Griffiths	James Gillespie	

27.8

		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 11th January 2018 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 15th February 2018 were received and noted. There were two completed audits presented at the last meeting. The first was a re-audit of patient satisfaction on Oral Medicine Clinics – this showed that the standard was met and patients were generally very satisfied with the Oral Medicine department.	

	The second audit looked at the monitors on the clinics to see if they were suitable for viewing radiological images. Two monitors failed (one on Orthodontics and one on Dec 2), and these are now due to be replaced. ND stated that "breaking glass" was reiterated to all. AC announced there was one more "breaking glass" incident recently and AC to update Richard Williams. AC has looked at the system and has raised concerns with Graham Shortland. EY to present to ALL administration staff AC it is essential that this is rolled out to **ALL** audits. All clinics including E&E for Emergency Medical Care, GK to arrange training and plan to role out to the rest of the UDH.	**ND/RG** **EY**
	Restorative Dentistry **- Mr G Bhamra** **Minutes from the Restorative Dentistry Audit** Group meeting on the 22nd February 2018 was received. AC confirmed that for Audits the presentations do not need to be minuted on the minutes as they block up everyone's email. They can be sent out on request. GB advised there were five presentations and all were received well: • Grace Kelly - MCA applications. • Kiran Amin - To assess referrals and submitted to EY for possible improvements. Key issues found majority 95% were from GDP's, Endo 43% and 33% had no name. Referral looking at going on-line for October 2018. • Stephanie Robinson - audit on to assess restorability of teeth indicated for root canal treatment based on radiographs and clinical assessment. (MClin dent doing similar audit GB to link up with Professor Gilmour) there are no real guidelines in place and could save on appointment times. • Polyvios Charalambous - Audit for quality of periodontal assessments for New Patients at the UDH. • Zainab Agha - A retrospective audit of complete denture patients transferred to neutral zone treatment at the UDH – Only one Consultant uses the neutral zone but from this audit more are going to use it. They also found that Primary Care dentists were afraid to do endodontics because of legalities / capabilities. GB the issue with "breaking glass was raised at the Restorative audit. IC confirmed that Endodontic referrals if suitable for the UDH/training then we accept them but if not suitable for the Schools requirements then the referrals are returned. We should be taking on only what is required.	
2.3	**Joint Orthodontic and Paediatric Dentistry** **- Ms Sarah Merrett** Minutes from the Joint Orthodontic and Paediatric Dentistry Audit Group meeting on the 15th February 2018 were received. SM informed the group that over the past few months there had been an increase in patients presenting to the Orthodontic Clinic who were over the age of 18 and had appliances placed overseas. They have been attending the Dental Hospital asking for treatment. This is now being taken up with the MCN (Managed Clinical Network) to discuss the best way for this group of patients to be treated as many do not meet the criteria for being treated within the Dental Hospital. Following on from a presentation on the 13th December 2017 on a never event, it is advised that that Paeds need to complete a WHO check list before extractions.	

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	SM informed group that Orthodontics had 2 nurses who had been on the Fluoride application course. BC chaired the last audit and raised concerns that the Agenda forms need to be reviewed at some point. SM to do presentation on IRMER at next meeting IC confirmed that Andy Ashraf was developing an Oral Surgery Checklist and that the WHO checklists have to stay for extraction. MAOL said that at the critical moment for tooth extraction that once forceps are on the tooth a second opinion / check for approval is made before extraction. GDC guidelines confirm that a dental nurse can confirm forceps on correct tooth. This has been used in Manchester with no issues and papers to be distributed to **ALL** areas.	**MAOL**
2.4	**Community Dental Service - Mr J Gillespie** JG sent CDS minutes from the 14th December 2018. DJ reported no actions. DJ said Design to smile working well – nothing to report. CE said there was a Joint locality meeting. DJ said staff were finding Datix too complicated	
2.5	**DSG HSC: Minutes of the Dental Division and School H & S Advisory Group** Nothing to report	
	GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY	
3.1	Health and Care Standards Monitoring data No Smoking And Smoke Free Environment Procedure document was tabled and discussed.	
3.2	Consent Distribution of IMCA.	
3.3	Patient Identification Policy JC meeting in UHW regarding wrists bands – update EY advised one machine will be ordered and will be kept in the GA area. This should alleviate any risks.	**AC**
3.4	Audit Plan Nothing to discuss	
	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 DJ said that Chandi is doing a PowerPoint for Health Standards	
	SAFE CARE	
5.1	Risk Register- Rowena Griffiths did not attend so left this on as: Still in progress, being reviewed and to be user friendly. Updates for all departments and RG to see CDS.	**RG**

	Inspection of hoist slings EY has been made aware. The Patient Hoist Sling inspection Procedure was tabled and discussed	
5.2	**Incident Report** Incidents: Document up to Feb 2018 was sent to the group. Datix issues /lack of reporting have been raised at all Audit groups. **New Serious Incident IRMER Breach** RG has HIW document to circulate. RG said there will be an improvement plan next week. (RG did not attend so have left this on for actioning). AC spoke with WMcL over an incident regarding multiple extractions and years later the D & E teeth had grown and required restorative treatment. There was debate whether this was a never event. AC to discuss never events at the next Welsh Dental meeting. AC stated that **ALL** the audit groups have had an IRMER presentation.	**RG**
5.3	Medicines Management Audit Report – Rowena Griffiths Nothing to report	
5.4	New Medical alerts The Confirming removal or flushing of lines and cannulae after procedures document was tabled and discussed.	
5.5	Medical devices/equipment issues Nothing to report	
5.6	Decontamination CDS WHTM01-05 Nothing to report	
5.7	HIW Inspections and report Nothing to report	
5.8	Infection, Prevention & Control Clinic inspection reports and improvement plans Nothing to report	
5.9	**NatSSIPs – Julia Charles** Nothing reported.	
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** Nothing update reported. BC has now stepped down and Vas Sivarajasingam will replace BC. Professor Morgana Vianna will be the link for the Joint Sub group.	
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. AC has documents for MCA leads 2017 will disseminate to the group • Sensory loss – EY advised group that the inspection tour of the UDH went well and will hear if UDH has been awarded the accreditation in 3-4 weeks.	**DJ** **AC**
	TIMELY CARE	
8.1	Nothing reported	
8.2	LIPS Bariatric Pathway Nothing reported	
	INDIVIDUAL CARE	
9.1	**Concerns** • Concerns Dec17 - Feb18 – this was tabled and discussed	
9.2	**Compliments** • Compliments Dec 17 - Feb18 The document was received and noted.	
9.3	**Safeguarding** Nothing to discuss	
	STAFF AND RESOURCES	
10.1	**Employee of the Month** • None reported	
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 raised smoking cessation on UHB sites and has asked Helen Poole to do a presentation on this subject. The guidelines have gone out to all staff and will be updated annually to all employees. IC will make a yearly statement on the smoking policy on his newsletter. GK submitted a patient story to the group regarding problems with SSSU not engaging with the patient. AC has asked that the patient storeys keep coming. MT & LA are getting a case ready for June 2018. AC to disseminate Patient Safety Notice - IV cover, counting instruments. Flush cannula's before leaving theatre – this should be normal practice.	**AC**

27.8

	EY – RTT will be updated to the Clinical Board. SM mentioned that the Ortho chairs are really falling apart. IC and AC are aware of this but down to funding. DJ & EY went to the award ceremonies and dental made seven entries and two were short listed. They both felt that there should be more awareness and promotion made of the Dental Hospital and CDS. EY to send IC the results of the "smiley face" survey. SM raised a suggestion for a compliment/concern box to go on each floor as not all compliments are logged especially if patients are verbally thanking staff. Need to speak with RG. CE highlighted that the action plans for the two recent Never Events had been sent to the Welsh Government. MAOL to go to all Audit groups to present an overview of Never Events.	**EY** **MAOL**

Date and time of next meeting:

Thursday 3rd May 2018	8.00 AM to 10.00AM	Ortho Seminar Room 1st Floor, UDH

27.8

Dental Clinical Board

Minutes of Quality, Safety & Experience Committee Group Meeting
3 May 2018 ~ 8 – 10 am
Orthodontic Seminar Room, 1st Floor, University Dental Hospital

Present:

Andrew Cronin (Chair) (AC)	Diana Wakefield (DW)	Catherine Evans (CE)
Nick Drage (ND)	Ivor Chestnutt (IC)	Shannu Bhatia (SB)
James Gillespie (JG)	Barbara Chadwick (BC)	Julia Charles (JC)
Mike Lewis (MAOL)		

Apologies:

Eira Yassien (EY)	Rowena Griffiths (RG)
Dinah Jones	Gurcharn Bhamra (GB)

In Attendance:
Ruth Taylor (RT) - Minutes

		ACTION
PRELIMINARIES		
	Break Glass Incidents AC presented the demonstration model provided by IT which outlines the process a user will see when accessing patient sensitive information. Sensitive results are highlighted in red and a caution message appears if this is accessed. This states that the user must have a justifiable reason for accessing the information before clicking through to the result. To date, there have been 4 incidences with the DCB – 2 relating to staff accessing their own records, 1 member of staff accessing the results of someone else and the final incident relates to someone accessing results while another user was logged in. This is being investigated further. It was agreed that these slides should be shared at all audit groups. **Never Events** MAOL gave a presentation on never events. One of the recommendations from the improvement plan following a previous never event was to disseminate information and raise awareness of what constitutes a never event. Dental never events include wrong site surgery, including wrong tooth extraction, even if re-implanted, wrong site block, wrong implant placement and retained foreign object. There have been 6 never events in the DCB since January 2016, 4 relating to wrong tooth extraction and 2 to wrong site surgery. All of these procedures were carried out under LA and involved both qualified staff and students. An overview of the process for reporting these incidents was given. MAOL will attend all audit groups to share this presentation. Following this presentation, BC suggested that this is not only shared at student induction, but is revisited throughout the training programme and set as a learning outcome. It could also be added to an OSCE station. It was also suggested that examples of near misses could be added to the presentation. AC reiterated the importance of ensuring this information is also shared with new staff members at induction and reinforced throughout the Board to show that we have a proactive approach to the management of never events.	

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	Incident Reporting Emma Stone attended the meeting and provided a brief presentation on incident reporting. This outlined the various types of incidences and the process for completing an E-DATIX incident form. A query was raised as to whether there was any evidence to show that we were under reporting and whether there were any particular areas this concerned. CE stated that there was no official data, but the data held from paper forms could be compared to the data being reported electronically to see if there has been a change since the electronic form was introduced. Concerns had been raised with the length of time it took to complete the on line form compared with the paper form and it was a possibility that individuals were not reporting incidents as it was seen to be too time consuming.	
1.1	**Welcome & Introductions** AC welcomed everyone to the meeting of the Quality, Safety and Experience Group. Diana Wakefield from the Safeguarding Team was welcomed to the meeting.	
1.2	**Apologies for absence** Received as above.	
1.3	**To receive the Minutes of the previous meeting** The minutes of the Quality, Safety & Experience meeting held on the 15 March 2018 were reviewed and amendments are required. These will be circulated once finalised. **Matters Arising** There were no matters arising.	
MONITORING & REPORTING – DENTAL CLINICAL BOARD SUB GOUPS		
2.1	**Oral Surgery, Medicine, Pathology & Radiology** **- Mr N Drage** The minutes from the OSMP Audit Group meeting held on 17 April 2018 were received and noted. ND confirmed that the Break Glass procedure was reinforced. 3 audit proposals were presented: • A service evaluation of the use of cone beam computed tomography in impacted canines at the University Dental Hospital Cardiff • Audit to assess the quality of the outpatient letters from the Oral Medicine Clinic at Cardiff Dental Hospital • An audit of the compliance by Cardiff University Oral Surgery Department to the new MRONJ protocol guidelines (SDCEP) prior to extractions (final year project) There were two completed audits presented: **Oral Pathology Request Form audit – Joshua Scaife, DCT** A retrospective audit of oral pathology request forms was carried out. This highlighted some areas for improvement in form completion and recommendations included the implementation of an electronic form or amendments to the current form highlighting mandatory fields. Unfortunately, neither of the Oral Pathology Consultants were present at the meeting to provide any comments. **Oral Surgery Referral Intelligence - Vas Sivarajasingam (Final Year Project)** This project looked at the level of complexity of referrals received in UDH. It was noted that a lot of referrals received were for Level 1 and 2 procedures, who could be treated in Primary Care. Over 50% of referrals come from 23 practices and further work needs to be done to ascertain why this is the case. Possible reasons include lack of skills/confidence of GDPs to carry out the treatment and that remuneration from the NHS was not particularly high. It was agreed that the upcoming implementation of E	

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	referrals should allow us to collect more accurate data in order to identify practices who are submitting inappropriate referrals.	
2.2	**Restorative Dentistry - Mr G Bhamra** The minutes from the Restorative Audit Group meeting held on 24 April 2018 were received and noted. It was noted that this was a low activity meeting with no presentations or documents to discuss. MAOL raised concerns that, as there were a high number of attendees, this was not a productive meeting. MAOL will write to the Audit Lead and Clinical Lead for Restorative Dentistry to highlight the importance of utilising this audit time appropriately.	**MAOL**
2.3	**Joint Orthodontic and Paediatric Dentistry - Ms S Merrett & Mrs S Bhatia** The minutes of the Joint Orthodontic and Paediatric Dentistry Audit Group meeting held on 17 April 2018 were received and noted. Fitzroy Hutchinson attended and provided an Environment presentation. The following audit was presented: **Emergency casual dental care provision in the Paediatric Dental Department** Data revealed that 21.4% of patients seen on the emergency clinic in the four months of data collection were deemed inappropriate when compared against locally agreed criteria. The recommendations were to ensure greater education of patients and general dentists as to the appropriate use of the emergency service referral pathway for the emergency service. This will be re-audited to assess the impact of the changes in due course. A DCT presented a patient story. SM discussed the IRMER incident and it was noted that this is classed as a notifiable event and not a never event. Concerns were raised with regard to where audit presentations were being stored due to the audit co-ordinator being on sick leave. RT has agreed to discuss this with Debbie Preece (DP). There were also concerns with regard the preparation of safeguarding patient notes. SB has discussed with DP and these files will now be provided. SB has developed a new compliment slip to document verbal compliments received on clinic. This will be forwarded to IC for approval.	**RT** **SB/IC**
2.4	**Community Dental Service - Mr J Gillespie** The minutes from the CDS Quality and Safety Meeting held on 14 December 2017 were received and noted. JG confirmed that there had not been a further meeting since this time, but a number of locality meetings had been held. The IRMER and Break Glass incidents have been discussed at these meetings. 4 audits carried out by DCTs were presented at the December meeting. **Review of the GA consent form used in the Royal Gwent Hospital** This showed that 10% of forms were completed with illegible hand writing. Action points were identified and have been disseminated to all. This will be re-audited in due course. **Audit on patients attending without their legal guardian** It was found that approximately 10% of children attended without their legal guardian. This meant that they had to return in order to gain appropriate consent. The recommendation was to change the appointment letter to the patient. **Parental Understanding of Fluoride Varnish** It was noted that the majority of parents were not aware what this was used for.	

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	Simplified BPE screening for under 18s. It was found that only 32% of staff were carrying out BPEs for patients aged between 7 – 17 years. It was noted that DCTs were doing so and it was qualified staff who were not. Therefore the recommendation is to increase understanding to ensure all staff are doing BPEs on a routine basis. Further audit proposals are planned.	
2.5	**Occupational Health and Safety Advisory Group (OHSAG) – Dr M Wilson** The minutes from the Dental Clinical Board and School Health and Safety Advisory Group held on 21 March 2018 were received and noted. MW was not in attendance, but provided the following report: Workplace inspections have been completed and actions are being addressed. The CU External Audit is taking place on 22 May 2018. Clinical areas may be visited and information has been circulated to all groups to ensure awareness of this audit. Emma Hingston has been appointed as the new Chair of the Clinical Safety Sub Committee. The first meeting was cancelled due to snow and has been rescheduled for May. Hand hygiene figures remain at > 95% for the second month running. 5 – 12 May 2018 is WHO Hand Hygiene Awareness Week. An audit of unused or "little-used" taps is taking place throughout the building in the context of water safety. PSN041 - Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders was tabled. This information has been circulated to the relevant UDH staff for awareness and more information has been requested to consider whether additional signage regarding their use and flow assurance are required. Access to the underground tunnels was discussed. IC confirmed that there had been a major review of the tunnel access and currently only the CRASH Team have access. All other patients need to be transferred over ground or by ambulance. JC raised concerns regarding the transfer of patients on trolleys and she will discuss this with RG. SB also raised concerns with nurses using the tunnels to collect equipment required in the CHfW from UDH. Unfortunately, at the current time, nurses will need to travel over ground to the Dental Hospital.	**JC/RG**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	**Health and Care Standards Monitoring data** Not discussed	
3.2	**Consent** Not discussed	
3.3	**Patient Identification Policy** Not discussed	
3.4	**Audit Plan** Not discussed	

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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** DJ sent her apologies. This was not discussed. **WHC 2008 (008) – Designed To Smile – Dinah Jones** DJ sent her apologies. IC confirmed that the D2S Programme remains one of the Chief Dental Officer's key priorities.	
SAFE CARE		
5.1	**Risk Register- Rowena Griffiths** RG sent her apologies. This was not discussed.	
5.2	**Incident Reports** The incident report dated February – March 2018 was received and noted. The previous incident relating to a pedestrian accident that had occurred on the ramp at the rear of the UDH building was raised. JC confirmed that this entrance can be used as an evacuation route in the event of a fire, but is not to be used as a general entrance/exit. MAOL will arrange with RT for a sign stating no entry to be displayed. The details of the recent IRMER event were not discussed. The following documents were received and noted: • **In57430 Improvement Plan - Wrong site surgery** • **In57108 Improvement Plan - Wrong tooth extraction** • **Improvement Plan Outstanding Recommendations** • **Updated Never Events information from WG.** Note was made that extraction of deciduous teeth is not a never event unless performed under GA. MAOL stated that England's 2015 document stated that this event was unlikely to cause lasting harm and was therefore not classed as a never event. Mike Pemberton has written a paper on never events and this will be a topic of discussion at the next ADH meeting in October. • **Patient Safety Team Internal Safety Notice ISN: 2017/003** • **PSN039 – Safe transfusion practice – use a bedside checklist**	**MAOL/RT**
5.3	**Medicines Management Audit Report – Rowena Griffiths** RG sent her apologies. This was not discussed.	
5.4	**New Medical alerts** The Safe Practice Reminder for all staff who use portable oxygen cylinders was received and noted.	
5.5	**Medical devices/equipment issues** Not discussed	
5.6	**Decontamination CDS WHTM01-05** Not discussed	
5.7	**HIW Inspections and report** There was nothing to discuss.	

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5.8	**Infection, Prevention & Control** **Clinic inspection reports and improvement plans** The CHC visited the Oral & Maxillofacial Unit on 15 March 2018 where they visited the clinic and spoke with staff and patients. They raised some concerns with regard to staff not introducing themselves to patients (Hello my name is). A patient satisfaction questionnaire has been developed and will be distributed to patients attending the Oral & Maxillofacial Unit shortly. The results of this will be collated and shared in due course. The CHC also raised concerns about the cleanliness of the ground floor toilets. EY has met with the Housekeeping Supervisor and daily checks of these facilities will be increased.	
5.9	**NatSSIPs – Julia Charles** It has been agreed that the first procedures to be written up are tooth extraction, root canal treatment and minor oral surgery and JC has already produced drafts documents. These will be shared with AC. Both LocSSIPs and NatSSIPs are due to be discussed at the next ADH meeting in October.	**JC/AC**
EFFECTIVE CARE		
6.1	**Monitoring of CB Clinical Audit plan** Not discussed	
6.2	**Research and development** Not discussed	
DIGNIFIED CARE		
7.1	**Initiatives to improve services for people with:** • **Dementia** Not discussed. • **Sensory loss** The DCB have been awarded the Action on Hearing Loss, Louder Than Words Accreditation. • **Mental Capacity Act** Not discussed.	
TIMELY CARE		
8.1	**RTT – Mrs E Yassien** EY sent her apologies. IC confirmed that the DCB had met their RTT target for Quarter 4. A number of waiting list initiative clinics were implemented in order to meet our target and IC wished to thank everyone for their support with these. It was also noted that we are now required to report our RTT figures on a monthly basis rather than quarterly.	
8.2	**LIPS Bariatric Pathway** Not discussed	
INDIVIDUAL CARE		
9.1	**Concerns** The concerns report dated February – April 2018 was received and noted.	
9.2	**Compliments** The compliments report dated March – April 2018 was received and noted.	

9.3	**Safeguarding – Professor B Chadwick** Diana Wakefield attended from the Safeguarding Team and provided an overview of the services she and her team can provide. She and Alice Fairman, Safeguarding midwife have been allocated to the DCB and are available to offer advice when required. DW outlined some of the training that is available including County Lines which relates to violent individuals crossing the borders from one county to another. She also highlighted the Ask to Act Form, which is available on CAVWeb and is an assessment form which can be used to identify victims of domestic and sexual violence. It was agreed that this should be shared at the OSMP Audit meeting. DW confirmed that all staff should have access to PARIS on their NHS desktop where they can review any safeguarding events that relate to an individual patient. SB asked if DW could attend a future Paediatric audit meeting to provide an overview and DW agreed. It was noted that due to an upcoming change in the Data Protection Regulations, it may not be possible to add safeguarding alerts to A&E patient records without the patient's consent. This will be discussed in more detail.	
STAFF AND RESOURCES		
10.1	**Employee of the Month** • March 2018 – Flu Champions, GA Theatres • April 2018 – Ruth Taylor, PA to Dental Clinical Board Both winners were congratulated.	
10.2	**Staffing levels – Eira Yassien** EY sent her apologies. This was not discussed.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
	The following documents were tabled at noted: • Procedure for the prevention, control & management of Multi Drug Resistant Organisms (MDRO) • All Wales Stage 2 Mortality Tool (DRAFT)	
Any Other Business		
	Nothing to discuss	

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Date and time of next meeting:

Thursday 28th June 2018	8.00 -10.00 am	TBC

PRIVATE QUALITY SAFETY AND EXPERIENCE COMMITTEE

12th June 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 17th April 2018	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting	Oral *Chair*
7	Safeguarding Update	*Executive Nurse Director*
8	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
9	Review of the Meeting	Oral – *Chair*
10	Date of next meeting Tuesday 18th September 2018	

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